CHILD ABUSE PREVENTION AND TREATMENT ACT (CAPTA)
Annual Report
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SUBSTANTIVE CHANGES TO STATE LAW
SECTION 106(b)(1)(C)(i)

The State of Iowa continues to maintain laws that are compliant with the requirements of CAPTA. No new laws were enacted over the past year that would negatively affect the eligibility of Iowa. However, on April 6, 2016, Governor Branstad signed SF2258 into law, **effective July 1, 2016**. This law was passed in order to accomplish the following:

- Implement federal requirements from the Preventing Sex Trafficking and Strengthening Families Act (P.L. 113-183), which addresses:
  - Human Trafficking
  - Reasonable and Prudent Parent Standard
  - APPLA for 16+
  - Transition Planning for 14+
    - Webinars and resources were provided on each of these four topics, beginning in July 2015, and remain available on the DHS Training website.
- Implement federal requirements from the Justice for Victims of Trafficking Act of 2015 (P.L. 114-22, amends the Child Abuse Prevention Treatment Act), which requires:
  - Child Sex Trafficking to be a new type of child abuse – without the requirement of a "caretaker"
  - Child Protective workers identify, assess, and provide services for victims of sex trafficking
- Modifies the child abuse definition of sexual abuse – to include any perpetrator who resides in a home with the child.
- Directs a stakeholder workgroup be established to address Drug Endangered Children.

Upon consultation with Children's Bureau Regional Office, it was determined that this law change would not require a written opinion for the State's Attorney General, as the law was passed specifically to maintain eligibility with new CAPTA requirements effective May 29, 2017 (P.L. 114-22).

PROGRAM AREAS SELECTED FOR IMPROVEMENT

SECTION 106(b)(1)(C)(ii)

In Iowa's CAPTA State Plan, submitted in June 2011, the Iowa Department of Human Services (IDHS) identified specific areas to target for improving Iowa's child protection system. Of the fourteen areas set forth in CAPTA, IDHS identified the following six for improvement:

1. **the intake, assessment, screening, and investigation of reports of child abuse or neglect;**

2. **(A) creating and improving the use of multidisciplinary teams and interagency, intra-agency, interstate, and intrastate protocols to enhance investigations; and**

   (B) improving legal preparation and representation, including—
   - procedures for appealing and responding to appeals of substantiated reports of child abuse or neglect; and
   - provisions for the appointment of an individual appointed to represent a child in judicial proceedings

3. **developing, strengthening, and facilitating training including—**
   - training regarding research-based strategies, including the use of differential response, to promote collaboration with the families;
   - training regarding the legal duties of such individuals;
   - personal safety training for case workers; and
   - training in early childhood, child, and adolescent development;

4. **developing and enhancing the capacity of community-based programs to integrate shared leadership strategies between parents and professionals to prevent and treat child abuse and neglect at the neighborhood level;**

5. **supporting and enhancing interagency collaboration among public health agencies, agencies in the child protective service system, and agencies carrying out private community-based programs—**
   - to provide child abuse and neglect prevention and treatment services (including linkages with education systems), and the use of differential response; and
   - to address the health needs, including mental health needs, of children identified as victims of child abuse or neglect, including supporting prompt, comprehensive health and developmental evaluations for children who are the subject of substantiated child maltreatment reports; and

6. **developing and implementing procedures for collaboration among child protective services, domestic violence services, and other agencies in—**

- investigations, interventions, and the delivery of services and treatment provided to children and families, including the use of differential response, where appropriate; and
- the provision of services that assist children exposed to domestic violence, and that also support the caregiving role of their non-abusing parents.

There have been no changes in the areas for which CAPTA grant funding is being utilized since Iowa submitted their CAPTA State Plan in 2011.

ANNUAL SUMMARY OF ACTIVITIES, TRAINING, AND SERVICES
SECTION 108(e)

The following section includes an update on recent *activities supported through the State's CAPTA grant, alone or in combination with other State or Federal funds*, in each of the areas identified in Iowa's State Plan.

INTAKE, ASSESSMENT, SCREENING, AND INVESTIGATION OF CHILD ABUSE OR NEGLECT

The intake, assessment, screening, and investigation of reports of child abuse and neglect continues to be a program area that IDHS utilizes CAPTA basic state grant funds to support. In recent years CAPTA funds have been used to support a policy position in the Division of Adult, Child, and Family Services at IDHS. This position serves as the State's Child Protection Program Manager, as well as Iowa's State Liaison Officer. This position plays an important role in developing and implementing policy as it relates to intake, screening, and assessment of reports of child abuse and neglect. This individual has also played a key role in many of the activities and workgroups mentioned throughout this report, including the implementation of a new Differential Response (DR) system in Iowa.

On January 1, 2014 the state of Iowa began its Differential Response system. Under this system Iowa now has two distinct pathways for responding to child abuse allegations—a Child Abuse Assessment or Family Assessment. The Family Assessment pathway involves a full family functioning assessment, as with a traditional Child Abuse Assessment, including an assessment of child safety and risk. The difference is that in a family assessment there is not a determination of whether or not the abuse occurred, but rather an evaluation of concerns reported and a recommendation for services the family may benefit from. In addition, following a Family Assessment, any family with a "moderate" to "high" risk assessment score are offered voluntary services through a statewide contracted program, called Community Care.

Differential Response did not impact the criteria for accepting a report for assessment. However, Code changes did impact worker response times, the labeling of perpetrators and victims, and report conclusion categories for less serious neglect cases following the acceptance of a report for assessment. In addition, Code changes established a firm path for cases to be re-assigned from the Family Assessment pathway to the Child Abuse Assessment pathway.

These decisions were based on the premise that safety of a child is first and foremost in both assessment types. The Department and stakeholders developed process and outcome measures to monitor implementation. Process measures were developed to indicate how the system is working and outcome measures were developed to measure a families' increased ability to protect and parent their children.

IDHS preliminary reports are already indicating promising results from the first two years of DR implementation. Process and outcome measures indicate that the system is working as designed and the outcomes for children and families are positive.

Highlights of the IDHS report findings from CY 2015 include the following*:

- 95% of children who receive a Family Assessment did not experience a substantiated abuse report within six months.
- 97.5% of families who are referred to Community Care services do not experience a Child in Need of Assistance (CINA) adjudication within six months of service.
- 92.4% of families who are referred to Community Care services do not experience a substantiated abuse report within six months of service.
- 43.6% more families were referred to state purchased services in CY15 than in CY13, which was the year just prior to implementation of the Differential Response model.
- 1,508 of the 24,355 families were re-assigned from the Family Assessment pathway to the Child Abuse Assessment pathway, which is only 1% higher than the original projected parameters.
- 57% of the cases reassigned resulted in a substantiated finding, which indicates pathway reassignment is being utilized as designed.

*Source: http://dhs.iowa.gov/sites/default/files/DR_System_Overview_CY2015.pdf

The State has also used CAPTA grant funding in the past year to enhance the implementation process for Differential Response by supporting Iowa's participation in national level conferences. CAPTA funding supported leaders from each of Iowa's field service areas (as well as policy and training staff) to attend the Kempe Center's International Conference on Innovations in Family Engagement in Minneapolis, MN in October 2015.

MULTIDISCIPLINARY TEAMS AND LEGAL PREPARATION AND REPRESENTATION

(A) Creating and improving the use of multidisciplinary teams and interagency, intra-agency, interstate, and intrastate protocols to enhance investigations; and

The Iowa Child Protection Council (CPC), which serves as both the State's CJA taskforce and as one of the State's Citizen Review Panels, has taken a particular interest in reviewing the current status and utilization of Multidisciplinary Teams (MDTs) in Iowa over the past few years. According to Iowa Code (235A.13, subsection 8), an MDT is defined as follows:

> *"Multidisciplinary team" means a group of individuals who possess knowledge and skills related to the diagnosis, assessment, and disposition of child abuse cases and who are professionals practicing in the disciplines of medicine, nursing, public health, substance abuse, domestic violence, mental health, social work, child development, education, law, juvenile probation, or law enforcement, or a group established pursuant to* ***section 235B.1, subsection 1****.*

The Iowa Code also establishes the following requirement of IDHS as it relates to MDTs (232.71B, subsection 11):

In each county or multicounty area in which more than fifty child abuse reports are made per year, the department shall establish a multidisciplinary team, as defined in ***section 235A.13, subsection 8****. Upon the department's request, a multidisciplinary team shall assist the department in the assessment, diagnosis, and disposition of a child abuse assessment.*

The Council has been particularly interested in the status of local Multidisciplinary Teams (MDTs) since the IDHS went through a significant reorganization from 2009-2010. As a result of significant changes in the structure and staffing of county IDHS offices, as well as dramatic populations shifts throughout the state (with younger populations moving away from rural counties and into more urban counties), it became apparent that there was a need to reexamine the idea of MDTs, as they were established in Iowa Statute in the 1980s.

Therefore, the Council conducted a brief review of the status of MDTs in 2012, but the IDHS felt a more thorough review was needed and sought out a contracted consultant in 2013 to assist with the review. In the fall of 2013, with the support of the Council and Children's Justice Act grant funds, the IDHS released an informal procurement opportunity for a researcher/consultant to assist the IDHS in facilitation of a stakeholder workgroup and in the research and evaluation of the current status of MDTs across the state of Iowa. The contract was awarded to Iowa State University (ISU) and began January 1, 2014.

The project consisted of the establishment of a stakeholder review panel that included the various disciplines outlined in the Iowa Code, i.e., medical, law enforcement, prosecution, education, social work, substance abuse, domestic violence, etc. Several of the Council members also served on the stakeholder workgroup, which met six times from February 2014 through August 2014.

Workgroup members reviewed the history and various definitions of MDTs, child abuse statistics, recent demographic shifts, and the current status of MDTs in Iowa. They examined similarities and differences in roles and responsibilities of IDHS (as defined by Iowa Code) and non-IDHS MDTs (i.e. Child Advocacy Centers, County Attorney MDTs, etc.). The group also reviewed results of telephone interviews conducted by ISU regarding the purpose and function of MDTs in seven other states.

In addition, findings of a newly developed 2014 MDT Survey administered and analyzed by ISU were evaluated by Workgroup members in light of earlier findings of a 1990 MDT Survey. The 2014 survey responses were analyzed overall and by various respondent subgroups (i.e., IDHS MDT members and non-IDHS MDT members). In general, where MDTs exist, the survey results indicated that these teams appear to be going well, but there is a need to improve on assuring that MDTs are developed, used, and accessed consistently across the state and in accordance with the law.

The work of this project was summarized in a final report (Multidisciplinary Team Approach to Protective Assessments: Review and Consultation, Final Report). The full report was submitted to Children's Bureau in 2015.

In short, the recommendations included the following:

1. Increase MDT staffing support
2. Create updated best practice guides for MDT processes and procedures
3. Increase accountability and evaluation across the system
4. Obtain IDHS investment and support for MDTs up and down the system (i.e., local, administrative, etc.)
5. Strengthen IDHS communication about MDTs to outside groups
6. Build and standardize training regarding MDT

Since last year, the IDHS is pleased to report that several of the MDT review recommendations have already been implemented. For example, the IDHS has created new MDT agreement forms and practice guidance documents that were rolled out to the field in the fall of 2015. These forms create greater flexibility in establishing teams for either child abuse, dependent adult abuse, or both. In addition, they create the ability to form "ad hoc" committees for the purposes of a specific review. The practice guidance also goes over specifics on forming teams, and using the new agreement form. These new documents can be found as Attachment A.

In terms of other recommendations from the report, the IDHS has considered how to work better with our state's Child Advocacy Centers (CACs) in bolstering MDTs across the state. One such project includes the use of Children's Justice Act grant dollars for multiple "mini-grants" for CACs to provide training specific to multidisciplinary child abuse assessments/investigations. 5 of these awards were made to CACs throughout the state and all projects should be implemented by September 2016. Outcomes for these projects will be noted in the 2017 CJA Annual Report.

In addition, we took this opportunity to update our MOUs with the various CACs and made some significant changes to assure CACs are reaching out to all counties in their assigned IDHS service area to assist with a multidisciplinary approach to investigations/assessments. Beginning July 1, 2016, all CAC MOUs will include an attached interagency agreement to be completed for all of Iowa's 99 counties to include agreements from the CAC, IDHS, the County Attorney's Office, and county/municipal law enforcement. This collaboration is critical in building and enhancing MDTs throughout the state.

(B) Improving legal preparation and representation

Another area of focus the IDHS utilizes CAPTA grant funds for is the preparation and procedures related to child abuse/neglect appeals of substantiated findings. The IDHS recognizes the rights to due process for any individual accused of child abuse and/or neglect and has in place a process by which individuals can appeal a decision made by the IDHS and request a hearing before an Administrative Law Judge. There is significant preparation work involved in appeals and as a result of the recommendations from the various workgroups in the past year it is anticipated that there will continue to be policy and practice changes as it relates to appeals. Therefore, CAPTA funds have been, and will continue to be, used to support salary and staff time for a position to assist with appeal preparation.

DEVELOPING, STRENGTHENING, AND FACILITATING TRAINING

The IDHS is involved in a variety of different training programs geared toward Child Protective Service intake workers, assessment workers, case managers, supervisors, and contracted service providers. These various training programs, despite different audiences, all cut across the four identified areas:

(A) training regarding research-based strategies, including the use of differential response, to promote collaboration with the families;
(B) training regarding the legal duties of such individuals;
(C) personal safety training for case workers; and
(D) training in early childhood, child, and adolescent development;

Many of these training initiatives are already outlined in the State's APSR and are funded through a variety of state and federal sources. However, there are a few training initiatives, specifically funded through CAPTA, which are outlined below and in further detail in a separate section of this report (on collaborations with Domestic Violence services).

CAPTA funds are used specifically to contract with Iowa State University's Child Welfare Training and Research Project, to fund a key training position. This position is the "Domestic Violence Liaison to IDHS". This role is critical to the state's training of Child Protective Workers. The individual in this role managed and organized Iowa's rollout of the Safe and Together Model™, a perpetrator pattern based, child centered, survivor strengths approach to working with domestic violence, originally designed for use in child welfare systems.

This rollout began in June of 2015 by introducing the model to 51 IDHS Leadership members. Following that event, 43 content experts, 132 IDHS supervisors, and a total of 904 front line IDHS workers and other community service providers received the training, through November of 2015. This resulted in a total of 1130 people across the state receiving training in the Safe and Together Model. This model has been critical in creating a paradigm shift towards a more domestic violence informed child welfare system by helping our child protective workers, and partners, build the skills necessary to engage non-perpetrating caretakers and promote collaboration with families. The next steps for this initiative include a plan to also provide the Safe and Together model training to Iowa's Juvenile Court Judges.

In addition to implementing the Safe and Together Model in Iowa, the state's Domestic Violence Liaison also played a critical role in the development and implementation of a new course on screening for mental health, substance abuse, and domestic violence. Although these topics are not new to our workforce, this new training course is providing attendees with concrete tools to appropriately screen all child protective cases for individual or co-occurring issues. This course was made a requirement for all Supervisors, Child Protective Workers (those responsible for the intake/assessment process), and Social Work Case Managers (though carrying ongoing child welfare cases). The rollout is currently underway across the state during the month of June 2016.

Although there are certainly other trainings offered by IDHS, and outlined in the State's APSR, these trainings were highlighted in this report section due to the use of CAPTA

funds in supporting one of the key trainers involved in the development and implementation of these specific trainings.

DEVELOPING AND ENHANCING THE CAPACITY OF COMMUNITY-BASED PROGRAMS TO INTEGRATE SHARED LEADERSHIP STRATEGIES BETWEEN PARENTS AND PROFESSIONALS TO PREVENT AND TREAT CHILD ABUSE AND NEGLECT AT THE NEIGHBORHOOD LEVEL

There are multiple initiatives through the IDHS which seek to develop and enhance community-based programs and shared leadership strategies to prevent and treat child abuse and neglect at the neighborhood level. While not all of these initiatives are funded directly through the CAPTA basic State grant, they often intersect closely with those that do.

COMMUNITY PARTNERSHIPS FOR PROTECTING CHILDREN (CPPC)

The Community Partnerships for Protecting Children (CPPC) approach aims to keep children safe from abuse and neglect and to support families. This approach recognizes that keeping children safe is everybody's business and that community members must be offered opportunities to help vulnerable families and shape the services and supports provided.

In Iowa, Community Partnerships have brought together parents, youth, social service professionals, faith ministries, local business, schools and caring neighbors to help design, govern and participate in programs that seek to create a continuum of care and support for children, youth and parents in their neighborhoods.

What is Community Partnership?

- Community Partnerships for Protecting Children (CPPC) is an approach that recognizes keeping children safe is everybody's business.
- It's an approach that neighborhoods, towns, cities, and states can adopt to improve how children are protected from maltreatment.
- A Community Partnership is not a *program* - rather, it is a way of working with families that helps services to be more inviting, needs-based, accessible, and relevant.
- Community Partnerships incorporate prevention strategies as well as those needed to address identified maltreatment.
- The Community Partnership approach aims to blend the work and expertise of both professionals and residents to bolster supports for vulnerable families and children.
- It's an opportunity for community members to get involved in helping families in need, and in shaping the types of services and supports needed by these families.
- It is a partnership of public and private agencies, systems, community members, and professionals who work together to:
    - prevent maltreatment before it occurs;
    - respond quickly and effectively when it does occur;
    - reduce the re-occurrence of child maltreatment, through tailored family interventions.

Community Partnership has four primary strategies that guide this approach:

- Individualize Course of Action (also referred to as a Family Team Decision Making)

- Community/Neighborhood Networking
- CPS Policy and Practice Change
- Shared Decision Making

IOWA CHILD ABUSE PREVENTION PROGRAM (ICAPP)

The Iowa Child Abuse Prevention Program (ICAPP) is the Department of Human Service's foremost approach to the prevention of Child Maltreatment. The premise behind the Iowa Child Abuse Prevention Program (ICAPP) is that each community is unique and has its own distinct strengths and challenges in assuring the safety and well-being of children, depending upon the resources available. Therefore, the Program has been structured in such a way that it allows for local Community Based Volunteer Coalitions or Councils to apply for Program funds to implement child abuse prevention projects based on the specific needs of their respective communities.

CAPTA funds will supplement a portion of the total, approximately $1.28 million annually, budgeted for local prevention programs for SFY 2016-2018. This was the first time contracts for grantees were awarded for a period of 3 years. These contracts began July 1, 2015. Competitive grants for this cycle were awarded in the following categories:

1. *Community Development*—for the use of council development, community needs assessment, program development, public awareness, community mobilization, collaboration, or network building (awards limited to $5,000).

2. *Core Prevention Services*—to include any projects that provide the following types of activities and services to children and families:

    a. *Parent Development*—to include, but not be limited to, parent education, parent-child interaction programs, mutual support and self-help, and parent leadership services. This service may also be targeted toward specific populations at greater risk, for example young parents, parents of children with disabilities, or non-custodial parents (such as fatherhood initiatives).

    b. *Respite Care Services*— the term "respite care services" means short term care services, including the services of crisis nurseries, provided in the temporary absence of the regular caregiver (parent, other relative, foster parent, adoptive parent, or guardian) to children who—
        (A) are in danger of child abuse or neglect;
        (B) have experienced child abuse or neglect; or
        (C) have disabilities or chronic or terminal illnesses.

    c. *Home Visitation*—these services include parenting instruction and family support services primarily delivered in a Participant's home. To be eligible for inclusion in this category, a Project must comply with the standards of a national Evidence-Based Practice model, such as Parents As Teachers, Nurse Family Partnership, Healthy Families America, or other models listed on the United States Department of Health and Human Services,

Administration for Children and Families' Home Visiting Evidence of Effectiveness website at: http://mchb.hrsa.gov/programs/homevisiting/models.html .

3. *Sexual Abuse Prevention*— the term "sexual abuse prevention" means services provided to prevent the likelihood of Child victimization through sexual abuse or exploitation. Projects funded under this area should focus on best practices in the prevention of child sexual abuse and exploitation and should, at a minimum, include some aspect of adult instruction. Examples would include public awareness campaigns, educator training, and parent/child instruction on topics such as healthy sexual development, media safety, etc.

