# Service Array Index

<table>
<thead>
<tr>
<th>Letter</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Access and Visitation Grant Funds</td>
<td>2</td>
</tr>
<tr>
<td>B.</td>
<td>Batterer Intervention Certification Program</td>
<td>2</td>
</tr>
<tr>
<td>C.</td>
<td>Child Victims’ Trust Fund Board</td>
<td>3</td>
</tr>
<tr>
<td>D.</td>
<td>Children’s Advocacy Centers</td>
<td>5</td>
</tr>
<tr>
<td>E.</td>
<td>Child Care</td>
<td>6</td>
</tr>
<tr>
<td>F.</td>
<td>Children’s Justice Act Grant</td>
<td>9</td>
</tr>
<tr>
<td>G.</td>
<td>Children’s Review Program</td>
<td>11</td>
</tr>
<tr>
<td>H.</td>
<td>Community Collaboration for Children, Community-Based Child Abuse Prevention, and Promoting Safe and Stable Families</td>
<td>22</td>
</tr>
<tr>
<td>I.</td>
<td>Community Services Block Grant</td>
<td>23</td>
</tr>
<tr>
<td>J.</td>
<td>Court-Appointed Special Advocates</td>
<td>25</td>
</tr>
<tr>
<td>K.</td>
<td>Diversion/Intensive In-Home Services Program</td>
<td>27</td>
</tr>
<tr>
<td>L.</td>
<td>Early Childhood Mental Health Initiative</td>
<td>29</td>
</tr>
<tr>
<td>M.</td>
<td>Family Alternative Diversion</td>
<td>30</td>
</tr>
<tr>
<td>N.</td>
<td>Family Preservation Program</td>
<td>31</td>
</tr>
<tr>
<td>O.</td>
<td>Family Resource and Youth Service Centers</td>
<td>36</td>
</tr>
<tr>
<td>P.</td>
<td>Family Violence Prevention Funds</td>
<td>37</td>
</tr>
<tr>
<td>Q.</td>
<td>Health Access’ Nurturing Development Services (HANDS)</td>
<td>39</td>
</tr>
<tr>
<td>R.</td>
<td>Kentucky Center for School Safety</td>
<td>39</td>
</tr>
<tr>
<td>S.</td>
<td>Kentucky Children’s Health Insurance Program</td>
<td>40</td>
</tr>
<tr>
<td>T.</td>
<td>Kentucky Education Collaboration for State Agency Children</td>
<td>41</td>
</tr>
<tr>
<td>U.</td>
<td>Kentucky Partnership for Families and Children, Inc</td>
<td>42</td>
</tr>
<tr>
<td>V.</td>
<td>Kentucky Strengthening Families</td>
<td>44</td>
</tr>
<tr>
<td>W.</td>
<td>Kentucky Strengthening Ties and Empowering Parents (KSTEP)</td>
<td>45</td>
</tr>
<tr>
<td>X.</td>
<td>Low Income Home Energy Assistance Program (LIHEAP)</td>
<td>47</td>
</tr>
<tr>
<td>Y.</td>
<td>Michelle P. Waiver Program</td>
<td>48</td>
</tr>
<tr>
<td>Z.</td>
<td>Multidisciplinary Commission on Child Sexual Abuse</td>
<td>48</td>
</tr>
<tr>
<td>AA.</td>
<td>Office for Children with Special Health Care Needs</td>
<td>49</td>
</tr>
<tr>
<td>BB.</td>
<td>Passport Health</td>
<td>53</td>
</tr>
<tr>
<td>CC.</td>
<td>Prevent Child Abuse Kentucky</td>
<td>54</td>
</tr>
<tr>
<td>DD.</td>
<td>Standardized Screening and Assessment</td>
<td>69</td>
</tr>
<tr>
<td>EE.</td>
<td>Rape Crisis Centers</td>
<td>71</td>
</tr>
<tr>
<td>FF.</td>
<td>Safe Infants/Safe Haven</td>
<td>74</td>
</tr>
<tr>
<td>GG.</td>
<td>Safety Net</td>
<td>77</td>
</tr>
<tr>
<td>HH.</td>
<td>Sobriety Treatment and Recovery Teams</td>
<td>78</td>
</tr>
<tr>
<td>II.</td>
<td>Social Services Block Grant</td>
<td>81</td>
</tr>
<tr>
<td>JJ.</td>
<td>Solutions</td>
<td>82</td>
</tr>
<tr>
<td>KK.</td>
<td>Targeted Assessment Program</td>
<td>83</td>
</tr>
<tr>
<td>LL.</td>
<td>Trauma-Informed Care</td>
<td>97</td>
</tr>
<tr>
<td>MM.</td>
<td>Work Incentive Program</td>
<td>99</td>
</tr>
<tr>
<td>NN.</td>
<td>Y-NOW Children of Prisoners Mentoring Program (YMCA Safe Place Services)</td>
<td>99</td>
</tr>
</tbody>
</table>
A. Access and Visitation Grant Funds

Federal Access and Visitation Grant funds provided to Kentucky are under the jurisdiction of the federal Office of Child Support Enforcement and are geared toward facilitating access and visitation of non-custodial parents who are experiencing difficulty in seeing their children due to issues such as poor relationships with the custodial parent, non-payment of child support, or allegations of domestic violence. In June 2016, the grant transferred from the Department for Community Based Services (DCBS/department) to the Department for Income Support’s Child Support Enforcement (CSE) program. CSE decided to collaborate with the Louisville Legal Aid Society (LAS) to establish an Access and Visitation Hotline in an effort to educate parents in all 120 Kentucky counties about access to and visitation with their children. A memorandum of agreement with LAS began on January 20, 2017. In April 2017, the hotline went live. Once operational, publicizing of the hotline occurred through public service announcements, print, media, press releases, and the addition of hotline information to both the CSE and LAS websites. LAS hired an attorney who is responsible for handling calls received on the hotline. Callers go through an intake process to ensure they meet the guidelines to receive services through LAS. The attorney captures the following data in the intake database: gender, race, age, reason for calling, and participation in an IV-D case. Race codes were revised to mirror the federal race codes and include American Indian or Alaskan, Asian, Black or African American, Hispanic or Latino, Native Hawaiian or Pacific Islander, White, Two or More Races, Data Not Reported, and Other. If necessary, callers are referred to a partnering legal aid program located in the geographical area where the caller resides. Staff in CSE then receives the above data in addition to data regarding how the hotline served the caller. Through the end of December, 1,534 persons have contacted the hotline for assistance related to access to and visitation with their child(ren). Child support paid the LAS $137,919.61 in calendar year 2019. At this time, there are no perceived barriers with the Access and Visitation Hotline or the partnership with LAS.

B. Batterer Intervention Certification Program

On January 1, 2018, the Batterer Intervention Certification Program was moved from DCBS to the Kentucky Coalition Against Domestic Violence (KCADV). KCADV now administers the state’s Batterer Intervention Certification Program by enrolling providers, conducting training, monitoring providers, and maintaining the provider list. There is at least one certified Batterer Intervention Provider offering services in 57 counties of the Commonwealth. In general, the unserved counties correspond with counties that are underserved in many other services (in the Eastern and Southeastern parts of the state).

Batterer intervention services are not funded through any state or federal grant. Services are provided to those court ordered to attend; however, there is variability in court practice across the state. In many of the unserved counties, judicial practice does not include mandating domestic violence offenders into batterer intervention programs. In counties that are economically disadvantaged, the absence of public funds to subsidize or offset the cost to individuals further exacerbates the issues around recruiting and retaining batterer intervention providers/programs in specific locations. However, a list of batterer intervention providers and the cities they serve may be found on the KCADV website, located at www.kcadv.org.

Certified providers provide individualized treatment, and have the capacity to address issues relevant to children exposed to domestic violence, parenting after violence, and shaken pediatric abusive head
trauma. Certified providers also assess for possible substance abuse and mental health issues. In 2019, four training events were held to certify new batterer intervention providers. Approximately 94 people registered to attend the BIP Certification Training in 2019. Forty participants were trained through the certification training in 2019.

KCADV staff, Nick Davis, and Kilen Gray (both BIP service providers) serve as the training faculty for BIP Certification training. Kilen Gray focuses on Hegemonic Masculinity, how society sends messages that cause gender roles to be seen a specific way, and discusses how gender roles can get in the way of progress in groups. Nick Davis discusses the specifics of BIP service provision and the needs of the BIP participants.

One of KCADV’s responsibilities is to monitor BIP providers. In 2019, KCADV completed site visits with 10 different providers and followed up with each provider to provide technical assistance. We also conducted a survey in which 70 participants responded.

<table>
<thead>
<tr>
<th>Batterer Intervention Program Data: 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Category</strong></td>
</tr>
<tr>
<td>Batterers Assessed*</td>
</tr>
<tr>
<td>Civil/DVO Referral</td>
</tr>
<tr>
<td>Criminal/Post-Conviction</td>
</tr>
<tr>
<td>Diversion</td>
</tr>
<tr>
<td>DCBS Referral</td>
</tr>
<tr>
<td>Self-Referral</td>
</tr>
</tbody>
</table>

*Referral sources are not exclusive categories and a single batterer may be referred by more than one referral source.

2019 Selected statistics:
- The average assessment cost: $59.00
- The average cost per group session: $22.60
- 135 total participants were referred for substance use disorder outpatient treatment services
- 960 total participants earned less than $30,000 per year
- 508 participants identified as Asian, Hispanic, or African American
- 525 participants ranged 18-29 in age

### C. Child Victims’ Trust Fund Board

In 1984, the passage of House Bill 486 established the Kentucky Child Sexual Abuse and Exploitation Prevention Board (CSAEP Board) and the Child Victims’ Trust Fund (CVTF). The CSAEP Board is an autonomous body within the Office of the Attorney General and exists as the sole organization in Kentucky with the statewide mission to prevent child sexual abuse. The organizational structure and duties of the CSAEP Board are set forth in KRS 15.900 to 15.940. Since its inception, the CSAEP Board has worked tirelessly to support high-quality prevention programs across the Commonwealth.
Assistance for programs has taken many forms, most notably financial support for prevention projects. Grants funded through the CVTF have been awarded to community and professional organizations throughout Kentucky, with technical assistance and operation oversight provided to the recipients. The CSAEP Board is increasingly aware of the need for funding prevention programs that engage in community education and enhance public awareness. The CSAEP Board also supports the regional Children’s Advocacy Centers (CACs) throughout the Commonwealth by providing supplemental funding for child sexual abuse medical examinations. The mission of the CSAEP Board is to help provide for the safety of Kentucky’s children by preventing child sexual abuse and exploitation through educating the public, funding innovative programs, and shaping public policy. The CVTF provides funding for regional and statewide prevention programs and reimbursement associated with the costs of medical examinations at CACs. The CVTF also provides for the education of professionals at conferences.

Regional Prevention Grants
Fiscal Year 2020 – awarded more than $85,000 to the following agencies: Child Watch Counseling and Advocacy Center
  - Funding will provide training to more than 12,000 children in the western region of the state and approximately 300 children attending the Boys and Girls Ranch.
    - The Safety Tools and Golden Rules training serves Ballard, Caldwell, Calloway, Carlisle, Fulton, Graves, Hickman, Livingston, Marshall, and McCracken Counties, as well as the campers of the KY Sheriffs’ Boys and Girls Ranch.
    - The curriculum delivers sexual abuse prevention education to preschool and elementary school aged children in schools. Primary topics discussed are body safety, abuse prevention, and internet safety.
  - Family Nurturing Center
    - Funding will provide 225 Stewards of Children trainings in the Northern region of the state to 3,000 adults.
      - The Stewards of Children training model serves Boone, Campbell, Grant, and Kenton Counties.
      - The training promotes core competencies in the areas of prevention strategies, recognizing the signs of sexual abuse, reporting requirements, and responding appropriately to disclosures. The training also includes a unique motivational component that directly addresses reluctance to report and the necessity of shared adult responsibility for every child.
  - Phoenix Rising
    - Funding will provide education, mentorship, and encouragement to children affected by human trafficking and exploitation.

Statewide Prevention Grants
Fiscal Year 2020 – awarded $33,078 to the following agency:
  - Prevent Child Abuse Kentucky – Reinventing Our Message: Phase II
    - This project builds upon last year’s program of Reinventing Our Message: Promoting Action and Prevention. The funding will help propel messaging around child sexual abuse prevention. This effort will be the first of its kind in the nation to launch a statewide re-messaging campaign aimed at the prevention of child sexual abuse.

Statewide Public Education and Awareness
During fiscal year 2018, the board awarded $80,000 to Mike Pistorino’s Listen While I Color program. Despite the board’s efforts, partnerships were unable to be secured in order to have sufficient funding
for full implementation. Other concerns were also presented and the board ultimately voted to withdraw the program from the board’s initiatives.

**Child Sexual Abuse Medical Reimbursement Program**

The CSAEPB board assists state designated CACs by assisting with the administrative costs of the specialized child abuse medical examinations. The board’s funding provides $75 per child medical examination. Medicaid does not reimburse the CACs at the full amount, thus the local CACs are also responsible for seeking other funding sources. Additionally, CACs provide prevention education to child victims during their assessments and evaluations.

In fiscal year 2020, the CVTF awarded $74,000 to assist with the costs of approximately 990 specialized child sexual abuse examinations in 15 CACs across the state.

The CSAEPB board provides $25,000 to organizations hosting conferences related to preventing child sexual abuse.

For FY2020, the board awarded medical reimbursement grants to 15 Children’s Advocacy Centers throughout the state. Additional grants were awarded for the focus of prevention of child sexual abuse and exploitation to one statewide and three regional programs.

The CSAEPB board has made good progress and continues to meet its mission. The board recognizes its responsibility of continuing to fund quality prevention programs with CSAEPB monies and to continue to provide funding to the CACs to assist with the administrative costs associated with the child sexual abuse medical examinations conducted at the centers.

**D. Children’s Advocacy Centers**

In 1998, Kentucky adopted a statewide CAC network, which provides for one CAC in each of Kentucky’s 15 Area Development Districts. This “regional CAC model” ensures that children in every geographic area of Kentucky have access to a CAC. The state model provides a core set of standards set forth in KRS 620.020 and 922 KAR 001:580 and modeled after the standards developed by the National Children’s Alliance. These standards require Kentucky CACs to provide (either directly or as part of a collaborative memorandum of understanding) the following services: forensic interviews, mental health services, specialized child abuse medical exams, advocacy, court preparation, professional training, and community education programming.

Central to the CAC model is the simple, yet powerful, concept of coordination between community agencies and professionals. This coordinated response to child abuse cases is known as a multidisciplinary team (MDT). CACs, along with the other partner agencies, promote timely and effective systemic responses to child abuse by reviewing investigations, coordinating service delivery, and reaching the appropriate disposition of cases in the criminal justice system. The goals of MDTs in Kentucky, as outlined by the Kentucky Commission on Child Sexual Abuse, include (1) the safety and protection for child victims of sexual abuse and (2) accountability of the child sexual abuse service system.

The state provides a critical base of funding that is roughly half of the total amount needed to operate the CAC network in Kentucky. As private, independent non-profit organizations, CACs receive additional funding from grants, individuals, and corporate funding opportunities. CACs are also eligible to receive Medicaid reimbursements for medical exams performed onsite and pursuant to 907 KAR 3.160. CACs also receive $75 for the case management services associated with child abuse medical exams from the CVTF.
## Children’s Advocacy Center Data
### Calendar Year 2019

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Number of Services Provided/ Persons Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>New children served</td>
<td>6,587</td>
</tr>
<tr>
<td>New caretakers served</td>
<td>5,074</td>
</tr>
<tr>
<td>Advocacy services: court, case management, referrals to services</td>
<td>56,686</td>
</tr>
<tr>
<td>Medical services: comprehensive forensic medical exam, general exam, follow up exams, referrals for further medical treatment</td>
<td>694</td>
</tr>
<tr>
<td>Forensic services: forensic interviews by CAC staff, forensic interviews hosted by the CAC for trained child welfare interviewers</td>
<td>5,554</td>
</tr>
<tr>
<td>Mental health services: individual, family and group treatment, mental health screening</td>
<td>12,575</td>
</tr>
<tr>
<td>New children staffed by KY MDTs</td>
<td>5,049</td>
</tr>
<tr>
<td>Total CAC cases seen through KY’s MDTs in 2020</td>
<td>23,237</td>
</tr>
<tr>
<td>Training programs conducted</td>
<td>772</td>
</tr>
<tr>
<td>Community partners trained</td>
<td>4,810</td>
</tr>
<tr>
<td>Community awareness events</td>
<td>634</td>
</tr>
</tbody>
</table>

CACs in Kentucky continually assess the quality of services available to Kentucky’s families and communities through examination of Outcome Measurement System (OMS) survey results. Responses from over 1,600 caregivers and investigative partners surveyed in 2019 demonstrate the critical role CACs play in the investigative and healing processes. According to the survey results, 99% of caregivers describe CAC staff as friendly and pleasant. In addition, 97% of community partners indicate that CACs provide important resources that improve their ability to work. One community partner described her experience with her local CAC like this: "I could not prosecute these cases without the resources the center has to offer. Their legal advisor is like my right hand in these cases and we often work together in gathering research to respond to motions that can harm the victims or infringe upon their rights".

### E. Child Care
The mission of DCBS’ Division of Child Care (DCC) is to provide leadership in building high quality, community-based access to childcare and early learning that enhances health, safety, permanency, well-being, and self-sufficiency for Kentucky’s children and families.

DCC strives to fulfill their mission through the following goals:
- Increase available quality child care that is developmentally appropriate, affordable, healthy, and safe;
- Provide access to early care and education, and provide support to early care professionals throughout the state;
- Engage families and community partners in collaborative decision making for early care and education;
- Provide safe child care services which support stability and self-sufficiency of families;
- Utilize technological resources to promote the improvement of outcomes in child care; and
• Expand data collection and management systems that allow for evidence-based management decisions.

The Child Care and Development Fund (CCDF) is the principal source of federal funding for DCC initiatives that maintain health and safety standards and improve child quality in childcare settings. Direct TANF dollars are used to fund Child Care Assistance Program (CCAP) benefits on behalf of individuals who receive public assistance. In addition, State General Funds and Tobacco Settlement Dollars are combined with CCDF dollars to fund the CCAP, child care quality initiatives, fitness determinations (background checks), and early care and education professional development. In order to assure continuation of a program of childcare services, the Cabinet must renew the CCDF State Plan every three years. The Cabinet currently operates under the provisions established in the CCDF Plan for FFY 19-21 submitted December 21, 2018.

DCC is directly responsible for oversight of the CCAP, the tiered quality rating and improvement system, childcare provider professional development, and childcare fitness determinations in all of Kentucky’s counties. Childcare technical assistance, recruitment, referrals, and licensing are also responsibilities of DCC for the entire state. These programs are contracted to state and community partners and supported by the Benefind assistance and support program online portal.

DCC has several mechanisms in place to support collaboration across service programs, which include internal departments within CHFS. Additional service provider collaboration through meetings and workgroups include, but are not limited to the Governor’s Office of Early Childhood, Kentucky Department of Education, Kentucky Head Start Collaborative, Department for Behavioral Health, Developmental and Intellectual Disabilities, and Department for Public Health, along with advocacy groups, including the Kentucky Partnership for Families and Children and the Prichard Committee for Academic Excellence.

DCC contracts with the Human Development Institute, University of Kentucky, for Child Care Aware Network of Services to provide technical assistance to increase quality in early childcare and education facilities and access to high quality licensed type I, licensed type II, and certified providers throughout the state.

DCC manages the CCAP. Children are eligible for childcare subsidies if the child has a current protection or prevention case or is in the care of fictive kin. DCC has made recent regulatory changes to allow CCAP funds to support childcare expenses for children in foster care.

DCC subsidizes childcare to eligible children and families to support low-income families, child safety, permanency, and well-being for children receiving protection and prevention services, and children in foster care.

On April 13, 2018, DCC filed regulation 922 KAR 2:270 Kentucky All STARS quality based graduated early childhood rating system for licensed child care centers and certified family child care homes. The emergency regulation repealed the state’s previous quality rating and improvement system, STARS for KIDS NOW, and replaced it with the new, tiered quality rating and improvement system: Kentucky All STARS.

In support of Kentucky All STARS, DCC introduced a new online system, which allows providers to submit All STARS forms, track submissions, and view correspondence from DCC. The All STARS provider portal is integrated with the Kentucky Integrated Child Care System, which serves as a clearinghouse for provider
licensure and quality rating data. The All STARS portal went live in June 2018.

In early 2018, Kentucky was awarded an additional 42 million dollars of discretionary funds through the Child Care Development Block Grant. The Administration for Children and Families requires that funds be obligated by September 30, 2019 and liquidated by September 30, 2020. To obligate the discretionary funds, emergency administrative regulation 922 KAR 2:160E was filed on November 30, 2018. The regulation was effective immediately and included a CCAP maximum payment rate increase for any county currently receiving less than the 40th percentile of the market rate. The regulation also immediately raised the discontinuance of childcare services at redetermination to 200% of the federal poverty limit and allowed for funding of childcare for foster children from CCDF funds. In addition, the regulation will allow full-time students enrolled in a certified trade school or an accredited college or university, or those participating in SNAP Employment and Training Program to be eligible for childcare effective June 28, 2019.

The National Background Check Program launched in March 2018. It is essentially a "one-stop shop" for providers to complete all required background checks. All child care staff members were required to have their background checks completed by the new system no later than September 30, 2018 in accordance with 922 KAR 2:280.

During Calendar Year (CY) 2019, an average of 46,013 children and 25,743 families received childcare assistance program benefits. Of the total number of children receiving benefits, there was an average of 6,662 children served as the result of a need for protective/preventive services. Children served as the result of protective/preventive services referrals get placement in safe and healthy environments supporting family unification. Total CCAP expenditures for CY 2019 were $143,588,482.

DCC contracts with the Kentucky Partnership for Early Childhood Services, housed at the University of Kentucky Human Development Institute, to provide coordination and administration of statewide Kentucky Child Care Resource and Referral (CCR&R) network services. Services provided through the CCR&R regional network include:

- 8 regional child care administrators, five (5) content area coordinators;
- 1 TA specialist health/safety;
- 4 technical assistance QRIS specialists;
- 24 quality coaches;
- 4 technical assistance health/safety coaches;
- 4 training coaches; and
- 13 professional development coaches to ensure adequate supply of quality childcare programs and services are available in each regional hub covering the Area Development District.

DCC, through its CCR&R contract, works actively to meet the needs of families, provide referral information to families seeking childcare, increase family knowledge of the characteristics of high quality early care and education services, and increase provider access to training and/or professional development opportunities.

DCC receives consultation and technical assistance upon request to Administration for Children and Families Region IV office and contracted affiliates.
Childcare report data collected through the Kentucky Integrated Child Care System (KICCS) assistance program is available to all 120 Kentucky Counties. Data reports compiled quarterly, annually and ad hoc on request are available for state and federal reporting. Data analysis of data reports to support decision making, legislative, regulatory, and program improvements.

Effective October 1, 2017 childcare application for eligibility determination transitioned to Benefind allows Kentucky’s families to easily access public assistance benefits and information 24/7 through an online application and account. The goal of Kentucky’s public assistance programs is to build strong families and obtain services such as food, cash, and medical assistance to become self-sufficient. Benefind is also a referral tool that used by parents in selecting quality childcare.

In 2018, DCC started work with the Kentucky Center for Statistics (KYSTATS) to improve the Early Childhood Profile, which is a cross-agency overview of early childhood education in the state. DCC worked to ensure that accurate and complete information was shared with KYSTATS from all our data management partners and that data represented in the report was accurate and easy to interpret. The new and improved report will assist policymakers, practitioners, and the public to make educational and policy decisions.

During CY 2019, Kentucky’s CCAP has experienced over a 2.24% decrease in child enrollment. Families served has decreased by more than 2% and the program has continued to sustain this without implementing a freeze in enrollment. This is likely due to transition of the CCAP to Benefind allowing more Kentucky families easier accessibility for accessing multiple public assistance program such as childcare, SNAP, etc. DCC has made recent regulatory changes to support the funding of childcare expenses for foster children using Child Care Development Block Grant funds. DCC, DPP, the Division of Family Support, and the Office of Administration and Technology are collaborating to implement process, policy, and systems changes effectively.

F. Children’s Justice Act Grant
The Children’s Justice Act (CJA) grants are provided to assist states in developing, establishing, and operating programs designed to improve:

1) The assessment and investigation of suspected abuse and neglect cases, including sexual abuse cases, in a manner that limits additional trauma to the child and child’s family;
2) The assessment and investigation of cases of suspected child abuse-related fatalities and suspected child neglect-related fatalities;
3) The investigation and prosecution of cases of child abuse and neglect, including sexual abuse; and
4) The assessment and investigation of cases involving children with disabilities or serious health-related problems who are suspected victims of child abuse or neglect.

The CJA grant is comprised of federal funds. The services and programs funded by the CJA are operating and available in various locations throughout the state.

The CJA task force grants are awarded after being reviewed and voted upon by the task force. Proposals are required to provide a plan for self-evaluation and thorough reporting prior to the release of funds.

CJA continued to fund Pediatric Forensic Medical Consultations for DCBS field staff. The task force has allocated $82,500 annually to assist in determinations of abuse and neglect, as well as provide expert
testimony as needed. This is a necessary service to field staff, as many communities do not have forensically qualified medical personnel.

The CJA taskforce utilizes a grant award system from a pool of applicants who have developed proposals according grant program instructions. Application instructions clearly outline CJA mandates as well as intended purpose and approved activities.

The CJA task force initiated the need for an assessment of Kentucky’s cases regarding Human Trafficking. The task force funded Project Prevention and Intervention for Victims of Trafficking (PIVOT) to continue research in this area, increase awareness, and improve systems to appropriately and effectively respond to child trafficking victims. Project PIVOT aimed research on how Kentucky handles child trafficking in the child welfare system, the best approach at screening/identifying potential victims, and the best response for child trafficking victims to limit additional trauma for the victim.

Additionally, the CJA task force initiated the need for an assessment of Kentucky’s survivors of domestic violence. The task force funded KCADV in which they aimed research on collecting data from survivors regarding their experiences with the child welfare system, foster care, out of home care, or the juvenile justice system when they were children and with their current children.

Additionally, they planned to offer two CARE (Child-Adult Relationship Enhancement) trainings, which increase knowledge of trauma-informed skills for general use by a variety of non-clinical adults who interact with traumatized children and caregivers such as daycare providers, foster parents, parents, child protection workers, child victim advocates, staff at domestic violence shelters, and non-clinical staff in residential treatment centers.

Project PIVOT:

In the first research aim to identify how child welfare handles a child trafficking case, data found positive trends, which included (1) law enforcement being involved in more cases than in previously reported cases and (2) a greater likelihood for professionals to report child trafficking cases than in previously reported cases. The research also found an alarming amount of cases were reported by family members and were often at home when the allegations were received. Additionally, cases were more likely to be substantiated and/or founded when law enforcement was involved, a forensic interview was conducted, and when a case involved drugs.

In the second research aim to identify the best approach/screening potential child trafficking victims, data found among the 14 states assessed, there were common experience in challenges to implement a screening tool such as the length of the tool, remaining training of reporters throughout the state, a lack of inclusive language, and unpredictability due to inconsistent reporting.

Lastly, in the third research aim to identify the best response for limiting additional trauma to child trafficking victims, work group meetings with the Kentucky Statewide Human Trafficking Task Force (SHTTF) were held to innovate effective and collaborative cross-agency communication, policies, and practice recommendations for ending child trafficking.

KCADV: KCADV proposed research regarding the risk of separation of children from non-offending parents who have experience, or are currently experiencing domestic violence, increased placement of children of
foster care, and/or termination of parental rights of protective parents. Specifically, KCADV seeks to (1) expand the research plan and intervention aspects to better define the problem and begin to craft direct intervention and (2) provide advocates with training from the University of Kentucky Child and Adolescent Trauma Treatment Institute (CATTI) clinic in Lexington designed to be used to support advocates in their work with children and the non-offending parents.

KCADV is still in the process of completing their research at this time by meeting with CHFS, and conducting focus groups and outreach with groups such as CASA, Mountain Comp, AOC, and Kentucky Child Support Program.

The task force began discussing a possible future direction of funding projects surrounding secondary trauma. Barriers were discussed regarding the by-laws and making the mandate surrounding this topic. Further discussions will be held at the next meeting regarding future projects.

Project PIVOT:
Based on the report, (1) there are more cases that involve law enforcement than in previously reported cases and (2) there is a greater likelihood for professionals to report child trafficking cases than in previously reported cases. Additionally, cases were more likely to be substantiated and/or founded when law enforcement was involved, a forensic interview was conducted, and when a case involved drugs.

G. Children’s Review Program
The Children’s Review Program (CRP) is a program of New Vista of the Bluegrass, Inc. and performs its functions under a contract between New Vista and DCBS. The mission of CRP is to support DCBS in its efforts to assure the safety, permanency, and well-being of DCBS-committed children who are placed in out-of-home care. CRP assigns levels of care to children in out-of-home care; provides direct assistance to DCBS workers in locating, facilitating, and maintaining placements; and collects, analyzes, and interprets data related to placements and children’s outcomes as part of its quality monitoring and assurance responsibilities. CRP maintains a database, which includes children’s placement history, level history, diagnosis and psychotropic medication history, IQ when available, and other child specific information. CRP provides services to each county of the commonwealth through CRP staff who are located in DCBS offices across the state and at the statewide CRP office in Lexington. CRP is funded through title IV-E and state general funds.

CRP has three primary functions: assessment, placement, and quality assurance, all of which work toward assuring the safety, permanency, and well-being of DCBS-committed children who are placed in OOH.

As part of the assessment function, clinical reviewers assigned 12,991 levels (2,430 initials, 8,529 utilization reviews, 929 redeterminations, and 1,103 reassignments) from January – December 2019.

As part of the placement function, regional placement coordinators assisted in or were involved with 6,898 placements and made 360,830 referrals. Statewide placement office personnel facilitated or were involved in 970 conference calls during 2019 (see additional details below).

As part of the quality assurance function, CRP maintained data on 12,388 children committed to DCBS at some point in 2019 and program information on 189 private child caring and private child placing (PCC/PCP) programs that operated in 2019. This information is continuously being updated on an
ongoing and as needed basis. In addition, during 2019, clinical reviewers identified 3,924 quality improvement issues related to the services provided to children while in out-of-home care. CRP’s functions are directed by the contract with DCBS and through ongoing contact with DCBS at many levels throughout the year. This includes monthly meetings with DCBS’ central office staff including the director and/or assistant directors in DPP and other central office staff. There are also weekly phone conferences between CRP placement staff and DCBS central office staff to discuss difficult to place children. In addition, CRP maintains ongoing communication with DCBS central office staff between meetings. CRP participates in committees and meetings as invited by DCBS. In the last year, this has included but not been limited to meetings involving the managed care organizations (MCOs), PCC/PCP providers, the Building Bridges Initiative (BBI), Family First Prevention Services Act (FFPSA), the CFSP CQI stakeholder group, and the House Bill 1 study group. CRP staff participate in utilization review committees in selected regions. CRP’s regional placement coordinators are co-located with DCBS staff throughout the state. CRP also has designated staff who work closely with the DCBS medical support team to assure that all medically complex children are identified and tracked appropriately and that level assignments are as accurate as possible based on both the child’s medical needs and other issues/behaviors. In several DCBS regions, CRP is involved in ongoing collaborative meetings between DCBS and PCC/PCP staff. A CRP staff person is actively involved in reviewing applications from programs applying to obtain a PCC/PCP agreement with DCBS.

In addition, CRP works closely with the PCC/PCP agencies individually and through their association, the Children’s Alliance of Kentucky, to improve outcomes for children in the custody of DCBS. A joint quarterly Quality Outcomes for Children Council meeting provides an opportunity to plan and track quality improvement activities. CRP representatives also regularly attend the Alliance’s Out-of-Home Care Council and PRTF Council meetings as community partners. CRP staff also work collaboratively with the private provider community to update comparative reports on a quarterly basis. This includes frequent email and telephone contact with providers around the state as part of CRP’s effort to encourage accurate reporting of the data contained in these reports. Each program’s comparative report provides information on program criteria, characteristics, and services that may be used in helping determine the most appropriate placement for a child. CRP is in frequent communication with the PCCs/PCPs for issues of data collection, level assignment, placement, and general consultation. For PCC/PCP programs that have questions, are new to the state, or have new leadership, CRP will provide information regarding the expectations of the programs as they relate to CRP. In 2019, CRP provided phone consultations to existing programs on an ongoing basis.

CRP posts detailed instructions on the CRP website for completion of the Application for Level of Care Payment (ALP), which is completed by providers at regular intervals regarding the behaviors and progress of children in their care. CRP staff also call programs about specific issues related to the completion of the ALP to improve a program’s accurate reporting on this form. In addition, when making referrals, regional placement coordinators receive packets from DCBS workers to forward to potential placements. If the referral packets are incomplete or are missing important information, the regional placement coordinator will communicate with the DCBS worker to get a more complete packet of information. The regional placement coordinator also provides detailed referral reason information, which supplements the packet provided by DCBS, and summarizes the child’s issues and needs.

Because CRP coordinates placements for children in DCBS custody, including children in psychiatric hospitals, it is important that CRP staff maintain relationships with psychiatric hospitals and MCOs. CRP tracks children in psychiatric hospitals through a census report generated by CRP, updated, and returned to CRP by the hospitals on a weekly basis. In addition, CRP continues to supplement the census report
by obtaining information from the hospitals and MCOs on an ongoing basis to be proactive in placement efforts with the goal of beginning discharge planning at the time of admission. CRP is involved in efforts focusing on improving the coordination of care with multiple government entities, providers, and consumers of DCBS services. In addition to other activities listed in this report, CRP is also involved with the Kentucky Partners for Youth Transition group and a Statewide Interagency Trauma-Informed Care Steering Committee coordinated by the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHID). CRP staff have also been actively involved in the Building Bridges Initiative (BBI) being spearheaded by the DCBS commissioner’s office.

