Kentucky Citizen Review Panel for Child Protective Services

Annual Report

2009

Prepared by members of the

Kentucky Citizen Review Panels and Blake L. Jones, Ph.D.

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Acronyms contained in this report and their meanings:

CRP Citizen Review Panels

CFHS Cabinet for Health and Family Services

CPS Child Protective Services

SRA Service Region Administrators

QSR Quality Service Review

CQA Continuous Quality Assessment

DCBS Department for Community Based Services

SOP Standards of Practice

Web sites:

Kentucky Citizen Review Panels: www.uky.edu/socialwork/trc

National Citizen Review Panel Virtual Community: www.uky.edu/socialwork/crp

Dear Citizen,

Thank you for taking a moment to read the 2009 Annual report of Kentucky's Citizen Review Panels. The Panels were formed in 1999 as a result of a federal amendment to the Child Abuse and Prevention Treatment Act. There are over 80 Panel members serving on five regional Panels in Kentucky, representing hundreds of volunteer hours. The Panels' mandate is to evaluate the policies and practices of the Kentucky Cabinet for Health and Family Services and to make recommendations for the improvement of child protective services. In turn, the Cabinet is required to respond to the Panels' recommendations—in writing—within three months.

I would like to emphasize that this report was written by the Citizen Review Panel members themselves. Within their recommendations and rationale, I hope you will see their deep commitment to assisting the Cabinet in better protecting Kentucky's children.

This is a public report and may be shared with anyone. It can be accessed electronically at www.uky.edu/socialwork/trc or you may obtain a hard copy by emailing Dr. Blake Jones at Bljone00@uky.edu.

I would like to thank Gayle Yocum, our Frankfort-based liaison for all of her hard work, and the many volunteers for their tireless efforts on behalf of Kentucky's children. I would also like to thank the Cabinet's liaisons who attended each meeting and were an incredible asset as the Panel members pursued their mission. Thank you to my excellent graduate student, Emily Lawson, for her very helpful work this year. Finally, many thanks go to the Chairpersons of the Panels: Bryan Fantoni, Heather Schill, Dr. Peggy Pittman-Munke, Geri Willis, and Genesia Kilgor-Bowling. Their leadership has been invaluable.

Blake L. Jones, Ph.D., **Program Coordinator**

Cabinet's Response to 2008 Recommendations

EASTERN MOUNTAIN CITIZEN REVIEW PANEL

The panel members provided an overall recommendation for DCBS/DPP to assess more closely the policy supports for all children who are not in their home of origin.

1) In regard to Relative Home Placements, SOP 7E.1.3B indicates that a home evaluation isn't due until 30 days after the placement. Conversely, if the child is in OOHC, the services begin within 72 hours. Concern – a thumbprint of case reviews indicate that some relative placements disrupt before the home evaluation is ever completed.

Recommendation – considering equalizing the services for all children, as it appears as though OOHC children receive more expedient services.

Central Office Response – Out-of-Home Care Branch

SOP (Standards of Practice) 7E.1.3 (B) states: The SSW (Social Services Worker) completes a criminal background check and child abuse and neglect check on the caretaker relative and each adult household member, and a child abuse and neglect check on each adolescent household member prior to the child's placement with the caretaker relative.

1. The SSW completes the relative home evaluation.
2. In some cases, the FSOS (Field Services Office Supervisor) approves placement in the relative's home after completing the records checks and home visit but prior to completion of the written home evaluation. If this occurs, the SSW completes the home evaluation within thirty (30) working days of the placement.

Best practice indicates the home evaluation should be completed prior to placement of the child in the relative's home. The home evaluation guides the decision as to the appropriateness of the placement for the child. The SSW has up to thirty (30) days to write the evaluation.

OOHC and Relative Placements have differing requirements due to the distinct nature of each. While foster parents providing OOHC are approved prior to the placement of a child, relative placements are crisis-driven and without time to pre-plan services. When DCBS places a child in OOHC, the foster parent(s) have completed 30 hours of pre-service training, thorough background checks (NCID, CAN, and Kentucky State Police for all adults in the home and CAN for Children 12+), credit and personal references, home environment requirements, health screenings and income requirements. It takes 4-5 months for a foster parent to complete the process.

Relative placements and kinship care placements must meet similar requirements initially, with the exception of training. DCBS doesn't have the advantage of approving the relative home evaluation prior to placement. Background checks are completed to address potential risks. It takes 2 weeks for the NCID checks to clear for relatives who have resided out of state within the last 5 years. The Kinship Care Specialist and the SSW work together in evaluating the relative.

Kinship Care relatives play a more active role in advocating for services. They do not receive the same benefits as foster parents, such as automatic approval of day care for working parents, clothing vouchers upon entry and yearly for school, training opportunities, assistance with transportation, and assistance with senior pictures and life books. OOHC and Kinship Care are funded through two different programs. Kinship Care is funded through Temporary Assistance for Needy Families (TANF) and Foster Care is funded through Title IV E.

Kinship Care Providers are provided with a one-time start-up cost of up to $350.00 per child if the need can be justified and documented in the home evaluation. Start-up costs cover the costs of items such as school clothing, school supplies, a deposit for a larger residence, furniture, baby items and an attorney if needed by the care taker relative in obtaining permanent. Kinship Care Providers also receive a medical card for all children

in the home. They must obtain permanent custody within one year of receiving Kinship Care.

Currently, only 7.1% (511) of the children are placed in relative placements who do not receive Kinship Care. There are 8,869 children receiving kinship care benefits. Kinship care is an alternative to foster care and is not designed to be an equivalent system. It preserves the family and is less traumatic for the child.

2) Training for resource parents is extensive, but no known specialized training for relative placements. Concern – Relative placement providers may have no training nor have the supports in place to assist in making this placement successful.

Recommendation – consider alternative ways to include relative placement providers in training opportunities or an avenue to seek assistance without the perception of failure being associated with seeking support.

Central Office Response -

Currently there are no trainings specific to relative placements. The DCBS (Department for Community Based Services) recognizes there can be many challenges in the caretaking of these children. The KY Department for Aging and Independent Living offers three assistance programs; National Family Caregiver Support Program, KY Caregiver Support Program and the Aging Caregiver Support Program. The KY Family Caregiver Program was created in 2006 to help grandparents caring for grandchildren. It is administered by the regional Area Agencies on Aging. Assistance is provided to grandparents in Kentucky who are the primary caregiver for a grandchild age 18 and younger. Grandparent is defined as related by blood, marriage or adoption of the parent. Grandparents of any age who meet financial guidelines and are not receiving Kinship Care can receive financial assistance or supportive services that include:

- information about services that are available
- assistance in gaining access to services

- individual counseling, support groups and caregiver training to assist caregivers in making decisions and solving problems related to the caregiver role
- financial assistance in the form of a grant or voucher for expenses related to the child

The Division for Aging and Independent Living (DAIL), sent packets of information on these programs to each Service Region Administrator (SRA). A letter explaining the programs and brochures were sent to each DCBS office. However, all staff may not be aware of the programs as services aren't being fully accessed. It may be prudent for information to be sent once again to all offices. Kinship Care Specialist's should receive the brochures and a letter encouraging them to provide the information to relatives who seek assistance and are not eligible for Kinship Care.

Lisa Durbin, Branch Manager for the Child Safety Branch, has extensive involvement with the Kinship Care (KC) Program. According to Ms. Durbin, KC providers can attend training opportunities offered to foster parents. While it is the responsibility of their DCBS foster care worker to get information to them, it appears a lack of coordination is a factor.

3) There is a local Eastern Mountain Policy that states when OOHC children return home, visits from the worker occur once a week the first month, then every other week the next month and then every 30 days thereafter. Concern – this policy is only for children leaving OOHC, therefore not providing the same level of supports for relative placements.

Recommendation – consider giving all children equal opportunity to succeed in the placements by providing similar level of supports to the child and family.

Central Office Response-

This policy is an Eastern Mountain Regional policy; it is not SOP (Standard Operating Procedure). Currently with caseloads and staffing issues, this policy has not always been feasible and is not practiced consistently across the region. The practice was initiated to

help prevent/address re-entry into OOHC (Out-Of-Home Care); therefore, it was not used with relative placements. It would be ideal to use the practice with all children returning to their parent's home whether from foster care or a relative placement. This would help to transition the children home and promote stability in the home once the children are returned. This is a
protocol that as a region we are reviewing to see if it is still a manageable task for the region.

There could be numerous services put into place to ensure the safety of the child upon return to the parent. Normally this is a transition and the SSW should be able to identify the high risk behavior and what has changed. The SSW will determine in either type of placement what protective safeguards will be needed to ensure the child's safety.

4) **When a child is placed back home after being in out of home placement there needs to be a new case plan within 5 days.** There appears to be time limits for case plans in all the other areas but this one, and we hope that this may assist with some reduction of reentry due to the fact that a child goes home and there isn't a new case plan to address their return or to assist with continuing to remain at home).

Central Office Response-

Although there isn't a formal new case plan when child is returned to home; the existing SOP/Regulation allows for modifications of the current case plan. The worker and family sit down and make necessary changes when child returns home. This can also include Safety Plans. It is imperative the family takes part in the modifications.

5) A case plan is reviewed every six months and recommendation acted upon but we felt six months is too long to wait to address a problem. There should be a review and formal follow up on the case plan in a more timely manner such as possible every two months so that if there is a problem then a new case plan is developed and services given sooner than later when things could potentially get worse **A case plan is good for six months**

and can be modified and evaluated more often. The recommendation is that the case plan have formal reviews more frequently and maybe even on monthly visits.

Central Office Response-

The case plan is continually monitored during home visits. If there are significant issues and/or concerns, a special review could be arranged and modifications made to the plan as appropriate. With these parameters, a planned review every six months allows time for the plan to be implemented prior to review.

Two (2) months though seemingly feasible, is basically not sufficient time to begin a new plan. Case plans can be very detailed and every opportunity must be given for the family to succeed. Family Team Meetings (FTM) involves family members, community partners and others with direct interest/involvement with the family.

SOP 7C.4 addresses the issue of monitoring the case plan:

Ongoing assessment of the family's progress towards the negotiated objectives and tasks are provided, at minimum, by:

1. Monthly face-to-face contact by the SSW with the family and children in the home, including identified fathers as outlined in SOP 7E.1.1(B);
2. Quarterly contact by the SSW with community partners;
3. Family Team Meetings within every six (6) months for In-Home cases and (3) months for Out-of-Home Care (OOHC) cases at a minimum; and
4. A new/revised ongoing CQA may be completed and the Case Plan revised as outlined in 7C.16 Case Plan and Visitation Agreement Revisions and Modifications when significant changes in the family occur, such as:
   (a) Change in the composition of the family;
   (b) Loss of job;
   (c) Change in family income;
   (d) Loss of basic needs being met; and
   (e) New referral.

5. A new/revised ongoing CQA is completed and the Case Plan revised when a change in placement of the child occurs.

SOP 7C.7.1 - Five (5) Day Conference, Family Team Meeting (FTM)

1. The SSW obtains current assessment information from the investigative SSW, the petition for removal and may consider information from previous CQAs to assist in completing the Case Plan.

2. The next ongoing Case Plan is due within six (6) months from the child's Temporary Removal Hearing (TRH) and order of temporary custody or placement date of a voluntary commitment, unless significant changes in family circumstances occur, requiring a new CQA and Case Plan.

9. The SSW submits to the court a Case Plan no later than thirty (30) calendar days after the effective date of the court order for each child placed in the custody of the Cabinet by either a commitment order or Temporary Custody Order. At the same time, the SSW sends a copy of the Case Plan to the Administrative Office of the Courts Citizen Foster Care Review Board Program.

SOP 7C.7.2 – Three (3) Month FTM Case Review

1. Family Team Meeting (FTM) case reviews, may be held by the SSW as appropriate, but are required to be held within three (3) months of a child's Temporary Removal Hearing (TRH) and order of temporary custody or placement date of a voluntary commitment.
2. A new CQA and Case Plan is not required for the Three (3) Month FTM Case Review and subsequent case reviews, however is required for the Six (6) Month FTM Periodic Review and all subsequent Periodic Reviews.
3. Subsequent FTM case reviews are required to be held within six (6) months of the previous review (e.g., Nine (9) Month FTM Case Review) while the child remains in OOHC.

SOP 7C.7.3 – Six (6) Month Periodic Review

1. Family Team Meeting (FTM) Periodic Reviews, may be held by the SSW as appropriate, but are required to be held within six (6) months of a child's Temporary Removal Hearing (TRH) and/or order of temporary custody or placement date of a voluntary commitment.

4. The SSW submits a Case Plan, at minimum, once every six (6) months to the court and the Administrative Office of the Courts Citizen Foster Care Review Board Program.

7. Public Law 96-272 requires the participation of one objective third party in the Periodic Review, who is not the case manager or in the line of supervision for that case. The Service Region Administrator (SRA) or designee approves third party participants who are not professional staff.

9. Upon review of the CQA, Case Plan and Visitation Checklist/Summary the FSOS or designee assesses the progress of the family during the FTM Periodic Review. If the family has not made sufficient progress and the case is currently a concurrent planning case, the SSW considers changing the permanency goal to the alternate permanency objective.

SOP 7C.7.4 – Nine (9) Month FTM Case Review

1. The SSW establishes the dates of the Twelve (12) Month Periodic Review and sends a copy of the DPP-165, Permanency Hearing Notification to the court requesting a Permanency Hearing no later than sixty (60) calendar days prior to the required due date, which is:

   (a) No later than twelve (12) months from the date the child entered OOHC by order of temporary custody during the Temporary Removal Hearing or placement as a result of voluntary commitment; and

   (b) Every twelve (12) months thereafter if custody and out-of-home placement continues.

   Pursuant to KRS 610.125 (3) the court is required to schedule a hearing within sixty (60) days of this notice and notify all concerned parties as noted on the DPP-165.

SOP 7C.7.5 – Twelve (12) Month FTM Periodic Review and Permanency Hearing

2. The Permanency Hearing, which is required no later than twelve (12) months from the date the child entered OOHC by order of temporary custody following the Temporary Removal Hearing or placement as a result of voluntary commitment and every twelve (12) months thereafter if custody and out-of-home placement continues.

6) We realize that "kinship care" sits out there kind of alone, and that when a child is in relative placement services offered to them are very limited and different than if in foster care placement. due to the fact that once the child is removed and placed with relatives dynamics change and this isn't just a typical child one takes in but a child who has obviously been through something and will therefore react and relatives need to know how to deal with this and what to expect--as well the fact that this is an added expense and struggle for the relative and they are in need of services such as respite and/or daycare. **We would like to recommend that there be some extended time limited services for relative placement and that this include training for the relatives such as foster parents may receive just shorter in duration**. These could include how to deal with grief, sexual abuse, and discipline.

Central Office Response-

This is an excellent suggestion and is already being discussed Currently, once a child is placed with a Kinship Care relative, the case will remain open and services offered to both the parent and the child. If the child is in need of therapy, the SSW will record this in the case plan and develop a plan as to how to meet this need. The relatives as well as the foster parents are often a part of the case planning process. If reunification with the parent fails, then permanency will be established with the K/C caregiver and the case will be closed. The caregiver will then need to seek counseling according to the recommendations of the therapist. Most cases are open and services are offered for at least six (6) months and often twelve (12) months if the SSW is still trying to reunite the child with the parent or the judge refuses to grant permanent custody. It would be

supportive if the agency could offer all relatives a short version of parenting classes. Most counties have parenting classes that a relative could attend in these types of situations, and the relative can also register for these classes on their own.

SOP 7E.1.7 (D) supports the narrative above: The SSW shall provide services or facilitate access to services for the kinship caregiver and the child, including case management, described in the child's permanency plan for at least six (6) months, beginning with the date of the placement of the child with the kinship caregiver, or until the kinship caregiver has permanent custody of the child.

7) **We believe that a family liaison/family mentor (similar to the S.T.A.R.T program in Martin County) would be helpful both for relatives doing relative placement and for parents who have their children removed and placed back.** We think that this kind of support may help thwart problems before removal and the hope that the folks would talk to the family mentor when in need.

Central Office Response-

Tina Willauer is the Director of the Kentucky Sobriety Treatment and Recovery Teams (K-S.T.A.R.T) program. She provided a historical perspective for K-S.T.A.R.T:

S.T.A.R.T was originally implemented in Kenton, Jefferson and Barren Counties in October of 2007 (although planning began in late 2006). These three sites began officially serving families in October of 2007. Since then we were awarded a federal grant through the Administration for Children and Families (ACF) to implement S.T.A.R.T in Martin County. Planning is underway in Martin County and they will begin serving families in September of 2008. The Barren County S.T.A.R.T program encountered implementation problems, and has been terminated. S.T.A.R.T is currently operational in Kenton, Jefferson and Martin Counties. Kenton and Jefferson are state funded and Martin is federally funded.

S.T.A.R.T is an intensive intervention model for substance abusing parents and families involved with the child welfare system that integrates addiction services, family

preservation, community partnerships, and best practices in child welfare and substance abuse 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.

S.T.A.R.T. philosophy is rooted in the Annie E. Casey Foundation's Family to Family values and is based on a collaborative approach to working with families. It is a component of the Cabinet for Health and Family Services' comprehensive Partners in Prevention program.

K-S.T.A.R.T is based on the successful and nationally recognized S.T.A.R.T. program in Cleveland, Ohio. Kentucky has modified and evolved the model to fit the needs of Kentucky families. While Martin County has been awarded federal funding to implement K-S.T.A.R.T, state funding is being used to fund the program in two other counties in KY: Kenton and Jefferson. Kenton and Jefferson counties began serving families in October of 2007 and Martin County will be serving families by September of 2008.