Funds are awarded to volunteer-based community councils throughout the State, who are able to apply for up to three projects in their respective communities. Most of these councils are organized by county; however, there are some, particularly in more rural areas of the State, which have combined to cover a multi-county area (up to four or five counties). A map of the projects that were awarded ICAPP funds, and the specific types of services funded by county, can be found in Attachment B. It should be noted that projects in 72 of Iowa's 99 counties have been awarded funds under ICAPP for SFY 2016-2018. In addition, it should be noted that of those 27 counties that did not receive funds (most because they did not apply for eligible projects), all but 2 (Lyon and Sioux) boarder at least one county where services are being provided.

Iowa is proud to be one of three states participating in a collaborative effort between University of Kansas and Friends National Resource Center to compare and analyze Protective Factor Survey (PFS) data. Iowa's PFS data has been presented at several venues, including the National Conference on Child Abuse & Neglect. In addition, the ICAPP program has expressed willingness to pilot new versions of the PFS, including the use of retrospective questions. Current PFS outcome data for ICAPP can be located in the State's APSR submission, as the program's largest funding source is actually Promoting Safe and Stable Families (PSSF).

CAPTA funds are also utilized to support the work of the Child Abuse Prevention Program Advisory Committee (CAPPAC), under the IDHS Human Services Council, the primary advisory body which oversees all activities of the IDHS. The duties of this committee are outlined in Iowa Code and include:

a. Advise the director of human services and the administrator of the division of the department of human services responsible for child and family programs regarding expenditures of funds received for the child abuse prevention program.
b. Review the implementation and effectiveness of legislation and administrative rules concerning the child abuse prevention program.
c. Recommend changes in legislation and administrative rules to the general assembly and the appropriate administrative officials.
d. Require reports from state agencies and other entities as necessary to perform its duties.

e. Receive and review complaints from the public concerning the operation and management of the child abuse prevention program.

f. Approve grant proposals.

CAPTA funds are used to support travel expenses for CAPPAC members to attend quarterly meetings to review the ICAPP program and its progress towards program goals. The CAPPAC also plays a unique role in reviewing the results of the competitive bidding process for community-based projects and in making recommendations to the IDHS in regards to funding for these projects.

MINORITY YOUTH AND FAMILY INITIATIVE (MYFI) & BREAKTHROUGH SERIES COLLABORATIVE

Other initiatives, which seek to build community and reduce the level of disproportionate representation in the child welfare system, are also key to developing and enhancing the capacity of community-based programming and shared leadership. Two such initiatives are the Minority Youth and Family Initiative and the Breakthrough Series Collaborative, as described in the Iowa APSR. While these programs are not funded directly through the State's CAPTA grant they work closely with community-based partnerships and local prevention providers to build relationships with minority communities and to assist in the development of community-based prevention programs that meet their specific needs.

Iowa continues to have strong community and neighborhood-level initiatives to address child maltreatment and disproportionate representation. The broader challenge, going forward, will be in continuing to identify the interconnectedness between various programs and to develop a more comprehensive continuum of care in the child welfare service array.

SUPPORTING AND ENHANCING INTERAGENCY COLLABORATION AMONG PUBLIC HEALTH AGENCIES, AGENCIES IN THE CHILD PROTECTIVE SYSTEM, AND AGENCIES CARRYING OUT PRIVATE COMMUNITY-BASED PROGRAMS

IDEA PART C

Revisions to CAPTA in 2004 required the determination of eligibility for the Part C Services for abused and neglected children under the age of 3. In Iowa the Early Access (IDEA Part C) initiative provides for a partnership between State agencies (Iowa Department of Human Services, Iowa Department of Public Health, Iowa Department of Education (IDOE), and Child Health Specialty Clinics) to promote, support, and utilize the services of Early Access.

The table below represents the number of CAPTA children (those referred following a Child Protective Assessment) on an Individualized Family Service Plan or IFSP (meaning receipt of Early Access services):

Children who receive Early ACCESS services (following a CPA)			
SFY	**# of Children referred**	**# of Children receiving services**	**Percent of children on IFSP**
SFY 15	2001	279	13.9%
SFY 14	2395	329	13.7%
SFY 13	2817	363	12.9%
SFY 12	3017	382	12.7%
SFY 11	2766	404	14.6%
SFY 10	3747	556	14.8%

The table below shows the number of children in foster care on an IFSP:

Foster Children who receive Early ACCESS services			
SFY	**# of children in foster care below age three**	**# of Children receiving services**	**Percent of children on IFSP**
SFY 15	1654	384	23.2%
SFY 14	1641	405	24.7%
SFY 13	1637	456	27.9%
SFY 12	1798	459	25.5%
SFY 11	2430	788	32.4%
SFY 10	2443	713	29.2%

During SFY 15 the number of children, following a CPA, who were referred to Early Access declined, however there was a slight increase in the percentage of those who were referred who ultimately went on to receive services (from 13.7% to 13.9%). The decline in service numbers in recent years is likely, at least somewhat, impacted by the decreases seen in the total number of identified eligible child “victims” in SFY 2014 and SFY 2015. One reason for this may be that, with the implementation of Differential Response, there are fewer children now identified as substantiated “victims”, meaning the number of automated referrals has decreased.

During SFY 14 the number of children in foster care who received services declined to 384 (from 405 in SFY 14). Unlike those numbers of children with a substantiated case of child abuse, foster care numbers (for children under 3) actually increased slightly during SFY 14-15 (from 1641 to 1654), resulting in a decline in the actual percentage of foster children with an IFSP from 24.7% to 23.2%.

It should be noted however that, with the implementation of Differential Response, a number of families are being diverted from formal child welfare services to more community-based services, such as Community Care. Many of the these families still may be receiving referrals to Early Access and obtaining IFSPs, we are just no longer able to tie those families to our formal child welfare system, as their participation is services is voluntary without a substantiated case of abuse.

The IDHS and the IDOE will continue to work through the Early ACCESS state team and with Early ACCESS regions to build upon existing collaborations between local IDHS offices and Early Access offices. Iowa also incorporated Early Access into the rollout of Differential Response, providing workers and contracting service providers with the information needed to make meaningful referrals and to encourage families to participate in eligible services, and will continue to expand on training opportunities.

In addition, with the rollout of the new mental health, substance abuse, and domestic violence screening training underway now, all Supervisors, Child Protective Workers (those responsible for the intake/assessment process), and Social Work Case Managers (though carrying ongoing child welfare cases) have received additional information and training on referring families to Early Access, even if there is not a substantiated case of abuse following the assessment (i.e., in the case of "Family Assessments"). A copy of the Early Access one-page overview that all DHS workers have been advised to discuss with families receiving an assessment can be found in Attachment C.

MATERNAL INFANT AND EARLY CHILDHOOD HOME VISITING

As IDHS continues to focus on the needs of early intervention we have partnered with the Iowa Department of Public Health (IDPH) in their undertaking of the Maternal Infant and Early Childhood Home Visiting (MIECHV) Grant Program. IDPH was allotted an initial formula grant for this program, authorized through the Affordable Care Act, and was later awarded a competitive expansion grant as well. Both the CPPC and ICAPP program managers for IDHS have been involved in the MIECHV Advisory Group throughout this process.

Part of the application process for State lead agencies applying for these funds was to conduct a comprehensive needs assessment to identify key at-risk communities throughout the State where there was a need for home visiting and family support services. IDHS, along with other agencies, contributed a significant amount of data to this assessment and have continued our involvement in the rollout of the State's evidence-based home visiting program.

During the past year, the IDHS also continued its work with partners involved in MIECHV and the state's Early Childhood Iowa (ECI) program to better align contract expectations and data collection across programs. For example, the IDHS's primary child abuse prevention program (ICAPP) had a question on the Protective Factor's Survey (created by the National Resource Center for Community-Based Child Abuse Prevention) that differed slightly from the PFS survey used by ECI programs. The tools were aligned to assure local programs with blended funding would easily be able to report the data to funders.

In addition, conversations are continuing as the State's ECI Program intends to shift over to use of the DAISEY Software System in the coming year for all MIECHV and Early Childhood Iowa programs. DAISEY is a web-based shared measurement system housed on a secure server at the University of Kansas. This system will replace the REDCap (Research Electronic Data Capture) system that was formerly being used for all MIECHV and ECI programs. Once the shift occurs, IDHS will reexamine whether it makes sense programmatically for us to move away from our existing web-based site

(www.iowafamilysurvey.org) used with our prevention programs (ICAPP and CBCAP) and partner with those programs utilizing DAISEY, as many projects at the local level utilize blended funding. At this point we plan to continue with our system for SFY 2017, but should have an update in next year's annual report.

It was also noted in the APSR that the IDHS CAPTA Program Manager has been involved with several interagency collaborations, including the following:

EARLY CHILDHOOD IOWA, IOWA DEPARTMENT OF MANAGEMENT

Early Childhood Iowa (ECI) was founded on the premise that communities and state government can work together to improve the well-being of our youngest children. The initiative is an alliance of stakeholders in Early Care, Health, and Education system that affect child prenatal to 5 years of age in the state of Iowa. ECI's efforts unite agencies, organizations and community partners to speak with a shared voice to support, strengthen and meet the needs of all young children and families.

In the past, ECI has included IDHS representation from the state's childcare bureau but, until recently, there was minimal involvement within the alliance from IDHS program staff involved in child welfare. However, knowing the connection between early childhood development, family support, and prevention of maltreatment, the IDHS child welfare bureau has made a more concerted effort to be involved with the alliance.

Recently the IDHS Prevention Program Manager (who oversees child abuse prevention and adolescent pregnancy prevention programs) became an active member of the ECI Results Accountability workgroup. The workgroup's purpose and responsibilities include:

- To define appropriate results and indicators, and serve as a clearinghouse for consistent definitions of result and performance measures among programs,
- To serve as a clearinghouse for national, state and regional data using existing data bases and publications to assure consistency in demographic and indicator data, and
- To serve in a consultative capacity to provide feedback on proposed results indicators and service, product, activity performance measures, including definitions, collection methods and reporting formats.

The group is currently exploring the use of integrated data systems (IDS) that have been used in various state and regional areas to link administrative data across government agencies to improve programs and practice. In April 2016, the group met with Dr. Heather Rouse, Iowa State University, to learn about her work in this field at the University of Pennsylvania, home of Actionable Intelligence for Social Policy (AISP). Additional information on IDS and AISP can be found here: http://www.aisp.upenn.edu/.

IOWA FAMILY SUPPORT, IOWA DEPARTMENT OF PUBLIC HEALTH

The State of Iowa has been working towards state infrastructure building in the area of family support for many years. However, as a recipient of Federal MIECHV (Maternal Infant Early Childhood Home Visitation) funding, the state had an opportunity to significantly advance this work. The Iowa Family Support Program is housed in the Iowa Department of Public Health (IDPH), Bureau of Family Health and serves as a hub for numerous programs, services, and initiatives including:

- The National Academy – an online learning environment built upon core competencies necessary for success in the field of family support
- The Iowa Family Support Network website – an information and resource referral source for various support programs in the state
- Parentivity – a new web-based community for parents currently being piloted in the state
- The Iowa Family Support Credentialing Program – an accreditation program for family support programs in Iowa
- Family Support Leadership Group – a multidisciplinary group of stakeholders from various public/private agencies who lead various state family support and/or home visitation programs
- Family Support Programming:
    - HOPES/HFI – Healthy Opportunities for Parents to Experience Success - Healthy Families Iowa (HOPES-HFI) follows the national Healthy Families America evidence-based program model.
    - MIECHV – Maternal Infant Early Childhood Home Visitation, federal funding for various evidence based home visitation models being used in a number of "high risk" communities in Iowa

The IDHS, Bureau of Child Welfare, has been actively involved in many of these efforts by participating on the Family Support Leadership Group and serving on the MIECHV State Advisory Committee.

DEVELOPING AND IMPLEMENTING PROCEDURES FOR COLLABORATION AMONG CHILD PROTECTIVE SERVICES, DOMESTIC VIOLENCE SERVICES, AND OTHER AGENCIES

Although collaboration often occurs at the local level between CPS and Domestic Violence (DV) Providers, there has not always been a consistent statewide effort to address this from a policy standpoint, primarily due to the lack of funding for such a position (i.e. a domestic violence content expert who works at the policy level).

The State recognized the need to more adequately address the co-occurrence of child maltreatment and domestic violence. IDHS also recognized that doing so requires increased collaboration and inter-disciplinary work. Although we have experienced some successes in collaboration in the areas of substance abuse and mental health (as these disciplines often follow a medical model approach that includes a clear plan for treatment) we still sometimes struggle, as do many states, with building meaningful collaborations between CPS and DV Advocates. Philosophically, these disciplines have, and often continue to be, at odds. While CPS has the responsibility to protect children from harm, DV Advocates are charged with the task of supporting victims of domestic violence and working together to plan for their safety.

In order to enhance this collaboration the IDHS utilized CAPTA funds to support a contract for a statewide DV specialist to provide case consultation services for field workers throughout the State. In addition to being available on a case-by-case basis, this subject matter expert is available to assist local communities in their collaboration efforts between local CPS workers and DV service providers, among other disciplines.

In addition, this individual serves as a point person in regards to policy issues related to DV and child maltreatment.

The DV Liaison began in November of 2011. In the first year, this individual attended the CPS worker training series to become acclimated to IDHS procedures and standards and researched the way that domestic violence is addressed here in Iowa as well as the procedures in other states. Through discussions with the Statewide CPPC Coordinator and other key players, ideas for improvement were noted.

In alignment with the "Blueprint for Forever Families" (the State's Permanency Plan) a "Blue Sheet" supplement was created for DV advocates to help inform them on how they may be involved in the child welfare system in a way that is helpful to families and children. This supplement was reviewed and approved by the Iowa Coalition Against Domestic Violence (ICADV). It is available on our website for DV advocates throughout the state.

A review of current domestic violence curriculum was performed, and the introductory training material for SP 301: Impact of Domestic Violence and Substance Abuse was revised to be more up-to-date with current DV research and curriculum. The DV Liaison also worked with a contractor to develop an advanced domestic violence training course entitled SP 548: Advanced Domestic Violence with Safety Planning and rolled this out during 2012-2013.

The role of the Domestic Violence Liaison has continued to expand over the past few years to include input on several committees including the Iowa Domestic & Sexual Violence Prevention Advisory Committee and the Iowa Domestic Abuse Death Review Team. The DV Liaison has also been invited to take part in many meetings and webinars to provide a "domestic violence lens" to other child welfare issues, with a large focus on training, community collaboration, and case consultation.

In 2014-2015 the role of the DV Liaison expanded to include case consultation, a blog on the Child Welfare Research and Training Project (CWRTP) website, establishment of a DV Advisory Committee, enhanced DV training to child welfare staff as well as partners, and proposed to IDHS leadership that all child welfare staff be trained in the Safe and Together Model™ by David Mandel and Associations, LLC.

Specifically in the past year (2015-2016), the DV Liaison has accomplished the following:

- Facilitated 9 IDHS formal trainings with over 240 participants and three webinars that were available statewide via live feed and recording.
- Managed and organized the roll out of the Safe and Together Model across the state. Safe and Together training numbers include: 43 CAP (Connect and Protect) content experts, 51 IDHS leadership members, 132 supervisors, 904 community day attendees (including frontline IDHS and partners. In total, 1130 people trained through Safe and Together June 2015 – November 2015.
    - Note previous section on "training" for additional information on this rollout.
- Continued to manage 5 CAP teams with a total of 41 members. This included the organization of two quarterly face-to-face meetings as well as several group calls and consults.

- Began collaboration with the Court Administrator's office to develop a plan for juvenile court judges to be trained in Safe and Together.
- Invited to Orlando to present on how Iowa has implemented the model at the David Mandel and Associates yearly symposium.
- Presented or trained at 7 other conferences or events, year reaching over 200 participants through the Community Partnerships for Protecting Children (CPPC) Initiative.
- Continued membership on the IDHS Training Committee as well as leadership of the subcommittee for the new mental health course (SP305) development.
- Participated in the focus group to design the new mental health, substance abuse, and domestic violence screening tool, and was also chosen as a trainer for that course.

In general, the DV liaison continued to actively participate on 4 committees: Domestic Violence Oversight Committee (as lead and facilitator), CPPC Executive Committee, Iowa Domestic and Sexual Violence Prevention Committee, and the Iowa Domestic Abuse Death Review Team. In addition, this individual took on leadership opportunities this year by supervising an AmeriCorps member, and assisting in the supervision of a graduate student. The DV Liaison was also consulted on the development of the new Dependent Adult Assessment Tool and collaborated with the IDHS Prevention Program Manager, as well faculty at Iowa State University, on the submission of a grant for evaluating a program for mothers of children whose fathers have participated in the 24/7 Dad program. Finally, the DV Liaison was invited to guest lecture to three different classes at the University of Northern Iowa (UNI) and Iowa State University (ISU) this past year.

CITIZEN REVIEW PANELS
SECTION 106(c)(6)

Following this annual report are attachments of the following Citizen Review Panel Annual Reports (Attachment D) and the State's response (Attachment E). Iowa's 3 Citizen Review Panels include:

- The Iowa Child Protection Council/Citizen Review Panel (Statewide CRP)
  - Jerry Foxhoven, Director
    Drake Legal Clinic—Middleton Center for Children's Rights
    2400 University Ave.
    Des Moines, IA 50311
    jerry.foxhoven@drake.edu
    (515) 271-2824

- The Cerro Gordo County Family Violence Response Team (Local CRP)
  - Mary J. Ingham
    Crisis Intervention Service
    PO Box 656
    Mason City, IA 50402
    Mary@CIShelps.org
    (641)424-9071

- Northwest Iowa Citizen Review Panel (Regional CRP)
  - Barb Small
    Mercy Child Advocacy Center
    801 Fifth Street
    Sioux City, IA 51102
    Smallb@mercyhealth.com
    (712) 279-2548

CAPTA Annual State Data Report Items:

***Information on Child Protective Service Workforce*:** For child protective service personnel responsible for intake, screening, assessment, and investigation of child abuse and neglect reports in the State, report available information or data on the following:

- information on the education, qualifications, and training requirements established by the State for child protective service professionals, including for entry and advancement in the profession, including advancement to supervisory positions;
- data on the education, qualifications, and training of such personnel;
- demographic information of the child protective service personnel; and
- information on caseload or workload requirements for such personnel, including requirements for average number and maximum number of cases per child protective service worker and supervisor (section 106(d)(10)).

STATE RESPONSE:

Education, Qualifications, and Training

The Iowa Department of Administrative Services (IDAS) maintains job descriptions, including education requirements, qualifications, and regular duties for all State employees, including CPS personnel. In Attachment F of this report you will find current job descriptions for the positions of *Social Worker III*, those social workers responsible for the intake, screening, and assessment of cases of suspected child abuse and/or neglect, and *Social Work Supervisor*, management positions responsible for providing supervision of all frontline social workers.

Any CPS worker (Social Worker III) must meet or exceed these education/qualification requirements in order to be considered for employment. Demographics on the specific breakdown of educational level and qualifications (i.e. the percentage of workers who hold a BA, BASW, MA, MS, MSW, etc.) of all State employees in this classification is not readily available, without conducting a comprehensive review of personnel files. Therefore a survey was administered to gather this data.