CRP provides consultation and assistance on an as needed basis for a range of DCBS initiatives. Consultative efforts draw on the wide range of clinical expertise among the staff of CRP including assistance with service planning for children with severe emotional disabilities and for those with intellectual and developmental disabilities. In 2019, these efforts continued to include meeting with DCBS staff and providing data and feedback on child-specific and program-level quality improvement issues that were noted during utilization reviews. In addition, quality improvement information is made available to each PCC/PCP agency. CRP continues to revise quality improvement categories as needed to address DCBS concerns related to children in care.

In addition, during 2019, CRP continued to work with DCBS on 5S (specialized services) programs for children with high intensity needs. CRP facilitates conference calls on referrals and placements for children in these programs and, at the request of DCBS, reviews records of children in these programs in order to report to DCBS how well the programs are providing the expected services. CRP staff have also worked with DCBS staff in the implementation and ongoing assessment of some PCC/PCP pilot programs (e.g., Home of the Innocents CATS Program, Key Assets, and Maryhurst).

As mentioned previously, CRP routinely convenes telephone conference calls to discuss and address difficult placements, for decision making on locating placements that best meet the needs of DCBS children, and for clinical consultation. Calls are also convened to monitor out-of-state placements in order to thoughtfully plan a child’s return to Kentucky and regular calls occur to support the new placement once the child returns. These conference calls may involve CRP and DCBS staff along with representatives of state guardianship, Protection and Advocacy, the Department for Behavioral Health, Developmental and Intellectual Disabilities, private providers, school/education personnel, MCOs, and/or families. DCBS also implements “disruption consultations” in an effort to reduce the number of placement changes for children by trying to prevent disruptions before they occur. CRP’s regional placement coordinators are involved in these efforts and will continue to support the Cabinet in addressing the issue of disruption.

In 2019, CRP completed data requests for DCBS (e.g., SCL difficult-to-place contact info, Eastern Mountain private foster parents and children) as well as for the Children’s Alliance and multiple providers.

In 2019, CRP continued to work to improve a Private Care Capacity and Occupancy Dashboard, which provides information to DCBS about the capacity and occupancy of private agencies throughout the state and presents the data over time and in a more user-friendly format.

For the past several years, CRP has also worked with the University of Kentucky to serve as an internship site for undergraduate psychology students during the fall and spring semesters.
The current annual budget for CRP is $2,266,949.

During 2019, a significant focus of the Cabinet was on Child Welfare Transformation. CRP has been involved at many levels. CRP’s primary involvement is related to changes required as part of the federal Family First Prevention Services Act (FFPSA). Kentucky opted to be an early implementer of the FFPSA to begin in October 2019. It is a requirement of FFPSA that all children (excluding clearly defined exceptions) being considered for placement in a qualified residential treatment program (QRTP) be evaluated within 30 days of placement to determine if congregate care is needed and appropriate. The assessment requires the use of an evidence-based, validated functional assessment tool to assess the strengths and needs of the child to help make this determination. Kentucky opted to use a version of the Child and Adolescent Needs and Strengths (CANS) assessment as its functional assessment tool. The QRTP assessment must be conducted by a trained professional or licensed clinician who is not an employee of the state agency and who is not connected to, or affiliated with, any placement setting in which children are placed by the State. DCBS asked that CRP conduct the QRTP assessments. In June, CRP submitted proposal to the Cabinet for conducting the assessments and began working with the Cabinet on the logistics of completing the assessments (e.g., developing a TWIST interface, developing a CANS algorithm relevant to Kentucky). Due to some unexpected issues related to QRTP definitions that have state and federal implications, this assessment process has not begun in Kentucky, but it is expected to begin in 2020.

The Cabinet has recently added specific performance indicators to PCC/PCP agreements. It is hoped that this performance indicator data will be used to evaluate and potentially reward programs’ performance in the future. During 2019, CRP began work with the PCC/PCPs to assure the validity of data collected to measure performance. CRP provides data on a regular basis to the PCC/PCPs so that the PCC/PCPs can verify the accuracy of the data or make corrections as needed. FY19 is considered a hold harmless year for the PCC/PCPs so that they can better assess where they are on the measures and where they need to make improvements. Due to budgetary issues, it is likely that the hold harmless period will be extended for an additional year. During the coming year, CRP will begin data analysis and report development so that reporting mechanisms will be ready when needed.

**Assessment:**
CRP assigns levels of care to children as they enter PCC/PCP agencies and as the children progress through the system. Levels are assigned by clinical staff based on definitions provided in 922 KAR 1:360 (PCC placement, levels of care, and payment). Information used in the level assignments is provided by the DCBS worker, the PCC/PCP, or through other sources. These levels represent the treatment and service needs of the child. The numbers of level assignments over the past six years are as follows:

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Total Reviews</th>
<th>Initials</th>
<th>Utilization Reviews</th>
<th>Redeterminations</th>
<th>Reassignments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>13,313</td>
<td>2,690</td>
<td>8,465</td>
<td>1,063</td>
<td>1,095</td>
</tr>
<tr>
<td>2018</td>
<td>13,522</td>
<td>2,938</td>
<td>8,287</td>
<td>1,237</td>
<td>1,060</td>
</tr>
<tr>
<td>2017</td>
<td>12,495</td>
<td>2,550</td>
<td>7,948</td>
<td>978</td>
<td>1,019</td>
</tr>
<tr>
<td>2016</td>
<td>12,342</td>
<td>2,421</td>
<td>7,687</td>
<td>1,070</td>
<td>1,164</td>
</tr>
<tr>
<td>2015</td>
<td>12,085</td>
<td>2,443</td>
<td>7,498</td>
<td>1,141</td>
<td>1,003</td>
</tr>
<tr>
<td>2014</td>
<td>12,031</td>
<td>2,547</td>
<td>7,422</td>
<td>1,118</td>
<td>944</td>
</tr>
</tbody>
</table>
For the previous six years, the number of level assignments had increased each year. During FY 2019, there was a slight decrease (less than 2%) from FY 2018; however, the FY 2019 number was still greater than any fiscal year from 2013 to 2017. Staff who assign levels of care are required to maintain acceptable levels of inter-rater reliability, which measures the extent of agreement among reviewers when assigning levels. CRP is required to maintain an average inter-rater reliability of .50 (half a level from the mean) or less. In FY 2019, CRP’s inter-rater reliability was .08.

During the last year, CRP has continued to work to collect IQ scores on children, especially those children who have been described as low functioning or developmentally delayed by DCBS or placement staff. This information is used in helping determine the most appropriate placement and treatment options for these children. CRP currently maintains 802 IQ reports on 598 children currently committed to DCBS. In 2019, 244 IQ reports (on 230 children) were entered into the CRP database. Please note that some children have more than one IQ report.

CRP has designated staff who work closely with the DCBS medical support team to assure that all medically complex children are identified and tracked appropriately and that level assignments for these children are as accurate as possible based on both the child’s medical needs and other issues/behaviors. In 2019, CRP tracked 325 DCBS children who were identified as medically complex at some time during the year.

CRP communicates with DCBS and PCCs/PCPs on a daily and ongoing basis regarding levels of care and other issues of concern.

Placement:
CRP’s regional placement coordinators are responsible for assisting DCBS staff in locating the placements that best meet a child’s needs. CRP’s database identifies placement options based on the child’s age, level of care, gender, IQ, and the proximity of the program to the child’s home county. An effort is made to keep siblings together whenever appropriate. CRP staff were involved in 6,898 placements in 2019. This is an increase from 2018. In 2019, for the second year in a row, placement coordinators made over 360,000 referrals.

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th># of Referrals</th>
<th># of Placements with RPC Involvement</th>
<th>Avg. # of Referrals per Placement</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>360,830</td>
<td>6,898</td>
<td>52.31</td>
</tr>
<tr>
<td>2018</td>
<td>369,604</td>
<td>5,055</td>
<td>73.1</td>
</tr>
<tr>
<td>2017</td>
<td>309,279</td>
<td>6,111</td>
<td>50.6</td>
</tr>
</tbody>
</table>

In addition, CRP provides information to DCBS staff about placement options for referred children; so that placement decisions can also be based on the PCC/PCP’s ability to provide treatment services for the child’s identified treatment needs. CRP maintains information on PCC/PCP programs statewide (including residential treatment, foster care, and independent living programs) regarding the evidence-based practices and other services they provide to meet the treatment needs of state committed children. When placement options based on a referred child’s age, level of care, etc. are identified, the regional placement coordinator shares information with the DCBS worker about the types of evidence-based practices and other services each program offers to address the treatment needs of the child being referred. CRP maintains a list of descriptions for the more than 80 evidence-based practices reported as being used at some point by the PCC/PCP programs (48 are reported as currently being used.
by 92 programs) and updates these as needed. These descriptions are provided to DCBS so that they can be posted on the DCBS website.

Another source of information provided to DCBS staff is the comparative report. This report is produced by CRP and updated quarterly for each PCC and PCP and includes information about admission criteria, services provided, staff qualifications, and how they compare to other similar programs in various areas including safety and permanency. In addition, the regional placement coordinators request foster home “snapshot” reports on any foster family considering placing a child and may request complete home studies on specific families from PCPs at the DCBS worker’s request. The regional placement coordinators work diligently to make sure that staff in the individual DCBS regions have available the information they need to make good placement decisions and encourage DCBS staff to use the reports and information that CRP provides when making those placement decisions, especially when there are multiple placement options.

CRP statewide placement staff, in addition to the regional placement coordinators, are frequently involved in conference calls with DCBS staff and others to determine the most appropriate placements and services for children. CRP routinely convenes telephone conference calls to discuss and address difficult placements, for decision making on locating placements that best meet the needs of DCBS children, and for clinical consultation. In 2019, CRP staff were involved in approximately 970 conference calls. This is an increase of more than 20% over 2018. For conference calls on children 16 and over, independent living coordinators may be invited to participate to ensure the region follows appropriate steps to prepare children for aging out of the system. Guardianship staff are invited to participate in conference calls on youth over the age of 18 who may be in need of these services, as they get closer to aging out of the DCBS system.

Because of the number and types of children in DCBS custody who are placed in psychiatric hospitals, it is important that CRP staff maintain relationships with psychiatric hospitals and MCOs. CRP tracks children in psychiatric hospitals through a census report generated by CRP to be updated and returned to CRP by the hospitals on a weekly basis. In addition, CRP supplements the census report by obtaining information from the hospitals and MCOs on an ongoing basis to be proactive in placement efforts with the goal of beginning discharge planning at the time of admission. CRP maintains and utilizes lists for children who are difficult to place and/or are in hospitals to effectively communicate with DCBS central office staff on challenging cases and updates these lists, as needed, to meet the changing demands of managed care. These lists are also used to track children who are at risk for disruption or decertification or whose services have already been decertified by the MCO at their current placement.

As part of the placement process, CRP works closely with the MCOs. Some of the MCOs are willing to put additional services in place for children to help move them to or maintain them in less restrictive or more community-based settings, including moving children back to Kentucky from out-of-state placements. CRP also routinely interfaces with the MCOs on difficult-to-place children to discuss whether these types of additional services would be available to support a child in Kentucky before out-of-state placement is considered. CRP works with the MCO, potential placing agencies, and DCBS to determine placement options and the additional services that would be needed to support the child once placed.

CRP maintains a database of PCP medically complex foster homes (homes in which the foster parents are trained to care for children with significant medical needs) to assure appropriate referrals for medically complex children. There are currently more than 171 homes on that list. CRP monitors the
DCBS PCC tracking system for medically complex foster homes. If a foster home is no longer listed as medically complex in the PCC tracking system, it is removed from the CRP list. CRP also provides a monthly report to DCBS identifying any medically complex children who are placed in non-medically complex homes.

Regional placement coordinators refer to transitional and independent living programs (ILPs) as appropriate. The CRP database provides a list of ILP providers by county and region. CRP’s comparative report provides additional information about each resource. Currently, CRP lists 12 agencies with 35 separate programs licensed to provide ILP services to state committed children.

CRP staff are actively involved in transitioning children who have been placed in out-of-state treatment programs back into placement in Kentucky. CRP convenes telephone conference calls as appropriate with DCBS staff, current out-of-state treatment providers, and others as needed while the child is in the out-of-state placement, again approximately one month after the child’s return, and then at ongoing regular intervals as needed to support and maintain the placement. The number of children in care had been decreasing overtime and in 2015, nine children were placed in out-of-state treatment sometime during the year and only two were in out-of-state placement at the end of the year. In subsequent years, the number of children in out-of-state placement had been gradually increasing. After a significant jump in 2018, the number of children placed in an out-of-state program sometime during the year leveled out in 2019. There were 31 children placed in out-of-state placement in 2019 compared to 27 in 2018. The number of children placed in out-of-state placement at the end of 2019 was 10, which is lower than 2018 when there were 16 children placed in out-of-state treatment programs at the end of the year.

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th># Children OOS During the Year</th>
<th># of Children OOS at End of Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>31</td>
<td>10</td>
</tr>
<tr>
<td>2018</td>
<td>27</td>
<td>16</td>
</tr>
<tr>
<td>2017</td>
<td>15</td>
<td>6</td>
</tr>
<tr>
<td>2016</td>
<td>11</td>
<td>4</td>
</tr>
<tr>
<td>2015</td>
<td>9</td>
<td>2</td>
</tr>
</tbody>
</table>

CRP staff work closely with DCBS to address the needs of the developmentally and intellectually disabled populations especially as they begin to age out of the DCBS system to assure a smooth transition to the adult system. CRP has a consultant for developmental and intellectual disabilities who works with DCBS to help determine the most appropriate placements to meet the youth’s needs. The consultant completed 40 written consultation reports in 2019 (down slightly from the 46 completed in 2018). CRP staff may at times work with supports for community living (SCL) programs to have them consider placing these youth under an individual placement agreement until SCL funding is available for the youth at 20.5 years of age. This may serve to reduce the number of transitions for the youth. From 2015 to 2017, the number of youth utilizing SCL services remained stable. However, in 2018, the number increased significantly to 92 DCBS youth being placed with an SCL provider sometime during the year and 74 DCBS youth being placed with SCL providers at the end of the year. The number of DCBS youth in SCL placements continued to increase in 2019 with a 105 youth placed in an SCL placement sometime in 2019. However, the number of DCBS youth in SCL at the end of the year remained at 74 (the same as in 2018).

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th># Youth in SCL During the Year</th>
<th># of Youth in SCL at End of Year</th>
</tr>
</thead>
</table>
DCBS currently works with two different agencies that have 5S (specialized) residential programs for high intensity children. CRP has been involved in helping determine children’s appropriateness for placement in these specialized services programs and has facilitated conference calls to discuss related referrals and placements. CRP staff also review the records of these programs to determine if agreed upon services have been provided. These service reviews are provided to DCBS and to the programs. During 2019, CRP completed 158 service reviews for Maryhurst’s specialized services program and 32 service reviews for Uspiritus- Brooklawn’s specialized program for a total of 190. Service reviews are completed on a quarterly basis for each youth in the program. In 2019, 89 different children resided in these programs (71 in Maryhurst and 18 in Uspiritus). CRP has continued to revise the reviews and aggregate reports to address requests from the programs and DCBS, such as tracking youth who have completed high school while in the program and tracking the average number of days for youth to complete the program.

CRP communicates with DCBS and/or PCC/PCPs on a daily and ongoing basis regarding placement referrals for children, clinical consultation, and other issues of concern.

Quality Assurance:
CRP receives quarterly or semiannual reports from the PCCs/PCPs regarding each child in their care. Through these reports, CRP is able to monitor some aspects of service provision by the PCCs/PCPs. As CRP’s clinical reviewers review these reports for level assignment information, they also note any concerns about a child’s safety or the services he/she may or may not be receiving. These quality improvement issues are also tracked by program. Depending on the seriousness of the concern, it may be reported in detail to DCBS or in a general (at least monthly) summary report. During 2014, CRP made this quality improvement information available to the PCC/PCPs on line through the CRP web application. With the on-line access, PCC/PCP staff can readily review any issues that have been noted about their programs and utilize the information for program improvement purposes. During 2016, CRP entered 2,653 quality improvement issues. This was down some from the more than 3,000 quality improvement issues that were entered in 2015. During 2017, CRP identified 3,652 quality improvement issues and in 2018, 3,913 were identified. In 2019, 3,924 quality improvement issues were recorded. The numbers remained high even though the PCC/PCPs have access to the information and are encouraged to use it for their own quality improvement purposes. CRP continues to monitor and adjust the system as necessary (e.g., modified definitions for safety, inadequate substance use, and insufficient number of mental health services to provide additional clarity.

DCBS has a tracking system for children in private foster care, residential, and independent living placements. CRP receives a weekly download from DCBS, which is integrated into the CRP system to ensure that placement information is as current and accurate as possible. In 2016, CRP reconciled 15,279 PCC tracking records with information in the CRP web application. In 2017, CRP reconciled 19,192 PCC tracking records with information in the CRP web application. In 2018, CRP reconciled 19,004 records and in 2019, 16,706 were reconciled.
CRP works closely with the PCC/PCP providers through their association, the Children’s Alliance of Kentucky, to improve outcomes for children in the custody of DCBS. A joint quarterly Quality Outcomes for Children Council meeting provides an opportunity to plan and track quality improvement activities.

CRP staff also work collaboratively with the PCC/PCP community to update comparative reports on a quarterly basis. This includes frequent email and telephone contact with providers around the state as part of CRP’s effort to encourage accurate reporting of the data contained in these reports. Each program’s comparative report provides information on program characteristics that may be used in helping determine the most appropriate placement for a child.

During 2019, CRP completed data requests for DCBS (e.g., SCL difficult to place contact info, Eastern Mountain private foster parents and children), as well as for the Children’s Alliance and multiple providers.

CRP provides the following reports to DCBS on a monthly basis:
- PCC Foster Home Occupancy Rates by Region;
- PCC Foster Home Occupancy Rates by Program;
- PCC Foster Home Occupancy Rates by County;
- Empty PCC Foster Homes;
- PCC Foster Care Medically Complex Foster Home Beds;
- Medically Complex Youth with Medically Complex Rating;
- Medically Complex Youth with Medically Complex Rating by MCO;
- Medically Complex Census, Private Medically Complex Foster Parents By Program;
- Private Medically Complex Foster Parents By Region;
- Medically Complex Children in Residential Care;
- Medically Complex Children in Non-medically Complex Homes;
- PCC Compliance Reports;
- Private Care Capacity and Occupancy Dashboard;
- Placement Stability Report;
- Youth Medication Report;
- Monthly Activity Dashboard, which includes current and trend data related to CRP’s assessment, placement; and
- Quality assurance functions.

CRP communicates with DCBS and/or PCCs/PCPs on a daily and ongoing basis regarding data collection and other issues of concern.

In the last year, the number of level assignments decreased slightly (less than 2%) over the previous year (13,522 in 2018 and 13,313 in 2019). This is the first year that there has not been an increase in at least seven years. Some contributing factors may include the reduction in total number of children in DCBS custody. CRP records indicate that there were 9,747 children in care at the end of 2018 and 9,038 at the end of 2019. In addition, there has been an increase in the number of relative and fictive kin placements and these types of placements do not require a level of care.

In 2019, CRP became more concerned about the number of children that seemed to be moving from placement to placement with little or no stability. While these concerns had been discussed in the past, CRP, with input from DCBS leadership, developed two placement stability reports, which are now
provided to the Cabinet on a monthly basis. The reports list the number of children who moved from a PCP foster home within 30 days of placement with the agency and the number of children with three or more placements in PCP foster care within the previous 90 days. DCBS has developed a protocol for following up on these cases of concern and has been collecting data in the process. The preliminary indications are that the moves early on in care are often related to moving the children into permanency (e.g., moves to relative or fictive kin). A concern and possible reason for at least some of the other moves may be due to PCP foster care agencies moving children between their homes without re-referring through CRP.

From 2018 to 2019, data shows a decrease in the number of PCP medically complex foster homes. There was a drop from 221 in 2018 to 171 in 2019. This change may be related in part to concentrated efforts on CRP’s part to encourage accurate reporting by the PCPs including closing homes in the tracking system that are no longer active.

The number of conference calls on difficult to place children increased by more than 20% in the last year after an 11% increase in the previous year. Even though DCBS’ central office has been working to involve regional leadership in problem solving before conference calls are scheduled and has been trying to streamline the processes in other ways, the large number of difficult to place children drives the need for the high volume of calls. Although finding placement/treatment options for difficult to place children is the primary focus on the majority of the calls, conference calls are also convened to address questions or to reach consensus regarding placement or treatment recommendations and to explore ways to prevent disruption and assure successful transitions.

During 2019, CRP continued to expand the number and types of reports and data available online where possible. A new online referral system was rolled out in January of 2019. This has made the referral process for both the PCC/PCPs and CRP much more efficient. Additional improvements occurred in CRP’s web application throughout the year. There has been a great deal of positive feedback regarding these enhancements from the PCC/PCP community. A continuing focus of 2020 will be to further enhance web application processes and to continue to expand the use of electronic communication and reporting where appropriate.

Near the end of 2019, CRP modules were developed within the TWIST system, which allows CRP staff to utilize a workbasket to access level of care forms and placement information directly from TWIST. Although CRP did not begin using the system before the end of the year, it is expected that a complete rollout of the module for level assignment and placement functions will occur in 2020. It is anticipated that this will make the process of requesting level assignments and placements much more efficient for the DCBS workers and for CRP staff. CRP will continue to work with the Cabinet on making necessary revisions to and refining CRP’s module within TWIST. In addition, CRP will develop protocols within CRP about the use of the module and associated workbasket and where appropriate, will provide guidance to DCBS staff about the type of information to include ensuring the most accurate level assignment and most appropriate placement.

In 2019, CRP made improvements to the CRP Monthly Activity Dashboard and the Provider Capacity and Occupancy Dashboard, which provides information about PCC/PCPs such as, number of referrals, received and related responses, timeliness of required reporting to CRP, information regarding quality improvement issues, etc. CRP will continue to work on making the provider dashboard available to providers in the coming year through the CRP web application. CRP will also continue to provide both dashboards to the Cabinet on a monthly basis.
CRP actively supports Kentucky’s Child Welfare Transformation efforts and will continue to do so during the coming year. The transformation effort includes many components such as the Families First Prevention Services Act (FFPSA) and the move toward decoupling services provided by the PCC/PCPs (previously anticipated for July 2020). CRP staff have been actively involved in meetings and have attended presentations regarding these efforts. As part of FFPSA in the coming year, it is expected that CRP will begin providing QRTP assessments as outlined in an earlier section of this report. CRP will also continue to work on verifying and analyzing data for the PCC/PCP performance measures that are now part of the PCC/PCP agreements.

At the request of the Cabinet, CRP recently submitted a proposal to begin doing exit interviews on children leaving PCC/PCP placement. The Cabinet is interested in collecting information in an ongoing way on a sample of DCBS youth leaving PCP therapeutic foster care agencies or PCC residential treatment facilities regarding the youths’ experiences while in care, in addition to their experiences with their DCBS workers. DCBS has asked that CRP submit a proposal for conducting exit interviews to obtain this information as a possible expansion of the current CRP contract. CRP is proposing that information regarding the youths’ experiences be obtained through face-to-face interviews with the youth. CRP would then compile the data from the interviews and submit it to DCBS on an ongoing basis. It is also anticipated that DCBS may be able to utilize data from the exit interviews to look at connections between youths’ reports of their experiences and their placement stability and other measures of well-being, and to gain additional information about the quality of services being provided to youth in PCC/PCP placement. CRP is awaiting a response to the proposal. CRP will begin developing and implementing an exit interview process if and when the proposal is approved.

CRP will continue to collect and report quality improvement issues and encourage their review by the PCC/PCPs in order to help inform areas that may become greater issues of concern when decoupling occurs.

In the last year, CRP developed a report for the Cabinet’s consulting medical director, Dr. David Lohr. Dr. Lohr provided information on the data elements that would be most helpful. The report includes children who are on multiple psychiatric medications. Dr. Lohr uses the report to determine which cases may be further consultation. CRP plans to continue this collaborative effort with Dr. Lohr and provide additional information as needed.

Late in 2019, CRP made some changes to the way evidence-based practices (EBPs) provided by PCC/PCPs are reported in the CRP web application. Specifications were put on the type of staff (clinical versus non-clinical) that could have associated EBPs. These EBPs are provided to DCBS to help them make placement decisions. CRP believes that these changes improved the accuracy of the reports. CRP would like to make additional changes to the way that EBPs are recorded and reported to distinguish those that can be used in a general way versus those with a more specific purpose. This is a planned focus for CRP in the coming year.

CRP staff have recently become involved in a Cabinet committee focused on improved treatment planning within the PCC/PCP community. One staff is actively involved in a related subcommittee and CRP plans to continue to be involved in and support these efforts in the coming year.
The number of non-LOC or non-traditional treatment programs, including several pilots, have been or are being developed across the state. CRP will continue to adapt workflows and procedures to support these efforts.

CRP will continue to work with DCBS to address placement issues (e.g., number of children placed out-of-state and issues related to their return, addressing placement needs of difficult-to-place children, improving placement processes, etc.). In the coming year, CRP will continue to communicate with and work with DCBS to meet other needs as they arise.

H. Community Collaboration for Children, Community-Based Child Abuse Prevention, and Promoting Safe and Stable Families

The Community Collaboration for Children (CCC) is funded by Promoting Safe and Stable Families (PSSF) and the Community-Based Child Abuse Prevention (CBCAP) program. PSSF funds are used exclusively for direct services. CBCAP funds are used for direct services, the regional network, and other initiatives such as child abuse prevention awareness (especially in April), fatherhood, and faith-based activities. Both CBCAP and PSSF funds are used to develop, operate, expand, and enhance community-based and prevention-focused programs. Two direct services are currently provided through these funding streams: In-Home Based Services (IHBS) and parent engagement meetings (PEMs).

1) IHBS are in every county across the state. This service targets low-risk families, such as families who have children with disabilities, teenage parents and parents who are young adults, parents with disabilities, young children, low incomes, and families who are struggling with other issues. IHBS are short-term, home-based services geared to develop, support, and empower the family unit. IHBS teaches parent education, child development, problem solving skills, appropriate discipline techniques, and how to be self-sufficient by coordinating available community resources.

2) Parent Engagement Meetings (PEMs) have the same target population. PEMs are currently available in Jefferson County and Daviess County. PEMs will also expand into a third county in CY 2020. PEMs bring families, agencies, and community partners together to resolve barrier for families that lead to truancy for children. Facilitators ensure an objective discussion of issues and explore resources. Referrals are accepted from the school system. PEMs target school-aged children (ages 5-11) who are at risk of educational neglect. In 2019, 428 families received PEM services and 80% of those cases were diverted from becoming involved with Kentucky’s child welfare agency.

CCC’s IHBS are provided in each county across the state. CCC is divided into 17 service areas (comparable to the area development districts (ADD)) and the service areas cover all 120 counties. CBCAP exclusively funds the regional networks that are located in each of the CCC service areas, which cover the entire state. Each region has an established regional network whose membership requires representation from DCBS; CCC service providers; Early Childhood Councils; Family Resource and Youth Service Centers; health departments, mental health service providers, court officials; domestic violence shelter representatives; other child and family serving prevention agencies; community leaders including the faith community; and local citizens including parents. A regional network is a community based collaborative within each service area whose members meet at least five times per year. The regional network provides collaboration and support to CCC service providers and the members share regional resources as well as discuss child abuse prevention in local communities. Needs of the region are discussed, DCBS data is shared as well as community partner data. Regional networks are a unique
component of the program and fulfill the statewide network requirement of the CBCAP program instructions.

In 2019, IHBS served 702 families with 1,546 children. The DCBS Training Branch provides training for agencies who provide IHBS and was developed to reflect all DCBS requirements, as well as promote strengths-based principles for family engagement. CCC vendors participate in quarterly statewide meetings and regional coordinator and supervisor orientations. CCC employs two parent leaders as an effort to increase parent involvement and build leadership skills.

IHBS and PEMs are coordinated separately from the regional networks. However, reporting on the status of services, client needs, trends, and counties served occurs at regional network meetings. Regional networks use available funds to further meet the needs of clients in the region by providing opportunities such as local mini-grants to supplement parenting education, access to training and other resources, as well as local community initiatives targeting prevention of child abuse and neglect.

The CCC program will continue to focus on IHBS across the state. Flat funding prevents any expansion and decreases the ability to retain employees due to a lack of salary increase in many years. In-home services continue to be the most effective and in-demand services for prevention of abuse/neglect. Regional network collaborations continue to be critical, as with funding limitations, creative solutions as well as decreasing duplication of services are needed.

Data reflects an increase in the number of overall families served, by 122 or 17%, for in-home services. Multi-families residing together, as well as the increase in family size, appear to be contributing factors. We are finding family issues are more complex and require increased services. Our expectation is that the positive outcomes for families will be reflected in NCFAS-G scores and overall family functioning.

Based upon the positive outcomes of the PEMs expansion of a second rural county will occur in CY 2020. There are barriers to additional expansions due a lack of funding.

I. Community Services Block Grant
The mission of the Community Services Block Grant (CSBG) is to reduce and eliminate poverty by providing opportunities for education, technical training, and employment that will improve living standards among those with low income and provide the client with dignity and self-respect. The efforts are for promoting self-sufficiency for the clients CSBG serves and to reduce the burden of dependency. The CSBG program is federally funded through the United States Department of Health and Human Services (HHS), Administration for Children and Families, Office of Community Services, and Division of State Assistance.

CSBG services are available statewide in all 120 counties. The services are made available through all 23 Community Action agencies (CAAs) within the state for clients that meet eligibility requirements based on 125% or below the federal poverty level. CSBG funds are allocated through CHFS. CHFS is responsible for administration, oversight, and allocation of the CSBG funds to the eligible entities within Kentucky.

The CAAs and CHFS’ DCBS service regions work in partnership to provide services, which complement the common mission and outcomes, to prevent child maltreatment, to promote quality foster care and adoption services, and to assist vulnerable adults or low-income families. Both parties have a joint
referral mechanism to identify and address the vital service needs of the CAAs geographic area and prevent the duplication of services.

Each CAA has a tripartite board that fully participates in the development, planning, implementation, and evaluation of the program serving that geographical area. The tripartite board must be composed of one-third democratically elected representatives of low-income individuals or families who reside in neighborhoods being served; one-third elected officials holding office at the time of their selection, or their representatives; and one-third of the board must be chosen from “business, industry, labor, religious, law enforcement, education, or other groups and interests in the community served.” The tripartite board must operate in accordance with KRS 273.437 and KRS 273.439 (2). Governing boards and community action boards adopt written bylaws that include: the purpose of the CAA; duties and responsibilities of the board; number of members on the board; qualifications for board membership; types of membership; the method of selecting a member; terms of a member; offices and duties; method of selecting a chairperson; a standing committee, if applicable; provision for approval of programs and budgets; the frequency of board meetings and attendance requirements; and provision of official record of meetings and action taken. The board meeting minutes are provided to CHFS, per the master agreement between the agencies. After approval by the board and signature of a board’s designed official, the minutes are sent to a policy analyst at DCBS, each board member, and the executive director.

Pursuant to KRS 273.441 (1) (e), each CAA collaborates and encourages business, labor, and other private groups and organizations to work together to encourage support of community action programs in order to provide additional private resources and capabilities.

Community Action for Kentucky provides technical assistance and training to the CAAs, a contract agent on behalf of CHFS. Additionally, CHFS offers technical assistance as needed and annual training to the CAAs to aid them in the preparation of their CSBG annual plan and budget proposals. Community Action for Kentucky has provided training to the CAAs on case planning for CSBG services. The CAAs submit an annual plan and budget proposal to CHFS. Each plan outlines CAAs’ efforts to appropriate funds, efforts, and services to low-income families in their communities. The plan requires a needs assessment process so the agencies can determine how to prioritize the domains outlined by module 2 of the annual report. The plan and budget proposal also sets forth a budget in accordance with 42 U.S. C. 9907. The funds are distributed to the CAAs by CHFS in accordance with 922 KAR 6:045.

Each CAA is required by 42 U.S.C. 9917 to implement Results Oriented Management and Accountability (ROMA). Results-management reporting impacts the way agencies document the results of their efforts. This tool is used in planning, organizing, directing, and self-evaluation. ROMA focuses on three broad areas: family, agency, and community.

The Office of Community Services (OCS) has enhanced the CSBG network’s performance and outcomes measurement system for local eligible entities identified in the CSBG Act as ROMA Next Generation (ROMA NG). This will improve the tracking and accountability measures reported by the CAAs and CHFS.

New goals have been implemented for ROMA NG, based on the theory of change. The following are the new community action goals:

1) Individuals and families with low income are stable and achieve economic security;
2) Communities where people with low incomes live are healthy and offer economic opportunity; and
3) People with low incomes are engaged and active in building opportunities in communities.

CAAs collect data utilizing the CSBG expenditures domains and the National Performance Indicators (NPIs) which are part of the annual report, module 2 through module 4. CSBG funding during the reporting period should be identified in the domain that best reflects the services delivered and strategies implemented. The CSBG expenditures domains listed in module 2, section A are as follows: employment, education and cognitive development, income infrastructure and asset building, housing, health/social behavioral development (including nutrition), civic engagement and community involvement, services supporting multiple domains, linkages, and agency capacity building. The CAAs submit the ROMA NPI reports to Community Action for Kentucky on a quarterly basis. Community Action for Kentucky submits the cumulative reports to the state at the end of the state fiscal year.

