**Service Array Index**

Table of Contents

[A. Access to Visitation Funds 1](#_Toc484087488)

[B. Batterer Intervention Certification Program 2](#_Toc484087489)

[C. Child Victim’s Trust Fund Board 3](#_Toc484087490)

[D. Children’s Advocacy Centers 4](#_Toc484087491)

[E. Child Care 5](#_Toc484087492)

[F. Children’s Justice Act (CJA) 8](#_Toc484087493)

[G. Children’s Review Program (CRP) 9](#_Toc484087494)

[H. Community Collaborations for Children (Community Based Child Abuse Prevention (CBCAP) and Promoting Safe and Stable Families (PSSF) Funds 10](#_Toc484087495)

[I. Community Services Block Grant 11](#_Toc484087496)

[J. Commission for Children with Special Health Care Needs 14](#_Toc484087497)

[K. Court Appointed Special Advocates 18](#_Toc484087498)

[L. Diversion/Intensive In-Home Services Program 18](#_Toc484087499)

[M. Early Childhood Mental Health Initiative 21](#_Toc484087500)

[N. Family Alternative Diversion (FAD) 22](#_Toc484087501)

[O. Family Preservation Program (FPP) 23](#_Toc484087502)

[P. Family Resource and Youth Service Centers 26](#_Toc484087503)

[Q. Family Violence Prevention Funds 27](#_Toc484087504)

[R. Health Access Nurturing Development Services (HANDS) 30](#_Toc484087505)

[S. Johnson County Community of Hope (JCCOH) 31](#_Toc484087506)

[T. Kentucky Center for School Safety (KCSS) 33](#_Toc484087507)

[U. Kentucky Children’s Health Insurance Program (KCHIP) 34](#_Toc484087508)

[V. Kentucky Education Collaboration for State Agency Children 35](#_Toc484087509)

[W. Kentucky Partnership for Families and Children, Inc. (KPFC) 38](#_Toc484087510)

[X. Kentucky Strengthening Families 39](#_Toc484087511)

[Y. Michelle P Waiver Program 40](#_Toc484087512)

[Z. Multidisciplinary Commission on Sexual Abuse 41](#_Toc484087513)

[AA. Passport Health 41](#_Toc484087514)

[BB. Prevent Child Abuse Kentucky 42](#_Toc484087515)

[CC. Project SAFESPACE (Screening And Assessment For Enhanced Service Provision to All Children Everyday) 56](#_Toc484087516)

[DD. Rape Crisis Centers 58](#_Toc484087517)

[EE. Safe Infant Services 59](#_Toc484087518)

[FF. Safety Net 60](#_Toc484087519)

[GG. Sobriety Treatment and Recovery Teams 61](#_Toc484087520)

[HH. Social Services Block Grant (SSBG) 62](#_Toc484087521)

[II. Solutions 64](#_Toc484087522)

[KK. Title IV-E Waiver Demonstration Project 81](#_Toc484087523)

[LL. Trauma Informed Care 82](#_Toc484087524)

[MM. Work Incentive Program (WIn) 83](#_Toc484087525)

[NN. Y-NOW Children of Prisoners Mentoring Program (YMCA Safe Place Services) 84](#_Toc484087526)

## Access to Visitation Funds

Federal Access and Visitation Grant funds provided to Kentucky are under the jurisdiction of the federal Office of Child Support Enforcement and are geared toward facilitating access and visitation of non-custodial parents, who are experiencing difficulty in seeing their children due to issues such as: a poor relationship with the custodial parent, non-payment of child support, or allegations of domestic violence. In June of 2016, the grant was transferred from DCBS to the Child Support Enforcement (CSE). CSE decided to collaborate with the Louisville Legal Aid Society (LAS) to establish an Access and Visitation Hotline in an effort to educate parents in all 120 counties about access to and visitation with their children. A Memorandum of Agreement with the LAS began on January 20, 2017. LAS recently hired an attorney who will be responsible for handling calls and is in the process of training the attorney and establishing the hotline. After the hotline is operational, it will be publicized through public service announcements, print, media, press releases and added to both the CSE and LAS websites. The attorney will be responsible for handling all calls coming into the hotline and, if necessary, may refer the caller for assistance to a partnering legal aid program located in the geographical area where the caller resides. Staff in CSE will then receive data related to the callers, how they were helped, if they were referred to a partner legal aid society in their geographic area, etc. Data collection will be forthcoming once the Access and Visitation hotline is operational.

## Batterer Intervention Certification Program

The Department’s Family Violence Prevention Branch administers the state’s Batterer Intervention Certification Program by enrolling providers, conducting training, and maintaining the provider list. The branch also monitors complaints about batterer intervention practices, if any are received. There is at least one certified Batterer Intervention Provider offering services in 57 counties of the Commonwealth. In general, the un-served counties correspond with counties that are underserved in many other services (in the Eastern and Southeastern parts of the state).

Batterer intervention services are not funded through any state or federal grant. Services are provided to those court ordered to attend; however, there is variability in court practice across the state. In many of the un-served counties, judicial practice does not include mandating domestic violence offenders into batterer intervention programs. In counties that are economically disadvantaged, the absence of public funds to subsidize or offset the cost to individuals further exacerbates the issues around recruiting and retaining batterer intervention providers/programs in specific locations. However, a list of [batterer intervention providers](http://chfs.ky.gov/dcbs/dpp/battererintervention.htm) and the cities they serve can be found on the department and Administrative Office of the Courts websites.

Certified providers provide individualized treatment, and have the capacity to include issues relevant to children exposed to domestic violence, parenting after violence, and shaken baby syndrome/abusive head trauma. Certified providers also assess for possible substance abuse and mental health issues. In 2016, four training events were held to certify new batterer intervention providers. Twenty-two mental health professionals participated. Fifteen applicants were certified during the calendar year.

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| **Batterer Intervention Program Data: 2016** | | | |
| **Category** | **Male (87%)** | **Female (13%)** | **Total** |
| Batterers Assessed\* | 2,301 | 442 | 3,012 |
| Civil/DVO Referral | 1,252 | 154 | 2,311 |
| Criminal/Post Conviction | 1,441 | 205 | 1,646 |
| Diversion | 424 | 82 | 506 |
| DCBS Referral | 530 | 91 | 621 |
| Self-Referred | 111 | 15 | 126 |

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

## Child Victim’s Trust Fund Board

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

The CVTF provides funding for both statewide and prevention programs, funding for reimbursement associated with the costs of medical examinations to CACs, and provides for the education of professionals at conferences.

*Regional Prevention Grants*

Fiscal Year 2017 – awarded $116,540 to the following agencies:

* Exploited Children’s Help Organization (ECHO)
* Family Nurturing Center
* Graves County Child Advocacy Center
* UK Research Foundation

*Statewide Prevention Grants*

Fiscal Year 2017 – awarded $43,000 to the following agencies:

* Prevent Child Abuse Kentucky (Approach 1 for new website)
* Prevent Child Abuse Kentucky (Approach 2 for train the trainer event)

*Statewide Public Education and Awareness*

Fiscal Year 2017 – awarded $46,530 to the following training:

* Department of Criminal Justice Training

*Child Sexual Abuse Medical Reimbursement Program*

The CVTF assists state designated CACs by assisting with the administrative costs of the specialized child abuse medical examinations.

In fiscal year 201, the CVTF awarded $82,650 to assist with the cost of approximately 1,102 specialized child sexual abuse examinations in 15 CACs across the state. Additionally, several conference sponsorships were awarded throughout 2016, which educate professionals about child sexual abuse and exploitation prevention. In 2016, the board also awarded the remaining half of the costs for FY2017 for a statewide child sexual abuse training for social workers, law enforcement, prosecutors, board grantees, medical professionals and other community partners. A national trainer was contracted and the title of the training is “Sex Offender Basics: What Professionals Need to Know.” The eight-hour training was coordinated in conjunction with the Kentucky Department of Criminal Justice Training, and was presented in 15 locations across the state. The training concluded in November 2016, surpassed expectations by training 1,229 individuals statewide, and came in under budget by approximately $11,000, which will be used to fund two additional training efforts to prosecutors and law enforcement regarding child sexual abuse cases.

## Children’s Advocacy Centers

Children’s Advocacy Centers provide child-focused, comprehensive services to child victims of sexual abuse, as well as their non-offending caregivers. Pursuant to state law (KRS 620.040), children’s advocacy centers are to be actively involved in the state protocol for child sexual abuse cases, cases are jointly investigated by the department and law enforcement, and the investigators are staffing the case directly with prosecutors and treatment providers in the context of a local multidisciplinary committee. In addition, children’s advocacy centers foster local and statewide training opportunities for the multidisciplinary team of community partners involved in child protection and prosecution of child sexual abuse cases. Children’s advocacy centers offer community training regarding use of the center, how a medical exam works for prosecution, and provide prevention and education activities to raise community awareness about the impact of sexual abuse.

Fifteen children’s advocacy centers are located strategically statewide. Children’s advocacy centers serve between five and seventeen counties. Thus, each center is deemed a regional children’s advocacy center and aims to serve children and families in each county of its perspective area development district. Each center actively provides the following services, by either direct service or a formalized referral agreement, to children and their non-offending caregivers:

* Multidisciplinary team investigations;
* Forensic interviews;
* Mental health services;
* Specialized child abuse medical examinations;
* Advocacy;
* Court preparation and advocacy;
* Public and professional training; and
* Prevention education.

Each center is:

* A private, independent 501c3 agency (tax-exempt) and is encouraged to seek additional funding from local communities and other grant writing opportunities (VOCA, etc.)
* A Medicaid provider and receives reimbursement for comprehensive child sexual abuse medical exams which are performed on site.
* Eligible to write for a Child Victims Trust Fund grant that provides $75 per medical exam for case management services.
* Potentially eligible for funding from the National Children’s Association (NCA) if accredited by NCA.

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| **Children’s Advocacy Center Data: Calendar 2016** | |
| **Service Category** | **Number of Services Provided/**  **Persons Served** |
| **New Children Served** | 6,129 |
| **New Caretakers Served** | 5173 |
| **Advocacy Services: court, case management, referrals to services** | 54859 |
| **Medical Services: comprehensive forensic medical exam, general exam, follow up exams, referrals for further medical treatment** | 879 |
| **Forensic Services: Forensic Interviews by CAC staff, Forensic Interviews Hosted by the CAC for trained child welfare interviewers** | 4833 |
| **Mental Health Services: Individual, Family and Group treatment, Mental Health Screening** | 8256 |
| **New Children Staffed by KY Multidisciplinary Teams** | 4382 |
| **Total CAC Cases seen through KY’s Multidisciplinary Teams in 2016** | 12666 |
| **Training Programs Conducted** | 497 |
| **Community Partners Trained** | 15387 |
| **Community Awareness Events** | 260 |

During 2016, Kentucky saw a significant advance in the administration of the network of Children’s Advocacy Centers. The fall of 2015 saw the election of Governor Matthew Bevin who has as one of his signature priorities to make improvements in the child welfare system. The biennium budget for fiscal years 2017 and 2018 saw an increased appropriation for Children’s Advocacy Centers, which has allowed them to more fully fund their professional association. This increase in resources has allowed the department to execute a new contract with the association that will provide for enhanced program development as well as enhanced programmatic and fiscal oversight.

## Child Care

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

* The goals of the Child Care Assistance Program (CCAP) are to support families in order to:

(1) Eliminate barriers to work and education for low-income parents;

(2) Strengthen and maintain families;

(3) Provide early educational opportunities for at-risk and vulnerable children;

(4) Prevent or remedy abuse, neglect, or exploitation of children;

(5) Prevent family dissolution; and

(6) Prevent a child’s placement in out-of-home care.

The Childcare and Development Fund (CCDF) is the principal source of federal funding for the CCAP and initiatives that maintain health and safety standards and improve child quality in childcare settings. Direct TANF dollars are used to fund CCAP benefits on behalf of individuals who receive public assistance. In addition, State General Funds and tobacco settlement dollars are combined with CCDF dollars to fund the CCAP, childcare quality initiatives, and early care and education professional development. In order to assure continuation of a program of childcare services, the Cabinet must renew the CCDF Plan every two years. The Cabinet currently operates under the provisions established in the CCDF Plan for FFY 16-18 submitted March 11, 2016.

On November 19, 2014, President Obama signed the Childcare and Development Block Grant (CCDBG) Act of 2014 into law.  This reauthorizes the childcare program for the first time since 1996 and represents an historic re-envisioning of the Childcare and Development Fund (CCDF) program. The new law makes significant advancements by defining health and safety requirements for childcare providers, outlining family-friendly eligibility policies, and ensuring parents and the public have transparent information about the childcare choices available to them. The sweeping changes of the Childcare and Development Block Grant and Kentucky’s participation in the federally funded Race-to-the Top Early Learning challenge grant provide Kentucky’s Division of Childcare with the unique opportunity to gain a new perspective and realign the current system due to the complex needs of Kentucky’s poorest families.

CCDBG Re-authorization requirements include:

* Increased requirements for consumer education to promote parental choice including information about the quality of childcare programs across the state.
* Expanded health and safety requirements and additional training requirements for childcare staff, licensing surveyors and expanded criminal background checks for childcare workers.
* Implementation and development of strategies to meet the needs of certain populations (infants, children with disabilities, homeless children and children with limited English proficiency).
* 12-month eligibility and additional guidance for redetermination of services including the phase out of care offered through CCDF funds and changes in reimbursements to families.
* Establish benchmarks for activities designed to enhance quality.
* Coordination with other programs that serve the specialized needs of targeted population groups.
* Increased emphasis on Public-Private partnerships within existing programs.
* Increasing access to children living in poverty to high-quality programs.
* Increased focus on implementing early learning and developmental guidelines.
* Enhanced emergency preparedness requirements.

During calendar year 2016, the Division of Child began working with partnerships and internal agencies on the development of plans and activities to meet federal reauthorization requirements.

The Division of Child submitted amendments to State Plan FFY 16-18 **for Administrative regulation amendment to 922 KAR 2:160, Childcare Assistance Program** adopted August 17, 2016 implementing:

* 12-month eligibility redetermination period,
* Graduated phase-out,
* Enhanced provider rate by $1 per child per day to child care providers serving a child in CCAP,
* Removed the mandate for child care providers to participate in the STARS for KIDS NOW Program due to forthcoming changes in Kentucky’s quality-rating system,
* Increased the income eligibility threshold used for applicant households.

The FFY 16-18 state plan is dedicated to the state’s compliance with or plans to comply with new requirements as set forth by the block grant’s reauthorization in 2014. Per reauthorization, the department and its partners will be working on a new criminal records background check system, which includes FBI fingerprinting (September 2017). DCC has pending legislation and ordinary regulation filed to meet system changes and federal reauthorization requirements surrounding the Comprehensive FBI Fingerprinting Background Checks for all childcare providers and staff. Per Reauthorization, the department and its partners will be improving the public search and interface for families to include new requirements (i.e., child deaths, monitoring inspection reports, complaints) (November 2017). The department will be implementing a new monitoring piece for Registered Providers to include an onsite visits (November 2016). In the past year, the DCC has enacted state regulatory changes, which make it possible to increase support to children at risk of entering foster care who are placed with relatives. Previous restrictions, which limited the period of eligibility and required that the protection case remain open to receive childcare assistance, have been removed. Childcare assistance can now be provided for as long as the family needs that support, as long as other requirements are met at redetermination.

DCC is directly responsible for the administration of the CCAP. DCC contracts with a statewide community based childcare service agent who determine eligibility for the CCAP, authorize payments, enroll non-regulated providers, and provide ongoing case management services to recipients in all of Kentucky’s counties.

DCC has several mechanisms in place to support collaboration across other programs and service providers such as The Governor’s Office of Early Childhood, which provides oversight to the KIDS NOW Tobacco Fund Initiative, and state agency workgroups including the Kentucky Department of Education, Kentucky Head Start Collaborative, Division of Mental Health, and Department for Public Health, along with advocacy groups, including the Kentucky Partnership for Families and Children and the Prichard Committee for Academic Excellence.

DCC routinely provides technical assistance to contracted statewide community based service agencies that administer the CCAP at the local level and contracts with the Human Development Institute, University of Kentucky, for technical assistance directly to childcare providers through STARS quality coordinators, and professional development counselors. DCC receives consultation and technical assistance upon request from the Administration for Children and Families Region IV office and contracted affiliates.

During SFY 2016, an average of 24,127 children and 13,044 families received CCAP benefits. Of the total number of children receiving benefits, an average of 7,562 children were served as the result of a need for protective/preventive services. Children served as the result of protective/preventive services referrals were placed in safe and healthy environments supporting family unification. Total CCAP expenditures for SFY 16 were $90,676,408. Enrollment in the CCAP is at the highest level in three years. This is likely due to implementation of the reauthorization requirements and increase in the eligibility income limit to 160% of the federal poverty level for 2016.

DCC contracts with the Kentucky Partnership for Early Childhood Services, housed at the University of Kentucky Human Development Institute to provide coordination and administration of statewide Kentucky Childcare Resource and Referral (CCR&R) network services. Services provided through the CCR&R regional network include eight (8) Regional Childcare Administrators, five (5) Content Area Coordinators, one (1) TA Specialist Health/Safety, four (4) Technical Assistance QRIS Specialist, twenty-four (24) Quality Coaches, four (4) Technical Assistance Health/Safety Coaches, four (4) Training Coaches, and thirteen (13) Professional Development Coaches to ensure adequate supply of quality childcare programs and services are available in each regional hub covering the Area Development District. DCC, through its CCR&R contract works actively to meet the needs of families, provide referral information to families seeking childcare, increase family knowledge of the characteristics of high quality early care and education services, and increase provider access to training and/or professional development opportunities.

Childcare report data is collected through the Kentucky Integrated Childcare System (KICCS) assistance program available to all 120 Kentucky Counties. Data reports are compiled quarterly, annually and ad hoc on request. Information from data pulls are evaluated to support decision making, legislative, regulatory, and program improvements.

## Children’s Justice Act (CJA)

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

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

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

The CJA task force has implemented a new grant application process this federal fiscal year and grants are awarded after being reviewed and voted upon by the task force. Proposals are required to provide a plan for self-evaluation and thorough reporting prior to the release of funds.

The CJA task force sought consultation with Catherine Luby, Administration for Children and Families, during regularly scheduled conference calls. Kathy Simms with the National Resource Center for Child Protective Services also assisted by hosting a webinar so that task force members could be informed about the Cabinet’s data collection and reporting requirements.

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

The CJA sponsored scholarships for $10,000 for professionals, law enforcement and foster parents to attend the annual Kids Are Worth it Prevention conference held in Louisville, KY.

The task force is also in the process of implementing a training to be delivered across the state to regional medical centers to help in the identification of victims of human trafficking.

## Children’s Review Program (CRP)

Children’s review is a program of Bluegrass.org Inc. (previously Bluegrass Regional Mental Health Board, Inc.) and performs its functions under a contract between the Bluegrass Board and the department. CRP is funded through Title IV-E and state general funds. CRP provides direct assistance to DCBS workers in locating, facilitating, and maintaining placements. CRP also collects, analyzes, and interprets data related to placements and children’s outcomes, and engages in quality monitoring and assurance activities. CRP maintains a database of children, which includes placement history, diagnosis and psychotropic medication history, IQ and other child specific information. CRP provides services to each county of the commonwealth through CRP staff who are located in DCBS offices across the state and at the statewide CRP office in Lexington.

CRPs functions are directed by the contract with DCBS and through ongoing contact with the department at many levels throughout the year. This includes monthly meetings with the Central Office Staff and weekly phone conferences between CRP and the department to discuss difficult to place children. CRP’s Regional Placement Coordinators are co-located with DCBS staff throughout the state and DCBS has designated staff to serve as CRP liaisons within each DCBS region. CRP also has a designated staff person who works closely with the Cabinet’s Medical Support Team to assure that all medically complex children are identified and tracked appropriately.

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

As part of the assessment function, Clinical Reviewers assigned 12,088 levels (2,478 initials, 7,723 utilization reviews, 853 redeterminations and 1,034 reassignments) from January 2016 – December 2016. In addition, during 2016, Clinical Reviewers entered 2,653 Quality Improvement issues.

As part of the placement function, Regional Placement Coordinators assisted in or were involved with 6800 placements and made 295,633 referrals. Statewide placement office personnel facilitated or were involved in over 470 conference calls during 2016 (see additional details below).

As part of the quality assurance function, CRP maintained data on 10,323 children committed to the Cabinet at some point in 2016 and program information on 177 PCC/PCP programs currently in operation. This information is continuously being updated on an ongoing and as needed basis.

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

The CJA task force initiated and recruited training for medical professionals on Human Trafficking in the higher populated areas where major highways intersect. Emergency room staff will be trained to identify victims, report and train co-workers upon completion of the course. This training will cover the entire state of Kentucky.

The task force is currently meeting to discuss how future projects can help minimize disruptions to children and families during investigations as well as the adjudication of allegations.

## Community Collaborations for Children (Community Based Child Abuse Prevention (CBCAP) and Promoting Safe and Stable Families (PSSF) Funds

The Community Collaboration for Children (CCC) is funded by Promoting Safe and Stable Families (PSSF) and the Community Based Child Abuse Program (CBCAP). PSSF funds are used exclusively for direct services. CBCAP funds are used for direct services, as well as the Regional Network and other initiatives, such as child abuse prevention awareness (especially in April), Fatherhood, and faith-based activities. Both CBCAP and PSSF funds are used to develop, operate, expand and enhance community-based and prevention-focused programs. Two direct services are currently provided through these funding streams. In-Home Based Services and Family Team Meetings are funded by a combination of CBCAP Grant funds and PSSF funds.

* 1. In-Home Based Services (IHBS) are in every county across the state. This service targets low-risk families such as: children with disabilities; teenage parents and parents who are young adults; parents with disabilities; families with young children; low-income families—families in poverty; and families who are struggling with issues. In-Home Based Services are short-term, home- based services geared to develop, support, and empower the family unit by teaching parent education, child-development, problem-solving skills, discussing appropriate discipline techniques, assisting parents in becoming self- sufficient and coordinating available community resources.
  2. Family Team Meetings (FTMs) have the same target population but are only available in Jefferson County as a pilot program. FTMs bring families, agencies and community partners together to resolve issues that exist within the family. Facilitators ensure an objective discussion of issues and explore resources. Referrals are accepted from DCBS and from Jefferson County school social workers. FTMs target school aged children (5 – 11), who are truant or at-risk of becoming truant or whose parent are unable to control their child and allows the child to become truant. In 2016, 209 families were served through FTMs in this pilot program.

CCC services are provided in each county across the state. CCC is divided into 17 service areas (comparable to the area development districts (ADD)) and the service areas cover all 120 counties. CBCAP exclusively funds the Regional Networks that are located in each of the CCC Service Areas, which covers the entire state. Each region has an established Regional Network whose membership requires representation from DCBS; CCC service providers; Early Childhood Councils; Family Resource and Youth Service Centers; Health Departments, Mental Health, Court officials; DV shelter representatives; other child and family serving prevention agencies; community leaders including the faith community; and local citizens including parents. A Regional Network is a community based collaborative within each service area whose members meet at least five times per year. The Regional Network provides collaboration and support to CCC service providers and the members share regional resources as well as discuss child abuse prevention in local communities. Needs of the region are discussed, DCBS data is shared as well as community partner data. Regional Networks are a unique component of the program and fulfill the statewide network requirement of the CBCAP Program Instructions. This past year each of the regional networks collaborated with an agency to provide parenting classes to families who need them. Parenting classes have been underfunded in the state for several years and have been identified as a need by community partners.

In 2016, In-Home Based Services served 643 families with 1,941 children. Staff now remain in the home for longer periods of time, which leads to fewer families served. Parenting Education Classes held 16 classes and served 69 individuals, including adults and teen parents. Trainings to provide In-Home Based Services and Parenting Education Classes are provided by the DCBS Training Branch and have been developed to reflect all DCBS requirements, as well as promote strengths-based principles for family engagement. CCC vendors participate in quarterly statewide meetings and Regional Coordinator & Supervisor orientations. CCC has also continued the contractual agreement with the Parent Liaison, who works with parents to build leadership skills and increase parent participation in the Regional Networks on a regional and statewide level.

CCC’s work on the CFSP is an ongoing task with direct services and federal mandates such as fatherhood initiatives, faith-based initiatives and collaboration with various suggested agencies such as Early Childhood service providers. CCC in-home services staff continues to provide Ages and Stages Questionnaire: 3and Ages and Stages Questionnaire: Social and Emotional screening to all children under the age of 5 ½ years. Having these tools helps to identify children in need of services for further prognoses. Increased use of data to identify needs or gaps in service has been encouraged to assist the Regional Networks with planning. CCC was integrated into sophisticated data collection systems during CY 2010 in order to build capacity for enhanced data analysis and reporting. Access to better data collection and analysis has contributed to progressive improvements in service planning, delivery, and outcomes.