The target population to be served in S.T.A.R.T. will include families dealing with substance abuse issues with a child three or younger who have a substantiated case of abuse or neglect with DCBS; or families identified as a Family in Need of Service due to a mother testing positive for drugs at the time of a child's birth.

The key components of K-S.T.A.R.T are:

- The pairing of a specially trained Child Protective Services (CPS) worker and a Family Mentor to share a caseload of families with the co-occurring issues of substance abuse and child maltreatment where at least one child is 3 or younger;
- 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 and intensively trained and supervised to provide K-S.T.A.R.T clients with both recovery coaching and help navigating the CPS system;

- Reduced caseloads for the K-S.T.A.R.T team of 15 families per worker/mentor pair;
- 12 basic tenets outline the program philosophy and collaboration;
- Program fosters integration between CPS, substance abuse treatment providers and other community partners by addressing differences in professional perspectives that have resulted in fragmentation of services.
- 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 abuse treatment, close collaboration among CPS and service providers, and shared decision-making among all team players, including the family;
- The use of TANF funding to pay for substance abuse treatment in Kenton and Jefferson;
- Collaboration with community partners, substance abuse providers, the courts, and the child welfare system dedicated to building community capacity and making K-S.T.A.R.T work;
- Sober parenting supports that include flexible funding for meeting basic needs such as housing and child care and intensive in home services;
- A holistic assessment for all clients, addressing substance abuse, mental health, domestic violence, and intellectual ability, and;
- Extensive program evaluation to indicate and document the program achievements and weaknesses. Evaluation findings are used to empower program improvements.

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 abuse 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.

Ms. Willauer was asked if K-S.T.A.R.T would be applicable to use for relative and parenting mentoring as recommended by the panel. She responded: "The S.T.A.R.T program model is specifically designed to address the co-occurring issues of substance abuse and child maltreatment. So this official model has not been used to serve any other population. I am sure that there are likely places in the country that may use a similar model to address other populations but I am not aware of any program specifics." However, she did share information on another program which may meet that need. "The Parent Advocate program is similar in philosophy to S.T.A.R.T as it pertains to birth parent engagement. In Jefferson and Kenton Counties they are using Parent Advocates to assist in child protection cases. The Parent Advocate is a parent who has been through the child protection system (CPS) and in most cases has been successful in regaining custody or maintaining custody of their children. Many are also recovering addicts but not all of them. There is a push to recruit parents that have experienced a variety of issues aside from just substance abuse. They are recruited to work in tandem with the CPS social worker to assist parents in navigating their way through the CPS system. They are able to engage birth parents in ways that CPS may not be able to and they are of great support to the birth parent's efforts in maintaining or regaining custody of their child. The Parent Advocate model is very much a new way of doing business in CPS and programs are being developed across the nation." Parent Advocates in Jefferson County are funded through Jefferson's Family to Family Program (Annie E. Casey).

8) There appears to be no follow up and community partners aren't aware of them (aftercare plans) and the part they may play with these families. **Aftercare plans need some type of follow-up**. **For example, there could be a family maintenance team or aftercare team and they could ensure that the family follows up with aftercare plans. There needs to be some follow up, time-limited support, and education and involvement of community partners in development and follow-up with aftercare plans. Finally, we encourage the use of more frequent and timely family team meetings.**

Central Office Response -

Aftercare Plans can provide a guide for the family as to issues identified as continuing factors in the well-being of the family. There has been discussion regarding Aftercare Plans in the regions and Central Office. Cases are not closed until safety concerns are resolved and risk factors eliminated. The Aftercare Plan is developed by the SSW, appropriate family members and others as a proactive planning step. There is an effort by the DCBS to keep the same worker for the family. This provides consistency and continuity. The family often feels a sense of disruption and intrusion when DCBS becomes involved. Maintaining the same worker is usually a benefit in this regard. Community partners often play a vital role in service provision to the family and are included in the Aftercare Plan when they provide ongoing services. The SSW is not required to maintain an open case until the family completes all items identified on the Aftercare Plan. For example; the Aftercare Plan indicates the family will participate in counseling until released by the therapist. The SSW relies upon the service provider to notify DCBS of any concerns or non compliance with the plan. There is certainly room to communication between the DCBS and service providers and to make the provider a more integral part in planning for the family. SOP 7G details the development of the Aftercare Plan and the role and responsibility of community partners.

1. Once the SSW, upon consultation with the FSOS, identifies that an Aftercare Plan is needed, the SSW:
   (a) Explores with the family and family's support system the need for continued services of another type or from another community partner;
   (b) Develops with the family, including identified fathers as outlined in SOP 7E.1.1(B) and the family's support system a specific and measurable plan for the family to obtain services to address existing needs;
   (c) Establishes with the family and the family's support system additional and potential resources that may be called upon to prevent maltreatment or home instability, should a situation or crisis arise in the future;
   (d) Provides any needed referrals; and
   (e) Advises persons served that they may request help from the Cabinet in the future.

4. The SSW negotiates the Aftercare Plan with the family and other relevant individuals involved. The plan is signed and dated by everyone who has a task/role on the plan and a copy provided to:
   (a) Family members, including children of appropriate age;
   (b) Alleged perpetrators (when safe to do so);
   (c) Relatives; and
   (d) Community partners involved.
5. When community partners are included in aftercare planning and are assigned specific tasks, the SSW documents on the aftercare plan that Community partner(s) will notify the SSW if the family has difficulty complying with the plan.
6. The FSOS reviews the Aftercare Plan with the SSW and documents the review in the case record.
7. The SSW files a hard copy of the Aftercare Plan in the case record.

NORTHEASTERN CITIZEN REVIEW PANEL

1) **CHFS adding a component to the CHFS Training Academy's Sexual Abuse segment. This component would include utilizing a CAC Executive Director to present training on children's advocacy centers**. The worker would also be required to visit their regional CAC, spending a specified amount of time (possibly one day), becoming familiar with the local CAC services, employees and policies.

Central Office Response- Division of Violence Prevention Resources – Sharon Hilborn, Director

The CHFS (Cabinet for Health and Family Services) is in agreement with the basis for the recommendation that both new and existing DCBS/Protection & Permanency (P & P). Workers should be trained about the advantages, services, and capabilities available through the network of Kentucky's fifteen designated Regional Children's Advocacy Centers (CAC). However, due to the time constraints, work loads, and differences in

CAC from region to region, it may be more effective to select a different venue to orient new staff to their respective CAC.

As a result of the re-organization of the DCBS Service Regions in 2007, the CAC service regions no longer "neatly" match up with the DCBS Service Regions. In fact, some DCBS Service Regions now encompass all or part of multiple CAC service areas. Example:

1. The Lakes Service Region is now served by Purchase Area Sexual Assault Center (CAC for Purchase ADD) (Area Developmental District), and Pennyrile CAC in the Pennyrile ADD.
2. The Northern Bluegrass Service Region has counties that are served by three separate CAC: CAC of Northern Kentucky (NKY ADD), Buffalo Trace CAC (Buffalo Trace ADD) and CAC of the Bluegrass.

In order to accomplish the goal of increasing the linkages, referrals and P & P workers knowledge about CAC, it may be more advantageous to establish some type of orientation sessions for new and existing staff between the Service Regions or county offices related to the CAC that serves the respective Service Region or county.

It may also be advantageous to structure separate orientation sessions for new versus existing P & P staff. For new staff it may be beneficial for them to take a day and spend at their CAC to meet the staff, discuss policies and referral procedures and possibly observe some services. Orientation sessions for existing P & P staff could be better handled through a "lunch and learn" type of meeting or some other structure that meets the needs of the two groups.

2) **DCBS workers become familiar with CAC policies and state laws which mandate certain policies.** To increase knowledge of current staff and to encourage building a partnership with local CAC, supervisors should schedule quarterly meetings/trainings with CAC executive director or other CAC designee. DCBS workers

can work with CAC to coordinate referral processes and discuss any concerns regarding increasing availability of services.

Central Office Response – Division of Violence Prevention Resources

CHFS is in agreement that increased coordination and communication between P & P staff and the network of designated, regional, CAC will enhance services and positive outcomes for the children and families served. If the "orientation" process discussed in #1 were implemented, the issue related to releasing taped forensic interviews and the other items mentioned in #2 would be items to be covered in the orientation process.

It should be noted that KRS 620.050 (10) explicitly details the persons/agencies that are able to access copies of taped forensic interviews conducted at CAC. Additionally, KRS 620.990 establishes that violations of the chapter are a Class B Misdemeanor.

3) Transportation issues were voiced as concerns during interviews. Families have trouble affording transportation to CAC especially if located in a county. **CAC's should look into ways to assist families with transportation cost.** Request for gas card donations, applying for grants to establish assistance funds at the CAC, and other fundraising efforts might prove helpful.

Central Office Response – Division of Violence Prevention Resources

Due to the rural nature of Kentucky, transportation to service centers/agencies is always identified as a potential barrier to accessing services. This issue is further complicated by the sharp increases in fuel costs within the past year. The increase in fuel costs is also a complicating factor for the DCBS as their workers are frequently traveling by automobile.

Efforts to maximize the effectiveness and efficiency of travel may be able to make some improvement in assisting families with the expense of traveling to CAC for services. However, in order to most effectively address transportation issues, CAC may need to

direct some of their local fund raising efforts at addressing the transportation needs of their clients and prospective clients.

Another option would be for CAC to begin exploring options for outreach or satellite offices in other locations in their service districts similar to what the network of Rape Crisis Centers and Domestic Violence (DV) Shelters have done. The establishment of satellite or outreach offices reduces the travel burden on clients for some of the available services while increasing the accessibility of the agency. Satellite or outreach offices would appear to be most beneficial in rural areas and large area development districts.

4) Shelters & DCBS develop and implement a multi disciplinary service team for each shelter that has a client with an open case

Central Office Response – Adult Protective Services Branch – Steve Fisher, Branch Manager

Advocacy toward a multidisciplinary investigative design in each service region will continue to be a priority with the Adult Protective Services (APS) Branch. The chief barrier to the formation of these specialized co-occurring child abuse and domestic violence teams is diminished staffing patterns throughout DCBS. A subcommittee of the Governor's Council of Domestic Violence and Sexual Assault, Co-occurring Child Abuse and Domestic Violence, was formed in 2007 to examine this issue.

Central Office Response – Division of Violence Prevention Resources

CHFS is in agreement that increased communication and coordination of services between P & P workers and Spouse Abuse Shelters will lead to an increase in positive outcomes for the clients served, both the adults and the children. The use of multidisciplinary teams to advise, evaluate, and inform practice in cases of concurrent domestic violence and child maltreatment would be the ideal "best practice" standard. However, before implementation of the multidisciplinary team approach, there needs to be an enhanced coordination between P & P workers and the DV Shelters first. This initial enhanced collaboration would increase the likelihood of success when inviting other members of the multidisciplinary team to participate.

Some of the short-term benefits from enhancing the collaboration are listed below:

- Clarifications of roles of P & P workers and DV Advocates/Shelter staff;
- Increased knowledge and understanding of policy and procedure for both service systems;
- Dispelling the myth that DV Advocates/Shelter staff are only interested in the welfare of adult victims;
- Dispelling the myth that DCBS is only interested in the welfare of children; and
- Dispelling the myth that the concept of best interest of children is in conflict between P & P workers and DV Advocates/Shelter Staff.

In Jefferson County, through a project funded by the Casey Foundation, there was a marked increase in collaboration between P & P workers and the DV Shelter/Program which lead to enhanced coordination and improved practice, through the use of a commonly accepted group of guiding principles. Adoption and use of the guiding principles is possible with minimal if any budgetary impact.

After P & P workers and the DV Shelters have been able to enhance and coordinate services between their two service systems, it would be beneficial to begin adding other disciplines to the team. Due to the high incidence in Kentucky and the fact that domestic violence and substance abuse are often co-occurring issues, utilizing the knowledge and skills of a Certified Alcohol and Drug Counselor (CADC) would be a recommended addition to the multidisciplinary group.

5) State provide funding for Mandatory Drug Testing.

Central Office Response –

The importance of drug testing in child protection casework is recognized.

In the past, the Cabinet was able to contract with a private provider to conduct drug testing in situations where the use of substances was suspected. Funds for the contract

were depleted in 2007. Since that time, the Cabinet has pursued other entities to provide this important service. Due to the current budgetary constraints, DCBS is unable to routinely pay for drug testing of clients.

6) Workers be accompanied by law enforcement when safety is an issue. Realizing this is a law enforcement shortage problem; **our recommendation is that Law Enforcement and DCBS review, revise protocol/procedure for law enforcement officers to accompany DCBS workers on spouse abuse reports.**

Central Office Response –

Domestic situations are some of the most volatile and are a leading cause of death for responding law enforcement officers. In Kentucky, Adult Protection Services are governed by KRS Chapter 209 – Protection of Adults, KRS Chapter 209A – Spousal Abuse or Neglect, 922 KAR 5:070 Adult Protective Services, and 922 KAR 5:102 Domestic Violence Protective Services authorizes the least restrictive provision of protective services in order to ensure the safety and well-being of an adult, while protecting the individual's right to self-determination and due process. The adult has the right to refuse services. SOP 4C.1 details the procedure for investigation of reports of domestic violence.

1. All protective service investigations require intervention techniques that consider the safety of the alleged victim and the SSW. Spouse/partner abuse or neglect situations may be particularly volatile and should be approached with caution. Safety of the SSW and the alleged victim is a critical factor when arranging contact with the alleged victim. When conducting a spouse/partner abuse or neglect investigation, the SSW:
   (a) Attempts to arrange a face-to-face interview with the alleged victim to conduct the investigation and offer protective services; and,
   (b) Attempts to obtain information from the reporting source, law enforcement, court and other appropriate individuals as to where the victim can safely be interviewed.

2. The SSW follows the consecutive steps outlined below and documents attempts to contact the alleged victim of spouse/partner abuse or neglect:

Step 1 - Telephone Contact (The preferred approach is telephone contact.)

(a) If a telephone number is available the SSW attempts to call the alleged victim to arrange a face-to-face interview at a location that is deemed safe for the alleged victim and the SSW (e.g., DCBS office, shelter, workplace or court):

(1) If both home and work telephone numbers are available, it is preferable to attempt telephone contact at the place of employment;

(2) If unsuccessful, the SSW attempts to contact the alleged victim at home; or,

(3) If the alleged victim is currently residing in a spouse abuse center an attempt may be made to discuss the allegations with the alleged victim at the center.

It may be necessary to make numerous telephone calls in an attempt to contact the alleged victim.

(b) If the alleged victim refuses to meet with the SSW, but agrees to a personal telephone interview, the SSW discusses the allegations to determine if abuse or neglect has occurred and offers protective services. The telephone interview meets the statutory requirement for a personal interview with the alleged victim who refuses to meet the SSW in person. During the conversation, the SSW:

(1) Attempts to assess the alleged victim's ability to protect any minor children in the home;

(2) Provides resource information to the alleged victim;

(3) Offers safety planning for protection; and,

(4) Provides the SSW's name, office telephone number, and the telephone number of the nearest spouse abuse center.

In order to promote victim safety, if a person answers who is clearly not the victim, the SSW does not identify the victim or identify the reason for the call.

Step 2 - Home Visit

If telephone contact is not successful, or a telephone number is not available, the SSW may make a visit to the home, when through collateral contacts (i.e. law

enforcement, shelter staff, etc.) it is determined that neither the alleged victim nor the SSW may be endangered, and after consultation with the FSOS or designee.

Step 3 - Letter

(a) The SSW sends the Standardized Letter in the following situations:

(1) When unable to successfully contact the alleged victim by telephone,

(2) No telephone number is available; or,

(3) If the information indicates a visit to the home is inadvisable.

(b) The Standardized Letter is sent in a plain envelope when attempting contact with the alleged victim;

(c) At least one follow up Standardized Letter is sent in a plain envelope when no response is received from the alleged victim; and,

(d) Upon the alleged victim's response to the Standardized Letter, the SSW attempts to arrange a face-to-face interview.

Step 4 - Process Issues

(a) If a spouse/partner abuse or neglect report indicates that the alleged victim does not want to be contacted by DCBS, staff exercises professional discretion in determining the appropriate plan of action based on the nature of the report.

(b) The SSW cannot initiate contact with the alleged perpetrator without the express permission of the alleged victim and if the alleged perpetrator is at home, it is inappropriate to interview the alleged victim at that time.

(c) The SSW documents all attempts to contact the victim and the permission or refusal of the victim to interview the alleged perpetrator in the case record.

(d) If child abuse or neglect is concurrently alleged with the spouse/partner abuse or neglect report or there is indication during the interview that the child (ren) may be in danger, the SSW generates a child protective services report and includes all allegations as part of the assessment.

7) A state vehicle for every county.

Central Office Response –

Available vehicles assigned to the DCBS are deployed throughout the nine service regions. It is not possible to provide all one hundred twenty (120) counties with a vehicle. Staff are also able to access a vehicle through the state motor pool as need arises. The SRA (Service Region Administrator) assesses the transportation issues of the region and collaboratively works with management staff on the utilization of available vehicles.

8) Each county office have at least one aide to help with transportation and supervised visitation.

Central Office Response –

The DCBS has benefited from the assistance of Transport Aides, who provide a valuable service to families and children and free up worker's time. Regional management is responsible for assessing and determining staffing needs in the region, including the type of staff most needed. Recently, DCBS has been able to post a limited number of Social Service Aide positions which may be used to assist with transportation and/or supervised visitation.