In order to meet the requirement of Performance Measurement under Section 678E(a)(1)(A) of the CSBG Act, CHFS submits Modules I-IV of the CSBG Annual report through the Online Data Collection operated by the Administration for Children and Families in pursuant of CSBG information memorandum 152. The CSBG Annual Report replaces the CSBG IS Survey. The four modules include (1) State Administration, (2) Agency Expenditures, Capacity, and Resources, (3) Community Level, and (4) Individual and Family Level. The modules “outline accountability and reporting requirements, including the establishment of a performance measurement system through which States and eligible entities measure their performance in achieving the goals of their community action plans” (information memorandum 152). Module I is completed by the cabinet and Modules II-IV will be completed by Community Action Kentucky, reviewed and then submitted by the Cabinet. The complete Annual Report will be submitted to the federal government by June 26, 2020.

DCBS completes biannual block grant status reports on CSBG for the state legislature in January and July. The status report reflects activities completed in the past six months such as expenditures, objectives, achievements, authorized changes, and evaluation of results. CHFS performs monitoring of the CAAs to determine the agencies’ compliance with applicable federal and state regulations and statutes, programmatic and financial requirements, and the agencies’ adherence to the CSBG plan and budget proposal. The Division for Administrative and Financial Management (DAFM) performs monitoring for the CAAs’ activities at the DCBS level. Monitoring is conducted on the calendar year. Each agency will be monitored at least once every three years. Depending on the findings of the monitoring, the CAAs may be required to submit a plan of corrective action. The CAAs are also subject to audit requirements per two CFR Part 200, Subpart F. CHFS, in cooperation with CAK, also monitors each of the 23 CAAs annually for the CSBG Organizational Standards in accordance with information memorandum 138.

J. **Court-Appointed Special Advocates**

Kentucky CASA Network, Inc. (KCN) is the state association for court appointed special advocate (CASA) programs. CASAs are trained volunteers, supervised by CASA programs, who are appointed by a judge to represent the best interests of dependent, abused, and neglected children in court. KCN assists in the development of new local CASA programs, monitors practices and policies of local CASA programs, and provides technical assistance to local CASA programs. KCN collects data from local CASA programs pertaining to the numbers of volunteers trained and children served. While the KCN does not administer CASA programs, for the period January 1, 2019-December 31, 2019, the KCN collaborated with a new local program to build capacity through training and prepare to provide direct services in its counties.
KCN is a statewide association. In 2019, there were 62 counties served by 23 local CASA programs. KCN works with local family courts or district courts if there is no family court, to establish local CASA programs in unserved areas.

KCN collaborates with local CASA programs across the state. One member represents local CASA programs on the KCN board of directors. KCN staff regularly communicates with local CASA programs through newsletters, conference calls, and email. KCN problem-solves with local CASA programs about matters affecting programs individually and as a group. KCN and local CASA programs have collaborated on grant requests, and KCN provides joint training opportunities for local CASA programs and in 2019 organized a statewide CASA conference.

KCN collaborates with various other local and statewide organizations, including but not limited to the DCBS, AOC, Kentucky Youth Advocates (KYA), and local family courts. KCN staff serves on an advisory committee for the Kentucky Victims Assistance Academy coordinated by the Kentucky Justice & Public Safety Cabinet and on the Prevent Child Abuse Kentucky Conference Advisory Council. KCN also serves on the Child Fatality Review Panel and Children’s Justice Act task force. KCN also works collaboratively with the state association for Children’s Advocacy Centers and other service providers in conference calls and meetings, participating in trainings, information, and data sharing.

Statewide, CASA programs experienced growth in volunteer advocates from 1,112 in 2018 to 1,313 in 2019, serving 3,818 dependent, abused, and neglected children in 2019. In 2019, 455 new volunteer advocates were trained.

In 2019, one local CASA program received full membership with the National CASA Association. Four established programs expanded into neighboring counties, and two programs merged to form CASA of Midwest Kentucky serving five counties.

In 2019, KCN provided/facilitated 13 training opportunities for local CASA program staff and board members and hosted a joint state conference with the AOC Citizens Foster Care Review Board (CFCRB) state board in November 2019. The conference was well attended, with the largest turnout to date for KCN’s statewide conference; there were more than 400 total registrations and approximately 350 attendees. Attendees included CASA volunteers (150), CASA Board Members (20), CASA staff (70), CFCRB State Board Members (60), AOC staff (20), and presenters and general admission attendees (30).

KCN received federal funding to hire staff to provide targeted technical assistance on program development and growth in implementing its aggressive strategic growth plan. For FY 2019, KCN was made the administrator of the state CASA grant funds available through the Justice and Public Safety Cabinet. This increased administrative function required KCN to adopt new policies and practices and bring on a grants specialist contractor to assist local programs with financial and programmatic reporting responsibilities. KCN also receives funding from Kentucky Justice and Public Safety Cabinet State CASA Grant, VOCA Grant, and National CASA Association Grant. The Children’s Justice Act Task Force Grant also provides KCN funding through their membership dues, fundraising events, and donations.

KCN’s 2018-2022 growth plan includes increasing the CASA program footprint into 34 new counties by year-end 2022 and adding 4 new multi-county programs. Barriers to increasing the CASA footprint are the number of counties in Kentucky, which can make sharing resources more complicated, and maintaining local organizers’ full engagement through the process of establishing a CASA program.
Another goal is to increase the number of total active volunteers to 1,400 by the end of 2021 so that CASA advocacy services are provided to more children. Barriers to achieving the increased volunteers is improving volunteer retention and raising awareness of CASA to attract new volunteers.

K. Diversion/Intensive In-Home Services Program

Diversion program services are provided to TANF-eligible families with children ages five through 17 who are at risk of removal from their biological families, relatives, or finalized adoptive families. Services are also provided to those children who are in OOH and have a plan to be returned to their families. The primary goals of the Diversion program are to 1) safely divert from OOH children committed to DCBS or who are at risk of commitment and placement in OOH, and 2) return children who have recently been placed in OOH but who, with in-home services, could be returned safely to their home. The program provides a timely (within 10 days of referral) initial clinical assessment by a staff person with at least a master’s degree in social work. The provider develops and implements an intervention plan that addresses the identified needs of the family. The family plan focuses on short-term needs and long-term sustainability of child safety. The program is available statewide.

An array of services is provided based on a comprehensive family assessment. The services must be family-focused and designed to keep children in the home without facing additional abuse or neglect. The target population is children and youth who are five to 17 years of age who can be safely maintained in or returned to their home with services. These services primarily include preservation and reunification services, clinical assessments, therapeutic child support services, parent development program, and crisis intervention services. The provider works around the family’s schedule and the diversion specialist is available to the family 24 hours a day, seven days a week.

The family service plan is developed within the first 30 days of entering the program. Program staff network and collaborate with community supports and resources such as community mental health centers (CMHCs), schools, faith-based services, housing, transportation, and medical services that can be utilized for sustained self-sufficiency. A wrap-around service delivery approach, including intervention and treatment plans, is then implemented. The family intervention can last up to six months or longer depending on the needs and progress of the family. Follow-ups are conducted at three months, six months, and one year after the family intervention to assess the success of the intervention.

In calendar year 2019, 721 families with 1,154 children were referred to the Diversion and 606 families with 1,056 children were accepted into the program (data retrieved 3.18.20).

There were 606 families referred to Diversion. Of those, 539 were accepted into Diversion and were considered to have successfully completed the service. In addition, 1,047 of 1,056 target children successfully completed the program indicating a 99% success rate. A percentage rate of 75% or more children remaining home safely at closure is an outcome measure that indicates that services were successful.

Diversion Program Outcomes, CY 2019

<table>
<thead>
<tr>
<th>Diversion</th>
<th>Families Accepted</th>
<th>Families Closed Complete</th>
<th># of Target children at risk</th>
<th># of children remained/reunified home at closure</th>
<th>% of children completing services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>488</td>
<td>433</td>
<td>869</td>
<td>819</td>
<td>94%</td>
</tr>
</tbody>
</table>
The Family First Prevention Services Act requires that services to families be provided using evidence-based practices with scientific ratings of promising, supported, and well supported. As the program begins to build capacity for using supported and well-supported EBPs for SFY 2021, Functional Family Therapy indicated for youth with varied behavioral and emotional issues will be implemented. Diversion services are being assessed to build capacity to serve families and youth with more complex issues using additional EBPs such as Motivational Interviewing and Trauma-Focused Cognitive Behavioral Therapy.

<table>
<thead>
<tr>
<th>Diversion Reunification</th>
<th>118</th>
<th>106</th>
<th>187</th>
<th>228</th>
<th>84%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Totals</td>
<td>606</td>
<td>539</td>
<td>1,056</td>
<td>1,047</td>
<td>99%</td>
</tr>
</tbody>
</table>

Families are assessed at intake and closure for family functioning using the North Carolina Family NCFAS. The scores on environment, parental capabilities, family interaction, family safety, and child well-being range from -3 (serious problems) to 0 (adequate) to 2 (clear strength). To simplify the reporting of NCFAS scores at intake and closure, scores are dichotomized into adequate or better (a score of 0 to 2) or not (a score of -3 to -1). The percent of families completing Diversion services (represented by “n”) in 2019 who scored adequate or better on each domain at intake and closure are presented below.

<table>
<thead>
<tr>
<th>Follow-up Activity Completed During Calendar Year 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 Month Follow Ups</td>
</tr>
<tr>
<td>Total # of Target Children with Follow Up</td>
</tr>
<tr>
<td>Total # of Target Children in Home at Follow Up</td>
</tr>
<tr>
<td>Percentage of Target Children in Home</td>
</tr>
<tr>
<td>6 Month Follow Ups</td>
</tr>
<tr>
<td>Total # of Target Children with Follow Up</td>
</tr>
<tr>
<td>Total # of Target Children in Home at Follow Up</td>
</tr>
<tr>
<td>Percentage of Target Children in Home</td>
</tr>
<tr>
<td>12 Month Follow Ups</td>
</tr>
<tr>
<td>Total # of Target Children with Follow Up</td>
</tr>
<tr>
<td>Total # of Target Children in Home at Follow Up</td>
</tr>
<tr>
<td>Percentage of Target Children in Home</td>
</tr>
</tbody>
</table>
At intake, families scored the lowest on Parental Capabilities and Child Well-Being. These are also the two areas where the biggest gains were made at closure. It is important to note that an increase in scores in Parental Capabilities (33%) normally correlates to an improvement in scores in Family Safety (33%) and Child Well-Being (28%).

Diversion contracts were renewed in CY 2019 for another biennium beginning SFY 2019 and ending in SFY 2021. As a result, service providers were able to continue accepting referrals and providing services with no disruption through the end of the year.

L. Early Childhood Mental Health Initiative

The Early Childhood Mental Health Program promotes the social and emotional growth of Kentucky’s children birth through age five by emphasizing the importance of nurturing relationships in multiple settings. There are 16 Early Childhood Mental Health Specialists (ECMHS) across the state located at the regional Community Mental Health Centers (CMHC). These specialists provide: consultation to early care and education settings; direct interventions to children and families identified as having social-emotional concerns; and training for early childhood professionals on social-emotional wellness and dealing with challenging behaviors. Additionally, the ECMH specialists serve as a resource for their own CMHC. A key goal of this program is to build capacity of mental health clinicians to work with the birth through five populations.

Program funded opportunities for professional development are presented statewide on early childhood mental health topics to the ECMHS. These trainings are at no cost and clinicians receive CEUs that can apply to licensure requirements.

Building the capacity of early care and education professionals supports the program goal to decrease the number of children expelled from early care and education settings. The ECMH’s provide trainings and consultations to early care and education programs at no cost. The goal is to build capacity of early
care and education professionals in addressing social/emotional issues of young children, eventually
decreasing the number of expulsions and referrals to the ECMHs.

This program is operational statewide and initial funding is through state dollars, specifically Phase I
Master Tobacco Settlement dollars. Services provided to children and families through the MCHCs are billed to Medicaid and private insurance. Program-funded opportunities for professional development are presented statewide on ECMH topics to the ECMH specialists. These trainings are at no cost and clinicians receive continuing education units that can apply to licensure requirements.

Building the capacity of early care and education professionals supports the program goal to decrease
the number of children expelled from early care and education settings. The ECMH specialists provide free trainings and consultations to early care and education programs. The goal is to build capacity of early care and education professionals in addressing social-emotional issues of young children, eventually decreasing the number of expulsions and referrals to the ECMH specialists.

Many ECMHs are members of Community Early Childhood Councils (CECC) and some hold office within
their perspective councils. The primary goal of all CECCs is to build innovative, collaborative partnerships that promote school readiness for children and families by bringing local partners together, identifying local needs, and developing strategies to address those needs. As members of CECC, the ECMHs assist with a variety of efforts including training community and family partners, needs assessment, grant writing and resource sharing. ECMHs also participate in other community groups on a regular basis such as Regional Inter-Agency Councils (RIACs) and District Early Intervention Committees (DEICs).

In addition to direct services provided to young children and their families, the ECMH specialists conducted 2,371 consultations with early childhood professionals in 2019. ECMH specialists provided 39 trainings to a variety of early care and education personnel and other stakeholders. Finally, they participated in 601 early childhood meetings including Community Early Childhood Councils, District Early Intervention Committees, Community Collaboration for Children Regional Networks, and Family Resource Youth Service Centers.

M. **Family Alternative Diversion**

Family Alternative Diversion is a diversion program for self-supporting families or families who could be self-supporting if short-term needs are met. FAD provides short-term temporary assistance to stabilize families and maintain self-sufficiency as an alternative to applying for on-going cash assistance. FAD is available to Kentucky Transitional Assistance Program (K-TAP) eligible families, not currently receiving cash payments, which are at or below the gross income limit for K-TAP for the appropriate family size. FAD is administered statewide and is funded by title IV-A, Temporary Assistance for Needy Families (TANF).

Individuals do not apply for FAD, but are screened for FAD eligibility when applying for K-TAP by local field staff. If it is determined a family could benefit from FAD, the family is given the opportunity to choose to receive either FAD or on-going cash assistance. To receive FAD payments, all short-term needs must be verified. Once expenses are verified, payments may be issued to either a vendor or vendor and applicant.

Families eligible for FAD may receive up to $1,300 to pay for verified short-term needs. The types of benefits provided include assistance with transportation, childcare, shelter, utility costs, or employment...
related expenses. FAD has a 3-month eligibility period and is not considered cash assistance. Therefore, FAD does not count towards the 60-month lifetime receipt of cash assistance. FAD may not be received more than once in a 24-month period and is limited to twice in a lifetime. Receipt of FAD payment excludes the benefit recipient from receiving on-going K-TAP benefits for 12-months, unless non-receipt would result in abuse or neglect of a child or the parent’s inability to provide adequate support due to the loss of employment through no fault of the parent. In addition to being determined eligible for FAD, additional services or referrals should be offered including: Supplemental Nutrition Assistance Program, Medicaid, childcare assistance, child support, and employment services.

In 2002, the University of Louisville conducted an evaluation of the FAD program. This evaluation indicated that FAD is assisting families in maintaining self-sufficiency and keeping them off the welfare rolls. From January 1, 2019 through December 31, 2019, an average of 13 families per month received a FAD payment. The average payment per family per month was $729.02.

No policy or procedural changes have been made to the FAD program during calendar year 2019. The Cabinet does not currently have plans to revise the program. There were no consultative efforts or technical assistance provided or received by a National Resource Center during calendar year 2019.

N. Family Preservation Program
The Family Preservation Program (FPP) describes an intensive, in-home crisis intervention resource using approved intensive family centered evidence-based practice models. The primary goal of the services is to support the cabinet’s efforts to ensure safety, permanency, and well-being of children by preventing unnecessary placement of children in OOHC, facilitate the safe and timely return home for a child or youth in placement, as well as enhance protective and parental capacities of caregivers.

The Family Preservation service array includes Intensive Family Preservation Services (IFPS) – for families with children at imminent and immediate risk of out-of-home placement. Family Reunification Services (FRS) – to help children in out-of-home care return to their families; and Families and Children Together Safely (FACTS) – for families with children at risk of out-of-home placement or returning from out-of-home care. Eligible families are referred by DCBS frontline staff and referrals are screened and approved by a designated DCBS regional staff person. Families served are evaluated using the NCFAS and other clinical assessments to provide a comprehensive assessment of family functioning and determine service needs. The lower scores on the NCFAS form the basis for goal development using evidence based intervention strategies and curricula that promote cognitive behavioral changes.

FPP services are provided statewide in all 120 Kentucky counties through contracts with non-profit agencies. Regional management teams are comprised of DCBS staff, including the person responsible for screening all family preservation and reunification referrals; the SRA or designee; the FPP supervisor; and the agency designee. This team determines any specialized FPP services and provides ongoing oversight of the services. FPP specialists and supervisors may participate in school-based meetings, coordinate mental health services, and locate both hard and soft resources such as housing, counseling, and parenting classes. FPP also networks with community partners including representatives from domestic violence shelters, family team meetings, drug task forces, IMPACT, mental health services, CACs, health departments, housing programs, and faith-based services.

FPP services provide a wide variety of family centered, strength based services for children, families that include a comprehensive family assessment and use of evidence based cognitive and behavioral change strategies, crisis intervention, parent education programs, family, and youth support services.
Additionally, FPP specialists are available to families 24 hours a day, seven days a week. A percentage rate of 75% or more of children remaining in the home indicates that the services were successful. The table below indicates that more than 93% number of children at risk were maintained in their homes at closure.

<table>
<thead>
<tr>
<th>Family Preservation and Reunification Services</th>
<th>Duration and Service Intensity</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IFPS - Intensive Family Preservation Services</strong></td>
<td><strong>Duration:</strong> Average 4-6 weeks. <strong>Service Intensity:</strong> Intensive in-home services provided for 6-10 direct hours per week. <strong>Caseload:</strong> 2 – 4 families at a time. <strong>Age limit:</strong> 0-17 years old.</td>
<td>858 of 933 families completed services 1,758 of 1,834 children remained safely in the home (95%)</td>
</tr>
<tr>
<td><strong>Referral Criteria:</strong> Imminent risk of removal of child from home.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>FRS (IVB) - Family Reunification Services</strong></td>
<td><strong>Duration:</strong> Average 3-6 months (extensions are based on need and progress made) <strong>Service Intensity:</strong> Average minimum 3-8 direct hours per week. <strong>Caseload:</strong> Not to exceed 6 cases at a time. <strong>Age limit:</strong> 0-17 years old</td>
<td>298 of 324 families completed services 543 of 576 children remained safely in the home (94%)</td>
</tr>
<tr>
<td><strong>Referral Criteria:</strong> A plan to return a child home from out-of-home care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>FACTS (IVB) - Families and Children Together Safely (preservation/reunification)</strong></td>
<td><strong>Duration:</strong> Average 3-6 months (extensions are based on need and progress made) <strong>Service Intensity:</strong> Average minimum 3-8 direct hours per week. <strong>Caseload:</strong> Not to exceed 6 cases at a time. <strong>Age limit:</strong> 0-17 years old</td>
<td><strong>FACTS Preservation</strong> 590 of 651 families completed services 1,163 of 1,216 children at risk remained safely in the home (97%) <strong>FACTS Reunification</strong> 111 of 119 families completed services 203 of 218 children at risk remained safely in the home (93%).</td>
</tr>
<tr>
<td><strong>Referral Criteria:</strong> Child at risk of removal from home or child in out-of-home care with a plan to be reunified with family.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

From January 1, 2019 through December 31, 2019 there were 2,027 families with 3,844 children at risk of out of home care placement or reunifying from foster care participating in one of the FPP services (data retrieved March 18, 2020). Of those children, 3,667 were reunified with their families or remained home safely at closure indicating a 95% success rate.

The following data shows the number of families and children served by service and the primary indicators of program goals to maintain children safely at home with the family and maintain permanency and stability in their living situations.

**Intensive Family Preservation (IFPS):**
- 933 families accepted
- 858 families completing services
- 1,834 children at imminent risk of placement
- 1,758 of 1,834 children remained safely in the home (96%)
Family Reunification Services (FRS):
• 324 families accepted
• 298 families completing services
• 576 children to be reunified
• 543 of 576 children safely returned to home (94%)

FACTS Preservation
• 651 families accepted
• 590 families completing services
• 1,216 children at risk
• 1,163 of 1,216 children at risk remained safely in the home (97%)

FACTS Reunification
• 119 families accepted
• 111 families completing services
• 218 children at risk
• 203 of 218 children at risk remained safely in the home (93%)

Projected numbers of families and children for 2020 based on a 25% increase on calendar year 2019 numbers are as follows:

Intensive Family Preservation (IFPS):
• 1,166 families accepted
• 1,073 families completing services
• 2,293 children at risk of placement
• 2,198 (96%) children to remain safely in the home

Family Reunification Services (FRS):
• 405 families accepted
• 373 families completing services
• 720 children at risk of placement
• 679 (94%) children to remain safely in the home

Families and Children Together Safely (FACTS) Preservation
• 814 families accepted
• 738 families completing services
• 1,296 children at risk of placement
• 1,275 (98%) children to remain safely in the home

Families and Children Together Safely (FACTS) Reunification
• 149 families accepted
• 139 families completing services
• 273 children at risk of placement
• 254 (93%) children to remain safely in the home

Additional funding was added to FPP contracts in March 2019, to serve an additional 25% of families. This was achieved by the 4th quarter of 2019, with an additional 27% served at that time.
Families and children who have completed FPP services are also followed at three, six, and 12 months to determine if the child who was at risk of removal (or was reunified) remains in the home. The six-month follow-up contact is a face-to-face visit with the family and child if possible and includes a review with the family of the maintenance of safety and family functioning goals.

Follow-up Activity Completed from January 1, 2018 - December 31, 2018

<table>
<thead>
<tr>
<th></th>
<th>IFPS</th>
<th>FRS</th>
<th>FACTS-P</th>
<th>FACTS-R</th>
<th>All FPP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>6 Month Follow-Up</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># Children at Risk with Follow Up</td>
<td>1,793</td>
<td>536</td>
<td>1,238</td>
<td>244</td>
<td>3,811</td>
</tr>
<tr>
<td># Children at Risk in Home at Follow-Up</td>
<td>1,630</td>
<td>471</td>
<td>1,138</td>
<td>214</td>
<td>3,453</td>
</tr>
<tr>
<td>Percent of Children at Risk in Home at Follow-Up</td>
<td>92%</td>
<td>88%</td>
<td>92%</td>
<td>88%</td>
<td>91%</td>
</tr>
<tr>
<td><strong>12 Month Follow-Up</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># Children at Risk with Follow-Up</td>
<td>1,866</td>
<td>392</td>
<td>1,229</td>
<td>296</td>
<td>3,783</td>
</tr>
<tr>
<td># Children at Risk in Home at Follow-Up</td>
<td>1,669</td>
<td>305</td>
<td>1,072</td>
<td>261</td>
<td>3,307</td>
</tr>
<tr>
<td>Percent of Children at Risk in Home at Follow-Up</td>
<td>89%</td>
<td>78%</td>
<td>87%</td>
<td>88%</td>
<td>87%</td>
</tr>
</tbody>
</table>

Families served are evaluated at intake, closure, and at interim for services extending beyond 45 days using the NCFAS and other clinical assessments. This provides a comprehensive assessment of family functioning and determines service needs. The NCFAS comprises five domains for preservation and seven domains for reunification, which are measured on a 6-point rating scale. Rating scores and change scores measure the family’s capacity to provide for the child’s needs and the lower scores form the basis for goal development. Improved closing scores can indicate increased parenting capacity in areas such as supervision, discipline of children and improved family communication and problem solving.

In the chart below, outcomes for families completing IFPS (represented by “n”) during 2019 are evaluated by showing the overall change in the percent of families who scored at or above baseline in each of the five categories at Intake and Closure.

**NCFAS Scores at intake and closure CY19**
The chart above shows significant improvement that families made in the domains of Parental Capacity, Family Safety, and Environment at the completion of IFPS services. Parental Capabilities domain is one of three domains namely; Parental Capabilities, Family Safety and Child Wellbeing, where families referred to FPP usually experience low scores ranging from moderate to serious problem. Comparison of the intake and closure scores reveal that greater gains were made in Parental Capabilities (35%), Family Safety (36%), and in Environment (30%). An increase in scores in parental capabilities normally correlates to an improvement in scores in Family Safety and Child Wellbeing. This shift in NCFAS scores indicates that incremental and impactful improvements can be measured during the IFPS intervention.

FPP services are funded through multiple funding streams:
- State General Funds help support IFPS to provide intensive in-home services to families with children at imminent and immediate risk of out-of-home placement.
- Title IV-B Subpart 2 Funds (PSSF) provide for FRS to help facilitate the reunification of children in out-of-home care return to their families. It also funds FACTS that provides less intensive preservation and reunification services to families with moderate risk for out of home placement and facilitates reunifications for children returning from OOHC.
- TANF funds also support and supplement preservation and reunification services statewide for TANF eligible families with children at risk of removal or are returning home from OOHC.

Future direction of the program includes the following:
- Continue to expand numbers served statewide, as additional funding becomes available.
- For CY 2020, the Cabinet will continue to assess the statewide implementation of EBPs for in-home services provision and provider readiness for capacity building and growth.
- The following IEBPs were approved for use in in-home services delivery statewide: Functional Family Therapy, Homebuilders Model, Motivational Interviewing, Multisystemic Therapy, Parent-Child Interactional Therapy, Sobriety Treatment and Recovery Teams, and Trauma-Focused Cognitive Behavioral Therapy.
• All FPP programs currently report their data online using the In-Home Services (IHS) Activities Data Collection tracking system. The data collected informs evaluative efforts.
• Interim checks matching data from the monthly reports submitted online are helping providers and central office improve both data entry and the quality of the reports that can be run. This has greatly improved the consistency of data reported statewide.
• The data collected is used to closely monitor service provision and to evaluate overall program improvement and quality assurance.

There are no new policies or administrative regulations affecting service provision at this time. There were no consultative efforts or technical assistance provided by the National Resource Center.

O. Family Resource and Youth Service Centers
The Family Resource and Youth Services Centers (FRYSCs) initiative was established by an act of the Kentucky General Assembly in 1990. The authorizing legislation indicates that the purpose of the local FRYSCs is to enhance students’ abilities to succeed in school. The legislation further clarifies the role of FRYSCs as focusing upon the non-academic barriers to education. The FRYSCs accomplish their mission through a comprehensive assessment of need of students, families, school personnel, and community partners. Their primary role is to serve as brokers of existing services as needs may indicate. They also are to work to identify gaps in and barriers to services as they assist students and their families. FRYSCs collect local data in the KDE’s “Infinite Campus” system. Services are funded through state general fund dollars as part of the state’s KDE budget. The Division of FRYSCs in CHFS provides state-level support and administrative coordination. The division of FRYSC (the state office) developed the following mission statement that encompasses the work of the initiative:
• Early learning and successful transition into school;
• Academic achievement and wellbeing while in school; and
• Graduation and transition into adult life.

At the state level, the Division of FRYSCs additionally conducts a minimum of three regional information-sharing meetings with local staff annually. Local FRYSC programs are located in 1,217 of Kentucky’s nearly 1,250 public schools. There is at least one program in all 120 of Kentucky’s counties. This initiative is a part of educational reform legislation that calls for centers to be established in or near schools where 20% or more of the school’s enrollment qualifies for free school meals. In the 2000 session of the General Assembly, this criterion was altered to 20% of a local school’s enrollment qualified for free or reduced priced school meals. Local FRYSCs have consistently worked to either connect with or initiate local collaborative partnerships to identify current resources and expand existing networks. FRYSCs staff attend local inter-agency councils and vision groups as well as other collaborative meetings. They are also statutorily required to be a part of local early childhood councils. The local FRYSCs are also involved in numerous community groups that focus of specific issues such as substance abuse, mental health counseling, physical health issues, and numerous others. Each local FRYSC is required to have an advisory council that involves community partners, parents, and school staff. Some communities have Kentucky Integrated Delivery System meetings, which serve as a collaborative effort to case conference regarding specific needs. Many local FRYSCs are involved in writing grants to fund initiatives through their local centers.

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
• 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
• Family crisis and mental health counseling

P. Family Violence Prevention Funds
The Family Violence Prevention and Services Grant is administered for CHFS, which contracts with the Kentucky Coalition Against Domestic (KCADV) for implementation. KCADV subcontracts with 15 domestic violence programs in the 15 area development districts across the state for direct service implementation regionally. The domestic violence programs provide shelter and related services to victims of domestic violence and their dependent children and are geographically distributed to be no more than sixty miles distance from any state resident. The mission of the KCADV is to end intimate partner violence, promote healthy relationships and engage communities through social change, economic empowerment, educational opportunities and other prevention strategies. Funding for KCADV comes from the Family Violence Prevention and Services Grant, the Kentucky General Fund, TANF, Kentucky Trust and Agency, and Social Services Block Grant.

KCADV operates a Training Institute, which provides continuing education for professionals, such as attorneys, nurses, social workers, teachers, and translators. The Coalition works closely with judges and frequently participates in law enforcement training. Local shelter programs who sub-contract with KCADV work with child protective services across the state to reunify children and parents. All local programs are involved with local coordinating councils, which bring together child protective services and other community agencies. This effort streamlines services to resolve problems in assisting victims of domestic violence and helps to prevent future instances of violence. All programs operating under KCADV provide court advocacy to victims of domestic violence and work closely with law enforcement agencies. Services offered use a trauma-informed approach and include, but are not limited to crisis lines, emergency shelter, intervention, advocacy, counseling, case management, children’s services, community education, technical assistance, product development, systems advocacy, and training.

2019 Programing Additions and Highlights
• Limited therapy for children ages 8-18
• Structured summer program with activities for moms and children
• Structured age appropriate groups for residential and non-residential children, including outreach
• Domestic violence victims group for teens ages 16-19
• Transportation to services is problematic in many of the regions. Several shelters have requested grant funds to obtain vehicles in order to address the transportation need highlighted by many survivors.
• Several shelters have opened walk-in clinics in highly populated urban areas that are accessible by public transportation.
Housing is a top priority, and KCADV administers two HUD grants that provide rental assistance to survivors totaling close to $900,000 in housing funds. These funds were awarded to KCADV and BRASS and went into effect in late 2019.

The Green Dot Primary Prevention Program for teens lowered rates of interpersonal violence by building awareness within the community and providing resources that could help alleviate the impact of interpersonal violence on victims and their children.

Themes for the summer activities centered on literature, related music, movies, and creative activities.

A separate area for teens to have a space of their own in the shelter has been created that includes computers, games, comfortable seating, books, headphones, music, etc. This room has been helpful in allowing teens to relax, process their feelings, and given them a sense of belonging.

GreenHouse 17, located in Lexington, KY, is operating a farm to create an agriculture-based healing environment to meet the needs of victims as they strive to rebuild their lives as survivors. The vision for the farm is to become an economically self-sustaining program that provides a reliable source of revenue for the agency. The farm program applies a trauma-informed care model based on the therapeutic benefits of nature-based activity. This program has received several national and statewide awards. GH17 provides health and beauty products as well as a flower community support agriculture (CSA) program.

Local shelter programs continue to recruit, hire and maintain bilingual professionals on their staff in an effort to ensure the ability to access, in person and/or by phone, interpreters for those clients with Limited English Proficiency (LEP). All shelters gives clients with LEP “I Speak” cards to keep with them. These cards explain the requirement of organizations that receive federal funds to provide interpreters to ensure access of services they are funded to provide. The cards also give information regarding the right to an interpreter free of charge and information regarding how agencies and businesses should respond to people who are LEP.

100% of KCADV member programs have language access policies in place. Language access policies include provisions for accessing certified ASL interpreters 24 hours a day, 365 days per year. Policies were reviewed and updated by KCADV staff so that all member programs have a standardized language access policy that also accounts for ASL interpretation needs.

The Women’s Crisis Center in northern Kentucky continues an agreement with St. Elizabeth Healthcare. This provides crisis intervention and safety planning in their five emergency departments located across the northern Kentucky area. Staff and specially trained volunteers respond 24 hours a day, 365 days a year to victims of intimate partner violence and their non-offending loved ones. They also receive calls from behavioral health units, intensive care units, oncology, and St. Elizabeth physician’s offices.

KCADV created a position designed to address substance use/mental health issues in member programs. The position will provide training, technical assistance, product development, and systems advocacy related to substance use, mental health, and systems involvement.

KCADV entered into an agreement to work with the Adult Substance Use Treatment and Recovery Services, Division of Behavioral Health to provide 10 peer support specialists that will provide direct substance use treatment activities to survivors in member programs.

KCADV conducted a series of focus groups with survivors to identify the level of systems involvement for survivors of violence and their risk for the removal of their children due to domestic violence.

Incorporation of the BIP program into Coalition office activities.
• KCADV began collecting data regarding survivors who have had their children removed due to domestic violence and lack of understanding of the dynamics of domestic violence.
• KCADV requested regulation changes to allow member programs to be able to administer emergency medication such as Narcan/Naloxone.
• KCADV operates an AmeriCorps*State grant that deploys 20 AmeriCorps members to member programs to assist with shelter service delivery and address the economic needs of survivors affected by poverty.
• Selected statistics:
  o 3,627 people were served through emergency shelter services.
  o 16,605 people received group counseling services.
  o 18,604 survivors received non-residential services through 15 member programs.
  o 209 men received domestic violence services through our programs.
  o 1,820 children received services from our programs.
  o 2,251 survivors who identify as African American, 651 who identify as Hispanic/Latino, and 77 who identified as American Indian/Alaskan Native received domestic violence services from our programs.
  o 342 survivors who identify as lesbian, gay, bisexual or transgender received services.
  o 310 survivors had Limited English Proficiency.
  o 223 survivors requested emergency assistance with an average of $264.22. A total of $58,921.68 was spent on these individuals/families.