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

In- home services continue to be the most effective and in demand services for prevention of abuse/neglect. The Network collaborations continue to be critical as funding becomes increasingly tight and creative solutions as well as decreasing duplication of services are needed.

## Community Services Block Grant

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

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

The CAAs and the department SRAs are required, through contractual agreements, to work in partnership to prevent a duplication of services, and provide services to compliment the common mission and outcomes. A written agreement is signed by both the CAA and SRA that is included in the approved CAA plan and budget approval. This agreement contains, but is not limited to: the roles of each agency; services to be provided; a joint referral mechanism; and assurance that through cooperative efforts, that both parties have been able to identify and address the vital service needs of the CAA’s geographic area.

Each CAA has a Tripartite Board that fully participates in the development, planning, implementation and evaluation of the program serving that geographical area. The Tripartite Board must be composed of one-third democratically elected representatives of low-income individuals or families who reside in neighborhoods being served; one-third elected officials holding office at the time of their selection, or their representatives; and one-third of the board must be chosen from “business, industry, labor, religious, law enforcement, education, or other groups and interests in the community served.” The Tripartite Board must operate in accordance with [KRS 273.437](http://www.lrc.ky.gov/Statutes/statute.aspx?id=13740) and [KRS 273.439 (2)](http://www.lrc.ky.gov/Statutes/statute.aspx?id=13741). Governing boards and community action boards adopt written bylaws that include: the purpose of the community action agency; duties and responsibilities of the board; number of members on the board; qualifications for board membership; types of membership; the method of selecting a member; terms of a member; offices and duties; method of selecting a chairperson; a standing committee, if applicable provision for approval of programs and budgets; the frequency of board meetings and attendance requirements; and provision of official record of meetings and action taken. The board meeting minutes are provided to the cabinet, as per the master agreement between the agencies. After approval by the board and signature of a board’s designed official, the minutes are sent to a Policy Analyst at the department, each board member, and the executive director.

Pursuant to [KRS 273.441 (1) (e)](http://www.lrc.ky.gov/Statutes/statute.aspx?id=41760), each CAA collaborates and encourages business, labor, and other private groups and organizations to work together to encourage support of community action programs in order to provide additional private resources and capabilities.

Technical assistance and training are provided to the CAAs by the Community Action for Kentucky (CAK), a contract agent on behalf of the cabinet. Additionally, the cabinet offers technical assistance as needed and annual training to the CAAs to aid them in the preparation of their CSBG Annual Plan and Budget proposals. CAK has provided training to the CAAs on case planning for CSBG services.

Each CAA submits the following data to both the Commonwealth and the Federal Government:

* Annual Plan and Budget Proposal: This document outlines the CAAs’ efforts to appropriate funds, efforts and services to low-income families in their communities. The plan requires a needs assessment process so that the agencies can determine how to prioritize the service categories outlined by the National Association for State Community Service Programs (NASCSP). The categories are as follows: employment; education; income management; housing; emergency services; nutrition; linkages; self-sufficiency; health; and other programs to eliminate the causes of poverty. The Plan and Budget Proposal also sets forth a budget in accordance with 42 U.S. C. 9907. (The funds are distributed to the CAAs by the Cabinet in accordance with 922 KAR 6:045).
* Results Oriented Management & Accountability (ROMA): Each CAA is required by 42 U.S.C. 9917 to implement ROMA. Results- management reporting impacts the way agencies document the results of their efforts. This tool is used in planning, organizing, directing and self-evaluation. ROMA focuses on three broad areas: family, agency, and community. Programs have multiple services under the NASCSP CSBG Service Categories. They are as follows: employment; education; income management; housing; emergency services; nutrition; linkages; self-sufficiency; health; and other programs to eliminate the causes of poverty. Kentucky is not currently utilizing the last category because agencies have found all of their services fall under the first nine categories. The ROMA reports are submitted to the state and federal Government quarterly with the cumulative report being submitted at the end of the state fiscal year.

The Office of Community Services has enhanced the CSBG Network’s performance and outcomes measurement system for local eligible entities identified in the CSBG Act as Results Oriented Management and Accountability System (ROMA). This will improve, the tracking and accountability measures reported by the CAAs and the Cabinet.

New goals have been implemented for ROMA NG, based on the Theory of Change. The following are the new Community Action Goals:

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

Kentucky has its own database system for local and federal reporting. The system is called CASTiNET and most of the agencies have upgraded their computer systems to accommodate CASTiNET. Agency level forms are distributed to the states by e-mail and CDs. The state contracts with the Community Action of Kentucky (CAK) that compiles agency data and enters it into the electronic database. The survey reports on the state’s use of CSBG funds, general information on local CSBG agencies, general information on the Community Action Agencies’ and the department’s accomplishments and coordination of funds, expenditures under each NASCSP service category, other resources generated and administered by the CSBG Network, and program participant characteristics. The design of this report captures how the state community action agencies are mobilizing resources, allocating funds, and reaching the low-income clients CAAs serve. The IS Survey will be phased out by March 2019 and will be replaced with the Annual Report.

On January 12, 2017, the Office of Community Services (OCS) received OMB approval for a new CSBG Annual Report. The new CSBG Annual Report marks the largest overhaul of CSBG data collection and reporting since the CSBG Information Survey (CSBG-IS) which was developed in 1983. CAAs will begin collecting data utilizing the new National Performance Indicators (NPIs) which are part of the Annual Report in July 2017.

The department completes half-year block grant status reports on CSBG for the state legislature in January and July. The cabinet performs monitoring of the CAAs to determine the agencies’ compliance with applicable federal and state regulations and statutes, programmatic and financial requirements, and the agencies’ adherence to the CSBG Plan and Budget Proposal. The CAAs may be required to submit a plan of corrective action, dependent upon the findings of the monitoring. The CAAs are also subject to audit requirements.

## Commission for Children with Special Health Care Needs

The Kentucky Commission for Children with Special Health Care Needs (CCSHCN) provides specialty and subspecialty pediatric care to medically underserved children. Created in 1924 by the state legislature to provide treatment to children with orthopedic conditions across the state, CCSHCN’s clinical services have since expanded to include treatment and care coordination for a variety of severe and chronic conditions. Funding for CCSHCN services originates from various sources: Title V/Maternal and Child Health Block Grant (supports the specialty clinic program); Maternal and Child Health categorical grants (support hearing screening and transitions); third party reimbursement (supports medical care); and state general funds. In addition to administering the state’s Title V Children with Special Health Care Needs medical services program, CCSHCN provides special services to address health care needs of children involved with the child welfare system and an Early Hearing Detection and Intervention program to ensure the assessment of hearing in newborns statewide. CCSHCN services are available statewide. Specialty clinics are offered through 12 regional offices, although not every clinic is available in every area. For the foster care population, medically complex home visitation services are currently available in all 120 counties, and CCSHCN nurse consultation services to child welfare are currently available in all nine DCBS service regions. The Medical Home for Coordinated Pediatrics clinic (primary care) is based in Lexington and primarily serves the Bluegrass area.

CCSHCN’s mission is to enhance the quality of life for Kentucky's children with special health care needs through direct service, leadership, education and collaboration. Services are family-centered and community-based with access to specialty providers coordinated through 12 regional offices. The agency’s website is located at <http://www.chfs.ky.gov/ccshcn>, where a directory of services lists programs available in all areas of the state.

Specialty medical clinics are available for the following conditions:

* Asthma (Severe) (Case management and financial assistance only)
* Cerebral Palsy
* Cleft Lip and Palate
* Craniofacial Anomalies
* Cystic Fibrosis
* Eye
* Hand (Case management and financial assistance only)
* Heart
* Hemophilia (Pediatric and Adult)
* Juvenile Rheumatoid Arthritis (Case Management and financial assistance only)
* Neurology/Seizure
* Neurosurgery
* Orthopedic
* Otology (combination of onsite clinics, case management, and financial assistance in areas where patients are seen in the private office.)
* Plastics/Reconstructive Surgery
* Scoliosis (Case Management and financial assistance only)
* Spina Bifida

As a public agency within the Kentucky Cabinet for Health & Family Services, CCSHCN shares a statewide parent organization with DCBS, Medicaid, and other important social service and health programs. Over the course of 90 years, CCSHCN has developed formal and working relationships with a variety of programs providing services to children. The network of direct providers for clients numbers in the hundreds. In addition to direct care provided in specialty clinics, children with eligible diagnoses may receive care coordination services from registered nurses. Depending on the individual needs of the child, this may involve varied activities such as:

* Advocating and helping patients and families understand their current health status and educating them on what they can do to improve it;
* Linking families with resources and providing cohesion among other professionals of the health care team to efficiently and effectively accomplish goals;
* Attendance at school meetings; or
* Home visits for Individual Health Planning meetings with DCBS social service workers.

In some regions, CCSHCN employs family consultants or social workers who assist families to access outside services or help with overcoming barriers to optimum care. A Family-to-Family Health Information Center program places parent-organized resource centers within CCSHCN clinics. Critical partnerships exist with the Home of the Innocents and state universities. In addition to sharing a medical director with the Home of the Innocents, a private child caring facility where Louisville therapy staffs (PT, OT, and SLP) have access to state-of-the-art equipment. Universities provide expertise by way of staffing the Medical Home for Coordinated Pediatrics (primary care clinic for children in foster care) and both the Lexington and Louisville Hemophilia Treatment Centers. A number of specialty providers have become active with CCSHCN due to their affiliations with Kentucky’s teaching hospitals.

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

CCSHCN prepared for a five-year needs assessment in 2015. Results of the assessment will guide the direction of services, especially with regard to any new or expanded programs. Priorities for the years 2016-2020 include transition to adulthood, improving access to care and services, ensuring adequate insurance coverage, and enhancing agency data capacity. In light of Kentucky selecting transitions services as a Title V National Performance Measure, emphasis will be placed on ensuring services for youth health care transitions to adult care in the child welfare area as well as with those youth enrolled in CCSHCN clinical programs and others served by the agency.

Subsequent to regulatory amendments, the medically fragile program is now known as the medically complex program, and CCSHCN has modified its terminology accordingly. When the changes took effect, CCSHCN Foster Care Support staff provided statewide training to all CCSHCN regional nurses to ensure standardized and consistent practice. This includes the engagement of all Medicaid Managed Care Organizations (MCO) case managers at Individualized Health Plan (IHP) meetings, and use of current records from primary care physicians and specialists in developing the IHP. The agency increased nurse consultant medically complex caseloads from 10 to 18 per nurse. Data collection methods have been refined and a monthly report is provided to DCBS management.

CCSHCN is no longer visiting medically supervised placements of medically complex children, in order to avoid duplication of services, and to maximize the capacity of limited resources. Although there is currently a vacancy in the Southern Bluegrass region, service continues as in the prior year. CCSHCN and department leadership continue to meet to discuss program management and the interagency Memorandum of Understanding. Due to vacancies in key positions at DCBS, regular meetings as envisioned between management have not occurred as often as anticipated; however, an open line of communication between the agencies exists. Additionally, pursuant to a focus study conducted during the previous reporting period, communication and coordination with the Department of Medicaid Services and MCOs is markedly increased.

Early Hearing Detection and Intervention (EHDI)

Kentucky’s EHDI Program oversees hearing screening at birth hospitals that deliver more than 40 births annually across the Commonwealth. 98% of all live births received a newborn hearing screening prior to discharge. In addition to providing technical assistance to hospital hearing screening programs, EHDI Program staff work with clinical audiologists and Part C providers to ensure that infants not passing their hospital based newborn hearing screening are able to receive diagnostic assessment of hearing and, if necessary, appropriate Early Intervention (EI). A memorandum of agreement with First Steps (FS) created a collaborative agreement with Part C to provide audiologic evaluation for all First Steps eligible infants and toddlers prior to onset of FS services, and a separate memorandum of understanding with DCBS provides for CCSHCN to fulfill the role of primary audiology provider for children in the custody of DCBS. In May 2016, the EHDI program began sending letters to infant’s Primary Care physicians informing them of the infant’s risk of hearing loss as well as when infants were diagnosed with hearing loss.

Foster Care Support Programs

Medically Complex: CCSHCN continues to collaborate with DCBS in teaming DCBS social service workers with CCSHCN nurses to visit medically complex foster care children once a month to address their medical needs. This program has an ongoing population of approximately 130 high-risk or “medically complex” children. The DCBS social service worker maintains his/her professional obligation for the medically complex foster care child’s care and wellbeing. The CCSHCN nurse develops a plan, and convenes and facilitates meetings of the individualized health plan (IHP) team, provides consultation for the DCBS social service worker and for the medically complex foster care children, and provides guidance and ongoing education for the foster parents as needed. CCSHCN is participating with the nine DCBS regions to provide services to medically complex foster care children statewide. Currently, all 120 Kentucky counties are able to receive services.

Nurse Consultation

CCSHCN nurse consultants housed in DCBS regional offices are full-time resources for child welfare personnel, children, families and foster care providers before, during and after a child's stay in out-of-home care (OOHC). This service includes children not considered “medically complex”, including over 8,000 in OOHC, and many more who are at risk of removal & placement. Expertise is currently provided in all DCBS service regions. Roles of Nurse Consultants include:

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

Hemophilia Treatment Centers (HTCs)

HTCs in Lexington and Louisville assists with factor products and other related medications needed to manage bleeding episodes. Each case is individual and must be reviewed before any determination can be made. CCSHCN is always payor of last resort. Families needing assistance complete an application process and must meet eligibility criteria.

Transition Program

CCSHCN’s Transition Program continues helping young people move from school to work, pediatric to adult health care and living at home to independent living. Staff work closely with young people and their families to help them plan for the future. Transition resource libraries are located in some CCSHCN clinics. These resource areas have computers, books and information about preparing for college, self-care and related issues.

Parent and Youth Involvement

The Youth Advisory Council (YAC) is comprised of youth from across the state with a variety of physical and mental disabilities. Most of the council members receive services from CCSHCN. This is a diverse group, which includes youth in the foster care program, and provides youth with disabilities a voice.

The Parent Advisory Council (PAC) is comprised of parents of children with disabilities who have received services from CCSHCN. This is a diverse group representing all regions of the state and provides a means for parents to provide input into CCSHCN’s services.

CCSHCN staff includes family consultants and social workers who can help families find resources, facilitate communication, and support parents as they seek services for their children. CCSHCN’s Family to Family Health Information Center initiative aims to create a network of families trained to support other families, encourage families to become involved in efforts that will lead to reduced barriers to care, and build family capacity to make informed choices and be involved in decision making at all levels.

Data

During 2016, CCSHCN provided services for 8,692 patients. Of the total number of patients seen, 76% had Medicaid/KCHIP, 17% had private insurance, and 4% had no insurance. CCSHCN accepted 1,680 new patients and discharged 1,940 patients. 17,480 visits were recorded.

During 2016, CCSHCN’s Early Hearing Detection and Intervention (EHDI) program received 52,007 hearing screening report forms. Failing the newborn hearing screening is considered a risk factor for hearing loss, according to JCIH. Of the infants screened, 2,070 failed on one or both ears; an additional 1,122 presented as Pass/Pass on the hearing screen but had other risk factors for late onset or progressive hearing loss documented. Therefore, the total number of infants at risk for hearing loss is 3,192.

During 2016, CCSHCN medically complex nurses made 1,590 home visits. At any one point in time, the total number of medically complex foster children served by the agency averages between 125-160. Approximately 140 new medically complex referrals were received during the reporting period.

During 2016, CCSHCN nurse consultants residing in DCBS offices provided the following services on behalf of children in the child welfare system (services outnumber referrals, as many cases require more than one type of service):

Referrals received: 330

Home visits made: 1332

IHP reviews: 277

Medical Record/Report Reviews: 707

Family Team Meetings/5 Day Conferences: 41

Sub Specialty Referrals: 244

Medical Passports Reviewed: 1,281

## Court Appointed Special Advocates

Kentucky CASA Network, Inc. (KCN) is the state association for Court-Appointed Special Advocate (“CASA”) programs. CASAs are trained volunteers, supervised by CASA programs, who are appointed by a judge to represent the best interests of dependent, abused, and neglected children in court. Currently, there are 45 counties served by 20 local CASA programs. KCN assists in the development of new local CASA programs, monitors practices and policies of local CASA programs, and provides technical assistance to local CASA programs. KCN is currently working with four family court judges to bring CASA programs into their courts in 2017. KCN collects data from local CASA programs pertaining to the numbers of volunteers trained and children served. KCN does not administer CASA programs. Funding sources include: The Kentucky Justice and Public Safety Cabinet; State CASA Grant Funds; National CASA Association; Membership dues; Fundraising events; Kentucky Bar Foundation and James Graham Brown Foundation. KCN works with local Family or District Courts, to establish local CASA programs in unserved areas.

KCN collaborates with local CASA programs. Two local CASA programs are represented on the board of KCN. KCN staff regularly communicates and problem-solves with local CASA programs about matters affecting programs individually and as a group. KCN and local CASA programs have collaborated on grant requests. KCN collaborates with various other local and statewide organizations, including, but not limited to: DCBS, AOC, Kentucky Youth Advocates, and local family courts. KCN collaborates with these and other service providers in conference calls, meetings, trainings, and information and data sharing.

|  |  |  |
| --- | --- | --- |
| **Local CASA Programs** | **2015** | **2016** |
| Children Served | 2,895 | 2,831 |
| New Volunteers Trained | 241 | 285 |
| Total Active Volunteers | 808 | 831 |

## Diversion/Intensive In-Home Services Program

The Diversion Program was initiated in 2005 in two service regions (eight counties) and became available statewide beginning SFY 2013. The Diversion Program was combined with the Family Preservation Program in one contract for SFY 2013. The purpose of the Diversion Program is to develop in-home services for TANF eligible clients that will 1) Safely divert from out-of-home care (OOHC) children committed to the Department of Community Based Services (DCBS) or who are at risk of commitment and placement in OOHC, and 2) Return children who have recently been placed in out of home care but who, with in-home services, could be returned safely to their home. The program provides a timely initial clinical assessment within 10 days of referral by a staff person with at least a Master’s degree in social work. The provider develops and implements an intervention plan that addresses the identified needs of the family. The family plan will focus on short-term needs and long-term sustainability of child safety.

An array of services is provided based on that assessment. The services must be family focused and designed to keep children in their home without additional abuse or neglect. The target population is children who are 5 – 17 years of age who can be safely maintained in or returned to their home with services. Services include, at a minimum, clinical assessment, therapeutic child support services, parent development program, and crisis intervention services. Each family develops a “family plan” that will continue to sustain the goal of keeping the children safe and in the family. The family plan is designed within the first thirty days of entering the program, and must include all relevant community supports such as Impact Plus, Community Mental Health Centers, Schools, faith based services, housing, transportation, and medical services that can be utilized for sustained self-sufficiency. A wrap-around service delivery approach, including intervention and treatment plans is then implemented.

The provider works around the family’s schedule and the family can contact the provider 24 hours a day, seven days a week. The family intervention lasts 3-4 months depending on the needs and progress of the family. The provider contacts the family three months, six months, and one year after the family intervention to assess the success of the intervention.

In calendar year 2016, 640 families were referred to the Diversion Program and 526 families began participation.

Also during 2016, 517 families ended their participation in the Diversion Program. Some of these families had begun receiving services in the previous calendar year. Based on the data reported, 431 families were considered to have successfully completed the service.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Program** | **Referrals Received** | **Families Accepted** | **Families Ending Services** | **Families**  **Closed Complete** |
| **Diversion** | 531 | 433 | 432 | 361 |
| **Diversion Reunification** | 109 | 93 | 85 | 70 |
| **Totals** | 640 | 526 | 517 | 431 |
| **Percentage** | \*\*\* | 83% | \*\*\* | 82% |

The 526 families, who began participation in the Diversion Program in 2016, represented 871 children identified as a target child (at risk of being placed out of the home). The 431 families who were closed complete represented 727 target children. 680 of those children remained in the home at the completion of the service, which indicates a 94% success rate.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Program** | **Total Children**  **Accepted** | **Target Children**  **Accepted** | **Total Children Closed Complete** | **Target Children Closed Complete** | **# Remaining at Home** |
| **Diversion** | 1078 | 748 | 888 | 638 | 595 |
| **Diversion Reunification** | 190 | 123 | 147 | 89 | 85 |
| **Totals** | 1268 | 871 | 1035 | 727 | 680 |
| **Percentage** | \*\*\* | \*\*\* | \*\*\* | 80% | 95% |

**Follow up Activity Completed During 2016**

|  |  |  |
| --- | --- | --- |
| 3 Month Follow Ups | Diversion and Reunification |  |
|  | Total # of Target Children with Follow Up | 647 |
|  | Total # of Target Children in Home at Follow Up | 587 |
|  | Percentage of Target Children in Home | 89.5% |
| 6 Month Follow Ups | Total # of Target Children with Follow Up | 663 |
|  | Total # of Target Children in Home at Follow Up | 567 |
|  | Percentage of Target Children in Home | 86.4% |
| 12 Month Follow Ups | Total # of Target Children with Follow Up | 636 |
|  | Total # of Target Children in Home at Follow Up | 529 |
|  | Percentage of Target Children in Home | 82.75% |

Calendar year 2016 represented the fourth full year of services in full swing. At the beginning of this time period, the providers’ contracts had been in place for a full 24 months and due to the two (2) year contract period being renewed once again in July of 2016 they were able to continue accepting referrals and providing services with no disruption through the end of the year.

Families are assessed at intake and closure for family functioning using the North Carolina Family Assessment Scales (NCFAS). The scores on environment, parental capabilities, family interaction, family safety, and child well-being range from -3 (serious problems) to 0 (adequate) to 2 (clear strength). To simplify the reporting of NCFAS scores at intake and closure, scores are dichotomized into adequate or better (a score of 0 to 2) or not (a score of -3 to -1). The percent of families ending services in 2016 who scored adequate or better on each domain at intake and closure are presented below.

At intake, families scored the lowest on child well-being and parental capabilities. Those are also the areas where the biggest gains were made at closure.

Diversion is funded through TANF MOE funds. Economic conditions and budget constraints could affect service delivery in the future. The Cabinet is committed to efforts keeping children in their homes safely and ensuring that children in out-of-home placements can return and be maintained in their home safely.

## Early Childhood Mental Health Initiative

The Early Childhood Mental Health (ECMH) Program supports and promotes the social and emotional growth of Kentucky’s children birth through age five by emphasizing the importance of nurturing relationships in multiple settings. Initial funding is through state dollars, specifically Phase I Tobacco Settlement dollars. Services provided to children and families through the mental health centers are billable to Medicaid and some private insurance, if eligible. There are 17 ECMH specialists across the state located at the regional Community Mental Health Centers (CMHC). These specialists provide: consultation to early care and education settings; direct interventions to children and families identified as having social-emotional concerns; and training for early childhood professionals on the importance of social-emotional wellness and dealing with challenging behaviors. Additionally, the ECMH Specialists serve as a resource for their own mental health centers. A key goal of this program is to build capacity of mental health clinicians in working with the birth through five populations.

Program funded opportunities for professional development are presented statewide on early childhood mental health topics to the ECMH Specialists. These trainings are at no cost and clinicians receive CEU’s that can apply to licensure requirements. ECMH Specialists participated in over 78 Professional Development activities including evidenced-based therapeutic practices in ECMH like Parent Child Interaction Therapy, Trauma Focused Cognitive Behavioral Therapy, Child Parent Psychotherapy, Nurturing Parenting Programs, Incredible Years Small Group and Teacher Training series. The ECMH Specialists have also attended many trainings pertaining to the treatment of young children birth through five. As the ECMH Specialists gain competence and deeper knowledge of social-emotional issues, they share this information with a variety of early childhood stakeholders within their region as well.

The final piece of the program concerns building the capacity of early care and education professionals. By increasing the support and knowledge regarding the promotion of early childhood mental health, it is the goal of the program to decrease the number of children expelled from early care and education settings. The Early Childhood Mental Health ECMH Specialists provide free trainings and consultations to early care and education programs. The goal is to build capacity of early care and education professionals in addressing social/emotional issues of young children, eventually decreasing the number of referrals to the ECMH Specialists.