9) New Spouse Abuse SOP's

Intake information from Centralized Intake for person's entering shelter was not forwarded to the county office in which the shelter is located.

Central Office Response – Adult Protection Branch

APS SOP 4C.2 articulates the expectation around this issue. The expectation is that Centralized Intake Staff will forward the DPP 115 report for assignment to the county in which the alleged victim is residing. This includes short term residency in shelter. When the DCBS staff in one county has contact with an alleged victim of spouse/partner abuse prior to the alleged victim entering a spouse abuse shelter in another county, the DCBS worker in the originating county completes the investigation. The DCBS worker may

contact the DCBS worker in the county where the center is located and request a courtesy interview with the alleged victim.

□□The SOP requires DCBS workers of the county the DV shelter is located to become involved with the shelter resident when they have no history of that family. The over all feeling is that DCBS workers from the county of origin should be involved in the investigation.

Central Office Response – Adult Protection Branch

APS SOP 4C.2 articulates the expectation around this issue. When an alleged victim enters a spouse abuse center without assistance or contact with DCBS staff, the county where the spouse abuse center is located conducts the investigation. If an incident occurs outside the county where the alleged victim resides the DCBS worker in the county of residence of an alleged victim conducts the investigation, if the victim did not enter a shelter in the county of incident. These expectations are largely centered on practical considerations concerning staff time and travel. Nothing in policy prohibits communication across county or region lines that would benefit the investigative worker from better serving the client. DCBS staff are expected to review prior agency history with the family and to communicate directly with other DCBS staff that has knowledge of the family.

□□Persons coming from other counties falling between the cracks. When they return to Home County there is no notification to the county of origin that the family had been in shelter and may need of continued service.

Central Office Response – Adult Protection Branch

APS SOP 4C.2 speaks to this issue. If an alleged victim requests services upon departure from a spouse abuse center, the DCBS worker from the county where the spouse abuse center is located notifies the DCBS worker in the county of relocation as to the need and the request for services. It is incumbent upon the adult victim to request this

notification to the county of relocation. Confidentiality and self determination issues make this necessary.

SOP 4C.2

1. In order to accomplish coordination of spouse/partner abuse or neglect services the following procedures are taken by DCBS staff:
   (a) The SSW discusses the services of the area spouse abuse center with each alleged victim during the investigative interview;
   (b) If the alleged victim requests assistance in securing safe shelter in the area spouse abuse center, the SSW assists in making the necessary arrangements;
   (c) After obtaining permission from the FSOS or designee, the SSW contacts the spouse abuse center and makes arrangements for accessing safe shelter;
   (d) In rare instances staff may provide transportation to the spouse abuse center;
   (e) If a request is made for the address or telephone number of spouse abuse centers, the SSW provides only the crisis line number; and,
   (f) Due to the confidential location of many spouse abuse centers and the potential risk to the alleged victim and others, the SSW cannot disclose the location of a spouse abuse center.
2. The following procedures outline DCBS staff responsible for completing the investigation:
   (a) When a SSW in one county has contact with an alleged victim prior to the alleged victim entering a spouse abuse shelter in another county the SSW in the originating county completes the investigation;
   (b) The SSW may contact a SSW in the county where the center is located to request a courtesy interview with the alleged victim;
   (c) When an alleged victim enters a spouse abuse center without assistance or contact with DCBS staff, the SSW from the county where the spouse abuse center is located conducts the investigation;
   (d) If an incident occurs outside the county where the alleged victim resides the SSW in the county of residence of an alleged victim conducts the investigation, if the victim did not enter a shelter in the county of incident;

(e) If an alleged victim requests services upon departure from a spouse abuse center, the SSW from the county where the spouse abuse center is located notifies the SSW in the county of relocation as to the need and the request for ongoing services;

(f) If the alleged victim relocates, the SSW in the county where the alleged victim resided at the time of the referral forwards the referral to the county of relocation if the SSW in the county has not had personal contact; and,

(g) If personal contact was made the SSW in the county prior to relocation requests a courtesy interview from the SSW in the county of relocation.

□□Both Partner Abuse Shelters and DCBS works believe a team service plan between the client, shelter and DCBS worker would be most beneficial to the client family system. That way all parties would be aware of all elements of the plan and the constraints if any that each party had.

Central Office Response – Adult Protection Branch

APS SOP 4E, 4E.1, 4E.2, 4E.3, 4E.4 and 4F.1 speak to this issue. The DCBS worker offers the spouse/partner victim the necessary protective or preventive services as identified in the assessment. These services are based on the voluntary request for or acceptance of services by the spouse/partner in need of services. A case plan is developed for the provision of services working with the adult victim and with the consent of the adult victim may include the following people in the case planning process: designated regional cabinet staff; family members; family friends; community partners including shelter staff or other individuals requested by the adult.

SOP 4E addresses APS CASE PLANNING. Policy specifically states:
The SSW offers the adult the necessary protective or preventive services as identified in the Adult CQA. These services are based on the voluntary request for or acceptance of protective services by the adult in need of services; the voluntary request for services by a

guardian on behalf of the adult; or, court ordered protective services, which are specified by the court and defined within the court order.

In order to provide the most comprehensive services to the adult, the SSW is encouraged to participate in local coordination efforts with community partners including, but not limited to Local coordinating Councils on Domestic Violence, Local Coordinating Councils on Elder Maltreatment, Multidisciplinary Geriatric Crisis Response and Intervention Teams, Adult Fatality Review Teams or TRIAD's. Participation will enhance interagency knowledge and cooperation thus enhancing the safety and stability of abused and/or neglected adults.

SOP 4E.1 outlines Case Plan Procedures:

1. Within thirty (30) calendar days after the approval of the investigative results and a decision to provide on-going services, the SSW develops a case plan with the adult, caretaker and others as appropriate.
2. Adults have the right to choose whom to involve in their individual case planning and should be encouraged to involve friends or family members who have the potential to be helpful in some way.
3. The SSW, with consent of the adult, may include the following people in case planning:
   (a) Designated regional cabinet staff;
   (b) Family members;
   (c) Family friends;
   (d) Community partners (i.e. medical providers, faith based organization members); or
   (e) Other individuals requested by the adult.
4. For voluntary cases the SSW identifies protective service needs to the adult based on the most recent Adult CQA.
5. If the most recent Adult CQA is over thirty (30) days old, a new CQA is required prior to the completion of the case plan.

6. Adult's voluntarily accepting services have the right to self-determination and can decide, with the SSW, which goal and objectives to address in their case plan.
7. The case plan must contain at least one family level objective (FLO) based on the Adult CQA.
8. The wording of the FLO is tailored to the adult's view of the problem and reflects their phrasing and terminology.
9. If the adult refuses to accept an FLO based on the highest risk identified on the Adult CQA, but agrees to an FLO which is not identified as the highest risk, the case plan is based on the objectives the adult wishes to address.
10. Case plans may contain an individual level objective (ILO) if the adult agrees or chooses to address such individual issues.
11. The ILO addresses personal patterns of behavior that are preventing an individual from achieving the family developmental tasks, however, it is not required that APS case plans contain an ILO due to the voluntary nature of these cases.
12. Tasks are completed for every FLO and ILO established in the case plan to identify what the family, SSW or other parties involved in the case are to complete.
13. There must be at least one task for each objective identified.
14. Rating anchors are only used to discuss an adult's concerns for their safety.
15. If the adult chooses not to have a family member involved (i.e. alleged perpetrator); the SSW develops the case plan only with the client.
16. In those circumstances the excluded person is not included as part of the FLO or ILO and should not sign the case plan.
17. In cases of spouse/partner abuse, the SSW should take particular care to assure the comfort and protection of potential victims by reassuring them it is their right to have services without designated others involved.
18. In cases of spouse/partner abuse, the first FLO addressed is physical safety.
19. When the alleged perpetrator is involved in the case plan, the first ILO should clearly address specific behavior surrounding the abuse, neglect or exploitation.
20. The adult, SSW, and others involved in the case planning sign the case plan. If the adult agrees to the case goals and objectives, but chooses not to sign the plan, the SSW documents this in the case record.

21. The SSW provides a copy of the DPP 154 Service Appeal Request to the victim. (Link to SOP 1A.8 Service Appeals). The SSW also provides a copy of the DPP 154 to the alleged perpetrator if they are requesting or being provided services.
22. The SSW must consider confidentiality a significant concern, since inappropriate access to the case plan might cause risk to the victim.
23. The FSOS approves all case plans.

SOP 4E.2 concerns the Prevention Plan in APS

1. The purpose of the Prevention Plan is to identify behaviors that the adult will address to prevent reoccurrence of abuse, neglect or exploitation. The Prevention Plan identifies high-risk situations and early warning signals/signs. It is intended to help the adult victim:
   (a) Prevent the high-risk situation;
   (b) Interrupt the high-risk situation early, if unable to prevent the situation; or,
   (c) Escape the high-risk situation.
2. If the adult victim gives permission to contact the alleged perpetrator and the individual is willing to cooperate, or is court ordered, the SSW may develop a Prevention Plan with this individual.
3. It may not be necessary, unless court ordered, to develop a Prevention Plan if the adult chooses not to give permission to contact the alleged perpetrator or include this individual in the case plan.
4. In on-going spouse/partner abuse cases that include the alleged perpetrator, a Prevention Plan is used as the spouse/partner abuse control plan.
5. If a treatment provider will be assisting with the Prevention Plan, it may be necessary for the SSW to contact the treatment provider to assist the adult in explaining the Prevention Plan and its critical role in prevention or reoccurrence of the high-risk situation.
6. The SSW enters the Prevention Plan as the case plan.

SOP 4E.3 describes the process for the ADULT PERSONAL DEVELOPMENT PLAN:

An adult may elect for safety reasons to work on individual issues separate from the family or care network, and it is within their rights to request that portion of the case remain confidential. The SSW and the adult may address the adult's ongoing personal development issues by developing a separate DPP-293, Adult Personal Development Plan within the case plan for the adult's individual level objectives (ILO). The adult may request that the DCBS-293, Adult Personal Development Plan, not be documented in the case plan, but remain a verbal agreement for the ILO.

1. If the Adult Personal Development Plan is written as their confidential portion of the case plan the SSW documents only those ILOs agreed to by the adult.
2. The plan cannot be shared outside of the Department with anyone other than the person for whom it has been developed without that adult's signed release.
3. If an adult agrees to the development of the plan, and agrees to it being a part of the case record, the SSW places a copy of the written plan in the case record. The DCBS-293, Adult Personal Development Plan, is not entered into TWIST.

SOP 4E.4 addresses the INDIVIDUALIZED ADULT SAFETY PLANNING UTILIZING THE PREVENTION PLAN

1. The Cabinet for Health and Family Services is mandated to offer services to protect adults from abuse, neglect, and exploitation. The SSW may use the Prevention Plan to address immediate safety concerns and provide the initial assistance and direction for such protection and prevention strategies to guard against additional abuse, neglect, and exploitation. The plan may be developed with the adult whenever there are safety risks identified such as:
   (a) To assist in transition from the assessment/investigation until an ongoing case plan is developed;

(b) When abuse, neglect or exploitation is currently occurring as identified by the Adult CQA, and the adult elects to remain in the household; or,

(c) When ongoing services are planned.

2. As with all voluntary adult services case planning, the contents of the plan are agreed to by the adult and need to be as specific, detailed and practical to address safety concerns and reviewed and revised as necessary. At the client's discretion, the plan may be written, verbal or refused.

Transportation

1) **Provide transportation for those parents who lack reliable transportation related to carrying out their plan (for example, to get to meetings, classes, visitation). In those areas where there is reliable access to public transportation, provide vouchers for transportation.**

Rationale:

Some counties have limited access to public transportation (bus or taxi). In counties where there is access to reliable public transportation, some clients cannot afford the transportation. Transportation is provided for foster parents to get to meetings but not to biological parents.

Central Office Response –

The current budget has presented many challenges for the DCBS and the entire Cabinet. At this time, budget limitations will not support the Department's ability to provide transportation for clients

2) **Give foster parents who have children of racial heritage who have different hair- and skincare needs from the caregiver some additional training and resources to help them take better care of the physical grooming and hygiene needs of these children. Provide a voucher for a visit to a hair- and skincare expert at least every six weeks. This expert will report back to the Cabinet that the foster parents are taking appropriate measures.**

Rationale: children with ethnically specific hair- and skincare needs (we are referencing predominately African American and biracial children, but there may be other ethnicities with similar needs) which are unmet or unrecognized by caregivers from different ethnical backgrounds.

Central Office Response-

The training for Foster Parents who have children of different racial heritage already exists in SOP/REG. This includes grooming necessities as well as religious differences. All try to be respected. A worker during a monthly visit monitors this aspect.

Resource Home's receive reimbursements for a variety of expenses related to the care of a child in the custody of the Cabinet. The standard reimbursement per diem is structured to include personal hygiene needs, including hair and skin care. Requests for extraordinary or special expenses must be submitted for agency approval prior to the expenditure. There are specific requirements for the amount of funds children in foster care receive for allowance, clothing, sports, etc. The chart below details the expenditures.

Child's Age	*Clothing*	*Incidentals*	*Allowance*
0-2	$25.00	$6.00	N/A
3-4	$30.00	$5.00	$1.00
5-11	$35.00	$5.00	$7.50
12+	$40.00	$10.00	$20.00

When a child comes into care and is placed in foster care, they receive an initial clothing allowance. A child can also receive a supplemental school clothing allowance if necessary.

Child's Age	*Amount*
Birth to 1 year of age	$100.00
1 to 2 years of age	$120.00
3 to 4 years of age	$130.00
5 to 11 years of age	$180.00
12 years of age and older	$290.00

The FSOS approves an annual supplemental school clothing allowance to a child age three (3) or above, who has been in care more than thirty (30) days, has used the

amount allotted for clothing allowance, is enrolled in school, and is placed in a DCBS Resource Home. The supplemental school clothing allowance for children:

(a) Ages 3-10 is $50; and

(b) Age 11 and above is $100.

The FSOS may authorize special purchases above and beyond the per diem and initial clothing allowance, up to $250.

Children in foster care have $650 for graduation expenses, including senior class ring, cap and gown rental, senior pictures, yearbook, prom ticket, graduation invitations and name cards. The $100 school clothing allowance, if unspent, may be applied to the graduation reimbursement, bringing the total graduation allowance to $750. A Resource Home parent will be reimbursed $60 for Christmas gifts for a child. and $25 for birthday gifts for a child. Receipts are not required.

Lifebooks are reimbursed up to a total of $70 for the initial six (6) month placement period per child and start-up costs. Thereafter, an additional $25 per child every six months may be reimbursed for maintenance of the lifebook. The lifebook follows the child through their placement history. Receipts are required prior to reimbursement being made in this SOP.

3) **A child's plan must provide relevant cultural competence training specific to the child's ethnic background and family culture.** For example (from a case reviewed): a private foster care provided as culture diversity content a discussion of holidays limited to Christmas, Easter and Cinco de Mayo to an African American child, and the caseworker signed off on this.

Central Office Response- Out-of-Home Care

The Department concurs that cultural competency should not be limited to the topics of Holidays and family celebrations. The case plan should be utilized to ensure specific tasks and actions are taken to meet a child and family's unique cultural needs.

1. Cultural competency is incorporated in pre-service training for all foster parents as required under 922 KAR 1:350, 922 KAR 1:310 and SOP 3A.4 Pre Service Family Preparation Training. Segments of pre-service training focus on preserving a child's religious practices and beliefs. Foster parents are required to:
2. Provide opportunities for development consistent with the child or child's families religious, ethnic, and cultural heritage, the Resource Home parent is to:

(a) Recognize, encourage and support the religious beliefs, ethnic heritage and language of a child and the child's family;

(b) Arrange transportation (whenever possible) to religious services or ethnic events for a child whose beliefs and practices are different from their own.

Workers assist foster parents in finding specific trainings to address the cultural needs of children placed in their homes. Additionally, all DCBS workers are required to complete cultural competence training. Workers are trained to assess the culture of each family.

SOP 7C.3 –Maintaining Cultural Connections provides guidelines for maintaining family connections and culture. The Cabinet is sensitive to need to preserve the natural heritage of the child.

1. The SSW assesses culture, which consists of all the ideas, objects, and ways of doing things in terms of describing the family's entire way of life, defined or observed by the family members and community partners.
2. The SSW uses positive aspects of the family's culture to motivate behavior changes.
3. The SSW assesses the needs of children, biological families and caregivers for cultural issues that will need to be addressed to maintain connections to a child's culture including identified fathers as outlined in SOP 7E.1.1(B).