Q. Health Access Nurturing Development Services (HANDS)
The Health Access Nurturing Development Services (HANDS) program is a voluntary home visitation program for new and expectant parents. Any parent expecting a new baby and residing in Kentucky is eligible. Services can begin during pregnancy or any time before a child is three months old. Families begin by meeting with a HANDS parent visitor who will discuss any questions or concerns about pregnancy or a baby’s first years. Based on the discussion, all families will receive information and learn about resources available in the community for new parents. Some families will receive further support through home visitation. HANDS is supported by federal Medicaid and state Tobacco Funds, and operates statewide as a free service program. The program is housed in the local health departments in all 120 counties in Kentucky. The primary goals of the HANDS program include:
  • Healthy pregnancies and births;
  • Healthy child growth and development;
  • Healthy, safe homes; and
  • Self-sufficient families

R. Kentucky Center for School Safety
Kentucky schools focus on providing a warm culture and climate for both students and staff conducive to high levels of productivity and outstanding academic performance. In today’s society, school safety is a daily issue that ranges from classroom management to school incident command for crisis situations. The Kentucky Center for School Safety (KCSS) staff is committed to providing training, resources, information and research.

KCSS’ belief is that school culture improves when a school-wide prevention plan consistently addresses the needs of all students to encourage a safe and healthy learning environment. The mission and scope of work for KCSS demanded that a statewide collaborative effort be undertaken. This collaborative partnership brings together a dynamic blend of experience and expertise in project management and
the provision of training and technical assistance to education, human service and justice professionals, teacher preparation, applied research, electronic communication, and school and community needs assessment.

The Kentucky Educational Collaborative for State Agency Children (KESAC) assists local education agencies to provide and assure high-quality educational support services through a collaborative delivery system involving the Kentucky Department of Education (KDE), Department of Juvenile Justice (DJJ), community based services, mental health services, developmental disabilities and addiction services, and private and public child and youth care programs. KECSAC provides administrative services, professional development, and leadership in an efficient and cost-effective manner that complies with state education reform initiatives and other applicable state and federal mandates. KECSAC provides a comprehensive evaluation of the delivery of educational services to state agency children including the administrative process, service delivery, program monitoring, and outcomes.

Throughout the year, KCSS is available to schools across Kentucky. KCSS, KDE, and KSBA collaborate to provide safe school assessments to any school in Kentucky. The voluntary assessment can enhance the school’s learning environment by examining climate and culture. KCSS oversees and distributes safe schools’ funds to each local school district, the Kentucky School for the Blind, and the Kentucky School for the Deaf. A safe school assessment is a service provided by the KCSS at no cost to the school or district. The KCSS staff takes great pride in being able to fully accommodate superintendents, principals, and other school personnel as well as parents and community members whenever they contact the center for assistance.

Additionally, KCSS is working closely with all schools statewide to address training for gun violence, safety, and bullying for students and staff. Due to the increase of gun violence in the school system, KCSS produced brochures to assist school staff to identify indicators of violence and areas of safety improvements. Current barriers to this initiative are fiscally based.

On July 13, 2018, Governor Bevin issued an executive order reorganizing various education boards and councils. The Governor abolished Center for School Safety (KRS 158.442 and KRS 158.443) then recreated it and reconfigured the KCSS Board of Directors. The KCSS Board of Directors was reduced from 12 members to 11 members. DCBS is no longer a required member. The board disbanded on 7/03/2018.

Other Board of Director members represent Circuit Court, Division of Mental Health, School Superintendents, Department of Education, Department of Juvenile Justice, Kentucky Education Support Personnel, Kentucky Association of School Councils, School Principals, School Boards, School Bus Drivers and teachers.

Changes implemented by the Executive Order will have minimal fiscal impact. The board will see a reduction in size, which could lead to nominal savings.

S. Kentucky Children’s Health Insurance Program
The Kentucky Children’s Health Insurance Program’s (KCHIP) mission is to promote responsible partnerships between families and community agencies in order to establish and maintain access to health insurance for Kentucky’s eligible children. A statewide program, KCHIP collaborates with various organizations and agencies in order to ensure quality access to care for enrollees. KCHIP contracts with DCBS and Benefind to determine eligibility for potential enrollees. KCHIP also works closely with local
health departments to provide age-appropriate screenings for enrolled children and with the Department for Public Health to provide vaccines for eligible enrollees.

All KCHIP enrollees receive a benefit package that provides comprehensive coverage to meet children’s physical and mental health needs. KCHIP covers health check-ups, screenings, prescriptions, medications, immunizations, physician office visits, hospital care, mental health, allergy injections, substance abuse, and other medically necessary services.

Additional information about KCHIP can be found at https://chfs.ky.gov/agencies/dms/Pages/default.aspx. Other Medicaid programs can be found at: https://chfs.ky.gov/agencies/dms/Pages/default.aspx.

Title XXI and state general funds fund KCHIP. Services are available statewide. KCHIP uses quality standards, performance measures, and information and quality improvement strategies to assure high-quality care for KCHIP enrollees. Data is collected to maintain fiscal resources and proper administration.

Per Affordable Care Act requirements, children below 138% of the federal poverty level (FPL) (P5 status codes) in the KCHIP Expansion Program were transitioned into Medicaid effective 1/1/2014. Per Centers for Medicare and Medicaid Services (CMS) direction and funding purposes, this group of children continues to be counted with the number of children served in the KCHIP Expansion Program. Per FY 2019 final reports, CMS 64 EC-21E (Expansion) and CMS-21E (KCHIP), 108, 297 children were served during FFY 2019.

As per the Department for Medicaid Services’ contract, the Managed Care Organizations, (Passport Health Plan (PHP), Humana, Well-Care, Aetna Better Health of KY and Anthem), must implement and operate a comprehensive Quality Assessment/Performance Improvement (QAPI) program that assesses, monitors, evaluates, and improves the quality of care provided to its members. The MCOs must provide QAPI program status reports to DMS quarterly. The QAPI program is reviewed annually for effectiveness with a final report submitted to DMS. The MCOs are required to implement steps towards improving performance goals for the Kentucky Outcomes Measures and HEDIS measures. The MCOs conduct annual surveys of member and providers’ satisfaction with the quality of services provided and their degree of access to services by participating in the Consumer Assessment of Healthcare Provider and System (CAHPS) Survey.

During the reporting period, Kentucky continued to coordinate with a statewide managed care system to expand outreach efforts and continue to increase awareness of the program at the community level. Eligibility passive renewal process was instituted in July 2015, which allowed eligibility to be recertified electronically via a match with the federal hub. Therefore, increases in enrollment trends are expected to continue. KCHIP’s ongoing goals are to continue to increase retention efforts, maintain current level of outreach, and to continue to increase enrollment.

T. Kentucky Education Collaboration for State Agency Children
KECSAC is a statewide collaborative that works with state agencies, school districts, and local programs to ensure that state agency children (SAC) receive a quality education comparable to all students in Kentucky. SAC are all children and youth placed in programs contracted, funded, and/or operated by DJJ, CHFS (which includes DCBS), and DBHDID in the state of Kentucky. All monies come from state general funds.
KECSAC is committed to the belief that all children can learn and have a right to quality education. KECSAC protects and assures this right by accessing resources and providing support to programs that educate SAC. Those children who do not receive an education of quality cannot realize their greatest potential. KECSAC believes these goals are achieved through the process of interagency collaboration. To accomplish the mission, all members of this statewide partnership must exemplify and publicly promote collaborative relationships with our partners and other associates. KECSAC provides facilitation services and mediation support to districts and programs when needed to settle disputes between school districts and programs. A quarterly newsletter, The Collaborative, is published by KECSAC to include annual census report, annual program directory, and quarterly and annual progress reports. Also included is the task of reviewing and recommending revisions to KECSAC regulations and statutes.

KECSAC staff meet every other month with the Interagency Advisory Group, which consists of the following collaborative partners: DJJ, DCBS, DBHDID, the Kentucky Department of Education (KDE) and the College of Education at Eastern Kentucky University.

KECSAC distributes the SACs fund to programs that serve SAC in educational settings. The funds must be used by educational programs in state educational districts to provide smaller student to teacher ratios (10:1) and to provide extended school days during the academic year (an additional 33 educational days are required in order to receive SAC funds).

Currently, KECSAC operates 80 educational programs in 50 school districts across Kentucky. Thirty-nine (39) of these programs contract with DCBS. Program improvement specialists use a tool, which aligns with Kentucky’s standards and indicators, to audit the educational services provided the youth in state care. Specialists observe classrooms, review prepared evidence, as well as interview the school administrator, program administrator, teacher, and students. If needed, recommendations for improvement are communicated to the program and a follow-up visit is scheduled. Attention is also paid to progress made from the previous year’s report to ensure programs are continuing to meet standards and improve curricula. Every program is visited at least once per year to ensure youth are receiving a quality education.

The percentage of children from DCBS being served by KECSAC programs has been increasing since 2006. The highest frequency of DCBS KECSAC served is age 17 with 503, followed by age 16 with 380, and age 15 with 268 students. The majority (1456 or 69%) of DCBS KECSAC students are male. The largest numbers of KECSAC students are in grades nine and ten. A significant number of DCBS children, 897 or 43%, are diagnosed with a disability. Emotional Behavior Disability is the highest frequency category with 337. Other Health Impaired is the second highest category with a frequency of 217. The majority of children served in KECSAC programs identify as white, 69%. Black or African American is the second highest race category with 22% (overrepresentation).

In addition to providing the funding for educational programs that serve state agency children, KECSAC also provides training to educators and administrators in the programs. Annually, KECSAC provides professional development opportunities for educators through their at-risk conference, KY Alternative Education Summit, and the New Educators Training. Professional development events are free to KECSAC program members and consistently rank very well in evaluations from attendees.

**U. Kentucky Partnership for Families and Children, Inc.**

Kentucky Partnership for Families and Children, Inc. (KPFC) is a statewide, non-profit, family organization that was founded in 1998. A family organization is an organization that has 51% or more
parents/primary caregivers raising children with behavioral health challenges. KPFC has five permanent employees; 50% of the staff is parents that have raised, or are raising, children with behavioral health challenges and 50% of the staff are adults that received services for children’s behavioral health disabilities under the age of 18. KPFC supports five different programs: transitional-age youth leadership; family and youth peer support specialists, family and youth network building; regional Peer Support Centers; and training for parents, teens, and provider partners. KPFC is partnering with DBHDID and DCBS on Kentucky’s System of Care FIVE grant that focuses on expanding and strengthening Kentucky’s services and supports for families that have involvement with child welfare services and have at least one child that has a serious emotional disability.

KPFC staff, parent leaders and transitional-age youth leaders participate on multitude of state level and regional level committees:

- SIAC Subcommittees,
- Children’s Justice Act Task Force,
- System of Care FIVE Grant Management and Implementation Team,
- Kentucky Partnership for Youth Transition,
- Transition Age Youth Launching Realized Dreams,
- Kentucky Interagency Transition Committee,
- Kentucky Behavioral Health Block Grant Council,
- Strengthening Families Leadership Team, and others.

KPFC staff, parent leaders, and transitional-age youth leaders also provide trainings/workshops across the state for professional groups as well as for foster/adoptive parents and teens: Reactive Attachment Disorder, Surviving Challenging Behaviors, Better Understanding ADHD/Bipolar Disorder/etc., Bridges Out of Poverty, and Youth Mental Health First Aid.

KPFC’s board also consists of 51+% parents and agency representatives from child welfare, courts, education, private childcare, etc.

KPFC receives funds from DBHDID and fees for service for training, fundraising and donations. KPFC services are available statewide. KPFC accomplished the following in 2019:

- Monthly e-newsletters disseminated to 2,500+
- Conference and workshop attendance: 500+
- Children’s Mental Health Awareness Day: 90+
- Resource requests: 500+

Many DCBS contracted PCPs and PCCs are embracing and implementing the Building Bridges Initiative (BBI), which utilizes System of Care values and principles including family-driven and youth-driven care. The philosophy is that children grow better in families and when possible in their home communities. Over past five years, Kentucky leaders at DBHDID and DCBS have prioritized BBI as how PCPs, PCCs, BHSOs, and CMHCs need to do business. This effort has included trainings, regularly scheduled meetings, and coaching/consultation received by BBI National.

KPFC has created three KPFC Peer Support Centers in three different regions of the state. These Peer Support Centers allow peer services to be offered in a flexible and creative manner. New data is showing that peer services are best when provided by a peer-run/family-run organization because this allows peer support specialists to provide the services needed to meet the needs of their customers and
doesn’t solely focus on what is billable. Barriers for effective/maximum service delivery for this program include the inability to bill Medicaid, the need for office space in various locations across the state, and finances to support peer support positions.

V. Kentucky Strengthening Families
Kentucky Strengthening Families (KYSF) represents a multi-disciplinary partnership of over 20 national, state, local, public, and private organizations dedicated to embedding six research-based protective factors into services and supports for children and their families. Supporting families is key strategy for promoting school readiness and preventing child abuse and neglect. All families experience times of stress, and research demonstrates that children grow and learn best in families who have the supports and skills to deal with those times. By supporting families and building their skills to cope with stressors, we can increase school readiness and reduce the likelihood abuse will occur in families. KYSF uses a nationally recognized strategy: Strengthening Families: A Protective Factors Framework, which is coordinated nationally by the Center for the Study of Social Policy. In April 2017, KYSF began to promote the complimentary Youth Thrive Protective Factor Framework for youth ages 9-26 years old. In 2018, Youth Thrive was combined with KYSF into a 2-day training event: Family Thrive.

The vision of KYSF is that all Kentucky children are healthy, safe, and prepared to succeed in school and in life through families that are resilient, supported, and strengthened within their communities. The mission of KYSF is to strengthen families by enhancing protective factors that reduce the impact of adversity and increase the well-being of children and families through family, community, and state partnerships. KYSF is supported by the Governor’s Office for Early Childhood through funds from the Race to the Top/Early Learning Challenge Grant and the Tobacco Settlement Dollars administered by the Department for Public Health. KYSF is a statewide, long-term initiative, with ten-year goals.

Kentucky Strengthening Families (Prenatal- Age 8) Protective Factors include:
- Parental Resilience: Families bounce back.
- Social Connections: Families have friends that can count on.
- Knowledge of Child Development: Families learn how their children grow and develop.
- Concrete Support in Times of Need: Families get assistance to meet basic needs.
- Social and Emotional Competence of Children: Families teach children how to have healthy relationships.
- Nurturing and Attachment: Families ensure children feel loved and safe.

Kentucky Youth Thrive (Age 9- Transitional Age Adult)
- Youth Resilience-Youth bounce back when life gives them challenges.
- Social Connections-Youth have genuine connections with others.
- Knowledge of Adolescent Development-Youth Understand-Youth understand the science of their development.
- Concrete Support in Times of Need-Youth find resources and support in their community that help them.
- Cognitive, Social and Emotional Competence-Youth know how to communicate their thoughts and feelings effectively.

The overarching goal of the Family Thrive framework is to achieve positive outcomes by mitigating risk and enhancing healthy development and well-being of children and youth. These guiding premises provide the foundation for Kentucky Strengthening Families (prenatal-elementary age) and Kentucky Youth Thrive (adolescent-transitional adults).
During 2019, the Kentucky Strengthening Families Leadership Team met monthly with workgroups consisting of Family Informed, Training and Technical Assistance, Evaluation, Partnerships and Integration and Communication. Representatives from over 20 partner organizations, departments, and agencies make up the Leadership Team.

Two Regional Leadership Teams were created in 2018. One in Northern Kentucky and one in Western Kentucky. The regional team membership is representative of similar partners as the state team. A third regional team formed in Floyd County in June 2019. All regional teams are securing grant funding for projects related the Kentucky Strengthening Families. These teams meet bi-monthly and representatives from the regional teams attend the state meeting.

Some of accomplishments include the following:
In 2019:
• Trained 160 individuals in hosting Parent and Youth Cafés
• Trained 60 new Family Thrive Trainers

Currently there are 144 master trainers for Family Thrive.

Protective Factor Surveys and Café evaluations for Parents and Youth are being collected in the regions. Training data and collective impact data along with self-assessments for service providers are being collected and will be analyzed in 2020. Family engagement best practices will be identified through the Preschool Development Grant in 2019. Once our new social and emotional consultant is on board, we will work to create a new system for accurately collecting date across the state, which will include active trainers, new trainers that participate in the Training of Trainers (TOT), and number of trainings.

Proposed future direction for the program includes:
• Expansion of regional teams
• Training specific to regions
• Regional Summits
• Parent and Youth Café Expansion
• Social media presence

W. Kentucky Strengthening Ties and Empowering Parents (KSTEP)
CHFS implemented the Kentucky Strengthening Ties and Empowering Parents (KSTEP) through the title IV-E waiver demonstration project, as a resource to prevent unnecessary removals of children and to reduce the number of children in out of home care (OOHC). KSTEP launched in July 2017 in Carter, Greenup, Mason, and Rowan Counties within DCBS’ Northeastern Service Region. KSTEP expanded to Bath, Montgomery, Lewis, and Fleming Counties in July 2019. KSTEP is currently in the processing of implementing KSTEP in Boyd, Lawrence, Elliott, Morgan, Menifee, Bracken, and Robertson Counties. This expansion will ensure that all counties in the Northeastern Service Region have the KSTEP program. KSTEP seeks to (1) reduce the need for out of home care (OOHC) placements, (2) shorten the duration of any necessary OOHC placements, (3) reduce repeat maltreatment, and increase well-being of families by enhancing caregivers’ capacity to care for children, and maintain them safely in their own homes. To achieve the above goals, the KSTEP program integrates substance abuse treatment services, child welfare practice, and family preservation services into an approach to deliver services that address the special needs of substance-affected families involved with DCBS. The title IV-E waiver demonstration
project ended on September 30, 2019. KSTEP is currently utilizing state funding during the transition to implementing the Family First Prevention Services Act, enacted on October 1, 2019.

As of March 1, 2020, there have been 391 referrals, serving a total 770 children since the programs’ inception. Since the involvement of those families with KSTEP, 722 children have remained in their home and 48 children have been placed in OOH or relative/kinship placement. This is a 94% success rate of keeping children in their home of origin. Since implementation in July 2017, KSTEP has had 269 cases that have closed and 148 of these cases were closed successfully which is defined as completing the program per design. There have been 12 incomplete referrals, 22 assessment only cases, 36 cases that were unable to meet the program requirements, 22 cases that chose to leave services prior to completion, nine cases that were closed due to permanent relative placement, one case that was moved to OOHC, one case that moved out of the service area, and 18 cases that were closed due to “other.” These closure reasons suggest that the children in cases that are not able to complete the program per its design are still able to remain safely in their home of origin with the assistance of KSTEP services.

From January 1, 2019 to December 31, 2019, KSTEP serviced 195 families and 370 children. Of those children, 358 remained in their home of origin, 12 children were placed in OOHC or in relative/kinship placement. In 2019, there was a 97 percent success rate of keeping children in their home of origin.

To assess the program impact of KSTEP, primary data and secondary data were collected, analyzed, and reported. Primary data were collected from KSTEP families at a multiple intervals throughout the life of the KSTEP case and included family level and individual level assessments (e.g., NCFAS, ASI, and PSI). Secondary data, including case management/service delivery activities documented in the KSTEP database and outcomes including repeat maltreatment and placement in out of home care documented in TWIST, were also collected. The length of time a case remained open varied. The following paragraphs outline what measures were administered at what interval, and by whom.

The NCFAS was administered to KSTEP families by the private providers upon entry into KSTEP, then around the mid-point of the KSTEP services (usually three to four months into the service cycle), and upon completion (usually at the end of eight months). The ASI was administered to primary caretaking adults (indicating substance misuse) residing in the home at the time the case is accepted to KSTEP by the contracted service providers. As indicated above, the ASI was administered upon entry into KSTEP, three to four months after entry into KSTEP, and at the conclusion of the eight-month KSTEP service period. Similar to the ASI, the PSI was administered to all primary caretaking adults residing in the home at the time of the maltreatment report is substantiated by contracted service providers. The instrument was administered at the outset of acceptance in KSTEP, at the end of the fourth month in KSTEP, and at the conclusion of KSTEP services.

All individuals involved in collecting primary data, no matter the measure, were trained in appropriate data collection procedures. Data collection occurrences were expected to take between one and two hours, however, these times may vary depending on factors such as the size of the family, etc.

Evaluation of KSTEP outcomes based on the above assessments focused only on the KSTEP cases and their pre-post growth. Analysis of data consisted of descriptive statistics, comparative analysis, and cost-benefit analysis. Data was analyzed using statistical software such as STATA 14.0 and IBM SPSS software and included testing of differences between experimental and control/comparison groups.
Analysis of primary data including NCFAS, ASI, and PSI results before KSTEP and after KSTEP services were used to evaluate outcomes of safety and well-being. Secondary analysis of administrative data (placements in out of home care, length of time in out of home care) for KSTEP families and a matched sample of families was employed to measure permanency outcomes. More information regarding the evaluation can be found in the Title IV-E Waiver Demonstration KSTEP Final Evaluation.

X. Low Income Home Energy Assistance Program (LIHEAP)
The mission of the Low Income Home Energy Assistance Program (LIHEAP) is to provide energy assistance benefits to eligible low-income families at or below 130% of poverty. Eligible applicants can receive assistance with home heating costs through two components: subsidy, which provides assistance to all eligible households; and crisis which provides assistance to eligible applicants experiencing a home heating crisis, identified by a past due notice, termination notice, or final notice. The program provides services/benefits to improve the quality of life for young children and vulnerable adults, making their home a healthier environment in which to live.

LIHEAP is federally funded through the United States Department of Health and Human Services (HHS), Administration for Children and Families (ACF), Office of Community Services (OCS), Division of State Assistance.

CHFS disperses these funds to Community Action Kentucky (CAK), who then distributes to the 23 Community Action Agencies (CAAs). LIHEAP services are available statewide in all 120 counties. They are accessed through the CAAs to clients that meet eligibility requirements based on 130% or below the federal poverty level.

Technical assistance and training are provided to the CAAs by CAK, a contract agent on behalf of CHFS. Fall and Spring training are hosted by CAK for the CAAs and appropriate staff at CHFS.

CAK collects data included in the Household Report and Performance Measures Report and submits it annually to ACF on behalf of CHFS. The Household Report includes information regarding the number of households served in crisis and subsidy. It also details the number of households weatherized through the weatherization program. It offers details of the number of households by poverty level, vulnerability of the household, including how many households have children age two and under, between 3-5 years old, and whether a household includes a member who is 60 and over or who has a disability. The Performance Measures Report provides information pertaining to the energy burden households carry in relation to the main type of their heating source. The number of homes having energy restored and the number of households preserving their heating source upon receiving LIHEAP are also reported.

The state plan is submitted annually to HHS. The plan shows Kentucky’s planned use for the allotment received. Components of LIHEAP are subsidy and crisis and are used between November and March. Outreach is one of the areas covered in the state plan to develop measures on how to let the public know about LIHEAP and its benefits.

DCBS completes half-year block grant status reports on LIHEAP for the state legislature in January and July. The Status report reflects activities completed in the past six months, i.e., expenditures, objectives, achievements, authorized changes, and evaluation of results. Categories include, but limited to types of fuel and vulnerable household members.
A Program Compliance Review is conducted by CAK for each agency a minimum of one time during the contract period. It is the agency’s responsibility to be available for and have documentation for CAKs review. Reviews are conducted through an on-site visit or a desk review. An on-site review is conducted for agencies that had issues in the prior year and agencies with certain risk factors, such as under new leadership, unspent funds, etc. A desk review is completed for agencies with no issues cited in the prior year and no risk factors were identified. An on-site review is conducted for each agency once every three years.

Goals for LIHEAP are measured, in part, by the number of Kentucky’s most vulnerable citizens served. In SFY 2019, 78,268 households were served in the subsidy component, and 78,340 households were served during the crisis component of LIHEAP. Four hundred ninety-six (496) households were served by weatherization.

**Y. Michelle P. Waiver Program**

The Michelle P. Waiver is a home and community-based waiver under the Kentucky Medicaid program developed as an alternative to institutional care for individuals with mental retardation or developmental disabilities. It was designed so that people who were placed in institutions could return to or remain in their communities. The Michelle P. Waiver allows individuals to remain in their homes with services and supports. Adults and children alike are eligible for the program as long as the meet the criteria for eligibility. In order to qualify, recipients must have intellectual disabilities (mental retardation) or developmental disabilities that meet the requirements for residence in an intermediate care facility or a nursing facility. Recipients must also meet Medicaid financial eligibility requirements.

Michelle P. Waiver services include:

- Case management
- Adult day training
- Supported employment
- Community living supports
- Behavior supports
- Occupational therapy
- Physical therapy
- Speech therapy
- Respite
- Homemaker service
- Personal care
- Attendant care
- Environmental/minor home adaptation
- Adult day health care

**Z. Multidisciplinary Commission on Child Sexual Abuse**

The Kentucky Multidisciplinary Commission on Child Sexual Abuse (KMCCSA), staffed by the Office of the Attorney General, is tasked with preparing and issuing a model protocol for local MDTs regarding investigation and prosecution of child sexual abuse and the role of the CACs on MDTs (KRS 431.660). In addition, KMCCSA reviews and approves protocols prepared by local multidisciplinary teams. They are responsible for advising local multidisciplinary teams on the investigation and prosecution of child sexual abuse. KMCCSA seeks funding to support special projects relating to the operation of local multidisciplinary teams. They receive and review complaints regarding local multidisciplinary teams,
and make appropriate recommendations. KMCCSA also makes recommendations to the Governor, Legislative Research Commission, and Supreme Court regarding any changes in state programs, legislation, administrative regulations, policies, budgets, and treatment and service standards which may facilitate effective intervention of child sexual abuse cases and the investigation and prosecution of perpetrators of child sexual abuse, and which may improve the opportunity for victims of child sexual abuse to receive treatment.

Local MDTs are mandated by KRS to exist in each county. Each local MDT is charged with completing and submitting the mandatory data collection tool by the end of January each year. In turn, KMCCSA is responsible for compiling and adopting an annual report reflecting the work of KMCCSA and local MDTs.

The Commission meets in Frankfort every other month and provides guidance to the statewide county teams. The commission shall be composed of the following members: the DCBS commissioner or designee, the DBHID commissioner or designee; one social service worker who is employed by DCBS to provide child protective services, who shall be appointed by the CHFS secretary; one therapist who provides services to sexually abused children, who shall be appointed by the CHFS secretary; the commissioner of the Department of Kentucky State Police or a designee; one law enforcement officer who is a detective with specialized training in conducting child sexual abuse investigations, who shall be appointed by the secretary of the Justice and Public Safety Cabinet; one employee of AOC appointed by the Chief Justice of the Supreme Court of Kentucky; two employees of the Attorney General’s Office who shall be appointed by the Attorney General; one Commonwealth’s attorney who shall be appointed by the Attorney General; the commissioner of the Department of Education or a designee; one school counselor, school psychologist, or school social worker who shall be appointed by the commissioner of the Department of Education; one representative of a children’s advocacy center who shall be appointed by the Governor; one physician appointed by the Governor; and one former victim of a sexual offense or one parent of a child sexual abuse victim who shall be appointed by the Attorney General. Appointees shall serve at the pleasure of the appointing authority but shall not serve longer than four years without reappointment. The Commission shall elect a chairperson annually from its membership. The Commission will review the MDT protocol to ensure the protocol is meeting best practice standards and has identified all current and pertinent legislation.

In the fall of 2015, KMCCSA presented the revised MDT protocol at the Prevent Child Abuse Kentucky Conference, the Kentucky Victim Assistance Conference, and the 17th Annual Ending Sexual Assault and Domestic Violence Conference. In addition, KMCCSA collaborated with the Kentucky Association of CACs and the regional CACs to present training on the protocol across the state. All local MDTs were asked to submit a revised local protocol by April 1, 2016. Since then, KMCCSA has reviewed and approved the protocols from nearly all local MDTs. Local MDTs continue to update their protocol to the newly revised model that was effective January 2016.

Kentucky Multidisciplinary Commission on Child Sexual Abuse has no monies, per se. The Attorney General’s Office pays for administrative fees that are incurred when this board meets. In 2017, the Child Victim’s Trust Fund awarded a minimal amount of money to the commission for any identified needs or materials. The Commission did not utilize the funds, thus the Child Victim’s Trust Fund awarded the Commission $5,000 for FY 2019.

AA. Office for Children with Special Health Care Needs
The Office for Children with Special Health Care Needs (OCSHCN) provides gap-filling specialty and subspecialty pediatric care to medically underserved children and youth with special health care needs
(CYSHCN), as well as enabling public health services statewide. Created in 1924 by the state legislature to provide treatment to children with orthopedic conditions across the state, OCSHCNs clinical services have since expanded to include treatment and care coordination for a variety of severe and chronic conditions. The agency endeavors to create a comprehensive, quality system of care for Kentucky’s CYSHCN, which are defined as children birth to age 21 who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who require health and related services of a type or amount beyond that required by children generally. In addition to administering the state’s title V children with special health care needs medical services program, OCSHCN provides special services to address health care needs of children involved with the child welfare system and a population-based early hearing detection and intervention (EHDI) program to ensure the assessment of hearing in newborns statewide.

OCSHCN’s mission is to enhance the quality of life for Kentucky’s CYSHCN through direct service, leadership, education, and collaboration. Services are family-centered and community-based with access to specialty providers coordinated through 11 regional offices and six satellite clinics. The agency’s website is located at http://www.chfs.ky.gov/agencies/cshcn where a directory of services and provider lists programs available in all areas of the state. OCSHCN provides services for the following: audiology services, clinical services, autism spectrum disorder, cardiology, cerebral palsy, cleft lip and palate, craniofacial anomalies, neurology, telehealth, ophthalmology, orthopedics, otology, scoliosis, transitioning to adulthood, supplemental services or care coordination, case management, social services, nutrition, therapy services, language interpretation, additional diagnostic and treatment services, First Steps point of entry, hemophilia treatment centers, family support services, family to family health information center, Spanish speaking support groups, and folic acid distribution. OCSHCN also collaborates with DCBS regarding foster care support.

Funding for OCSHCN services originates from various sources, including state general funds. Those sources are the title V Maternal and Child Health Block Grant (supports the specialty clinic program), CDC grants (support hearing screening and transitions), and third party reimbursement/agency receipts (supports medical care).

OCSHCN services are available statewide. For the foster care population, medically complex home visitation services are currently available in all 120 counties. OCSHCN nurse consultation services for child welfare staff are currently available in all nine DCBS service regions.

As a public agency within CHFS, OCSHCN shares a statewide parent organization with DCBS, Medicaid, and other important social service and health programs. Over the course of 96 years, OCSHCN has developed formal and working relationships with a variety of programs providing services to children. In addition to direct care provided in specialty clinics, children with eligible diagnoses may receive care coordination services from registered nurses. Depending on the individual needs of the child, this may involve varied activities such as:

- Advocating and helping patients and families understand their current health status and educating them on what they can do to improve it;
- Linking families with resources and providing cohesion among other professionals of the health care team to efficiently and effectively accomplish goals;
- Attendance at school meetings; and
- Home visits for individual health planning meetings with DCBS frontline staff.
OCSHCN employs family consultants and social workers who assist families to access outside services or help with overcoming barriers to optimum care. A family-to-family health information center program places parent-organized resource centers within OCSHCN clinics and establishes a network of parents who provide peer support. Critical partnerships exist with the Home of the Innocents, a private child caring facility where Louisville therapy staff (PT, OT) have access to a state-of-the-art therapy pool. Universities provide expertise by way of administering the Lexington and Louisville Hemophilia Treatment Centers. A number of specialty providers have become active with OCSHCN due to their affiliations with Kentucky’s teaching hospitals. In addition, the Louisville OCSHCN office is a point of entry for Kentucky’s Early Intervention Program’s KIPDA Region.

Through a formal needs assessment process (pursuant to the Maternal & Child Health Title V Block Grant), agency strategic planning, and ongoing interagency communication, OCSHCN works with state, local, and regional medical providers to ensure that services are available to meet the needs of all Kentucky CYSHCN. In addition to involvement on a case level, several OCSHCN staff are active on boards and councils (such as Kentucky Council on Developmental Disabilities, State Interagency Council for Services and Supports to Children, and Transition-Age Youth) that further the agency’s mission. OCSHCN also receives input from formal stakeholder advisory groups of youth and parents.

**Early Hearing Detection and Intervention (EHDI) Program**

Kentucky’s EHDI Program oversees hearing screening at birth hospitals that deliver more than 51,400 births annually across the state. Ninety-eight percent (98%) of all live births received a newborn hearing screening prior to discharge. In addition to providing technical assistance to hospital hearing screening programs, EHDI program staff work with clinical audiologists and Part C providers to ensure that infants not passing their hospital based newborn hearing screening are able to receive diagnostic assessment of hearing and, if necessary, appropriate early intervention. A memorandum of agreement with First Steps created a collaborative agreement with Part C to provide audiologic evaluation for all First Steps eligible infants and toddlers prior to onset of First Steps services, and a separate memorandum of understanding with DCBS provides for OCSHCN to fulfill the role of primary audiology provider for children in the custody of DCBS. The EHDI program sends letters to each infant’s primary care physician informing them of the infant’s risk of hearing loss, as well as when infants are diagnosed with hearing loss.