Many Early Childhood Mental Health Specialists are members of Community Early Childhood Councils (CECC), some of which hold office within their perspective councils. The primary goal of all CECCs is to build innovative, collaborative partnerships that promote school readiness for children and families by bringing local partners together, identifying local needs, and developing strategies to address those needs. In the 2016 fiscal year, the Governor’s Office of Early Childhood awarded $1.2 million to 78 CECCs serving 112 Kentucky Counties. As members of CECC, the ECMH Specialists assist with a variety of efforts including training community and family partners, needs assessment, grant writing and resource sharing.

In addition to direct services provided to young children and their families, the

ECMH Specialists conducted 2,544 consultations to childcare providers, in FY 16. ECMH Specialists provided 53 trainings to 1,048 childcare providers. They also provided 187 trainings to 1,324 participants including colleagues, parent/guardians, educators, foster parents, and other community partners. Finally, they participated in 216 early childhood meetings including Community Early Childhood Councils, District Early Intervention Councils, Community Collaboration for Children Regional Networks, Family Resource Youth Service Centers, etc.

## Family Alternative Diversion (FAD)

FAD provides short-term temporary assistance to stabilize families and maintain self-sufficiency as an alternative to applying for on-going cash assistance. FAD is available to Kentucky Transitional Assistance Program (K-TAP) eligible families, not currently receiving cash payments, which are at or below the gross income limit for K-TAP for the appropriate family size. FAD is administered statewide. Families eligible for FAD may receive up to $1,300 to pay for verified short-term needs. The types of benefits provided include assistance with transportation, childcare, shelter, utility costs, or employment related expenses. FAD has a 3-month eligibility period and is not considered cash assistance. Therefore, FAD does not count towards the 60-month lifetime receipt of cash assistance. FAD may not be received more than once in a 24-month period and is limited to twice in a lifetime. Receipt of FAD payment excludes the benefit recipient from receiving on-going K-TAP benefits for 12-months, unless non-receipt would result in abuse or neglect of a child or the parent’s inability to provide adequate support due to the loss of employment through no fault of the parent. In addition to being determined eligible for FAD, additional services or referrals that may also be offered include: Supplemental Nutrition Assistance Program, Medicaid, childcare assistance, child support, and employment services.

Individuals do not apply for FAD, but are screened for FAD eligibility when applying for K-TAP by local field staff. If it is determined a family could benefit from FAD, the family is given the opportunity to choose to receive either FAD or on-going cash assistance. To receive FAD payments, all short-term needs must be verified. Once expenses are verified, payments may be issued to either a vendor or vendor and applicant. From January 1, 2016 through December 31, 2016, an average of 52 families per month received a FAD payment. The average payment per family per month was $364.57. No policy or procedural changes have been made to the FAD program during Calendar Year 2016. The Cabinet does not currently have plans to revise the program.

## Family Preservation Program (FPP)

The Family Preservation Program (FPP) describes a short term, intensive, in-home crisis intervention resource using approved intensive family centered evidence-based practice models intended to prevent unnecessary placement of children, maintain children safely in their home, and facilitate the safe and timely return home for a child in placement.  Family Preservation Program service array includes: Intensive Family Preservation Services (IFPS) – for families with children at imminent and immediate risk of out-of-home placement; Time-Limited Reunification (FRS) – to help children in out-of-home care return to their families, and Families and Children Together Safely (FACTS) – for families with children at risk of out-of-home care or who may be in the home or returning from out-of-home care.

The service array programs (IFPS, FRS and FACTS) provide a wide variety of services for children and families that include a comprehensive family assessment of family functioning using the North Carolina Family Assessment (NCFAS) and the use of evidence based therapeutic interventions and curricula that promote cognitive and behavioral changes.

Eligible families are referred by a DCBS social services worker or through the Regional Interagency Council (RIAC) and referrals are screened and approved through a designated DCBS regional staff person.

FPP services are funded through multiple funding streams:

* State General Funds and TANF MOE funds help support the Intensive Family Preservation Services (IFPS) to provide intensive in-home services for families with children at imminent and immediate risk of out-of-home placement.
* Title IV-B Subpart II Funds, Promoting Safe & Stable Families and TANF MOE funds provide for time-limited reunification services (FRS) to help facilitate the reunification of children in out-of-home care return to their families within 15 months of their last date of entry into out-of-home care.
* Title IV-B Subpart II funds and TANF MOE funds also support Families and Children Together Safely (FACTS) provide services for families with children at risk who may be in the home or are returning from out-of-home care.

Geographical area: Family Preservation Program Services are provided statewide through contracts with non-profit agencies in each DCBS region serving all 120 Kentucky counties.

Networking: Regional management teams comprised of DCBS staff, including the person responsible for screening all family preservation and reunification referrals and the SRA or designee; the Family Preservation Program (FPP) supervisor; and agency designee, determine any specialized FPP services and provide ongoing oversight of the services. FPP and Diversion staff regularly communicates and collaborates with DCBS staff to improve service delivery to families. In the course of providing services to families, workers and supervisors may participate in school-based meetings, coordinate mental health services, and locate both hard and soft resources such as housing, counseling and parenting classes. FPP and Diversion staff also use and network with community partners that include but are not limited to Domestic Violence Shelters, Family Team Meetings (FTMs), Drug Task Force, IMPACT, Mental Health Services, Children’s Advocacy Centers, Health Departments, and community partnerships such as housing programs and Faith Based services.

**Family Preservation and Reunification Services continuum and Outcomes**

|  |  |  |
| --- | --- | --- |
| **Family Preservation and Reunification Services** | **Duration and Service Intensity** | **Calendar Year 2015 Data** |
| **IFPS** - Intensive Family Preservation Services  **Referral Criteria:** Imminent risk of removal of child from home. | **Duration:** Average 4-6 weeks.  **Service Intensity:** Intensive in-home services provided for 5-10 direct hours per week.  **Caseload:** 2 – 4 families at a time.  **Age limit:** 0-17 years old. | 851 of 957 families completed services  1738 of 1861 children remained safely in the home (94%) |
| **FRS** - Family Reunification Services  **Referral Criteria:** Plan to return child home within the 15-month period (of last 22 months) since the child entered out-of-home care. | **Duration** Average 4-17 weeks  **Service Intensity:** Average minimum 3-8 direct hours per week.  **Caseload:** Not to exceed 4 cases at a time.  **Age limit:** 0-17 years old | 157 of 185 families completed services  250 of 284 children remained safely in the home (88%) |
| **FACTS** - Families and Children Together Safely (preservation/ reunification)  **Referral Criteria:**  Child at risk of removal from home or child in out-of-home care (longer than 15 months) to be reunified with family. | **Duration** Average 4-17 weeks  **Service Intensity:** Average minimum 3-8 direct hours per week. Intensity is determined based on needs of family.  **Caseload:** Not to exceed 4 cases at a time.  Age limit**:** 0-17 years old | **FACTS Preservation**  437 of 481 families completed services  837 of 885 children at risk remained safely in the home (94%)  **FACTS Reunification**  105 of 117 families completed services  186 of 202 children at risk remained safely in the home (92%). |

From January 1, 2016 through December 31, 2016, there were 1,739 families with 3,232 children at risk of out of home care placement or reunifying from foster care participating in one of the FPP services (data retrieved March 21, 2017). 3,024 of those children were reunified with their families or remained home safely at close indicating a 94% success rate.

The following data shows the number of families and children served by service and the primary indicators of program goals to maintain children safely at home with the family and maintain Permanency and stability in their living situations. A percentage rate of 75% or more of children remaining in the home indicates that the services were successful.

Intensive Family Preservation (IFPS):

• 957 families accepted

• 851 families completing services

• 1861 children at imminent risk of placement

• 1751 of 1861 children remained safely in the home (94%)

Time-Limited Reunification (FRS):

• 185 families accepted

• 157 families completing services

• 284 children to be reunified

• 250 of 284 children safely returned to home (88%)

FACTS Preservation

• 481 families accepted

• 437 families completing services

• 885 children at risk

• 837 of 885 children at risk remained safely in the home (94%)

FACTS Reunification

• 117 families accepted

• 105 families completing services

• 202 children at risk

• 186 of 202 children at risk remained safely in the home (92%)

Families and children who have completed FPP services are also followed at 3, 6, and 12 months after completing services to determine if the child who was at risk of removal (or was reunified) remains in the home. The 6-month follow up contact is a face-to-face visit with the family and child if possible and includes a review with the family of the maintenance of safety and family functioning goals.

**Follow- up Activity Completed from January 2016 -December 2016**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **6 Month Follow Up** | **IFPS** | **FRS** | **FACTS Preservation** | **FACTS Reunification** | **All FPP** |
| **Number of Children at Risk with a Follow-Up** | 1624 | 252 | 732 | 157 | 2765 |
| **Number of Children at Risk in Home at Follow-Up** | 1334 | 215 | 638 | 131 | 2318 |
| **Percent of Children at Risk in Home at Follow-Up** | 82% | 85% | 87% | 83% | 84% |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **12 Month Follow Up** | **IFPS** | **FRS** | **FACTS Preservation** | **FACTS Reunification** | **All FPP** |
| **Number of Children at Risk with a Follow-Up** | 1326 | 246 | 752 | 153 | 2477 |
| **Number of Children at Risk in Home at Follow-Up** | 1057 | 185 | 633 | 130 | 2005 |
| **Percent of Children at Risk in Home at Follow-Up** | 80% | 75% | 84% | 85% | 81% |

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

In the chart below, outcomes for families completing IFPS (represented by “n”) during 2016 are evaluated by showing the overall change in the percent of families who scored at or above baseline in each of the five categories at Intake and Closure.

The chart above shows significant improvement that families made in the domains of Parental Capacity and Family Safety at the completion of IFPS services. Parental Capabilities domain is one of three domains namely; Parental Capabilities, Family Safety and Child wellbeing, where families referred to the Family Preservation Program usually experience low scores ranging from moderate to serious problem. Comparison of the intake and closure scores reveal that greater gains were made in Parental Capabilities (33% increase) and in Family Safety (30% increase). An increase in scores in parental capabilities normally correlates to an improvement in scores in family safety and child wellbeing. This shift in NCFAS scores indicates that incremental and impactful improvements can be measured during the IFPS intervention.

Current and upcoming activities:

* For SFY 2017 - 2018, the Cabinet will require Service Providers to select and be trained in preapproved intensive evidence-based practice (EBP) models for In-Home Services provision.
* All FPP programs currently report their data online using the In-Home Services (IHS) Activities Data Collection tracking system. The data collected informs evaluative efforts.
* Interim checks matching data from the monthly reports submitted online are helping providers and Central Office improve both data entry and the quality of the reports that can be run. This has greatly improved the consistency of data reported statewide.
* The data collected is used to closely monitor service provision and to evaluate overall program improvement and quality assurance.

## Family Resource and Youth Service Centers

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

* Early learning and successful transition into school;
* Academic achievement and wellbeing while in school; and
* Graduation and transition into adult life.

At the state level, the Division additionally conducts a minimum of three regional information-sharing meetings with local staff annually. Local FRYSC programs are located in 1180 of Kentucky’s nearly 1250 public schools. There is at least one program in all 120 of Kentucky’s counties. This initiative is a part of educational reform legislation that calls for centers to be established in or near schools where 20% or more of the school’s enrollment qualifies for free school meals. In the 2000 session of the General Assembly this criterion was altered to 20% of a local school’s enrollment qualified for free or reduced priced school meals. Local FRYSCs have consistently worked to either connect with or initiate local collaborative partnerships to identify current resources and expand existing networks. FRYSC staff attend local Inter-Agency Councils and Vision groups as well as other collaborative meetings. They are also statutorily required to be a part of local Early Childhood councils. The local FRYSCs are also involved in numerous community groups that focus of specific issues such as substance abuse, mental health counseling, physical health issues, and numerous others. Each local FRYSC is required to have an advisory council that involves community partners, parents, and school staff. Some communities have KIDS meetings (Kentucky Integrated Delivery System) which serve as a collaborative effort to case conference regarding specific needs. Many local FRYSCs are involved in writing grants to fund initiatives through their local centers.

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

* Preschool child care
* After-school child day care
* Families in training
* Family literacy services
* Health services and referrals

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

* Referrals to health and social services
* Career exploration and development
* Summer and part-time job development (high school only)
* Substance abuse education and counseling
* Family crisis and mental health counseling

## Family Violence Prevention Funds

The Family Violence Prevention and Services Grant is administered for Kentucky by the Cabinet for Health and Family Services (CHFS), which contracts with the Kentucky Coalition Against Domestic(KCADV) for implementation. KCADV subcontracts with 15 domestic violence programs in the 15 area development districts across the state for direct service implementation regionally. The domestic violence programs provide shelter and related services to victims of domestic violence and their dependent children. The mission of the KCADV is to end intimate partner violence, promote healthy relationships and engage communities through social change, economic empowerment, educational opportunities and other prevention strategies. Funding for KCADV comes from the Family Violence Prevention and Services Grant, Kentucky General Fund, Temporary Assistance for Needy Families, Kentucky Trust and Agency, and Social Services Block Grant.

Shelters are geographically distributed to be approximately 60 miles from any resident in the state.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **SFY 2011** | **SFY**  **2012** | **SFY**  **2013** | **SFY**  **2014** | **SFY 2015** | **SFY**  **2016** |
| **Children who are residents** | 1,713 | 1,823 | 1,713 | 1,252 | 1,244 | 1,512 |
| **Agency advocacy** | 10,151 | 11,881 | 15,434 | 12,945 | 6,190 | 2,184 |
| **Individual counseling**  **contacts** | 11,773 | 7,735 | 52,867 | 56,475 | 11,418 | 20,299 |
| **Group counseling hours** | 7,880 | 4,952 | 29,122 | 24,458 | 5,431 | 6,294 |
| **Group counseling participants** | 10,827 | 6,316 |  |  |  |  |
| **Non-residential**  **Services for**  **Children** |  |  | 892 | 684 | 854 | 860 |
| **Eligible but unable to shelter** | 576 | 1,271 | 1,554 | 1,347 | 1,506 | 1,164 Adults and Children |
| **Children who receive services** | 932 | 699 | 892 | 1,252 | 2,098 | 2,354 |
| **Agency advocacy** | 1,329 | 1,695 | 15,635 | 12,945 | 6,190 | 26,894 |
| **Individual counseling participants** | 1,942 | 1,762 |  |  |  | 3,770 |
| **Group counseling sessions** | 826 | 879 | 29,122  hours | 24,458  hours | 5,695 hours | 5,093 hours |
| **Group counseling participants** | 740 | 790 |  |  |  |  |

The Kentucky Coalition AgainstDomestic Violence Association started collecting data in SFY 2009, requesting victims to complete surveys concerning awareness of resources in the community and confidence in safety plans. The following chart demonstrates the percentages of individuals who had a better understanding of the resources in the community and confidence in their safety plan for the past 5 years.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Residential Surveys** | **SFY 2011** | **SFY 2012** | **SFY 2013** | **SFY 2014** | **SFY 2015** | **SFY 2016** |
| **Awareness of resources in the community** | 97% | 94% | 91% | 94% | 94% | 95% |
| **Confidence in safety plan** | 96% | 96% | 94% | 96% | 96% | 97% |
| **Non-residential Surveys** | **SFY 2011** | **SFY 2012** | **SFY 2013** | **SFY 2014** | **SFY 2015** | **SFY 2016** |
| **Awareness of resources in the community** | 97% | 96% | 96% | 97% | 97% | 96% |
| **Confidence in safety plan** | 97% | 98% | 97% | 98% | 98% | 96% |
| **Support Group Services** | **SFY 2011** | **SFY 2012** | **SFY 2013** | **SFY 2014** | **SFY 2015** | **SFY 2016** |
| **Awareness of resources in the community** | 93% | 96% | 92% | 94% | 94% | 96% |
| **Confidence in safety plan** | 95% | 97% | 92% | 96% | 96% | 97% |

The Kentucky Coalition Against Domestic Violence (KCADV), along with their member programs, has conducted and participated in many training events. During the last state fiscal year, member programs have provided 460 professional training initiatives with 11,155 participants. They participated in 474 public awareness events and had 555 media contacts to educate the community about the plight of victims of domestic violence and the services offered locally. In addition, the KCADV reports that 2,267 youth targeted public education programs were held with 11,820 participants and 460 community education programs were held with 11,155 participants.

The Kentucky Coalition Against Domestic Violence operates an annual Training Institute, which provides educational sessions for groups such as attorneys, nurses, social workers, teachers, and translators. The Kentucky Coalition Against Domestic Violence works closely with judges and frequently participates in law enforcement training.

The local programs associated with KCADV work with Child Protective Services across the state to reunify children and parents. All local programs are involved with the local coordinating councils, which bring together child protective services and other community agencies, to streamline services and resolve problems in assisting victims of domestic violence and prevent future instances of violence. All programs operating under KCADV provide court advocacy to victims of domestic violence and work closely with law enforcement agencies.

During SFY 2016, the domestic violence shelters provided shelter and services to 18,942 victims of domestic violence and their 1,906 dependent children, for a statewide total of 20,902.

Services offered by programs across the state consist of crisis lines, emergency shelter, intervention, advocacy, counseling, case management, children’s services, public education, community awareness, and professional training. Counseling services for SFY 2016 are detailed in the following chart:

|  |  |  |  |
| --- | --- | --- | --- |
| **Counseling Services** | | | |
| **Residents** | | **Non-Residents** | |
| **Ind. Counseling** | |  | |
| **Women** | 74,333 | **Women** | 16,871 |
| **Men** | 302 | **Men** | 1,343 |
| **Children** | 7,478 | **Children** | 400 |
| **Total** | 82,113 | **Total** | 18,614 |
| **Group Counseling Hours** | |  | |
| **Women** | 28,843 | **Women** | 7,886 |
| **Men** | 51 | **Men** | 1,157 |
| **Children** | 5,533 | **Children** | 81 |
| **Family** | 713 | **Family** | 310 |
| **Total** | 35,140 | **Total** | 9,154 |

Domestic violence shelters have recently incorporated or developed a plan for the following:

* Limited therapy for children ages 8–18
* Structured summer program with activities for moms and children
* Structured age appropriate groups for residential and non-residential children, including outreach
* DV victims group for teens ages 16–19
* Special groups for moms and children including music group and a reading group, encouraging moms and children to be together
* Boy scouts – weekly meetings
* Permanent supportive apartments that should be ready for occupancy soon.
* The Green Dot Primary Prevention Program for teens lowered rates of interpersonal violence by building awareness within the community resources that could help elevate the impact of interpersonal violence on victims and their children.
* Themes for the summer activities centered on literature, related music, movies, and creative activities.
* A separate area for teens to have a space of their own that includes computers, games, comfortable seating, books, headphones, music, etc. This room has been helpful in allowing teens to relax, process their feelings, and given them a sense of belonging.
* Additional space for children's activities.

## Health Access Nurturing Development Services (HANDS)

The Health Access Nurturing Development Services (HANDS) program is a voluntary home visitation program for new and expectant parents, as well as a recent expansion to parents who are parenting other children. Services can begin during pregnancy or any time before a child is three months old. Families begin by meeting with a HANDS Parent Visitor who will discuss any questions or concerns about pregnancy or a baby's first years. Based on the discussion, all families will receive information and learn about resources available in the community for new parents. Some families will receive further support through home visitation. HANDS is supported by federal Medicaid and state Tobacco Funds, and operates statewide as a fee for service program. The program is housed in the local health departments in all 120 counties in Kentucky. The primary goals of the HANDS program include:

* Health pregnancies and births
* Health child growth and development
* Healthy, safe homes
* Self-sufficient families

## Johnson County Community of Hope (JCCOH)

The Johnson County Community of Hope (JCCOH) was developed with the insight and guidance of Judge Janie McKenzie-Wells and Susan Howard, SRA in the Eastern Mountain Service Region, after Casey Family Programs expressed interest in supporting a rural and community based initiative - featuring a substance abuse treatment component - that would be responsive to the needs to Johnson County and help strengthen families. The newly created Johnson County Community of Hope’s vision was to build a community based set of services and interventions that would serve to reduce the number of children in out of home care, and the number of dependency, neglect and abuse cases across the county. A Steering Committee was created and worked to develop and coordinate a substance abuse program within the community. After almost a year of work and planning, the committee devised a three-prong approach to meeting the needs of the community. In conjunction with the substance abuse program, a mentoring sub-committee was created to establish a program of that provides skills and resources to the women involved in the JCCOH substance abuse program, in addition to others within the community. Weekly sessions include: life skills, ages and stages, reality life skills, health care and supportive services, child’s play, gardening, financial aid and scholarships, budgeting, quilting and crocheting, CPR and first aid - and the list continues to grow. These sessions are based upon a needs inventory developed by the committee and distributed to the participants by the substance abuse program peer mentors. As needs are identified within the population receiving services, the mentoring committee strives to meet the needs by the coordination of sessions targeting their specific requests. All speakers and presenters are from the local community. They present within their area of expertise. (These services continue to occur, however they are now being held at the JCCOH substance abuse treatment location as opposed to the Johnson County Public Library. This change in location has greatly increased attendance and interest in the sessions). Referrals to the program are primarily received from the department, as well as Family Court and self-referrals. As of 2015, 62 referrals have been made to the program. The treatment program has been accepting clients for approximately five months. Within this short timeframe, there are currently 26 women participating within the program.

Throughout the reporting period (January 1, 2016 – December 31, 2016) JCCOH has continued to use the three-prong approach to meeting the needs of the community. The JCCOH Steering Committee held quarterly meetings throughout 2016 with the last meeting being held on November 4th, 2016. The Governing Board, along with key Steering Committee members, has worked to strategically expand membership and to generate interest in JCCOH. Ms. Bonnie Blankenship of the Federal Reserve Bank of Cleveland continues to be a member of the Steering Committee and is a valuable resource and continues to work with the committee on the pressing need of housing. Adam Rice from Congressman Hal Roger’s office was present for most of 2016’s Steering Committee meetings and continues to support the program.

The Governing Board and the Steering Committee commissioned the University of Kentucky Social Work program to conduct research regarding JCCOH programs in 2016. Dr. Ted Godlaski from the University of Kentucky was the lead researcher for the project. Dr. Godlaski utilized face-to-face interviews with JCCOH clients and staff in addition to using the Client Evaluation of Self and Treatment (CEST) as the primary evaluation tool. Dr. Godlaski was present at the November Steering Committee meeting and presented the results of his research. Dr. Godlaski found that almost all of the clients interviewed had a negative view of treatment upon entering the program, after being in the program their attitudes changed dramatically to a positive view of treatment, the women felt welcomed in a non-judgmental fashion, and all felt that the staff had their best interest at heart. The women also found great benefit in the programs offered at the Johnson County Public Library. In his report, Dr. Godlaski concluded by saying “by every measure it would appear that the Johnson County Community of Hope is successful in achieving its mission to assist substance misusing women who have lost custody or are at risk of losing custody of their dependent children to change their lives in responsible and beneficial ways. “

The Substance Abuse committee and the Mentoring committee have begun to focus their efforts around two key areas: sustainability and housing. In regards to sustainability, the Mentoring Committee has added a grant writer in order to train/advise committee members on the grant writing/application process. The ability to obtain grants will be critical in making JCCOH sustainable moving forward. Housing has been identified as one of the most pressing issues facing the women who are currently participating in the JCCOH substance abuse program. In order to address this issue, Susan Howard has brought together stakeholders within the community such as representatives of the Johnson County Housing Authority, Bonnie Blankenship, and key members of the Mentoring/Substance Abuse committees. Plans are currently underway to be able to utilize non-traditional types of housing such as repurposed storage containers. This idea has had great success in other communities and the committee is excited to pursue this opportunity.

The JCCOH substance abuse program continues to offer treatment and peer support services five days a week. The program has 21 women participating at this time. This number fluctuates as some women leave the program and new referrals are made. 31 new referrals have been made during this reporting period, several participants have been able to develop payment schedules for fines, resolve bench warrants, and have paid child support or made arrangements to make payments. 8 participants have had their children (23 kids) returned to their custody during this reporting period, 8 have lost custody and permanency was granted to relatives, 7 have lost custody of their children with the permanency goal being changed to adoption, and 8 are now getting supervised visitation. The program has had 6 participants to graduate and several of the participants are now attending college classes.

The substance abuse program also began a Narcotics Anonymous group for the participants and was able to purchase the NA Big Books and the Just for Today Medication text for each of the participants. Participants also received backpacks with the JCCOH logo to carry their materials to the program.

Through a collaborative effort between the department, Big Sandy Area Development District, and Casey Family Programs the substance abuse program continues to employ a Job Coach. The job coach has been very successful having been able to find employment for six participants. The Job Coach also teaches employment readiness, interview skills, resume writing, and establishes relationships with employers in the community, which will benefit the participants.