4. At the time of removal the SSW inquires of both parents whether or not either is of Native American heritage or a member of an Indian tribe.
5. Upon finding a child is a member of an Indian tribe or eligible for membership in an Indian tribe the SSW consults with the Family Services Office Supervisor (FSOS) or designee on case planning and adheres to the Indian Child Welfare Act (ICWA) (Link to http://www.cdhs.state.co.us/cyf/Child_Welfare/icwa/icwa_Home.htm), which regulates placement proceedings involving Indian children to include:
   (a) The family's rights to protection under the ICWA;
   (b) The family's rights apply to any:
      (1) Child protective case;
      (2) Adoption;
      (3) Guardianships;
      (4) Termination of parental rights action;
      (5) Runaway or truancy matter; or
      (6) Voluntary placement of children;
   (c) Placement cases involving Indian children be heard in tribal courts, if possible;
   (d) Permitting a child's tribe to be involved in state court proceedings;
   (e) Requiring testimony from expert witnesses who are familiar with Indian culture before a child can be removed from the home (except during an emergency situation or approval by the FSOS); and
   (f) If a child is removed, either for foster care or adoption, be placed with:
      (1) Extended family members;
      (2) Other tribal members; or
      (3) Other Indian families.
6. The SSW consults with the FSOS or designee on any concerns relating to the Multiethnic Placement Act and Interethnic Adoption Provisions (MEPA-IEP),(Link to http://www.acf.hhs.gov/programs/cb/publications/mepa94/) in case planning and placement considerations for the purpose of:
   (a) Removing barriers to permanency for children in the child protective system;
   (b) Ensuring that adoption or foster placements are not delayed or denied based on race; color or national origin; and

(c) Not assuming that needs based on race, color or national origin can only be met by a racially or ethnically matched parent.

7. The FSOS researches the procedures with a Central Office specialist when questions arise concerning ICWA or MEPA-IEP.

Child Custody and Placement Issues

4. **There is a concern regarding what happens to a child when placement with an appropriate relative – which occurs without court intervention – extends beyond a reasonable term (such as 90 days or more). The Cabinet is appropriate in making these temporary placement decisions. However, in situations where relative placement extends beyond a reasonable term, and the parent(s) are not working the treatment plan or not progressing well enough to have the child returned, then the recommendation is for Court intervention to be sought.**

Rationale:

Not only does the Court have the power to keep the child with the relative, but involvement with the Court would give the relative a legal custody document, as well as providing to the Cabinet the support of the Court to better motivate parents to comply with the treatment plan. It will also give the relative the power to seek permanent relative placement if reunification is not achieved, and give the child the permanency desired by AFSA. Finally, judicial supervision over the placement of the child with the relative would add a level of protection for the Cabinet should something happen to the child while in the relative's care.

Central Office Response-

The SSW can request by agreement with the parent that the child stay with a friend or a relative until the child's safety can be established. This should be a short term situation and should not include long term arrangements. If the relative placement does not provide the child safety and protection, and assessment indicates the child needs to be removed from the home, the court must be involved.

5) **Change present foster care system to give DCBS more control over private foster care.**

Rationale:

Private foster care company would screen applicants and then submit names to DCBS to more screening, which must include a personal interview by DCBS personnel before family is approved to accept children. Further, DCBS would provide all foster parent training. This would avoid much of the inconsistency of quality of care present in private foster care. Please also see Recommendation #15 below regarding the need for additional funding.

Central Office Response-

DCBS and all private child-caring/child-placing agencies met on October 1 to begin discussions regarding the future of out-of-home care. As an outgrowth of that meeting, .focus groups will be held on the issues of: services to intact families and/or Kinship Care providers; treatment foster care; recruitment and training of foster parents; placement stability; treatment work with families of children in care; and specialty programs. Areas of concern specific to foster care include training components as well as the overall approval process.

6) **Recommend private childcare homes and facilities adhere to specific child to-caregiver ratios (recommend NAEYC standards of child care ratios as recommended practice), particularly regarding care of special needs or medically at-risk children.** Also, include in any caregiver to child ratio the foster parent's own biological or adopted children, regardless of their age if under 18.

Central Office Response – Out-of-Home Care Branch

Child to caregiver ratios for Private Child Care Agencies have already been established in 922 KAR 1:310, Standards for Child Placing Agencies. The caregiver's own children are

included in the ratios. Foster parents who provide care for medically fragile and therapeutic children have a lower ratio and are required to attend additional training and provide additional services to meet the child's specific needs. The Office of the Inspector General (OIG) provides oversight to PCP agencies. OIG monitors the agency's contract and if the agency is in violation they could lose their contract if the identified deficiencies are not corrected. Below is specific language from 1:310 if you would like to include.

(2) A therapeutic foster care home shall receive a minimum of twenty-four (24) hours of annual training.

(3) A child-placing agency that provides therapeutic foster care shall maintain an ongoing therapeutic foster care preparation and training program that:

(a) Provides a minimum of twenty-four (24) hours of annual training; and

(b) Maintains a record of preparation and training completed.

Section 8. Additional Requirements for Therapeutic Foster Care. (1) A therapeutic foster care home shall accommodate the needs of a child who is unable to live with the child's own family and who:

(a) May benefit from care in a family setting; and

(b)1. Has clinical or behavioral needs that exceed supports available in a foster home; or

2. Is transitioning from group care as part of the process of returning to family and community.

(2) The number of children residing in a therapeutic foster care home that does not care for a child in the custody of the cabinet, shall be limited to a total of six (6) children, including no more than two (2) therapeutic foster care children.

(3) Justification for an exception to subsection (2) of this section shall be:

(a) Documented in the therapeutic foster care parent's file; and

(b) Authorized by the treatment director.

(4) The number of children residing in a therapeutic foster care home that cares for a child in the custody of the cabinet, shall be limited to a total of four (4) children, including no more than two (2) therapeutic foster care children.

(5) The child-placing agency shall request an exception to subsection (4) of this section in accordance with 922 KAR 1:350, Section 2(2).

(6) A treatment director shall supervise a treatment team and shall participate in the development of the ITP and the quarterly case consultation.

(7) A child-placing agency shall provide or contract, as specified in KRS 199.640(5)(a)(2), for therapeutic services individualized for the child, as needed, at least two (2) times per month.

(8) A therapeutic foster care parent shall be responsible for:

(a) Participation in the development of an assessment, ITP, and supervision plan as specified in Section 6(7) of this administrative regulation;

(b) Facilitation of in-home services provided by a social services worker at least two (2) times per month;

(c) Adequate supervision of the child and implementation of components of the ITP, including daily log documentation as specified in the ITP;

(d) Working with the child-placing agency to promote stability and avoid disruption for the child;

(e) Working with the child-placing agency in the development of a plan for the smooth transition of the child to a new placement, in the event of a disruption; and

(f) Providing independent living services for a child twelve (12) years of age or older consistent with a child's ITP.

(9) Except for a child who is the legal responsibility or in the custody of the cabinet or the Department of Juvenile Justice, the child-placing agency shall be responsible for:

(a) A preplacement conference, in a nonemergency placement, for the purpose of:

1. Developing permanency goals and a discharge plan for the child, including independent living services;

2. Developing a plan for the implementation of services;

3. Identifying the treatment goals; and

4. Developing a behavior management plan if applicable; and

(b) Inviting and encouraging attendance to the preplacement conference by:

1. The prospective therapeutic foster care home;

2. A respite care provider approved in accordance with section 13(4) of this administrative regulation;

3. The child, if appropriate; and

4. The child's family.

(10) The social services worker shall:

(a) Have a first face-to-face visit with a child and therapeutic foster care parent on the day of the child's placement;

(b) Have another face-to-face visit with the therapeutic foster care parent or child within ten (10) calendar days of the child's placement;

(c) Telephone or visit, on a weekly basis, at least one (1) of the therapeutic foster care parents of each child on the therapeutic foster care worker's caseload;

(d) Visit a therapeutic foster care parent a minimum of two (2) times a month with at least one (1) visit being in the foster home;

(e) Visit the foster child face-to-face a minimum of two (2) times a month with at least one (1) visit in the therapeutic foster care home and one (1) visit outside the foster home;

(f) Carry a caseload of not more than twelve (12) therapeutic foster care children, taking into account:

1. Required responsibilities other than the case management of a child in foster care;

2. Additional support, contact, and preparation needed by a therapeutic foster care home, due to the extent of the needs of the child served; and

3. The intensity of services provided to the child and the child's family;

(g) Conduct a quarterly case consultation, including the:

1. Foster home;

2. Child's public agency worker;

3. Child-placing agency treatment director and social services worker; and

4. Child and the child's family of origin, to the extent possible;

(h) Provide or contract for therapeutic services individualized for a child at least two (2) times each month based on the child's needs assessed in the child's ITP;

(i) Identify the support needed by the foster family, including a:

1. Plan for respite care as provided in section 13 of this administrative regulation;

2. Plan for twenty-four (24) hour on-call crisis intervention; and

3. Foster home support group;

(j) Recommend and prepare an aftercare plan for a child, prior to discharge from therapeutic foster care, to ensure a successful transition; and

(k) Document a quarterly case consultation and revision to a child's ITP as determined by the case consultations.

(11) The child-placing agency shall:

(a) Meet requirements specified in Section 6(1) through (3) and (7) through (11) of this administrative regulation; and

(b) Annually reevaluate a therapeutic foster care home in accordance with Section 15 of this administrative regulation.

Section 9. Medically-fragile Child. (1) A medically-fragile child shall be:

(a) A child in the custody of the cabinet; and

(b) Determined by the cabinet to meet the medically-fragile requirements of 922 KAR 1:350.

(2) The decision to accept a medically-fragile child shall be optional to a child-placing agency.

(3) If a child placed with a child-placing agency in a non-medically-fragile foster home becomes medically-fragile in accordance with subsection (1) of this section, the commissioner or designee and child-placing agency shall reevaluate the placement and ensure the child's needs can be met. Please refer to the regulation for additional information.

7) **Look at level of care to be provided by foster homes and see if foster home is truly providing a higher level of care.** One way to do this would be to compare services provided by most basic level foster home to see if there has actually been a change in service provided when the child's placement has changed. Also, recommend better and much more extensive training for those foster parents providing higher levels of care, both on physical and mental health issues – with DCBS either providing training or directly approving third-party trainer(s).

Central Office Response – Out-of-Home Care Branch

OIG (Office of Inspector General) monitors Private Child Placing Agencies to ensure they are meeting the terms of their contracts based on the regulatory requirements. Children placed in therapeutic, care plus or medically fragile foster homes receive more services (mental health counseling, physical therapy, occupational, medical equipment, etc.). They are more closely monitored by the Cabinet and require two (2) monthly face-to-face visits by the caseworker. The child's case plan and CQA should provide detailed information regarding specific services.

Recruitment and Certification staff also monitors these homes to ensure they are meeting their training requirements. Care Plus, Medically Fragile and High Risk foster homes are required to complete 24 hours of Cabinet Sponsored specialized training beyond the pre-service training requirement. The curriculums are based on national models and tested methods, which include components to address physical and mental health care needs. Additionally, DCBS specialized homes are required to complete 24 hours of Cabinet sponsored training annually. The Cabinet works with the training consortium and develops training to address the unique needs of the children and families. Trainers are utilized through the university training consortium and through select DCBS foster parents and R&C staff who have successfully completed the training of trainers.

Private Child caring foster parents who wish to become care providers for medically fragile children must attend the same cabinet sponsored training as DCBS foster parents.

8) **African American and Caucasian children are at risk differently from the system. Some form of anti-racism training should be mandated for all foster parents.**

Rationale:

Workshops should be offered in the school systems (including FRYSC's) about criteria for reports and referrals – focusing on offering more services to minority families that come to the attention of FRYSC's and on more speedy referrals for

DCBS for Caucasian families. Further, we recommend that the Kentucky Dept. of Education add these training topics to their mandatory staff in-service requirements, along with the commitment to seek out qualified Cabinet staff or designees to deliver the training(s). Please also see Recommendation #15 below regarding the need for additional funding.

Central Office Response -

DCBS currently offers trainings related to investigations and placement decisions to FRSYCs throughout Kentucky. Each of these trainings focuses on special population issues and stresses the importance of assessing situations within a culturally sensitive environment. Discussions have occurred with the Department of Education concerning training issues, but DCBS has no ability to force changes to their mandatory staff in-service training requirements.

Recommends that Kinship Care cases be eligible to receive Child Care Assistance (CCA), if necessary, for an indefinite period when children in the custody of the Cabinet are placed in their home. The assistance should NOT be subject to financial qualifications. It is the understanding of the Lakes Citizen Review Panel that Foster Care parents are eligible for this Child Care Assistance without financial restrictions, but that Kinship Care relatives must take permanent custody after a one-year period and will not receive the Child Care Assistance after that. In order to make for an equitable situation, it would appear that both families need to be eligible to receive the same assistance.

Central Office Response -

Per KAR 1:130 - Eligibility for the Kinship Care program shall not establish entitlement to a child care subsidy payment. Eligibility for child care assistance is determined by the child care broker and is based on income. While many agree it would be beneficial for K/C relatives to receive child care assistance and a kinship care subsidy, funds are not available to provide both at this time. The K/C relative receives $300.00 per month/per child. This per diem can be utilized for day care expenses.

By design, the K/C program was not intended to be comparable to the foster care program. This enabled less stringent eligibility requirements for relatives; thus providing more children the opportunity to be placed in the home of a family member, rather than foster care.

Community and Partner Education Issues, Especially Regarding Racial Disproportionality

9) **Need better enforcement of DCBS guidelines concerning neglect and abuse for Caucasian children.** This needs to begin with training in the school systems to FRYSC and other school personnel (including teachers, nurses, support staff, transportation staff, etc.) about what must be reported, by law. Investigations should not allow families with custody of

children to claim if the custodial member[s] of the family is [are] not meeting the needs but another relative that lives close by is to have an unsubstantiated case but should open and follow-up on the case. Certainly anti-racism training is critical but a part of this training must involve teaching community members to see Caucasian children's issues through the same lens as community members see those of African American children. (It is assumed that African American families and children have issues, while issues with white families and their children are ignored much to the detriment of Caucasian children). Further, we recommend that the Kentucky Dept. of Education add these training topics to their mandatory staff in-service requirements, along with the commitment to seek out qualified Cabinet staff or designees to deliver the training(s).

Central Office Response – Jim Grace, Assistance Director P & P -

Mr. Grace has been involved with the Family Resource Youth Services Centers for many years. He responded to the recommendation by stating: "Live training is currently provided each year to new FRYSC Coordinators by DCBS staff. This training includes specific information about acceptance criteria and investigative requirements and placement considerations. Additionally, the training curriculum has been provided to FRYSC management to distribute to individual school systems throughout Kentucky."

"While DCBS sees the importance of addressing racial disporportionality, all investigations and placement decisions are made based on safety/risk assessments of individual families and children."

Training regarding Mandatory Reporting will be developed and made available on disk for each local DCBS office to use when asked to present on the issue. The goal is to provide consistent information. Local newspapers will be asked to run an article on mandatory reporting in order to reach a larger audience. The course will be available on www.train.net under the MECAN (Medical Elements of Child Abuse and Neglect) series. The KY CARE (Child Abuse Recognition Education) program which provides peer-to-peer physician led training, also addresses the issue of appropriate reporting.

Mental Health and Substance Abuse Issues

10) **Recommend more focus toward prevention and education efforts regarding alcohol and marijuana abuse.**

Rationale:

Most case files in the two offices in which cases were reviewed involved substance abuse by of alcohol and marijuana. Perhaps require drug checks for parents with convictions related to alcohol and marijuana. Steps should be taken to insure a referral to Drug Court in every area where is available. If Drug Court is not available, mandate diversion to local drug programs until Drug Court is available. Certainly not ignore methamphetamines, but be equally vigilant about other drugs of abuse including alcohol, marijuana and prescription drugs.

Central Office Response –

Use of substances is increasingly seen in families involved with DCBS. The following statistics were provided by the Information and Qualitiy Improvement unit within DCBS. There are often barriers in accessing services for the parents who are using substances. One of the most prevalent factors is lack in therapeutic services, especially inpatient treatment.

Reports made between July 1, 2007 and June 30, 2008

	#	%
Reports Investigated or FINSA	49,471	
Reports Investigated or FINSA with Substance Abuse	14,099	28.5
Neglect	10,281	72.9
Abuse	2,811	19.9
Substantiated Reports	9,843	
Substantiated Reports with Substance Abuse	5,670	57.6
Neglect	4,644	81.9
Abuse	1,026	18.1
Services Needed Reports	1,885	
Services Needed Reports with Substance Abuse	760	40.3
Neglect	338	44.5
Abuse	30	4.0
Reports with a Case Opened	10,111	
Reports with a Case Opened and Substance Abuse	5,744	56.8
Neglect	4,334	75.5
Abuse	756	13.2

Children who have entered OOHC since 2005

	% of Children with	" " for Children	" " for Children

	Condition Present at Removal from Home	under 12 at 1st entry	12 and older at 1st entry
Drug Abuse by Parent	18.1%	23.6%	8.1%
Alcohol Abuse by Parent	4.6%	5.3%	3.3%
Drug Abuse by Child	2.7%	0.3%	7.1%
Alcohol Abuse by Child	0.8%	0.1%	2.1%

DCBS will train staff in the importance of assessing for and recognizing substance abuse. At present, staff are being trained on drug testing for newborns. The course is titled "Newborn Drug Testing - Implications for DCBS". This training was developed and is trained through collaboration between the Medical Examiner's Toxicology Laboratory, the Child Fatality Program Nurse, and the Child Safety Branch. The course is three (3) hours in length and is presented in two (2) parts.

The 1st 1 1/2 hours is presented by Michael K. Ward from the Medical Examiner's Laboratory. Mr. Ward's training is titled "Toxicological Elements of Prenatal, Perinatal, and Neonatal Drug Testing. His training objectives are : 1) when to pursue drug testing for your client; 2) Types of testing utilized in Drug Screens; 3) Specimens that can be tested; 4) Drugs that impact the safety of the baby (and mom) and how they do so; and 5) how to document your facts.

The 2nd 1 1/2 hours is presented by Debbie Acker, RN - nurse from the Child Fatality program and Steve Hartwig from the Child Safety Branch. The objectives of this part of the training are: 1) Distinguish the differences in drug testing in the urine and the meconium; 2) identify potential collateral contacts; 3) list types of written supporting documentation needed; and 4) Contrast the investigation of an infant still in the hospital and an infant who has already been discharged.