**Foster Care Support Programs**

Medically Complex: OCSHCN continues to collaborate with DCBS in teaming DCBS frontline staff with OCSHCN nurses to visit medically complex foster care children once a month to address their medical needs. This program has an ongoing population of approximately 140 high-risk or medically complex children. DCBS frontline staff maintains their professional obligation for the medically complex foster care child’s care and well-being. The OCSHCN nurse reviews medical records, assists with meetings of the individualized health plan team, assists DCBS with specialty provider consultation, and for the medically complex foster care children, provides guidance and ongoing education for the foster parents as needed.

Nurse Consultant Inspectors: OCSHCN nurse consultant inspectors housed in DCBS regional offices are full-time resources for child welfare personnel, children, families, and foster care providers before, during, and after a child’s stay in OOHC. This service includes children not considered medically complex.
who are at risk of removal and placement. Expertise is provided in all DCBS service regions. Roles of nurse consultant inspectors include:

- Interpretation of medical records and reports;
- Consultation to frontline staff and foster care families on medical issues;
- Home visitation, when appropriate, for other children in foster care for assessment;
- Teaching and education of foster families and frontline staff on medical procedures, treatments, and expected outcomes;
- Assurance of the maintenance of updated, current Medical Passports;
- Care coordination of medical, dental, and behavioral health services (including provision of important drug interaction information);
- Tracking the utilization of health services, including prevention and wellness programs; and
- Consultation on medical issues for children at risk for OOHC.

Other Programs/Initiatives
Hemophilia Treatment Centers (HTCs)
HTCs in Lexington and Louisville assists with factor products and other related medications needed to manage bleeding episodes. Each case is individual and must be reviewed before any determination can be made. Families needing assistance complete an application process and must meet eligibility criteria.

Transition Program
OCSHCN’s transition program continues helping young people move from school to work, pediatric to adult health care, and living at home to independent living. OCSHCN nurses and social workers utilize an age appropriate transition checklist to work closely with young people and their families to help them plan for the future. OCSHCN nurses, social workers, and family consultants help families find resources, facilitate communication, and support parents as they seek services for their children and youth. OCSHCN nurses work with youth and families, in collaboration with local adult providers, to assist youth to transfer to an adult health care provider at age 18 when the youth becomes an adult.

Parent and Youth Involvement
The Youth Advisory Council (YAC) is comprised of youth from across the state with a variety of physical and mental disabilities. Most of the council members receive services from OCSHCN. This diverse group provides youth with disabilities a voice.

The Parent Advisory Council (PAC) is comprised of parents of children with disabilities. Most of the council members have children that have received services from OCSHCN. This is a diverse group representing several regions of the state and provides a means for parents to provide input into OCSHCNs services.

OCSHCNs Family to Family Health Information Center initiative has created a network of families trained to support other families, encourage families to become involved in efforts that will lead to reduced barriers to care, and build family capacity to make informed choices and be involved in decision making at all levels.

In 2019 OCSHCN had three new KARs enacted through the General Assembly. The new KARs covered the application process for clinical programs, billing and fees, and the process of contracting with medical personnel. Each KAR replaces preexisting internal policies in order to make the process more clear and accessible to the public. They may be viewed with OCSHCN EHDI KAR at: https://apps.legislature.ky.gov/law/kar/TITLE911.HTM.

2020 APSR Submission, Attachment 11 52
During 2019, OCSHCN provided specialty medical services to 8,714 patients. Of the total number of patients seen, 72% had Medicaid/KCHIP, 20% had private insurance, and 8% had no insurance. OCSHCN accepted 2,316 new patients and discharged 1,893 patients; 16,655 visits were recorded.

During 2019, OCSHCN’s EHDI program received 50,508 hearing screening report forms. Failing the newborn hearing screening is considered a risk factor for hearing loss, according to the Joint Committee on Infant Hearing. Of the infants screened, 1,098 failed on one or both ears. The total number of infants that passed the hearing screen was 48,592.

During 2019, OCSHCN medically complex nurses made 1,300 home visits. At any time, the total number of medically complex foster children served by the agency averages around 237. Approximately 164 new medically complex referrals were received during the reporting period.

During 2019, OCSHCN nurse consultant inspectors residing in DCBS offices provided the following services on behalf of children in the child welfare system (services outnumber referrals, as many cases require more than one type of service):

- Referrals received: 164
- Home visits made: 1,300
- IHP reviews: 245
- Medical Record/Report Reviews: 898
- Family Team Meetings/5 Day Conferences: 12
- Sub Specialty Referrals: 191
- Medical Passports Reviewed: 1,126

OCSHCN is uniquely poised to assist DCBS in meeting the health needs of children and youth involved in the child welfare system. Medically complex home visits have continued as children and youth are referred by DCBS.

Foster care support programs continue uninterrupted. OCSHCN has a full staff of nurse consultant inspectors, who have completed orientation and training and take referrals.

OCSHCN’s Foster Care Support Section appreciates DCBS’ continued support. OCSHCN leadership continues to feel that the partnership with DCBS is a vital one, and remains consistent with OCSHCN’s mission. As a title V (Maternal and Child Health services) agency, OCSHCN prepared a five-year needs assessment in 2015, results of which guide the direction of services, especially with regard to any new or expanded programs. Priorities for the years 2016-2020 include transition to adulthood, improving access to care and services, ensuring adequate insurance coverage, and enhancing agency data capacity. In light of Kentucky selecting transitions services as a title V national performance measure, emphasis is placed on ensuring services for youth health care transitions to adult care in the child welfare area.

BB. Passport Health
The Passport Health Plan (Passport) is a provider-sponsored health maintenance organization (HMO) that provides medical services for children 0 to 18 years of age. Passport serves approximately 170,000 members in Kentucky, which is comprised of the following 16 counties: Jefferson, Oldham, Trimble, Carroll, Henry, Shelby, Spencer, Bullitt, Nelson, Washington, Marion, Larue, Hardin, Grayson, Meade,
and Breckinridge. Passport is a Medicaid program. Children in foster care in the above counties are specifically supported by a liaison between Passport and the child welfare agency. Program staff ensure that children who come into care have medical coverage that promotes healthy development and better outcomes for all who are involved. A monthly report is developed to guarantee that children in care are presently active with Passport so that coverage is available to pay for all their medical claims. A certain code is entered into Passport’s system for children in care to declare special privileges for extended coverage. In addition, daily information is specified regarding the status of a child’s placement to ensure ongoing health coverage as well. On a monthly basis, service plan forms are given to Passport to review with a social worker to see which children need medical case management. Case management services can be for physical, mental, and/or behavioral health. When a child may need specialized services regarding a unique medical challenge, the MCO liaison coordinates services to meet individualized needs to ensure positive outcomes. Passport’s social worker collaborates with child benefit workers to review the health needs associated with Passport. Passport social workers, central office MCO liaisons, and child benefit workers ensure that mental and physical health services are utilized appropriately in cost and care, and that there are comprehensive referrals being made when needed to ensure positive outcomes.

**CC. Prevent Child Abuse Kentucky**

Prevent Child Abuse Kentucky’s (PCAK) mission is to prevent the abuse and neglect of Kentucky’s children through advocacy, education, awareness, and training. PCAK seeks to build a safer Kentucky, strengthening families two generations at a time, by increasing awareness of child maltreatment through sustainable statewide partnerships. PCAK utilizes a network of partners, professionals, and volunteers to engage in the prevention of child abuse and neglect and develop effective prevention strategies and programs throughout the Commonwealth. Through the various community-based programs, parents and children are afforded the opportunity to learn and create a positive attitude toward their differing roles. With this knowledge, the cycle of child abuse can be broken; the aspects of abuse can be identified, treated, and prevented; and parents and children can develop and maintain open, warm, and loving relationships.

On January 1, 1987, PCAK was created through a merger of Parents Anonymous of Kentucky and the Kentucky Chapter for Prevention of Child Abuse. These two statewide agencies were formed in Kentucky in 1977-1978 and had been active as pioneers in the child abuse field since their creation. The merger resulted from a desire to combine the primary, secondary, and tertiary prevention aspects of the two autonomous agencies. This merger created the Kentucky Council on Child Abuse and the board of directors approved the name change to Prevent Child Abuse Kentucky in April 1999. PCAK is affiliated with Prevent Child Abuse America, headquartered in Chicago. The agency is statutorily funded utilizing a portion of state birth certificate fees (KRS 213.141).

PCAK works closely with CHFS personnel to ensure the goals and services provided under its programs are aligned closely with the overall child and family services plan. All subcontractors, which are local community agencies, are required to implement evidence-based parent education/support group services. All subcontractors are required to have a process to receive referrals from the state child welfare agency and serve families at risk. PCAK subcontracts, through annual requests for proposal, with programs serving parents in each of the nine service regions. The state office of PCAK provides the administration, coordination, training, maintenance, and enhancement functions necessary to allow the evolution of viable child abuse prevention options for families. PCAK conducts a variety of outreach programs (Kids Are Worth It! ® Child Abuse Prevention Conference; self-help, parent education, and support groups; educational workshops and institutes; 1-800 CHILDREN parent support resource;
Partners in Prevention; Child Abuse Prevention Month; awareness tools; and fatherhood initiatives) throughout the year. Each activity is reported separately below.

**Prevent Child Abuse Kentucky (PCAK), Kids Are Worth It! ® Statewide Child Abuse and Neglect Prevention Conference**

Kids Are Worth It! ® (KAWI) Conference is a statewide child abuse and neglect prevention conference. The conference focuses on child abuse and neglect issues across the prevention continuum from primary prevention through permanency planning for youth in care. The conference meets the training, continuing education, programmatic and networking needs of a broad, multidisciplinary audience. Workshop, plenary, and networking sessions offered provide participants with information and tools to promote and support best practice. Participants learn new skills, receive information to enhance existing skills, and are provided networking opportunities to improve relationships and collaboration with colleagues working within or in support of the child welfare system.

The conference is funded through CBCAP, grants, sponsorships, and private/corporate donations. The conference is planned collaboratively between PCAK staff and a diverse advisory committee representing a variety of disciplines (including legal, public health, mental health, substance abuse, community services, medical, and law enforcement). This committee also represents varieties of geographical regions across the state. The Kids Are Worth It! ® Conference provides a unique training opportunity to both staff and service providers within the child welfare system. State and national experts provide high quality, state-of-the-art workshop and plenary sessions relevant to the broad audience providing a variety of services to children and families. Care is taken to ensure all material presented are relevant to participants regardless of geographic location within the state.

The 2019 Kids Are Worth It! Conference was delivered September 9-10, 2019, at the Lexington Convention Center, Lexington. The conference reached 604 individuals with 536 participants attending workshop and plenary sessions. In addition to the provision of 37 workshops, there were two keynote sessions. Participants from 89 counties (identified in the Kentucky map below), across all nine DCBS service regions were present; representing 74% of Kentucky counties.

---

**2019 Participant Representation Map**

Participant counties of work are highlighted in blue
**Evaluation Summaries**
Participants were provided the opportunity to complete an overall conference evaluation. Two hundred eighty-eight (288) evaluations (54% response rate) were received.

The percentages below represent those who indicated they were either Extremely Satisfied or Satisfied with the category below:

<table>
<thead>
<tr>
<th>Please rate your overall experience:</th>
<th>2018 Overall Responses</th>
<th>2019 Overall Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Conference as a whole</td>
<td>98.64%</td>
<td>99.65%</td>
</tr>
<tr>
<td>b. Registration process</td>
<td>97.96%</td>
<td>98.26%</td>
</tr>
<tr>
<td>c. Workshop choices</td>
<td>95.92%</td>
<td>95.84%</td>
</tr>
<tr>
<td>d. Keynote sessions</td>
<td>97.28%</td>
<td>96.16%</td>
</tr>
<tr>
<td>e. Networking opportunities</td>
<td>90.81%</td>
<td>96.12%</td>
</tr>
</tbody>
</table>

The percentages represent those who indicated they Strongly Agreed or Agreed with the category in below:

<table>
<thead>
<tr>
<th>As a result of attending the conference:</th>
<th>2018 Overall Responses</th>
<th>2019 Overall Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. I am better prepared to prevent child abuse and neglect.</td>
<td>96.26%</td>
<td>95.1%</td>
</tr>
<tr>
<td>b. I learned of a new resource, which will assist me in my work to improve outcomes for children and families.</td>
<td>95.91%</td>
<td>97.91%</td>
</tr>
<tr>
<td>c. I learned a new skill, which will assist me in my work to improve outcomes for children and families.</td>
<td>95.56%</td>
<td>94.43%</td>
</tr>
<tr>
<td>d. I was able to network with community partners.</td>
<td>91.47%</td>
<td>93.33%</td>
</tr>
</tbody>
</table>

Open-ended responses were solicited on the overall evaluation in addition to individual workshop evaluations. When asked what aspects of the conference were most beneficial, respondents indicated the following:
- “Good variety of topics & attendees. Gave a more rounded vision of needs for families & agencies with opportunity to become the solution in action.”
- “Lots of information provided, knowledgeable presenters, all enthusiastic about their topics.”
- “The information presented was pertinent to my profession. I thoroughly enjoyed all the speakers & presentations! Excellent conference!”
- “Most of the trainings were valid an important to my specific job. I learned about many new agencies to be able utilize for clients and families.”
- “The topics referred to real issues that we face with clients daily.”

**Self Help, Parent Education, and Support Groups**
Services are available in every service region and served 61 counties (of 120) in the state in 2019. Subcontractors are required to utilize the evidenced based Nurturing Parenting curricula along with...
administration of the parallel Adult-Adolescent Parenting Inventory (AAPI) pre- and posttest. The utilization of a single curriculum enhances programmatic consistency across service providers and strengthens program evaluation through universal use of the AAPI. PCAK created a single account with provider satellites for providers to enter their AAPI data, which allowed for collection and data analysis. Currently, one PCAK staff member is a trained facilitator of Nurturing Parenting and Parent Café as a way to enhance self-help work. Programmatic, training and evaluation changes have been implemented to encourage integration of the protective factors framework into service delivery. Furthermore, providers are required to administer a drug and alcohol-screening tool to all participants at intake. Majority of the providers use UNCOPE. As part of service delivery, each provider offers an education component on child welfare, from investigation to case resolution. Subcontractors are asked to distribute the child welfare agency’s child removal handbook, When Your Child is Removed from Your Care and parents are asked to complete the child welfare agency’s Customer Satisfaction Survey.

The content delivered each week of the parent education sessions and/or support group is designed to provide parents with skills relevant to healthy parenting, while encouraging permanency and well-being within the family structure. PCAK collects attendance and referral data from each subcontractor monthly during each SFY. An analysis of the calendar year records reflects 1,138 families began a parent education and/or parent support program with one of the 14 providers during 2019. In this period, PCAK subcontractors provided 15,357 duplicated incidents of service.

PCAK staff utilize a two-prong approach to measure program impact. For several years, the program has been evaluated through a retrospective survey collected from participants at program completion. Questions on the survey instrument focus on demographic data, as well as parenting skills gained while attending the program and how the individual feels about him/herself afterwards. Program participants are clearly told their answers will not have any impact on an individual’s personal situation. This self-report tool has consistently shown positive program impact.

In 2019, PCAK partnered with The Center for Family and Community Well-Being at the University of Louisville to conduct a comprehensive evaluation of outcomes across multiple domains. The evaluation includes analysis of the AAPI pre- and post-test data collected as well as data collected from the PCAK generated Parent Education Survey. The Adult-Adolescent Parenting Inventory (AAPI) is a tool used to measure the effectiveness of PCAK’s parent education programs. Based on the known parenting and child rearing behaviors of abusive parents, responses to the inventory provide an index of risk for behaviors known to be attributable to child abuse and neglect. The AAPI is universally recognized as a valid and reliable tool used to assess parenting attitudes, knowledge, and history.

The AAPI includes both a pre- and post-assessment. The pre-test collects data to determine the program participant’s entry-level capabilities. The post-test data is collected at the completion of the program to determine level of growth and future intervention needs of the family.

The information gained through this assessment includes:
- Knowledge: What do parents know about appropriate parenting practices?
- Attitudes: What attitudes do parents have about raising children?
- History: What childhood history do parents and teens have that affects their parenting?

Responses to the AAPI provide an index of risk in five specific parenting and child rearing behaviors:
- Construct A - Inappropriate Expectations of Children
- Construct B - Parental Lack of Empathy Towards Children’s Needs
Construct C - Strong Parental Belief in the Use of Corporal Punishment
Construct D - Reversing Parent-Child Family Roles
Construct E - Oppressing Children’s Power and Independence

Parents who score “high risk” in the constructs measured by the AAPI are at greater likelihood of abusing their children.

The final report outlining evaluation results is still in the revision process, but some preliminary outcomes include:
• Among those parents that have completed the program, there is an upward trend of positive impact of parenting skills and program satisfaction.
• Parent protective factors increased after program completion.
• Participants reported increased support after program completion.
• Almost all participants reported some negative childhood experience.

Prevent Child Abuse Kentucky Educational Workshops and Institutes
PCAK provides educational offerings to requesting groups statewide, focusing on issues impacting local communities and actively engaging the community in preventing child maltreatment. Activities are supported through CBCAP funds, PCAK general funds, grants, private donations, training honoraria, and corporate giving. PCAK offers specialized trainings, train-the-trainer workshops, and continuing education credit for participants. Curricula on a variety of child maltreatment related topics are available and each audience participates in an individualized learning experience. PCAK has expanded its training offerings, now providing the following workshop topics:

Adverse Childhood Experiences: Understanding and Responding to Toxic Stress
Fifty-nine (59) percent of Kentuckians report experiencing at least one adverse childhood experience, such as child maltreatment. These traumatic events can have a negative impact on the health and social wellbeing throughout someone’s lifespan. In a safe, stable, and nurturing environment, children can adapt and build resilience in response to these negative experiences. This workshop explores current research regarding the impact of toxic stress, evidence informed practices designed to mitigate the effects of toxic stress on children and strategies for supporting families.

Connect the Dots
Connect the Dots highlight four easy-to-remember steps to address challenging behaviors. The four steps encompass both the well-being and the well-doing of children to ensure strong social and emotional skills needed for success in school and life. Connect the Dots resources and trainings are for anyone who works with children ages one to five years old. This universal tool can be used in any setting serving families and children by teaching children how to recognize and express their emotions appropriately.

Engaged Fathers: Improving Outcomes for Children
Fathers are instrumental in the healthy growth and development of children. This workshop reviews research on the positive and negative outcomes, which are directly influenced by the involvement of fathers in children’s lives. Attendees are provided with tools to assess the father-friendliness of their organizations and service delivery models. Discussion surrounds changes in practice which, when instituted, may affect the engagement of fathers in the lives of children.
Family Thrive
The overarching goal of the Family Thrive framework is to achieve positive outcomes by mitigating risk and enhancing healthy development and well-being of children and youth. The guiding premises provide the foundation for KYSF and Kentucky Youth Thrive (KYYT). This approach can be used in any setting serving families, youth, and children typically without making huge changes in daily practice.

Internet Safety
The Internet Safety training provides strategies to educate, monitor, and communicate internet safety. Because of this training, participants will understand risks and learn how to keep children protected both from unsafe material as well as from predators who are unyielding in their efforts. This training has been designed to support parents and other caregivers in their efforts to assure the safety of children in their care.

Kentucky Strengthening Families
Supporting families is a key strategy for promoting school readiness and preventing child abuse and neglect. Attendees will learn how to apply the KYSF Protective Factor Framework in their community, organization, or program through the following training objectives: (1) Ability to list and explain each of the six Protective Factors; (2) Recognizing the importance of strengthening families based on research; (3) Identifying strategies for how your program can align current program practices with the Protective Factors; and 4) Developing a plan for how you will promote the protective factors in your workplace so every interaction you have with families is strength-based and high impact.

Kentucky Strengthening Families Training of Trainers
KYSF represents a multi-disciplinary partnership of over 20 national, state and local, and public and private organizations dedicated to embedding six research-based Protective Factors into services and supports for children and their families. Supporting families is a key strategy for preventing child abuse and promoting school readiness. PCAK is excited to be able to deliver the KYSF Training of Trainers curricula to those interested in delivering this training in their communities. This curriculum enables trainers to provide the three-hour training for interested community members. They will be able to share the importance of Strengthening Families based on the research behind the movement. Trainers will also be able to help participants develop a plan for how they will promote the six Protective Factors in the workplace so every interaction with families will be strength-based and high-impact. Participants receive an individual set of training materials including the PowerPoint presentation, access to videos, evaluation documents, as well as other materials.

Pediatric Abusive Head Trauma
Kentucky statute requires education on the identification and prevention of pediatric abusive head trauma. In partnership with experts in child maltreatment, PCAK has developed curricula to meet the needs of a variety of professionals impacted by this legislation.

Preventing Child Maltreatment Death: A Community Effort
Everyone has a role to play in keeping children safe and ensuring children reach their full potential. Through lecture and group work, participants are empowered to act to end the tragedy of child death and near death at the hands of those charged with caring for them.

Protecting Your Children: Advice from Child Molesters
Using film clips of interviews with various types of sex offenders, participants will understand the techniques perpetrators use to target, seduce, and exploit children. This workshop will challenge common misperceptions about children’s ability to protect themselves and promote the idea that all adults must be informed and take an active role in promoting child safety. Participants will learn effective prevention strategies for use in a variety of settings.

**Protocol for Youth-Serving Organizations, Colleges & Universities: How Do You Keep Children and Youth Safe While Under Your Supervision?**

Summer camps, colleges/universities, athletic organizations, the faith community, and other youth-serving organizations all have a duty to ensure the children and youth they serve are safe while under their care. This training is suitable for athletic personnel, title IX administrators, summer camp counselors/staff, and others. The training covers topics including recognizing & reporting child abuse, strategies for screening and selecting employees and volunteers, strategies for ensuring safe environments and others. A planning tool for organizations is included in the training.

**Recognizing, Reporting, and Preventing Child Abuse and Neglect**

Through lecture, video, injury identification, and group work, attendees are prepared to recognize, report, and prevent child abuse and neglect within their role as child and/or family-serving professionals. This workshop reviews Kentucky mandated reporting laws, definitions of abuse and neglect, what to expect after a report has been made to the authorities and outlines specific action steps which prevent child maltreatment.

**Reinventing Our Messages: Promoting Action for the Prevention of Child Sexual Abuse**

The way in which individuals talk about social problems affects how people understand their causes and solutions. Everyone has beliefs and values that are used to help decide the meaning of messages received. Intentional framing is needed to understand complex issues and build support for programs and policies. Research and analysis have shown PCAK that there is work to do regarding child sexual abuse and its prevention. PCACK wants its messages to promote action and move individuals to intervention and prevention. This workshop will summarize the work already completed around reframing child sexual abuse messaging in Kentucky, as well as the importance of adequate message frames moving forward. Participants will leave with an understanding of proper framing for difficult topics, and the tools to create new appropriate messages for difficult social issues, specifically child sexual abuse.

**Resilience**

Participants will screen a 60-minute documentary produced by James Redford. This documentary summarizes the science behind the Adverse Childhood Experiences Study and provides an in-depth look at how toxic stress can trigger hormones that wreak havoc on the brains and bodies of children, putting them at a greater risk for disease, homelessness, and early death. Resilience, however, also chronicles the dawn of a movement determined to fight back. Trailblazers in pediatrics, education, and social welfare are using cutting-edge science and field-tested therapies to protect children from the insidious effects of toxic stress. A question and answer session will follow the film, allowing participants the opportunity to bring this national movement into a local context for implementation.

**Stewards of Children**

PCAK staff is credentialed by the Darkness to Light organization as an Authorized Facilitator of the Stewards of Children curriculum. Stewards of Children is an evidence-based workshop, documented to “increase knowledge, improve attitudes, and change child-protective behaviors.” The two to three hour
workshop is conducted in small group settings and is geared toward all adults interested in preventing child sexual abuse.

**The Connection between Intimate Partner Violence and Child Maltreatment**

Intimate partner violence (IPV) affects the entire family and is found in approximately 55% of KY households with substantiated cases of child maltreatment. Attendees will learn about common dynamics of IPV, how children are impacted by the violence, and techniques for preventing child maltreatment when working with families impacted by IPV.

**Trauma Informed Care**

Traumatic events can have a significant impact on an individual's health and life, and can lead to a sense of powerlessness, fear, hopelessness, and a constant state of alertness within an individual. Trauma informed care is an approach to engaging people that recognizes the potential presence of trauma symptoms and acknowledges the role that trauma may play in an individual's life. When a human service agency becomes trauma-informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma affects the lives of individuals.

**Understanding Typical Child Development: A Tool to Prevent Child Sexual Abuse**

Understanding typical child sexual development is critical to keeping children safe. Often parents do not understand when and how to discuss sexual abuse. Training participants will understand the typical stages of child development and learn how to help caregivers talk to their children about healthy sexual development as a tool to prevent child sexual abuse.

**Working with Families in Substance Abuse Recovery**

Substance abuse is commonly present in cases where child maltreatment has been substantiated. Through lecture and group work, attendees will become familiar with the continuum of prevention, the connection between substance abuse and child maltreatment, and specific techniques to prevent child maltreatment in families impacted by substance abuse.

PCAK will continue to provide educational workshops and institutes to the public as requested. Additional PCAK staff are being trained as workshop presenters. As new workshops are developed at the request of participants, PCAK’s listing of workshop topics continues to increase, and is always shared on the PCAK website: [https://www.pcaky.org/trainings](https://www.pcaky.org/trainings). As communities become more aware of PCAK workshops and educational offerings as a resource for preventing child maltreatment, PCAK receives greater numbers of requests.

PCAK collaborates with DCBS and other key stakeholders to ensure workshops and institutes serve as high quality professional development venues, applicable to the needs of diverse audiences. PCAK workshops and institutes are strategically located to ensure child maltreatment prevention education is accessible to audiences statewide. PCAK promotes trainings through networking and engagement of community partners. Invitation listings are developed based on the target audience and region of the state in which it will be located. Partners instrumental in announcing events include DCBS; the Department for Public Health, DBHDID; DCC; FRYSCs; and well as other locally based entities. PCAK utilizes web-based advertising including the website, electronic newsletters, and social media (Facebook, Twitter).
Workshops and institutes, which are specific to one discipline, include a segment on the importance of a multi-disciplinary approach to prevention. PCAK provides workshops and institutes, which incorporate components across the entire continuum of prevention. Participants are equipped with knowledge on risk factors, warning signs, and protective factors, which enhance the strength-based approach to prevention. Participants leave with tangible tools for working with children and families such as local and statewide community resources. Participants receive materials in addition to education. Training of the trainer institutes provides training materials, resources for future participants, and ongoing technical assistance. DCBS staff members are invited to attend or participate as co-presenters in many PCAK trainings. This provides professional development opportunities for DCBS staff and encourages communities to align themselves with DCBS as a resource to assist in meeting local needs.

All PCAK educational workshops and institutes focus on protecting children from abuse and neglect and supporting families so children reach their full potential. Professionals are empowered to act when recognizing indicators of child maltreatment and to incorporate practices to enhance community and family protective factors. As an active member on the Kentucky External Child Fatality and Near Fatality Review Panel, PCAK utilizes experienced staff to provide accurate data on trauma, risk factors, and the protective factors that can prevent fatalities and near fatalities. Workshops on preventing pediatric abusive head trauma and the communities' role in preventing child maltreatment deaths broaden participants' understanding of the issue. Participants learn about PCAK resources and services including the annual Kids Are Worth It! ® conference; written and electronic materials; parent support programming; additional training opportunities; and, technical assistance for agencies wishing to incorporate child abuse prevention into their programs. PCAK utilizes resources, materials, and technical assistance from the national affiliate Prevent Child Abuse America. This relationship provides access to best practices from sister chapters throughout the country. Additionally, PCAK has utilized resources and information from Child Welfare Information Gateway, the National Center for Child Death Review, and many others.

During 2019, trainings were offered locally, regionally and statewide. PCAK provided training opportunities in each of the nine DCBS regions. Trainings often have a wide reach through statewide curriculum offerings and intentional offering of workshops in locations, which draw participants from surrounding counties. In 2019, PCAK served 1,367 participants and provided 34 trainings. PCAK staff continues to be active on the KY Strengthening Families Leadership Team and can integrate these concepts into other PCAK training curricula. PCAK staff continue to work with those who have implemented KY Strengthening Families into their work to ensure these efforts continue.

**Prevent Child Abuse Kentucky (PCAK), 1-800-CHILDREN Parent Support Resource**
The 1-800-CHILDREN parent support resource functions as a free parent support and referral service, which is available via phone, email, and the PCAK website. Funded by CBCAP, the 1-800-CHILDREN parent support resource line provides support to families to prevent incidents of abuse or neglect. Parents, caregivers, and the professionals offer support, encouragement, and information regarding local resources, which promote the safety and well-being of Kentucky children and families. The 1-800-CHILDREN parent support resource offers 24-hour access via email and the web. PCAK staff answer calls 8:00a.m.-5:00p.m. Monday-Friday; during all other times, callers are referred to 1-800-4ACHILD to ensure 24-hour access to support via phone.

Staff are trained to respond to caller concerns and have access to a wide variety of resources. When parents, caregivers, and professionals contact the 1-800-CHILDREN parent support resource, callers receive guidance in problem solving and referrals to the most appropriate resources in their local...
communities. Utilizing local social service providers for referrals not only connects callers with local and accessible resources, but also builds the community’s capacity to care for Kentucky children and families. The 1-800-CHILDREN parent support resource also serves as an engagement tool to connect citizens interested in learning about being involved in child abuse and neglect prevention efforts. Volunteer opportunities, specific child abuse and neglect related resources, and other pertinent information is provided.

The 1-800-CHILDREN parent support resource interconnects PCAK programs and services with family service providers statewide. The 1-800-CHILDREN phone line is advertised at all PCAK trainings and is included on all PCAK resource materials. Professionals working with children and families can provide this information to the clients they serve. The 1-800-CHILDREN parent support resource serves as the point of contact for citizens to learn about programs, information, events, and volunteer opportunities, which affect child maltreatment prevention. DCBS frontline staff are encouraged to share the 1-800-CHILDREN parent support resource with parents and caretakers involved with the DCBS system and can be utilized as a component of safety and aftercare planning when appropriate.

- Approximately 55,295 pieces of material displaying 1-800-CHILDREN were distributed throughout the Commonwealth during 2019.
- Staff communicated information regarding 1-800-CHILDREN during 51 formal trainings and numerous presentations on various topics to a variety of audiences reaching 3,683 individuals.
- Staff were involved in 86 outreach opportunities reaching 4,234 individuals statewide.
- The 1-800-CHILDREN parent support resource continued to include toll-free and local calling, email services, and web-based resource materials.

Data regarding usage of the 1-800-CHILDREN parent support resource is tracked monthly. Information captured includes number of calls received, the originating location for the call, type and number of referrals made. Some notable data from January 1, 2019 to December 31, 2019 includes:

- 187 calls were made to the 1-800-CHILDREN toll free parent support line.
- On average, the 1-800-CHILDREN toll free parent support line was utilized 16 times per month.
- On average, 61.25% of all callers were referred to DCBS.

Since the last reporting period, 1-800-CHILDREN parent support calls to the toll-free number have remained stable. This could indicate individuals utilizing the services are able to have their needs met through local, alternative means, including email, calls to the local resources, and the web-based service directory.

PCAK places high value on the continuous quality improvement process and will continue analyzing 1-800-CHILDREN parent support resource data to ensure parents have access to high quality support via phone, email, and the web.

PCAK, Partners in Prevention

PCAK Partners in Prevention is a network of agencies, individuals, and businesses with coverage to the entire state. During 2019, PCAK had 236 partners in prevention. These partners allowed for statewide coverage. The network consists of service providers such as volunteer groups, schools, hospitals, businesses, mental health providers, faith-based entities and other community organizations working to spread the message of child abuse prevention. Affiliates are involved in PCAK programming such as trainings and workshops, Self-Help, Parent Education and Support Groups, Child Abuse Prevention Month (CAPM), Kids Are Worth It! Conference, as well as regional and community awareness campaigns. PCAK takes a targeted approach in contacting, meeting with, and formalizing partnerships
with groups who will utilize the resources provided in a method increasing the development of awareness and prevention work across Kentucky.

All partners are involved in work to bring awareness to child abuse and neglect by distributing and sharing PCAK prevention information throughout their region. Qualitatively, PCAK maintains relationships with each individual partner, offering technical assistance to help build greater capacity in meeting prevention program and awareness needs of partners. Conversation and observation find partners are pleased with their experience through this network. Partners continue to assist PCAK in becoming a clearinghouse for Child Abuse Prevention Month ideas, seeking funding opportunities for prevention efforts that are well dispersed across the state, and continually brainstorming ideas and applying strategies to engage communities in each region.

As a part of the agency’s quality improvement efforts, PCAK staff initiated a plan to examine our existing partnership efforts. PCAK staff assembled a workgroup who examined existing practices on an ongoing basis. This group’s strategic plan included increased partner engagement via regional partner meetings, quarterly updates via electronic newsletters and emails, and allowing partner conversations from these initiatives to drive next steps in developing appropriate prevention resources for the state. One meeting was held in Pike County during 2019, serving four counties: Pike, Martin, Floyd, and Johnson. Using input from this meeting, staff continue to review all resources, materials, trainings, and website content. Partner meetings have further led staff to a plan for reviewing the reading level and content of all current brochures; review options for addressing non-English speaking resources; investigate digital mobile capabilities; develop a plan for creating more Public Service Announcements; and use meeting outcomes to drive content for partner newsletters. This process has been ongoing throughout 2018 and 2019, and 2020 will bring further opportunities to expand our work with partners across the Commonwealth.