The JCCOH was able to move into their own building in December 2016. The new building includes a kitchen, two conference rooms, therapy rooms, and a group room. The new facility offers much more space and privacy for the staff and clients. There are also plans to build transitional housing in close proximity to the facility.

As part of the Education Committee, the High Expectations Coordinator serves at-risk youth in both the Paintsville Independent School System and the Johnson County School System. At-risk youth are defined as possibly re-entering foster care, having extreme acting out behaviors, unmet mental health needs, truancy, substance abuse, social isolation, and the inability to concentrate on classroom issues among others. The overarching goal of the High Expectations program is having fewer children in foster care. To this end, the High Expectations Coordinator coordinates the educational program for the at-risk youth, provides service coordination, strengthens partnerships between the school, home, and the community, provides counseling to individual students, and works to build strong families.

For the reporting period, the High Expectations Coordinator had 117 referrals, provided services to 96 students, had an average caseload of 37 students, and had four students in out of home care and one student in an adoptive placement. Key activities for the reporting period included regular meetings with school principals and resource directors, regularly scheduled meetings with students to discuss grades and progress, regularly scheduled meetings with cabinet social workers and families to discuss active cases, participate in student conferences, and attend regularly scheduled meetings with school based therapists to discuss student issues, progress, and concerns.

In October 2016, JCCOH was able to purchase 14 Chrome books for at-risk youth in the Johnson County School system. Chrome Books give teachers access to Google Classroom and other online learning activities that allow them to personalize education for each individual student.

## Kentucky Center for School Safety (KCSS)

Kentucky Center for School Safety (KCSS) is a statewide collaborative effort. Activities are funded through state general funds. A board of directors operates the center, and the board oversees projects and dispersal of state funds to all school districts for projects and activities that enhance school safety. The 12-member board is appointed by the Governor and meets quarterly. KCSS Board of Directors approved a formula for the distribution of funds to all KY school districts:

**SFY17**

Amount to be appropriated: $10,378,300

Minus $20,000 base for each district ($3,500,000 total)

$5,778,300 remaining funds to be distributed at $9.52 per pupil based upon current average daily attendance of 605,555.

Members of the center include representatives from the Kentucky Educational Collaborative for State Agency Children (KECSAC), Department for Juvenile Justice (DJJ), Department for Mental Health (DMH), Department for Community Based Services (DCBS) and Kentucky Department of Education (KDE). The center collaborates with the Kentucky School Boards Association (KSBA) Murray State University, and the University of Kentucky. Additionally, KSBIT (Kentucky School Boards Insurance Trust) works with KCSS to provide the services of Loss Control Specialists for schools/districts.

Kentucky Center for School Safety (KCSS), Kentucky Department of Education (KDE), and Kentucky School Boards Association (KSBA) collaborate to provide safe school assessments to any school in Kentucky. The voluntary assessment can enhance the school's learning environment by examining climate and culture. KCSS oversees and distributes safe schools funds to each local school district, the Kentucky School for the Blind, and the Kentucky School for the Deaf. A Safe School Assessment is a service provided by the Kentucky Center for School Safety at no cost to the school or district.

During the 2013 legislative session, HB 354 passed. This requires that all schools have an emergency plan, emergency drills, an annual report sent to the Department of Education, a lockdown practice, and local boards to review crime prevention designs when constructing new schools and develop protocols for student records within the student information system, which provides schools receiving the records an awareness of prior offenses. It encourages chiefs of police to receive training on issues pertaining to school and student safety. It encourages sheriffs to receive training on issues pertaining to school and student safety. In addition, it includes the adoption of an emergency response plan as part of school council duties.

## Kentucky Children’s Health Insurance Program (KCHIP)

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

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

Additional information about KCHIP can be found at [http://www.kidshealth.ky.gov](http://www.kidshealth.ky.gov/) and other Medicaid programs can be found at <http://chfs.ky.gov/dms/KCHIP.htm>.

Title XXI and State General Funds fund KCHIP and services are available statewide. KCHIP uses quality standards, performance measures, and information and quality improvement strategies to assure high quality care for KCHIP enrollees. Data is collected to maintain fiscal resources and proper administration.

Due to the Affordable Care Act requirements, children below 138% FPL (P5 status codes) in the KCHIP Expansion Program were transitioned into Medicaid effective 1/1/2014. Per CMS direction and funding purposes, this group of children continues to be counted with the number of children served in the KCHIP Expansion Program. Per FY 2016 final reports, CMS 64 EC-21E (Expansion) and CMS -21E (KCHIP), 92,728 children were served during FFY 2016. KCHIP operated within its forecasted expenditures, averted the elimination of any services and maintained enrollment levels without instituting a waiting list, lowering eligibility or reducing benefits.

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

The MCO’s 2016 CAHPS survey indicates that overall utilization of health services by KCHIP recipients are high; access to needed care and specialized care do not appear to be major problems for KCHIP recipients; recipients’ are largely satisfied with their experiences of care; and evaluations of health care providers, health services and KCHIP-related health plans are generally positive.

KCHIP’s goals are to continue to increase retention efforts, maintain current level of outreach, and to continue to increase enrollment.

## Kentucky Education Collaboration for State Agency Children

Kentucky Educational Collaborative for State Agency Children (KECSAC) is a statewide collaborative that works with State agencies, school districts and local programs to ensure that State Agency Children receive a quality education comparable to all students in Kentucky. “State Agency Children” (SAC) are all children and youth placed in programs contracted, funded and/or operated by the Department of Juvenile Justice, the Cabinet for Health and Family Services, which includes the Department for Community Based Services (DCBS) and the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) in the State of Kentucky.

KECSAC is committed to the belief that all children can learn and have a right to quality education. KECSAC protects and assures this right by accessing resources and providing support to programs that educate State Agency Children. KECSAC staff meets quarterly with the Interagency Advisory Group, which consists of the following collaborative partners: Department of Juvenile Justice, Department for Community Based Services, the Department for Behavioral Health, Developmental and Intellectual Disabilities and the Kentucky Department of Education and the College of Education at EKU.

KECSAC distributes the state agency children’s fund to programs that serve state agency children in educational settings. The funds must be used by educational programs in state educational districts to provide smaller student to teacher rations (10:1) and to provide extended school days during the academic year (an additional 35 educational days are required in order to receive State Agency Children Funds). In addition to providing the funding for educational programs that serve state agency children, KECSAC also provides training to educators and administrators in the programs. Annually, KECSAC provides professional development opportunities for educators through their At-risk conference and *Teaching in Action Series*. Professional development events are free to KECSAC program members and consistently rank very well in evaluations from attendees.

Currently, KECSAC operates 86 educational programs in 52 school districts. Thirty-nine of these programs contract with the department. In KECSAC schools there are 346 full-time certified on-site educators, 166 Full-time Exceptional Education Certified, 7 full-time emergency certified educators, 59 full-time administrators, 140 full-time teaching assistants and 98 other support staff.

Program improvement specialists use a tool, which is aligned with Kentucky’s standards and indicators, to audit the educational services provided the youth in state care. Specialists observe classrooms, review prepared evidence, as well as interview the school administrator, program administrator, teacher, and students. If needed recommendations for improvement are communicated to the program and a follow-up visit is scheduled. Attention is also paid to progress made from the previous year’s report to ensure programs are continuing to meet standards and improve curricula. In 2015-2016, every program is visited at least once to ensure youth are receiving a quality education.

KECSAC Services Include:

* Distributing state agency children’s funds to school districts for local programs serving state agency children.
* Providing program improvement support through annual visits completed by Program Improvement Specialists.
* Providing training and technical support to SAC and other educators and administrators.
* Providing facilitation services and mediation support to districts and programs when needed to settle disputes between school districts and programs.
* Publishing a quarterly newsletter, *The Collaborative,* annual census report, annual program directory, and quarterly and annual progress reports.
* Reviewing and recommending revisions to KECSAC regulations and statutes.

As illustrated below, the total number of children served in KECSAC programs in 2016 was 2150. DCBS children comprised 1351 or 62.8% of the total population served.

Below is the number of children of state agency children broken down by classification, which includes: children court ordered to attend the program, children committed to or in the custody of DCBS and children placed in a private facility.

The number of children from the department being served by KECSAC programs has been increasing since 2006. This rise may the result of the court system attempting to serve more children through community resources and divert children from entering into the Department of Juvenile Justice (DJJ).

The chart below denotes the count of youth in program type.

Senate Bill 200 went into effect July 2015. The purpose of this legislation is to use resources more efficiently in order to hold youth accountable, and in the process achieve better outcomes. This legislation affects youth who have a status, misdemeanor, or Class D felony offense. In addition, “This legislation makes major changes to the policies and practices in the Administrative Office of the Courts and Department of Juvenile Justice. The legislation makes minor changes to the policies and practices in the Department for Community-Based Services (DCBS), the Department of Behavioral Health, Developmental and Intellectual Disabilities (DBHDID), and the Department of Education (KDE). The legislation also creates new responsibilities for local agencies that are named representatives of the newly established Family, Accountability, Intervention and Response (FAIR) teams. Moreover, this legislation may result in fewer children being served by KECSAC programs in the future.

## Kentucky Partnership for Families and Children, Inc. (KPFC)

KPFC is a private, not for profit, family organization that serves the entire state of Kentucky. KPFC is the state chapter for the National Federation of Families for Children’s Mental Health and is the Center for Mental Health Services Statewide Family Network grantee for Kentucky. Since KPFC is a family-organization, over 51% of the KPFC board of directors must be parents/primary caregivers of children with emotional, behavioral, and/or mental health disabilities. KPFC staff, parent leaders and transitional-age youth leaders participate on multitude of state level and regional level committees:

* SIAC Subcommittees;
* University of Louisville’s Project SAFE SPACE in partnership with DCBS and DBHDID;
* Kentucky Center for Instructional Discipline (PBIS);
* Parent/Professional Conferences planning teams;
* Children’s Justice Act Task Force;
* Transition Age Youth Launching Realized Dreams;
* Kentucky Interagency Transition Committee;
* Strengthening Families Leadership Team, and others.

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

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

In 2016, KPFC succeeded in the following:

• Quarterly newsletters disseminated to 3000+.

• Conference and workshop attendance: 500+

• Children’s Mental Health Awareness Day: 90+

• Resource requests: 500+

## Kentucky Strengthening Families

Kentucky Strengthening Families (KYSF) represents a multi-disciplinary partnership of over 20 national, state and local, and public and private organizations dedicated to embedding six research-based Protective Factors into services and supports for children and their families. Supporting families is a key strategy for promoting school readiness and preventing child abuse and neglect. All families experience times of stress, and research demonstrates that children grow and learn best in families who have the supports and skills to deal with those times. By supporting families statewide and building their skills to cope with stressors, school readiness can be increased and a reduction in the likelihood abuse will occur in families. Kentucky Strengthening Families is using a nationally recognized strategy—Strengthening Families: A Protective Factors Framework – which is coordinated nationally by the Center for the Study of Social Policy. The vision of KYSF is that all Kentucky Children are healthy, safe and prepared to succeed in school and in life through families that are supported and strengthened within their communities. The mission of KYSF is strengthening families by enhancing protective factors that reduce the impact of adversity and increase the well-being of children and families through family, community, and state partnerships. KYSF is supported by the Governor’s Office for Early Childhood (GOEC) through funds from the Race to the Top/Early Learning Challenge Grant and the Early Childhood Comprehensive Systems Grant administered by the Department for Public Health. KYSF is a statewide, long-term initiative, with ten-year goals.

The Strengthening Families conceptual framework involves building research-based Protective Factors around young children by working differently with their families across all child- and family-serving organizations and systems. This approach includes aligning systems with protective factors, using data driven decision-making, marshaling leadership and making policy and systems changes on multiple levels.

In 2013, the Governor’s Office of Early Childhood and the Kentucky Department for Public Health convened a group inclusive of many organizations that touch families to explore the implementation of the Strengthening Families framework. These organizations represented by the Leadership Team made a commitment to embed the protective factors in the daily practice of government and community-based programs. In January 2014, the Leadership Team developed a strategic plan to move the Kentucky Strengthening Families initiative forward in the Commonwealth and has revised this plan in 2015, 2016, and 2017. Workgroups have created tools to assist partnering agencies and programs with embedment of the KYSF Protective Factor framework into programs. These tools include a website, marketing materials, childcare training, Theory of Change, level of involvement tool, program assessment tools, as well as Parent Café training and toolkit.

KYSF trainers were recruited based on training locations and the types of services their agency provides to families and children. Trainers from 28 different home-based cities provide statewide coverage for face-to-face trainings in all system types. KYSF instituted Web-Based Learning Communities to help trainers from across the state and different service systems stay connected. Trainers can access system-specific resources and collaborate with other trainers across the state in online discussion boards. Learning Community Leads are assigned to each of the six overarching system groups to help facilitate networking and partnership among trainers. In the fall of 2015, a free web-based KYSF training was launched to further support providers who are unable to attend face-to-face trainings. This web-based version is free of charge with over 1,693 participants having utilized this training. The Training and Technical Support Workgroup meets in person bi-monthly to provide support and continue innovating more ways to support this cohort of trainers and web-based module users. To date, over 5,000 service providers have been trained on Kentucky Strengthening Families. In April 2017, the KYSF Leadership Team will host its first annual KYSF Summit to over 180 participants from 50 state, regional or agency teams. These teams will develop their own agency or community action plan during the KYSF Summit to begin to implement or further embed the Protective Factor Framework into their existing services or community.

KYSF workgroups are creating tools to assist in partnering agencies and programs with embedment of the KYSF Protective Factor framework into programs. These tools include a website, marketing materials, childcare training, program assessment tool, and the Parent Café training and toolkit. Accomplishments since the last submission include: Trained over 110 trainers for the KYSF Overview Training, including 61 ECE-TRIS Active Credentialed Trainers; Developed online trainings and 387 trainings have been completed as of March 2017; Marketing materials developed; Provided training to over 100 people on how to host the KYSF Parent Café and toolkit.

The leadership team has completed a baseline collective impact survey and will reassess in the future. The leadership team developed an agency self-assessment tool that was piloted in April 2016.

Through the recent work completed by the Systems Integration and Evaluation workgroup, several new tools have been developed including Theory of Change, Level of Involvement, Agency Readiness Survey, and agency self-assessment tools. These tools will be introduced at the KYSF Summit in April 2017 for agencies and communities to implement. Each team that attended will provide data as well as feedback on the usefulness of these implementation and evaluation tools in the coming months. The System Integration and Evaluation workgroup has finalized the existing system indicators to measure the impact of the overall KYSF Initiative.

KYSF receives technical assistance from the Center for Study of Social Policy and CDC Essentials for Childhood TA system for non-grant funded sites.

## Michelle P Waiver Program

The Michelle P. Waiver (MPW) is a home and community-based waiver under the Kentucky Medicaid program developed as an alternative to institutional care for individuals with mental retardation or developmental disabilities. It was designed so that people who were placed in institutions could return to or remain in their communities. MPW allows individuals to remain in their homes with services and supports. Adults and children alike are eligible for the program as long as the meet the criteria for eligibility.

Michelle P services include:

* Case Management
* Adult Day Training
* Supported Employment
* Community Living Supports
* Behavior Supports
* Occupational Therapy
* Physical Therapy
* Speech Therapy
* Respite
* Homemaker Service
* Personal Care
* Attendant Care
* Environmental/Minor Home Adaptation
* Adult Day Health Care

The Department of Medicaid has changed who can perform services for Occupational (OT), Physical (PT) and Speech Therapies in the Michelle P Waiver program for members under the age of 21. The Early Periodic Screening, Diagnosis and Treatment Special Services (EPSDT SS) program will provide therapy services. In order for the agency to continue providing OT, PT, and Speech Therapy services to their current members, they will have to become Early Periodic Screening, Diagnosis and Treatment Special Services providers. The Department of Medicaid sent a letter to all providers on October 1, 2012 informing them of the change.

## Multidisciplinary Commission on Sexual Abuse

The Kentucky Multidisciplinary Commission on Child Sexual Abuse (KMCCSA), staffed by the Office of the Attorney General, has worked for the past two years to update the model protocol for local multidisciplinary teams regarding investigation and prosecution of child sexual abuse and the role of the children's advocacy center on multidisciplinary teams (KRS 431.660). The model protocol provides an extensive description of each team member's role and responsibility. The statute requires protocols to be developed in each county or group of contiguous counties by the team (KRS 431.600). In the fall of 2015, the Commission began to present the Revised Multidisciplinary Team Protocol at the Prevent Child Abuse Kentucky Conference, Kentucky Victim Assistance Conference and the 17th Annual Ending Sexual Assault and Domestic Violence Conference. In addition, the Commission collaborated with the Kentucky Association of Children’s Advocacy Centers and the regional Children’s Advocacy Centers to present training on the protocol across the state. The updated/revised model protocol went into effect January 2016. All Multidisciplinary Teams will have submitted their revised MDT Protocol by April 1, 2016. The Commission will begin reviewing the protocols after submission.

## Passport Health

The Passport Health Plan is a provider-sponsored HMO that provides medical services for children 0 to 18 years of age. The Plan serves approximately 243,893 members in the Commonwealth of Kentucky, which is comprised of the following 16 counties: Jefferson, Oldham, Trimble, Carroll, Henry, Shelby, Spencer, Bullitt, Nelson, Washington, Marion, Larue, Hardin, Grayson, Meade, and Breckinridge. Passport is a Medicaid program. Children in foster care in these counties are specifically supported by a liaison between Passport and the child welfare agency. Program staff ensure that children who come into care have medical coverage that promotes healthy developments and better outcomes for all who are involved. A monthly report is developed to guarantee that children in care are presently active with Passport so that coverage is available to pay for all their medical claims. A certain code is entered into Passport’s system for children in care to declare special privileges for extended coverage. In addition, daily information is specified regarding the status of a child’s placement to ensure on-going health coverage as well. On a monthly basis, service plan forms are given to Passport to review with a social worker to see which children need medical case management; this can be for physical, mental, and behavioral health. When a child may need specialized services regarding a unique medical challenge, the MCO liaison coordinates services to meet any individualized need to ensure a positive outcome. The Passport social worker collaborates with child’s benefit workers to review the health needs associated with Passport. Passport’s social worker, the central office MCO liaison, and child benefits workers ensure that mental and physical health services are utilized appropriately in cost and care, and that there are comprehensive referrals being made when needed to ensure positive outcomes.

## Prevent Child Abuse Kentucky

PCAK’s mission is to prevent the abuse and neglect of Kentucky’s children. Goals include: promoting public awareness regarding the prevalence of child abuse and neglect and ways to engage in the prevention of child abuse and neglect, and develop effective prevention strategies and programs. PCAK is a statewide, non-profit network of parents, professionals and volunteers cooperating to develop and maintain child abuse prevention programs throughout the Commonwealth. Through the various community-based programs, parents and children are afforded the opportunity to learn and create a positive attitude toward their differing roles. With this knowledge, the cycle of child abuse can be broken; the aspects of abuse can be identified, treated, and prevented; and parents and children can develop and maintain open, warm and loving relationships.

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

PCAK works closely with Cabinet personnel to ensure the goals and services provided under its programs are aligned closely with the overall Child and Family Services Plan. All subcontractors, local community agencies, are required to implement evidence-based parent education/support group services. All subcontractors are required to have a process to receive referrals from the state child welfare agency and serve families at risk. PCAK subcontracts, through annual requests for proposal, the programs serving parents in each of the nine service regions. The state office of PCAK provides the administration, coordination, training, maintenance and enhancement functions necessary to allow the evolution of viable child abuse prevention options for families. PCAK conducts a variety of outreach programs (Self Help/Parent Education/Support Groups, Partners in Prevention, the statewide “Kids Are Worth It! ®” conference, child abuse prevention month activities, awareness tools, educational initiatives, hotline activities, fatherhood initiatives) throughout the year. Each activity is reported separately below.

**Self Help, Parent Education, and Support Groups**

Services are available in every service region and served 91 counties (of 120) in the state in 2016. Subcontractors are required to utilize the evidenced based Nurturing Parenting curricula along with administration of the parallel Adult-Adolescent Parenting Inventory (AAPI) pre and posttest. The utilization of a single curriculum enhances programmatic consistency across service providers, and strengthens program evaluation through universal use of the AAPI. PCAK created a single account with provider satellites for providers to enter their AAPI data, which allowed for collection and data analysis. Programmatic, training, and evaluation changes have been implemented to encourage integration of the protective factors framework into service delivery. Furthermore, providers are required to administer the UNCOPE assessment to all participants at intake, which is a drug and alcohol screening tool. As part of service delivery, each provider offers an education component on child welfare, from investigation to case resolution. Subcontractors are asked to distribute the child welfare agency’s “[Child Removal Handbook](http://chfs.ky.gov/NR/rdonlyres/196B2F37-D45C-41B7-91A7-DE5873AB9EC5/0/ChildRemovalHandbook2.pdf),” and parents are asked to complete the child welfare agency’s [Customer Satisfaction Survey](http://chfs.ky.gov/dcbs/dcbssatisfactionsurveys.htm).

The content delivered each week of the parent education sessions and/or support group is designed to provide parents with skills relevant to healthy parenting, while encouraging permanency and well-being within the family structure. PCAK collects attendance and referral data from each subcontractor monthly during each SFY. An analysis of the calendar year records reflect 1,296 families began a parent education and/or parent support program at one of the 18 locations during 2016. In this period, PCAK subcontractors provided 13,798 duplicated incidents of service.

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

In 2016, PCAK conducted an in-depth analysis of the AAPI pre and post test data collected from parent education program participants. The Adult-Adolescent Parenting Inventory (AAPI) is a tool used to measure the effectiveness of Prevent Child Abuse Kentucky’s (PCAK) parent education programs. Based on the known parenting and child rearing behaviors of abusive parents, responses to the inventory provide an index of risk for behaviors known to be attributable to child abuse and neglect. The AAPI is universally recognized as a valid and reliable tool used to assess parenting attitudes, knowledge and history.

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

The information gained through this assessment includes:

* Knowledge: What do parents know about appropriate parenting practices?
* Attitudes: What attitudes do parents have about raising children?
* History: What childhood history do parents and teens have that affects their parenting?

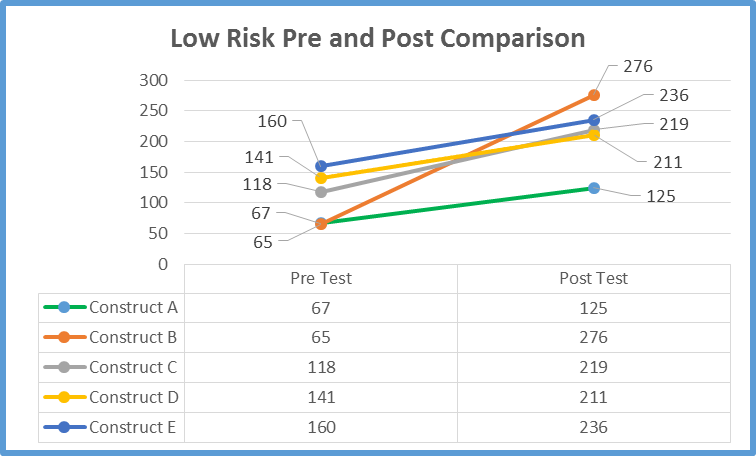
Responses to the AAPI provide an index of risk in five specific parenting and child rearing behaviors:

* Construct A - Inappropriate Expectations of Children
* Construct B - Parental Lack of Empathy Towards Children's Needs
* Construct C - Strong Parental Belief in the Use of Corporal Punishment
* Construct D - Reversing Parent-Child Family Roles
* Construct E - Oppressing Children's Power and Independence

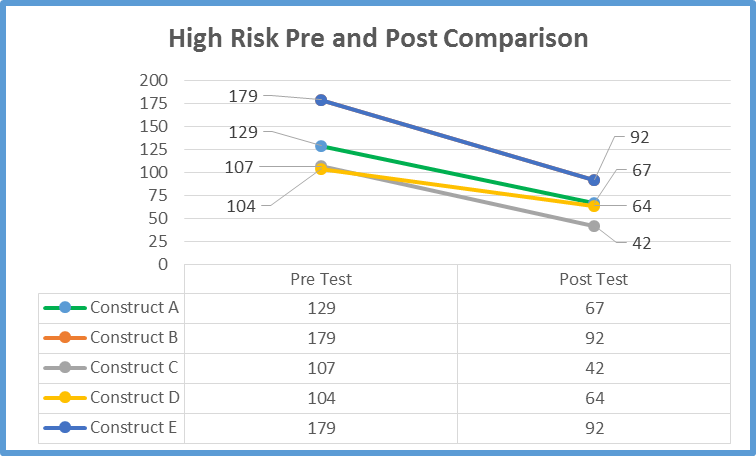
Parents who score “high risk” in the constructs measured by the AAPI are at greater likelihood of abusing their children.