Of the 289 staff identified as having a role in the intake, screening and assessment of child abuse and neglect there were 198 responses to the survey (69% response rate). Therefore current educational data is available on the following number of individuals and is summarized in the tables below:

- 117 Social Worker IIIs and IVs
- 71 Social Work Supervisors
- 10 Social Work Administrators

Highest Degree Obtained	
167	BA/BS (84%)
31	Master's Degree (16%)
198	**TOTAL**

BA/BS Area of Degree		Master's Area of Degree	
52	BA/BS in Social Work (31%)	12	Master's in Social Work (39%)
102	BA/BS in a HS Related Field (61%)	18	Master's in a HS Related Field (50%)
11	BA/BS in another area (7%)	1	Master's in another area (6.5%)
2	Not indicated (1%)	0	Not indicated
167	**TOTAL**	**31**	**TOTAL**

Social Work Licensure Level (if applicable)	
12	LBSW (Licensed Bachelor Social Worker)
8	LMSW (Licensed Master Social Worker)
3	LISW (Licensed Independent Social Worker)
23	**TOTAL**

Training Requirements

In addition to new worker training for all social workers new to the IDHS, ongoing training requirements, after the initial 12 months with the Iowa Department of Human Services, include:

- Minimum of 24 hours child welfare training annually for all Social Workers
- Minimum of 24 hours child welfare/ supervisory training annually for all Social Work Supervisors

[Source: Iowa Department of Human Services 24 Hour Guidelines approved by Service Business Team (SBT) June 2007, Effective date: July 2007]

Demographic Data on CPS Personnel

The IDHS maintains demographics data on all social work personnel. The following data includes demographic information on those specific "social worker" classifications involved in the intake, screening and assessment process. This includes intake and assessment workers (Social Worker 3s), team lead intake workers (Social Worker 4s), Social Work Supervisors, and Social Work Administrators. The data is broken down then by front line social workers and management positions.

Table 1. TOTAL BREAKDOWN BY JOB TITLE

1. Personnel	
199	Social Worker 3s and 4s (Screening, Intake, Assessment)
79	Social Work Supervisors
11	Social Work Administrators
289	**TOTAL**

Table 2. GENDER DISTRIBUTION

2.1 Hourly (Social Worker 3s/4s)		2.2 Management (Supervisors/Administrators)	
35	Male (18%)	23	Male (29%)
164	Female (82%)	67	Female (71%)
199	**TOTAL**	**90**	**TOTAL**

Table 3. RACE/ETHNICITY DISTRIBUTION

3.1 Hourly (Social Worker 3s/4s)		3.2 Management (Supervisors/Administrators)	
4	African American (2%)	0	African American
0	American Indian/Alaska Native	0	American Indian/Alaska Native
4	Asian/Pacific Islander (2%)	0	Asian/Pacific Islander
4	Hispanic/Latino (2%)	0	Hispanic/Latino
8	Not disclosed (4%)	1	Not disclosed (1%)
179	White (90%)	89	White (99%)
199	**TOTAL**	**90**	**TOTAL**

Table 4. DISABILITY STATUS

4.1 Hourly (Social Worker 3s/4s)		4.2 Management (Supervisors/Administrators)	
2	Yes (1%)	0	Yes
180	No (90.5%)	88	No (98%)
17	Did Not Disclose (8.5%)	2	Did not Disclose (2%)
199	**TOTAL**	**90**	**TOTAL**

Table 5. AGE RANGE

5.1 Hourly (Social Worker 3s/4s)		5.2 Management (Supervisors/Administrators)	
6	20-29 years (3%)	0	20-29 years
61	30-39 years (31%)	25	30-39 years (28%)
69	40-49 years (35%)	31	40-49 years (34%)
53	50-59 years (27%)	28	50-59 years (31%)
10	60+ years (5%)	6	60+ years (7%)
199	**TOTAL**	**90**	**TOTAL**
Avg. Age = 45		**Avg. Age = 46**	

Caseload Data

IDHS child protective workers (those preforming assessments) were assigned an average of 13 new cases a month in calendar year 2015, including cases alleging adult abuse. A one page breakdown of child abuse statistics can be found on the IDHS website here: http://dhs.iowa.gov/sites/default/files/childwelfarebythenumbers2015.pdf

The IDHS does not currently set a "maximum" caseload for workers in any given time period, as time factors involved in every case may vary greatly depending upon the area of the State and the needs of the family. Although caseloads in rural areas may, on average, be lower than cases in major metropolitan areas, the travel time involved to visit families can often be greater, as many rural offices cover multi-county areas.

Juvenile Justice Transfers: Report the number of children under the care of the State child protection system who were transferred into the custody of the State juvenile justice system in Federal FY 2015 (specify if another time period is used). Provide contextual information about the source of this information and how the State defines the reporting population (section 106(d)(14) of CAPTA).

STATE RESPONSE:

Juvenile Justice Transfers in Iowa for FFY 2015 totaled 45. This information is extracted from our SACWIS system and pulls data on the number of cases where case management services have been transferred from the supervision of IDHS to Juvenile Court Services (JCS). The IDHS is continuing to explore whether this is the most accurate way to pull this data and will continue conversations around this topic in the coming year. Any decisions to change the way data is pulled to arrive at this number will be discussed in the next annual report.

Excerpt from 2017 APSR Program Instruction:
Describe the policies and procedures the state has in place to address the needs of infants born with and identified as being affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder, including a requirement that health care providers involved in the delivery or care of such infants notify the child protective services system of the occurrence of such condition of such infants (section 106(b)(2)(B)(ii) of CAPTA). We note that such notification should occur in any instance in which an infant is demonstrating withdrawal symptoms due to prenatal drug exposure, whether the drugs were obtained legally or illegally.

State Response:
The following response includes multiple "policy statements" pulled directly from the Iowa Department of Human Services, Child Welfare Service Employee Manual, and includes Iowa Code citations were applicable.

Policy statement: Every person as defined in Iowa law is a mandatory reporter of child abuse when within the scope of the person's professional practice or employment the person examines, attends, counsels, or treats a child and reasonably believes the child has been abused. (Iowa Code Section 232.69 and 232.70)

Additional Commentary: All health care providers in the delivery or care of such infants are, by law, mandatory reporters of abuse.

Policy statement: A mandatory reporter is required to make an oral report to the Department within 24 hours of becoming aware of an abusive incident and must make a written report to the Department within 48 hours of the oral report. A mandatory reporter must contact law enforcement if there is reason to believe that the child needs immediate protection. (Iowa Code Section 232.70(6))

Additional Commentary: All health care providers in the delivery or care of such infants, as mandatory reporters, are required by law to promptly notify child protective services regarding allegations of abuse.

Policy statement: A report constitutes an allegation of the presence of illegal drugs when an illegal drug is alleged to be present in a child's body or a child is alleged to have been exposed to an illegal drug that would result in the drug being present in the child's body. (Iowa Code Section 232.68(2)(a)(6))

Additional Commentary: Iowa Code Section 232.77(2) states:
If a health practitioner discovers in a child physical or behavioral symptoms of the effects of exposure to cocaine, heroin, amphetamine, methamphetamine, or other illegal drugs, or combinations or derivatives thereof, which were not prescribed by a health practitioner, or if the health practitioner has determined through examination of the natural mother of

the child that the child was exposed in utero, the health practitioner may perform or cause to be performed a medically relevant test, as defined in section 232.73, on the child. The practitioner shall report any positive results of such a test on the child to the department. The department shall begin an assessment pursuant to section 232.71B upon receipt of such a report. A positive test result obtained prior to the birth of a child shall not be used for the criminal prosecution of a parent for acts and omissions resulting in intrauterine exposure of the child to an illegal drug.

Iowa Administrative Code (IAC) Chapter 441—175 further defines "illegal drug":

"Illegal drug" means cocaine, heroin, amphetamine, methamphetamine or other illegal drugs, including marijuana, or combinations or derivatives of illegal drugs which were not prescribed by a health practitioner.

The IDHS interpretation has been to consider even a prescription "drug" being used "illegally" (i.e., not in the manner it was prescribed to the identified patient by a health practitioner) to meet the threshold of an "illegal drug".

In addition to allegations of "child abuse" as defined by Iowa Statute specific to the category of "Presence of Illegal Drugs" an allegation that a newborn may be affected by a Fetal Alcohol Spectrum Disorder, could also be considered under the category of Denial of Critical Care, or "neglect", if it appears the caregiver has failed to provide adequate medical treatment or supervision.

Policy statement: A report constitutes an allegation of denial of critical care when a person responsible for the care of a child fails to provide adequate food, shelter, clothing, medical or mental health treatment, supervision, or other care necessary for the child's health and welfare. (Iowa Code Section 232.68(2)(a)(4)(a))

Additional Commentary: Iowa Administrative Code (IAC), 441-175.21 further defines the following subcategories of Denial of Critical Care relevant to an infant's health care needs:

4. Failure to provide adequate health care *to the extent that there is danger of the child suffering injury or death. A parent or guardian legitimately practicing religious beliefs who does not provide specified medical treatment for a child for that reason alone shall not be considered abusing the child and shall not be placed on the child abuse registry. However, a court may order that medical service be provided where the child's health requires it.*

7. Failure to provide for the adequate supervision *of the child that a reasonable and prudent person would provide under similar facts and*

circumstances when the failure results in direct harm or creates a risk of harm to the child.

8. Failure to respond to the infant's life-threatening conditions *(also known as withholding medically indicated treatment) by providing treatment (including appropriate nutrition, hydration and medication) which in the treating physician's reasonable medical judgment will be most likely to be effective in ameliorating or correcting all conditions, except that the term does not include the failure to provide treatment (other than appropriate nutrition, hydration, or medication) to an infant when, in the treating physician's reasonable medical judgment any of the following circumstances apply: the infant is chronically and irreversibly comatose; the provision of the treatment would merely prolong dying, not be effective in ameliorating or correcting all of the infant's life-threatening conditions, or otherwise be futile in terms of the survival of the infant; the provision of the treatment would be virtually futile in terms of the survival of the infant and the treatment itself under the circumstances would be inhumane.*

Therefore, if a mandatory reporter has reason to believe a child's health care needs (including those resulting from substance exposure) are not being met by a caregiver and, as a result, there is a danger of the child suffering injury or death, the mandatory reporter is required to report this as an allegation of child abuse to child protective services. In other words, even if there is not a confirmation (via testing) of legal or illegal substance exposure (or FASD affects), a health care provider shall report any concerns that the caregiver has failed to provide for adequate health care.

In addition, current policy manual for Intake Practice Guidance (Chapter 17 A(3) specifically indicates the following (pg. 16-17):

Failure to provide proper supervision could be indicated by:

- The caretaker has left an infant unattended in a bathtub, near an open flame or in a precarious physical position,
- The caretaker has left a child who is incapable of self-supervision,
- The caretaker has knowingly selected a babysitter who is incapable of ensuring the safety of the child,
- A parent overmedicates a child,
- A caretaker locks a child in a closet or attic,
- The caretaker chains or ties a child,
- <u>The caretaker's use of alcohol or illegal drugs has impacted on the caretaker's ability to provide proper supervision, or</u>
- A child is abandoned.

Further, if the allegations still do not rise to the level of an act of abuse or neglect having *already occurred*, the IDHS shall assess the allegations to determine whether they constitute an allegation of a Child In Need of Assistance (CINA).

Policy statement: The Centralized Service Intake Unit (CSIU) shall evaluate the credibility of the facts and circumstances alleged and the information gathered to determine if the concerns constitute an allegation of a Child In Need of Assistance as statutorily defined. (Iowa Code Section 232.2)

Additional Commentary: Iowa Code Section 232.2(6) provides for following the definitions (that may be relative to substance exposed infants) of a "child in need of assistance", to include a child:

b. Whose parent, guardian, other custodian, or other member of the household in which the child resides has physically abused or neglected the child, or is imminently likely to abuse or neglect the child.

c. Who has suffered or is imminently likely to suffer harmful effects as a result of any of the following:

(1) Mental injury caused by the acts of the child's parent, guardian, or custodian.

(2) The failure of the child's parent, guardian, custodian, or other member of the household in which the child resides to exercise a reasonable degree of care in supervising the child.

(3) The child's parent, guardian, or custodian, or person responsible for the care of the child, as defined in section 232.68, has knowingly disseminated or exhibited obscene material as defined in section 728.1 to the child.

e. Who is in need of medical treatment to cure, alleviate, or prevent serious physical injury or illness and whose parent, guardian, or custodian is unwilling or unable to provide such treatment.

m. Who is in need of treatment to cure or alleviate chemical dependency and whose parent, guardian, or custodian is unwilling or unable to provide such treatment.

n. Whose parent's or guardian's mental capacity or condition, imprisonment, or drug or alcohol abuse results in the child not receiving adequate care.

o. In whose body there is an illegal drug present as a direct and foreseeable consequence of the acts or omissions of the child's parent, guardian, or custodian. The presence of the drug shall be determined in accordance with a medically relevant test as defined in section 232.73.

Response Time

In terms of the pathway that these types of cases would go down, if the allegation is Presence of Illegal Drug, it will be assigned as a Child Abuse Assessment and the observation time will be assigned by the supervisor at intake:

- **One hour** when the report involves an immediate threat or high risk to the child's safety

- **24 hours** when the report doesn't involve immediate threat or high risk to the child but the person alleged responsible has access to the child
- **96 hours** when the report doesn't involve an immediate threat or high risk to the child and the person alleged responsible clearly does not have access to the child Response time starts from the time when the intake contact is concluded.

If the allegation is made as one of Denial of Critical Care, it may go down the Child Abuse Assessment pathway, or it may go down the Family Assessment pathway, assuming none of the following criteria are met:

- The alleged abuse type includes a category other than Denial of Critical Care (DCC)."
- The allegation requires a 1-hour response or alleges imminent danger, death, or injury to a child.
    - The allegation is meth and at least one child victim is under six years old.
    - There is a separate incident open on the household that requires a child abuse assessment.

      Note: "Immediate threat" or "imminent danger" means conditions which, if no response were made, would be more likely than not to result in sexual abuse, injury or death to a child (IAC 441-175.21)
- The child has been taken into protective custody as a result of the allegation.
- There is an open DHS service case on the alleged child victim or any sibling or any other child who resides in the home or in the home of the non-custodial parent if they are the alleged person responsible.
- The alleged person responsible is not a parent (birth or adoptive), legal guardian, or a member of the child's household.
- There has been TPR (in juvenile court) on the alleged person responsible or any caretaker who resides in the home.
- There has been prior Confirmed or Founded abuse within the past 6 months which lists any caretaker who resides in the home as the person responsible.
- It is alleged that illegal drugs are being manufactured or sold from the family home.
- The allegation is failure to thrive or that the caregiver has failed to respond to an infant's life- threatening condition.
- The allegation involves an incident for which the caretaker has been charged with a felony under chapter 726 of the Iowa Code (including neglect or abandonment of a dependent person; child endangerment resulting in the death, serious injury, or bodily injury of a child or minor; multiple acts of child endangerment; or wanton neglect of a resident of a health care facility resulting in serious injury).

Conclusion

Given the flexibility provided for in statute, and the policy clarifications that are present in the IDHS Employee Manual, Iowa has multiple policy mandates regarding the notification by health care providers and the required response by child protective services for infants affected by illegal substance abuse or

withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder. Additional guidance provided to Iowa's mandatory reporters can be found in the manual, accessible to the public at:

https://dhs.iowa.gov/sites/default/files/Comm164.pdf

Excerpt from 2017 APSR Program Instruction:

Describe the state's policies and procedures for developing a plan of safe care for infants born and identified as being affected by illegal substance abuse or withdrawal symptoms or Fetal Alcohol Spectrum Disorder (section 106(b)(2)(B)(iii)). Describe which agency or entity is responsible for developing a plan of safe care, how it is monitored and how follow-up is conducted to ensure the safety of these infants.

State Response:

The following response includes multiple "policy statements" pulled directly from the Iowa Department of Human Services, Child Welfare Service Employee Manual, and includes Iowa Code citations were applicable.

Policy Statement: If the child is conditionally safe, the child protection worker shall develop a safety plan with the primary caretaker responsible for the safety of the child within 24 hours of the first contact with the child.

Additional Commentary: CPA Assessment Procedures Manual specifically outlines the following as it relates to substance-exposed infants:

Title 17, Chapter b(1), Page 23:

Safe Plan of Care for Infants Born With Presence of Illegal Drugs

1. Complete a "safe plan of care" (safety plan) for infants who are born positive for illegal drugs or exhibit withdrawal symptoms.
    - Establish a safety plan whenever a safety concern is identified. The mother's substance abuse is a safety concern.
    - If the safety assessment determines that a safety plan can address all safety concerns identified, the infant's removal is not necessary.
2. Develop the "safe plan of care" to include referral to appropriate services. In addition to identification of informal support systems, appropriate services may include:
    - Substance abuse evaluation or treatment
    - Visiting nurse services
    - Home visitor parenting programs
    - Early access
    - Safety plan services
    - Family safety, risk, and permanency services

IDHS child welfare workers are responsible for the development of the safety plan. In terms of how the plan is monitored and follow-up on, that may include

the IDHS child welfare case manager, as well as contracted providers of "Safety Plan Services (SPS)" and/or "Family safety, risk, and permanency services (FSRP)".

The expectations for what is included are those items identified in manual in #2: Substance abuse evaluation or treatment, Visiting nurse services, Home visitor parenting programs, Early access, Safety plan services, Family safety, risk, and permanency services. A "Safe Plan of Care" may indicate things like, "Mom will contact ABC Treatment Center by 10/1/16 to schedule substance abuse evaluation", "Dad will take infant to scheduled developmental assessment at Area Education Agency on 10/5/16", "Mom and Dad will continue participation in XYZ home visitation program". The "safe plan of care" is to be completed on Iowa's "Safety Plan" form:

http://dhs.iowa.gov/sites/default/files/470-4461.pdf

Additional information about Safety Plan Services (SPS) can be located in Iowa's APSR submission, but in summary:

If a child is assessed as "conditionally safe" during the course of a child abuse assessment or CINA Assessment, a referral to SPS can be made. These cases may not automatically be referred (opened) to SPS services but they would be eligible if "conditionally safe". The Safety Plan (which may include an infant "safe plan of care" if relevant) would identify the specific tasks that ensure safety, who completes the tasks, how often, how monitored, back up plan, etc. If a CPS assessment worker refers a family to SPS, oftentimes, it is the SPS worker who is responsible for monitoring some of the tasks. There may be other family members identified on the Safety Plan who are also identified as options to monitor. SPS is a daily service and one unit is 15 calendar days. The assessment worker can refer up to a 2nd unit for a total of 30 days. So, if SPS is referred, the family would be monitored daily during the course of the child abuse or CINA assessment (as long as no modifications are listed by the assessment worker and a 2nd referral is made). The most common documentation within a Safety Plan if the parent does not follow through usually refers to the possibility of a removal of the child from the home, contacting the County Attorney's office, etc.

Excerpt from 2017 APSR Program Instruction:
Describe any technical assistance the state needs to improve practice and implementation in these areas, including how to support mothers and families, as well as infants, through a plan of safe care.

State Response:
The state has fairly clearly defined law and policy around illegal drugs (including those used outside of the parameters for how they were prescribed by a practitioner). However, since the addition of the term "Fetal Alcohol Spectrum Disorder" (FASD) in CAPTA language there has not been clear guidance on how states are to define FASD and how it is diagnosed.

According to experts, diagnosing FASD requires expertise and a thorough assessment that often includes observation of physical growth and development (of the body and brain) over a period of time. Therefore, it is not often that FASD is diagnosed in infancy, absent admission of excessive alcohol consumption during pregnancy. It has been noted, in fact, that general pediatricians would not likely be qualified to make a clinical diagnosis of FASD, as a child should be seen by a geneticist to rule out other disorders.

Therefore, it would be helpful to hear what other states have done regarding this issue and/or how they have incorporated FASD into their state laws.

AMENDMENTS TO CAPTA MADE BY P.L. 114-22, THE JUSTICE FOR VICTIMS OF TRAFFICKING ACT OF 2015

Effective May 29, 2017

Excerpt from 2017 APSR Program Instruction:

Describe the steps that the state is taking or will need to take to address the amendments to CAPTA relating to sex trafficking in order to implement those provisions by May 29, 2017.

State Response:

As noted in the first section of this report, on April 6, 2016, Governor Branstad signed SF2258 into law, **effective July 1, 2016**. This law was passed in order to accomplish the following:

- Implement federal requirements from the Preventing Sex Trafficking and Strengthening Families Act (P.L. 113-183), which addresses:
  - Human Trafficking
  - Reasonable and Prudent Parent Standard
  - APPLA for 16+
  - Transition Planning for 14+
    - Webinars and resources were provided on each of these four topics, beginning in July 2015, and remain available on the DHS Training website.
- Implement federal requirements from the Justice for Victims of Trafficking Act of 2015 (P.L. 114-22, amends the Child Abuse Prevention Treatment Act), which requires:
  - Child Sex Trafficking to be a new type of child abuse – without the requirement of a "caretaker"
  - Child Protective workers identify, assess, and provide services for victims of sex trafficking
- Modifies the child abuse definition of sexual abuse – to include any perpetrator who resides in a home with the child.
- Directs a stakeholder workgroup be established to address Drug Endangered Children.