This training was piloted in Eastern Mountain and Southern Bluegrass regions and has been approved to go statewide. Evaluations thus far have been positive.

11) **Better state funding for Community Mental Health Centers so that these are less dependent on available grant money to provide staffing and services.**

Rationale:

More strict administration and accountability that all funds (State funds, grant dollars, etc.) are used to meet the documented needs of the community served should be required. Rationale: There are long waiting periods for services for mental health issues and an insufficient staff resulting in expensive referrals to private providers where these exist. Much of the service provided quickly is related to whatever funding was captured for the "trendy drug or topic" of the moment.

Central Office Response –

Community Mental Health Centers are an integral piece of the service network for families. Many of the families receiving services from the DCBS do not have private insurance and have limited options for therapeutic services. The Community Mental Health Centers are heavily accessed and the DCBS concurs with the recommendation that additional funding would be beneficial. Panel members are encouraged to express their concerns to their legislators and to participate in advocacy efforts to achieve stable and increased funding.

12) **Have content of groups and counseling through group homes submitted to and overseen by DCBS so that Cabinet personnel are aware of what children are really receiving.** By this is meant the same kind of records that providers must give to insurance companies in order to be paid. These records would indicate the level of client change in compliance with the plan from one level to the next.

Rationale:

From reading cases and reports from service providers it is difficult to see what services are actually being provided.

Central Office Response-

The OIG, Division of Regulated Child Care (DRCC) ensure that licensed private child caring and child placing providers (PCC) are adhering to regulatory requirements, which include, based on the needs of the child, therapeutic services. These services should be documented in the child's Individual Treatment Plan (ITP) that is developed and maintained by the PCC. DCBS meets regularly with DRCC and is advised when there are systemic concerns with a provider. DCBS also contracts with the Children's Review Program (CRP) who reviews information submitted by providers in order to determine an appropriate level of care (which determines payment). CRP also advises DCBS when it appears a child is not receiving the therapeutic services the child needs. The PCC provides the child's DCBS SSW with a monthly progress report which summarizes the progress (or lack thereof) that the child has made during the last month. This is another opportunity of oversight to ensure the child is receiving appropriate therapeutic services. Finally, DCBS requires PCCs to be accredited, which also imposes the accrediting body's requirements for treatment protocols and plans.

Additional Support for DCBS

13) **Recommend that DCBS be allowed to hire more paraprofessional social service aides to supplement, not supplant, existing professional Cabinet staff positions.** Families would be more likely to accept services initiated through the use of social service aides who also could help with parenting and homemaker support. This would give a way to monitor a family that is borderline. Rationale:

Some cases are difficult to substantiate but referrals to DCBS seem ongoing. This would be a way to monitor these cases and keep them from escalating. This

would allow degreed caseworkers to focus on the more serious cases.

Central Office Response –

Social Service Aides have greatly contributed to and supported the work of the SSW. They have also played an integral role with service provision to families served by DCBS. Recently, DCBS was able to post a limited, number of SSA positions. Decisions about work stations for these positions are determined by the SRA based on staffing

needs within the service region. Community partners are currently utilized for parenting and homemaker support.

JEFFERSON CITIZEN REVIEW PANEL

1) **The Cabinet should consider the implementation of a program whereby those attending training are reimbursed in advance of incurring expenses or upon completing that week's training. The Cabinet should take all necessary steps to enact a reasonable reimbursement policy and provide for immediate reimbursement on these limited issues which occur before a worker will have even received a pay check from the Cabinet.**

Central Office Response – Training Branch

Cost and timely reimbursement is definitely an issue. Most participant lodging rooms have refrigerators and microwaves which allow those who want to cut cost to do so. Training has brainstormed possible solutions with some groups. Suggestions have included refrigerators, participants bringing food to share, Pro-Cards for Academy students, cash up front, etc. Rooms at state parks can be directly billed to the cabinet.

The Academy rotates around 3 cities-Louisville, Richmond and Bowling Green. Exceptions have been made to reduce cost and make it more convenient (i.e, Jefferson had 75% of the participants so Academy was moved from Bowling Green to Louisville). Academy begins at noon on the first day and ends at noon on Friday to reduce the number of meals attendees must purchase and to prevent overtime travel. Throughout the years, the number of classroom training days has been reduced, however the skills, knowledge, and policies and procedures required to perform the job are ever increasing. On average at least 7 regions have new staff hired monthly so finding a most common place to conduct the training is virtually impossible, if a new group begins each month.

Central Office Response – Division of Administration and Financial Management – Renee Close, Director

Ms. Close provided the following response, "Most of the department's funding sources require payment AFTER a service/expense has occurred. This makes the recommendation very tenuous to the limited funding capacity we currently have."

"The two employee credit unions offer a service that few seem to know about. Employees may request assistance financially due to the price of fuel. At the CCU staff can still get a travel loan and at the CCU and KECU staff can request an unsecured credit loan and can add amounts to the line of credit in the amount of the anticipated travel voucher. It can be payroll deducted and then paid off when the travel check is received. This is one way to help with cost of travel."

She cited the following website resources for staff. The Training Branch will be asked to provide this information to employees in the Academy and New Employee Orientation training.

http://www.ccuky.org/prodserv/loans/persnl_ln.html
https://www.ccuky.org/prodserv/loans/travel_ln.html
http://www.kecu.org/personal.htm

2) **The Cabinet should review all course materials and eliminate those elements of the course work that would qualify the course for college credit, at a minimum for those individuals completing the training that have already received their degrees and do not require further college credits.**
The Cabinet should ensure that any academic requirements necessary for graduate credit are not unduly impacting the workers ability to perform training when in the office.

Central Office Response – Training Branch

In the beginning of the university partnership it may have been true that the content was more academic. However, universities have done a very good job of hiring instructors with DCBS experience who understand the job. The university partnership and Training Branch philosophy sets the foundation for this training to be competency-based. The Academy includes some theory to help staff understand why a method is "best

practice" or aligns with values, ethics and Standard of Practice. Also, it is impossible to teach a new worker about every conceivable situation they may encounter. Therefore, it is necessary that they have a conceptual foundation from which they can critically assess the complex problems they will encounter in their daily work. The lesson plans are written according to Adult Learning Theory which includes an Anticipatory Set, Instructional Input, Checking for Understanding, Guided Practice and Independent Practice components. Basically, what this means is we discuss **why** they need to learn a component, they **learn** the competency, we **check** to see if they know what they learned, they **practice** with a group or with guidance to insure they do something correctly and then individually **perform** the task. Sometimes all this happens inside the classroom. Sometimes it's at their office but it's usually a combination of the two.

3) **If homework is to be assigned by the Academy to be completed during the "100 days in the office" then this homework cannot conflict with the daily training experience that a worker can earn by shadowing other workers and assisting on cases. Either the academy should limit the homework assigned, or find a better method by which the workers attending the Academy can incorporate their shadowing of workers with assignments (i.e. – Required to turn in a Family Assessment on a specific week, new worker would shadow a worker and complete, with supervision, the Family Assessment forms in TWIST.**

Central Office Response – Training Branch

Training Title	Location	Time
NEO	In Region	3 Days
Foundations	Academy-Course 1	5 Days
TWIST Part 1	"(2 Locations)	2 Days
Medical	"(2 Locations)	1 Day
Assessment	"	5 Days

Case Planning	"	5 Days
TWIST Part 2	"(2 Locations)	3 Days
Meeting the Needs of DV	Academy-Course 2	4 Days
Meeting the Needs of Vul. Adults	"	4 Days
Assessment and Case Management of CSA	Academy-Course 3	2 Weeks BB/5 Days
TOTAL		37 Days Training
	4 Days x 5 Weeks x 5 Months	100 Days in Office

To balance official learning and field learning is a challenge in every part of the work force today. When you need an employee, you need that person NOW not later. However, we also know—in this job—lives are at stake if someone makes a mistake. Therefore, training before they begin the job is a MUST. The above chart shows the actual days of travel and classroom time ("official training") taken from the 5 months it takes a new staff member to complete the entire Academy. As you can see, there are 100 days in the office; time for shadowing of fellow workers and getting to know the families that will become their new cases. We encourage this type of learning and provide workers and supervisors with exercises they can use in the office to reinforce and expand upon classroom learning.

In the past and sometimes currently, participants were given various numbers of cases the first day in the office. Participants were spending most of their training time standing in the halls on the phone to deal with their cases or missing training all together to attend court, transfer a child to a new placement, etc. Some staff were quitting within the first month because they were too overwhelmed. Upper management made a decision that no cases were to be given to new staff until they had at least completed Course 1. This was also critical from a liability stand point.

We agree that the bulk of tangible learning takes place in the field during a "transition of learning" phase. This is when what they have learned in "class" is applied directly to the field. We attempt to aid this "Transition of Learning" in various ways. First, we have

prepared Learning Reinforcement Tools for each Academy course. These tools were developed to be used by the supervisor to challenge workers and connect classroom and field experiences. A big problem we currently have is supervisors are so busy, many find it hard to find time to use these tools or to mentor their workers when they are in the office. When staff are as overwhelmed as our supervisors, it is difficult to handle all the day-to-day tasks of a supervisor, not to mention training a new staff.

Second, after teaching a skill or knowledge component in the classroom, staff is asked to apply that skill or knowledge to a case scenario, something they've seen in the field or a case they know they will receive. This is part of adult learning. For example, after going through the 10 Family Solution Skills, workers are split into two groups. The instructor and trainer each take a group of students to opposite sides of the classroom. The instructor/trainer becomes a parent in the given scenario. Participants play the role of worker and must demonstrate at least one of these skills. They may use more than one skill but must use the one given specifically to them. Other participants try to recognize the skill being performed as well as perform their specific skill.

The 100 days of work in which workers are not in "formal training" varies based on supervisors and regions. Participants report a whole spectrum of activities. Some will say they sit in their offices because there's nothing to do. Others supervise visits and transport clients to appointments. Others have reported that they were actually sent to school or day care to remove children. Balance is again a critical piece here. A variety of activities that build on classroom learning and prepare staff for future case work is important. Currently, what seems to work best for new staff is when supervisors split a case load among several workers but give the list of cases to the new staff. The new staff can then shadow several workers to get to know the families and various styles of case work before feeling responsible for the activities of their case.

At least 90% of case scenarios were taken from personal experiences in this field so at one time; they were "real" cases. Originally, we used a case scenario for the CQA that is turned in for a grade. We now ask participants to choose one of the cases that will be

assigned to them and will need a new CQA in the near future. This allows participants to begin the CQA and allows the Academy instructors/trainers to clearly see areas where participants may be having difficulty.

4) **The Cabinet should strive to adopt a "Hire Before the Need" mindset wherein the Cabinet is always hiring or training individuals to fill the job openings that come on a regular basis. T**he Panel understands the importance of training workers BEFORE they begin working in earnest with families, it is solely within the Cabinet's discretion and ability to correct the situation by either stream-lining the training process or "Proactively" and "Prospectively" hiring people to replace turnover so that they might be able to begin work at a quicker rate. Addressing the overworked supervisors by providing a steady-stream of workers, trained and ready to work will allow the supervisors to act in more of a mentoring role which everyone agrees is the
ideal situation and most likely to foster the team spirit which must exist in each
individual work group.

Central Office Response –

The Public Child Welfare Certification Program was designed to infuse additional bachelor's level Social Work graduates familiar with the Department's philosophy and work into the pool of applicants for available positions. This past spring, when hiring was very slow, PCWCP graduates from last December who were still seeking employment were offered the opportunity to attend DCBS required training so when they were hired they would have already met some of the training requirements. Personnel rules do allow for an overlap of positions, on a case by case basis, but the specific position has to be identified. Ultimately, DCBS hires based on the funding available to support positions. The Department is committed to proper training for each staff member along with coaching and mentoring in the local offices throughout the training period.

5) Probation is too quick. By the time the worker gets through the academy, there is very little time for the supervisor to determine how a worker is going to do with the job. Since

the worker cannot take any cases, the supervisor's hands are tied until the worker has finished the academy, which can take up to 4 months. Probation is 6 months.

The Cabinet must simply change this requirement for individuals who are hired within the Cabinet and who must complete the Academy as a condition of their employment. Probation should extend a total of 6 months from the COMPLETION of the Academy training.

Central Office Response –

The hiring and personnel requirements regarding probation are determined by the policies and procedures mandated by the State Personnel Cabinet. The opportunities to amend these policies and procedures are limited; however, when those occasions do arise, DCBS may certainly provide input for consideration.

6) Workers must sign a release for the training branch to give the supervisors any information about how the worker is doing in the academy. Supervisors must ask the worker to sign the release. Most workers will not sign these releases and thus there is a disconnect between what is happening at the Academy and how the worker is evaluated within his/her own working group.

RECOMMENDATIONS

This is a prime example of bureaucratic malaise hindering the effectiveness of the very program it exalts. **The Cabinet, ACROSS THE BOARD, should require a complete waiver of all confidentiality with reference to grades, performance, and behavior for all training or education provided to employees at the cost of the Cabinet.** If the Cabinet is paying for training, be it at a University or Seminar, as a condition of employment that an employee's performance, grade and behavior during the training are of great significance. All the Cabinet must do is provide and mandate the execution of a waiver upon employment from the employee.

Central Office Response – Training Branch

The Department continues to work toward this end for its employees. Supervisors have the authority to ask an employee to review his/her grades on assignments and/or participation any time. Grades reflect timeliness, attentiveness, cooperation in group activities, respect for others, and overall social work values, attitude and behavior. Supervisors simply ask the employee to sign onto Blackboard, go to the student tools area, click on gradebook, and they can review scores together.

7) **Invest in communications with the supervisors to determine what portion of the training is ineffective or how the Cabinet can better respond to on-going changes in procedure that will produce the most prepared worker upon completion of training.** The Cabinet should consider incorporating a "scorecard" of sorts on which a training worker can track the events that he/she has participated in and upon which the supervisor can comment and acknowledge the training has been completed. This recommendation is not meant to infer trainees should have cases of their own during Academy training but when in the office, they should be involved in specific case from start to finish to begin getting a sense of the system.

Central Office Response – Training Branch

Training Branch staff meet every quarter to review comments from evaluations, survey results and suggestions received through emails or personal contacts. Also, content is based on SOPs, research on best practice, etc. It is certainly recognized there is a disconnect between what the academy offers and what supervisors think workers receive. Within the last 6 months LRPA (Learning Reinforcement and Program Application) training was held in two regions. Every supervisor in Jefferson Region and Salt River Region attended the training and had opportunity for input. This training had several objectives but the biggest one was to have a direct connection with the supervisors to see what worked and what didn't, to give them a walk-through of the Academy courses and again address the Learning Reinforcement Tools. Many supervisors stated they did not have time to use the Learning Reinforcement Tools or go over the CQA with new staff (a part of the student's grade).

8) **The Cabinet should recognize that Jefferson County, like some other urban areas, faces challenges that are unique and should seek to tailor some or all of the training to address the unique issues with working in an Urban environment with greater numbers of cases, children, in some cases a more diverse culture, and with different proceedings in Court than other, rural counties. The Cabinet should consider an additional continuing education requirement for Jefferson County workers to complete which would address Jefferson County Specific items during or immediately following the basic Academy training.**

Central Office Response – Training Branch

We believe that each of our offices throughout the 120 counties of this state provides unique challenges and opportunities for our staff. We have a process
in place where as new staff members complete the training in the Academy, they will then return to their regions where the education and training they have received will be reinforced through the supervision, mentoring, and coaching
that will be provided by their supervisor and team members. It is during this experience on a local level that the uniqueness of the area should be addressed and the new staff exposed to the regional specific education and training.
If the regional management within Jefferson County would like to impose additional requirements they certainly may do that. The regional training coordinator and management staff in Jefferson should be able to identify the content.

9) **Time management training is an absolute necessity. For the Cabinet to neglect to train new recruits in time management when so much of their job, happiness, and success will be tied to managing the needs of so many people is a disservice to both the workers and the families they serve. The Cabinet should add this as a component of training and should consider it a first, very important step to preventing worker burnout, the main cause in the large worker turnover.**

Central Office Response – Training Branch

Time management training is and has been available and recommended within the first six months of hire on the employee's staff development plan. The curriculum is available to the Regional Training Coordinator in Jefferson County and is available upon request.

10) **Team work should be one of the greatest instilled value taught at the Academy in order to foster an environment that will prevent the type of worker burnout which is causing the excessive turnover. Teaching the mindset at the Academy will give the worker's the tools to use to ask for help, and to know that asking for help is both encouraged and preferable to giving less than their best for the welfare of the families they serve.**

Central Office Response – Training Branch

The values and concepts related to the TEAM concept is woven throughout the Academy curriculum. Staff are encouraged to seek advice, approval, and to collaborate with supervisors, central office and team members. Specific office and team protocols will need to be discussed and reinforced locally within the work unit and between the new employee and supervisor.

11) **The Cabinet and the State Government need to work together to maintain the funding at its current level at a bare minimum and fight to increase the funding so that the proper number of workers can be brought into work cases.**

Central Office Response -

DCBS has strong support from Secretary Miller and the CHFS leadership in addressing and responding to workforce issues of DCBS, notwithstanding current constraints.