In summary, participants in PCAK’s parent education program demonstrated significant positive changes in all five constructs measured by the AAPI. The number of families found to be at low risk increased, while the number of families at high risk decreased. Chart #1 reflects an increase in the number of families at low risk, and Chart # 2 demonstrates similar movement in families from high risk toward low risk behaviors and attitudes.

**LOW RISK Pre and Post-test Comparison (Chart #1):** The pretest results demonstrate the number of parent education participants within the low risk category for each construct at the beginning of parent education classes. The post-test results demonstrate the number of parents moving from high or medium risk category to the low risk category at the end of their parent education classes.



**Chart 1**



**HIGH RISK Pre and Post-test Comparison (Chart #2):** The pretest results demonstrate the number of parent education participants within the high-risk category for each construct at the beginning parent education classes. The post-test results demonstrate the number of parents moving from high or medium risk category to the low risk category at the end of their parent education classes.

**Chart 2**

**Chart 1**

Positive changes were noted in each construct, with families moving from high to low risk in all five constructs. Rates of movement within each construct are summarized below:

Construct A *addresses appropriate and inappropriate expectations of children*.

*Explanation*: Parents who exhibit low risk in this category understand growth and child development and tend to be supportive of their children.

*Findings*: An indication of the positive impact of the PCAK parenting education programs include an **86.57%** *increase* in the number of parents at *low risk* for Construct A. In direct correlation, the number of parents high risk in Construct A saw a *reduction* of **48.06%**.

Construct B *assesses the ability of parents to demonstrate empathy towards their children*.

*Explanation*: Parents exhibiting a high level of empathy understand and value their children’s needs. Children are nurtured and encouraged to display normal developmental behaviors. Parents increase their capacity to recognize the feelings of their children and are more successful at communicating with them in a healthy manner.

*Findings*: In Construct B, results included a **324.62%** *increase* in the number of parents considered to be at *low risk* to abuse their children while the percentage of parents considered to be at *high risk* in this category was reduced by **48.6%.**

Construct C *addresses parental belief in the use of corporal punishment*.

*Explanation*: Parents who are considered to be low risk demonstrate an understanding of alternatives to physical force while disciplining their children; these parents tend to have respect for their children and their needs.

*Findings*: The number of parents considered to be at *low risk* *increased* by **85.59%** while the number of parents considered to be *high risk* in this category was *reduced* by **60.75%.**

Construct D *focuses on parental ability to enforce appropriate parent-child family roles*.

*Explanation*: These parents tend to have adult relationships where their needs are met. They find comfort, support and companionship from peers, thereby allowing and encouraging their children to grow and develop at their own pace. Parents who exhibit high-risk behaviors tend to perceive their children as objects for adult gratification, and treat their children as confidants and peers.

*Findings*: Following completion of the parenting education program, there was a **49.65%** *increase* in the number of parents considered to be at *low risk* while there was a **38.46%** decrease in the number of parents considered to be at *high risk*.

Construct E *addresses parental capacity to support the child’s power and independence*.

*Explanation*: The parent who is considered to be at low risk places a high value on children’s ability to problem solve and make good choices. Children are encouraged to express their own views while remaining cooperative and respectful of their parents.

*Findings*: There was a **47.50%** *increase* in the number of parents considered to be at *low risk* for abusing or neglecting their children and a **48.6%** decrease in the number of parents considered to be at *high risk*.

**PCAK, Partners in Prevention**

PCAK Partners in Prevention is a network of agencies, individuals and businesses with coverage to the entire state. During 2016, PCAK had 117 Partners in Prevention. These partners allowed for statewide coverage. The network consists of service providers such as volunteer groups, schools, hospitals, businesses, mental health providers, faith-based entities and other community organizations working to spread the message of child abuse prevention. Affiliates are involved in PCAK programming such as trainings and workshops, Self-Help, Parent Education and Parent Support Groups, Child Abuse Prevention Month (CAPM), Kids Are Worth It! Conference, as well as regional and community awareness campaigns. PCAK takes a targeted approach in contacting, meeting with, and formalizing partnerships with groups who will utilize the resources provided in a method increasing the development of awareness and prevention work across Kentucky.

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

As a part of the agency’s quality improvement efforts, PCAK staff initiated a plan to examine our existing partnership efforts. PCAK staff assembled a work group to examine existing practices, developed strategic plans and conducted a partner survey. This survey was conducted in December of 2016, with improvement efforts to be implemented in 2017.

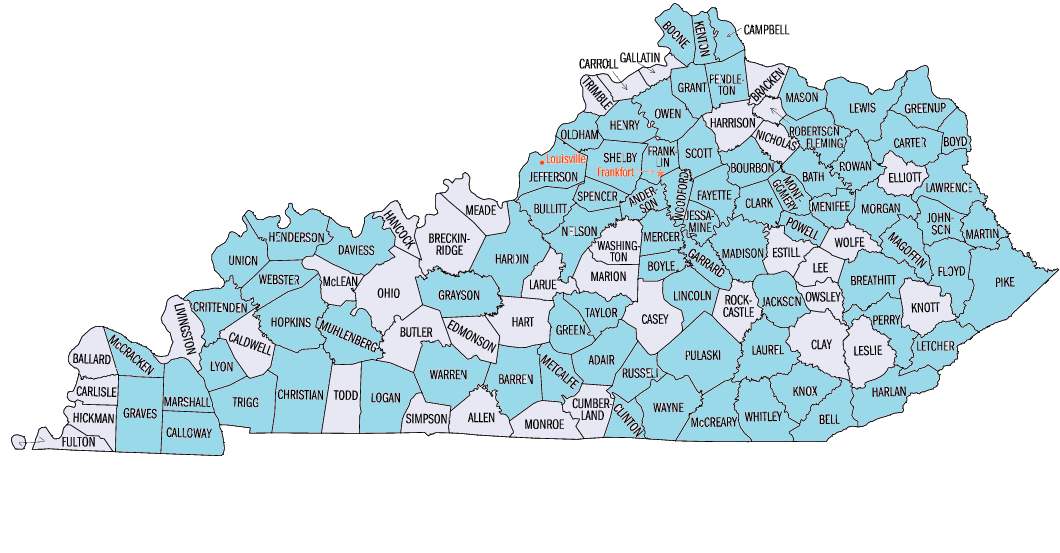
**Prevent Child Abuse Kentucky (PCAK), Kids Are Worth It! ® Statewide Child Abuse and Neglect Prevention Conference**

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

The conference is funded through CBCAP, grants, sponsorships (including Children’s Justice Act funds) and private/corporate donations. The conference is planned collaboratively between PCAK staff and a diverse advisory committee representing a variety of disciplines (including legal, public health, mental health, substance abuse, community services, medical, local government and law enforcement). A variety of geographical regions across the state are also represented by this committee. The advisory committee always includes representatives of the Department for Community Based Services (DCBS) to ensure conference content is relevant to current trends and needs identified in the child welfare system. The Kids Are Worth It! ® Conference provides a unique training opportunity to both staff and service providers within the child welfare system. State and national experts provide high quality, state-of-the-art workshop and plenary sessions relevant to the broad audience providing a variety of services to children and families. Care is taken to ensure all material presented are relevant to participants regardless of geographic location within the state.

New skills are taught; existing skills are enhanced and service providers are given the opportunity to learn to work together more effectively as it relates to contributing to the safety and wellbeing of children and families in Kentucky. Participants gain knowledge of resources available in their local communities and throughout the state. They are able to share successes and challenges and learn from each other as well as from their training sessions.A law enforcement officer may learn how to create a trauma sensitive environment for victims while learning about a new resource referral for clients. A childcare worker may learn how to identify and report pediatric abusive head trauma, but also how to refer families in need to services in the community. The conference provides a unique opportunity to engage participants in prevention efforts across the child welfare continuum.

The 2016 Kids Are Worth It! Conference was delivered September 12-13, 2016. The conference reached 572 individuals with 473 attending workshop and plenary sessions. In addition to the provision of thirty-two workshops, there were two keynote sessions. Participants from 80 counties (identified in the Kentucky map below), across all nine DCBS Service Regions were present; representing 66% of Kentucky counties.



**Conference Participation by Profession**

An *Overall Conference Evaluation* was provided to attendees at the conference. Two-hundred and fifteen *Overall Conference Evaluations* were received, reflecting a 46% response rate. Participants rated their overall experience on a five point Likert scale. The overall conference evaluation responses, provided below, reflect a high-quality experience for participants.

This percentage represents those who indicated they were either Extremely Satisfied or Satisfied with the category below:

|  |  |
| --- | --- |
| **Please rate your overall experience:** | **Overall**  **Responses** |
| 1. Conference as a whole | 99.07% |
| 1. Registration process | 98.60% |
| 1. Workshop choices | 99.53% |
| 1. Keynote sessions | 90.70% |
| 1. Networking opportunities | 88.84% |

This percentage represents those who indicated that they Strongly Agreed or Agreed with the category below:

|  |  |  |
| --- | --- | --- |
| **As a result of attending the conference:** | **Overall**  **Responses** | **DCBS**  **Responses** |
| 1. I am better prepared to prevent child abuse and neglect. | 95.81% | 95.83% |
| 1. I learned of a new resource, which will assist me in my work to improve outcomes for children and families. | 95.81% | 93.75% |
| 1. I learned a new skill, which will assist me in my work to improve outcomes for children and families. | 96.4% | 95.83% |
| 1. I was able to network with community partners. | 87.91% | 85.42% |

As a tool to assess extended impact of knowledge gained through the conference, participants were emailed an invitation to participate in a 60-day follow up survey. Ninety-six participants responded, yielding a 20% response rate. Participants continue to report the conference experience as impactful. A summary of results follow:

* 76.04% agree or strongly agree they learned a new skill by attending the conference.
* 88.54% agree or strongly agree the different perspectives provided in multi-disciplinary workshops and keynotes positively affected their work. While 10.42% remained neutral.
* 56.25% agree or strongly agree they utilized a new community resource or community partner to support families. While 42.71% remained neutral.
* 67.71% agree or strongly agree they are better equipped to prevent maltreatment or intervene in a manner, which supports families and children. 32.25% report remaining neutral.

Respondents who indicated the education they received through the conference changed their practice were asked to describe how their work has changed. A sampling of comments includes the following:

* “I am now more knowledgeable about synthetic drugs, safe sleep, and human trafficking. I feel that my gained knowledge in those areas have made me more aware of risk factors. I also feel more comfortable discussing and mentoring my clients about safe sleep practices.”
* “I am more knowledgeable about synthetic drugs and have been able to apply this knowledge while discussing drug screens with clients. I have also been able to help co-workers learn more about synthetic drugs.”
* “Perspective is a living thing and the classes I attended allow me to get out of my normal environment and experience how others feel and believe in what we (Law Enforcement) are doing and what that job is supposed to be.”
* “I have more of an understanding and a new perspective of how stress can impact the lives of our children and their parents and how that affects how their children are treated. That has helped me have more of an understanding for our families.”
* “I learned some things that have been "common practice" in our court system that are not BEST practice and I'm more re-energized than ever to point that out and stand up for a child's timeline in court.”
* “I have been able to provide DV victims and drug addicts with more resources and information. I have also been able to assist parents in parenting children with needs, via looking at their developmental age.”
* “I feel more confident in my work, and feel refreshed in the sense that my job is actually making a difference, even in the hard times.”
* “I am so thankful for having the opportunity to attend the KAWI conference 2016! I made networking connections. I learned a lot from the workshops. The speakers/presenters were so full of knowledge and made me think about the job we do and the children we serve, as well as how the public thinks, how the average citizen feels, how children feel, about the work we do. I strive to make every day better than the day before!”
* “The information learned in the session about disciplining traumatized children has been beneficial for me to help my foster parents as they work through what is sometimes a daunting task. I also plan to use the personal values cards that I received during the engagement session.”
* “I feel more informed with working with clients, and discussing things such as corporal punishment. I also have been working on engaging the fathers more in my work and seeing how to reach out to them as well to get them involved with their case plan.”

**Prevent Child Abuse Kentucky (PCAK), Child Abuse Prevention Month (CAPM)**

During national child abuse prevention month, PCAK provides leadership to a statewide public education and awareness campaign to promote child abuse and neglect prevention. Efforts are funded through CBCAP, corporate and individual donations. PCAK collaborates with the state child welfare agency, community partners, professionals, parents and caregivers to develop resources and materials. Awareness materials provide individuals with statewide information and services; and are made available through the PCAK website, trainings and community meetings. The 2016 child abuse prevention month campaign included the following activities:

* Via Gubernatorial Proclamation, April 2016 was declared Child Abuse Prevention month. Many communities across the state hosted proclamation ceremonies, engaging local elected officials such as mayors and judges, declaring April Child Abuse Prevention Month. PCAK distributed local proclamation templates as a strategy to ensure consistent messaging throughout the state. The Gubernatorial Proclamation and Press Conference in Frankfort was held on March 24th.
* On March 29th, in conjunction with the Office of First Lady Bevin, PCAK held a statewide kickoff – A pinwheel planting on the Capitol Lawn. Many partners showed up to plant pinwheels, which were left up for two weeks to bring awareness to child abuse and neglect in Kentucky.
* Communities across the state had an array of events to include community proclamation ceremonies, pinwheel plantings, rallies, family-fun activities and resource fairs.
* PCAK leadership continued a partnership with the Kentucky Press Association (KPA) to facilitate engagement of statewide media outlets. The KPA sent a media advisory to all members regarding CAPM, and encouraged local media outlets to provide coverage.
* There were 228 CAPM related events reported to PCAK in 2016.
* Staff developed CAPM resources available through the PCAK Information and Data Center. Resources included campaign ideas, templates for media outreach, event planning, faith-based materials, statistics and relevant data, tip sheets for parents and caregivers and suggestions for engaging communities in grass roots prevention efforts.
* Staff developed a tool kit with instruction and resources on both implementing Child Abuse Prevention Month efforts as well as the Pinwheels for Prevention Campaign. This resource was used to assist local groups in the planning and hosting of awareness activities.
* Over 41,341 pinwheels were distributed across the Commonwealth. This number is lower than years past as the pinwheels from Prevent Child Abuse America arrived late into April.
* Electronic announcements promoting child abuse prevention month and the availability of the online resources were distributed via social media, the PCAK webpage and email distribution. There were 8,399 views to the PCAK webpage during the campaign.
* Targeted announcements were also sent to DCBS staff, educators, mental health professionals, childcare providers, law enforcement officials, health departments and legal professionals.
* 100% of Kentucky counties were engaged with PCAK in child abuse prevention month efforts.
* In advance of child abuse prevention month, 73,277 child abuse awareness materials were distributed across the state to local communities.
* During the 2016 campaign, PCAK had 66,074 Facebook post views. There was an increase of 438 Facebook likes, and 208 Twitter followers.

Resources made available by the Children’s Bureau were utilized in the development of the 2016 CAPM materials. Links to the Children’s Bureau and other national organizations were provided on the PCAK website as resources to local communities. PCAK also benefits from affiliation with Prevent Child Abuse America and sister chapters throughout the country. This affiliation provides ideas and resources to strengthen Kentucky’s efforts.

**Prevent Child Abuse Kentucky (PCAK), Awareness Tools**

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

* “Ages and Stages: A Parent’s Guide to Discipline” brochure designed to educate individuals on child development and keys to effective discipline.
* “Hold Them, Hug Them, Love Them But Never Shake a Baby” brochure designed to educate parents on the dangers of shaking a baby, and provider tips for coping with crying.
* “How Well Do You Know Your Love Interest” brochure is a guide for caregivers in choosing a partner, focusing on the impact this decision has on a child.
* The Internet Safety Toolkit is an easy to comprehend guide for parents and caregivers to provide education on internet safety.
* “Preventing Child Neglect” brochure defines neglect and educates the reader on how to recognize and respond to neglect.
* “Preventing Child Sexual Abuse” brochure educates readers on the dynamics of child sexual abuse and prevention strategies.
* “How do I Choose a Safe Caregiver” Tip Sheet educates readers on the importance of choosing someone safe to care for their child.
* “Understanding Typical Healthy Child Development” Tip Sheet educates readers on what to expect from their child as he/she develops.
* “As a Parent, What Can I do to reduce the Risk of Child Sexual Abuse” Tip Sheet parents on ways to reduce the risk of sexual abuse for their children.

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

PCAK has worked to ensure the online resources are available on our website, [www.pcaky.org](http://www.pcaky.org), to include electronic copies of all available brochures; parenting tip-sheets; tools for involvement in awareness campaigns such as Pinwheels for Prevention or Child Abuse Prevention Month; as well as the 1-800-CHILDREN parent support searchable database.

The agency will continue to work with CHFS, community partners, and when appropriate, national organizations, to stay abreast of current variables in the field of child abuse and neglect prevention in an on-going effort to maintain and expand our resources. Trends continuing to emerge in 2016 include internet safety, child sexual abuse prevention, evidence based prevention, pediatric abusive head trauma, prevention/awareness programs targeted to children, parenting strategies, grandparents raising grandchildren, trauma-informed care, building child and parent resiliency, child fatality prevention and strengthening families through building protective factors. PCAK works collaboratively with community partners to promote systems improvements by creating tools to support multi-tiered prevention of abusive head trauma for parents provided by birth hospitals, healthcare professionals and home-visiting programs. Staff have also collaborated with medical professionals, childcare providers, parenting programs, early child home visiting programs and other agencies towards developing a statewide public awareness campaign to also address “safe sleeping”.

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

PCAK tracks baseline data regarding awareness tools requested and distributed. Included in this tracking system are the parties requesting materials, number of materials requested and distribution location. PCAK believes awareness promotes education, which, in turn, plays a relevant role in the reduction of incidences of child abuse and neglect. In 2016, over 78,246 pieces of materials were distributed across the Commonwealth designed to educate and promote awareness of child abuse and neglect. PCAK encourages the reproduction of this literature, many agencies make copies of the brochures and pamphlets sent to them by PCAK and distribute them to other local agencies and civic organizations. To assist in meeting this need, PCAK has developed printer friendly online versions of printed material. During 2016, 2,238 followers liked agency’s Facebook business page. Twitter followers grew to 2,199. Instagram followers grew to 118. There were 41,650 hits to the PCAK website.

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

* The most requested informational brochures address pediatric abusive head trauma, what is child abuse, the stages of child development and child sexual abuse. They are, “Hold Them, Hug Them, Love Them but Never Shake a Baby”, which reflects the intentional focus within PCAK and other advocacy organizations in addressing high instances of pediatric abusive head trauma in Kentucky; “What Everyone Should Know about Child Abuse”, reflecting the need for education of what to look for and how to report; “Ages & Stages: A Parent’s Guide to Discipline”, reflecting the need for parents to understand appropriate child development and positive strategies towards discipline; and “Preventing Child Sexual Abuse”, reflecting PCAK’s statewide focus on child sexual abuse prevention.
* The agency has a wide variety of resource available, and at times has difficulty meeting the demand. The agency is using technology to assist in providing this information in a more efficient and cost effective means. This need has driven the PCAK agency goal to make the Information and Data Center Kentucky’s premier source for child abuse and neglect prevention information. The Center will inform Kentuckians via data, research findings, national and state trends and best practices; and will utilize all media formats to inform the public of PCAK programs, trainings and child abuse prevention initiatives.

**Prevent Child Abuse Kentucky (PCAK), Educational Workshops and Institutes**

Prevent Child Abuse Kentucky (PCAK) provides educational offerings to requesting groups statewide, focusing on issues impacting local communities and actively engaging the community in preventing child maltreatment. Activities are supported through CBCAP funds, PCAK general funds, grants, private donations, trainings and corporate giving. PCAK offers specialized trainings, train the trainer workshops, and continuing education credit for participants. Curricula on a variety of child maltreatment related topics are available and each audience participates in an individualized learning experience. Topics include: recognizing, reporting, and preventing child maltreatment; preventing Pediatric Abusive Head Trauma; internet safety; the connection between substance abuse and child maltreatment; working with at risk parents; preventing child maltreatment deaths; engaging communities in child abuse prevention during April and year round; adult focused child sexual abuse prevention; engaging fathers; and addressing racial inequality in the child welfare system. Working closely with Cory Jewell Jensen, nationally recognized expert in sexual offender treatment, PCAK developed a new curriculum available to communities across the state. This new curriculum uses video clips of child sexual abuse offenders to identify the techniques pedophiles use to target, seduce and exploit children. Through a grant provided by Child Victim’s Trust Fund, PCAK hosted two training of trainer sessions that prepared 108 trainers to provide the new curriculum in their communities. Another session is planned for February 2017.

In May of 2016, PCAK staff conducted a training of trainers preparing 49 individuals from throughout the Commonwealth to train others. The goals were to expand availability of training to parents and community partners in keeping children safe from internet predators. Utilizing PCAK publication, “Internet Safety Tool Kit” as its foundation, attendees were co-trained on this topic by staff members from the Kentucky State Police Internet Crime Against Children Unit and the U.S. Attorney’s Office, Eastern District Office.

PCAK collaborates with DCBS and other key stakeholders to ensure workshops and institutes serve as high quality professional development venues, applicable to the needs of diverse audiences. PCAK workshops and institutes are strategically located to ensure child maltreatment prevention education is accessible to audiences statewide. PCAK promotes trainings through networking and engagement of community partners. Invitation listings are developed based on the target audience and region of the state in which it will be located. Partners instrumental in announcing events include the Department for Community Based Services, Department for Public Health, Department for Behavioral Health, Developmental and Intellectual Disabilities, Division of Child Care, Family Resource and Youth Services Centers, as well as other locally based entities. PCAK utilizes web-based advertising including the website, electronic newsletters, and social media (Facebook, Twitter).

Workshops and institutes, which are specific to one discipline, include a segment on the importance of a multi-disciplinary approach to prevention. PCAK provides workshops and institutes, which incorporate components across the entire continuum of prevention. Participants are equipped with knowledge on risk factors, warning signs, and protective factors, which enhance the strength-based approach to prevention. Participants leave with tangible tools for working with children and families such as local and statewide community resources. Participants receive materials in addition to education. Training of the trainer institutes provide training materials, resources for future participants, and on-going technical assistance. DCBS staff members are invited to attend or participate as co-presenters in many PCAK trainings. This provides professional development opportunities for DCBS staff and encourages communities to align themselves with DCBS as a resource to assist in meeting local needs.

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

During 2016, trainings were offered locally, regionally and statewide. PCAK was able to provide training opportunities in each of the nine DCBS regions. Trainings often have a wide reach through statewide conferences and intentional offering of workshops in locations, which draw participants from surrounding counties. In 2016, PCAK served 1,680 participants, and provided 41 trainings. PCAK staff continues to be active on the KY Strengthening Families Leadership Team, and three staff have participated in a Strengthening Families training of trainers. These staff are now able to provide specific Strengthening Families curricula; and integrate these concepts into other PCAK trainings.

PCAK will continue to provide educational workshops and institutes to the public as requested. Additional PCAK staff are being trained as workshop presenters. As new workshops are developed at the request of participants, PCAK’s listing of workshop topics continues to increase. As communities become more aware of PCAK workshops and educational offerings as a resource for preventing child maltreatment, PCAK receives greater numbers of requests.

**Prevent Child Abuse Kentucky (PCAK), 1-800-CHILDREN Parent Support Resource**

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

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

The 1-800-CHILDREN parent support resource interconnects PCAK programs and services with family service providers statewide. The 1-800-CHILDREN phone line is advertised at all PCAK trainings and is included on all PCAK resource materials. Professionals working with children and families can provide this information to the clients they serve. The 1-800-CHILDREN parent support resource serves as the point of contact for citizens to learn about programs, information, events and volunteer opportunities, which affect child maltreatment prevention. The statewide resource directory, utilized by staff answering the 1-800-CHILDREN phone line and published as a searchable database on the PCAK website connects information seekers to social service providers throughout the state. The directory contains statewide listings for a broad range of services including DCBS, mental health, support groups, parent education, legal and basic needs, and more. PCAK staff interacts with service providers to maintain current information in the directory. DCBS Social Workers are encouraged to share the 1-800-CHILDREN parent support resource with parents and caretakers involved with the DCBS system and can be utilized as a component of safety and aftercare planning when appropriate.