New Child Sex Trafficking Abuse Code:

Iowa Code section 232.68(2)(a)(11) defines "Child Sex Trafficking" as the recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a child for the purpose of commercial sexual activity as defined in Iowa Code section 710A.1

- "Commercial sexual activity" means any sex act or sexually explicit performance for which anything of value is given, promised to, or received by any person and includes, but is not limited to, prostitution, participation in the production of pornography, and performance in strip clubs.
- **NOTE: This category of child abuse does not require caretaker status.**

Next Steps:

- Notice of the changes is being communicated to the field through Service Help Desk releases and tidbits as available.

- Field supervisors have been encouraged to review the upcoming changes with staff and await further details regarding the policy, practice, form, and system changes.
- Further discussion and an opportunity for questions was offered on the July 21, 2016 Bi-Monthly Service CIDS (conference call with IDHS filed supervisors).
- A webinar regarding the new Child Sex Trafficking Abuse Code and Sexual Abuse Code Modification was released to the IDHS field staff, including supervisors and administrators for review, beginning June 17, 2016.
- A follow up teleconference, to provide an additional opportunity for questions prior to the July 1, 2016 rollout, was offered to the IDHS field staff, including supervisors and administrators on June 28, 2016.

Excerpt from 2017 APSR Program Instruction:

Provide an assessment of the changes the state will need to make to its laws, policies or procedures to ensure that victims of sex trafficking, as defined in sections 103(9)(A) and (10) of the TVPA, are considered victims of child abuse and neglect and sexual abuse. We note that it is likely that some states will need to make changes to state laws to come into compliance. Indicate whether the state is electing to apply the sex trafficking portion of the definition of "child abuse and neglect" and "sexual abuse" to persons who are over age 18 but have not yet attained age 24.

State Response:

See response to previous section. Iowa has already passed new laws to ensure victims of sex trafficking are also defined as victims of "child abuse and neglect" and "sexual abuse". Also, as previously noted, updates to Iowa Administrative Code (IAC) or "rule" are currently underway, as well as updates to the IDHS Employee's Manual, forms, and data systems.

Because Iowa law defines "child" as "any person under the age of eighteen years" the new law will not apply to persons who are over age 18, but have not yet attained age 24. Iowa criminal code would still consider these young adults as victims of sex trafficking, but they would not fall under the jurisdiction of child protective services for the purposes of opening a new assessment of child abuse.

Excerpt from 2017 APSR Program Instruction:

Provide an update on the state's progress and planned activities in the coming year to develop provisions and procedures regarding identifying and assessing all reports involving known or suspected child sex trafficking victims.

State Response:

The State of Iowa has been working on the issue of child sex trafficking for several years. On April 17, 2015 over 100 individuals, from across the State of Iowa and the US, gathered in Des Moines for a Human Trafficking Kickoff Training Event. The primary audience for this training was child protection workers (intake and assessment workers). However, partners from law enforcement, victim's services, Child Advocacy Centers, and other family-centered service providers were invited to the table as well. Each IDHS service area was asked to identify several "practice champions" (from child

protective services, as well as other community partners) to send to the event. These champions then were charged to lead ongoing local events to continue the conversation. The results of survey feedback from this initial event were highlighted in last year's CAPTA report and our again summarized below.

Pre and Post Survey Results –Human Trafficking Kickoff Training Event

Results of the Pre and Post survey were as follows:

Statement*	Pre-Survey Mean**	Post-Survey Mean**	Difference in Mean
1	4.05	6.29	+ 2.24
2	3.53	5.90	+ 2.37
3	3.48	5.57	+ 2.09
4	4.27	5.87	+ 1.60
5	3.86	5.92	+ 2.06
6	4.57	6.08	+ 1.51

*Survey Statements were worded as follows:

1. I know and understand the different types of child trafficking and the prevalence of child trafficking in Iowa.
2. I know and understand the state and federal laws relative to child trafficking.
3. I know and understand my own professional role and responsibilities as they relate to child trafficking assessments and investigations.
4. I know and understand how to screen, identify, and assess trafficking victims by asking appropriate questions
5. I know and understand the roles and responsibilities of other multidisciplinary professionals as they relate to child trafficking assessments and investigations.
6. I feel confident in my ability to work with other professional disciplines in responding to cases of child trafficking.

**Rating Scale: Pre and Post survey statements were rated on a scale from 1 = Strongly Disagree, 2 = Moderately Disagree, 3 = Somewhat Disagree, 4 = Neither Agree Nor Disagree, 5 = Somewhat Agree, 6 = Moderately Agree, 7 = Strongly Agree.

Additional Human Trafficking Training

In addition to the kickoff event held in 2015, there have been multiple learning opportunities for IDHS child protective services workers and partners, at both the state and local levels. CJA funds were used to support several local service area interdisciplinary training events over the last year. In addition, the IDHS partnered with the Crime Victim Assistance Division (CVAD) of the Attorney General's office to send many of our staff to cross training with victim service providers and law enforcement over the summer of 2015.

Even prior to the enactment of this law, which will create sex trafficking as a new and separate category of abuse, IDHS child protective workers were being trained to accept any allegations involving sex trafficking of minors. There were multiple training opportunities, including a required "Human Trafficking" webinar – addressing the child

sex trafficking portion of the Preventing Sex Trafficking and Strengthening Families Act. This webinar is still available on the IDHS Training website and covers the following:

a. Child Trafficking Indicators
b. Child Trafficking Intake Guidance
c. Child Trafficking Assessment Guidance

Additional guidance documents that accompanied this required webinar can be located in Attachment H.

Excerpt from 2017 APSR Program Instruction:

Provide an update on the state's progress and planned activities in the coming year to develop provisions and procedures for training CPS workers about identifying, assessing and providing comprehensive services to children who are sex trafficking victims, including efforts to coordinate with state law enforcement, juvenile justice, and social service agencies such as runaway and homeless youth shelters.

State Response:

Another key piece of state legislation passed this session, as it relates to sex trafficking, includes the establishment of a new state office. In summary the law establishes an "office to combat human trafficking" within the Iowa Department of Public Safety (IDPS). The full text of this bill, Senate File 2191 follows:

Section 1. NEW SECTION. 80.45 Office to combat human trafficking.

1. An office to combat human trafficking is established within the department. The purpose of the office is to oversee and coordinate efforts to combat human trafficking in this state.

2. The commissioner shall appoint a coordinator to staff the office. Additional staff may be hired, subject to the availability of funding.

3. The office shall do all of the following:

a. Serve as a point of contact for anti-human trafficking activity in this state.

b. Consult with and work jointly with other governmental agencies and nongovernmental or community organizations that have expertise in the areas of human trafficking prevention, victim protection and assistance, law enforcement, and prosecution for the purpose of combatting human trafficking in this state.

c. Develop a strategy to collect and maintain criminal history data on incidents related to human trafficking.

d. Develop a strategy for sharing victim and offender data among governmental agencies.

e. Apply for or assist other governmental agencies, as assistance is needed, to apply for grants to support human trafficking enforcement, prosecutions, trainings, and victim services.

f. Research and recommend trainings to assist governmental agencies to identify and respond appropriately to human trafficking victims.

g. Take other steps necessary to advance the purposes of the office.

h. By November 1, 2017, and annually thereafter, submit a written report to the general assembly regarding the office's activities related to combatting human trafficking and occurrences of human trafficking within this state.

4. For purposes of this section, "human trafficking" means the same as defined in section 710A.1.

The IDHS has already begun talks with representatives from IDPS and an update will be provided in next year's report on new efforts and initiatives coordinated in collaboration with this new office.

Excerpt from 2017 APSR Program Instruction:
In addition, no later than May 29, 2017, states must submit the new CAPTA assurances relating to sex trafficking. These assurances are to be provided in the form of a certification signed by the State's Governor (see Attachment F). The signed assurance may be returned with the 2017 CAPTA Annual Report submitted with the APSR due June 30, 2016, if the state is ready to submit them by that time. If not, the state may submit the certification at a later date, but no later than May 29, 2017.

State Response:
Because Iowa's new trafficking law (SF2258) does not take effect until July 1, 2016, the IDHS will wait until after that date to have the Governor sign the certification. Once the signed certification is received, it will be submitted to Children's Bureau. It is anticipated this will be completed by late summer or early fall of 2016, well before the May 29, 2017 deadline.

Excerpt from 2017 APSR Program Instruction:
If the state anticipates it will be unable to submit these assurances by May 29, 2017, provide an explanation as to why that is the case.

State Response:
Not applicable – see previous response.

Excerpt from 2017 APSR Program Instruction:
Identify any technical assistance needs the state has identified relating to implementation of the amendments to CAPTA made by the Justice for Victims of Trafficking Act of 2015.

State Response:
While the state's Child Sex Trafficking abuse laws will not take effect until July 1, 2016, the IDHS field has already been trained to begin identifying and providing for these victims over the past year. Currently, the most difficult barrier involves initially identifying victims of human trafficking. These victims, who are already vulnerable children being targeted and manipulated by the person(s) trafficking them, will often not identify themselves victims. The victims are often trained by their captors to lie, not cooperate with state officials, and to runaway back to their captors.

As a result, it is difficult to distinguish a victim of trafficking from children who may simply be demonstrating some of the trafficking indicators. While IDHS field staff continue to be encouraged to follow up with the next logical question as indicators are identified, and to work with law enforcement on any potential trafficking concerns, the task remains difficult. It would be helpful to know if there is more recent national data on victims to assure we are looking at the most accurate and up to date indicators. It

would also be helpful to hear what other states have done in attempt to flesh these victims out to assure they are receiving the most appropriate service and level of service available.

ATTACHMENT A
NEW MDT FORMS AND PRACTICE GUIDANCE

Multidisciplinary Team (MDT) Agreement

☐ Child Abuse MDT ☐ Dependent Adult Abuse MDT ☐ Both

WHEREAS, the Department has statutory responsibility to respond to abuse reports and recommend whether court action be taken, and, if so, what action, and

WHEREAS, many professionals and interested persons in the community have expertise in the area of child and dependent adult abuse, neglect or protection and have demonstrated concern for children and dependent adults in the community, and

WHEREAS, the formation of a joint body to review incidents of suspected child or dependent adult abuse or neglect and to assist the Department in protecting children and dependent adults from abuse is desirable, and

WHEREAS, the Department has statutory authority to disseminate abuse information to lawfully constituted multidisciplinary teams,

NOW, THEREFORE, the , here called the "team," and the Iowa Department of Human Services, here called the "Department," agree on this day of , 20 , to the following terms and conditions:

1. The team is composed of Department representatives and persons in the community with experience and skills in the protection of children and dependent adults from abuse and who are authorized by law to serve on the team as defined in Iowa Code sections 235A.13 and 235B.1. Members serve on a voluntary basis at the request of the Department. The Department has sole responsibility for the selection of its members.
2. The purposes of the activities of the team are solely to assist the Department in the assessment, diagnosis, and disposition of child and/or dependent adult abuse cases.
3. The team will select its time and place for meetings at the convenience of the members.
4. If consultation is deemed necessary by the Department, during the course of the assessment or evaluation of alleged abuse, the team will review and provide recommendations.
5. The Department may consider the recommendation of the team in a specific abuse case but shall not be bound by the recommendation in any way.
6. Any written report or document produced by the team shall be made a part of the Department's assessment file for the case and shall be subject to all confidentiality provisions of Iowa Code sections 217.30, 235A, and 235B and 441 Iowa Administrative Code Chapters 175 and 176. Any written records maintained by the team shall be destroyed when this Agreement lapses.
7. No team member shall redisseminate child or dependent adult abuse information obtained solely through the multidisciplinary team. This shall not preclude redissemination of information as authorized by Iowa Code.
8. The team members serve without compensation from the Department. Department representatives receive no additional compensation for serving as team members.

9. Office supplies necessary to the operation of the team will be provided by the Department. The team will acquire no other real or personal property.

10. Any professional work, including treatment, research or publication, undertaken by team members using information obtained from team meetings will be initiated only after obtaining Department authorization through regular procedures.

11. Any party to this Agreement may withdraw with or without cause upon 30 days' notice. This Agreement will expire annually on July 1 unless extended by mutual agreement of the parties. Agreements must be renewed annually on or before July 1 of every year.

12. Individuals may be added to the team on an ad hoc basis for a specific case review with the approval of the Department. Any individual not a part of the regular team makeup, and identified on the current signed Agreement, shall sign and date page five of this Agreement for each meeting attended during the term of the Agreement. This page may be duplicated as needed, but shall be maintained with the original signed team Agreement. By signing, the ad hoc member agrees to the same terms and conditions of regular team members.

Multidisciplinary Team (MDT) Core Members

Medical Member		**Public Health and/or Nursing Member**	
Signature of authorized representative:	Date:	Signature of authorized representative:	Date:
Printed name:		Printed name:	
Title:		Title:	
Alternate:		Alternate:	
Mental Health Member		**Social Work Member (non-DHS)**	
Signature of authorized representative:	Date:	Signature of authorized representative:	Date:
Printed name:		Printed name:	
Title:		Title:	
Alternate:		Alternate:	
County Attorney		**Law Enforcement Member**	
Signature of authorized representative:	Date:	Signature of authorized representative:	Date:
Printed name:		Printed name:	
Title:		Title:	
Alternate:		Alternate:	
DHS Protective Services Member		**Other (i.e., Service Provider)**	
Signature of authorized representative:	Date:	Signature of authorized representative:	Date:
Printed name:		Printed name:	
Title:		Title:	
Alternate:		Alternate:	

Multidisciplinary Team (MDT) Core Members (Cont.)

This sheet can be used for any additional members of the core team. Indicate the discipline each additional member represents. This page may be duplicated as needed.

Discipline:		**Discipline:**	
Signature of authorized representative:	Date:	Signature of authorized representative:	Date:
Printed name:		Printed name:	
Title:		Title:	
Discipline:		**Discipline:**	
Signature of authorized representative:	Date:	Signature of authorized representative:	Date:
Printed name:		Printed name:	
Title:		Title:	
Discipline:		**Discipline:**	
Signature of authorized representative:	Date:	Signature of authorized representative:	Date:
Printed name:		Printed name:	
Title:		Title:	
Discipline:		**Discipline:**	
Signature of authorized representative:	Date:	Signature of authorized representative:	Date:
Printed name:		Printed name:	
Title:		Title:	
Discipline:		**Discipline:**	
Signature of authorized representative:	Date:	Signature of authorized representative:	Date:
Printed name:		Printed name:	
Title:		Title:	
Discipline:		**Discipline:**	
Signature of authorized representative:	Date:	Signature of authorized representative:	Date:
Printed name:		Printed name:	
Title:		Title:	
Discipline:		**Discipline:**	
Signature of authorized representative:	Date:	Signature of authorized representative:	Date:
Printed name:		Printed name:	
Title:		Title:	

☐ Child Multidisciplinary Team (MDT) Members

Victim Services Member		Substance Abuse Member	
Signature of authorized representative:	Date:	Signature of authorized representative:	Date:
Printed name:		Printed name:	
Title:		Title:	
Alternate:		Alternate:	
Child Development and/or Education Member		**Juvenile Court Services Member**	
Signature of authorized representative:	Date:	Signature of authorized representative:	Date:
Printed name:		Printed name:	
Title:		Title:	
Alternate:		Alternate:	
Other (i.e., Service Provider)		**Other (i.e., Service Provider)**	
Signature of authorized representative:	Date:	Signature of authorized representative:	Date:
Printed name:		Printed name:	
Title:		Title:	
Alternate:		Alternate:	

☐ Dependent Adult Multidisciplinary Team (MDT) Members

Area Agency on Aging		Other (i.e., Adult Service Provider)	
Signature of authorized representative:	Date:	Signature of authorized representative:	Date:
Printed name:		Printed name:	
Title:		Title:	
Alternate:		Alternate:	
Other (i.e., Adult Service Provider)		**Other (i.e., Adult Service Provider))**	
Signature of authorized representative:	Date:	Signature of authorized representative:	Date:
Printed name:		Printed name:	
Title:		Title:	
Alternate:		Alternate:	

Department of Human Services Approval

Agency, Iowa Department of Human Services	
Signature of authorized representative:	Date:
Printed name:	
Title: Service Area Manager or Designee	

Ad Hoc Member Attendance

With approval of the Department, ad hoc members may be asked to participate in a specific MDT meeting. Any ad hoc member, not on the original team Agreement, shall sign in to each and every meeting attended. This page may be duplicated as needed, but shall be maintained with the original signed team Agreement. By signing, the ad hoc member agrees to the same terms and conditions of regular team members.

Discipline:		**Discipline:**	
Signature of authorized representative:	Date:	Signature of authorized representative:	Date:
Printed name:		Printed name:	
Title:		Title:	
Discipline:		**Discipline:**	
Signature of authorized representative:	Date:	Signature of authorized representative:	Date:
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Printed name:		Printed name:	
Title:		Title:	

Iowa Department of Human Services

Child Abuse and Dependent Adult Abuse

Multidisciplinary Team Practice Guidance

Overview

Multidisciplinary Teams (MDTs) are to be used for consultation during the course of abuse assessments to discuss assessment, diagnosis, coordination of services, possible referrals, and disposition. MDTs are defined under the following:

- Iowa Code 232.71(B), 235A.13(8), and 235B.1
- 441 Iowa Administrative Code 175.32(3), 175.36(235A), and 176.15(235B)

Form 470-2328 is the *Multidisciplinary Team (MDT) Agreement* for the Iowa Department of Human Services. This form is specifically for use with MDTs defined under the Code citations above. Please note that there are different types of multidisciplinary teams outlined in other Iowa Code sections. Form 470-2328 and affiliated protocols are not transferrable to other types of MDTs outlined in other sections of the Iowa Code or Administrative Rules. The Department is not bound by MDT recommendations.

MDTs are composed of team members outlined in the code citations mentioned above. Members of a team shall include, but are not limited to professionals practicing in the disciplines of:

- Medicine,
- Nursing,
- Public health,
- Mental health,
- Social work,
- Domestic violence,
- Child development,
- Education,
- Law,
- Probation, or
- Other disciplines relative to serving children or dependent adults.

The members serve voluntarily and must be approved by the Department.

Foundational Elements

- MDTs shall be developed in county or multicounty areas in which more than 50 child abuse cases are received annually. Local or regional teams, according to service area, can be used to include dependent adult protective assessments as well. MDTs may contain some of the same core members for either child abuse or dependent adult abuse consultation.

- According to Iowa Code, MDTs for dependent adults must include the:
  - Area Agencies on Aging (also now the Aging and Disability Resource Centers),
  - County attorneys,
  - Health care providers, and
  - Other persons involved in advocating or providing services to dependent adults.
- MDT members are selected and established by the Department through execution of the *Multidisciplinary Team (MDT) Agreement*, form 470-2328. The team is considered approved by the service area manager (SAM) or designee as evidenced by signature on the *Agreement* annually, on or before July 1 of each year. Members can also be added on an ad hoc basis as needed with approval from the Department.
- MDTs shall be convened at the Department's request during the course of an abuse assessment or evaluation.
- The specific function of the MDT is to assist the Department during the course of abuse assessments and evaluations only. No case specific information can be discussed outside the scope of the abuse assessment or evaluation.
- The Department is not bound by the team's recommendations.
- Any written information distributed by the Department to the MDT should be collected upon termination of the meeting.
- Team recommendations or consultation should be documented in the contacts portion of the assessment or evaluation.
- Copies of renewed *MDT Agreements* should be forwarded July1 of each year to program managers for child abuse and dependent adult abuse. Please include any ad hoc additions to your teams.

Multidisciplinary Team Establishment

- Every service area must have MDTs available to child abuse and dependent adult abuse protective workers. The teams must consist of standing members who can be convened during an assessment. Ad hoc members can be asked to participate as needed but must be approved by the Department. Ad hoc members must also sign form 470-2328 when attending the MDT.
- Each service area needs to identify and mobilize local efforts to recruit professionals to participate in and sustain MDTs. The Department is required to have MDTs per Iowa Code.
- Identifying an MDT coordinator for each service area is recommended, but not required.