Prevent Child Abuse Kentucky (PCAK), Child Abuse Prevention Month (CAPM)
During national child abuse prevention month, PCAK provides leadership to a statewide public education and awareness campaign to promote child abuse and neglect prevention. Efforts are funded through CBCAP, corporate and individual donations. PCAK collaborates with the state child welfare agency, community partners, professionals, parents, and caregivers to develop resources and materials. Awareness materials provide individuals with statewide information and services; and are made available through the PCAK website, trainings and community meetings. The 2019 child abuse prevention month campaign included the following activities:

- Via Gubernatorial Proclamation, April 2019 was declared Child Abuse Prevention month. Many communities across the state hosted proclamation ceremonies, engaging local elected officials such as mayors and judges, declaring April Child Abuse Prevention Month. PCAK distributed local proclamation templates as a strategy to ensure consistent messaging throughout the state.
- On March 27, in conjunction with the Office of the Governor and First Lady Bevin, PCAK held a statewide kickoff to include a pinwheel planting on the Capitol Lawn. Many partners showed up to plant pinwheels to bring awareness to child abuse and neglect in Kentucky. Following, PCAK hosted a networking reception where Governor Bevin signed a proclamation.
- Communities across the state held an array of events to include community proclamation ceremonies, pinwheel plantings, rallies, family-fun activities, trainings/conferences and resource fairs.
- PCAK leadership continued a partnership with the Kentucky Press Association (KPA) to facilitate engagement of statewide media outlets. The KPA sent a media advisory to all members regarding CAPM and encouraged local media outlets to provide coverage.
There were 296 CAPM related events reported to PCAK in 2019.

Staff developed CAPM resources available through the PCAK Information and Data Center. Resources included campaign ideas, templates for media outreach, event planning, faith-based materials, statistics and relevant data, tip sheets for parents and caregivers, and suggestions for engaging communities in grassroots prevention efforts.

Staff developed a tool kit with instruction and resources on both implementing Child Abuse Prevention Month efforts as well as the Pinwheels for Prevention Campaign. This resource was used to assist local groups in the planning and hosting of awareness activities.

Over 54,219 pinwheels were distributed across the Commonwealth.

There were 1,958 pinwheel lapel pins distributed across the Commonwealth.

There were 176-yard signs distributed across the Commonwealth.

Electronic announcements promoting child abuse prevention month and the availability of the online resources were distributed via social media, the PCAK webpage, and email distribution. There were 21,202 hits to the PCAK webpage during the campaign.

Targeted announcements were also sent to DCBS staff, educators, mental health professionals, childcare providers, law enforcement officials, health departments, and legal professionals.

100% of Kentucky counties were engaged with PCAK in child abuse prevention month efforts.

In advance of and during the month, 60,946 child abuse awareness materials were distributed across the state to local communities.

During the 2019 campaign, there was an increase of 207 Facebook likes, 45 Twitter followers, and 68 Instagram followers.

Resources made available by the Children’s Bureau were utilized in the development of the 2019 CAPM materials. Links to the Children’s Bureau and other national organizations were provided on the PCAK website as resources to local communities. PCAK also benefits from affiliation with Prevent Child Abuse America and sister chapters throughout the country. This affiliation provides ideas and resources to strengthen Kentucky’s efforts.

Prevent Child Abuse Kentucky (PCAK), Awareness Tools
Using CBCAP funds, corporate and in-kind donations, PCAK provides an array of awareness tools throughout the year. Based on the varying learning styles of adults today, and the ways people receive information, awareness tools include brochures, electronic resources, as well as video, print and media campaigns. We have coined this group of resources as the “PCAK Information and Data Center,” a term reflecting the variety of media through which tools are distributed. Awareness tools serve to strengthen the ability of the public and professionals of the Commonwealth to gain knowledge regarding the issue of child abuse and neglect. CHFS staff and community partners are consulted regarding emerging trends in the field of child abuse and neglect prevention. This information assists in determining the content and topics of awareness materials offered by PCAK. These community partners, in conjunction with PCAK staff, provide ongoing review of materials to ensure the accuracy of the information available for distribution. Examples of awareness tools available on these subjects include:

- “Ages and Stages: A Parent’s Guide to Discipline” brochure designed to educate individuals on child development and keys to effective discipline.
- “How Well Do You Know Your Love Interest” brochure is a guide for caregivers in choosing a partner, focusing on the impact this decision has on a child.
• The Internet Safety Toolkit is an easy to comprehend guide for parents and caregivers to provide education on internet safety.
• “Preventing Child Neglect” brochure defines neglect and educates the reader on how to recognize and respond to neglect.
• “Preventing Child Sexual Abuse” brochure educates readers on the dynamics of child sexual abuse and prevention strategies.
• “How do I Choose a Safe Caregiver” Tip Sheet educates readers on the importance of choosing someone safe to care for their child.
• “Understanding Typical Healthy Child Development” Tip Sheet educates readers on what to expect from their child as he/she develops.
• “As a Parent, What Can I do to reduce the Risk of Child Sexual Abuse” Tip Sheet educates parents on ways to reduce the risk of sexual abuse for their children.
• “Coping with Crying” Tip Sheet educates parents on ways to deal with baby’s crying, in effort to reduce stress and acting out in harmful ways, reducing pediatric abusive head trauma.
• “Summer Camp Tips – Selecting the Right Camp” educates parents on the questions to ask prior to enrolling their child in any summer camp or youth serving organization activity.
• “When a Child Talks About Sexual Abuse…” Tip Sheet addresses how adults should react and respond to child sexual abuse disclosures.
• “Recognizing Child Sexual Abuse – Know the Facts” Tip Sheet educates adults on the statistics, definition, safety tips, and warning signs around child sexual abuse.
• “Child Sexual Abuse Risk Reduction Protocol for Youth-Serving Organizations” is a guide designed for youth-serving organizations who are interested in adopting strategies to prevent child sexual abuse.

All resources are driven by needs identified within Kentucky and designed to meet the needs of parents and professionals. For instance, because pediatric abusive head trauma is the primary cause of physical abuse deaths in Kentucky, tools and awareness campaigns addressing this have been deemed critical. In addition, research has shown the reality that many children each year are abused by their parent’s love interest or their caregiver, which deemed it necessary to have a resource to help parents make these decisions.

PCAK has worked to ensure the online resources are available on our website, www.pcaky.org, to include electronic copies of all available brochures, parenting tip-sheets, and tools for involvement in awareness campaigns such as Pinwheels for Prevention or Child Abuse Prevention Month. The online Information and Data Center continues to be used widely throughout the state for ordering and downloading child abuse prevention resources: https://www.pcaky.org/information-and-data

Through a grant from Well-Care Health Plans, Inc., PCAK developed and launched a Pediatric Abusive Head Trauma Prevention and Safe Sleep Campaign in conjunction with the Kentucky Hospital Association. PCAK created and sent educational DVDs, posters, and other resources to 17 birthing hospitals. All resources are available on the PCAK website, YouTube channel, and Facebook page.

YouTube: https://www.youtube.com/user/PCAKY
Website: https://www.pcaky.org/node/427

Further, PCAK has increased efforts for the “Ask the Expert” campaign in 2019, releasing videos on topics such as child abuse and neglect data and research, adverse childhood experiences and resiliency,
human trafficking, safe sleep, and teen mental health. These Ask the Expert videos had approximately 4,432 total views. Staff will continue to work to enhance this awareness and educational initiative into 2020.

The agency will continue to work with CHFS, community partners, and when appropriate, national organizations, to stay abreast of current variables in the field of child abuse and neglect prevention in an ongoing effort to maintain and expand our resources. Trends in 2019 included internet safety, child sexual abuse prevention and the way we talk about it to the public, evidence-based prevention, pediatric abusive head trauma, prevention/awareness programs targeted to children, parenting strategies, grandparents raising grandchildren, trauma-informed care, building child and parent resiliency, child fatality prevention, and strengthening families through building protective factors. PCAK works collaboratively with community partners to promote systems improvements by creating tools to support multi-tiered prevention of abusive head trauma for parents provided by birth hospitals, healthcare professionals, and home-visiting programs. Staff have also collaborated with medical professionals, childcare providers, parenting programs, early child home visiting programs, and other agencies towards developing a statewide public awareness campaign to also address safe sleep. Staff continued conversations with the KY Hospital Association, while receiving a grant from Well-Care Health Plans of KY, to update prevention resources around pediatric abusive head trauma prevention. These new resources debuted in 2019.

Citizens and professionals are encouraged to utilize PCAK’s awareness tools to educate and advance their knowledge as to the existence and impact of child abuse and neglect. The utilization of social media has proven to be advantageous for the agency, allowing PCAK to reach a multitude of citizens who may not have traditionally been familiar with the agency.

PCAK tracks baseline data regarding awareness tools requested and distributed. Included in this tracking system are the parties requesting materials, number of materials requested and distribution location. PCAK believes awareness promotes education, which, in turn, plays a relevant role in the reduction of incidences of child abuse and neglect. In 2019, over 60,946 pieces of materials, with 101 downloads, were distributed across the Commonwealth designed to educate and promote awareness of child abuse and neglect. PCAK encourages the reproduction of this literature, many agencies make copies of the brochures and pamphlets sent to them by PCAK and distribute them to other local agencies and civic organizations. To assist in meeting this need, PCAK has developed printer friendly online versions of printed material. During 2019, 5,406 followers liked agency’s Facebook business page. Twitter followers grew to 3,309. Instagram followers grew to 1,156. There were 65,016 hits to the PCAK website.

PCAK evaluates the resource library using tracking and distribution databases. Consumer satisfaction surveys and inferential statistics are utilized as well to determine the needs of consumers throughout the state:

- The most requested informational brochures continue to address pediatric abusive head trauma, child sexual abuse prevention, and the role of every person to report suspected child abuse and neglect. They are, “Hold Them, Hug Them, Love Them but Never Shake a Baby”, which reflects the intentional focus within PCAK and other advocacy organizations in addressing high instances of pediatric abusive head trauma in Kentucky; “Preventing Child Sexual Abuse”, reflecting PCAK’s statewide focus on child sexual abuse prevention; and “What Everyone Should Know about Child Abuse”, reflecting the need for education of what to look for and how to report.
The agency has a wide variety of resource available, and at times has difficulty meeting the demand. The agency is using technology to assist in providing this information in a more efficient and cost-effective means. This need has driven the PCAK agency goal to make the Information and Data Center Kentucky’s premier source for child abuse and neglect prevention information. The Center informs Kentuckians via data, research findings, national and state trends and best practices; and will use all media formats to inform the public of PCAK programs, trainings, and child abuse prevention initiatives. https://www.pcaky.org/information-and-data

Prevent Child Abuse Kentucky (PCAK), Fatherhood Initiatives
PCAK has provided community services and education geared toward greater engagement of fathers for over 15 years, particularly around child abuse prevention. The focus of PCAK efforts has been on improving outcomes for children by enhancing the engagement of fathers. PCAK strives to engage local and statewide partners in efforts to raise awareness on the importance of fathers in improving outcomes for children and the need for a cross-systems approach to enhancing the community’s capacity to effectively engage fathers.

PCAK seeks to address the engagement of fathers through trainings and community events. Staff have developed specific curricula to address the importance of fatherhood engagement. These trainings highlight the importance of involving fathers in children’s lives, addressing all outcomes in the areas of safety, permanency, and well-being. These trainings are provided in various settings, and in partnership with agencies such as public health, local government, etc. Similarly, PCAK staff have also been engaged in community events promoting the value of father engagement. These events include activities such as community baby showers, social media posts, and fatherhood celebrations. PCAK also provides opportunities for locally and nationally recognized presenters to teach community partners and providers best practices in working with and serving fathers.

PCAK benefits from strong partnerships with agencies across the state. Partnerships cultivated throughout the state assist in the distribution of fatherhood training and resource materials. These partnerships have been particularly important as PCAK has been a leader to create a statewide collaborative, the Commonwealth Center for Fathers and Families (CCFF), formerly identified as the Kentucky Fatherhood Initiative. During 2019, CCFF had several accomplishments including development of a clear mission (to support fathers and families in providing for the safety, permanency, and well-being of children through education, advocacy, and collaborative partnerships) and drafting a strategic plan outlining goals for promoting statewide positive fatherhood involvement. CCFF applied for and was one of 11 states awarded a grant by the Fatherhood Research and Practice Network, which allowed for development of the strategic plan as well as partially funded the 2019 Fatherhood Summit.

The Summit, held in Lexington, was delivered to 267 individuals, including summit attendees, exhibitors, presenters, CCFF members, and volunteers. Participants indicated their profession and county of work during the registration and evaluation processes. The professions included representatives from state government, mental health, law enforcement, education, corrections, non-profit organizations, faith-based organizations and other community social service providers.

PCAK continues to play a vital role in statewide fatherhood work. A PCAK staff member currently serves as an executive officer for CCFF and is involved on several subcommittees including network and fund development, special events, communications, and legislative inclusion. PCAK’s leadership with fatherhood efforts helps to promote healthier childhoods across the Commonwealth.
DD. Standardized Screening and Assessment

Project SAFESPACE was a 5-year; $2.5 million grant entitled Promoting Wellbeing and Adoption after Trauma. The grant was funded by the Children's Bureau. The grant ended September 29, 2018. At that time, DCBS initiated a contract with University of Louisville to maintain one clinical consultant position through state funds, as well as the subcontract with Advanced Metrics in order to access the KIDnet system for web-based data entry of the functional assessments. Screening and assessment is now fully integrated into the Department’s practice.

Screening and assessment is designed to enhance behavioral health services for children in OOHIC through implementation of a continuum of evidence-based universal screening, functional assessment, outcome-driven case planning, treatment, and descaling of ineffective services. Screening and assessment occurs statewide for children in OOHIC.

The clinical consultant continues to collaborate with the Department for Behavioral Health Development and Intellectual Disabilities (DBHDID) and Eastern Kentucky University (Training Branch). During this reporting period, the implementation team continued to hold bi-monthly steering committee meetings to drive the work forward and engage in collaborative decision-making. The clinical consultant regularly interfaces with community partners, including private providers, community mental health centers, and other agencies (such as CASA).

Standardized screening and assessment implementation includes a process for early identification of child trauma and behavioral health needs through standardized screening and assessment. DCBS frontline staff administer a compilation of screeners based on the child’s age upon entry into OOHIC, (e.g., Child PTSD Symptom Scale, CRAFFT, Strengths and Difficulties Questionnaire, Upsetting Events Survey, and Young Child PTSD Checklist). Screeners are specifically to be administered within the first 10 days of entry. For children seven years and older, the screener should primarily be informed by the child whereby information is solicited in a face-to-face interview. Screening is completed in Kentucky’s Comprehensive Child Welfare Information System (CCWIS): The Worker Information System (TWIST), whereby scores are tabulated and both detailed and summary reports are generated. While screening is required for children entering OOHIC, it may be completed for any child served by DCBS.

Screening is designed to achieve the following: standardize decision-making and give priority for those in need of behavioral health services, inform the provider about child and family needs, alert the child welfare worker as to the child’s perception of experiences, engage caregivers and youth around assessment and treatment needs, and support leveling and placement.

Children identified as needing a standardized clinical assessment receive a provider completed Child and Adolescent Needs and Strengths (CANS) Assessment. Kentucky is currently using both the younger and older child versions of the CANS, (i.e., ages 0-4 and 5-17 years). The Kentucky CANS assesses six domains, 69 items for younger children, six domains, and 79 items for children ages five and older. Providers have 30 days to complete the initial CANS and then update the CANS every 90 days. Providers complete the CANS in a web-based application that interfaces with TWIST. Through an automated data push and pull between TWIST and the CANS web-based application, child demographic information remains consistent across the systems ensuring data integrity. In return, high level assessment information is communicated directly back to the DCBS frontline staff in the form of a report detailing significant areas of concern, strengths, change over time, recommended evidence-based practice, and intensity of service. This streamlined approach allows for efficient information sharing and aggregate data matching aligning child needs and treatment with child welfare outcomes. DCBS staff are trained
to use CANS results to better understand clinically identified treatment needs and monitor progress. Assessment results are to be used to engage caregivers and youth, communicate with providers and partners, and incorporated in case planning at the 90-day family team meeting.

Rates of compliance in regards to completion of the screener and CANS assessment were analyzed for each region during this reporting period (January 1, 2019-December 31, 2019). The table below describes the number of children in OOHC, the number of children screened, and the number of children who needed a CANS assessment based on screener results.

<table>
<thead>
<tr>
<th>Region</th>
<th># Entered OOHC</th>
<th># Children Screened</th>
<th>% Children Screened</th>
<th># Screened in for CANS</th>
<th>% Screened in for CANS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern Mountains</td>
<td>330</td>
<td>302</td>
<td>91.52%</td>
<td>202</td>
<td>61.21%</td>
</tr>
<tr>
<td>Jefferson</td>
<td>536</td>
<td>383</td>
<td>71.46%</td>
<td>246</td>
<td>45.90%</td>
</tr>
<tr>
<td>Northern Bluegrass</td>
<td>700</td>
<td>530</td>
<td>75.71%</td>
<td>347</td>
<td>49.57%</td>
</tr>
<tr>
<td>The Lakes</td>
<td>481</td>
<td>397</td>
<td>82.54%</td>
<td>275</td>
<td>57.17%</td>
</tr>
<tr>
<td>Two Rivers</td>
<td>964</td>
<td>653</td>
<td>67.74%</td>
<td>423</td>
<td>43.88%</td>
</tr>
<tr>
<td>Cumberland</td>
<td>540</td>
<td>491</td>
<td>90.93%</td>
<td>312</td>
<td>57.78%</td>
</tr>
<tr>
<td>Salt River Trail</td>
<td>735</td>
<td>585</td>
<td>79.59%</td>
<td>363</td>
<td>49.39%</td>
</tr>
<tr>
<td>Northeastern</td>
<td>498</td>
<td>347</td>
<td>69.68%</td>
<td>222</td>
<td>44.58%</td>
</tr>
<tr>
<td>Southern Bluegrass</td>
<td>627</td>
<td>469</td>
<td>74.80%</td>
<td>292</td>
<td>46.57%</td>
</tr>
<tr>
<td>Total</td>
<td>5411</td>
<td>4157</td>
<td>76.82%</td>
<td>2682</td>
<td>49.57%</td>
</tr>
</tbody>
</table>

The following screeners are administered to children under five entering OOHC: Young Child PTSD Checklist (ages 0-6) and the Strengths and Difficulties Questionnaire (ages 2 and older). Children identified as needing an assessment receive a Child Adolescent Needs and Strengths Assessment (CANS). The younger child CANS has a minimum of six domains and 69 items.

CANS Compliance
CANS compliance continues to be an area of focus for the Department. More than 76% of children placed in private child caring/placing agencies have received a CANS Assessment. Conversely, more than 80% of children placed in state foster homes, relative placements, or with fictive kin do NOT have a CANS assessment. There are many barriers to completion, including referrals not being made timely, foster families choosing non-CANS trained providers, and the age of the child (young children not being served by agencies).

All children entering OOHC during the reporting period were targeted for screening. Any child identified through screening as needing a CANS assessment and served by a community mental health provider, independent provider, or a private child caring/placing agency should have received a CANS assessment.

The Department implemented standards of practice (SOP 4.26.3 Standardized Screening and Assessment for Children in Out of Home Care) in 2019. This SOP details the procedures for screening and assessment.
Evaluation activities continued in 2019 through the University of Louisville. The contract for data analysis ended on September 30, 2019. The evaluation focused on qualitative measures (focus groups and interviews) and quantitative measures (data analysis assessing mental health/emotional well-being, safety and permanency outcomes, compliance data, and analysis of recommended treatment modalities).

A number of positive outcomes were observed through the evaluation of the project. Collaboration between child welfare and behavioral health agencies, and trauma readiness-related organizational outcomes improved over time. Advances in child wellbeing were noted in two ways. Statistically significant functional improvement was observed for the majority of children in treatment over time. Given that, this state had no standardized way to measure this prior to the project and therefore this is a significant achievement. In addition, statistically significant improvement in CFSR wellbeing outcomes were found for children served by the project. Equally important, rich data regarding the needs, strengths, and potential impact of specific treatment modalities of children in out-of-home care was made available for improving services for individual children as well as to inform interorganizational service capacity decision-making.

Efforts have continued to focus on full integration into casework and treatment planning. The workforce needs continued education around ways to incorporate recommendations for evidence-based treatment into case planning. Additionally, many children in OOHCP are served by independent providers. These providers are being trained in the CANS assessment so they can also provide assessments for children in OOHCP in an effort to increase CANS compliance and ensure all children who have screened in for a CANS assessment receive the assessment. The clinical consultant continues to work to train agency staff in the CANS and ensure that CANS are completed timely.

Barriers continue to exist related with the length of time needed for full engagement and education of the workforce. In addition, project time is challenged by the ongoing attention is needed to ensure fidelity to protocols and quality assurance.

The Department is working in collaboration with DBHDID on the System of Care 5 grant. Through this grant, the Departments plan to implement screening and assessment for all children in open DCBS cases.

**EE. Rape Crisis Centers**

Kentucky has 13 regional Rape Crisis Centers (RCCs) which cover all 120 counties and operate on a regional model, with each center covering anywhere from five to 17 counties. The Area Development District model was used as the template for RCC coverage. Kentucky’s RCCs are governed by KRS 211.600-608 and 922 KAR 8:010. There are three configurations of the RCCs: independent rape crisis center (sexual victimization only), independent dual rape crisis center (sexual assault/children’s advocacy center) and community mental health center-based rape crisis program. All configurations are 501(c)(3) non-profits and have independent Boards of Directors that provide governance.

Kentucky’s RCCs provide services to victims of all ages who have been sexually abused and/or assaulted. Additionally, the centers provide intervention services to the victim’s family and friends to support the healing process of sexual victimization. The following services are available at every RCC:

- **24-hour Rape Crisis Line. Call 1-800-656-HOPE (4673) to be connected to a local rape crisis center**
- Counseling and support for survivor and for family and friends
- Accompaniment and advocacy in hospitals, law enforcement settings, and other legal settings
- Therapy services or professional referrals for therapy
- Support groups or professional referrals to support groups
- Referrals to appropriate community resources
- Assistance with Crime Victims Compensation Fund claims
- Prevention & Public Awareness Programming, presentations may be available on the following topics:
  - Green Dot in KY High Schools and Communities – evidence informed bystander intervention curriculum that has proven effectiveness in reducing rates of sexual violence perpetration, victimization, sexual harassment, and bullying.
  - Shifting Boundaries – evidence informed intervention designed to reduce dating violence and sexual harassment among middle school youth by highlighting the consequences of this behavior for perpetrators and increasing faculty surveillance of unsafe areas.
  - Dynamics of Sexual Violence
  - Legal and Medical Aspects of Sexual Violence
  - Dating Violence and/or Healthy Relationships
  - Rape Awareness and Prevention
  - Responding to Violence in Faith Communities
  - Sexual Harassment
  - How Family & Friends Can Help
  - Child Sexual Violence & Adult Survivors of Child Sexual Violence Consultation
  - Consultation for professionals working with survivors of sexual assault
  - In-service trainings for professionals

The RCCs receive funding from several sources to provide services, including CHFS. Data is collected and submitted through quarterly reports from each RCC to the program administrator at CHFS. Data collected includes demographics of victims served, crisis hotline calls, medical advocacy and assistance with the sexual assault forensic evidence exam, court advocacy information, crisis and long term counseling, multidisciplinary team involvement, community education/professional trainings, and volunteer service hours.

Each RCC is a private 501(c)(3) agency and is encouraged to seek out additional revenue streams. RCCs receive their funding through subcontracts with each of the 13 regional RCCs. The Cabinet has an MOU with Kentucky Association of Sexual Assault Programs (KASAP) to administer the funds that the Cabinet receives for rape crisis work. The SFY19 contract includes state general funds in the approximate amount of $ 4.7 million, as a group, $544,315 in rape prevention and education funds from the Center for Disease Control to Kentucky Department for Public Health and passed on to DCBS for the implementation of primary prevention programming, including the nation’s first evaluated, evidence informed bystander intervention program (Green Dot in Kentucky high schools) and $97,025 in preventive health and health services to further support primary prevention efforts. RCCs also write and receive several federal, (i.e., Victim of Crime Act, Violence Against Women Act, and Sexual Assault Services Program) and local grants, (i.e., United Way, local fiscal government awards) that are not
included in the contract with KASAP and are driven by each agency’s board of directors’ fundraising ability.

There are 13 RCCs strategically located in each of the 15 Area Development Districts (ADD). These RCCs therefore are deemed regional RCCs and aim to serve victims and family members in each county of its respective ADD. RCCs serve an average of nine counties with some RCCs serving as many as 17 counties. DCBS contracts with KASAP, the member-based federally recognized state sexual assault coalition that represents the individual RCCs on issues related to all RCCs.

The RCCs work collaboratively with a number of partners to achieve the outcomes that they have experienced over the years. In particular, DCBS children and their caretakers make up 10% of the RCC new victims receiving services. Close work with DCBS frontline staff and RCC advocates and/or clinicians provide a critical link in the well-being of DCBS children who may be in out of home placements due to documented abuse or neglect. RCC advocates are also members of each county’s multidisciplinary teams that staff child sexual abuse cases. This opportunity to connect with the legal guardians of children in care improves the overall outcomes of children navigating the long journey of healing after reporting or disclosing sexual abuse. Many representatives from other child-serving or victim-serving agencies sit on various RCC boards of directors, reflecting the core mission of most communities to stop abuse from happening to their children.

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Number of Services Provided/Persons Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>New victims served</td>
<td>5,066</td>
</tr>
<tr>
<td>New family &amp; friends served</td>
<td>1,079</td>
</tr>
<tr>
<td>Legal advocacy services: court, case management, referrals to services</td>
<td>1,997</td>
</tr>
<tr>
<td>Medical advocacy services: sexual assault forensic exam (SAFE), follow up exams, referrals for further medical treatment</td>
<td>1,919</td>
</tr>
<tr>
<td>Crisis calls received</td>
<td>3,263</td>
</tr>
<tr>
<td>Counseling sessions provided</td>
<td>19,670</td>
</tr>
<tr>
<td>DCBS client total</td>
<td>550</td>
</tr>
<tr>
<td>Prevention/education sessions (including Green Dot in Kentucky high schools)</td>
<td>2,903</td>
</tr>
<tr>
<td>Prevention/education participants (including Green Dot in Kentucky high schools)</td>
<td>195,449</td>
</tr>
<tr>
<td>Volunteer hours</td>
<td>63700</td>
</tr>
</tbody>
</table>

922 KAR 8:010 has been updated by a committee of the KASAP Board in collaboration with DCBS staff and submitted for filing to the Legislative Research Commission, where it is waiting to be filed and heard by the legislative committee. The KY Board of Nursing has approved a regulation change (in place since 1996) governing Sexual Assault Nurse Examiners (SANE) to permit the training and credentialing of pediatric/adolescent SANEs. Until this time, SANEs could only perform forensic examinations on children age 14 and above. KASAP has traditionally been the only trainer of SANEs, however, is now collaborating with pediatricians serving in CACs to develop the didactic and clinical portions of SANE P/As, who will meet children and their families in hospital emergency departments, where the rape
crisis centers will dispatch advocates to meet them. Victims of chronic child sexual assault will still go the CAC and will be examined by a pediatrician. In addition, since the passage of the 2016 SAFE Act, rape crisis center advocates are assisting law enforcement in reducing the backlog of rape kits by helping them notify victims.

Each RCC captures client feedback after services are completed. In the most recent iteration of the RCCs self-evaluation of advocacy and counseling services, Healing Voices 2012, the 13 RCCs demonstrated significant reduction in trauma symptoms by victims attending counseling services. The biggest reductions in trauma symptomology and increases in one’s sense of empowerment were reported by clients attending 10 or more counseling sessions. Likewise, advocacy services were reported to be similarly effective in reducing victims’ negative experiences through the legal and medical advocacy services offered by RCCs.

Clients receiving services at RCCs say:
- “This place saved my life.”
- “I feel so much better with everything. I cannot trust anyone usually and I feel safe with all the workers here they are helpful with everything. I would refer anyone here for treatment.”
- “I am glad I finally took the step to come here & seek help & believe in the end it will help me.”
- “This is my safe place. And, I’m getting more healthy.”
- “The center always gives me help and hope.”
- “I am ready to deal, heal and thrive!”

The regular trend seen within RCC data is an increase in services with either stagnant or decreasing funds to support the work required. The RCCs continue to improve their evidence base of effective services to victims of sexual crimes. One of the few coalitions focused on establishing and improving outcomes related to victims’ services, KASAP and its 13 member organizations show commitment to and excellence in providing quality services to KY’s victims of sexual crimes.

FF. Safe Infants/Safe Haven

Kentucky Revised Statute 405.075, part of "The Representative Thomas J. Burch Safe Infants Act" provides that a person may leave a newborn infant less than 30 days old with an emergency medical services provider, police station, fire station, hospital, or participating place of worship. The Safe Infants Law states that the parent will not be criminally prosecuted for abandoning an infant less than 30 days old, if the baby is taken to one of the above-determined safe places and has not been physically abused or neglected after birth. The parent may voluntarily provide information about the baby. Within 30 days of the baby’s abandonment, the parent may ask for the baby’s return, and DCBS may provide services to the parent to help the family stay together and safe. After 30 days, the Cabinet will begin the process of terminating the parental rights and making the child available for adoption. The statutory provisions afford parents a safe and anonymous option when they are unable to care for their newborn children. The provisions also help children obtain more timely permanency.

The program is funded through Social Services Block Grant (SSBG) and state funds.

The Department’s central office continues to receive requests for safe infant brochures and packets from community agencies. The requests are routed to the state Board of Emergency Medical Services that compiles hospital packets and mails them to requestors. A large portion of the requests for these packets comes from law enforcement, fire departments, and hospitals. The program’s information and
downloadable posters are also available on the Departments’ internet site, https://chfs.ky.gov/agencies/dcbs/dpp/cpb/Pages/safeinfantsact.aspx. The site also contains a power point presentation updated in 2016 by the state Board of EMS. In previous years, the CHFS’ Office of Communications has issued a statewide press release regarding the details of the Safe Infants Act. The web site also contains a list of frequently asked questions. Brochures have been translated to Spanish and were purchased for distribution to all universities and colleges in the state. They have also been sent to all DCBS offices across the state.

As a result of amendments to the Safe Infant Act in the 2016 legislative session, the Division of Protection and Permanency began working with partners at PCAK and Norton Children’s Hospital to increase awareness of the program. DCBS and partners have consulted with Timothy Jaccard who is the founder/president of AMT Children of Hope Foundation in New York and is considered the father of the national safe haven initiative http://www.amtchildrenofhope.com/index.php. Mr. Jaccard has shared information and resources to include signage, hospital protocol manual, and access to his AMT Children of Hope Foundation hotline that offers assistance 24 hours per day/7 days per week to pregnant and new mothers who are considering a safe infant placement for their child. In collaboration with PCAK and Norton Children’s Hospital, a hospital protocol was developed for utilization in hospitals across the state that includes appropriate signage to designate safe infant sites. The Child Protection Branch continues to work with these agencies to finalize the materials.

In the 2016 legislative session, amendments were made to the Safe Infants Act by extending the relinquishment period from 72 hours to 30 days after birth. In addition, the amendment added participating places of worship to acceptable safe infant sites. KRS 405.075 was amended by the General Assembly to include the following language: "(5) A staffed police station, fire station, hospital, emergency medical facility, or participating place of worship may post a sign easily seen by the public stating that: "This facility is a safe and legal place to surrender a newborn infant who is less than 30 days old. A parent who places a newborn infant at this facility and expresses no intent to return for the infant shall have the right to remain anonymous and not be pursued and shall not be considered to have abandoned or endangered their newborn infant under KRS Chapters 508 and 530."

History
(2002-2019)
• There have been 53 Safe Infants incidents involving 54 infants since 2002 (one incident involved a set of twins).
• Of the 54 infants, eight were delivered at home, one was delivered in the hospital parking lot, and 45 were delivered in the hospital.
• The infant delivered in the hospital parking lot was discovered to have been left at the hospital entrance. Neglect was substantiated, but the judge determined probable cause that the child was left with the intent to leave the child according to the Safe Infant Act.
• Of the 54 infants, 42 have been adopted, one has a pending adoption hearing, two have pending TPRs, and nine were returned to their parents.
• Average length of time to TPR is 6.88 months with three months being the shortest amount of time and 13 months being the longest.
• Average length of time for adoption to occur is approximately 5.68 months. One of the cases from 2007 took 37 months for adoption to finalize, and it appears this is the exception to the remainder of the data. In this particular case, the child was born with severe birth defects, and the adoptive parents were waiting for the child’s surgeries and medical interventions to occur prior to adoption.
• Ages of mother (if able to identify): 15, 17, 18, 22, 23, 24, 25, 26, 27, 28, 30, 33, 34, 40, as well as 30 unknowns.
• Infants - Males and Females: 23 males and 31 females.
• Races of infants: 23 Caucasian, 7 African American, 2 Hispanic, 1 Indian, 1 biracial and 20 unknown/declined to disclose.
• Reasons cited for abandonment, if identified: had other kids and could not financially afford another; five infants were the product of rape; mother under age 18; already has one child and cannot handle a second one; cannot care for the child; an alternative to abortion; husband does not want the child; wants to give the child a better life; 15 y/o mother was afraid that the maternal grandfather would kill her if he found out about the baby; child had severe birth defects; mother was homeless; mother reported that she wanted to anonymously place child up for adoption; mother overwhelmed and afraid she will hurt the baby; mother concerned she’ll be disowned by her family due to cultural issues; child born with birth defects; parents are illegal immigrants and afraid if deported due to the new administration; and the baby will not be able to receive the medical care needed.
• One mother reported using the Safe Infants Act with a previous child.