* Approximately 54,348 pieces of material displaying 1-800-CHILDREN were distributed throughout the Commonwealth during 2016.
* Staff communicated information regarding 1-800-CHILDREN during 41 formal trainings and numerous presentations on various topics to a variety of audiences reaching 3,847 individuals.
* The 1-800-CHILDREN portion of the PCAK website was visited 867 times.
* The 1-800-CHILDREN parent support resource was broadened to include toll-free and local calling, email services, and web-based resource materials.

Data regarding usage of the 1-800-CHILDREN parent support resource is tracked on a monthly basis. Information captured includes number of calls received, the originating location for the call, type and number of referrals made. Some notable data from January 1, 2016 to December 31, 2016 includes:

* 250 calls were made to the 1-800-CHILDREN toll free parent support line.
* On average, the 1-800-CHILDREN toll free parent support line was utilized 21 times per month.
* On average, 59% of all callers were referred to DCBS.

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

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

**Prevent Child Abuse Kentucky (PCAK), Fatherhood Initiatives**

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

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

PCAK collaborates with the Lexington Leadership Foundation’s Fayette County Fatherhood Initiative, in delivery of the Inside Out Dads to the local detention center. The parenting program for incarcerated fathers is operated with agency general funds. Trainings and community events have been offered in partnership with public health, Lexington Fayette County Urban County Government, family resource centers, etc. These programs are funded with general fund, grant funding from local government and other non-profits. Materials and resources addressing fatherhood are funded in part with CBCAP, as well as corporate and in-kind donations. Inside Out Dads is currently offered in Fayette County Kentucky, but program participants may reside from any county in Kentucky. All other fatherhood related services are offered and provided statewide.

In FY 2016, PCAK sought and received funding from a local funding source to develop a specialized parenting program targeting fathers and their children. The program utilizes a hybrid of the Nurturing Parenting Curricula and is delivered in close collaboration with community partners (faith community, Head Start, etc.). The intent of the program is to deliver parent education curricula in a setting which engages the father and his children in learning and interacting together. The program consists of ten three hour sessions and comprising of the following components: 1) a hot meal for the fathers and children to share social time together; 2) a lesson time specific to the fathers, while the children are in a separate room engaged in parallel learning activities; and, 3) a time to bring together a father and child to discuss what they have learned. The program engages “mentors” from the faith community to provide ongoing support to fathers, and community partnerships to address identified barriers.

PCAK benefits from strong partnerships with agencies across the state. Partnerships cultivated throughout the state assist in the distribution of fatherhood training and resource materials. These partnerships have been particularly important as PCAK has been a leader in an effort to create a statewide collaborative to enhance service delivery and eliminate barriers facing fathers in the child welfare and other systems. These efforts, beginning in 2016, have involved meetings with PCAK staff, community partners and leadership from DCBS. These meetings have recently culminated in a cross-system strategic planning meeting schedule to occur in the spring of 2017.

## Project SAFESPACE (Screening And Assessment For Enhanced Service Provision to All Children Everyday)

Project SAFESPACE (Screening And Assessment For Enhanced Service Provision to All Children Everyday) is 5 year, $2.5 million grant entitled Promoting *Wellbeing and Adoption after Trauma*. The grant is funded by the Children's Bureau. The project is designed to enhance behavioral health services for children in out-of-home care through implementation of a continuum of evidence-based universal screening, functional assessment, outcome-driven case planning, treatment and descaling of ineffective services. Overall project goals include the following:

* Redesign of the behavioral health service delivery system;
* Reconfiguration of the infrastructure and inter/intra agency procedures to support an evidence based continuum of screening, functional assessment, outcome-oriented case planning and treatment;
* Universal behavioral health screening for children in out-of-home care by the Department for Community Based Services staff;
* Implementation of a functional assessment of children in out-of-home care serviced by private child care agencies and community mental health centers;
* Assessment driven case planning and evidence based treatment to conduct systematic progress monitoring;
* Improvement in the social-emotional well-being of children in out-of-home care and those placed for adoption.

The grant for SAFESPACE is held at the University of Louisville, in partnership with the Department for Community Based Services, the Department for Behavioral Health Developmental and Intellectual Disabilities, Eastern Kentucky University, and Kentucky Partnership for Families and Children. SAFESPACE facilitates consistent meetings in a multitude of mediums with the goal of collaborative decision-making. During the reporting period, SAFESPACE facilitated monthly steering committee meetings, held a statewide implementation team meeting, and began monthly regional implementation team meetings at both the DCBS and provider levels.

SAFESPACE is linked with the ongoing behavioral health redesign known as the System of Care (SOC). The overall goal of SOC is to enhance behavioral health services to children and families. The SAMHSA funded cooperative agreement was recently expanded in Kentucky to include statewide rollout of previous lessons learned and infrastructure support to an existing entity charged with coordinating service needs across systems. Through the Kentucky Initiative for Collaborative Change (KICC), SAFESPACE is able to capitalize on this infrastructure support in order to promote project goals.

SAFESPACE is an active partner in the Kentucky Child Welfare Performance and Accountability Partnership, formerly referred to as the Performance Based Contracting (PBC) initiative. SAFESPACE shares several common goals with this initiative such as standardize assessment across all private child caring and private child placing agencies and enhancement of evidence based practices. During the reporting period, SAFESPACE’s principle investigator continued her work served on the PBC Fiscal Monitoring Workgroup. The SAFESPACE project manager serves on the Practice Workgroup.

SAFESPACE is also an active partner in Kentucky’s Title IV-E Child Welfare Waiver Demonstration. During the project’s needs assessment phase DCBS worker focus groups yield concerns about standardized screening and assessment not being offered to the in-home population as a means of secondary prevention. While extension of standardized screening and assessment to the in-home population is beyond the scope of SAFESPACE’s current work, this partnership offers the opportunity to consider standardize clinical assessments across the in-home and OOHC populations. Such consideration allows the possibility of outcomes data to inform service array reconfiguration across the child welfare population. Since both projects share the same pilot region (i.e. Northeastern), there also exists the potential to share resources and mutual learning. The SAFESPACE project manager serves on the Steering Committee and participates in Kentucky Strengthening Ties and Empowering Families (KSTEP) Workgroup.

During the reporting period, implementation existed within 38 counties spanning two pilot regions (i.e. Northeastern, Southern Bluegrass, and Salt River Trail). This staged implementation allowed the process to be tested while the web-based application and workforce capacity was developed. All children entering out-of-home care during the reporting period in implementing areas were targeted for screening. Implementation began in February of 2016 in very limited counties with reduced out-of-home care populations. As of 12/31/17, approximately 404 children had received a screener. Of those children screened, 55% (223) met screening criteria for an assessment. At the end of the reporting period, approximately 50 assessments had been completed. Standardized screening and assessment will expand into four service regions (i.e. Jefferson, Cumberland, Two Rivers, and The Lakes) in 2017. The two comparison regions will be added before September of 2018.

Kentucky Administrative Regulation was revised to permit use of SAFESPACE tools (i.e. screeners and the CANS) for purposes of private child caring/placing levels of care. This change will allow for reduced duplication and greater efficiency.

Evaluation activities for the reporting period include the development of management reports in TWIST needed for tracking screening and assessment completion. Development of reporting capabilities necessary for aligning screening and assessment scores with child welfare outcomes has begun. Targeted case reviews were also initiated. Formal evaluation will occur with the semi-annual federal report submission in 2017. Screening themes included lower rates of needed assessments for children under 5 years. On average 80% of children between the ages of 6-17 years were determined to need an assessment while only 18% of children under 5 years screened-in for a CANS.

Barriers related with the length of time needed for full engagement and education, understanding of impacts to the leveling process, and challenges related with the opening of Kentucky’s Medicaid provider pool resulting in the need for independent private provider inclusion have been encountered. In addition, the managerial attention needed to ensure fidelity to protocols and quality assurance has been a challenge.

## Rape Crisis Centers

Kentucky Association of Sexual Assault Programs (KASAP) provides specialized services to victims of sexual violence and their friends and family members through a network of 13 regional Rape Crisis Centers (RCCs). The RCCs cover all 120 counties and operates on a regional model, with each center covering anywhere from 5 to 17 counties.  The Area Development District model was used as the template for RCC coverage. Each RCC is statutorily mandated to provide crisis counseling, mental health services, advocacy services, consultation, public education and training programs for professionals. Services are made available free of charge and are provided to adult and child survivors of sexual violence, including those who experience an acute incident and those who were victimized in their past. The Cabinet has a MOU with the Kentucky Association for Sexual Assault Programs (KASAP) to administer the funds that the department receives for rape crisis work. The SFY17 contract includes state general funds in the approximate amount of $ 3.3 million, as a group, $446,111 in Rape Prevention and Education funds from the Center for Disease Control to KY Public Health and passed on to community based services for the implementation of the nation’s first evaluated, evidence informed bystander intervention program (Green Dot in KY High Schools) and $97,025 in Preventive Health and Health Services to support advocacy work occurring in the rape crisis centers. RCCs also write and receive several federal (i.e., Victim of Crime Act and Violence Against Women Act) and local grants (i.e. United Way, local fiscal government awards) that are not included in the contract with KASAP and are driven by each agency’s Board of Directors’ fundraising ability.

The RCCs work collaboratively with a number of partners to achieve the outcomes that they have experienced over the years. In particular, DCBS children and their caretakers make up 20% of the RCC new victims receiving services. Close work with DCBS caseworkers and RCC advocates and/or clinicians provide a critical link in the well-being of DCBS children who may be in out of home placements due to documented abuse or neglect. RCC advocates are also members of each Kentucky County’s multidisciplinary teams that staff child sexual abuse cases. This opportunity to connect with the legal guardians of children in care improves the overall outcomes of children navigating the long journey of healing after reporting or disclosing sexual abuse. Many representatives from other child-serving or victim-serving agencies sit on various RCC boards of directors, reflecting the core mission of most communities to stop abuse from happening to their children.

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| **Rape Crisis Center Data: Calendar 2016** | |
| **Service Category** | **Number of Services Provided/**  **Persons Served** |
| New Victims Served | 4,412 |
| New Family & Friends Served | 823 |
| Legal Advocacy Services: court, case management, referrals to services | 2,246 |
| Medical Advocacy Services: Sexual Assault Forensic Exam (SAFE), follow up exams, referrals for further medical treatment | 1,747 |
| Crisis Calls Received | 3,900 |
| Counseling Sessions Provided | 15,165 |
| DCBS Client Total | 665 |
| Prevention/Education Sessions (including Green Dot in KY High Schools) | 2,826 |
| Prevention/Education Participants (including Green Dot in KY High Schools) | 82,513 |
| Volunteer Hours | 93,314 |

## Safe Infant Services

Kentucky Revised Statute 405.075, part of "The Representative Thomas J. Burch Safe Infants Act" of 2002, provides that a person may leave a newborn infant less than 72 hours old with an emergency medical services provider, police station, fire station, hospital, or participating place of worship. This Safe Infants Law states that the parent will not be criminally prosecuted for abandoning an infant less than 30 days old, if the baby is taken to one of the above-determined safe places and has not been physically abused or neglected after birth. The parent may voluntarily provide information about the baby. Within thirty days of the baby’s abandonment, the parent may ask for the baby’s return, and DCBS may provide services to the parent to help the family stay together and safe. After thirty days, the Cabinet will begin the process of terminating the parental rights (TPR) and making the child available for adoption. The statutory provisions afford parents a safe and anonymous option when they are unable to care for their newborn children. The provisions also help children obtain more timely permanency.

The department continues to receive requests for safe infant brochures and packets from community agencies. The requests are routed to the state Board of Emergency Medical Services that compiles hospital packets and mails them to requestors. We continue to have several requests for these packets from law enforcement, fire departments, and hospitals. The program’s information and downloadable posters are also available on our internet site, <http://www.chfs.ky.gov/dcbs/dpp/KYSafeInfants.htm>. The site also contains a power point presentation updated in 2016 by the state Board of EMS.

As a result of amendments to the Safe Infant Act in the 2016 legislative session, the division began working with partners at Prevent Child Abuse Kentucky and Norton Children’s Hospital to increase awareness of the program. This included meeting with the founder/president of AMT Children of Hope Foundation in New York, Mr. Jaccard, who is considered the “father” of the national safe haven initiative (<http://www.amtchildrenofhope.com/index.php>). Mr. Jaccard has shared information and resources, including signage, hospital protocol manual and access to his AMT Children of Hope Foundation hotline that offers assistance 24 hours per day/7 days per week to pregnant and new mothers who are considering a safe infant placement for their child. The division is currently drafting a hospital protocol manual for Kentucky’s hospitals and working to secure appropriate signage for designated safe infant sites.

History

(2002-2016)

* Since implementation of the law, there have been 39 Safe Infants incidents involving 40 infants since 2002 (one incident involved a set of twins).
* All but four of these cases were hospital deliveries. In one of the exceptions, the child was discovered to have been left at the hospital entrance. Neglect was substantiated, but the judge determined probable cause that the child was left with the intent to leave her according to the Safe Infant Act. In the other two cases, the children were delivered at home and taken to a hospital.
* Of these 40 infants, 33 have been adopted, 1 has a pending termination of parental rights, and 5 were returned to their parents. In one of these Return to Parent cases, the father petitioned the court for custody, which he received. In the other four cases, the mothers returned to reclaim their child within the 30-day period. DCBS opened a case and offered services. There is also a case from 2013 in which the mother returned to reclaim the child. There were concerns about the mother’s home, thus an emergency custody order was issued to the Cabinet. The child is currently placed with a relative.
* Average length of time for adoption to occur is approximately 12.6 months. One of the cases from 2007 took 37 months for adoption to finalize, and it appears this is the exception to the remainder of the data. In this particular case, the child was born with severe birth defects, and the adoptive parents were waiting for the child’s surgeries and medical interventions to occur prior to adoption.
* Average length of time to TPR is 6.697 months with three months being the shortest amount of time and 12 being the most.
* Infants - Males and Females: 19 males and 21 females.

## Safety Net

Safety Net is a short-term intervention program that provides services to former recipients of Temporary Assistance for Needy Families (TANF) cash assistance who are no longer eligible for assistance due to failure to comply with participation requirements or reaching their 60-month lifetime limit of receipt. The goal of Safety Net is to prevent out-of-home placement of children in these families. The program is funded through Title IV-A. Safety Net services are administered statewide.

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

Staff from the Division of Family Support notifies the Division of Protection and Permanency (DPP) staff when a family is no longer eligible for TANF cash assistance due to failure to comply with participation requirements or reaching their 60-month lifetime limit of receipt. Within fifteen days, DPP staff contacts the family to arrange a home visit to complete an assessment. After the completion of the assessment, DPP staff may help the family develop a plan of action and refer the family to community resources to assist in meeting any unmet needs of the family. If financial assistance is needed and the family is at or below 200% of the federal poverty level, the family may receive up to $635 for over a four-month period within the twelve-month period following discontinuance. These benefits are used to meet basic needs such as shelter, food, clothing or utilities.

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

From January 1, 2016 through December 31, 2016, an average of 29 families per month received Safety Net services. The average payment for Safety Net services was $327.63.

There have been no changes in policy or practice during the calendar year of 2016. The cabinet intends to continue to provide Safety net services for families who lose TANF benefits to prevent out-of-home placement of children and to assist the family in maintaining stability.

## Sobriety Treatment and Recovery Teams

The Kentucky START program is an intensive intervention model for substance abusing parents and families involved with the child welfare system that integrates addiction and recovery services, family preservation, community partnerships, and best practices in child welfare and substance use disorder treatment. The program aims to address systems issues that result in barriers to families being able to access services in a timely manner. It requires an approach to service delivery that involves cross-system collaboration and flexibility to meet the unique needs of this population. START is based on the successful and nationally recognized S.T.A.R.T. program in Cleveland, Ohio. Kentucky began implementing START in 2007, has modified, and evolved the model to fit the needs of Kentucky families. Daviess County was awarded federal funding to implement START and state funding is being used to fund the program in three other counties in KY: Kenton, Jefferson and Boyd. A fifth site in rural Martin County had federal grant funding for six years and has now shifted to a less intensive model. As part of Kentucky’s Title IV-E Waiver, START is being expanded. Jefferson County has added a second START team and Fayette County is implementing START as well. For this current year, plans are underway to expand the program by adding a second START team in Kenton County.

The key components of Kentucky’s START program 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; Jefferson serves families who are referred due to the birth of a drug affected infant.
* 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 START clients with both recovery coaching and help navigating the CPS system;
* Reduced caseloads for the START team of 12- 15 families per worker/mentor pair;
* 12 basic tenets outline the program philosophy and collaboration;
* 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, Jefferson and Boyd;
* Collaboration with community partners, substance abuse providers, the courts, and the child welfare system dedicated to building community capacity and making START work;
* Sober parenting supports that include flexible funding for meeting basic needs such as housing transportation, child care and intensive in home services;
* A holistic assessment for all clients, addressing substance 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.

In 2016, START teams served 289 families. This included 513 adults and 584 children.

In addition to direct services to families, expansion of the program and multiple presentations and workshops at regional and national conferences, there were 2 new publications about START in peer-reviewed journals. Additionally, the START program is listed on the California Evidence Based Clearinghouse for Child Welfare (CEBC) as a program with Promising Research Evidence. Here is the direct link to the listing on the CEBC: <http://www.cebc4cw.org/program/sobriety-treatment-and-recovery-teams/detailed>. When people are looking for evidence-based programs to help families in the child welfare system, they will see START as one of their options.

While the overall START program is still partially supported by TANF MOE funds, federal grant funds and state general funds, the expansion of Medicaid in KY is now another source of funding that supports the program through paying for certain substance use disorder treatment services. By using Medicaid to pay for treatment services, providers have been able to use less TANF MOE funds during the past year.

Additionally, KY is now utilizing Title IV-E waiver funds to support the expansion of START to other communities. The purpose of Kentucky’s Title IV-E waiver demonstration project is to further the state’s progress toward the CFSR outcomes of safety, permanency, and well-being of families and children involved in the child welfare system. Through the waiver, Kentucky aims to reduce the need for out-of-home care (OOHC) placements and shorten the duration of necessary OOHC placements through the expansion of the START program. As of October 2015, Jefferson START has expanded from one team to two teams and is serving families under the Title IV-E Waiver. Fayette County is in the process of implementing a START team and began serving families in February 2017. Kenton County will also expand to a second START team. Pre work and planning has begun at this site with hopes to begin serving families in early 2018.

## Social Services Block Grant (SSBG)

States are able to consolidate a number of programs into a single grant under the Social Services Block Grant (SSBG). SSBG is funded through Title XX of the Social Security Act. Federal grant awards for each State are determined by a statutory formula based on the State’s population. States have the flexibility to determine what services will be provided, who is eligible to receive the services, and how funds are to be distributed. Services are available statewide and are directed at one or more of the five (5) national goals:

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

SSBG services are used to support, in whole or in part, the state mandated social services programs administered by the Department for Community Based Services (DCBS). When feasible, services are purchased through written agreements with service providers throughout the State. The following is a list of providers contracted to provide services for adult protection, child protection, residential services (for juveniles), and training: 1) Department of Juvenile Justice.; 2) Eastern Kentucky University; 3) Kentucky Coalition Against Domestic Violence, Inc.; 4) Seven Counties and 5) University of Louisville.

The Worker Information SysTem (TWIST) captures the number of clients receiving SSBG services. Data generated from TWIST indicate that child protective services are supportive of the child welfare outcomes. This data is evaluated every six (6) months and used in reporting to the Legislative Research Commission (LRC). Additional reports are submitted to the Federal government annually. TWIST data reflect an increase in child protective services each year, indicating the continuing need for child welfare services statewide.

|  |  |
| --- | --- |
| **Calendar Year 2016 Data** | |
| **SSBG Service** | **Number of Clients Served** |
| Adult/Domestic Violence Protection | 151,466 |
| Child Protection | 349,878 |
| Home Safety Services | 5,685 |
| Juvenile Services | 3,393 |
| Residential Treatment | 520 |

* Adult/Domestic Violence Protection

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

* Child Protection

Provides children and their families with services designed to prevent or remedy abuse, neglect, or exploitation (e.g., identification of children at risk; investigation of reports of abuse, neglect or dependency; removal of the child from the home when necessary; or information and referral services).

* Home Safety Services

Provides services to prevent the removal or repeat maltreatment of a child, or to maintain an adult’s safety in the home or community (e.g., arranging for community agencies to provide help with day-to-day household tasks; instructing and assisting with meal planning; nutrition; budgeting; or general household management).

* Juvenile Services

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

* Residential Treatment Services

Provides a comprehensive treatment-oriented living experience, in a 24-hour residential facility for juvenile offenders committed to the Cabinet or the Department of Juvenile Justice. (These services are provided through a written agreement with the Department of Juvenile Justice).

* Staff Training

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

## Solutions

Solutions is an intensive treatment and support program serving Breathitt, Knott, Lee, Letcher, Owsley, and Wolfe Counties that works intensively with female clients to address substance abuse, mental health, intimate partner abuse, and/or other victimization issues. The majority of the project’s clients are non-custodial parents who are DCBS clients with the goal of keeping children in the home and/or reuniting children with their parents.

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

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

Starting in 2007, $2 million of TANF MOE funds has been provided each year and allocated into contracts with the Community Mental Health Centers (CMHCs) that provide services for START and Solutions and additional funds are contracted to Eastern Kentucky University to employ family mentors and program managers.

1. **Targeted Assessment Program**

The Targeted Assessment Program (TAP) is a nationally recognized Kentucky model for assisting parents involved in public assistance and child welfare systems overcome multiple barriers to self-sufficiency, stability and safety within federally mandated timeframes. For the past 17 years, the Department for Community Based Services (DCBS) has collaborated with the University of Kentucky to provide TAP services. The TAP model co-locates professional Targeted Assessment Specialists (assessors) at public assistance and child protective services offices in Kentucky counties designated by DCBS. TAP assessors conduct client assessment in four primary areas – substance use and abuse, mental health, intimate partner violence victimization, and learning problems – as well as other barriers for families including housing, transportation and other basic needs, physical health problems, legal difficulties, and deficits in education and employment.

Mental Health

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

Substance Use

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

Intimate Partner Violence Victimization

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

Learning Problems

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

The Targeted Assessment Program is supported with Temporary Assistance to Needy Families (TANF) funds. Eligibility criteria include receipt of TANF benefits or TANF-eligibility with a family income of 200 percent of poverty and below. Parents referred by the Division of Protection and Permanency (DPP) must have a child in the home or a plan for reunification. By identifying and addressing substance use and mental health disorders, intimate partner victimization, and learning deficits/disabilities, TAP services support DCBS efforts to meet safety, permanency, and well-being outcomes for children. The clinical expertise and evidence based intervention provided by TAP supports DPP in providing “reasonable efforts” to prevent removal or reunify families presenting multiple risk factors. The following services are provided in all TAP counties:

* Assessment
* Referral
* Strengths-based case management/case coordination
* Pre-treatment
* Follow-up
* Consultation and training

TAP co-locates assessors on-site at the DCBS Division of Family Support and the Division of Protection and Permanency offices in 35 of 120 counties. TAP services are available in all nine DCBS Protection and Permanency service regions, with the highest number of TAP counties in the Eastern Mountain and Two Rivers DCBS service regions. Kentucky’s more populated urban counties are assigned higher number of assessors, but most TAP counties are more rural with lower populations and have one to two assessors. One assessor serves Lee and Owsley Counties, while another assessor works half time in Perry County and half time in Wolfe County. TAP established two field supervisor positions in Western Kentucky; they were hired, trained and assumed their new responsibilities in Fiscal Year 2016. They join two other field supervisors serving Eastern Kentucky; all field supervisors are assigned approximately 50% assessor and 50% supervisory responsibilities. TAP has found that co-locating these positions regionally increases TAP efficiency and access, enhances cost-effectiveness, and ensures better communication and support for DCBS and TAP.

**University of Kentucky Targeted Assessment Program, Service Map**

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During Fiscal Year 2016, TAP facilitated or participated in 24 TAP advisory council meetings and 39 planning and implementation meetings with DCBS staff. In addition, TAP facilitated 19 local community selection committee meetings to fill TAP staff vacancies. TAP provides consultations to DCBS staff for participants who have been referred to TAP as well as non-TAP participant cases. During FY 2016, TAP provided 14,138 case consultations for TAP participants and 3,356 case consultations for non-TAP participants. In support of and in collaboration with DCBS, TAP staff participated in Family Team Meetings to engage and support the family in the case planning, case management, and case closure processes. Family Team Meetings bring together parents, families, other significant adults, and child welfare and other professionals for collaborative case planning and shared decision-making. During FY 2016, TAP assessors participated in 1,401 Family Team Meetings statewide. These collaborations strengthen communication between DCBS and TAP and enhance services for families. The sharing of information and expertise is an invaluable part of case planning to improve outcomes.