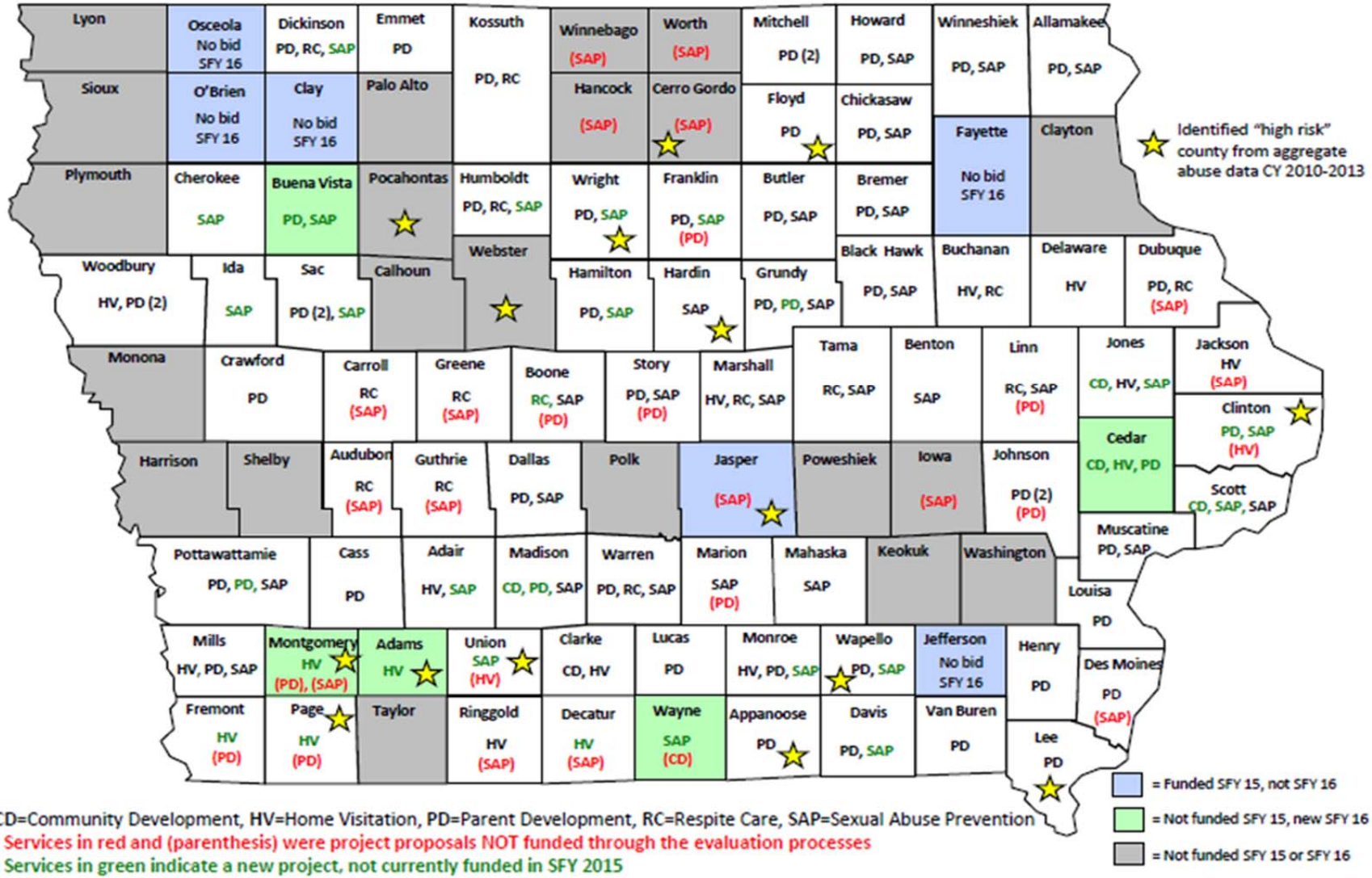
- MDTs may be used for both children and dependent adults. Please use the MDT core members page to indicate those people who will attend both types of MDT. Core members would include:
    - County attorneys,
    - The Department of Human Services,
    - A medical professional,
    - Public health or nursing,
    - A mental health processional,
    - A service provider, and
    - Law enforcement.
- **Child MDTs** require a different core group composition than dependent adults. You may invite Juvenile Court Services, Area Education Agencies, or other service providers.
- **Dependent Adult MDTs** require core group inclusion of the Area Agencies on Aging. You may invite other community agencies such as the Office of the Substitute Decision Maker, a Consumer-Directed Attendant Care (CDAC) provider, or other adult service providers.

Procedures

- Team members must know what is expected of them. Each discipline has an area of expertise and the Department must clearly express the expectations of each member for an effective group process.
- Going over the *MDT Agreement* as a group is recommended to establish the scope of the team's role and expectations of the members.
- Multidisciplinary Team members have immunity from civil or criminal liability for aiding and assisting the Department in an abuse investigation.
- The frequency of the meetings is as needed during abuse assessments. There is no minimum or maximum frequency or duration specified as long as a meeting does not occur outside the scope of an abuse assessment.
- Cases to be presented are selected by the Department. If a case is put forth for discussion by another team member, the Department must decide if the case can be reviewed by the team.
- Cases can be presented to the team in the way determined most efficient *for the worker* seeking consultation.
- Ad hoc members must sign in every time they are in attendance. The SAM or the SAM's designee should receive a copy of ad hoc member attendance.
- No visitors are permitted to attend Multidisciplinary Teams. Confidentiality concerning child abuse and dependent adult abuse laws prevent anyone who is not a team member from attending. An exception to this is of course, the Department social worker presenting the case.
- Each *Agreement* must be renewed on or before July 1 of each year. A copy must be sent to Central Office. Each service area can retain copies at their discretion.

ATTACHMENT B
ICAPP (Iowa Child Abuse Prevention Program)
Awarded Projects Map for SFY 2016-2018

SFY 2016 ICAPP Project Grant Awards



Key: CD=Community Development, HV=Home Visitation, PD=Parent Development, RC=Respite Care, SAP=Sexual Abuse Prevention

Note: Services in red and (parenthesis) were project proposals NOT funded through the evaluation processes

Note: Services in green indicate a new project, not currently funded in SFY 2015

ATTACHMENT C
EARLY ACCESS HANDOUT

EARLY ACCESS
EARLY INTERVENTION IN IOWA

CONTACT US TODAY!

We are available to discuss your concerns, your child's development and help you find support that fits your needs.

Toll-free Phone: 1-888-IAKIDS1 (1-888-425-4371)

www.iafamilysupportnetwork.org

EARLY ACCESS AND FAMILIES

What is Early ACCESS?

Early ACCESS is Iowa's early intervention system for infants and toddlers with or at risk for developmental delays or disabilities and their families. The focus of Early ACCESS is to support caregivers to help their children learn and grow throughout their everyday activities. This means Early ACCESS providers work with parents and other caregivers to help their children learn.

How do young children learn?

Children learn doing the activities that their caregivers and other children around them do all day long. Caregivers and other children are teaching young children without even realizing it!

Children learn in multiple places. Getting a drink or snack and then washing hands afterwards may occur in the family kitchen, at a restaurant, or at child care. Children learn how to participate with their family and others in all their daily routines and activities.

How do caregivers learn to support their child's growth?

Early ACCESS service providers get to know families' daily activities, priorities, and hopes for their child. Together, service providers and caregivers plan and practice interventions that can be used throughout the day in routines and activities that the family already does.

Early ACCESS Vision & Mission

Vision:
Every infant and toddler with or at risk for a developmental delay and their families will be supported and included in their communities so that the children will be healthy and successful.

Mission:
Early ACCESS builds upon and provides supports and resources to assist family members and caregivers to enhance children's learning and development through everyday learning opportunities.

What are everyday routines and activities?

Routines are activities we do so much that we may not have to think about what we are doing to complete them. For example, changing diapers, getting snack, getting the mail, or picking up toys are all routines. Inviting children to assist with routines and activities is a way to help them learn and grow. Routines are predictable so we know what is coming next.

Other activities that may not be done as often as routines can be helpful for children too. For example, watering flowers, playing peek-a-boo, dropping brothers and sisters off at school, or feeding the dog can all be good teaching and learning activities.

Does this work? I am not a trained therapist or teacher.

Yes.

Service providers do not expect caregivers to do what they do. They support families by coaching them to help their child grow and learn. Everyday routines and activities are teaching and learning opportunities. The more children are able to practice skills, the more they are being supported in development.

What happens if I don't have time? Do I have to have a schedule?

There is no need for a special time or schedule. Children learn throughout the day when they are part of activities and routines, such as snack, bath time, getting dressed, and going in the car. Service providers work with caregivers to find ways to embed learning into these activities.

Family Guided Routines Based Intervention is a project within The Communication and Early Childhood Research and Practice Center (CEC-RAP). CEC-RAP is a collaborative center within the College of Communication and Information, School of Communication Science and Disorders at Florida State University. For more information, visit the FGRBI website at: http://fgrbi.fsu.edu.

ATTACHMENT D
CITIZEN REVIEW PANEL REPORTS

The Child Protection Council
Iowa's Statewide Citizen Review Panel
Annual Report

The Child Protection Council, Statewide Citizen Review Panel (CPC) meets on a bi-monthly basis in Des Moines, Iowa. The members also attend conferences and trainings throughout the year related to the work of the panel. The CPC seeks to encourage public outreach and input in assessing the impact of current Iowa law, policy, and practice on families and the communities in which they live. These meetings are open to the public, and public notice is made of the date, time, location, and agenda of the council meetings. The CPC Annual Report is also posted on the IDHS website. Members of the public who are unable to attend meetings can direct comments and questions to the Department or State coordinator though this website.

Summary of Panel Activities in SFY 2015

CPC meetings were scheduled and/or held during SFY 2016 (July 1, 2015-June 30, 2016) on the following dates, from 10am-2pm in Des Moines, Iowa:

Date	Presenters, Activities, and /or Topics Covered
07/14/2015	Face-to-face meeting: **Presentation: Iowa Dept. of Public Health, Mandatory Reporter Training** • Karin Ford, IDPH **Presentation: Steve Scott** • Child Abuse Statistics – CY 2014 **Presentation: Lisa Bender/Chaney Yeast/Roxanne Riesberg** • Grantees meeting 6/10 and 6/11 • Discussion on increase in OVC (Office for Victims of Crime) funding • Recommended IDHS connect with CVAD (Crime Victims Assistance Division) of the AG's office regarding this **Intake Review Planning**
09/08/2015	Face-to-face meeting: **Presentation** • Jana Rhoads, IDHS Training – overview of CPS law/policy in Iowa and introduction to review tool to be used for the CPC review in November • Sample Case Review (Closed Session) – CPC used review tool to walk through a sample family assessment case in preparation for November's case review
11/10/2015	Face-to-face meeting: **CPC Intake Review Day** • Members worked in small groups with IDHS field representatives to review a total of 50 CPS accepted intakes: o 25 Child Abuse Assessments o 25 Family Assessments • Review Debrief/Discussion
01/12/2016	Face-to-face meeting: **Presentation: Iowa Community Care** • Mindy Norwood, IDHS Program Manager

	• Chris Secrist, Executive Director, MIFTC • Lisa Bellows, Program Director, Community Care, MIFTC o Overview of Community Care Program o Q & A with Council **Presentation: Steve Scott** • Whitepaper summary from Commission to Eliminate Child Abuse and Neglect Fatalities Discussion: Follow-up on CPC Intake Review Study and Recommendations
03/08/2016	Face-to-face meeting: **Presentation: Doug Wolfe, IDHS Juvenile Court Liaison** **Gail Barber, Court Improvement Project (CIP)** • Presentation and discussion on CIP and Juvenile Court Services **Presentation on Differential Response CY2015 Report** • Janee Harvey, IDHS Child Welfare Bureau Chief
05/10/2016	Face-to-face meeting: **Presentation on MCOs (Managed Care Organizations)** • Amerigroup, Inc. Presentation and Q & A **Presentation: Steve Scott** • Child Abuse Statistics – CY 2015 **2016 CJA Annual Report/Application** • Overview of subcommittee review • Discussion on upcoming projects

Annual Recommendations of the Child Protection Council

Given the CPC's Intake Review this past year, the recommendations made this year centered on the items noted in the review. A more thorough explanation of the recommendations may be gathered from the full CPC Intake Review Report located in Attachment H.

- **Recommendation:** The IDHS should address system changes on "allows access" question by addressing the auto default to "NO".
- **Recommendation:** The IDHS should provide clarification on: 1) What specific information is required for TPR to be the reason for assignment to a CAA, and 2) How the information should be documented within the intake. For example, is "hearsay" from the reporter (not confirmed by FACS or another state's system) reason enough to assign as a CAA? Also, what specific "events" should be looked for in FACS to confirm that a TPR did, in fact, occur?
- **Recommendation:** The CPC would like to conduct an additional review to look at the actual "assessments" related to these intakes, particularly those FAs that changed pathways, to determine if there were indications at intake to suggest these were not appropriate for a FA. If trends do become evident (i.e., things at intake that appear "predictive" of reassignment), the CPC would like the IDHS to consider changes to the intake screening tool.

- **Recommendation:** The IDHS should look closer at how ID/DD screening occurs during the assessment process and consider additional ways to support families of children with disabilities in getting appropriate screening and service referrals.
- **Recommendation:** The IDHS should work towards increasing consistency on system lookups, particularly for intakes done Afterhours.
- **Recommendation:** The IDHS should explore issues of substance abuse and domestic violence (as these were the most prevalent concerns in FAs) and whether there are indications of "imminent danger" in some cases that make them inappropriate for a FA.

Progress and Implementation of Prior Recommendations

Case Review/Differential Response

As noted in this report, as well as the full CPC Intake Review Report (Attachment H to CAPTA report), the Council and partners at IDHS found the review to be very insightful. As a result of the activity there has been additional discussion regarding other potential reviews the Council would like to conduct. For example, the Council is interested in looking again at these same cases reviewed to see how the actual assessments ended. There is particular interest in looking at cases where the pathway decision at intake was reassigned and, if so, for what reasons. Council members feel this would be critical information to consider in looking at whether the criteria for assigning pathway should be changed.

Multidisciplinary Teams

The Council was also successful in recommending the IDHS do a comprehensive review of MDTs. Members provided input for consideration in the State's preparation of an informal bid solicitation for an external consultant and several members sat on the stakeholder workgroup. The IDHS has since made multiple efforts to enhance multidisciplinary approaches to child protective assessments, through internal policy and practice changes, as well as in our relationships with key partners, such as our Child Advocacy Centers.

Interdisciplinary Training

The Council has also been actively involved in the development and implementation of numerous trainings and learning opportunities throughout the state in recent years. Several members of the Council worked closely with IDHS staff and community partners to continue offering learning opportunities in the state in 2015-2016. One of the newest training initiations being the child welfare response to Human Trafficking, as noted in the full IDHS CAPTA report, as well as the 2016 Children's Justice Act submission. Finally, the Council recently elected to use CJA funds to expand interdisciplinary training opportunities (for child protective assessment workers and partners) through the state's various Child Advocacy Centers. These trainings are described in greater detail in the 2016 Children's Justice Act submission and outcomes will be noted in next year's report.

Future Direction and Focus of the Child Protection Council

The Council intends to stay actively involved in the child welfare system reform efforts currently underway, including the ongoing review of Iowa's Differential Response system. Several of the Council members served on the initial exploratory workgroup and were involved again in the task-oriented workgroups that were formed to assist in various areas of the implementation process.

The Council will also continue to be involved in those training efforts mentioned above, to enhance the knowledge, skills, and confidence of multidisciplinary professionals involved in the safety, well-being, and permanency of Iowa's children. Council members will also continue to reach out to agencies/staff involved in mandatory report training and curricula approval to provide input and ideas on ways to improve this system.

Finally, several Council members are actively engaged and interested in a new Drug Endangered Children workgroup that was legislatively mandated in SF 2258. This group will continue to explore the issues and concerns Council members have in regards to the unique health and safety needs of infants and children exposed to substances.

North Iowa Domestic & Sexual Abuse Community Coalition
Cerro Gordo County Citizens Review Panel
Annual Report

The North Iowa Domestic & Sexual Abuse Community Coalition/Cerro Gordo County Citizens Review Panel meets 10 times/year in Mason City, Iowa. The members of the Coalition also attend conferences and trainings throughout the year related to the work of the panel and their individual discipline. The Coalition also seeks to encourage public outreach and input in assessing the impact of current Iowa law, policy, and practice on families and the communities in which they live. The Coalition will provide an annual written report outlining activities and making recommendations for changes. The team will make this report available to the public to allow for input.

Summary of Panel Activities in SFY 2015

Coalition meetings were scheduled and/or held during SFY 2015 (July 1, 2015-June 30, 2016) on the following dates, from noon to 1:00 p.m. in Mason City, Iowa.

Date	Presenters, Activities, and /or Topics Covered
07/09/15	• The Child Abuse Prevention Council is collaborating with the Coalition to open a Child Protection Center in Mason City. • The Sexual Assault Response Team continues to meet monthly *for case reviews and educational opportunities. Lieutenant Colonel Michael Kuehn with the Iowa Army National Guard attended our most recent meeting to share information about military response to sexual assault.* • *Mary Ingham (CIS) and Doug Se*gwick represented Iowa at the National Citizens Review Panel Conference in Portland, Oregon in May. There were numerous interesting breakout sessions, as well as opportunities to connect and network with panel members from other states and territories.
08/13/15	• The Sexual Assault Response Team continues to meet monthly for training and case review. *SART protocol has been reviewed and informally approved by all participating agencies. We will be working to get formal signatures in the next month.* • The Child Abuse Prevention Council and Child Protection Center planning committee continue to meet prior to the Coalition meeting. The two groups meet together at 11:00 a.m. before each Coalition meeting. In an effort to facilitate the development of a local child protection center, three work groups have been established: • Site Selection-Jason Hugi, Chair • Fund Raising-Jennifer Kammeyer, Chair • Services-Mary Ingham, Chair

	• Information is currently available for the 13th Annual National Family Violence Apprehension Detail. Law enforcement entities interested in participating must register directly with the National SWEEP Coordinator Carrie Jo Paine at DVWarrantSweep@clackamas.us. Civilians interested in participating should contact Mary Ingham (Mary@CIShelps.org) by October 10th. • The Remember My Name ceremony has been moved to October 2, 2015. The event will begin at noon and be held at Music Man Square. • Case Review
09/10/15	• Domestic Violence Awareness Month planning o Remember My Name o Media Awareness o Letters to the Editor o Family Violence Apprehension Detail
11/12/15	• The Child Protection Center workgroup provided an update. • The Sexual Assault Response Team continued to meet monthly for training and case review. • Reviewed Domestic Violence Awareness Month activities • Updates from the North Iowa Child Abuse Prevention Council on their structure and plans for the future • Case Review
12/10/15	• Update on child abuse trends for local counties • SART continues to meet on a monthly basis. The meetings consist of both training and case review. • Update on Child Abuse Prevention Council • Godfather's Pizza Coupons were distributed.
01/14/16	• Coalition members sold a total of 244 Godfather's Certificates during December and received a cash donation in lieu of purchase, resulting in a net profit of $1,103 for the Coalition! • Jason Hugi provided an update on the child protection center project. • Officers for 2016 were elected: President-Jason Hugi Vice President-David Hepperly Secretary-Mary Ingham Treasurer-Kevin Pals
02/11/16	• Jason Hugi provided an update on the child protection center project. • Sexual Assault Awareness Month (April)-The SART is developing several activities for the month. • Child Abuse Prevention Month (April)-There are no specific plans in the works at this point, but will work to raise awareness in conjunction with the Child Protection Center plans.