SOUTHERN BLUEGRASS CITIZEN REVIEW PANEL

Recommendations from Family Team Meeting Group:

1) **Add some sort of "mentoring" aspect to the training of new front line workers coming out of the academy. These mentors should be those who are using best practices, are considered "good" supervisors and those who value the profession (not those who are burnt-out).**

2) **Provide additional training for those workers leading Family Team Meetings.**

3) **Clarify what the SOP says about team meetings so every worker is on the same page about the expectations and purpose of them.**

Southern Bluegrass Regional Response - Grace Akers, Service Region Administrator (SRA)

The SBSR (Southern Bluegrass Service Region) agrees that Family Team Meetings (FTM) are vital to establishing positive working relationships with families, addressing any critical issues that may arise in a case, and to develop case plans that the family can feel ownership towards and invested in. We recognize how positive the FTM format that UK provides for Fayette County has been for the clients in Fayette County and want to assure that this is being offered to families throughout the region. Two of the SRAAs (Service Region Administrator Associates) in the SBSR have developed FTM training over the summer of 2008 which will be provided to all supervisors and frontline staff in the SBSR during the fall of 2008. This training will assure that supervisors and frontline staff are given detailed information on; SOP related to FTMs, how FTMs should be facilitated, who should be involved in the FTM, and how to assure that families are given a voice and are heard during the FTMs. This training will also be offered at a later time as new staff are hired and begin working with families.

The SBSR also feels that new staff needs to be and should be mentored and trained by their FSOS and experienced team members as they work through the academy and begin working with clients. Although we do not have the resources to establish a mentoring program at this time, the management team will discuss with local office supervisors that new staff that have not been trained in facilitating FTMs should have their supervisor, an experienced team member, or an FTM facilitation service provide, facilitation services for all their FTMS.

Central Office Response –

A Family Team Meeting (FTM) is defined in SOP 7C as an array of conferences such as Case Planning Conference, Five (5) Day Conference, Family Case Plan Meeting, Family Unity Meeting, Family Group Decision Making, Case Reviews and Periodic Reviews. Through the Family Team Meeting, members implement the Comprehensive Family Services (CFS) approach for the provision of services to achieve desired outcomes, pursuant to KRS 194B.010, Cabinet for Families and Children -- Functions.

A Family Team Meeting requires participation of family member(s), SSW (including internal Cabinet partners, if warranted) and community partners. Attendance by community partners that perform a service in attainment of the family's desired objectives as documented in the Case Plan qualify as an FTM. The SSW makes a concerted effort with the family to promote and explain the necessity for community partner involvement in case planning for successful attainment of desired outcomes. The SOP Manual has a Resource Section. Under that heading is a Five-Day Conference tip sheet and Promoting Family Team Meetings.

Central Office is currently reviewing policy to check for adherence to Kentucky Revised Statute (KRS) and Kentucky Administrative Regulation (KAR). The review is also to check for clarity. This process will be ongoing for the next several months.

Recommendations for the Educational Collaborative Task Group:

1) **Once a year provide ongoing training to the education system on recognizing and reporting child abuse.**

Southern Bluegrass Regional Response – Grace Akers, (SRA)

The SBSR agrees that establishing positive working relationships with school personnel is vital. Regional management fully supports the idea of completing training with various employees of the educational system throughout our region. The training will be offered to school personnel in each county. The presenters will be local office staff, a member of the Centralized Intake team, and a CPS Specialist. This training will provide school personnel with a face to face meeting with local staff who they may have to one day work with, training by Centralized Intake staff on the referral acceptance criteria, in addition to how and when to make a referral, and the CPS Specialist can field questions about SOP and explain to staff the various tracks a case can take once being accepted as an investigation.

2) **Once a year there should be an annual county meeting to evaluate progress in communication and collaborative efforts between the school systems and DCBS.**

Southern Bluegrass Regional Response – Grace Akers, (SRA)

The SBSR agrees and recognizes the need to make continual efforts to maintain relationships with local school personnel. Due to this recommendation the regional management team has establish a school liaison in every DCBS office who school personnel can contact with any problems or questions they may have. In addition we will contact the local school boards and request that they also provide a liaison in their school system who DCBS staff can contact regarding any questions or problems. Furthermore, we will send out letters annually, from the local offices to every principal in the county letting them know who the DCBS liaison is in their county, and will offer to schedule a meeting between DCBS staff and school personnel. This letter will also make them aware of the training that the SBSR has developed for school personnel and offer this training to their staff.

3) Work to form a partnership with the Universities Education and Early Childhood Education programs to make sure that teacher preparation includes information on recognizing and reporting child abuse.

Central Office Response –

School personnel are vital to the identification of children thought to have been abused or neglected. Regions vary as to their partnership with the school system. Addressing the issue of child abuse and neglect to those individuals in college in any field of study would be appropriate. It certainly is important for individuals who will have direct contact with children. As previously stated, a Mandated Reporter course is being developed. The DCBS can make the disk available to appropriate entities.

Eastern Mountain Citizen Review Panel

Genesia Kilgore-Bowling, Chair

*Jenny Beth Claxon**
Sandlin
Rita Whicker
Charlotte Logan
Deborah Hensley
Darlene Johnson
Donna VanHoose
Emily Whitt
Laura Kretzer
Deborah Clemons
Anita Cantrell
Mandy Stumbo
Genesia Kilgore-Bowling
Irene Davis
Josie Wright
Katie Fekety
Paul Jean Rosenberg
Deanna Johnson
Donna Creech
Joanna Fugate
Glenda Shrum
Bridget Turner

* *DCBS Liaison*

EASTERN MOUNTAIN REGION

*Panel chose to narrow our focus on recurrence and examine the rate of recurrence among a very vulnerable population – children 0-5 years of age.

The panel also worked in two groups: "Big Sandy Region" and "KY River Region".

Panel Activities

- Reviewed policies and procedures related to the following:
  - *Aftercare Planning*
  - *Family Team Meetings (FTM)*
  - *Determination of Findings of Investigation or FINSA, specifically the portion concerning the finding of "Unable to Locate"*
  - *Case planning*
- Reviewed 26 closed cases from the five counties composing the Eastern Mountain Region to look for trends and barriers
- Conducted focus groups with social service workers
- Conducted survey with community partners

Concern 1 – Unable to Locate Findings

A review of the closed cases revealed several "unable to locate" findings. This is of great concern to the Panel because research shows that the age of the child influences recurrence (i.e. the younger the child, the more likely they are to experience recurrence).

SOP 7B.9.15-17 states that the finding of "Unable to locate" may be used after the Social Service Worker has made reasonable efforts to locate the child and family, documents those efforts in twist, and receives approval from the supervisor. The Panel finds that the phrase "has made reasonable efforts" is vague and very subjective.

Recommendation: The panel recommends the development of a tool/checklist to be used by SSW and Supervisor, to ensure that all creative and appropriate attempts have been exhausted when trying to locate a child before the case is assigned an "unable to locate" finding.

Concern 2 – Aftercare Planning

The panel believes that Aftercare Plans are in immediate need of attention. It is the understanding of this Panel that Family Team Meetings are not required to be utilized at the closing of a case and during negotiations of the Aftercare Plan. This often leads to the Aftercare Plan becoming nothing more than a paper document shared between the family and DCBS. Community partners play a vital and necessary role in the provision of services and the success of the family and should therefore, be included in the closing of a case and aftercare plan.

Furthermore, SOP 7G.5 states "**WHEN** community partners are included in aftercare planning and are assigned specific tasks, the SSW documents on the aftercare plan that community partner(s) will notify the SSW if the family has difficulty complying the with plan". The language of the SOP provides further evidence that the use of community partners is optional. Currently, if the community partners working with the family are not involved in the FTM and aftercare planning, they are excluded from the plan and are not legally able to access such making it impossible for them to monitor compliance with the plan. In order for the plan to be shared, the client must sign a release of information due to HIPPA and confidentiality laws.

In addition, research conducted with community partners revealed a theme centered on the desire for increased communication and involvement with DCBS as a way to strengthen the relationship between the various agencies and as a way to prevent the recurrence of child maltreatment.

Recommendation: The panel recommends DCBS consider revising the Aftercare Planning SOP to **require** the use of FTM's, taking care to include community partners, to ensure the development of a more inclusive and sound Aftercare Plan with a strong emphasis on prevention of recurrence of maltreatment. This increase in communication and involvement will provide, in some sense, a follow-up to the aftercare plan.

The panel also recommends that DCBS explore the feasibility of a step-down of services or a process where the family could be monitored by the courts, community partners or family members in a more formal manner.

Concern 3 – Neglected TWIST Screens

While attempting to review cases, it was noted that prevention and aftercare plans were not easily accessible. In fact, 21 out of the 26 cases reviewed, did not have aftercare plans. It most cases the Social Service Worker would document that a plan had been completed but would not include any specifics regarding the tasks negotiated. The same was found to be true of court screens as they were rarely entered or updated. This practice makes it impossible for individuals to obtain this information without seeking a hard copy, which may take some time.

Recommendation: The panel recommends that DCBS consider revising SOP 7G to require that Social Service Workers enter the Aftercare plan in TWIST during the closing summary. In addition, worker trainings should stress the importance of completing all applicable TWIST screens by emphasizing the importance of information sharing.

Concern 4 – Lack Of Familial Demographic and Support Data

While reviewing cases for trends and barriers related to recurrence, demographic data for families was next to impossible to obtain for many cases. Having an intimate understanding of the family and its members could yield important trends in the issue of recurrence. On a similar note, it was also next to impossible to discern what supports the family had utilized in the past and what was in place before first report of recurrence.

Recommendation: The panel recommends the creation of a checklist with the CQA to obtain demographic data on the family and its members. The same is recommended for support service data. A checklist screen would allow easier access to the support services the family has completed, are currently utilizing, and what they could benefit from. This

would streamline data and result in less work (i.e. less text to enter) for the Social Service Workers.

Concern 5 – Prevention

The Panel's work with Social Service Workers and community partners has revealed a gap in preventive services. The Panel feels strongly that the old adage "An ounce of prevention is worth a pound of cure" is extremely relevant here and could be useful in the prevention of recurrence.

Recommendation: The panel recommends that DCBS re-implement preventative assistance to aid families at risk with basic needs in order to alleviate family stress and hardship, which in turn may prevent child maltreatment and possible removal. In addition, the Panel also recommends that services be expanded to families who are referred but lack evidence for a substantiated finding in order to prevent child maltreatment. Perhaps, the development of a Prevention Team that would have access to services similar to those offered to foster parents (support, money, transportation, parent education, community services) would be of benefit to those families at risk and prevent child maltreatment.

Concern 6: Public Education

The Panel's focus group with Social Service Workers and survey with various community partners revealed a theme centered around the need for the public and court system to be educated about the role and responsibilities of DCBS, as well as the limitations of the department. This lack of knowledge presents a tremendous barrier to effective collaboration between agencies, effective management of cases within the court system, and direct services with clients.

Recommendation: The panel recommends that the CHFS consider developing and implementing a public awareness campaign regarding the role of DCBS in the state and

within communities. For example, partner with community newspapers to run articles on the importance and role of DCBS, write letters to the editors of regional newspapers, conduct Q & A sessions in various communities, conduct yearly community trainings for agencies and court personnel, and schedule TV interviews with local stations such as WYMT's Issues and Answers program. This type of community outreach can not only educate the public about the function, importance, and even limitations of DCBS, but can also help to dispel myths about the agency and even help to change the public's image of Social Service Workers as the enemy, agents of social control, and "baby snatchers".

Concern 7: Worker Training Issues

The Panel's work this year with focus groups, surveys, and case reviews raised red flags for the Panel regarding symptoms of burn-out among the Social Service Workers. This was also documented by community partners who have observed the same during daily interactions with the workers. These indicators include, but are not limited to, the following:

- Decreased professionalism among workers
- Negative attitudes toward community partners
- Negative and cynical attitudes toward clients and families as evidence by victim-blaming (i.e. The family is the reason why there was a failure in this case; not negotiating tasks and plans with the client but using the same over and over again without considering the individual strengths, barriers, family dynamics, and feasibility of such tasks)
- Negative attitudes toward the profession
- Moderate to strong resentment toward families that are resistant to change
- Frustration with the lack of services available in the family
- Frustration with the agencies structure and availability of services
- Low professional self-esteem because of inability to meet client's needs

- Not following through with all requirements (i.e. completing all screens in TWIST, missing deadlines, failure to complete a comprehensive assessment of family strengths and risks, resenting the process, etc)

The Panel recognizes that the causes of burnout are multiple and can be related to the nature of the work, the client, and the individual worker. The Panel also recognizes that, just as there are many causes of burn-out, there are just as many, if not, more strategies to prevent it. A review of the literature regarding the topic revealed that trainings dealing with personal coping strategies are often the best proactive approach. This prompted the panel to explore the training requirements for workers and supervisors. Much to our dismay, the results of our exploration revealed only one training for workers that focused on the topic (Taking Care of Yourself) and was shocked to find that it was only a one-time training. In addition, our exploration revealed no obvious trainings for supervisors related to recognizing signs of burnout and addressing the topic with employees. It is important to note that this may be embedded in the training series but it is not obvious nor does it seem to "fit" under any of the required training workshops currently offered.

A review of the training series for both workers and supervisors also leaves one to question the degree to which employees, especially those not holding social work degrees, are trained in utilizing the planned changed approach, empowerment and strengths perspective, and how often these basic social work concepts are reinforced throughout the training series.

Recommendation: The Panel recommends the following in terms of training/preparation:

- Yearly trainings (face-to-face) for ALL workers regarding burn-out prevention and caring for oneself.
- Consider the development of formal support groups and de-briefing sessions for workers, particularly those who work with severe cases of child maltreatment and child fatality cases/reviews; and consider mandatory attendance every 3-6 months.

A supportive environment and understanding/wisdom from seasoned workers can play a huge role in the prevention of burnout.

- The panel recognizes that DCBS workers spend a great deal of time in training and it could even be said that they are overloaded with such. However, the Panel feels strongly that new workers, especially those without social work degrees, should have a separate training (i.e. not embedded in another training topic) to introduce and stress the importance of the planned change process, empowerment, and the strengths perspective. These integral concepts are the identity of social work and should be incorporated and reinforced in all subsequent trainings. The use of these central concepts not only provide the worker with tools but provides the family with a greater sense of ownership and responsibility which will improve the therapeutic relationship and reduce resistance.
- Consider an additional training focusing on coping with client resistance and strategies to deal with such. This would not only help to prevent worker burnout but would also help to improve and strengthen the therapeutic relationship.
- Consider an additional training for supervisors focused on recognizing signs of burnout among workers and equip supervisors with tools to handle the situation if recognized.

ADDITIONAL NOTEWORTHY OBSERVATIONS:

Panel noted a theme among both workers and community partners regarding the need for substance abuse services. This problem cannot be overstated!

There is a limitation and issue related to incidence reports regarding recurrence. Our review of closed cases revealed that there were many staff errors related to entering investigation findings. In all 26 cases, there was at least one error in which another referral was entered and translated into another substantiation which results in the case being opened (even if the worker chose not to open the case). Instead of deleting the referral, a new one is entered. This practice has a profound impact on the number of

recurrence cases. Most agencies would consider this to be the same referral and same investigation, however, these reports are being or may be counted twice. If this occurs, the numbers will increase falsely.

The lack of support services and funding in rural areas most likely plays a very important role in the number of recurrence cases.

The need for extended parent training was consistently noted – parent re-education is a very long and intense process.

Kentucky River Panel Recommendations

1. Aftercare- monitor clients for longer periods of time even after the case is closed- step down process monitored by community partners, family members, etc- to provide support, access to resource, etc. Set them up with "natural" resources- even set a court review ever six months.

2. Universal and equalized services and standards for relative placements and foster parents. Examples include access to daycare, annual permanency reviews in court, transportation assistance, etc.

3. Re-implement preventive assistance to aid families with basic needs to prevent removals. Therefore, money is saved- cheaper to keep kids in the home than pay foster parents and other agencies.

4. Expand services to families who are not severe enough to open neglect/ abuse case with P and P to prevent neglect/abuse.

5. Increase general public education and awareness of DCBS roles and responsibilities.

6.

Policy:

KYHFS/DCBS: B-3: KYHFS/DCBS will make referrals to First Steps for children under age 3 who are involved in a substantiated case of child abuse or neglect; (b) or who are identified as affected by illegal substance abuse, or withdrawal symptoms resulting from prenatal drug exposure (CAPTA) or (c) refer a child who experiences a substantiated case of trauma due to exposure to family violence (section 320 of Family Violence Prevention Act).

Change policy and practice to include all children under age of 18 to have a mandatory referral for mental health assessment and services as with the case plan with parent's treatment services. Children should be court ordered and or required to participate in effective treatment services for substance abuse, relationship issues, and exposure to violence, etc.

Northeastern Citizen Review Panel

Gerri Willis, Chair

Shari Stafford
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Ann Johnson
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Reoccurrence isn't just a problem for DCBS; it's a problem for our state and nation…

NE Kentucky - P&P, SSW

The Citizens Review Panel is a federally mandated group of professionals and private citizens who are responsible for determining whether state and local agencies are

effectively discharging their child protective responsibilities, pursuant to the 1996 amendments to the Child Abuse Protection ad Treatment Act (CAPTA) and any subsequent amendments. Through a review of policies, procedures, research and case reviews, the purpose of the "respective" Citizens Review Panel is to promote child safety and quality services to children and families.

Government agencies are formally charged with protecting abused and neglected children from further harm, but individual citizens and community entities are an essential part of successful efforts to care for and protect children.

The charge to all Citizens Review Panels across the Commonwealth during fiscal year 2008-09 was to study the issue of reoccurrence of child abuse and neglect cases within the KY Cabinet for Health and Family Services, Department of Community Based Services (DCBS).