During Fiscal Year 2016, TAP completed 2,306 baseline assessments for participants referred by DCBS divisions and other sources. Referrals to TAP (n=3,401) continue to be primarily from DCBS Protection and Permanency (81%, n=2,767) and DCBS Family Support (15%, n=496). Assessors also completed 3,395 case closure reports for participants who terminated TAP services during the fiscal year. Of these terminating participants, 67% (n=2,286[[1]](#footnote-1)) had received a baseline assessment. Mental health was the most prevalent of the four targeted barriers, with almost three-fourths (72%) of those assessed self-reporting mental health as a barrier to self-sufficiency. Notably, many participants were assessed with multiple barriers. Nearly two-thirds (62%, n=1,426) of those assessed prior to termination were found to have two or more barriers, nearly one-fourth (n=532; 23%) were assessed with three or more barriers.

Evaluation

Assessors completed 3,395 case closure reports for participants who terminated TAP services during the fiscal year. Of these terminating participants, 67% (n=2,286[[2]](#footnote-2)) had received a baseline assessment. Terminating participants who received an assessment had an average of 11 direct contacts with TAP prior to termination, with an average duration of services of 32 weeks.

Of the 2,286 terminating participants who were assessed, over four-fifths (88%; n=2,012) showed improvement in accessing needed services. Among terminating participants who received an assessment, progress in overcoming major barriers to self-sufficiency was rated (from No Progress to A Lot of Progress) by assessors as:

* 83% of terminations identified with Mental Health as a barrier showed progress
* 82% of terminations with Substance Abuse as a barrier showed progress
* 88% of terminations with Intimate Partner Violence as a barrier showed progress
* 57% of terminations with Learning Problems as a barrier showed progress

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

* Housing (34%)
* Transportation (32%)
* Social/Family Relationships (32%)
* Parenting (22%)

As presented in the table below, 80% (403) of those terminating TAP services who received an assessment and identified parenting difficulties (n=505) were rated by Assessors as having made progress. In addition, over three-fourths (609, 78%) of those who identified housing as a barrier (n=783) made progress; over four-fifths (612, 84%) of terminating participants identifying difficulties in their social/family relationships (n=726) were rated as having made progress; and 69% (506) of terminating participants reporting problems with transportation (n=738) improved access to transportation.

Among assessed participants terminating TAP services (n=2,286), 1,788 (78%) were recommended for pre-treatment services and 1,636 (92%) participated. Seventy-one percent of those participating in pre-treatment were rated with average to high levels of engagement. TAP recommended service coordination for 1,807 (79%) of terminating participants, of which 1,654 (92%) participated. Sixty-nine percent of those participating in service coordination were rated with average to high levels of engagement.

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

As noted previously, progress ratings for each identified barrier are presented in the table below. The number of participants with a specific identified barrier is reported as well as the level of progress made. The first barrier presented below, for example, is Mental Health. Among assessed participants terminating TAP services in FY 2016, 1,640 reported mental health problems while engaged in TAP services. Of these 1,640 participants, Assessors rated 1,361 (83%) as having made any progress (from A Little to A Lot) in overcoming mental health barriers. The number and percent of participants in each of the progress categories is also shown. This pattern is repeated for each barrier.

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

|  | **Assessed Participants Terminating TAP with**  **Identified Barrier** |
| --- | --- |
| **Mental Health** | **n=1,640[[3]](#footnote-3)** |
| **Any Progress** (i.e. a little, some, moderate, or a lot of progress) | **1,361 (83%)[[4]](#footnote-4)** |
| A Little Progress | 378 (23%) |
| Some Progress | 467 (29%) |
| Moderate Progress | 433 (26%) |
| A Lot of Progress | 83 (5%) |
| No Progress | 279 (17%) |
| **Substance Abuse** | **n=1,329** |
| **Any Progress** (i.e. a little, some, moderate, or a lot of progress) | **1,088 (82%)** |
| A Little Progress | 277 (20%) |
| Some Progress | 287 (22%) |
| Moderate Progress | 382 (29%) |
| A Lot of Progress | 142 (11%) |
| No Progress | 241 (18%) |
| **Intimate Partner Violence** | **n=831** |
| **Any Progress** (i.e. a little, some, moderate, or a lot of progress) | **730 (88%)** |
| A Little Progress | 168 (20%) |
| Some Progress | 187 (23%) |
| Moderate Progress | 268 (32%) |
| A Lot of Progress | 107 (13%) |
| No Progress | 101 (12%) |
| **Learning Problems** | **n=396** |
| **Any Progress** (i.e. a little, some, moderate, or a lot of progress) | **225 (57%)** |
| A Little Progress | 89 (22%) |
| Some Progress | 84 (21%) |
| Moderate Progress | 42 (11%) |
| A Lot of Progress | 10 (3%) |
| No Progress | 171 (43%) |
| **Transportation** | **n=738** |
| **Any Progress** (i.e. a little, some, moderate, or a lot of progress) | **506 (69%)** |
| A Little Progress | 193 (26%) |
| Some Progress | 189 (26%) |
| Moderate Progress | 90 (12%) |
| A Lot of Progress | 34 (5%) |
| No Progress | 232 (31%) |
| **Housing** | **n=783** |
| **Any Progress** (i.e. a little, some, moderate, or a lot of progress) | **609 (78%)** |
| A Little Progress | 187 (24%) |
| Some Progress | 190 (24%) |
| Moderate Progress | 171 (22%) |
| A Lot of Progress | 61 (8%) |
| No Progress | 174 (22%) |
| **Child Care** | **n=140** |
| **Any Progress** (i.e. a little, some, moderate, or a lot of progress) | **106 (76%)** |
| A Little Progress | 23 (17%) |
| Some Progress | 24 (17%) |
| Moderate Progress | 49 (35%) |
| A Lot of Progress | 10 (7%) |
| No Progress | 34 (24%) |
| **Physical Health** | **n=333** |
| **Any Progress** (i.e. a little, some, moderate, or a lot of progress) | **303 (91%)** |
| A Little Progress | 63 (19%) |
| Some Progress | 137 (41%) |
| Moderate Progress | 96 (29%) |
| A Lot of Progress | 7 (2%) |
| No Progress | 30 (9%) |
| **Basic Needs for Children** | **n=261** |
| **Any Progress** (i.e. a little, some, moderate, or a lot of progress) | **224 (86%)** |
| A Little Progress | 57 (22%) |
| Some Progress | 72 (27%) |
| Moderate Progress | 83 (32%) |
| A Lot of Progress | 12 (5%) |
| No Progress | 37 (14%) |
| **Providing Enough Food** | **n=104** |
| **Any Progress** (i.e. a little, some, moderate, or a lot of progress) | **95 (91%)** |
| A Little Progress | 14 (13%) |
| Some Progress | 27 (26%) |
| Moderate Progress | 43 (41%) |
| A Lot of Progress | 11 (11%) |
| No Progress | 9 (9%) |
| **Problems Obtaining Work** | **n=623** |
| **Any Progress** (i.e. a little, some, moderate, or a lot of progress) | **461 (74%)** |
| A Little Progress | 127 (21%) |
| Some Progress | 112 (18%) |
| Moderate Progress | 139 (22%) |
| A Lot of Progress | 83 (13%) |
| No Progress | 162 (26%) |
| **Problems at Work** | **n=107** |
| **Any Progress** (i.e. a little, some, moderate, or a lot of progress) | **88 (82%)** |
| A Little Progress | 22 (21%) |
| Some Progress | 38 (35%) |
| Moderate Progress | 24 (22%) |
| A Lot of Progress | 4 (4%) |
| No Progress | 19 (18%) |
| **Problems with Education** | **n=196** |
| **Any Progress** (i.e. a little, some, moderate, or a lot of progress) | **113 (58%)** |
| A Little Progress | 41 (21%) |
| Some Progress | 42 (22%) |
| Moderate Progress | 24 (12%) |
| A Lot of Progress | 6 (3%) |
| No Progress | 83 (42%) |
| **Difficulty Meeting DCBS Requirements** | **n=855** |
| **Any Progress** (i.e. a little, some, moderate, or a lot of progress) | **705 (82%)** |
| A Little Progress | 234 (27%) |
| Some Progress | 202 (24%) |
| Moderate Progress | 215 (25%) |
| A Lot of Progress | 54 (6%) |
| No Progress | 150 (18%) |
| **Legal Problems** | **n=327** |
| **Any Progress** (i.e. a little, some, moderate, or a lot of progress) | **279 (85%)** |
| A Little Progress | 89 (27%) |
| Some Progress | 99 (30%) |
| Moderate Progress | 72 (22%) |
| A Lot of Progress | 19 (6%) |
| No Progress | 48 (15%) |
| **Problems with Social/Family Relationships** | **n=726** |
| **Any Progress** (i.e. a little, some, moderate, or a lot of progress) | **612 (84%)** |
| A Little Progress | 196 (27%) |
| Some Progress | 253 (35%) |
| Moderate Progress | 139 (19%) |
| A Lot of Progress | 24 (3%) |
| No Progress | 114 (16%) |
| **Parenting** | **n=505** |
| **Any Progress** (i.e. a little, some, moderate, or a lot of progress) | **403 (80%)** |
| A Little Progress | 100 (20%) |
| Some Progress | 125 (25%) |
| Moderate Progress | 159 (31%) |
| A Lot of Progress | 19 (4%) |
| No Progress | 102 (20%) |

Work readiness was identified as a barrier for 21% (n=476) of assessed participants terminating TAP services. As shown in the table below, 78% (n=370) of terminating participants identified with work readiness as a barrier were rated as showing improvement in work readiness. In addition, there was greater improvement for submitting applications for employment and obtaining employment than for participation in job training or continuing education.

**Work Readiness Progress among Participants Terminating TAP Services**

|  | **Work readiness identified as barrier among participants terminating TAP services (n=476)** |
| --- | --- |
| **Improved Work Readiness** |  |
| **Any Progress** (i.e. a little, some, moderate, or a lot of progress) | **370 (78%)** |
| A Little Progress | 109 (23%) |
| Some Progress | 106 (22%) |
| Moderate Progress | 115 (24%) |
| A Lot of Progress | 40 (9%) |
| No Progress | 106 (22%) |
| **Submitted Applications for Employment** |  |
| **Any Progress** (i.e. a little, some, moderate, or a lot of progress) | **360 (76%)** |
| A Little Progress | 95 (20%) |
| Some Progress | 102 (22%) |
| Moderate Progress | 105 (22%) |
| A Lot of Progress | 58 (12%) |
| No Progress | 116 (24%) |
| **Obtaining Employment** |  |
| **Any Progress** (i.e. a little, some, moderate, or a lot of progress) | **273 (57%)** |
| A Little Progress | 53 (11%) |
| Some Progress | 38 (8%) |
| Moderate Progress | 97 (20%) |
| A Lot of Progress | 85 (18%) |
| No Progress | 203 (43%) |
| **Participation in Job Training** |  |
| **Any Progress** (i.e. a little, some, moderate, or a lot of progress) | **203 (43%)** |
| A Little Progress | 61 (13%) |
| Some Progress | 61 (13%) |
| Moderate Progress | 55 (12%) |
| A Lot of Progress | 26 (5%) |
| No Progress | 273 (57%) |
| **Continued Education** |  |
| **Any Progress** (i.e. a little, some, moderate, or a lot of progress) | **106 (22%)** |
| A Little Progress | 30 (6%) |
| Some Progress | 26 (5%) |
| Moderate Progress | 33 (7%) |
| A Lot of Progress | 17 (4%) |
| No Progress | 370 (78%) |

In Fiscal Year 2016, of the 2,286 assessed participants terminating TAP services, 24 participants had SSI or SSDI applications approved with TAP assistance. An additional 91 participants had applied for SSI or SSDI with TAP assistance, and their applications were still pending at the time their TAP cases were closed.

Aggregate baseline assessment data obtained since July 1, 2005 has been examined. The percent of TAP participants assessed with barriers to self-sufficiency from Fiscal Year 2006 through Fiscal Year 2016 is shown in the figure below. The percent of participants identified with a mental health barrier has remained consistent year to year and remains the most prevalent barrier. The percent of participants assessed with a substance abuse barrier increased, from 40% in Fiscal Year 2006 to 55% in Fiscal Year 2016. The percent of participants assessed with an intimate partner violence barrier remained steady during Fiscal Years 2006-2011. However, that percent decreased to 46% in Fiscal Year 2012 and 43% in Fiscal Year 2016. This decrease may be due to a change in the data-collection instrument implemented with the web-based system in Fiscal Year 2012 as well as changes in DCBS referral practices. The percent of participants screened with learning problems and deficiencies has varied year to year, from 40% in Fiscal Years 2006 and 2010 to 26% in Fiscal Year 2016. These changes may reflect DCBS referral practices, particularly in the Division of Family Support.

**Percent of TAP participants assessed with barriers to self-sufficiency at baseline**

**(FY 2006 – FY 2016).**

The percent of TAP participants assessed with unmet basic needs barriers from Fiscal Year 2006 through Fiscal Year 2016 is shown in the figure below. The percent of participants assessed at baseline with unmet basic needs has increased during this period, from a low of 43% in Fiscal Year 2006 to a high of 64% in Fiscal Year 2014. In Fiscal Year 2016, the percent of assessed participants with unmet basic needs remained high but decreased slightly to 61%. The most commonly identified basic needs reported by participants in Fiscal Year 2016 were: social/family relationships, transportation, housing and parenting problems as barriers. Possible reasons for the increase in the percentage of participants reporting unmet basic needs could be related to the economic downturn and declining resources due to state and federal funding cuts. Another possible reason for the increase could be the type of referrals received from the referral sources, as TAP is known to be a program that addresses unmet basic needs.

**TAP Participants reporting unmet basic needs at baseline (FY 2006-FY 2016)**

In 2016 TAP received a request from the Division of Protection & Permanency (DPP) to survey TAP Assessors on selected factors, including how well DPP workers understand client barriers, how TAP services and assessment information are utilized by DPP, and how well DPP workers communicate and/or collaborate with TAP. Of particular interest were DPP workers’ and other community members’ perceived understanding of and attitudes towards medication-assisted treatment (MAT) for opiate addictions. Availability of MAT and other services was also of interest. The request specified comparing findings from the current year with similar surveys conducted in previous years when possible. In addition to summarizing the findings from the survey, the purpose of this report is to identify potential training needs and opportunities to improve DPP services.

TAP surveyed 47 Assessors co-located in DCBS offices in 33 counties in nine DCBS service regions throughout the state, with a 100% response rate for eligible Assessors. However, there were TAP vacancies in Bullitt, Campbell, Jefferson, Kenton, and Knott Counties. Survey items were identified by state DCBS DPP staff. The survey was implemented electronically using Qualtrics Survey Solution software licensed to the University of Kentucky. The results are presented below.

TAP Utilization

Assessors were asked what percentage of their time was working with DPP referrals and reported that, on average, 78% was working with individuals referred by DPP. Assessors reported that, on average, more than half (52%) of DPP referrals to TAP are out-of-home cases (i.e. children removed, with possibility of reunification). About one-fourth (27%) of DPP referrals are in-home/high-risk cases (i.e. children at risk of removal); 15% of referrals are in-home/low-risk cases (i.e. generally opened due to neglect; low removal risk); and 6% of DPP referrals are FINSA (Family in Need of Services Assessment) cases. This is consistent with percentages reported in previous years but overall, TAP was utilized more often for out of home cases than in-home cases this year. Assessors reported that almost half (48%) of the time, referrals to TAP are made at the beginning (i.e. intake, investigation) phase, with almost half (45%) of referrals made in the middle (on-going) phase or in the middle/ongoing phase of DPP cases. The majority of assessors (98%) rated overall utilization of TAP by DPP to be either “very good” (45%, n=21) or “good” (53%, n=25). Two percent (n=1) described DPP utilization of TAP as “fair” and no assessors reported “poor” utilization of TAP.

DPP Workers’ Communication & Collaboration with TAP

Assessors reported that communication between DPP workers and TAP was generally “very good” (60%, n=28) or “good” (36%, n=17) which increased compared to last year. Questions about DPP case planning collaboration differentiated between formulation and implementation of case plan objectives. When asked about DPP workers’ collaboration with TAP in formulating DPP case plan objectives, more than half of assessors (53%, n=27) described DPP workers’ collaboration with TAP as “good” (36%, n=17) or “very good” (21%, n=10). Thirty percent (n=14) of assessors reported DPP does a “fair” job of collaboration with TAP in this area, and 13% (n=6) indicated “poor” collaboration with TAP on case plan objectives formulation. When asked about DPP collaboration with TAP on implementing DPP case plan objectives, almost three-fourths of assessors (70%, n=33) described DPP workers’ collaboration with TAP as “good” (43%, n=20) or “very good” (28%, n=13). Twenty-three percent (n=11) of assessors reported DPP does a “fair” job, and 6% (n=3) indicated “poor” collaboration with TAP in implementing case plan objectives. When asked how often TAP is included in Family Team Meetings (FTMs), assessors indicated “more often than not” or “often” which decreased from 55% in 2015 to 42%, with less than half reporting they were included. More than half (n=27, 58%) of assessors reported they were only “sometimes” (n=22, 47%) or “rarely” (n=5, 11%) included in FTMs, which increased from last year. Participation in Five Day Conferences was a new area in 2015, so 2016 was the first opportunity for comparison. When asked how often they were invited to Five Day Conferences, the majority of assessors to whom this question applied (80%, n=35) reported they were “rarely” or “sometimes” included in Five Day Conferences, while 11% (n=5) reported they were “often” included and 9% (n= 4) reported they were “very often” invited. This is a slight improvement from last year.

Use of TAP information

One-third of assessors (44%, n=20) reported that DPP staff make “very good” use of the information TAP provides, an improvement compared to 2015. Less than half of assessors (45%, n=21) reported that workers make “good” use of TAP information, compared to 58% (n=30) last year. Nine percent (n=4) of assessors indicated that DPP staff make “fair” use of TAP information, which was the same as in 2015. One assessor (2%) indicated DPP workers make “poor” use of TAP information in 2016 compared to none in 2015. Assessors noted the lack of TAP information in DPP’s electronic case record (iTWIST) and commented on the benefits to DPP clients if TAP were given access to iTWIST and could enter information. Assessors also suggested early referral to TAP and inclusion in Five Day Conferences would help increase collaboration on the formulation of case plans.

Incorporating Understanding of Barriers into DPP Casework

Assessors reported that DPP workers generally do a “good” to “very good” job in understanding major barriers to self-sufficiency, family stability, and safety when working with DCBS clients. This is an improvement from last year, when ratings were generally between “fair” and “good”. Assessors reported that DPP workers are most able to incorporate their knowledge into casework when addressing unmet basic needs related problems (average score: 3.3), and least able to apply it when addressing cognitive and educational deficits (average score: 2.7). Compared to 2015, there were slight increases for all barriers except mental health, which remained the same. When assessors indicated DPP workers had “poor” or “fair” understanding of at least one of the barriers, they were asked to provide a brief example to assist with future training; learning problems, substance use disorders, and intimate partner violence were most often mentioned. Assessors reported specific concerns about the need for improved DPP worker understanding of major barriers, particularly on the obstacles commonly faced by families in crisis, and the increased complexity of situations involving multiple barriers. 2016 survey respondents indicated that an improved understanding of these and all barriers could result in more effective engagement strategies, case planning, and ongoing case work.

Perceived Understanding of and Attitudes towards Medication-Assisted Treatment

Assessors were asked to rate the level of “appropriate understanding” of medication-assisted treatment (MAT) for opiate addiction among four groups: DPP workers, DPP supervisors, judges, and other community partners. Assessors reported that 69% of DPP workers, 77% of DPP supervisors, 64% of judges, and 63% of other community partners possess understand this treatment approach. When compared to 2015, it reflects an increase of more than 10 per cent across all groups. Assessors were also asked to comment on overall attitudes regarding MAT. Most indicated that while stigma remained, acceptance and knowledge increased, largely due to an increase in MAT education and the increase in heroin use and overdoses. Assessors indicated that the availability of MAT in their county/region was either “good” (45%, n=21) or “very good” (36%, n=17%). This was a new question, so past ear data is unavailable for comparison.

Reunification

When asked how often TAP was included in transition planning for reunification, slightly more about a third of TAP assessors indicated they were “often” (36%, n=17) consulted or directly involved in transition planning. This represents a 13% increase from 2015. The percent of assessors included in transition planning “rarely” decreased from 25% in 2015 to 13% in 2016. When asked how often the DPP worker consults them about a participant’s readiness for reunification, less than half of assessors indicated they were consulted “often” (40%, n=19) or “more often than not” (9%, n=4), which represents an increase. Less than half (45%, n=21) reported being consulted “sometimes,” while 6% (n=3) reported they were rarely consulted. Assessors were also asked how often DPP workers consulted them about relapse prevention and safety planning. Less than half (45%, n=21) indicated that DPP workers consulted them “often”, and 13% (n=6) reported being consulted “more often than not.”

The results summarized above point to several opportunities to improve both DPP and TAP services as identified by the assessors surveyed. These include: increased utilization of TAP during early stages of case development; increased overall utilization of TAP; increased TAP involvement in Family Team Meetings; continued improvement in collaborative case planning; continued improvement in communication between DPP workers and TAP assessors; continued enhancement of DPP workers’ understanding of major barriers; continued improvement in DPP/TAP collaboration with regard to reunification readiness, transition planning, relapse prevention, and safety planning.

Final Assessor Comments

Large caseloads and frequent worker turnover were noted as primary concerns by assessors this year. However, Assessors expressed appreciation for the caseworkers and collaboration with TAP, noting their dedication and hard work under extremely difficult circumstances. Some assessors noted progress in their counties in the last six months and were hopeful that staffing changes were settling down.

The results point to several opportunities to improve both DPP and TAP services. These include: increased utilization of TAP during early stages of case development; increased overall utilization of TAP; increased TAP involvement in Family Team Meetings and Five Day Conferences; continued improvement in collaborative case planning; continued improvement in communication between DPP workers and TAP assessors; continued enhancement of DPP workers’ understanding of major barriers; continued improvement in DPP/TAP collaboration on reunification readiness, transition planning, relapse prevention, and safety planning.

Continued collaboration between TAP and DCBS supervisors/staff, at local and regional levels, could be very beneficial in terms of meeting needs and maximizing opportunities for service improvement. Regional data included in this study can help DPP and TAP to explore regional differences identified by survey participants, especially those related to the strengths, weaknesses, and unique characteristics of each part of the state. Through increased understanding of approaches and communication/collaboration strategies that have been effective in certain regions, a set of recommended practices could be used to meet the needs of other regions. Similarly, understanding practices in regions that are struggling with communication and collaboration could enhance understanding of the barriers involved and identify new solutions. For example, protocols that encourage earlier referral and improved communication could be jointly developed, and training could be developed to address enhanced case planning. TAP assessors could provide in-house trainings on targeted barriers, perhaps during new worker orientation as well as throughout the year.

Although progress is being made, given ongoing stigma, negative attitudes and the continued limited understanding of medication-assisted treatment (MAT), there appears to be a need for additional training of DPP staff, judges, service providers, and other community members. With the increase of heroin use in Kentucky, as well as heroin-related deaths, this training should be designed to highlight the benefits of MAT, while also addressing concerns about treatment implementation and outcomes.

In many TAP counties, inadequate services for mental health, substance use, intimate partner violence, and learning difficulties remain a serious concern. However, during 2014-2016, more low-income families had increased access to services with the Affordable Care Act as well as the Kentucky expansion of Medicaid. These developments significantly expanded access to health services for TANF eligible parents. While initially, only physical health care services were more accessible for TAP participants, in 2015 and 2016, the availability of substance abuse and mental health treatment services also increased in parts of the state as providers developed more services.

TAP assessors continue to compliment DPP workers and remain aware of the demands and difficulties they face. Assessor concern about the adverse relationship between caseload size and casework quality continued this year. Assessors noted that some DPP workers go beyond their job requirements and possess exceptional case planning, communication, and collaboration skills. It may be helpful for DPP to identify these staff, as well as counties that excel in collaboration, to develop model practices. These model practices could then be used statewide, which could promote more consistent casework and services locally, regionally, and across Kentucky. Selected strategies in 2017 are presented below.