Situations that occurred that could have perhaps been avoided if the safe infants Law had been utilized include the following:
• An infant left in a shoebox in March 2007; however, it was left at an unoccupied duplex, and this is not a designated place.
• An infant was also delivered and placed on a doorstep; the child was not considered Safe Infant because the child was not left at an appropriate location.
• An infant was placed in a plastic bag upon delivery at Bellarmine College.
• There were two additional fatalities that occurred in 2008 that could have been avoided if the mother had utilized the Safe Infants Law.
• In 2009, an infant was left in a garbage receptacle immediately after delivery; toilet paper was stuffed in the infant’s throat.
• In 2011, an infant was suffocated by the teenage mother, who was subsequently charged with homicide.
• In 2013, an infant was left in a garbage can inside a department store in Louisville. The mother was initially charged with abuse of a corpse and tampering with physical evidence.
• In 2014, a mother reportedly did not know she was pregnant, delivered her infant at home, and placed the infant in a garbage can. The infant survived and criminal charges are pending. Also in 2014, the remains of an infant were located on the property of a home in deplorable conditions where nine other children were removed and the parents were charged with wanton endangerment.
• In 2015, there were two incidents in which Safe Infant could have been utilized. The first occurred in January: Mother delivered the baby in a toilet. She put the child in a garbage bag and was going to put the child in a dumpster until someone intervened. The infant survived. The second occurred in July: Mother (age 15) delivered the baby at a local hospital while visiting her grandmother who was hospitalized. Mother wrapped the child in linen and put the baby in a dresser drawer. The infant did not survive, and the mother was criminally charged.
• In November 2017, a deceased infant was located inside of a bag on a busy neighborhood street in Lexington. The mother was never located.
• In 2018, there were two incidents in which Safe Infant could have been utilized. The first occurred July: Mother delivered the baby at home. The infant was deceased upon arrival to the hospital. The autopsy concluded that while the child was born alive, the results were suggestive
of multiple scenarios, including heat exposure, smothering/suffocation, and neglect. Due to this information, the cause of death was determined to be homicide. The second occurred in December: A baby was found in a garbage bag outside an apartment complex. An autopsy showed the baby had cranial bleeding and fractured ribs. The infant did not survive, and the mother was criminally charged.

• In 2019, CHFS received a near fatality investigation regarding a newborn found in a toilet by EMS. The mother gave birth at home, claiming that she was unaware of the pregnancy. The infant was apparently birthed into the toilet (head down) and left there until EMS arrived. Child was in critical condition upon arrival to the hospital.

GG. Safety Net
Safety Net is a short-term intervention program that provides services to former recipients of Temporary Assistance for Needy Families (TANF) cash assistance who are no longer eligible for assistance due to failure to comply with participation requirements or reaching their sixty month lifetime limit of receipt. The goal of Safety Net is to prevent out-of-home placement of children in these families. The program is funded through title IV-A and services are administered statewide.

Services are designed to assist families in developing the skills necessary to manage their home, family relationships, and prevention of home disruption. Activities include assessment of the family and home; problem solving; and intervention in crisis situations, including utility shutoffs or insufficient food, clothing, housing, employment, etc. Referrals to community resources may also be made to meet any immediate needs the family may have.

Staff from the Division of Family Support notifies DPP staff when a family is no longer eligible for TANF cash assistance due to failure to comply with participation requirements or reaching their sixty month lifetime limit of receipt. Within 15 days, DPP staff contacts the family to arrange a home visit to complete an assessment. After the completion of the assessment, DPP staff may help the family develop a plan of action and refer the family to community resources to assist in meeting any unmet needs of the family. If financial assistance is needed and the family is at or below 200% of the federal poverty level, the family may receive up to $635 for over a four month period within the 12 month period following discontinuance. These benefits are used to meet basic needs such as shelter, food, clothing, or utilities.

Each service region is allocated a specific amount of Safety Net funds. A monthly log containing the name of the family, the purpose and amount of expenditure, names of families denied, and the resources utilized is maintained in each local office. In addition to the monthly log, DPP workers document how Safety Net prevented out-of-home placements and family instability. A copy of the regional log, invoices, receipts, and checks issued are submitted each month to the Division of Administration and Financial Management.

From January 1, 2019 through December 31, 2019, 63 families received Safety Net services. This was an average of five families per month, and $1,751.61 per month.

There have been no changes in policy or practice during the calendar year of 2019. The cabinet intends to continue to provide Safety Net services for families who lose TANF benefits to prevent out-of-home placement of children and to assist the family in maintaining stability. No consultative efforts or technical assistance was provided or received by the National Resource Center during calendar year 2019.
HH. Sobriety Treatment and Recovery Teams

The Kentucky Sobriety Treatment and Recovery Teams (START) is an intensive intervention model for parents struggling with substance use and families involved with the child welfare system that integrates substance use disorders (SUD) and recovery services, family preservation, community partnerships, and best practices in child welfare and substance use disorder treatment. The program aims to address systems issues that result in barriers to families being able to access services in a timely manner. It requires an approach to service delivery that involves cross-system collaboration and flexibility to meet the unique needs of this population.

The key components of START are:

- Specially trained Child Protective Services (CPS) worker and a Family Mentor share a caseload of families with co-occurring parental substance use and child maltreatment where at least one child is 5 or younger with a focus on substance-exposed infants.
- The family mentor brings real-life experience to the team and is a recovering person with at least 3 years’ sobriety and previous CPS involvement. She/he is rigorously screened, trained, and supervised to provide START families with both recovery coaching and help navigating the CPS system;
- Reduced caseloads for the START team of 12-15 families per worker/mentor pair;
- 12 basic tenets outline the program philosophy and collaboration;
- Integration between CPS, substance use disorder treatment providers, and community partners by addressing differences in professional perspectives;
- A service delivery model that is more frequent, intense, and coordinated, seeking to intervene quickly upon receipt of the referral to CPS;
- Quick access to substance use treatment and close collaboration among CPS and service providers;
- Shared decision-making among all team players, including the family;
- Collaboration with community partners, substance use disorder providers, the courts, and the child welfare system dedicated to building community capacity and making START work;
- Sober parenting supports that include flexible funding for meeting basic needs such as housing, transportation, child care, and intensive in-home services;
- A holistic assessment for all clients, addressing substance use, mental health, and trauma; and
- Extensive program evaluation to indicate and document the program achievements and challenges.

Specific objectives are to reduce recurrence of child abuse/neglect; provide comprehensive support services to children and families; provide quick and timely access to substance use disorder treatment; improve treatment completion rates; build protective parenting capacities; and increase the county, region, and state’s capacity to address co-occurring substance abuse and child maltreatment.

Kentucky START is based on the successful and nationally recognized START program that originated in Cleveland, Ohio. Kentucky began implementing START in 2007 and has modified and evolved the model to fit the needs of Kentucky families. State and federal funding is currently used to fund the program in seven counties in KY: Kenton, Campbell, Boone, Jefferson and Boyd, Daviess, and Fayette. Due to positive outcomes and as part of Kentucky’s title IV-E waiver demonstration project, START was expanded. Jefferson County and Kenton County added a second START team, and a team was implemented in Fayette County. Boyd County also began taking cases under the title IV-E waiver in July.
2017. Daviess began taking cases under the waiver in July 2018. The title IV-E waiver ended September 30, 2019. In addition, in 2018, DCBS received funding for START to add two additional sites, in Campbell and Boone Counties through SAMSHA funding from the Kentucky Opioid Response Effort (KORE).

In 2006, Kentucky DCBS sought to improve the system of care serving families with co-occurring child maltreatment and substance use disorders by investing $2 million TANF MOE funds annually into the Substance Abuse Initiative. This funding for the DCBS Substance Abuse Initiative has been renewed each year since 2007. A Regional Partnership Grant (RPG) was awarded to the DCBS in October 2012 to fund the expansion of the START program into Daviess County. This grant provided $2.5 million dollars over a 5-year period.

The funds for substance use disorder (SUD) treatment are disseminated through contracts with six community mental health centers (CMHCs): Centerstone, Northkey, Kentucky River Community Care (KRCC), Pathways, New Vista, and Mountain Comprehensive Care Center. In five of these CMHC sites, a START program was established (Northkey provides services for three sites including one existing site and the two newer sites). In the sixth region, KRCC established the Solutions program which is a substance use disorder treatment (SUD) treatment program serving women in the following counties (Breathitt, Knott, Letcher, Wolfe, Lee, and Owsley) and also serving men in Letcher, Lee, and Perry Counties. With the expansion of Medicaid in Kentucky and a benefit to cover substance use disorder services, DCBS was able to use less TANF MOE and title IV-E waiver funds for substance use disorder treatment services. START requires CMHCs to bill all behavioral health services to Medicaid before using other funding. A process is in place for CMHCs to request funds for services that are not Medicaid or insurance billable. The START director and assistant directors are in charge of managing the approval of these funds when requested.

Kentucky became an early implementer of the Family First Prevention Services Act (FFPSA) in October 2019. START is one of the prevention services in Kentucky’s FFPSA plan. Kentucky has submitted an independent systematic review for START until a review by the Clearinghouse is completed.

Below are the number of children and families served by START in 2019.

Families by START site:
- Boone: 14
- Boyd: 51
- Campbell: 10
- Daviess: 49
- Fayette: 62
- Jefferson: 132
- Kenton: 106

Overall, START served 424 families, 710 adults, and 762 children.

In addition to direct services to families, and expansion of the program, START leadership and evaluation team provided one publication and multiple presentations and workshops at regional and national conferences in 2019.

Publications:

Presentations:

Additionally, the START program is listed on the California Evidence Based Clearinghouse for Child Welfare (CEBC) as a program with Promising Research Evidence. The CEBC listing can be found at: http://www.cebc4cw.org/program/sobriety-treatment-and-recovery-teams/detailed.

Additionally, there continues to be a focus on developing consistent practice guidelines in the area of substance exposed infants (SEIs) and how to address Neonatal Abstinence Syndrome (NAS). START leadership is involved in the state’s plan of safe care in an effort to ensure compliance with CAPTA requirements.

Technical assistance and consultation were provided regularly by the Children’s Bureau and the National Center on Substance Abuse and Child Welfare (NCSACW) during the RPG grant periods. START has worked closely with both of these entities who were extremely helpful in supporting the growth and sustainability of START in Kentucky. Additionally, technical assistance has been received from Children and Family Futures around fidelity to the model, hiring, coaching of new leadership, and evaluation.

All START sites participate in a both a process evaluation and an outcome evaluation. The process evaluation regularly monitors fidelity to the START model. Specifically, sites are evaluated on how quickly: (1) families are referred to START; (2) the first family team meeting is conducted; (3) adults are assessed by the drug treatment provider. Other process outcomes, such as retention and intensity of treatment, are regularly assessed. Results of the evaluation can be found in the title IV-E waiver demonstration project final evaluation.

During this review period, the START director, assistant directors, and START family mentors transitioned from an employment contract through Eastern Kentucky University (EKU) to a new contract with the University of Kentucky (UK), College of Social Work’s Training Resource Center (TRC). While the new partnership brings positive change, the transition significantly affected the process to fill vacant family mentor positions across all sites. Hiring was on hold for a period of about seven months, during which time some additional vacancies were added. This impacted the program’s ability to serve additional families during this time. Positively, since this time, 10 new family mentors have been hired and onboarded and the program is in the process of interviewing for the remaining vacant positions.

START leadership has regular contact with regional leadership for each site to provide any updates, address challenges and to collaboratively support direct supervisors for the START teams. This will continue during the next review period with a focus on challenges specific to each site. High turnover of frontline staff, supervisors, and family mentors is a barrier in many sites. Additionally, a lack of referrals when eligible family’s exist is another concern. Education is provided throughout the sites to ensure that staff know when a family is appropriate to refer to a START team.
II. Social Services Block Grant

States have the ability to consolidate a number of programs into a single grant under the Social Services Block Grant (SSBG). SSBG is funded through title XX of the Social Security Act. Federal grant awards for each state are determined by a statutory formula based on the state’s population. States have the flexibility to determine what services will be provided, who is eligible to receive the services, and how funds are to be distributed. Services are available statewide and are directed at one or more of the five national goals:

- Achieving or maintaining economic self-support to prevent, reduce, or eliminate dependency;
- Achieving or maintaining self-sufficiency, including reduction or prevention of dependency;
- Preventing or remedying neglect, abuse, or exploitation of children and adults unable to protect their own interests, or preserving, rehabilitating or reuniting families;
- Preventing or reducing inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care; and
- Securing referral or admission for institutional care when other forms of care are not appropriate or providing services to individuals in institutions.

SSBG services are used to support, in whole or in part, the state mandated social services programs administered by DCB. When feasible, services are purchased through written agreements with service providers throughout the state. The following is a list of providers contracted to provide services for adult protection, child protection, residential services (for juveniles), and training: Department of Juvenile Justice (DJJ); EKU; Kentucky Domestic Violence Association, Inc.; Seven Counties/Centerstone; and the University of Louisville.

Kentucky’s CCWIS/TWIST captures the number of clients receiving SSBG services. This data is evaluated every six months and is used in reporting to the Legislative Research Commission (LRC). Additional reports are submitted to the federal government annually. TWIST data reflect an increase in child protective services each year, indicating the continuing need for child welfare services statewide.

<table>
<thead>
<tr>
<th>Calendar Year 2019 Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSBG Service</td>
</tr>
<tr>
<td>Adult protection</td>
</tr>
<tr>
<td>Child protection</td>
</tr>
<tr>
<td>Home safety services</td>
</tr>
<tr>
<td>Juvenile services</td>
</tr>
<tr>
<td>Residential treatment</td>
</tr>
</tbody>
</table>

Adult protection provides protective services to adults designed to prevent and remedy abuse, neglect, or exploitation; increase employability and/or self-sufficiency; or prevent inappropriate placement, (e.g., investigate complaints of abuse, provide supportive services, or counseling).

Child protection provides children and their families with services designed to prevent or remedy abuse, neglect, or exploitation, (e.g., identification of children at risk; investigation of reports of abuse, neglect, or dependency; removal of the child from the home when necessary; or information and referral services).
Home safety services provides services to prevent the removal or repeat maltreatment of a child, or to maintain an adult's safety in the home or community, (e.g., arranging for community agencies to provide help with day-to-day household tasks; instructing and assisting with meal planning; nutrition; budgeting; or general household management).

Juvenile services provides children and their families with services designed to prevent or remedy abuse, neglect, or exploitation, and to help prevent the youth’s future involvement with the juvenile or criminal justice system, (e.g., interaction with courts on behalf of juveniles; counseling; psychological testing and/or psychiatric consultation; or utilization of appropriate resources).

Residential treatment services provides a comprehensive treatment-oriented living experience, in a 24-hour residential facility for juvenile offenders committed to CHFS or DJJ. These services are provided through a written agreement with DJJ.

Staff training provides ongoing training for DCBS staff that addresses the skills and knowledge base necessary to carry out their duties with regard to services provided by the SSBG programs.

JJ. Solutions

Kentucky River Community Care /Solutions is an intensive treatment and support program serving Breathitt, Knott, Lee, Letcher, Owsley, Perry, and Wolfe Counties that works intensively with clients to address substance use, mental health, intimate partner abuse, and/or other victimization issues. Solutions initially served only female clients, however, expanded services to serve males in several of the counties using the same model. Solutions’ approach is through a trauma informed perspective. Additionally, in several of the counties there is transitional housing for both men and women where clients are in a safe and supportive environment in which to enhance their recovery. The majority of the project’s clients are parents who are DCBS DPP clients with the goal of keeping children in the home and/or reuniting children with their parents.

Participants in the program receive group, family, and individual therapy for both substance use disorders and other behavioral health issues. They have the opportunity to earn a GED, learn employment and interview skills, and develop parenting skills. The program considers the unique history of women in the area and includes trauma sensitive practices. All programs implemented through Solutions are evidence-informed practices such as using Seeking Safety and Nurturing Parenting programs. Solutions has been able to provide onsite supervision for parents, which has been beneficial. Participants are transported to the treatment services as needed.

The program also provides case management/case coordination and advocacy services to assist clients in accessing domestic violence shelter services; legal services; medical services, including psychiatric care; safe and sober housing; education and employment; and services for their children. Solutions staff members also provide onsite parenting classes for the clients. The staff participates in family treatment team meetings, case collaboration meetings, and ongoing case reviews. DCBS and the courts are provided weekly progress reports on referred clients.

In August 2019, Kentucky River Community Care, Inc. opened a new recovery center, the Rebound Center that offers additional support to clients who have a substance use disorder. The center offers onsite peer support staff, support groups, educational programs, and community events throughout the year. Many of our clients that are in the Solutions Program benefit from the recovery center.
Starting in 2007, $2 million of TANF MOE funds were provided each year and allocated into contracts with the CMHCs that provide services for Solutions.

KK. Targeted Assessment Program

The Targeted Assessment Program (TAP) is a nationally recognized Kentucky trauma-informed model for assisting parents involved in public assistance and child welfare systems overcome multiple barriers to self-sufficiency, stability, and safety within federally mandated timeframes. For the past 20 years, the DCBS has collaborated with the University of Kentucky to provide TAP services. The TAP model co-locates professional Targeted Assessment Specialists (TAS-assessors) at public assistance and child protective services offices in Kentucky counties designated by DCBS. TAP assessors conduct client assessment in four primary areas—substance use, mental health, intimate partner violence victimization, and learning problems—as well as other barriers for families including housing, transportation, other basic needs, physical health problems, legal difficulties, and deficits in education and employment. Participant strengths are also assessed.

Mental Health

The mental health assessment includes questions from the Mini International Neuropsychiatric Interview (M.I.N.I.) and Breslau’s 7-Item Post-Traumatic Stress Disorder (PTSD) Screening Scale which measure: depression, suicidal ideation, anxiety, mania, PTSD, and thought disorders. History of childhood (under age of 14) neglect, emotional abuse, physical abuse, sexual abuse or assault, and foster care placement is assessed along with any history of treatment for mental health problems. Mental health problems are defined as “having an acute episode of a mental illness in the past year, having a chronic mental illness, or having a severe and persistent mental illness” (SPMI).

Substance Use

Substance use disorders are also assessed in TAP. The assessor asks about current and past substance use, the amount of use, the consequences of use, the physical and psychological impact the use is having on life, and the need for current treatment. Questions include lifetime and past 3-month use of specific legal and illicit substances—tobacco, alcohol and prescription medications, indicators of substance abuse and dependence, as well as history of treatment, including DUI classes and self-help groups. The substance use assessment incorporates questions adapted from the Addiction Severity Index (ASI), as well as substance misuse and dependence screens. Substance use problems are operationally defined as “the use of drugs or alcohol which affects social, physical, cognitive, legal, or occupational functioning.”

Intimate Partner Violence Victimization

Intimate partner violence (IPV) victimization is assessed by asking each person his or her previous experiences with emotional, physical, and sexual abuse in intimate relationships, and current risk of harm by an intimate partner. Lifetime and past 3-month measures for 21 indicators of abuse and violence are used, as well as the history of services for IPV. TAP assesses risks of the person’s current situation and assists with safety planning. IPV victimization measures include questions adapted from the Conflict Tactics Scale (CTS). IPV is defined as “experiencing abuse or violence at the hands of a current or past intimate partner or still being troubled by the effects of an abusive relationship in the past.”

Learning Problems

Learning problems are assessed using the Washington State Learning Needs Screening Tool to identify whether the individual may have difficulty performing certain tasks or has a family history that may
indicate a learning disability. Learning problems are operationally defined as a suspected learning disability or a learning deficiency. A learning deficiency is defined as a “problem that results from a lack of education due to poor educational opportunities or family issues such as dropping out of school because of an early pregnancy.” A learning disability is defined as “a neurological disorder that impairs the brain’s ability to receive, process, and respond to information.”

TAP is supported through TANF funds. Eligibility criteria includes receipt of TANF benefits or TANF-eligibility with a family income of 200 percent of poverty and below. Parents referred by DPP must have a child in the home or a plan for reunification. By identifying and addressing substance use and mental health disorders, intimate partner victimization, and learning deficits/disabilities, TAP services support DCBS efforts to meet safety, permanency, and well-being outcomes for children. The clinical expertise and evidence based intervention provided by TAP supports DPP in preventing removal or reunifying families presenting multiple risk factors. The following services are provided in all TAP counties:

- Assessment
- Referral
- Strengths-based case management/case coordination
- Pre-treatment, including Motivational Interviewing
- Follow-up
- Consultation and training

TAP co-houses 57 assessors at the DCBS Division of Family Support and DPP offices in 35 of 120 counties designated by DCBS: Barren, Boone, Boyd, Breathitt, Bullitt, Campbell, Christian, Daviess, Fayette, Floyd, Nelson, Hardin, Henderson, Hopkins, Jefferson, Johnson, Kenton, Knott, Laurel, Lee, Letcher, McCracken, Madison, Magoffin, Martin, Muhlenberg, Ohio, Owsley, Perry, Pike, Pulaski, Rowan, Union, Warren, and Wolfe. TAP services are available in all nine DCBS service regions, with the highest number of TAP counties in the Eastern Mountain and Two Rivers Service Regions. Kentucky’s more populated urban counties are assigned higher number of assessors, but most TAP counties are more rural with lower populations and have one to two assessors. One assessor serves Lee and Owsley Counties; one assessor serves both Henderson and Union Counties; and one assessor works half time in Perry County and half time in Wolfe County. Five field supervisor positions were established in Eastern, Western, and Central Kentucky; all field supervisors are assigned approximately 50% assessor and 50% supervisory responsibilities. TAP has found that co-locating these positions regionally increases TAP efficiency and access, enhances cost-effectiveness, and ensures better communication and support for DCBS and TAP.
During Fiscal Year (FY) 2019, TAP facilitated or participated in 42 TAP advisory council meetings and 63 planning and implementation meetings with DCBS staff. In addition, TAP facilitated 24 local community selection committee meetings to fill TAP staff vacancies. TAP provides consultations to DCBS staff for participants who have been referred to TAP as well as non-TAP participant cases. During FY 2019, TAP provided 12,169 case consultations to DCBS for TAP participants and 2,559 case consultations for non-TAP participants. In support of and in collaboration with DCBS, TAP staff participated in family team meetings to engage and support the family in the case planning, case management, and case closure processes. Family team meetings bring together parents, families, other significant adults, and child welfare and other professionals for collaborative case planning and shared decision-making. During FY 2019, TAP assessors participated in 1,403 family team meetings statewide. These collaborations strengthen communication between DCBS and TAP and enhance services for families. The sharing of information and expertise is an invaluable part of case planning to improve outcomes.

During FY 2019, TAP completed 2,085 baseline assessments for participants referred by DCBS divisions and other sources. Referrals to TAP (n=3,026) continue to be primarily from DCBS DPP (83%, n=2,497) and DCBS Family Support (15%, n=461). Assessors also completed 3,053 case closure reports for participants who terminated TAP services during the fiscal year. Of these terminating participants, 68% (n=2,072) had received a baseline assessment. Mental health and substance use were the most prevalent of the four targeted barriers, with more than three-fourths (76%) of those assessed self-reporting mental health as a barrier and more than half (57%) reporting substance use as a barrier to self-sufficiency and family safety. Notably, many participants were assessed with multiple barriers. Nearly two-thirds (n=1,346; 65%) of those assessed prior to termination were found to have two or more barriers, with more than a quarter (n=551; 26%) assessed with three or more barriers.

Evaluation
Assessors completed 3,053 case closure reports for participants who terminated TAP services during the fiscal year. Of these terminating participants, 68% (n=2,072) had received a baseline assessment. Terminating participants who received an assessment had an average of 10 direct contacts with TAP prior to termination, with an average duration of services of 30 weeks.

Of the 2,072 terminating participants who were assessed, nearly nine out of every 10 (87%) showed improvement in accessing needed services. Among terminating participants who received an assessment, progress in overcoming major barriers to self-sufficiency was rated (from No Progress to A Lot of Progress) by assessors as:

- 82% of terminations identified with Mental Health as a barrier made progress
- 83% of terminations with Substance Use as a barrier made progress
- 83% of terminations with Intimate Partner Violence as a barrier made progress
- 56% of terminations with Learning Problems as a barrier made progress

When needed, TAP provides case coordination to facilitate engagement and improve access to recommended services and resources. Through case coordination, TAP assists with resolving external barriers such as difficulties with transportation, food, housing, utilities, and childcare. These external or structural barriers may be primary for some participants. For example, taking participants to housing authorities, food banks, and the gas company is often a prerequisite for further participation. Until a parent finds housing, feeds her or his children, or gets the utilities turned back on, s/he may not be able to focus on the need for other services. Assessors may teach skills such as accessing public transportation for upcoming appointments, or selecting a childcare provider. Further, assessors help ensure that participants arrive for recommended services at appointed times and often attend initial participant appointments not only to model how and when to get there, but also to facilitate a connection with the provider. Among terminating participants who received assessment, the most common unmet basic needs were:

- Housing (35%)
- Transportation (30%)
- Social/Family Relationships (29%)
- Parenting (20%)

As presented in the table below, 84% (n=348) of those terminating TAP services who received an assessment and identified parenting difficulties were rated by assessors as having made progress. In addition, more than three-fourths (n=552, 77%) of those who identified housing as a barrier made progress; over four-fifths (n=506, 86%) of terminating participants identifying difficulties in their social/family relationships were rated as having made progress; and 66% (n=400) of terminating participants reporting problems with transportation improved access to transportation.

Among assessed participants terminating TAP services (n=2,022), 80% (n=1,665) were recommended for pre-treatment services and 1,477 (89%) participated. Seventy (70) percent (n=1,033) of those participating in pre-treatment were rated with average to high levels of engagement. TAP recommended service coordination for 1,658 (80%) of terminating participants, of which 1,508 (91%) participated. Sixty-nine (69) percent (n=1,030) of those participating in service coordination were rated with average to high levels of engagement.

Progress ratings for other barriers, such as difficulty meeting DCBS requirements, legal difficulties, physical health problems, and childcare are also presented in the table below. No Progress was rated if a participant did not engage or became disengaged, refused or was resistant to services, or if the
participant could no longer be contacted. Further, if services did not exist or were not available, (e.g., waitlists) or if the focus of pre-treatment and/or service coordination was to address other barriers or basic needs, (e.g., housing) there may have been no progress in overcoming certain identified barriers. Participants who moved to a non-TAP county or who were unable to be contacted were rated by assessors on the last contact before termination.

The number of participants with a specific identified barrier is reported in the table below, as well as progress made. The first barrier presented, for example, is mental health. Among assessed participants terminating TAP services in FY 2019, 1,577 reported mental health problems while engaged in TAP services. Of these 1,577 participants, assessors rated 1,303 (82%) as having made any progress (from A Little to A Lot) in overcoming mental health barriers. The number and percent of participants in each of the progress categories is also shown. This pattern is repeated for each barrier.

### Progress in Overcoming Barriers to Self-Sufficiency among Participants Terminating TAP

<table>
<thead>
<tr>
<th>Identifying Category</th>
<th>Assessed Participants Terminating TAP with Identified Barrier</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental Health</strong></td>
<td>n=1,577</td>
</tr>
<tr>
<td>Any Progress (i.e. a little, some, moderate, or a lot of progress)</td>
<td>1,303 (82%)(^1)</td>
</tr>
<tr>
<td>A Little Progress</td>
<td>332 (21%)</td>
</tr>
<tr>
<td>Some Progress</td>
<td>491 (31%)</td>
</tr>
<tr>
<td>Moderate Progress</td>
<td>398 (25%)</td>
</tr>
<tr>
<td>A Lot of Progress</td>
<td>82 (5%)</td>
</tr>
<tr>
<td>No Progress</td>
<td>274 (18%)</td>
</tr>
<tr>
<td><strong>Substance Use</strong></td>
<td>n=1,178</td>
</tr>
<tr>
<td>Any Progress (i.e. a little, some, moderate, or a lot of progress)</td>
<td>983 (83%)</td>
</tr>
<tr>
<td>A Little Progress</td>
<td>256 (22%)</td>
</tr>
<tr>
<td>Some Progress</td>
<td>273 (23%)</td>
</tr>
<tr>
<td>Moderate Progress</td>
<td>366 (31%)</td>
</tr>
<tr>
<td>A Lot of Progress</td>
<td>88 (7%)</td>
</tr>
<tr>
<td>No Progress</td>
<td>195 (17%)</td>
</tr>
<tr>
<td><strong>Intimate Partner Violence</strong></td>
<td>n=868</td>
</tr>
<tr>
<td>Any Progress (i.e. a little, some, moderate, or a lot of progress)</td>
<td>730 (83%)</td>
</tr>
<tr>
<td>A Little Progress</td>
<td>168 (22%)</td>
</tr>
<tr>
<td>Some Progress</td>
<td>229 (23%)</td>
</tr>
<tr>
<td>Moderate Progress</td>
<td>257 (31%)</td>
</tr>
<tr>
<td>A Lot of Progress</td>
<td>76 (7%)</td>
</tr>
<tr>
<td>No Progress</td>
<td>138 (17%)</td>
</tr>
<tr>
<td><strong>Learning Problems</strong></td>
<td>n=311</td>
</tr>
<tr>
<td>Any Progress (i.e. a little, some, moderate, or a lot of progress)</td>
<td>174 (56%)</td>
</tr>
<tr>
<td>A Little Progress</td>
<td>83 (27%)</td>
</tr>
<tr>
<td>Some Progress</td>
<td>60 (19%)</td>
</tr>
<tr>
<td>Moderate Progress</td>
<td>25 (8%)</td>
</tr>
<tr>
<td>A Lot of Progress</td>
<td>6 (2%)</td>
</tr>
<tr>
<td>No Progress</td>
<td>137 (44%)</td>
</tr>
<tr>
<td><strong>Transportation</strong></td>
<td>n=609</td>
</tr>
<tr>
<td>Any Progress (i.e. a little, some, moderate, or a lot of progress)</td>
<td>400 (66%)</td>
</tr>
</tbody>
</table>

\(^1\) Percentages under each barrier represent the percent of participants making any progress with the identified barrier. Any progress includes a little, some, moderate, and a lot of progress.
### Assessed Participants

<table>
<thead>
<tr>
<th></th>
<th>Terminating TAP with Identified Barrier</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Housing</strong></td>
<td></td>
</tr>
<tr>
<td>Any Progress (i.e. a little, some, moderate, or a lot of progress)</td>
<td>n=715</td>
</tr>
<tr>
<td>A Little Progress</td>
<td>186 (31%)</td>
</tr>
<tr>
<td>Some Progress</td>
<td>136 (22%)</td>
</tr>
<tr>
<td>Moderate Progress</td>
<td>68 (11%)</td>
</tr>
<tr>
<td>A Lot of Progress</td>
<td>10 (2%)</td>
</tr>
<tr>
<td>No Progress</td>
<td>209 (34%)</td>
</tr>
<tr>
<td><strong>Child Care</strong></td>
<td></td>
</tr>
<tr>
<td>Any Progress (i.e. a little, some, moderate, or a lot of progress)</td>
<td>n=120</td>
</tr>
<tr>
<td>A Little Progress</td>
<td>190 (27%)</td>
</tr>
<tr>
<td>Some Progress</td>
<td>156 (22%)</td>
</tr>
<tr>
<td>Moderate Progress</td>
<td>148 (21%)</td>
</tr>
<tr>
<td>A Lot of Progress</td>
<td>58 (7%)</td>
</tr>
<tr>
<td>No Progress</td>
<td>163 (23%)</td>
</tr>
<tr>
<td><strong>Physical Health</strong></td>
<td></td>
</tr>
<tr>
<td>Any Progress (i.e. a little, some, moderate, or a lot of progress)</td>
<td>n=242</td>
</tr>
<tr>
<td>A Little Progress</td>
<td>51 (21%)</td>
</tr>
<tr>
<td>Some Progress</td>
<td>100 (41%)</td>
</tr>
<tr>
<td>Moderate Progress</td>
<td>61 (25%)</td>
</tr>
<tr>
<td>A Lot of Progress</td>
<td>2 (1%)</td>
</tr>
<tr>
<td>No Progress</td>
<td>28 (12%)</td>
</tr>
<tr>
<td><strong>Basic Needs for Children</strong></td>
<td></td>
</tr>
<tr>
<td>Any Progress (i.e. a little, some, moderate, or a lot of progress)</td>
<td>n=233</td>
</tr>
<tr>
<td>A Little Progress</td>
<td>48 (21%)</td>
</tr>
<tr>
<td>Some Progress</td>
<td>77 (33%)</td>
</tr>
<tr>
<td>Moderate Progress</td>
<td>66 (28%)</td>
</tr>
<tr>
<td>A Lot of Progress</td>
<td>9 (4%)</td>
</tr>
<tr>
<td>No Progress</td>
<td>33 (14%)</td>
</tr>
<tr>
<td><strong>Providing Enough Food</strong></td>
<td></td>
</tr>
<tr>
<td>Any Progress (i.e. a little, some, moderate, or a lot of progress)</td>
<td>n=75</td>
</tr>
<tr>
<td>A Little Progress</td>
<td>13 (17%)</td>
</tr>
<tr>
<td>Some Progress</td>
<td>21 (28%)</td>
</tr>
<tr>
<td>Moderate Progress</td>
<td>23 (31%)</td>
</tr>
<tr>
<td>A Lot of Progress</td>
<td>4 (5%)</td>
</tr>
<tr>
<td>No Progress</td>
<td>14 (19%)</td>
</tr>
<tr>
<td><strong>Problems Obtaining Work</strong></td>
<td></td>
</tr>
<tr>
<td>Any Progress (i.e. a little, some, moderate, or a lot of progress)</td>
<td>n=508</td>
</tr>
<tr>
<td>A Little Progress</td>
<td>113 (22%)</td>
</tr>
<tr>
<td>Some Progress</td>
<td>81 (16%)</td>
</tr>
<tr>
<td>Moderate Progress</td>
<td>102 (20%)</td>
</tr>
</tbody>
</table>

Percentages under each barrier represent the percent of participants making any progress with the identified barrier. Any progress includes a little, some, moderate, and a lot of progress.
Work readiness was identified as a barrier for 15% (n=317) of assessed participants terminating TAP services. As shown in the table below, 77% (n=243) of terminating participants identified with work readiness as a barrier were rated as showing improvement in work readiness. In addition, there was greater improvement for submitting applications for employment and obtaining employment than for participation in job training or continuing education.
### Work Readiness Progress among Participants Terminating TAP Services

<table>
<thead>
<tr>
<th>Improved Work Readiness</th>
<th>Work readiness identified as barrier among participants terminating TAP services (n=317)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Any Progress</strong> (i.e. a little, some, moderate, or a lot of progress)</td>
<td>243 (77%)</td>
</tr>
<tr>
<td>A Little Progress</td>
<td>80 (25%)</td>
</tr>
<tr>
<td>Some Progress</td>
<td>60 (19%)</td>
</tr>
<tr>
<td>Moderate Progress</td>
<td>71 (23%)</td>
</tr>
<tr>
<td>A Lot of Progress</td>
<td>32 (10%)</td>
</tr>
<tr>
<td>No Progress</td>
<td>74 (23%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Submitted Applications for Employment</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Any Progress</strong> (i.e. a little, some, moderate, or a lot of progress)</td>
<td>226 (71%)</td>
</tr>
<tr>
<td>A Little Progress</td>
<td>59 (18%)</td>
</tr>
<tr>
<td>Some Progress</td>
<td>51 (16%)</td>
</tr>
<tr>
<td>Moderate Progress</td>
<td>72 (23%)</td>
</tr>
<tr>
<td>A Lot of Progress</td>
<td>44 (14%)</td>
</tr>
<tr>
<td>No Progress</td>
<td>91 (29%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Obtaining Employment</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Any Progress</strong> (i.e. a little, some, moderate, or a lot of progress)</td>
<td>183 (58%)</td>
</tr>
<tr>
<td>A Little Progress</td>
<td>42 (13%)</td>
</tr>
<tr>
<td>Some Progress</td>
<td>39 (13%)</td>
</tr>
<tr>
<td>Moderate Progress</td>
<td>42 (13%)</td>
</tr>
<tr>
<td>A Lot of Progress</td>
<td>60 (19%)</td>
</tr>
<tr>
<td>No Progress</td>
<td>134 (42%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Participation in Job Training</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Any Progress</strong> (i.e. a little, some, moderate, or a lot of progress)</td>
<td>137 (43%)</td>
</tr>
<tr>
<td>A Little Progress</td>
<td>45 (14%)</td>
</tr>
<tr>
<td>Some Progress</td>
<td>37 (12%)</td>
</tr>
<tr>
<td>Moderate Progress</td>
<td>32 (10%)</td>
</tr>
<tr>
<td>A Lot of Progress</td>
<td>23 (7%)</td>
</tr>
<tr>
<td>No Progress</td>
<td>180 (57%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Continued Education</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Any Progress</strong> (i.e. a little, some, moderate, or a lot of progress)</td>
<td>62 (19%)</td>
</tr>
<tr>
<td>A Little Progress</td>
<td>15 (5%)</td>
</tr>
<tr>
<td>Some Progress</td>
<td>23 (7%)</td>
</tr>
<tr>
<td>Moderate Progress</td>
<td>14 (4%)</td>
</tr>
<tr>
<td>A Lot of Progress</td>
<td>10 (3%)</td>
</tr>
<tr>
<td>No Progress</td>
<td>255 (81%)</td>
</tr>
</tbody>
</table>

In FY 2019, of the 2,072 assessed participants terminating TAP services, 26 participants had SSI or SSDI applications approved with TAP assistance. An additional 58 participants had applied for SSI or SSDI with TAP assistance, and their applications were still pending at the time their TAP cases were closed.