	• National Crime Victims' Rights Week (April 10-16)-Will work to raise public awareness through media and social networking.
03/10/16	• Coordinated Community Response/SART- The committee has been talking about completing victim surveys. These are phone call surveys checking in with victims to see what we can improve on and if they are getting the services they need. • Community Education/Public Awareness- CIS is working on the Un-Run campaign and is seeking sponsors to "run" during the month of April. This is a fundraiser and awareness event where people can pledge to donate money without having to actually run. There will be more information coming out this next month. The registration process will start in April. There are also two events in April planned that will be held at Music Man Square for Sexual Abuse Awareness month. On April 6th, the event is called Writing on The Wall where participants will build a "wall of awareness" out of cardboard building bricks. On April 20th, the event will be Take Back the Night with a walk around the mall after the Clothes Line event. There is potentially going to be a self-defense class out at NIACC along with booths setup in the cafeteria during lunch time bringing awareness to sexual abuse. Coffee shops in the area are also being asked to take part in the Cup of Prevention event. The coffee shops could donate a certain percentage of their sales to CIS, and then people from the public could have a chance to sit down and have a cup of coffee with someone from the SART team.
05/12/16	• Jason Hugi provided an update on the Child Protection Center. • The Coalition reviewed the successes and challenges of Sexual Assault Awareness Month, Child Abuse Prevention Monday and National Crime Victims' Rights Week. We discussed ways to combine events for Sexual Assault Awareness & Child Abuse Prevention, ideally fun family events for parents and kids. • Crisis Intervention Service has received new grant funding to support expanding their collaboration with the DHS Safe & Together model, as well as another grant for trafficking education, prevention and services. • IowaCASA will hold their Annual SART Summit on May 23rd in Des Moines. • ILEA is hosting a 2-day Sexual Assault Investigations training on May 23 & 24 in Des Moines.

Annual Recommendations of the Cerro Gordo County Citizens Review Panel

Recommendations of the Coalition are as follows:

- Enhance training on best practices related to the intersection of domestic violence, sexual assault and child abuse.
- Continue with quarterly case reviews.
- Increase individual case consultations.
- Open a local Child Protection Center in collaboration with Allen CPC (Waterloo)
- Expand panel membership

Progress and Implementation of Prior Recommendations

The team was originally organized to provide a coordinated community response to domestic violence and sexual assault, with a primary interest in adults. Approximately seven years ago, the scope was broadened to include children. The team completed a countywide safety & accountability audit that examined how child witnesses of domestic violence were identified by intervening organizations and whether the interventions help or hinder the child.

A Safety and Accountability Audit is designed to examine, in an inter-disciplinary way, whether institutional policies and practices enhance victim safety and enforce offender accountability. The premise behind the process is that workers are institutionally organized to do their jobs. In other words, workers are guided in how they do their jobs by the forms, policies, philosophy, practices and culture of the institution in which they work. A Safety and Accountability Audit, therefore, is not a performance review of individual employees. It examines the local and/or State institution or system in terms of the practices, policies and procedures in regard to handling domestic violence cases. Safety and Accountability Audits involve mapping the system, interviewing and observing workers and analyzing paperwork and other text generated through the handling of domestic violence cases.

The team will comply with the requirements set forth by the Child Abuse Prevention and Treatment Act. The team will identify strengths and weaknesses of the child protective service system in Iowa (Iowa Department of Human Services) and those of community-based services and agencies. Within the scope of its work the team will review these child protective systems in Iowa by clarifying expectations of these agencies by reviewing consistency of practice with current policies, and analyzing current child abuse trends. The team will provide feedback to the state and local agencies and the public at large as to what is, or is not working, and why, and recommend corrective action if needed.

Some members of the team formed a sub-group to conduct a safety & accountability audit to look specifically to increase accountability of the system to better protect victims of domestic violence, hold batterers accountable, and to integrate the concerns and expertise of African Americans into domestic violence prevention and intervention. This audit was completed in October 2007.

Coalition members continue to represent a broad range of stakeholders and they are dedicated to ensuring that the varied interests of North Iowa's children and adults are heard when making local decisions, as well public policy recommendations.

Future Direction and Focus of the Coalition

The Coalition plans to continue to work to raise local awareness of the intersection of domestic violence, sexual assault and child abuse.

The Coalition will continue with quarterly case reviews and consultations (as needed), in an effort to enhance victim safety and hold offenders accountable.

The majority of the energy of this group is focused upon the development and implementation of a Child Protection Center in Mason City. The workgroup with collaborating with Allen CPC (Waterloo) in an effort to be a satellite project of Allen.

The Community Initiative for Native American Families and Children
Woodbury County Citizen Review Panel
Annual Report - 2016

The Community Initiative for Native American Families and Children (CINCF) meets every month at Four Directions in Sioux City, Iowa. The Woodbury County Citizen Review Panel is part of this team. The members also attend conferences, events, and trainings throughout the year related to their work on CINCF team. The goal of CINCF is to better understand, articulate, and address issues contributing to the disproportional and disparate number of Native American children and families involved with Department of Human Services of Woodbury County. The Woodbury County Citizen Review Panel Report is posted on the IDHS website. Members of the public can direct comments and questions to the Department or State Coordinator through this website.

Summary of Panel Activities in SFY 2015/16

CINCF meetings (all face-to-face meetings) were scheduled and/or held during SFY 2015/16 (July 1, 2015 through June 30, 2016) on the following dates, from 1:30pm to 4pm in Sioux City, Iowa:

Date	Presenters, Activates, and/or Topics Covered
7-15	• Four Directions (4D) celebrates its 6th year of their formal relationship with DHS and Siouxland Human Investment Partnership (SHIP). • DHS looking at raised concern of non-Native parents who have adopted Native children and will seek to immerse the children in Native culture. • Native Youth Standing Strong continues to meet at Four Directions every Tuesday. The program offers cultural crafts, ceremonies, trips etc. • The Health Department of the Winnebago Tribe has placed a part-time person at Four Directions. The person will offer patient advocacy. • The memorial March to Honor Lost Children to offer educational conference and will include Fetal Alcohol Syndrome and Power of Illusion. Local theaters will show Sober Indian, Dangerous Indian and there will be a Healing Ceremony scheduled as well.
8-15	• Thirty people attended a summer program called, "Securing Your Parental Rights with Actions, Not Words". • Jackson Recovery is offering free assessments and transportation for self-identified Native Americans. The substance abuse center also encourages cultural traditions and ceremonies. • Sober Indian, Dangerous Indian is showing at multiple colleges in Nebraska. • Frank LeMere traveled to Washington DC to partake in talks regarding

	health care issues at Indian Health Services hospital in Winnebago NE.
9-15	• Ongoing meetings to plan for the Memorial March to Honor Lost Children in November continue. Will include educational conference. • The Sioux City Police Department and Four Directions to hold a town hall meeting regarding vagrancy, arrests, and other afflictions facing the community. There is a lack of a 24hour/day place where people can go. • A partnership between the Siouxland Native Community and Winnebago Tribal Health was announced. Focus will be homelessness, addiction, and other issues affecting the native population living outside of the reservation. • Frank LeMere received the Jim Wolf Equal Justice Award at the Good Apple Award ceremony in Omaha. The awards honor outstanding community activists and organizations that stand up for justice and opportunity for all Nebraskans.
10-15	• CINCF continues their efforts meeting with the City, police department and community members about homelessness, mental health issues, alcohol abuse, suicide prevention, panhandling, etc. Frank LeMere to address these issues at the Memorial March conference. • Ho-Chunk to assume the building lease for Four Directions
11-15	• No meeting. Memorial March occurred.
12-15	• The 13th Annual Memorial March to Honor Lost Children was the most successful of all marches in terms of participation and elevation of discussion of Native children and families in the DHS system. Many aspects of that involvement including disproportionality, collaboration, issues of race, advocacy, and healing as well as vigilance and remembrance were addressed at length. Greater than 1000 people, Native and non-Native were engaged in in the March activities including the march, the documentaries and conference attendance. • A CINCF member attended the Iowa Commission on Native American Affairs in Des Moines. Siouxland's homeless and Indian health services were brought up. A fact-finding committee is to be set up. • TIPS/MAPP class has been set up for Native families to become foster parents.
1-16	• Winnebago Hospital now offering medical services now offered at Four Direction • Frank LeMere wrote a letter to President Obama regarding concerns at White Clay. The letter was hand delivered. • Vagrancy meetings continue every month. The group now has six subcommittees that are moving forward.

	• The Warming Shelter is now open 24/7. The shelter is supported by donations. Students at Briar Cliff University are conducting an interview survey with the homeless.
2-16	• Memorial March committee has begun meeting. • A July conference will be held with continuing discussion regarding Fetal Alcohol Syndrome discussion with Dr. Ira Chasnoff.
3-16	• Sioux City Police Officer updated CINCF on juvenile arrests in the Siouxland schools. Students will be kept in detention until parents can pick them up in lieu of going to juvenile detention. The tracking system has been updated and video equipment is utilized at the schools with 98% accuracy. • Students completed their surveys. Each participant received a $5 gift card. • Motherhood is Sacred was started at Jackson Recovery. They also provide evaluations for children. Barriers for mothers/women in recovery are housing and employment. • Vagrancy group and sub committees continue to meet. • 7 Generations Games will pilot their Native American program for grade school children in Siouxland. The games include intertwined math and culture.
4-16	• DHS shared data from the Woodbury County Native Unit Relative Placement. The Unit is currently at 62% ICWA eligible children in relative placement • May is Foster Care Month. Iowa Kid's Net will hold recruitment and appreciation at Four Directions. • On April 22nd the Iowa Commission on native Affairs hosted their Quarterly meeting at Four Directions. Member s of the media attended, spotlighting the need for Native American Foster Homes.
5-16	• A new parenting program will start at Jackson Recovery. It will be an intense 2-day class. • CINCF members spoke at the NICWA conference about the Memorial March, its meaning, how it has evolved, and events associated with the March. Frank LeMere received the NICWA Member of the Year award. • A spokesperson from Keystone Treatment and Outreach Center in Canton, SD talked about it substance abuse and mental health inpatient facility. There are 122 beds, 20 are occupied by Native Americans. • Htanipi Owas – Working together is a new Siouxland group that works with Native Americans through initiatives for youth, parks, and the city's homeless population

6-16	• DHS reported 62% ICWA Eligible children placed with relatives. Subsidized Realtive placements is a concern. To be discussed at next meeting. • A spokesperson from Keystone Treatment and Outreach Center to return in August to give a presentation about the high alcohol content in beer at a low cost.

Annual Recommendations of the Woodbury County Citizen Review Panel

Recommendations of the Panel are as follows:

1. Increase Native American foster families by 5 to a total of 10 by utilizing the Native Families for Native Children (NF4NC) grant:
    - Continuing collaboration the DHS Native unit and Iowa Kids Net recruitment efforts and the formation of a support group for Native American foster parents
    - Continuing to work with the NF4NC grant for recruitment and retaining native American Foster Homes.
    - Working with BCU and NF4NC promoting Native American Foster Care classes.
2. Increase enrollment in “Securing Your Parental Rights” class to 30 for Fiscal year:
    - Promoting the 2-day classes in the Native community
    - Working with the University of Iowa and BCU creating to provide parent curriculums and training
3. Promoting Four Directions to be the Center for much needed services for the Native American Community by:
    - Continuing to be a forerunner in the Native community.
    - Working collaboratively with the Winnebago Tribe and Indian Health Services to support Four Direction and offer health care locally.
    - Continue active participation on the Vagrancy committees

Progress and Implementations of Prior Recommendations

In FY 15 a goal of the Panel was to decrease the number of Native American Children in Care in Woodbury County. Data was taken from the Iowa Department of Human Services ROM Reports using “Unit: In Time Period. January 2016” and managed filters by County of Removal for year to year comparison See table:

Woodbury County Children in Care

Month	Total Children in Care	Relative Foster Home	Trial Home Visit	Non Relative Foster Home	Runaway	Group Care	Institution
Jan – 16	414	118	69	127	3	44	24

Type of Placement for American Indian/Alaska Native Children (DHS Responsibility)

Month	American Indian or Alaska Native	Relative Foster Home	Trial Home Visit	Non-Relative Foster Home	Runaway	Group Care	Institution
Jan – 16	65	26	9	24	0	5	0

In January 2016, IDHS was responsible for 65 American Indian/Alaska Native Children placement cases in Woodbury County. This is an increase over January 2015. This higher number could be attributed to the information being taken from a point in time and the numbers fluctuate monthly. Of those 65 children 9 were on a Trial Home Visit and residing in their home. This resulted in 50 children placed outside of their home. Of those 50 children, 26 were placed with a relative and 24 were placed with a non-relative, and 5 children were placed into Group Care.

The Panel continued to promote the knowledge of the Iowa ICWA laws through ongoing training locally, regionally, and nationally. Case studies were also reviewed at CINCF meeting and members were updated through electronic communication.

Working with BCU and Native American BCU students, curriculum for foster care parents and parenting classes has been reviewed and updated. The community remains committed to increasing native American Foster Homes as it continues to be involved in the NC4NF grant for the recruitment and retention of native Foster Homes.

Future Direction and Focus of the Woodbury County Citizen Review Panel

The future direction and focus of the Woodbury County Citizen Review Panel will consist of recruitment for Native American Foster Homes and to continue to lower the disproportionate number of Native Children in out of home care. There is currently five Native Foster Homes in Western Iowa. To lower the disproportionate number of Native American children in Foster Care, efforts will continue with the CINCF group, working with BCU to assist Native American graduates with BSW's, and other local initiatives.

ATTACHMENT E
STATE'S RESPONSE TO ANNUAL CITIZEN REVIEW PANELS

STATE RESPONSE TO IOWA'S CITIZEN REVIEW PANELS
SECTION 106(c)(6)

Following is the State's response to the recommendations of the Child Protection Council State Citizen Review Panel, the Cerro Gordo County Family Violence Response Team and the Northwest Iowa Citizen Review Panel.

Iowa Child Protection Council Citizen Review Panel Recommendations

The Iowa Child Protection Council Citizen Review Panel made six recommendations in their report this year. Those recommendations were all specifically related to the CPC Intake Review conducted in November of 2015. The recommendations and the State's response are highlighted below (and also located in Attachment H CPC Intake Review Report):

- **Recommendation:** The IDHS should address system changes on "allows access" question by addressing the auto default to "NO".
    - **Next steps/Action taken:** Jason Geyer (CSIU Administrator) has brought this to the attention of CWIS (Child Welfare Information System) staff. In addition, this has been discussed in new worker training and with CSIU staff.
- **Recommendation:** The IDHS should provide clarification on: 1) What specific information is required for TPR to be the reason for assignment to a CAA, and 2) How the information should be documented within the intake. For example, is "hearsay" from the reporter (not confirmed by FACS or another state's system) reason enough to assign as a CAA? Also, what specific "events" should be looked for in FACS to confirm that a TPR did, in fact, occur?
    - **Next steps/Action taken:** This report will be shared with the internal IDHS "Intake Advisory Council", made up of CSIU staff/sups, field staff/sups, and IDHS child protective service help desk staff. The group will discuss recommendations and decide what, if any, action needs to occur.
- **Recommendation:** The CPC would like to conduct an additional review to look at the actual "assessments" related to these intakes, particularly those FAs that changed pathways, to determine if there were indications at intake to suggest these were not appropriate for a FA. If trends do become evident (i.e., things at intake that appear "predictive" of reassignment), the CPC would like the IDHS to consider changes to the intake screening tool.
    - **Next steps/Action taken:** IDHS CJA Program Manager will explore options for a future review by the CPC in the coming year.
- **Recommendation:** The IDHS should look closer at how ID/DD screening occurs during the assessment process and consider additional ways to support families of children with disabilities in getting appropriate screening and service referrals.
    - **Next steps/Action taken:** IDHS is currently mandated by federal law (Child Abuse Prevention and Treatment Act or CAPTA) to refer all children 0-3 with a "substantiated" case of abuse for ID/DD screening. The way

this has been done is primarily through an automated referral system to Early Access. The IDHS and the IDOE (Iowa Department of Education) are currently exploring ways to better engage families in this process. Additional action related to Early Access can be located in that section of the State CAPTA report.

- **Recommendation:** The IDHS should work towards increasing consistency on system lookups, particularly for intakes done Afterhours.
    - **Next steps/Action taken:** This report will be shared with the internal IDHS "Intake Advisory Council", made up of CSIU staff/sups, field staff/sups, and IDHS child protective service help desk staff. The group will discuss recommendations and decide what, if any, action needs to occur.
- **Recommendation:** The IDHS should explore issues of substance abuse and domestic violence (as these were the most prevalent concerns in FAs) and whether there are indications of "imminent danger" in some cases that make them inappropriate for a FA.
    - **Next steps/Action taken:** As a result of this concern brought up by a number of reviewers, IDHS staff reviewed all FAs to determine the number/percentage of the 25 randomly chosen cases that included allegations of domestic violence and/or substance abuse (to determine the true extent of these issues in FA intakes) and the findings indicated that:
        - **Domestic Violence:** 16 of the 25 FAs chosen at random specifically included allegations of violence between adult caretakers (64%). The vast majority of these were IPV (Intimate Partner Violence) situations, although one allegation included a physical altercation between a mother and grandmother.
        - **Substance Abuse:** 7 of the 25 FAs chosen at random specifically included allegations of substance abuse (28%). However, in also looking at the narrative "Additional Information" sections of the 25 intakes, another 7 indicated some form of concern by the reporter of possible drug and/or alcohol abuse, even if not rising to the level of being an allegation itself. Therefore substance abuse was, at minimum, mentioned in 14 of the 25 intakes or 56%.
        - **One or both:** In total, all but 4 of the 25 cases (88%) included concerns of domestic violence and/or substance, either within the allegation itself or within the additional information section.
    - **Next steps/Action taken:** The IDHS is aware of the common issues and family dynamics that often correlate with the majority of child abuse cases (i.e., mental illness, substance abuse, and domestic violence). In order to address some of these things, the IDHS has done the following:
        - The IDHS recently implemented the Safe & Together Model, a perpetrator pattern based, child centered, and survivor strengths approach to working with domestic violence. All field staff have received this training and CSIU staff will be receiving soon.

- The IDHS continues to look at how the term "imminent danger" is defined and how it is used in practice and convened an internal workgroup on the topic in 2015.
- The IDHS is reviewed additional tools and guidance and is currently rolling out training in the month of June 2016 to all field staff (see additional sections of CAPTA report on training).

Cerro Gordo County Family Violence Response Team Recommendations

The **Cerro Gordo County Family Violence Response Team** made five recommendations in regards to the State's policy and practices in the handling of cases involving domestic violence. Some of these recommendations are geared toward local coordination while others are relevant to a Statewide review of IDHS policy and practice.

Recommendations:

- Enhance training on best practices related to the intersection of domestic violence, sexual assault and child abuse.
- Continue with quarterly case reviews.
- Increase individual case consultations.
- Open a local Child Protection Center in collaboration with Allen CPC (Waterloo)
- Expand panel membership

State Response: The IDHS recognizes the high rate of co-occurrence between domestic violence and child maltreatment. In response, the State has continued to work towards enhancing the skills necessary for our child welfare workers to successfully partner with families facing domestic violence.

As discussed, in an earlier portion of the State CAPTA report, the IDHS utilized CAPTA funds to contract for a fulltime Domestic Violence Liaison. This individual has been working to provide case consultation services and to update and enhance training for IDHS Social Workers in the area of domestic violence, as noted in that section, including the last year's rollout of the "Safe & Together" model by David Mandel & Associates, LLC.

In addition, the State's CRP Coordinator will continue to act as a resource to the Cerro Gordo County Family Violence Response Team as applies to best practices regarding case review and engaging new panel members.

Finally, as noted in this year's Children's Justice Act annual report and grant, the IDHS has proposed utilizing $54,000 of CJA funding in SFY 2017 to assist in establishing the Mason City satellite Child Advocacy Center that the Cerro Gordo County Family Violence Response Team has been advocating for in recent years. An update on this project will be provided next year.

Northwest Iowa Citizen Review Panel Recommendations

The **Northwest Iowa Citizen Review Panel** has made several recommendations to their local county office related to efforts to reduce disproportionate representation of Native children and families in the child welfare system.