The Northeast KY Citizens Review Panel offers the following observations and recommendations as evidenced by data collected from focused conversations with frontline social workers, supervisors, community partners and citizens; and review of DCBS Policies and Standard Operating Procedures (SOPs) related to Caseload size, and social service processes of Assessment, Family Team Meetings, Aftercare Planning, and Closure.

Observation:
The majority of those participating in focused conversations led by members of the Panel, revealed common themes across the NE counties:

1. There is a frighteningly significantly number of substance-involved (prescription medications) parents/guardians in the NE region. There are very limited screening and treatment options available to clients, especially in rural areas. Caseworkers reflect a growing concern for personal safety as a result of working with potentially volatile cases.
2. It appears that many counties are experiencing caseloads that appear to be greater than the recommended average of 18 cases. Workloads are increasing as a result of high

OOHC caseloads and the severity of case related issues, i.e. - substance abuse, domestic violence, and mental health disorders.

3. The utilization of (FTM) Family Team Meetings appears to be at the worker's discretion as to the development, implementation, and evaluation of their usefulness in the Case Planning Process and the delivery of ongoing services, especially in aftercare planning.

4. The public image of DCBS seems to be mostly negative with little credit given to the positive attributes of the staff and their efforts to protect the safety of KY's children. In addition, public awareness and public response to the increased risk and incidence of child maltreatment as related to substance abuse, especially in the eastern and northeastern regions of the state, does not appear to be a state priority.

Recommendations:

1. Survey participants overwhelming indicated substance abuse, especially prescription drugs, as the number one factor related to the reoccurrence of child maltreatment cases. Various state reports seem to suggest that at many as 60-80% of all OOHC cases are related to substance abuse. Frontline workers report great difficult in securing needed drug screens and treatment services. In review of SOP 1B.5, Drug Testing: The timeliness of acquiring court orders, assisting clients in seeking payment sources for repeat drug screens, waiting for results, and making referrals to treatment that is very limited, is negatively impacting casework planning. The NE KY Panel recommends giving Drug Testing Priority Status by: a) where and how feasible streamlining the procedure to give priority to drug testing requests – immediacy and timeliness of accessing information, including reviewing and revising SOPs to create greater efficiency of this vitally important process, b) SRA or designee to regularly attend KY ASAP meetings in the region to gain knowledge of possible use of grant funds/sources to pay for drug screening and to encourage the development of additional resources for DCBS's substance involved clients, c) provide SSW's with a continually updated resource guide to share with clients detailing available drug screening and treatment options within the region, state, and neighboring states d) provide continuous professional development for

staff on issues of substance abuse, e) consider providing a specialist on addictions to each regional office, f.) start a public awareness campaign to alert the public and legislators regarding the value of and need for Drug and Family Courts systems in the region.

2. In review of a May 2009 TWIST Caseload Summary Report, 32 SSWs are assigned 19-31 caseload, with 13 of those having 25 –31 cases. Some teams appear to have below state average caseloads, while other teams seem to have an over abundance of cases; making some county averages appear within state recommendations. Teams working with OOHC cases also voice a tremendous workload of extra requirements consisting of supervised visitation, transport, court appearances, and documentation, and so forth.

There are 636 OOHC cases in the Northeastern Region. More rural smaller counties with fewer staff members (for example, Lawrence County) have extraordinary high caseloads. National literature suggests that when systems are short-staffed, there is far greater risk of bad things happening. Studies of critical incidents, including child fatalities (the Northeast region has experienced child deaths this year), child injuries, and children missing from foster care or lost in the system, almost always involve an overworked caseworker who didn't have sufficient time to adequately access or monitor the child's situation (New York-Division of Management Audit {1998}. Casework Deployment in Selected Child Welfare Programs Report (96 S 52).

The Northeast Panel recommends: a) Local supervisors be given the discretion to redirect case assignments to team members to equalize the caseload and workload, b) fill vacant frontline positions immediately, or hire new SSW's to assist with the growing number of high-risk OOHC cases, c) utilize retired SSW's for interim work or contract work as feasible to ease the burden of high caseloads and workloads in the Northeast Region, d) maximize supervisory oversight of SSW's with high caseloads.

3. In focused conversations with frontline workers and supervisors, most SSWs state they make use of FTM, but do not do so regularly, nor do they always engage community partners in the process. Scheduling conflicts, time needed to contact community partners,

and unclear expectations of the benefit of FTM's appear to be barriers to successful case planning. In review of SOP 7C, "A Family Team Meeting requires participation of family member(s), SSW (including internal Cabinet partners, if warranted), and community partners when/if applicable". According to SOP 7C, a FTM is required "on all second (2nd) referrals substantiated on children age three (3) and younger"; and "prior to case closure on all Out of Home Care cases". It appears that FTM's are not always utilized to make informed decisions, especially when considering closing a case and providing after care services. Review of case records should indicate reliable information regarding assessment and a strengths-based prevention plan that can clearly be identified in the case plan. The SSW is charged with incorporating strategies, which encourages acceptance and utilization of the Family Team Meeting approach in case planning. The case record should indicate more that a mere "reporting" of the number of sessions a client attends to a community partner-based support service. The Case Plan should be an exemplary document with measurable goals and objectives that informs decision-making throughout the process. The Northeast Panel offers: a) a recommendation to strengthen the language of the current SOP 7C, from "when/if applicable" to read, "is required to" include community partners, b) make DCBS, "Community Based", truly meaningful by developing formal MOA's (Memorandums of Agreement) for Family Team Meetings with specific key service providers, such as, Comprehensive Community Mental Health Centers, Health Departments, Family Resource Youth Services Center and so on; offering cross-training opportunities and staffing meetings with partnering MOA agencies, c) update SSW's knowledge base and skills on "community organization and asset building " – partnership strategies, d) cases will not be closed until CQA documents an extensive Prevention Plan that has been developed, implemented, and evaluated in full partnership with the family and participating community partners, especially targeting OOHC and repeat cases, e) close communication and confidentiality gaps by strongly encouraging and/or recommending families be fully engage in their own care by signing appropriate releases of information allowing for the disclosure of needed information to secure 'wrap-around" type community services with community partners to strengthen functioning and personal skills to care for ones child/children and family.

4. In light of the national media attention (Diana Sawyer's, "Children of Appalachia" TV special and newspaper reports of Eastern and Northeast KY being the "Painkiller Capitol of the US"), and the overwhelming response of those participating in the focused conversations indicating that issues of reoccurrence are significantly impacted by the drugs, culture of the region, and worker attitudes; the Northeast Panel clearly agrees that it is past time for a massive media campaign demanding a public response to the alarming increase in child maltreatment cases related to substance abuse across the Commonwealth, particularly in the Northeast Region. The Panel recommends: a) a "Blue Ribbon Task Force" and "Statewide Summit" to be implemented as soon as possible to publically address the above-mentioned issues. Each region should be represented on the Task Force and at the Summit with frontline workers and community stakeholders serving as engaged agents of change. The purpose of this recommendation is to enhance public awareness, build community capacity, generate "out of the box or around the corner" thinking about child maltreatment, and to establish statewide goals and objectives for prevention and intervention social service delivery. A 2-5-and 10-year master plan should be developed specific to each region's particular needs and that of the state. All future funding, recruiting and retention of staff, professional development and services should reflect the master plan. Just as education was reformed in 1990, so should the Cabinet consider such an austere move to ensure the safety of its children and youth.

The Lakes Citizen Review Panel

Dr. Peggy Pittman-Munke, Chairperson

Peggy Meriedeth	*Gloria Olney*	*Beth Moore*
Wendy Lay	*Linda Johnson*	*Sharon Bush*
Dianne Glasscock	*Evie Paschall*	*Jean Shipley*
Maria Huntley	*Sherry Litchfield**	*Kristi Griffey**

** DCBS Liaisons*

Issues in rural and urban areas related to child protection differ. Rural caseworkers are bonded into the same communities that contain child protection clients. This sometimes makes it difficult for caseworkers to push clients to work the CPS plan with the diligence required.

Resources often are very scarce and are not readily available both because of scarcity and because of transportation issues. There is often a lack of consistency in quality of services across the region. Many clients lack any knowledge of resources other

than that provided by their CPS caseworker, placing a heavy burden on the caseworker to be an accurate source for all possible resources. Some clients live in geographically isolated areas, making a meaningful support network difficult to obtain.

Recommendations from the Lakes Region:

1. Parents must demonstrate both sustained income and housing for a period of six months before eligibility for return of children in OHC. Parents should be strongly encouraged to develop job skills by accessing services available through community agencies if the parent[s] is/are physically and mentally capable of holding employment.
2. Parents should be involved in the case planning in a way that results in an incrementalized plan with time frames for each item. Rationale: too many clients begin to work their plans only when a court hearing is eminent or when DCBS is talking about a change of plan to termination of parental rights necessitating a much longer term of time in out of home care. This results in emotional trauma to the child and greater cost to the state.
3. In cases involving out of home care, ask the court to assign a CASA worker where available. Rationale: national data show that better outcomes occur when a CASA worker is assigned to the case.
4. Work case plan aggressively. This means that the caseworker comes into the home more often than mandated at the beginning of the case. Rationale: The most successful cases indicate that the worker began working the case plan aggressively from the beginning of the case.
5. Supervisors need to monitor workers who are less successful with out of home care and provide more supervision and use of regional office services earlier in the case. Workers should be encouraged to use the regional planning services early in the case planning process, not wait until three months into the case.
6. Differential training on boundary issues should be offered to rural and urban workers. In more rural areas, boundary issues are often a key factor since workers are more likely to bond with the parents to the detriment of the children's best interest. Rationale: In some cases it appeared that the worker was too concerned about being

liked or about the feelings of the parent to be able to work the case aggressively enough to help the parent[s] make lasting change in a timely way.

7. Blanket the case in available services from the beginning. Those cases that had prevention type services [HANDS program] or more intensive services such as family unification or family preservation services seemed to have better outcomes. If these services are insufficient in a community, DCBS should work with other community resources to develop these services. Financial services and drug abuse intervention services should be a part of the services offered early in the case.

8. Parent child visitation [from the literature] is a significant predictor of successful family reunification. If visits are supervised, visitation should have a remedial focus, and the supervision should be aimed at directing parent skills and abilities to manage their children effectively. More funding is needed from the state to be able to provide sufficient supervised visitation of this kind.

9. Foster parents who are able to mentor the parents and help the parents with their parenting issues generally are factors in more successful outcomes. Foster parents should have more training in mentoring parents.

10. Better assessments of cases including adequate assessment of strengths and needs of families and children, building on strengths and addressing specific needs, and aggressively carrying out plans are all associated with better outcomes. [Children's Information Gateway. Family Reunification What the Evidence Shows]

11. Workers need to make the case with the Court for TPR earlier in the case when a thorough assessment indicates the unlikelihood of parents to obtain the requisite skills or improve existing situations in a timely way. With the few cases in Western Kentucky that were recurrences of OHC or child protection involvement, it was fairly apparent at the onset of the case that factors necessary for successful reunification were not present. Instead, these families were characterized by low functioning parents, inability or unwillingness to work the case plan in a sustained way, long term drug use, extensive criminal histories, lack of a healthy social support network etc. Failure to achieve TPR in a timely way results in children who will not achieve safety and permanency in a timely way.

One thing that all recommendations have in common is a need for more resources from the state devoted to child protection. These resources include higher staff levels for DCBS including more front line workers with smaller case loads, case aides to help with homemaking and parenting skills and more funds to help achieve necessary mental health, parenting, and substance abuse evaluations, and money to provide transportation in rural areas where in counties there is no public transportation including taxi service.

Jefferson Citizen Review Panel

Bryan Fantoni, Chair

*Laura Johnson**	*James Harrington*	*Bonnie Swicegood*
Mary Lou Cambron	*Shari Christoff*	*Sheila Nelson*
Phillis Thompson	*Barbara Carter*	*Rus Funk*
Marjie Miller	*Kate Miller*	*Cynthia Curtsinger*
Charlie Baker	*Rebecca Johnson*	

**DCBS Liaison*

Overview

This year, all Citizen's Review Panels ("CRPs") agreed to participate in an experiment wherein all state CRPs would focus on a single issue that the Cabinet had previously identified through studies was in need to attention or the Cabinet was consistently missing federal guidelines or goals. To this end, the panels voted to limit their focus to the issue of reoccurrence of abuse or neglect within their respective regions. All CRPs were given significant numerical and statistical information developed

by the Cabinet to assist in identifying areas that are most affected by the reoccurrence of abuse or neglect or contribute to reoccurrence occurring within families. As a caveat to the following, all statements herein are prefaced on the foundation that by providing services in initial investigations in a better or different manner, the Cabinet can preventively affect the amount of reoccurrence those families will experience. These recommendations assume that the Cabinet agrees with the premise that an ounce of prevention is worth a pound of abuse and neglect. With that in mind, and to that end, the Jefferson County CRP ("Jefferson CRP" or "Panel") identified three (3) risk factors that were disproportionally represented in families experiencing reoccurrence in abuse or neglect: Substance Abuse ("SA") (Alcohol or Drug); Domestic Violence ("DV"); and Mental Health ("MH"). These risk factors did not lend themselves to a pattern of reoccurrence (DV did not then result in reoccurrence of DV, etc.) such to direct our inquiry specifically within one group or the other.

Accordingly, the panel initially reviewed a set number of cases in Jefferson County which fell within the studied period for general background. Thereafter, the panel met with three groups involved in the providing of services to children on the sole issue of preventing reoccurrence to determine if there were common themes throughout the groups which might lead to recommendations on the issue of reoccurrence. Specifically, the Jefferson CRP met with a group of experienced County Attorneys handling family court matters in Jefferson County, the ENTIRE Family Court Judiciary (consisting of over 10 judges) for Jefferson County, and a team of front-line CPS workers. From these meetings and further investigations and discussions with other representatives of the Cabinet, the Jefferson CRP has, by these recommendations, discovered significant opportunities wherein the Cabinet can improve the excellent services it provides to families and children that will particularly impact the possibility of reoccurrence of abuse and neglect.

Observation #1

The Panel, through the various discussions with community partners, has been informed of the widening gap between what the function of the Jefferson Alcohol and Drug Abuse Center ("JADAC") is and what the expectation is of JADAC's function and use. This

disconnect between the JADAC protocols, Contract with the State, and the Cabinet and Court's need for information is directly affecting the system's ability to prevent reoccurrence. Specifically, JADAC is not providing a free exchange of information regarding individuals under Court order to participate in the program with respect to their continued drug use or their level of activity within the program. For obvious reasons, the Cabinet and the Court must have immediate access to this information to determine if a family member is complying with the Court's and Cabinet's requirements in hopes of fostering family reunification. Even more troubling is the fact that the Commonwealth of Kentucky and the Cabinet within, contract with JADAC to provide these services only to be told that the Cabinet is not entitled to the results or reports of progress. This is an untenable arrangement which is hindering the system's ability to prevent reoccurrence.

Recommendations #1: To remedy this, and other problems, the Panel makes the following recommendations, based in part on the assumption that the person ordered to attend JADAC has signed a waiver and provided such to the CPS worker managing their case:

1. Ensure that all workers are requiring the execution of a waiver allowing the worker, the Court, and the County Attorney to have access to all information relating to the individuals participation in JADAC programs that are Court ordered.
2. The Cabinet needs to reevaluate their Contract with JADAC to ensure that 1) JADAC is currently in compliance with the Contract and 2) that the Contract addresses these issues of limitation of information. Specifically, the Cabinet should seek to include language in the Contract or Agreement whereby JADAC is required, if requested by the Courts or the Cabinet, to provide current and accurate information.

    a. Receive timely info on drug testing

    b. Free exchange of information re: individual's participation in services

c. Updates to cabinet re: status of individual

Observation #2

The Panel, through its many discussions with community partners has come to the conclusion that the Cabinet's contract with 7 Counties is either not being followed or is inadequate to accomplish the Cabinet's goals. Further, the Community partners are running into internal problems within 7 Counties in receiving timely information relative to their cases which directly impacts the ability of these community partners to prevent reoccurrence of abuse and neglect. Specifically, the Community partners have the following concerns:

1. 7 Counties therapist not releasing info to workers or courts and not willing to engage with Court's on the issues of child preparedness to return to home or status of child in therapy (HIPPA)3
2. 7 Counties follows some internal protocol of working with the oldest child in a family first and then going down the line, ending with the youngest. This takes too long and is arbitrary. Each case should be looked at independently and the children should be done in the order most beneficial to the family, not the organization. Further, these initial intake sessions meant to determine the level of services a child may need are not occurring in a manner that is considered even remotely timely considering the Cabinet's interest in reunifying the family as quickly as possible. In fact, sometimes these initial evaluations are not conducted on all children for well over a month from the date of the initial intake

Recommendations #2:

The Cabinet should consider reviewing its contract with 7 Counties to bring the terms of service 7 Counties is expected to provide within the confines of reasonable expectations. To the extent 7 Counties is not meeting the current requirements of the Contract, these issues should be immediately addressed. To the extent the contract is silent regarding any of the above issues, the Cabinet should seek to amend the Contract to properly provide services in a quick and timely manner and to effectuate a coordinated approach to

family care and therapy between 7 Counties, the workers and the Courts. To the extent releases must be executed by family members to allow the free flow of information between therapists and workers or the Courts, these releases should be created and executed by the Cabinet. To the extent the workers or the Court's already have the authority to request and receive information relating to the families treatment, 7 Counties should be informed of such authority and the Cabinet should place its full weight behind enforcing 7 Counties' duties to the families and the Cabinet. Short of these steps being taken and accepted voluntarily by 7 Counties, the Cabinet should look to other providers who will voluntarily agree to cooperate with the community partners so as to better the treatment received by families and prevent reoccurrence of abuse and neglect.