Increase earlier referral to TAP

In 2017, TAP will continue to work with DPP to increase the percentage of referrals made in the intake/investigation phase of a child welfare case. TAP currently receives referrals from the Division of Protection and Permanency at any point in the life of the case. Through experience gained in the last 17 years, DPP and TAP have determined that referring to TAP as early as possible is optimum. Since the Adoption and Safe Families Act limits time to 12 months in order to achieve reunification or permanent placement, DCBS should continue to make “reasonable efforts” to preserve and reunify families. The TAP approach provides a resource that allows DPP to “front load” services for families. For some cases, TAP can assist parents in accessing appropriate services more quickly than typical so children can remain safely in the home. For other cases where children have been removed due to abuse or neglect, TAP services can help reduce the amount of time for the child to reach permanency, whether the outcome is return to home or determination that DPP has met the requirement for reasonable efforts and termination of parental rights is warranted.

In 2012, referrals to TAP were made at the beginning (intake/investigation) phase of the child welfare case (48%) or in the middle/on-going phase of the case (44%). Referrals from intake/investigation increased to more than half in in 2013 (55%) and 2014 (52%). Assessors reported a slight decrease in early referral to TAP in 2015, with 47% of referrals made by intake/investigation. 2016 survey responses were consistent, with 48% of referrals made in the intake/investigation phase and 45% of referrals made in the middle/ongoing phase of the child welfare case. In 2017, TAP will continue to collaborate with DPP to increase the number of referrals made as early as possible.

There are existing opportunities supporting early referral through the Best Practice/Model Court initiative. In communities implementing best practices (Fayette, Hardin, Johnson, Kenton and Laurel Counties), TAP will collaborate with the Division of Protection and Permanency and Family Court or District Court judges to initiate referral to TAP for assessment early in the case. With release and consent, TAP will facilitate communication with courts, DCBS, participants, lawyers, and Guardians ad Litems when applicable. This ensures earlier identification of barriers and recommendations for services, including additional evaluation when warranted, to assist DCBS with more individualized case planning. This practice will also help ensure assessments ordered by the court are appropriate, non-duplicative, and use resources wisely. Collaborating with TAP is an engagement strategy that gives more parents the opportunity to take an active role in their case plans, improves communication between DCBS, the court, clients, TAP and other service providers. For example, during 2015, the Fayette County Model Court Assessment Committee implemented a pilot project with one Family Court in which DCBS referral to TAP and engagement with the parent begins at the removal hearing. Assessment is conducted within two weeks, TAP participates in the Five Day Conference, and recommendations can be incorporated into the case plan. The assessor then provides a range of TAP services to participants and communicates regularly with the DPP worker and court. During 2016, eligibility was extended to relative placement cases. This project may be expanded to a second Family Court in Fayette County in 2017. In 2017, TAP will provide consultation to DCBS and a new Family Court Judge in Daviess County to determine whether a similar project could be implemented.

Another example is a strategy that was implemented by DPP and TAP in Jefferson County during 2016, piloting the co-location of an assessor with the Intake and Investigation (I&I) teams in Louisville, KY. Co-location with I&I improved collaboration with and consultation to I&I, encouraged earlier initiation of TAP services, and increased frontloading services for vulnerable families. Fayette County DCBS and TAP developed another strategy in 2016 to increase early referrals. Fayette TAP assessors rotated to participate in daily DPP Intake Team case assignment meetings for new referrals to DPP and help identify appropriate TAP referrals. This strategy successfully increased earlier referral to TAP. These strategies will continue in 2017.

In meetings with DCBS regional staff, TAP supervisory staff will initiate discussions of these and other ways to increase earlier referrals to TAP. Strategies will include: a) TAP presentations to DPP intake & investigation teams about program services and ways to refer; b) encouraging TAP participation in “Five Day Conferences,” where potential referrals could be identified and accepted; c) regional and county-level TAP implementation meetings with DCBS management staff to facilitate earlier referrals and to address systemic barriers; and d) use data to identify those counties or individual workers where referrals appear to be delayed and provide additional support to encourage earlier referrals.

Increase use of TAP information

Although overall use of the information TAP provides to DPP has increased, improvement is needed, especially inclusion in TAP participants’ electronic DPP records and incorporating information in case plan formulation and reunification planning. Assessors noted the lack of TAP information in DPP’s electronic case record (iTWIST) and commented on the benefits to DPP if TAP were given access to iTWIST to obtain and enter case-specific information. TAP management will continue to discuss opportunities for TAP access with DPP management. TAP supervisors will initiate discussions of ways to increase collaboration on the formulation of case plans so plans reflect individual differences and needs. Early referral to TAP and inclusion in Five Day Conferences would support this goal. TAP will also discuss ways to increase consultation throughout the case, especially when planning reunification, and will encourage increased Family Team Meetings to discuss reunification.

Increase service access

Service access for physical health care and behavioral health care has increased due to the implementation of the Affordable Care Act and Kentucky’s expansion of Medicaid. If a participant is not enrolled in Medicaid, TAP assists in accessing benefits and provides information. TAP is in a key position to provide an independent assessment and referral to appropriate care and assist participants in navigating systems. While behavioral health services expanded in some areas of the state during 2016, the number of providers continues to grow, especially for substance abuse treatment. TAP will continue to expand resource directories to include new providers and the types of services. In all TAP counties, TAP staff will continue to keep up to date on available services and Managed Care Organizations (MCOs) coverage in order to educate participants and DCBS staff and facilitate referrals to the most appropriate services.

Expand TAP pre-treatment strategies

In response to gaps in services, TAP continues to explore ways to expand pre-treatment strategies in order to help participants meet their DPP case plan goals. For example, TAP has provided intimate partner violence and substance use pre-treatment education and treatment support for participants in both individual and group settings. In 2016, collaboration between the Nelson County TAP assessor and DPP supervisor led to the identifying no accessible and affordable parenting classes, which was a primary barrier to families meeting their DPP case plan goals. TAP applied for and received a mini-grant from the Community Collaboration for Children to purchase the STEP parenting curriculum, and classes were successfully provided. In 2017, TAP will explore the feasibility of providing parenting education tailored to the needs of parents with multiple barriers in other TAP counties.

Provide consultation and training to meet identified needs

In 2017, TAP will continue to be available to provide consultation and training to DCBS and other community partners when requested. TAP assessors provided presentations on TAP services to DCBS staff and community partners in their communities throughout the year. The most common barrier reported by DPP to training participation is lack of staff time due to large caseloads. Approaches to addressing this barrier include providing training during regular DPP staff meetings and providing training through individual case consultation. TAP will continue to work with DPP to increase the number of Five Day Conferences, periodic case planning conferences, and Family Team Meetings to which TAP is invited during 2017.

## Title IV-E Waiver Demonstration Project

The Title IV-E Waiver Demonstration Project is awarded to states by The Department for Health and Human Services. HHS has the authority, through Section 1130 of the Social Security Act, to grant waivers to states that provide flexibility in spending Title IV-E funds to implement new approaches to prevent foster care placement, and to improve outcomes for children if these proposals meet federal standards. Waiver demonstration projects do not provide additional funding to carry out new services; rather they allow for more flexible use of federal funds in order to test new approaches to service delivery and financing structures, in an effort to improve outcomes for children and families involved in the child welfare system.

The state is currently participating in a Title IV-E Waiver Demonstration Project targeting substance abuse and family violence to prevent removal. As of October 2015, Jefferson START has expanded from one team to two teams and is serving families under the Title IV-E Waiver. Fayette County is in the process of implementing a START team and began serving families in February 2017. Kenton County will also expand to a second START team. Pre work and planning has begun at this site with hopes to begin serving families in early 2018.

In addition to START, the state is developing a new in-home services intervention. Kentucky Strengthening Ties and Empowering Parents (KSTEP, formally known as ESFP) is being developed to expand upon Kentucky’s currently offered in-home service array that will target children under age 10 whose parents have substance abuse and are at moderate to imminent risk of entering out of home care. Creation of this program will cover a current service gap for families with substance abuse factors. Additionally, KSTEP intends to expand and improve services for families and children by building capacity in the area of family violence, through training and technical assistance for key stakeholders and the provider community. KSTEP will be piloted in the Northeastern Service Region in Carter, Greenup, Mason and Rowan counties. It is anticipated that KSTEP will begin accepting referrals on July 1, 2017.

KSTEP will emphasize collaboration between families, DCBS, non-profit behavioral health providers and CMHCs to achieve positive outcomes. DCBS is collaborating with non-profit behavioral health agencies to provide in-home services and with CMHC’s to provide quick access to substance use disorder treatment. This will involve regularly scheduled meetings and weekly contacts.

It is anticipated that the waiver will: increase positive outcomes for children in their home, improve their safety and well-being, and prevent child abuse and neglect. Furthermore, it is expected that this will decrease entry and re-entry into foster care.

Anticipated barriers include: the system currently relies on more restrictive placement settings, high staff turnover, provider capacity, and training/time commitment for providers.

## Trauma Informed Care

Trauma Informed Care is an approach toward engaging providers, which recognizes the potential presence of trauma symptoms and the role that trauma may play in an individual’s life. The approach seeks to change the paradigm from one that asks, “What’s wrong with you?” to one that asks, “What has happened to you?”Most consumers of behavioral health services have experienced at least one traumatic event in their lives. Programs and Services related to Trauma Informed Care are offered at a statewide level for consultation and oversight assistance. Specific trainings are offered at a regional level, in an effort to train all direct care staff across the state.

One administrative program management staff with the department continue to be involved with the Statewide Steering Committee on Trauma Informed Care. Quarterly meetings involve training and resource building surrounding Trauma Informed practice. The Steering Committee consists of representatives from Public Health, Early Childhood Development, School systems, Mental Health professionals, Correctional systems, Medical professionals, Disability Rights Advocates, Sexual Assault Prevention Advocates, and Domestic Assault Prevention Advocates. The committee allows for additional collaboration with community partners, as well as offers additional information gathering and distribution.

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

Currently, one psychiatric hospital in the state offers a sixteen (16) week program, where youth are patients of the hospital and have the ability to complete a standardized curriculum for TF-CBT. One of the challenges of this program is, that although this program is set up to be at a lower level of care than an acute psychiatric admission, there is only an agreement with one of the five MCOs in the state to refer participants into this program, which provides the TF-CBT as well and a highly supportive environment.

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

DCBS currently partners with private agencies that are working with trauma informed curricula or milieu models. Two large private residential and foster care agencies are currently implementing the Risking Connections trauma focused program (<http://www.riskingconnection.com/rc_about.php>). There are significant costs associated with implementation of this program, which continues to be a challenge both for the agencies that are currently using the program, as well as for those who would like to use this model in the future.

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

During the late part of 2015, staff from the department and a large agency in Eastern KY-Ramey-Estep Home (REH) - that provides both residential, substance abuse and therapeutic foster care, traveled to Winchester, Virginia to see the demonstration of the Ukeru System at the Grafton Health Care facility. Ukeru is a system of milieu management and client services that has the purpose of reducing use of seclusion and physical management, reducing injuries to staff, reducing agency costs and enhancing the treatment atmosphere. As of this date, the department, DBHDID and the REH are investigating grant possibilities to implement Ukeru at the first agency in Kentucky. For more on Ukeru, see their website at <http://www.ukerusystems.com/>. Due to financial constraints, this has not been implemented in Kentucky at this time.

## Work Incentive Program (WIn)

WIn is a work expense reimbursement program. Eligible recipients receive a monthly payment to cover any work-related expense for a period up to nine months. WIn assists families transitioning off welfare by enabling the family to achieve or maintain self-sufficiency. WIn also promotes family stability preventing out-of-home care placement of children. WIn is funded by Title IV-A. WIn is available statewide to eligible Kentucky Transitional Assistance Program (K-TAP) recipients whose K-TAP case discontinues with earnings. Eligible WIn recipients may receive a work expense reimbursement payment for $130 for up to nine months. Work expenses may include transportation costs, clothing necessary for work, food, etc. Receipt of WIn does not exclude individuals from receiving other benefits such as The Supplemental Nutrition Assistance Program or Medicaid. WIn was created as a result of a study conducted by Manpower Demonstration Research Corporation (MDRC). The findings of this study indicated income supports proved to be more effective than case management in helping individuals stay off welfare and remain self-sufficient.

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

No changes in policy or practice have been made to the WIn program during calendar year 2016. From January 1, 2016 through December 31, 2016, an average of 348 WIN payments were issued per month for a total of $560,170.00.

## Y-NOW Children of Prisoners Mentoring Program (YMCA Safe Place Services)

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

Y-NOW, the mentoring component of YMCA Safe Place Services, has been working with unique populations of youth since 1996, including both middle and high school students, Hurricane Katrina evacuees, youth who are at-risk of dropping out, youth transitioning from 8th to 9th grade, and Children of Prisoners.

Y-NOW collaborates with the local school system (Jefferson County Public Schools), family and juvenile court, Neighborhood Place, the Cabinet for Health and Family Services, Seven Counties (now Centerstone), Probation & Parole, and other agencies involved with children of prisoners. The program service area is the Greater Louisville metro area.

All services are offered free of charge to the youth and family. Funding for the Y-NOW Children

of Prisoners mentoring program comes from Metro United Way, Louisville Metro Government, and other local organizations and individuals.

For the past 12 years, Y-NOW has worked almost exclusively with youth who have a parent incarcerated. The trauma to a child of having an incarcerated parent has been likened to experiencing the death of a loved one, but the grief that the child experiences often goes unnoticed and unacknowledged. It is common for them to exhibit anxiety, shame, fear, sadness, and guilt. In addition, these inward battles present themselves in anti-social behaviors that have resulted in an alarming profile: Children of incarcerated parents are at an increased risk of anxiety, depression, aggression, truancy, substance abuse, attention disorders and poor scholastic performance. In fact, studies indicate that children of prisoners are more likely to become incarcerated themselves one day. Our goal is to break that cycle.

Outcomes

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

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| **MUW Indicators/Outcomes (2015/16 Class)** | **New Matches** | **Sustained Matches** |
| 75% demonstrate an improvement in school performance (grades, suspensions, attendance)  85% report improvement in family relationship (Stability, communication, no runaways, etc.)  75% have no new arrest and/or out of control behavior  75% will not initiate any (or any new) contact with family/juvenile court  80% pass to the next grade | 68%  81%  90%  86%  92% | 80%  90%  90%  90%  90% |

|  |  |  |
| --- | --- | --- |
| **MUW Indicators/Outcomes** | **2015/16 Class** | **All Y-NOW Participants (2004-2015)** |
| % Achieve Academic Success (Improvement) | 52% | --- |
| % Pass to Next Grade | TBD | 101/124 |
| % Missing Less than 10 days of school | 72% | --- |
| # Graduated Middle School | --- | 226/299 |
| # Graduated High School and/or Earn GED | --- | 131/299\* |
| # Currently enrolled in Elementary/Middle/High School | --- | 124/299\* |
| # Enrolled in 2 or 4 year college or Technical School, or in Armed Forces | --- | 71/131 |
| # Graduated 2 or 4 year college or Technical School, or completed Armed Forces commitment | --- | 24 |

\* Important to note that while 299 have participated in Y-NOW program, we cannot locate 43, thus we are unable to measure/track their academic achievements/progress. Some have moved out of county, we know, but others have more than likely dropped out. Additionally 11are in residential/correctional facilities and 30 are known to have dropped out.

Volunteer Recruitment/Training

Volunteer Mentors are recruited from the community at large, thoroughly screened, and participate in a 2-day training workshop to be educated on the special needs of the youth population, prior to being paired with a youth, monthly mentor meetings, and weekly phone coaching support the mentors throughout the follow-through program. Volunteers are also recruited, screened and trained to support the youth enrollment process, 3-day camp, Departure, and Welcome Home.

Youth Referrals/Youth Enrollment

Youth referrals primarily come from area schools, the cabinet, and families. Phone calls were made to more than 70 youth who met the requirements of the program and expressed an interest in joining the community. Four youth enrollment sessions were held, during which 18 volunteers assisted 30 youth in completing their 7-page application. Volunteers also interviewed each youth to finalize both their personal and educational goals for the year.

Caregiver/Guardian/Parents

To educate and improve their ability to support the diverse needs of their youth, caregivers/parents/guardians participate in a 3-hour training workshop; monthly phone calls and quarterly meetings continue this support throughout the follow-through program.

Youth/Mentor Camp Retreat

To prepare for camp, a team of 16 volunteers donated an entire day to help transport two vans full of equipment, materials, and supplies to the campsite. They then decorated and prepared the course room where all group meetings would be held. After completing a full day of training, 17 volunteers accompanied a busload of 24 youth to Country Lake Christian Retreat, Underwood, IN. A 3-day camp retreat is conducted with the youth and mentors to kick-off the program. It includes a variety of guided group conversations and experiential activities designed to have the youth take a look at what’s getting in the way of them being successful and begin to develop an action plan for their future (particularly around their education). A fair amount of time is spent building trust and creating a safe and supportive community so that the youth can begin to talk about what it is like to have an Incarcerated Parent. The youth also do a high ropes course. Camp would not have been successful without the help of the 19 Departure and Welcome Home volunteers.

One-to-One Mentoring Match

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

10-month Follow-Through Program

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

Sustained Relationships/Youth Leaders

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

Key Accomplishments

1996:

* Project N.O.W. (New Outlook Within) launched as a result of Louisville citizens advocating for this effective program here in Louisville
* First residential course at YMCA Camp Piomingo with youth referred from Jefferson County Courts, JCPS, and Housing Authority.
  + WHAS-TV film crew wins an Emmy for their documentary of the residential (camp).

1997:

* Kentucky Dept. of Juvenile Justice awards Project N.O.W. $100,000 for two years.

1999:

* + Funding from the Community Juvenile Justice Partnership Grant.

2000:

* + Mental Health Association of Kentucky awards the program the Phillip P. Ardery Youth Second Chances Award.

2002:

* + Received a $220,000 federal grant from the Office of Juvenile Justice and Delinquency Prevention (JUMP). Project N.O.W. was one of 66 recipients (out of 863 applicants) to receive the grant and the only recipient in Kentucky.
  + Program offices and activities were moved from Berry Blvd to new Crittenden Dr. facility.

2003:

* + First contracted program - Independent Living Program for the Cabinet, 10 (16-19) year-old youth.
  + Camp Loucon used for the first time. OJJDP (JUMP)

2004:

* Y-NOW logo/theme is developed.
  + Y-NOW received a 3-year $157,000 grant from the Department of Health & Human Services to begin a Children of Prisoners Mentoring program. As one of 52 programs funded in the pilot year, Y-NOW was the only program in Kentucky to be chosen.
  + Valerie Steinlander (a long-time Y-NOW volunteer) was awarded a Bell Award from WLKY-TV.

2005:

* + A contestant on *The Apprentice* was the keynote speaker at the Y-NOW Children of Prisoners Graduation Ceremony courtesy of our corporate sponsor, Chase.
  + Youth leader training program began for past youth graduates to assist in the facilitation of the residential and aftercare phase for the new groups.
* A 4-year volunteer in the Y-NOW program, was named a YMCA Outstanding Volunteer.
* A mentor of the Y-NOW Children of Prisoners program was awarded the “Building Strong Families” Award from Metro United Way.
* In acknowledgement of our success with the Y-NOW Children of Prisoners program, the Department of Health & Human Services awarded us a one-time grant of $50,000 to work with Hurricane Katrina evacuees in Louisville.
* Director facilitates HK workshop.

2006:

* Y-NOW scores a perfect 100 and is awarded a 3-year $225,000 grant to continue working with Children of Prisoners from the Department of Health & Human Services through 2010.
* Katrina youth, families, and mentors travel to New Orleans thanks to the Crusade for Children with WHAS-TV riding along and filming.
* Two volunteers were acknowledged as YMCA Outstanding Volunteers
* *WHAS-TV* re-visit for a look at the evolution of the Y-NOW program and the success and challenges for Children of Prisoners.
* Director co-facilitates COPs camp.

2007:

* Began effort to maintain/sustain relationship with past Children of Prisoners.
* Y-NOW is one of 3 programs across the country interviewed for a special Nick News feature on Children with an incarcerated parent.
* Y-NOW staff facilitate camp without any consultants.
* 2x mentor was honored as a YMCA Outstanding Volunteer.
* Two past youth participants and current Youth Leaders are awarded 2 of 4 inaugural Character Awards from the YMCA of Greater Louisville.

2008:

* A volunteer was honored as a YMCA Outstanding Volunteer.
* Y-NOW received our first referral from an Incarcerated Parent.
* A former Children of Prisoners youth (and youth leader) steps up for the 2008/09 program to serve as Logistics/Production Manager at camp.
* Two volunteers appear in YMCA Spirit video talking about their volunteer experience with Y-NOW.
* Y-NOW is one of four MCP programs across the country asked to submit a story for publication to DHHS on one successful match. Y-NOW was also asked to go through a security clearing for a possible meeting with White House staff. (That meeting never materialized.)

2009:

* New Program video and radio spot produced.
* A volunteer recognized as a YMCA Outstanding Volunteer.
* A former Project NOW youth becomes a Y-NOW Mentor.
* A former Project NOW youth serves as a camp volunteer.
* Y-NOW Mentoring Services creates Facebook “Fan Page”.
* More than 105 youth now in “sustained relationship”
* DHHS rewards Y-NOW a 3-year grant that affords 3 more years of Children of Prisoners funding.
* A youth in the 2008/09 program, is honored with a Youth Achievement Award from YMCA Safe Place Services.
* Director was a featured speaker at NACIP (Children of Incarcerated Parents Symposium), Victory Over Violence (Kentucky FRYSCs), and KIPDA (Grandparents Raising Grandchildren)

2010:

* A volunteer recognized as a YMCA Outstanding Volunteer.
* Y-NOW Mentoring Services Facebook Page has more than 160 fans.
* 126 youth now in “sustained relationship”
* Y-NOW video is shown at the Opening Ceremony/Breakfast of the National Mentoring Children of Prisoners Conference in New Orleans.
* Former Y-NOW Children of Prisoners youth wins full scholarship to UofL/Speed School.
* Y-NOW conducted community service project (art murals) at local halfway house, working with inmates/parolees.
* WHAS-TV does feature of Y-NOWs meeting inmates/parolees at halfway house.
* Director and staff appear on WFPL (local NPR station) to discuss Y-NOW program.
* Director appears on “Senior Savvy” to discuss Y-NOW.
* 2010/11 program goes to the street level to find youth – evidenced by the fact that more than 5 or the 28 youth participants are living in homeless shelters.

2011:

* A Volunteer is recognized as a YMCA Outstanding Volunteer.
* A mentor is nominated for a DHHS Outstanding Mentor Award.
* Y-NOW Mentoring Services Facebook Page has more than 225 fans.
* 130 youth now in “sustained relationship”
* 16 “sustained” Y-NOW Children of Prisoners youth are now in college; an additional 10 are headed fall 2011.
* Director conducts training for Grandparents Raising Grandchildren (KIPDA) and Camp Loucon staff/counselors on working with “high risk youth”.
* Y-NOW youth raise over $3,500 towards a youth trip in July 2011 (a record amount fundraised).
* Program reduces due to federal budget cuts (DHHS cuts Mentoring Children of Prisoners funding).

2012:

* Y-NOW alumni and members of Iota Theta Fraternity at UofL participate in several events at Safe Place.
* 2012 Miss America speaks at Safe Place Together 4Teens Fundraising Breakfast.
* 8 volunteers take on being Participation Managers (“HoneyBees”) and are later recognized as YMCA Outstanding Volunteers.
* A youth volunteer is awarded a YMCA Character Award and full scholarship to UofL.
* Director was a featured speaker at Victory Over Violence (Kentucky FRYSCs).
* Frontline Documentaries/PBS attends Y-NOW meeting as she begins work on a documentary on mass incarceration.

2013:

* Y-NOW Facebook page now has 265 likes, including a number of caregivers.

UofL Football coach and football players spend an evening at Safe Place discussing overcoming adversity.

* Y-NOW conducts pilot program at Kenwood Elementary School for children of prisoners.
* Two youth volunteers were nominated for YMCA Character Awards.

2014:

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

2015:

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

2016:

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

1. Terminating participants may have been referred or assessed prior to FY 2016. [↑](#footnote-ref-1)
2. Terminating participants may have been referred or assessed prior to FY 2016. [↑](#footnote-ref-2)
3. The number of assessed participants terminating TAP experiencing specific barriers is noted for each barrier. [↑](#footnote-ref-3)
4. Percentages under each barrier represent the percent of participants making any progress with the identified barrier. Any progress includes a little, some, moderate, and a lot of progress. [↑](#footnote-ref-4)