Recommendations of the Panel are as follows:

1. Increase Native American foster families by 5 to a total of 10 by utilizing the Native Families for Native Children (NF4NC) grant:
    - Continuing collaboration the DHS Native unit and Iowa Kids Net recruitment efforts and the formation of a support group for Native American foster parents
    - Continuing to work with the NF4NC grant for recruitment and retaining native American Foster Homes.
    - Working with BCU and NF4NC promoting Native American Foster Care classes.
2. Increase enrollment in "Securing Your Parental Rights" class to 30 for Fiscal year:
    - Promoting the 2-day classes in the Native community
    - Working with the University of Iowa and BCU creating to provide parent curriculums and training
3. Promoting Four Directions to be the Center for much needed services for the Native American Community by:
    - Continuing to be a forerunner in the Native community.
    - Working collaboratively with the Winnebago Tribe and Indian Health Services to support Four Direction and offer health care locally.
    - Continue active participation on the Vagrancy committees

State Response: The local IDHS is deeply involved in all of the activities recommended. Local staff continue to be a part of the local Native recruitment team and staff have been involved with Briar Cliff and other Siouxland agencies, including Iowa Kids Net, on the NF4NC (*Native Families for Native Children*) grant IDHS staff are also involved, at the local and state levels, on the Native PSMAPP (*Partnering for Safety and Permanence: Model Approaches to Partnership in Parenting*) classes through Briar Cliff and have student interns working on recruitment efforts. The NF4NC grant is now in its third year. The IDHS continues to be part of the team along with the State of Nebraska, Winnebago Tribe, Ponca Tribe, Omaha Tribe and the Santee Sioux Tribe. To date Woodbury County has 5 active Native Foster Parents. There are also 2 Native Families currently waiting to be trained.

The local IDHS actively promotes and refers the Native parenting classes to all families involved in child welfare services. IDHS provides significant funding for the classes and serves as the primary referral source, in constant collaboration with Four Directions and Briar Cliff University. IDHS also funded a Native American Social Worker to become trained as a facilitator of the *Motherhood is*

Sacred program and make that available to families, in addition to funding (including in-kind support) and referrals to a successful youth program – *Native Youth Standing Strong*.

Woodbury County continues to offer Motherhood Is Sacred Classes through a contract with Chiara Cournoyer. Classes average 6-8 per session which is offered throughout the year. Woodbury County also sent Roland Warner, Native Liaison, to be trained as a Facilitator, for Fatherhood Is Sacred, this past year. Roland has been averaging anywhere from 8-13 participants per class.

Finally, the local IDHS has financially, to the extent funding is available, as well as professionally, supported Four Directions as a center for services to Native adults and children and our Service Area Manager consistently participates in discussions about continuing to identify solid housing and funding for these programs to continue. The IDHS also continues to financially support a class at Four Directions, titled “Securing Your Parental Rights.”

ATTACHMENT F
STATE OF IOWA JOB DESCRIPTIONS AND MINIMUM QUALIFICATIONS
(SOCIAL WORKER 3 AND SUPERVISOR)

Class Code: 03016
23016

IOWA DEPARTMENT OF ADMINISTRATIVE SERVICES ▼
HUMAN RESOURCES ENTERPRISE

SOCIAL WORKER 3

DEFINITION

Performs intensive social work services, protective service assessments/evaluations, or lead-work duties in a county, area, regional office, or institution; performs related work as required.

The Work Examples and Competencies listed are for illustrative purposes only and not intended to be the primary basis for position classification decisions.

WORK EXAMPLES

Assists a supervisor by performing, in accordance with set procedures, policies and standards, such duties as instructing employees about tasks, answering questions about procedures and policies, distributing and balancing the workload and checking work; may make occasional suggestions on reassignments.

Obtains and evaluates referral information from mandatory and permissive reporters to determine if a child abuse assessment, dependent adult abuse assessment or Child in Need of Assistance assessment should be completed. This information may be gathered in person (face to face interview) or via the telephone utilizing active listening, probing questions to fill in gaps in information or to clarify inconsistencies. The information is the first step in the assessment process and will subsequently be provided to child/adult protective assessment workers so that safety and risk can be assessed and appropriate services to families, children and/or dependent adults can be provided.

Provides intensive casework services for clients with difficult, complex and complicated problems, possibly requiring a reduced caseload on a full-time basis.

Deals with individuals and groups having sociopathic personalities, impulsive behavior that may be self-destructive or depredatory, and others with chronic mental illness, mental retardation or a developmental disability.

Makes professional decisions and recommendations that can have a serious impact on the life of the person served.

Provides or directs the preparation of necessary records and reports.

Gives advice and consultation when unusual, difficult, or complex cases are encountered.

Functions as a case management program specialist by reviewing case records of case managers and providing written and verbal feedback related to performance, compliance with applicable standards and policies.

Evaluates reports of child or dependent adult abuse; assesses strengths/needs of clients and recommends service interventions.

Serves as a member of an institutional interdisciplinary treatment team; provides casework and group work services.

Performs outreach activities gathering and evaluating information regarding clients or programs, developing an assistance or treatment program, and coordinating activities with relevant community agencies, as directed.

Completes or directs the preparation of necessary records and reports.

COMPETENCIES REQUIRED

Knowledge of casework methods, technique, and their application to work problems.

Knowledge of the principles of human growth and behavior, basic sociological and psychological treatment and therapy practices.

Knowledge of interviewing skills and techniques.

Knowledge of group work methods, and basic community organization techniques.

Knowledge of environmental and cultural factors inherent in social work.

Knowledge of federal, state, and local legislation relative to public assistance and welfare programs.

Knowledge of federal and state rules, policies, and procedures as they relate to the sector of responsibility.

Ability to deal courteously and tactfully with other public and private agencies.

Ability to use interviewing skills and techniques effectively.

Ability to plan, instruct, and guide others in social work services.

Ability to interrupt rules, regulations, policies, and procedures.

Displays high standards of ethical conduct. Refrains from dishonest behavior.

Works and communicates with all clients and customers providing professional service.

Displays a high level of initiative, effort, attention to detail and commitment by completing assignments efficiently with minimal supervision.

Follows policy and cooperates with supervisors.

Fosters and facilitates cooperation, pride, trust, and group identity and team spirit throughout the organization.

Exchanges information with individuals or groups effectively by listening and responding appropriately.

EDUCATION, EXPERIENCE, AND SPECIAL REQUIREMENTS

Graduation from an accredited college or university and the equivalent of three years of full-time experience in a social work capacity in a public or private agency;

OR

graduation from an accredited college or university with a Bachelor's degree in social work and the equivalent of two years of full-time experience in a social work capacity in a public or private agency;

OR

a Master's degree in social work from an accredited college or university;

OR

an equivalent combination of graduate education in the social or behavioral sciences from an accredited college or university and qualifying experience up to a maximum of thirty semester hours for one year of the required experience;

OR

employees with current continuous experience in the state executive branch that includes the equivalent of one year of full-time experience as a Social Worker 2 shall be considered as qualified.

NECESSARY SPECIAL REQUIREMENTS

For designated positions, the appointing authority may request those applicants possessing a minimum of twelve semester hours or education, six months of experience, or a combination of both, or a specific certificate, license, or endorsement in the following areas:

089 Certified Addiction Counselor in the State of Iowa
863 ability to speak Spanish fluently
920 case management

For designated positions in case management, the appointing authority may request those applicants possessing a Bachelor's degree from an accredited college or university with a major or at least 30 semester hours or its equivalent in the behavioral sciences, education, health care, human services administration, or social sciences and the equivalent of 12 months of full-time experience in the delivery of human services in the combination of: chronic mental illness, developmental disabilities, and intellectual disabilities as a Targeted (Medicaid) Case Manager;

OR

an Iowa license to practice as a registered nurse and the equivalent of three years of full-time nursing or human services experience with the above population groups.

Applicants wishing to be considered for such designated positions must list applicable course work, experience, certificate, license, or endorsement on the application.

NOTE:

At the time of interview, applicants referred to Glenwood and Woodward State Hospital-Schools will be assessed to determine if they meet federal government employment requirements as published in the Federal Register, Section 20-CFR-405.1101.

Effective Date: 07/12 BR

Class Code: 03025

IOWA DEPARTMENT OF ADMINISTRATIVE SERVICES ▼
HUMAN RESOURCES ENTERPRISE

SOCIAL WORK SUPERVISOR

DEFINITION

Directs, plans and supervises a unit of social workers providing intensive casework services in a county, service area or institution, or performs specialist and supervisory duties related to social work programs in a county, service area or in the central office; performs related work as required.

The Work Examples and Competencies listed are for illustrative purposes only and not intended to be the primary basis for position classification decisions.

WORK EXAMPLES

Supervises and evaluates the work of lower level specialists/subordinate staff; effectively recommends personnel actions related to selection, disciplinary procedures, performance, leaves of absence, grievances, work schedules and assignments, and administers personnel and related policies and procedures.
Plans, directs, and supervises a statewide program in providing consultant services to community social service organizations.

Assists in planning and implementing the goals and objectives of programs and projects; assists in budget preparation; directs special projects requested by the organization; formulates policies, procedures, and guidelines for the concerned area of program responsibility.

Works collaboratively to determine what projects should be initiated, dropped, or curtailed; analyzes budget allocations and keeps the organization/unit informed of the status of funds.

Provides consultant services in a defined geographic area of the state; meets with interested groups and individuals to implement the goals, objectives, and purposes of the project.

Advises specialists/subordinates in reaching decisions on the very highly complex problem cases.

Prepares or directs the preparation of records and reports, including data entry.

COMPETENCIES REQUIRED

Knowledge of the principles of supervision, including delegation of work, training of subordinates, performance evaluation, discipline, and hiring.

Knowledge of the administrative process of planning, organizing, staffing direction, budgeting, and controlling as it is applied to a public agency.

Knowledge of casework methods, techniques, and their applications to work problems.

Knowledge of the rules, regulations, and goals related to social work programs.

Knowledge of the purposes, goals, and objectives of social work programs.

Knowledge of interviewing skills and techniques.

Knowledge of the principles of human behavior.

Knowledge of the basic principles of community organization.

Ability to plan, organize, direct, and evaluate the work of subordinates.

Ability to interpret and apply multiple rules and policies regarding employee relations in a collective bargaining environment.

Ability to make logical and accurate decisions based on interpretations of program rules and regulations and administrative support data.

Ability to interact with elected officials, community representatives, volunteer groups, regional planning committees, and other groups in order to develop and maintain effective working relationships related to the delivery of services.

Ability to interact with subordinates, supervisors, clients, the general public, and the news media in order to establish effective working relationships.

Ability to project staffing and program needs for the administrative area based on resources available, existing personnel, and budget constraints.

Ability to evaluate state and federal service and financing program operations.

Ability to effectively communicate orally and in writing in order to persuade, interpret and inform subordinates, clients, general public, public and private officials.

Displays high standards of ethical conduct. Refrains from dishonest behavior.

Works and communicates with all clients and customers providing professional service.

Displays a high level of initiative, effort, attention to detail and commitment by completing assignments efficiently with minimal supervision.

Follows policy and cooperates with supervisors.

Fosters and facilitates cooperation, pride, trust, and group identity and team spirit throughout the organization.

Exchanges information with individuals or groups effectively by listening and responding appropriately.

EDUCATION, EXPERIENCE, AND SPECIAL REQUIREMENTS

Graduation from an accredited four year college and experience equal to four years of full-time work in a social work capacity in a public or private agency;

OR

professional experience in a social work capacity may be substituted for the required education on the basis of one year of qualifying experience for each thirty semester hours of education;

OR

a Bachelor's degree in social work from an accredited four year college or university and experience equal to three years of full-time experience in a social work capacity in a public or private agency;

OR

a Master's degree in social work from an accredited college or university and experience equal to one year of full-time work in a social work capacity in a public or private agency;

OR

any equivalent combination of graduate education in the social or behavioral sciences from an accredited college or university and qualifying experience up to a maximum of thirty semester hours for one year of the required experience;

OR

employees with current continuous experience in the state executive branch that includes experience equal to 24 months of full-time work as a Social Worker 2, or 12 months as a Social Worker 3/4 or Social Work Supervisor 1 or any combination of the above equaling 24 months shall be considered as qualified.

SELECTIVE CERTIFICATION

For designated positions, the appointing authority may request those applicants possessing a minimum of twelve semester hours of education, six months of experience, or a combination of both, or a specific certificate, license, or endorsement in the following area:

920 case management - For designated positions in case management, the appointing authority may request those applicants possessing a Bachelor's degree from an accredited college or university with a major or at least 30 semester hours or its equivalent in the behavioral sciences, education, health care, human services administration, or social sciences and the equivalent of 12 months of full-time experience in the delivery of human services in the combination of: chronic mental illness, developmental disabilities, and intellectual disabilities;

OR

an Iowa license to practice as a registered nurse and the equivalent of three years of full-time nursing or human services experience with the above population groups.

Applicants wishing to be considered for such designated positions must list applicable coursework, experience, certificate, license, or endorsement on the application.

NOTE:

At the time of interview, applicants referred to Glenwood and Woodward State Hospital-Schools will be assessed to determine if they meet federal government employment requirements as published in the Federal Register, Section 20-CFR-405.1101.

Effective Date: 03/12 BR

ATTACHMENT G
IDHS CHILD TRAFFICKING GUIDANCE DOCUMENTS

Iowa Department of Human Services
Child Trafficking Indicators

Use the list of indicators below to guide you in asking further questions, making further inquiry about the concerns being reported, or to determine whether a referral should be made to the appropriate law enforcement agency.

This is just a sample of possible indicators of child trafficking of a minor. One indicator in and of itself does not determine that human trafficking is occurring, but rather should cause the worker to ask the next logical question.

- ☐ Chronic runaway/homeless youth
- ☐ Is not enrolled in school, or is not attending school, or has significant gaps in schooling
- ☐ Over-sexualized demeanor or promiscuous behaviors
- ☐ Any information about child being placed on the internet for purpose of solicitation (ex. online ads on Backpage and Craigslist)
- ☐ Child possesses or has access to excessive amount of cash and/or hotel keys
- ☐ Unable or unwilling to give local address or information about parents
- ☐ Presence of older adult or boyfriend/girlfriend who seems controlling
- ☐ Any reference to a pimp or manager or "daddy" or "bottom girl"
- ☐ Cannot or will not speak on own behalf or is not allowed to speak to others alone
- ☐ Inability or fear to make eye contact or demeanor shows anxiety, depression, submissiveness, tension, or nervousness
- ☐ Unusual monitoring of child's location or environment (ex. tracking devices, use of multiple phones, or closed circuit cameras)
- ☐ Has heightened sense of fear or distrust of authority
- ☐ Child threatened to be reported to police or immigration
- ☐ Inter or intra state transportation of a child seems suspect
- ☐ Lives at workplace, or with employer, or lives with many people in confined area, or living arrangements seem suspect
- ☐ Child "pay" goes directly towards rent, debt, living expenses, necessities, or fees
- ☐ Forced to peddle
- ☐ Lying about age, or false ID, or no form of identification
- ☐ Does not have access to identity or travel documents or documents appear fraudulent

March 2015

Overview

Human trafficking (AKA trafficking) means participating in a venture to recruit, harbor, transport, supply provisions, or obtain a person for:

a. Forced labor or services that results in involuntary servitude, peonage, debt bondage, or slavery.
b. Commercial sexual activity through the use of force, fraud, or coercion, except that if the trafficked person is under 18 years of age, the commercial sexual activity need not involve force, fraud, or coercion.

The first point of contact for a child victim of trafficking will most likely be law enforcement and/or a state child welfare agency. The primary goal is to ensure that trafficked children are correctly identified and that they receive the appropriate protections and referrals. Iowa Code (sections 232.70 and 232.71B) provides the authority to refer potential trafficking information to the appropriate local law enforcement agency.

Keep in Mind

Cases of trafficking present as complex and time-consuming and are often overlooked or mislabeled. Many older minors walk, talk, and appear to be mini-adults. Society often writes these teenagers off as delinquent or criminals, believing they have the capacity to be complicit in prostitution and promiscuity. Under federal and state laws, a 16 or 17 year-old trafficking victim is to be treated the same as a 12 year-old trafficking victim.

Victims of human trafficking often do not immediately seek help or self-identify as victims. They may also try to protect the trafficker and have a sense of loyalty or positive feelings toward the trafficker, even referencing them as a "boyfriend" or relative.

Remember, sex trafficking cases of minors does not require the use force, fraud, or coercion. Any minor involved with prostitution is considered a victim of trafficking.

Process for DHS Social Workers

- Be familiar with the indicators to human trafficking.
  - Refer to *Child Trafficking Indicators*.
- Use indicators to guide your questions of the reporter regarding human trafficking.
  - Have *Child Trafficking Indicators* readily available as a reference during the intake call.
  - Document the reporter's knowledge or concerns regarding human trafficking or indicators of human trafficking as "HUMAN TRAFFICKING" in the "Additional Information" section of the intake document.
- When the intake is accepted as a child protective assessment (child abuse assessment or family assessment) or as a CINA Assessment:
  - Human trafficking information will be transmitted to the CPW via special communication which highlights the need for the CPW to refer the human trafficking information to the appropriate law enforcement agency.
- When the intake is rejected:
  - The designated intake staff refers the human trafficking information to the appropriate law enforcement agency.

March 2015

Overview

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a. Forced labor or services that results in involuntary servitude, peonage, debt bondage, or slavery.
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Remember, sex trafficking cases of minors does not require the use force, fraud, or coercion. Any minor involved with prostitution is considered a victim of trafficking.

Process for DHS Social Workers

- Be familiar with the indicators to human trafficking.
  - Refer to *Child Trafficking Indicators*.
- When the incident is assigned as a child protective assessment (child abuse assessment or family assessment) or as a CINA Assessment:
  - Upon review of the intake, the CPW will refer the human trafficking information received from intake (which is documented as "HUMAN TRAFFICKING" in the "Additional Information" section of the intake) to the appropriate law enforcement agency.
  - Note: This referral must be made whether or not the CPW is conducting a joint assessment/investigation with law enforcement.
- Use indicators to guide your questions during the course of the assessment.
  - Have *Child Trafficking Indicators* readily available as a reference during the assessment.

March 2015

- Document any subject or collaterals knowledge or concerns regarding human trafficking or indicators of human trafficking.
  - Document in the "Summary of Contacts" section of the assessment report if the information pertains to an allegation.
  - Document in the appropriate domain of the Safety Assessment if the information does not pertain to an allegation.

➢ When additional human trafficking information is learned during the course of the assessment:
- The CPW will refer the human trafficking information to the appropriate law enforcement agency.
- Note: This referral must be made whether or not the CPW is conducting a joint assessment/investigation with law enforcement.

ATTACHMENT H
CPC INTAKE REVIEW REPORT

CHILD PROTECTION COUNCIL, INTAKE REVIEW 11/10/15

BACKGROUND

The Child Protection Council (CPC), Statewide Citizen Review Panel, requested to do a case review specific to the Iowa Department of Human Services (IDHS) implementation of Differential Response. The CPC anticipated that the review would address the following:

- Whether or not decisions on pathway assignment are made consistently and correctly, following the criteria identified in Iowa Statute and Iowa Administrative Code (IAC).
- Whether the established intake criteria supports the intent of Differential Response (to engage families in a less adversarial manner), while still maintaining child safety.
- Whether they feel there are any needed policy or practice changes as it relates to the intake process in general and, in particular, the pathway assignment screening criteria.

DESIGN STUDY

The onsite review included 50 accepted intakes with an allegation of Denial of Critical Care (DCC) from the 1st quarter of SFY 2016 (July, Aug, and Sept. 2015). In order to allow reviewers to read an adequate number of cases assigned to each pathway, the distribution of cases included:

- 25 “Child Abuse Assessment (CAA)” intakes, randomly selected from the above parameters (i.e. DCC Allegation only 7/15-9/15), and
- 25 “Family Assessment (FA)” intakes, randomly selected from all possible FAs (7/15-9/15).

A standardized evaluation tool was developed by the Intake Review “Team Leads” (identified at the end of this report) to guide reviewers through the intake process and each required component of an intake, including the pathway screening tool. The tool was tested for inter-reviewer reliability internally with IDHS field supervisors and again with CPC members using a sample case before the onsite review date.