Observation #3

Substance Abuse is a risk factor in most families served by the Cabinet. Random Drug Screens are often utilized to determine whether drug use is present. The results of these screens factor into recommendations made by the Cabinet to remove/return children. Families are required to pay for these drug screens unless the screen is by court order. The screens are expensive and are not truly being done randomly. It is reported by workers that clients are told when to come in for the drug screen, often weeks in advance. Often it takes several days for a case to be heard in court and the appropriate order issued.

Recommendation #3:

Workers should have the ability to request true random drug screens without extensive authorization and get access for clients to obtain random drug screens on an immediate, as-needed basis. Regional service providers could be contracted to provide this needed service. The Cabinet could consider partnering with Probation and Parole, or other services serving the same family to share information gathered from other, non Cabinet related drug testing.

Observation #4

It has been universally agreed that cases are being closed too early by the Cabinet and families are reverting back to their old ways once they are not being monitored by the Cabinet or the Courts. This fact is evidenced by the study conducted by the Cabinet that showed the rate of reoccurrence stops dropping and begins to re-escalate immediately after the Cabinet closes the case. The Panel understands that under current guidelines, keeping a case open after the family has reached some level of compliance would require tremendous continued effort on the part of workers as they would still be required to conduct home visits and prepare necessary casework. Nevertheless, keeping cases open for some period of time longer than they are currently, on average, is an absolute necessity. It is irrefutable that the longer the families are monitored, the more successful they can become in preventing reoccurrence.

Recommendation #4:

The Cabinet should consider a new team that would shepherd cases after the active worker is done and the family is reunited, for a period of 6 months to ensure that the family continues to do what they are supposed to do. In lieu of a new team, the Cabinet's protocol should include some lesser degree of monitoring that does not require home visits each month when a family is done but still being monitored for compliance. Alternatively, the Cabinet could seek the appointment of CASA (Court Appointed Special Advocates) to step into cases and provide some monitoring (at no cost to the cabinet) during this stage. Lastly, the Cabinet could consider placing these types of cases with more experienced workers within the teams who could manage the monitoring of these families on a reduced level of involvement.

Observation #5

One of the greater, proportionate areas of reoccurrence occurs in families suffering from some aspect of mental health problems. As the community partners note, often parents with mental health problems are better parents when properly medicated than parents with substance abuse problems. All can attest that mental health medical compliance is

particularly hard to monitor and the potential for an individual to go off their medication, potentially causing another instance of abuse or neglect, is extremely high and a common occurrence. These families clearly need specialized and increased monitoring.

Recommendation #5:

Cabinet should consider employing "clinicians" to work long-term with families that have mental health issues causing their abuse or neglect. This long-term approach works with the homeless and this would prevent the families from having the reoccurrence that happens when the individual stops taking their medicines or attending their therapy. All mental health cases should be identified on certain criteria and placed with a unique team trained in these unique cases (similar to the Domestic Violence, Crimes against Children Unit team). Alternatively, a member of each team could be given specialized training by mental health professionals in working with individuals with mental health issues and could handle those cases for their specific team.

Observation #6

Jefferson region has not hired new front line staff since January 2008. The region cannot hire if the average caseload is below 17 families. The caseload count incorporates non-case carrying staff into this figure. Administrative support staff, specialists, supervisors, etc. in addition to the Family Services Workers are divided by the total number of family's to determine the caseload count. No difference is accounted for when a family has 1 child vs. a family that has 4 children.

Recommendation #6:

In our discussions with frontline staff and supervisor's we were informed that there are teams with 2-4 workers each carrying over 17 cases and many reported carrying 30+ cases. The cabinet should implement a weighted caseload count which would accurately reflect the number of cases being carried by frontline staff and this weighted system would more accurately reflect the case load of the workers. Additionally, while the system should take into account the number of families being served by one worker, it

must also take into account the number of children within the families that each worker is managing.

Observation #7

The Cabinet is normally requiring parents to complete a number of steps before family reunification is proper. These steps may involve drug screens, counseling, and other assorted tasks, each of which are time consuming. Families are being negatively impacted by these requirements when there is no initial planning to accommodate the family needs or no consideration for other necessities like jobs or medical needs.

Recommendation #7:

Cabinet should be wary of the conditions it places on families that contradict the working needs of the family. For example, Dad has to work certain times and requiring him to be at X during those times directly affects his ability to provide for the family and may jeopardize the family even more. Economic instability as a result of the Cabinet's action sets up the family to fail. The Cabinet should consider adopting a plan wherein the worker, when initially meeting with the family, establishes times and dates when all members of the family, individually, can be available to participate in services. With this in hand early on, the Worker can help facilitate scheduling such to have as minimal an impact on the family as possible. If drug testing needs to be done and the parent works 9-5, then the drug testing would be done after 5 or at lunch and not in the middle of the day. Having services close to the families in the Neighborhood Places absolutely assists with this need, and if anything, their use should increase and the Cabinet should consider opening more to better saturate the areas most in need of services.

Observation #8

DVOT, now known as BIP Programs do not properly or easily capture the number of batterers being referred to them. There are too few providers and the expense of these programs can be prohibitive for a family barely getting by with little to no income, especially if the family is split as a result of domestic violence. BIP programs cost as

much as $40 per week for 28 weeks, requiring a total payment of $1,120.00. For indigent families this financial burden may be the only thing standing in the way of family reunification, to the detriment of the children the Cabinet is tasked to serve. Lastly, studies have shown that for a BIP program to be successful in breaking the cycle of abuse through the batterer, it must last, in some instances, over a year. While this contradicts the Panel's previous comments in some ways, BIP programs are so significant in impacting families that mandating a longer program is a valid exception, provided that the program has benchmarks whereby a batterer can be reintroduced to the family.

Recommendation #8:

Cabinet should work to expand DVOT programs in scope (number of providers) and time (length of program) as they are not currently capturing all offenders and not keeping those they have long enough. BIPs should be offered on a rolling income scale to allow for families who are essentially indigent, to have the services and move toward reunification as a more wealthy family would be able to. The cabinet should work to expand the Domestic Violence Unit and work to ensure that the DV Unit of the Cabinet has access to up-to-date training (with the availability of webinars and other electronic training opportunities, this should not be prohibitively expensive). The Cabinet should work more closely with the BIP/DVOT providers' network to ensure that the experience of children is taken into account by BIP/DVOT providers and that the impact of domestic violence on children is included in BIP/DVOT programming.

Observation #9

When families are coming into services as a result of a report of abuse or neglect, regularly there is a lag time of weeks before any counseling services can be provided by the family despite the ability of the Cabinet to begin such services before appearing in Court for the first hearing. Families first coming into care are at the most malleable and receptive to services and this opportunity to teach families is being missed to the detriment of the family. A large portion of this problem comes from 7 Counties unwillingness to adopt a protocol wherein families are seen in an emergent fashion, close

in time to the abuse, but act to manage the new family like any other family and schedule them weeks, if not a month or more down the road.

Recommendation #9:

The Cabinet should review its contract with 7 Counties to see if this type of protocol can be set up with 7 Counties such that emergent families (families coming into care for the first time ever) are seen as soon as possible, if not within a few days. This will not only better assist the family in working through their issues in a quicker manner, but it will give the worker some idea of the family's interest in working with the Cabinet and the scope of the problems that the Cabinet is going to be addressing. With this knowledge in hand, the Cabinet will be in a better position to inform the Court of the case specifics upon attending the first hearing, giving everyone involved a leg up. If these protocols are not present in the contract with 7 Counties, they should be incorporated or made a part of the Contract and 7 Counties should be completely informed of their obligation to provide this level of care for the Cabinet's emergent families.

Observation #10

Families are being asked to go and do any number of things before the Cabinet will recommend reunification. Much of the time, despite the limited presence of Neighborhood Places, these services are provided in a central location requiring costly travel for a family below or at the poverty level.

Recommendation #10:

Cabinet needs to factor transportation issues in when making families attend counseling or receive services, i.e. TARC tickets or other concerns. The Cabinet should consider continued de-centralization of services to be one of its main priorities and increased reliance on Neighborhood Place-type services. Alternatively, the Cabinet could seek private funding or support from businesses or transportation entities to provide free or reduced rate transportation. Free or reduced TARC tickets would go a long way in reducing these issues.

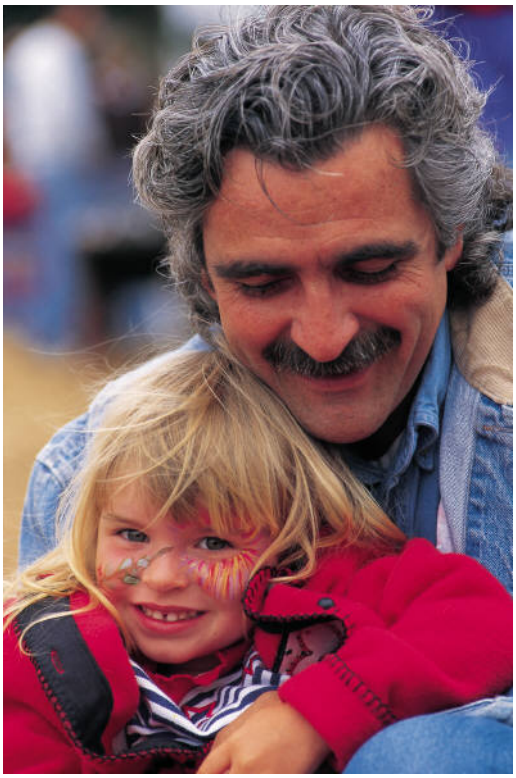
Observation #11

The absolute consensus between all the community partners this panel met with is that in-home services are 1000x more effective than out of home services and then use should be increased 1000 fold.

Recommendation #11:

Along the same lines of decentralizing much of the Cabinet's services and functions, the Cabinet should look to expand the number and types of in-home services. The ability to work with a family in their own environment gives workers and service providers the opportunity to interact with families in a less stressful environment and see the family dynamic at work in real life. To the extent the Cabinet can lessen the impact its involvement with families has on the children, the Cabinet should make every move to change its policies and approaches.

Southern Bluegrass Citizen Review Panel



Heather Schill, Chairperson

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Nancy Shinn
Heather Schill
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Brandon Rayford
Cynthia Kay
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Fayette County Workgroup

The Fayette County work group reviewed case files and then interviewed supervisors working in that county. Our goal was to research the problem of re-occurrence of child abuse and neglect and determine what, if any specific factor(s) helped to prevent it. The items listed below are our recommendations that would help to prevent re-occurrence.

1. More In-Home Services: Services such as Impact offered by Croney and Clark, and the Hands Program that work with the families in their homes are vital. However, many individuals are not eligible for these programs because they do not receive Medicaid. Supervisors have asked that if possible, some contractual arrangement be made with these programs to assist those who are not Medicaid eligible.
2. Drug and Alcohol Treatment: Given the overwhelming rise in substance abuse-related cases, there is a need for policy revision to fit with this new population. Families must have access to and be supported in obtaining quality assessment and treatment of this problem. Flexibility is needed in case planning and child placement to help ensure the success of recovery.
3. Community Partners Agencies that have contracted with the Cabinet should be held accountable for their contracts. They should be required to meet all timelines and other terms of their contract. In particular, supervisors are concerned about children that have been removed to a private foster care system. When children are moved within the system, or when workers in the system meet with the child(ren), reports are to be forward to the caseworker for their files. This information is not relayed on a timely basis and hampers their case management.

According to the supervisors interviewed, the current caseload at the Fayette County Office can run as high as 25 cases per worker. Caseworkers are to maintain a 37-1/2 hour workweek, which is almost impossible with the amount of cases they carry. Although positions are open at the office and these are being filled, turnover is high and one offsets the other. Additionally, there have been changes in management at the office during the

past several years that has caused a great deal of confusion. Because of this, morale is very low.

The issue of morale is one that our team considers important to the quality of protective services to Kentucky's children and consequently, to the prevention of recurrence of child abuse and neglect. We understand that the Cabinet has a team of individuals that are working to improve the morale of the office. Although well intentioned, these efforts do not appear to be promoting a more positive atmosphere.

We asked the supervisors specifically what their "wish list" would be to improve morale, working conditions, and case planning for their office. Please remember, these are their recommendations.

1. Measures of effectiveness need to include both meaningful quantitative statistics and qualitative measures. When individuals are reviewed, the process encompasses a review of the Twist System. Workers must have a minimum of 90% of all their notes processed in the system. The system is thus quantitative in their eyes. However, they feel the cabinet should consider some qualitative issues when reviewing caseloads of workers. Perhaps there could be a systematic manner to classify cases that would encompass the following factors that complicate case management:
    a. Size of the family,
    b. Age and location of the children, should they be removed from the family,
    c. Complexity of the situation – does the case revolve around domestic violence, drug abuse, or childhood sexual abuse.

2. Policy changes/reorganization should require direct input from front line staff. During the past four years, management and policy changes have been made within the Cabinet. Reduction in upper management staff was to allow the hiring of additional front line workers. However, supervisors feel that the reverse is happening. That is, more management level staff is being hired than are front line workers. These changes have caused confusion and discourse among staff workers.

Additionally, front-line supervisors feel that changes in policies are made without the input from front line workers. Their recommendation is that policy makers should have a minimum of two years *recent* experience in the "trenches". They also feel that it would be beneficial to call on current front-line supervisors to assist in the review and change of policies.

3. The safety needs for workers needs to be addressed. Supervisors understand that there is the need for caseworkers to make home visits with families. They also understand that our system has been cited for the lack of home visits made by workers. However, they are concerned for the safety of their staff. Since an investigation has already been made, they have recommended that the initial meeting with the family should be at their office, rather than the client's home. This would allow the caseworker time to assess the case, gain awareness of the parents and children, and begin to formulate a case plan that would be meaningful for the client.

Madison/Jessamine Working Group

As our team began to discuss the statewide topic of reoccurrence of child abuse and neglect, we thought that the best way to gather information would be to talk directly to the front-line workers who deal with these issues on a daily basis. We also felt it would be very important for our group to talk to workers in each county in our region in order to find out what differences/similarities existed in the urban, suburban and rural areas.

Therefore, our team, with the very helpful assistance of Kristen Krebs, set up focus group meetings with front-line workers from each county in the region. Under Kristen's planning, our group held four different focus group sessions. Our first session took place with workers from Lincoln, Garrard, Mercer and Boyle Counties and was held at the Garrard County DCBS office. Our second session took place with workers from

Clark and Madison Counties and was held in the Madison County DCBS office. Our third meeting took place with workers from Jessamine and Fayette Counties and was held at the DCBS office in Fayette County. Our fourth and final meeting took place with workers from Estill and Powell Counties and was held at the Estill County DCBS office.

At each of the focus group meetings we asked the front-line workers the following questions and recorded their answers. After we completed all the focus group meetings, we looked for differences and similarities in their answers and created our recommendations.

We asked:

1. Consider a case of child abuse where there was no reoccurrence (a successful case). What went well? What made the difference? How can this be replicated in the future?

2. Consider a case of neglect where there was no reoccurrence (a successful case). What went well? What made the difference? How can this be replicated in the future?

3. Consider a case of child abuse where there was reoccurrence (an unsuccessful case). What went wrong? What made the difference? How can this not be replicated in the future?

4. Consider a case of neglect where there was reoccurrence (an unsuccessful case). What went wrong? What made the difference? How can this not be replicated in the future?

5. What do you see as solutions? Both long term and short term?

6. What would help your families be more successful?

7. Would having a third party facilitator at family team meetings be a useful tool for your county? Why? Why not?

Recommendations to DCBS

1. Create positions for more front-line workers to help reduce case loads.

2. Partner with an agency such as the Child Care Resource and Referral Agencies throughout the Commonwealth to train professionals in each community (or county) to lead parenting trainings. These trainings would follow a consistent 12 week curriculum.

These professionals would volunteer their time for one 12 week session per year. The trainings could cost $5 per session in order to cover material costs and to keep costs low for participants. We could fund the training of the trainers through a grant. Each R&R has offices and training sites in every county.

3. As a way to reduce the many issues in the region regarding lack of transportation for clients, use PCWPC students as support aides/ transportation aids while they are waiting on their permanent DCBS placements.

4. Replicate/Broaden Louisville's Parent Advocate Program across the region/state, in order to provide more successful mentor families for DCBS client families.

5. Create a consistent implementation of the drug testing policy across the region which is affordable for the clients. Explore the idea of workers giving clients drug testing in their homes (i.e. Arkansas case workers) or having drug testing available at the region's DCBS offices both of which would create less barriers for clients to receive testing. [Front line workers suggest the two main barriers for drug testing are the transportation to testing sites and the cost for the testing, which varies from $20-35 depending on the county].

6. Utilize Community Partners (in particular these individuals within the school systems: school social workers, school counselors and/or family resource center staff) in a more meaningful way in order to learn more information about family history and/or family patterns.

Rationale for how we arrived at these recommendations:

After completion of our four focus group meetings, our working team compiled our collective notes and began looking for possible recommendations. The six recommendations which we have selected were chosen based directly on the conversations we had with the front-line workers. These recommendations come from the rural, suburban and urban workers, and therefore, we see them as issues which need to be addressed across the entire Southern Bluegrass region.