In 2020, TAP received a request from DPP to continue to study the prevalence of barriers to self-sufficiency among TAP participants from FY 2008 to FY 2019. The percent of TAP participants with
barriers result is presented graphically below. Mental health has consistently been the most prevalent barrier across all years. The prevalence of participants assessed with mental health barriers remained steady at 75% in FY 2019. The percent of participants assessed with a substance use barrier decreased from 58% in FY 2018 to 52% in FY 2019. The percent of participants assessed with an intimate partner violence barrier remained steady during FY 2008-2011 and remained at 47% between FY 2017 through 2019. The percent decreased in FY 2012 due to a change in the data-collection instrument implemented with the web-based system, then stabilized in subsequent years. In FY 2018, 40% of participants were identified with intimate partner violence, a seven percent decrease compared to FY 2017. The percent of participants screened with learning problems and deficiencies has varied year to year, ranging from a high of 40% in FY 2010 to a low of 24% in FY 2019.

**Percent of TAP participants assessed with barriers to self-sufficiency at baseline (FY 2008 – FY 2019)**

The percent of TAP participants assessed with unmet basic needs barriers from FY 2008 through FY 2019 is also presented graphically below. The percent of participants assessed at baseline with unmet basic needs has increased from a low of 45% in FY 2008 to a high of 64% in FY 2014 and again in FY 2019. The percent of assessed participants with unmet basic needs remained high for the past eight years. The most commonly identified unmet basic needs reported by participants in FY 2019 were housing, transportation, social support (social/family relationships), and parenting. This is consistent with the previous FY.
In 2020, TAP received a request from DPP to continue to examine TAP opioid use trends among TAP participants from FY 2012 through FY 2019. The percent of TAP participants self-reporting opioid use at baseline assessment in the previous three months is presented in the figure below. Compared to FY 2018, during the three months prior to the baseline assessment, use of heroin and other opiates continued to decrease in FY 2019. Oxycontin use increased slightly during the same period, while use of Buprenorphine, Methadone, and IV drugs was consistent with the previous year.

**Percent of TAP participants (n=18,816) self-reporting opiate use 3 months before baseline assessment (FY 2012 through FY 2019)**
The percent of TAP participants self-reporting opioid use in their lifetime is presented below. Compared to FY 2018, participants served in FY 2019 reported decreased use of Heroin, Oxycontin, Buprenorphine, and other opiates. Reported Methadone and IV drug use was consistent with the previous year.

**Percent of TAP participants (n=18,816) self-reporting lifetime opioid use at baseline assessment (FY 2012 through FY 2019)**

At the request of DPP, in 2020 TAP also prepared a special report about TAP participants who were involved with DPP during FY 2019. This brief report summarizes DPP involvement and child welfare outcomes among TAP participants who had completed baseline assessment and were discharged from the TAP program between July 1, 2018 and June 30, 2019 (n=2,072). Case closure data is used for all measures. It is important to note that TAP case closure and DPP case closure have separate timelines. As presented below, of the 2,072 assessed participants who terminated TAP services during FY 2019, around four of every five participants (80.1%; n=1,659) had DPP involvement.

**Percentage of Participants with DPP Involvement (n=2,072)**
The figure below presents the current child supervision statuses among DPP involved TAP participants (n=1,659) at the time of termination of the TAP case. More than one category may be selected by assessors when completing the case closure instrument. As shown in the figure below, at the time of TAP case closure, nearly half of all assessed TAP participants involved with DPP had full custody of their child(ren) (44.8%; n=744). Nearly one quarter (24.7%) had unsupervised visitation, and over one third (36.7%) had supervised supervision.

**Current Child Supervision Status among TAP Participants (n=1,659)**

![Bar chart showing the distribution of child supervision statuses among TAP participants.]

The table below presents the DPP case status for participants at the time of TAP termination. More than one category may be selected by assessors when completing the case closure instrument. As shown below, at the time TAP case closure, more than a third of participants had open DPP case and were working towards reunification (37.1%). For 532 participants (32%), the children had never been removed, and of these, 281 cases (16.9%) remained open for monitoring while 251 cases (15.1%) had been closed by DCBS. Families were reunified, with the DCBS case were closed, for 137 cases (8.3%).

**DPP Case Status among TAP Participants (n=1,659)**

<table>
<thead>
<tr>
<th>DPP Case Status</th>
<th>Number of participants who reported status</th>
<th>Percent of participants who reported status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open: working towards reunification</td>
<td>616</td>
<td>37.1%</td>
</tr>
<tr>
<td>Open for monitoring and support; children never removed</td>
<td>281</td>
<td>16.9%</td>
</tr>
<tr>
<td>Closed; children never removed</td>
<td>251</td>
<td>15.1%</td>
</tr>
<tr>
<td>Open for monitoring and support; family reunited</td>
<td>162</td>
<td>9.8%</td>
</tr>
<tr>
<td>Closed; family reunited</td>
<td>137</td>
<td>8.3%</td>
</tr>
<tr>
<td>Closed; custody not returned to parent</td>
<td>130</td>
<td>7.8%</td>
</tr>
</tbody>
</table>
At the request of DPP, TAP initiated a Parental Protective Factors Pilot Project in FY 2018 and completed statewide implementation during FY 2019. Through this pilot project, all TAP staff have been trained to use the Strengthening Families framework to increase and family health and well-being and reduce the likelihood of child abuse and neglect. During the TAP assessment, DPP referred participants are screened for the six universal family strengths: parental resilience, social connections, concrete support for families, knowledge of parenting and child development, social and emotional competence of children/nurturing, and attachment. By adding this to TAP’s strength-based assessment process, assessors are better able to increase parental strengths and provide support where needed. TAP incorporates information related to protective factors screening in assessment summary reports, monthly case status reports, and other case consultation with DPP caseworkers and supervisors. TAP also engages participants in strengthening parental protective factors through individualized plans.

With the passage of FFPSA and early implementation in Kentucky in October 2019, TAP has worked at the local and regional level to ensure TAP services are made available to as many families as possible as early as possible to prevent removal. TAP has always promoted early referral and front-loading of services, but in response to this Act, systemic changes are occurring within DPP to support this practice. TAP’s strengths-based, trauma-informed engagement approach involves a parent in developing an individual plan to resolve any internal or external barriers to service engagement, improve their understanding of their DPP case plan, and enhance parent and child well-being. Further, TAP supports improved communication between the DPP caseworker and the parent. For those parents whose children have been removed, TAP continues provide its individualized services to support and health and well-being of families, increase protective factors, and consult closely with the DPP caseworker on client progress.

DCBS initiated an expansion of TAP services through the TAP Opioid Use Disorder (OUD) Project in FYs 2019-2020 through a Memorandum of Understanding (MOU) between DBHDID and DCBS. Funded by the SAMSHA, this TAP expansion is one of three DCBS projects supported by a Kentucky State Opioid Response (SOR) grant through KORE. The purpose of KORE is to increase access to evidence-based treatment, reduce unmet treatment need, and reduce opioid-related overdose deaths by supporting the implementation of a full continuum of high-quality, evidence-based opioid prevention, treatment, and recovery support services. TAP OUD will co-locate assessors and supervisory staff in DCBS offices in state selected high-risk counties. TAP OUD relies on a strong state/university partnership and the ability to efficiently replicate implementation to expand TAP services in counties with the highest Kentucky Overdose Index Scores (2017) in the Jefferson, Northern Kentucky, Northeastern, Southern Bluegrass, Eastern Mountain, and Cumberland Service Regions (see map below). Twelve (12) TAP OUD assessor positions are co-located at DCBS offices in 10 counties designated by DCBS. This includes four counties that already have TAP services: Floyd, Jefferson, Kenton, and Madison Counties and eight new counties: Bath, Bell, Clark, Grant, Jessamine, Montgomery, Pendleton, and Whitley. Three TAP OUD assessor positions also have field supervisor responsibilities. The target population is low-income parents served by DCBS with or at risk for opioid use disorders. TAP OUD will increase participant engagement, reduce barriers to treatment, increase access to evidence-based treatment, such as Medication Assisted Treatment, and other community services, and increase treatment retention. During FY 2020, TAP will complete all TAP OUD staff hiring and training and implement services in all counties. Multidisciplinary advisory councils will be established in all regions.

<table>
<thead>
<tr>
<th>Goal Status</th>
<th>TAP OUD</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open; goal changed to adoption, legal custodianship, planned permanent living arrangement, or other form of TPR</td>
<td>110</td>
<td>6.6%</td>
</tr>
<tr>
<td>Closed; parental rights terminated (TPR)</td>
<td>3</td>
<td>0.2%</td>
</tr>
</tbody>
</table>
The project’s service map, according to DCBS service region, is presented below:

**Targeted Assessment Program Opioid Use Disorder Project 2019-2020 Service Map by DCBS Service Region**

![Map of Kentucky showing service regions]

**TAP and TAP OUD Project 2019-2020 Service Map by DCBS Service Region**

![Map of Kentucky showing service regions]

In FY 2019, TAP was asked to provide national consultation and presentations focused on opioid and other substance abuse among low-income parents. For example, TAP was highlighted at the National
Governors Association Center for Best Practices’ annual Human Services Policy Advisors Institute, held from August 13-15, 2018 in Washington, D.C. Barbara Ramlow, TAP Director, and Carl Leukefeld, TAP Principal Investigator presented Kentucky’s Targeted Assessment Program: An Approach for Addiction and Other Barriers as part of an Institute session on the impact of substance abuse on human services programs. Ms. Ramlow was also invited by Office of Human Services Policy, Office of the Assistant Secretary for Planning and Evaluation, Department for Health and Human Services to develop a proposal for a panel presentation at the National Rx Drug Abuse and Heroin Summit held in Atlanta, GA April 22-25, 2019. The proposal was approved. Ms. Ramlow participated on and TAP was featured in the panel presentation: Human Services Responses to the Opioid Crisis. On September 17, 2019, Barbara Ramlow was an invited speaker for a panel at the Institute for Research on Poverty (IRP) annual Poverty Research and Policy Forum - Human Services Programs and the Opioid Crisis held in Washington D.C. This annual forum is co-hosted by the IRP and the Office of Human Services Policy in the Office of the Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services (HHS). The 2019 forum brought together stakeholders from the research, practitioner, and policy making communities and sought to enhance understanding of: a) how the opioid crisis is hindering human services programs in meeting their objectives; b) how human services programs can facilitate successful treatment and recovery for individuals with opioid use disorder; and c) how human services programs can address the effects of the opioid crisis on their objectives. Ms. Ramlow’s presentation, Supporting engagement in treatment and recovery in child welfare and public assistance programs, highlighted TAP and its collaboration with DCBS.

In Fall 2019, TAP was selected to be one of 12 promising approaches invited to participate in the State Temporary Assistance to Needy Families (TANF) Case Studies Project sponsored by the Office Planning, Research and Evaluation (OPRE) in collaboration with the Office of Family Assistance (OFA) in the Administration for Children and Families at the U.S. Department for Health and Human Services. This study seeks to expand the knowledge base about innovative programs assisting low-income individuals and families. OPRE has contracted with Mathematica Policy Research and its partner, MEF Associates, to conduct the study, which featured a three day site visit in Kentucky December 10-12, 2019 TAP coordinated the site visit, which included activities in one urban and one rural county (Louisville and Hazard). Each county site visit included interviews with TAP assessors and supervisors, DPP and Family Support staff, and community partners. Two TAP participants were interviewed at each site, one referred by Family Support and one referred by Protection & Permanency. Two structured case reviews were also conducted at each site. A report is anticipated by June 2020.

LL. Trauma-Informed Care

Trauma Informed Care is an approach toward engaging providers, agencies, and systems with the goal of recognizing that every person encountered may have trauma exposure and may present with trauma symptoms and the role that trauma may play in an individual’s life. One of the first key aspects of this approach seeks to change the paradigm from one that asks, “What’s wrong with you?” to one that asks, “What has happened to you?” Most consumers of behavioral health services have experienced at least one traumatic event in their lives.

During 2019, due to staff turnover, the Clinical Services Branch Manager attends the quarterly meetings of the Statewide Steering Committee on Trauma Informed Care. These quarterly meetings are hosted at the University of Kentucky Center on Trauma and Children (UK), and are facilitated by staff at UK and DBHDID. Agenda items involve training and resource building surrounding trauma informed practice. The Steering Committee consists of representatives from The Department for Public Health, early childhood development, school systems, mental health professionals, correctional systems, medical
professionals, disability rights advocates, sexual assault prevention advocates, and domestic violence prevention advocates. The committee allows for additional collaboration with community partners, as well as offering additional information gathering and distribution.

Several foster care providers and residential providers throughout the state continue to work toward training therapists in Trauma Focused Cognitive Behavioral Therapy (TF-CBT), which is a specific mode of cognitive behavioral therapy. TF-CBT has proven to be effective in helping participants learn new skills to help process thoughts and feelings related to traumatic life events; manage and resolve distressing thoughts, feelings, and behaviors related traumatic life events; and enhance safety, growth, parenting skills, and communication.

Currently, one psychiatric hospital in the state offers a 16 week program, where youth are patients of the hospital and have the opportunity to complete a standardized curriculum for TF-CBT. One of the challenges of this program is that although this program is set up to be at a lower level of care than an acute psychiatric admission, there are not agreements with all of the five Medicaid Managed Care Organizations (MCOs) in the state to refer participants into this program, which provides the TF-CBT as well and a highly supportive environment. Although this inpatient/residential TF-CBT program is a needed service, unfortunately the some MCOs elect not to cover this service. This creates a barrier to accessing this service based solely upon the algorithm used to assign members to MCOs.

The University of Kentucky Center on Trauma and Children operates the Child and Adolescent Trauma Treatment and Training Institute (CATTTI Clinic http://www.uky.edu/CTAC/CATTTI). CATTTI provides in-depth trauma assessments and training for providers on how to best serve and treat children that have experienced traumatic events—including those that are clients of DCBS.

DCBS currently collaborates with private agencies that are working with trauma-informed curricula or milieu models. Two large private residential and foster care agencies are currently implementing the Risking Connections trauma-focused program (http://www.riskingconnection.com/rc_about.php). There are significant costs associated with implementation of this program, which continues to be a challenge both for the agencies that are currently using the program, as well as for those who would like to use this model in the future. Additionally, while the Risking Connections model works well, there are subgroups of child welfare clients that tend to have a poor response to Risking Connections.

The Kentucky Coalition Against Domestic Violence has changed the training curriculum for all of their victim advocates working in shelters and non-residential sites. The new curriculum was developed by the National Center on Domestic Violence, Trauma, and Mental Health. Adopting a trauma-informed approach to domestic violence advocacy means attending to survivors’ emotional and physical safety. Just as the advocates help survivors to increase their access to economic resources, physical safety, and legal protections, using a trauma-informed approach means that they also assist survivors in strengthening their own psychological capacities to deal with the multiple complex issues that they face in accessing safety, recovering from the traumatic effects of domestic violence and other lifetime abuse, and rebuilding their lives. It also means ensuring that all survivors of domestic violence have access to advocacy services in an environment that is inclusive, welcoming, de-stigmatizing, and that does not re-traumatize.

An interesting dynamic has come up a few times related to access to “certified” trauma informed care providers. There have been a few (five or less) cases over the past two to three years where the courts have ordered DCBS to pay specific providers that are “certified” in trauma informed care. There is the
appearance that a certification—which takes time and financial investment—has been seen as the only appropriate way to deliver this service. At this point there are very few “certified” trauma informed treatment providers within the network of private foster care and residential treatment providers and due to the expense and time commitments, the number is likely to remain low for the foreseeable future.

As part of becoming more trauma informed, the University of Louisville, in partnership with DCBS, received a trauma grant from the Children’s Bureau to incorporate universal behavioral health screening and assessment. SAFESPACE was a 5-year $2.5 million grant entitled: Promoting Wellbeing and Adoption after Trauma. The grant was funded by the Administration on Children, Youth and Families - Children’s Bureau. That grant came to completion in September 2018. More information on SAFESPACE and the integration of screening and assessment into DCBS practice can be found above in Section DD Standardized Screening and Assessment.

**MM. Work Incentive Program**

The Work Incentive Program (WIN) was created as a result of a study conducted by Manpower Demonstration Research Corporation (MDRC). The findings of this study indicated income supports proved to be more effective than case management in helping individuals stay off welfare and remain self-sufficient. WIN is a work expense reimbursement program. Eligible recipients receive a monthly payment to cover any work-related expense for a period up to nine months. WIN assists families transitioning off welfare by enabling the family to achieve or maintain self-sufficiency. WIN also promotes family stability, preventing out of home care placement of children. WIN is funded by title IV-A. WIN is available statewide to eligible K-TAP recipients whose K-TAP case discontinues with earnings. Eligible WIN recipients may receive a work expense reimbursement payment for $130 for up to nine months. Work expenses may include transportation costs, clothing necessary for work food, etc. WIN income is considered a reimbursement and therefore is excluded when determining eligibility in the Supplemental Nutrition Assistance Program or Medicaid.

To be eligible for WIN, the individual must be discontinued from K-TAP with earnings; be employed; have a work expense; have a child in the home; be a resident of Kentucky; and have total gross earned and unearned income at or below 200% of the federal poverty level. Individuals may only receive WIN once in a lifetime. Additionally, they may not waive receipt of WIN in order to receive WIN later. If the individual no longer meets WIN requirements or reappears for K-TAP, WIN payments will stop even if months are remaining in the eligibility period. Effective November 2012, payments for WIN are generated from the Online Tracking Information System (OTIS). The first payment for WIN is automatically issued once a K-TAP case with earnings is discontinued. For the remaining months, the recipient receives a form to verify eligibility that must be completed and returned to the local office to continue to receive the WIN payment.

No new policy or practice was implemented during calendar year 2019. From January 1, 2019 through December 31, 2019, an average of 249 WIN payments were issued per month for a total of $388,440 dollars. No consultative efforts or technical assistance was provided by a National Resource Center during calendar year 2019. No data/evaluation was conducted during calendar year 2019 for WIN.

**NN. Y-NOW Children of Prisoners Mentoring Program (YMCA Safe Place Services)**

YMCA Safe Place Services is a social service branch of YMCA of Greater Louisville. Beginning in 1974, YMCA Safe Place Services has touched the lives of thousands of teens and their families by providing emergency shelter, outreach, family mediation, and mentoring services. YMCA Safe Place Services’
mission is to accept, affirm, and advocate for teens and families in crisis through programs that empower youth to reach their full potential in spirit, mind, and body.

Y-NOW, the mentoring component of YMCA Safe Place Services, has been working with unique populations of youth since 1996, including both middle and high school students, Hurricane Katrina evacuees, youth who are at-risk of dropping out, youth transitioning from eighth to ninth grade, and children of prisoners.

Y-NOW collaborates with the local school system (Jefferson County Public Schools), family and juvenile court, Neighborhood Places, CHFS, Centerstone, Probation & Parole, and other agencies involved with children of prisoners. The program service area is the Greater Louisville metro area.

All services are offered free of charge to the youth and family. Funding for the Y-NOW Children of Prisoners Mentoring program comes from Metro United Way, Louisville Metro Government, and other local organizations and individuals.

For the past 14 years, Y-NOW has worked almost exclusively with youth who have a parent incarcerated. The trauma to a child of having an incarcerated parent has been likened to experiencing the death of a loved one, but the grief that the child experiences often goes unnoticed and unacknowledged. It is common for them to exhibit anxiety, shame, fear, sadness, and guilt. In addition, these inward battles present themselves in anti-social behaviors that have resulted in an alarming profile: children of incarcerated parents are at an increased risk of anxiety, depression, aggression, truancy, substance abuse, attention disorders, and poor scholastic performance. Studies indicate that children of prisoners are more likely to become incarcerated themselves one day. The goal of Y-NOW is to break that cycle.

Outcomes
• To increase the success of youth in school;
• To prevent or reduce the use of physical violence against others in the community, home, and school;
• To prevent or reduce the risk of delinquency and involvement in the court system(s); and
• To improve family relationships (and support system).

<table>
<thead>
<tr>
<th>MUW Indicators/Outcomes</th>
<th>NEW MATCHES (IN 2019)</th>
<th>SUSTAINED MATCHES</th>
</tr>
</thead>
<tbody>
<tr>
<td>75% demonstrate an improvement in school performance (grades, suspensions, attendance)</td>
<td>82%</td>
<td>80%</td>
</tr>
<tr>
<td>85% report improvement in family relationship (Stability, communication, no runaways, etc.)</td>
<td>91%</td>
<td>90%</td>
</tr>
<tr>
<td>75% have no new arrest and/or out of control behavior</td>
<td>96%</td>
<td>92%</td>
</tr>
<tr>
<td>75% will not initiate any (or any new) contact with family/juvenile court</td>
<td>89%</td>
<td>92%</td>
</tr>
<tr>
<td>80% pass to the next grade</td>
<td>85%</td>
<td>91%</td>
</tr>
</tbody>
</table>
MUW Indicators/Outcomes

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>% Achieve Academic Success (Improvement)</td>
<td>83%</td>
<td>---</td>
</tr>
<tr>
<td>% Pass to Next Grade</td>
<td>85%</td>
<td>---</td>
</tr>
<tr>
<td>% Missing Less than 10 days of school</td>
<td>78%</td>
<td>---</td>
</tr>
<tr>
<td># Graduated Middle School</td>
<td>---</td>
<td>269</td>
</tr>
<tr>
<td># Graduated High School and/or Earn GED</td>
<td>---</td>
<td>186</td>
</tr>
<tr>
<td># Currently enrolled in Elementary/Middle/High School</td>
<td>---</td>
<td>168</td>
</tr>
<tr>
<td># Enrolled in 2 or 4 year college or Technical School, or in Armed Forces</td>
<td>---</td>
<td>**</td>
</tr>
<tr>
<td># Graduated 2 or 4 year college or Technical School, or completed Armed Forces commitment</td>
<td>---</td>
<td>**</td>
</tr>
</tbody>
</table>

* Due to limitations with tracking and access to youth data, we do not have the capacity to track youth past high school

Volunteer Recruitment/Training

There is a full Saturday volunteer training for mentors (first half of day retreat volunteers will attend) instead of two half-day trainings. This prevents mentors from spending two entire weekends with Y-NOW (training weekend and retreat), especially since weekends are within two weeks of each other. Youth Enrollment training with the volunteers occurs briefly before each session. The volunteer recruitment specialist goes over what paperwork the volunteers will help the youth with while the director meets with the youth about the program and what they are about to sign up for.

Retreat volunteers have the option to sign up for the entire three-day retreat or can sign up for part of it. Instead staying the entire retreat weekend, partial retreat volunteers attend the retreat from Friday am until after lunch on Saturday. A lot of mentors arrive to the retreat on Saturday morning, so partial retreat volunteers fill the void of missing adults and then are able to leave (and make room for mentors, as space is limited in our course room at the retreat) Saturday around 1pm. This volunteer option has increased volunteer participation at the retreat.

Youth Referrals/Youth Enrollment

Youth referrals primarily come from area school counselors, therapist, and families. While referrals are accepted all year long, youth recruitment and enrollment process increases two months prior to each retreat kick-off (February - March for the Spring cohort and August – September for the Fall cohort). Phone calls are made to youth who met the requirements of the program and expressed an interest in joining the community. Four youth enrollment sessions are held per cohort, during which volunteers assisted youth in completing their five-page application. Volunteers also work with each youth to finalize both their personal and educational goals for the year.

Caregiver/Guardian/Parents

Case mangers reach out to referrals and start scheduling and conducting individual caregiver meetings two to three months before the kick-off retreat. These meetings are completely centered on the caregiver’s availability and needs; meetings are typically conducted with the case manager at either Safe Place or the family’s home. Meeting with the caregiver individually allows the case manager to explain the program and paperwork in detail, answer any questions the caregiver may have, and establish a relationship between the caregiver and case manager – which has been very beneficial for the program.
Youth still come in for shorter Youth Enrollment sessions to fill out their paperwork and meet other youth who will be in the program with them.

Case managers continue to conduct monthly phone calls with caregivers throughout the follow-through program and will provide additional support and resources as needed to caregivers, youth, and families. Caregivers are also invited to two family days during the 10-month program, as well as the gradation celebration at the end of the program.

**Youth/Mentor Retreat**

To prepare for retreat, volunteers (5-10 people) donate a few hours to help staff load and unload two vans full of equipment, materials, and supplies to the retreat site. Volunteers also help staff setup and prepare the course room where all group meetings would be held. This site setup occurs the day before each retreat. On the day of each retreat, 5-10 departure volunteers help staff check youth in for the retreat (collect medications, sign them in, search their bags, etc.). After all youth are checked in and have read a commitment statement in front of the group, retreat and partial retreat volunteers (15-20 volunteers) accompany a busload of 25-30 youth and staff to Country Lake Christian Retreat, Underwood, IN. A 3-day retreat is conducted with the youth and volunteers/mentors to kick-off the program. It includes a variety of guided group conversations and experiential activities designed to have the youth take a look at what is getting in the way of them being successful and begin to develop an action plan for their future (particularly around their education). A fair amount of time is spent building trust and creating a safe and supportive community so that the youth can begin to talk about what it is like to have an incarcerated parent. The youth also do a high ropes course. Mentors usually join the group at the retreat Saturday morning and staff for the rest of the weekend. Youth are paired with their mentor Saturday night of the retreat during a special ceremony.

**One-to-One Mentoring Match**

Each youth receives a weekly phone call and face-to-face visit from a thoroughly screened and trained volunteer mentor to receive support and work on their goals.

**10-month Follow-Through Program**

Group meetings take place twice monthly, and are designed to address specific topics of interest to the youth population, (e.g., trust, responsibility, diversity, integrity, anger management, communication, peer pressure, human sexuality, and responsible sexual behavior). The youth and their mentors also plan a community service project and lock-in. Throughout the year, Y-NOW case management staff and mentors work closely with the schools to monitor performance, and other community agencies, (e.g., juvenile/family court, drug assessment, truancy diversion) to ensure the full complement of the youth needs are met.

**Sustained Relationships/Youth Leaders**

Upon graduation, youth have the opportunity to continue participation on two levels. First, alumni gatherings/reunions are offered annually for the youth and mentors to come back together and catch up. Many youth and mentors continue to work together once they have graduated, and ongoing support is provided as needed. Second, those youths who take part in training and meet all criteria have the opportunity to serve as a Youth Leader for the next program.

**Key Accomplishments over the past five years**

2014:

- Our first alumni to graduate from College with a Bachelor’s Degree
• 11-year-old is speaker at Together 4Teens Breakfast
• Conducted 2-day workshop for Kenwood and Field Elementary Children of Prisoners
• YSPS hires new outreach specialist who will be responsible for volunteer recruitment for Y-NOW.

2015:
• 6x mentor is hired as new FT volunteer/case manager.
• 18-year-old volunteer is honored as YMCA Volunteer of the Year.
• 14 year old is featured speaker at YMCA Safe Place Services Together 4Teens Breakfast.
• YMCA of Greater Louisville produces 30-second TV spot on Y-NOW Children of Prisoners Mentoring Program.
• Y-NOW hires PT volunteer coordinator
• YMCA Safe Place Services commits to launching a second Y-NOW class annually beginning in 2016.
• Y-NOW Facebook page now has 476 likes (fans).
• 250+ youth have participated in the Y-NOW Children of Prisoners Mentoring Program. 83% of who should have graduated HS have (or received GED). 50+ are in college/vocational school/armed forces.

2016:
• Y-NOW part-time volunteer coordinator goes full-time as volunteer recruitment specialist.
• 13 year old is featured speaker at YMCA Safe Place Services Together 4Teens Breakfast.
• Y-NOW case manager was hired in preparation for the launching of a second Y-NOW class.
• The extended leave of absence and ultimate separation of the long time program director from YMCA Safe Place Services resulted in the engagement with sustained matches/alumni not being as effective and the launching of a second Y-NOW class was delayed.
• 299 Youth have participated in the Y-NOW Children of Prisoners Mentoring Program. 87% of who should have graduated HS have (or received a GED).

2017:
• 16-year-old youth leader is featured speaker at YMCA Safe Place Services Together 4Teens Breakfast.
• A second class of Y-NOW was added in the spring of 2017.
• The Case Manager resigned in June, requiring the Director to step in and manage the Spring 2017/18 class of Y-NOW.
• The end of November Y-NOW finally was able to reach full employment.
• 299 youth have completed the 3-day retreat. Of the 299 youth, 269 youth completed the 12 or 10-month follow-through program. 88% of youth who should have graduated HS have (or received a GED).

2018:
• The inaugural spring class graduated in January 2018 with 23 youth.
• 14-year-old youth leader is featured speaker as YMCA Safe Place Services Together for Teens Breakfast.
• Director retired, Fall case manager was promoted to director and new Fall case manager was hired.
• To-date 387 youth have completed the 3-day retreat. Of the 387 youth, 331 youth completed the 12 or 10-month follow-through program.
• Youth Leader was nominated and won a Youth Character Award, which includes scholarship money for college.

2019:

• Y-NOW alumni from 2014-15 class is featured speaker as YMCA Safe Place Services Together for Teens Breakfast. Same youth went on to give invocation at 2019 annual Mayor’s Breakfast.
• Staff re-established Y-NOW alumni event in August. Over 40 alumni, mentors, and family members gathered at Safe Place to reconnect, eat and, play games.
• To-date 434 youth have completed the 3-day retreat. Of the 434 youth, 372 youth completed the 12 or 10-month follow-through program.
• Three Y-NOW youth (2 alumni and 1 current participant) won Youth Character Awards, which includes scholarship money for college.
• Out of the 203 Y-NOW alumni who should have graduated high school, 186 have graduated on time; meaning 92% of alumni have graduated high school on time.