On the actual review day, Nov. 10, 2015, the CPC was broken into small teams of 2 members each, paired with an IDHS field supervisor (teams are identified at the end of this report). Each team reviewed several cases assigned to each pathway (4-5 of each CAAs and FAs), using the standardized tool. Reviewers were also asked to identify 2 strengths and 2 opportunities for improvement for each case reviewed. The small groups then came together in the afternoon to discuss general themes and common strengths and opportunities.

PROJECT TIMELINE

A timeline of the preparation and activities specific to the evaluation tool development and the onsite review is below. The persons responsible include those team leads identified at the end of this report.

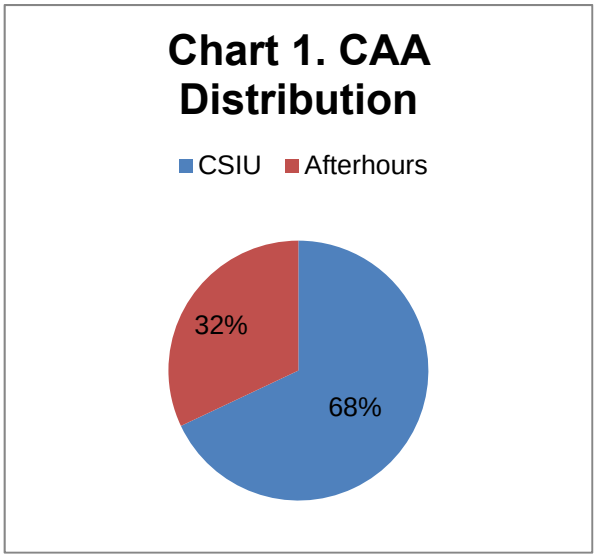
Intake Review Timeline		
Deadline	**Task**	**Person responsible**
Tool Development		
2/27/2015	Initial team meeting	LB, MG, JR, JG
March	Draft changes to tool	LB
4/10/2015	Review draft tool/timeline	LB, MG, JR, JG
4/20/2015	Tool/timeline due	LB, MG, JR, JG
July	Feedback to finalize tool	SBT
September	Tool finalized	LB
Review		
5/12/2015	CPC meeting - discuss plan and expectations (i.e. must attend both Sept/Nov meetings)	LB
July	Identify field supervisors to participate in Sept/Nov CPC meetings	SBT
July	Plan for Sept/Nov CPC Meetings	LB, MG, JR, JG
August	Pull sample case for internal inter-reviewer reliability	JR (DOFO)
8/11/2015	Team meets w/ field reps on tool and does an internal inter-reviewer reliability	LB, MG, JR, JG, RR, Field Reps
9/1/2015	Follow-up call with field reps on revised tool and sample case	LB, MG, JR, JG, RR, Field Reps
9/8/2015	CPC Meeting-training on CPS process in AM and inter-reviewer reliability activity in PM	LB, MG, JR, JG, RR, Field Reps
9/29/2015	Review team meets to finalize discussion questions and debrief sample review	LB, MG, JR, JG, RR
October	Pull case samples from July, Aug, and Sept 2015 - review for associated cases and pull; copy and make case files	LB, MG, JR, JG, RR
10/19/2015	Follow-up call with field reps before review and conduct another sample case review	LB, MG, JR, JG, RR, Field Reps
10/26/2015	Review cases pulled	LB, MG, JR, JG, RR
11/10/2015	Onsite - refresher on tool in AM and then group review and large group discussion	LB, MG, JR, JG, RR, Field Reps
Nov-Dec	Prepare a report of findings	LB, MG, JR, JG, RR
1/12/2016	Discuss recommendations with CPC	LB (others TBD)
Jan-Feb	Reviewer data validation and finalize report	LB

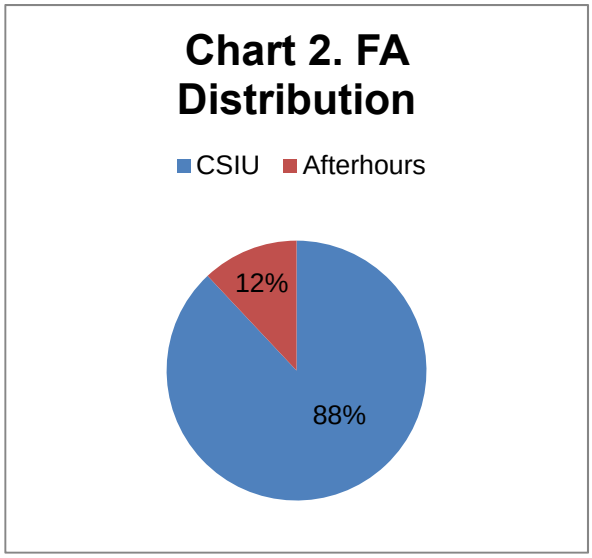
REVIEW FINDINGS - QUANTITATIVE DATA

The review results were initially analyzed from a quantitative lens, looking only at whether the various intake criteria were met (i.e., yes or no). It was also determined, in looking at the data, that it was necessary to consider the various subsets. For example, although both pathways were equally distributed in the pull (25/25), it became relevant to review the data in terms of the cases that were accepted for intake by the Centralized Service Intake Unit (Mon-Fri 8:00am-4:30pm) and those accepted Afterhours, as there were some distinct differences in whether certain criteria was met.

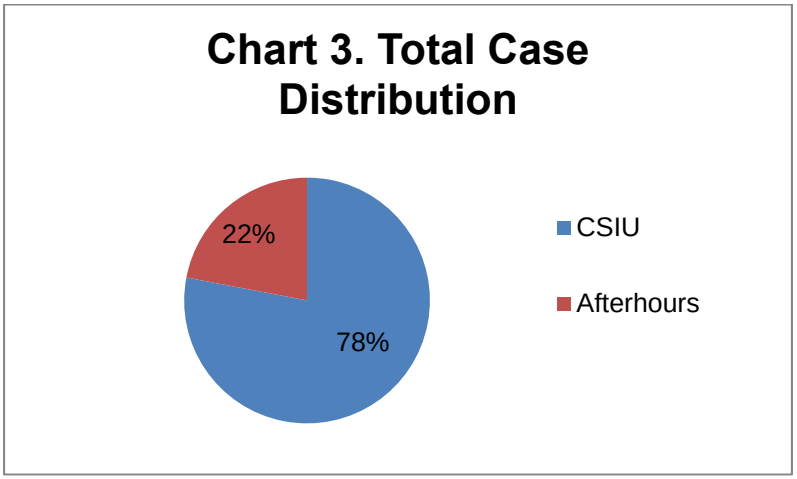
It should also be noted that there was a significant difference in the distribution of cases by pathway, depending on when they were called in. For example, allegations called in to CSIU were much more likely to be assigned as a FA when compared to allegations called in Afterhours. This is not to suggest that there are differences in practice, but more likely a result of the nature of Afterhours calls commonly arising from "emergency situations" (i.e. referrals from law enforcement, emergency departments, etc.).

Charts 1 and 2 below illustrate this difference. For example, of the 25 randomly pulled intakes that were assigned as a Child Abuse Assessment, 68% of them came in to CSIU and 32% came in Afterhours. However, for those assigned as Family Assessments, 88% were called in during regular business hours and only 12% of them were assigned as the result of an Afterhours report.





Because of this significant difference it was determined that it was important to look not only at the decision process and compliance levels based on the *pathway*, but also to consider *when* the intake was accepted. Chart 3 illustrates the combined total distribution for all 50 cases.

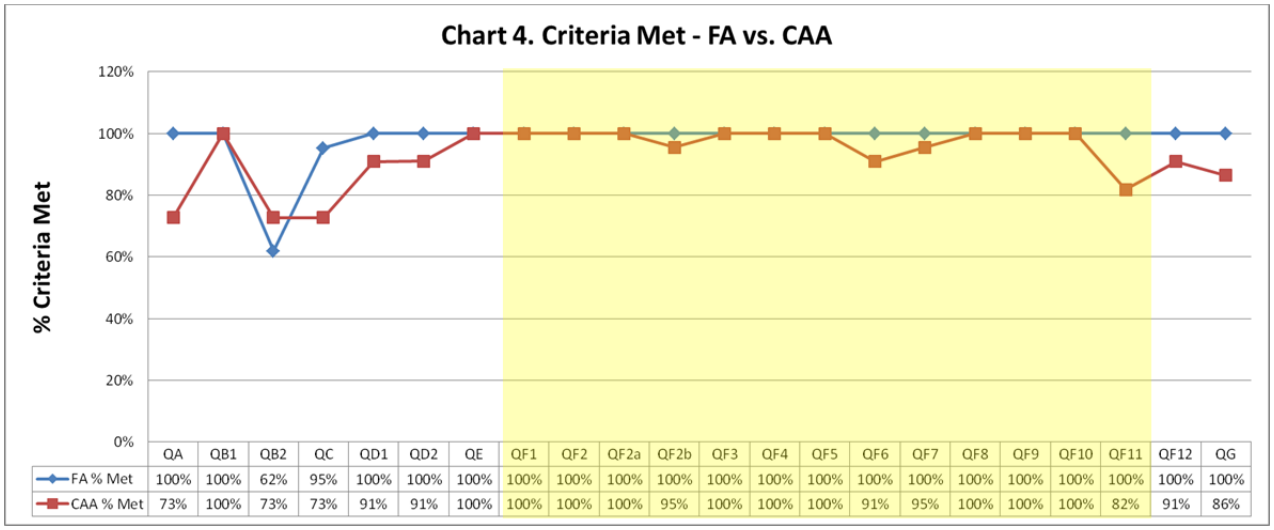


Reviewers were not able to complete the tool on all 50 cases during the time allotted, but each group did get through the majority of their cases. In all, a total of 43 of the 50 cases were fully reviewed (22 CAAs and 21 FAs) and had evaluation tools completed. Following the review all data points on the 43 cases completed were compiled to look at statistics regarding the various criteria being met. During the initial compilation of data it became apparent that there were some obvious reviewer errors in the items marked on the evaluation tool. As a result, it was determined that IDHS staff would do a full review of the 43 completed cases to validate whether the "criteria met" answers were correct.

In a few situations, reviewers mistakenly said "no", a criterion was not met. In many situations that had to do with the questions regarding the "intake screening tool" portion used within each intake to determine the assessment type. For example, if the condition was NOT present (i.e. "the alleged abuse type includes a category other than DCC", and the box was NOT checked, then the criteria was actually met because the tool was used correctly (so should have been marked as "yes"). Some reviewers interpreted this as "no", the condition was not present, so answered "no" criteria not met. Follow-up clarification occurred with the reviewers who did this and those reviewers confirmed they intended to state that the condition was not present vs. indicating that the criteria was not met. Therefore, those items were changed to accurately reflect the fact that the criteria were met

In other situations, errors were made due to a lack of understanding the expectations, or because reviewers had not fully read the tool guidance. For example, as long as the required information was in the intake (even the "additional information" section), the criteria should have been marked "yes". In other words, if collaterals and contact information are identified in the additional information section (vs. the full box for collateral name, phone, address, etc.), the criteria was still met and should have been marked "yes". In another situation, one team of reviewers took "examples" of possible child safety issues (listed on the tool) as questions that were *required* to be asked on all intakes. For example, they marked "no" because not every reporter was specifically asked about a child's "medical needs" or "environmental hazards". These are not required questions, but rather examples of potential safety concerns. Although some reporters may know this information, many will not. Therefore, these errors were also corrected (i.e., when the criteria were met in accordance with intake policy and practice but marked as "no").

Of the 22 criteria, 14 of them were specific to the intake screening tool (QF1-QF11). This becomes particularly relevant when looking at the level of compliance based on pathway decision. Chart 4, below, shows that on all FAs that were fully reviewed (N=21), the intake screening tool criteria (QF-QF11) was met 100% of the time. In other words, when a case was selected to go down a Family Assessment pathway, decisions were made correctly on each tool question 100% of the time. This varies somewhat with CAAs, in that when asked if all items on the tool were checked correctly (QF11), reviewers only answered "yes" 82% of the time.



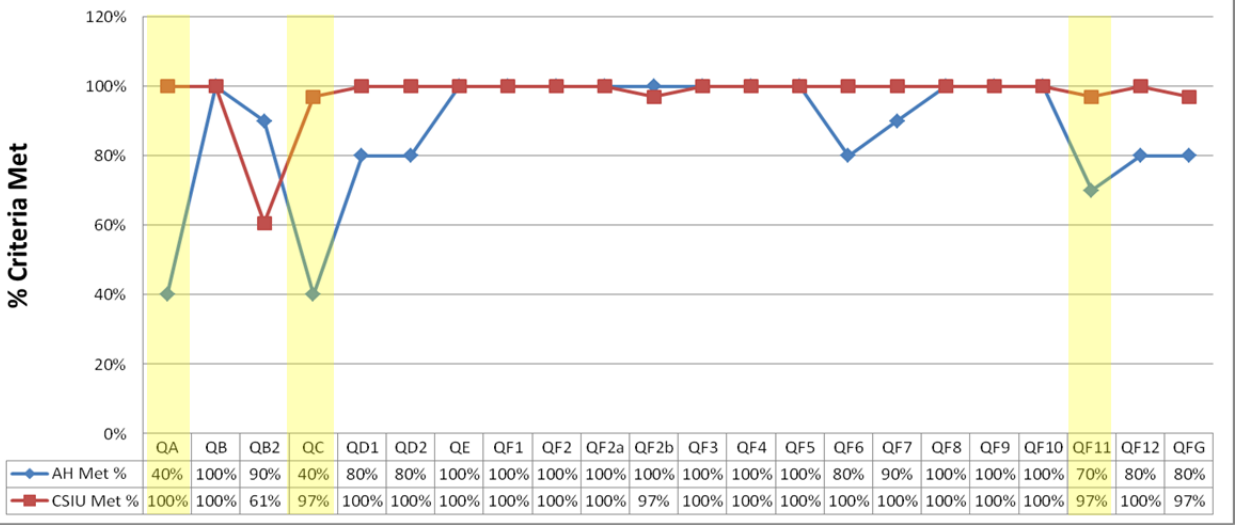
	QA	QB1	QB2	QC	QD1	QD2	QE	QF1	QF2	QF2a	QF2b	QF3	QF4	QF5	QF6	QF7	QF8	QF9	QF10	QF11	QF12	QG
FA % Met	100%	100%	62%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
CAA % Met	73%	100%	73%	73%	91%	91%	100%	100%	100%	100%	95%	100%	100%	100%	91%	95%	100%	100%	100%	82%	91%	86%

There were a total of 4 cases, of the 22 CAAs that were reviewed, where the tool was reportedly used incorrectly. 2 of the cases were a result of choosing the correct pathway, but not selecting ALL of the correct boxes, while the other 2 were cases where reviewers were uncertain about whether the case should have actually been assigned as a FA vs. a CAA. Both of these situations had to do with the prior TPR (Termination of Parental Rights) box being checked, but with no indication from the lookups (i.e., FACS or ICAR) or narrative documentation as to where this information was obtained from and/or which caretaker had a prior TPR. Reviewers felt that without this information documented in the intake it was difficult to determine whether the box should have, in fact, been checked.

Upon a more in-depth review of the cases involving TPRs it became clear that one case was the result of specific information stated by the reporter (who believed a father had his parental rights terminated), but nothing was confirmed before assigning as a CAA. The other case appeared to have been a result of a system entry error. It is assumed that the reason the TPR box was checked was a result of "transfer to adoption worker" being listed on an "event list" (in FACS) on a child in the household. Upon review by IDHS staff, it appears this was a mistake in FACS, as the family had never had juvenile court involvement and the child was still a member of the home. In this case, the assessment, according to policy, could have been assigned as a FA. As a result of both of these situations, related to TPRs, it is recommended that practice guidance be reviewed to clearly indicate what is considered a reliable source of information to assign as a CAA for the reason of TPR and how/where this information should be documented.

In reviewing the compliance level of other intake criterion, it was easier to see the trends when looking at *when* the call came in vs. the *pathway*. For example, on evaluation tool question QA ("Collect adequate information on all involved parties") and QC ("Complete all relevant system look-ups") there were significant differences in whether the criteria was met based on when the intake was accepted, with QA criterion met 100% (CSIU) vs. 40% (Afterhours), and QC criterion met 97% (CSIU) vs. 40% (Afterhours). In addition, 3 of the 4 CAA errors mentioned in the preceding section also occurred during Afterhours, with Q11 criterion ("all items appropriately checked") met 97% (CSIU) vs. 70% (Afterhours). This is illustrated in the highlighted sections below. This discrepancy was also addressed in the qualitative feedback discussed later.

Chart 5. Criteria Met - Afterhours vs. CSIU



	QA	QB	QB2	QC	QD1	QD2	QE	QF1	QF2	QF2a	QF2b	QF3	QF4	QF5	QF6	QF7	QF8	QF9	QF10	QF11	QF12	QFG
AH Met %	40%	100%	90%	40%	80%	80%	100%	100%	100%	100%	100%	100%	100%	100%	80%	90%	100%	100%	100%	70%	80%	80%
CSIU Met %	100%	100%	61%	97%	100%	100%	100%	100%	100%	100%	97%	100%	100%	100%	100%	100%	100%	100%	100%	97%	100%	97%

One surprising finding was QB2 ("Whether the person alleged responsible has access to the child."). It was determined that this was only being checked correctly in 61% of the CSIU cases and 90% of the Afterhours cases. It was discovered during the review, by a CSIU Supervisor who was one of the field reps, that this was the result of an automated programming issue in the system. If a worker attempted to proceed through the intake screen without answering that particular question, the system would automatically default to "No", indicating the alleged perpetrator did not have access to the child. This then was often conflicting with what the narrative suggested. Since the review this system issue has already been brought to the attention of CWIS (Child Welfare Information System) staff and been addressed in field worker training.

REVIEW FINDINGS - QUALITATIVE DATA

In addition to the quantitative data, reviewers had the opportunity to indicate 2 strengths and 2 opportunities for improvement on each case that was reviewed.

Some of the most common **strengths** included the following:

- Documentation
  - Good/thorough narrative descriptions and/or additional information
- Pathway assignment applied correctly, based on tool
- Lookups completed and/or indicated "nothing found"
- "Huge" growth in the intake process (from 2009 review done by CPC)

Similarly, many of the things identified as strengths in some cases were also noted as **opportunities for improvement** on other cases, including:

- Documentation – inadequate or missing information (particularly on Afterhours intakes), examples:
  - System look-ups, additional information, documentation of where TPR info was found, etc.
  - Child safety – not clear if intake worker is asking questions to solicit this information at time of intake. If so, not always documented.
- System issues (i.e., Perpetrator access question) mentioned several times in reviewer comments.

GENERAL COMMENTS/QUESTIONS

Reviewers were also asked to discuss their general thoughts, perceptions, following the process. Some of the themes identified included the following:

- The tool was used correctly, but are we serving the child's actual needs?
- Particular concern for children with intellectual/developmental disabilities, as a high risk population for abuse, and considering that abuse is often a contributing factor to delays.
  - In discussion it was noted that, in the past (before DR), all substantiated reports of abuse were automatically sent a referral for Early Access. Some of the questions raised included the following:
    - With Family Assessments, are CPWs doing any ID/DD screening? What about Community Care?
- "Afterhours intakes have a decided lack of information" – this was mentioned several times and is clear in the quantitative analysis as well. In particular, system look-ups and required additional information questions were often incomplete.
- Concerns regarding the high prevalence of substance abuse and domestic violence in FAs and whether these should be viewed as more than just a supervision issue.

- **Recommendation:** The IDHS should address system changes on "allows access" question by addressing the auto default to "NO".
    - **Next steps/Action taken:** Jason Geyer has brought this to the attention of CWIS (Child Welfare Information System) staff. In addition, this has been discussed in new worker training and with CSIU staff.
- **Recommendation:** The IDHS should provide clarification on: 1) What specific information is required for TPR to be the reason for assignment to a CAA, and 2) How the information should be documented within the intake. For example, is "hearsay" from the reporter (not confirmed by FACS or another state's system) reason enough to assign as a CAA? Also, what specific "events" should be looked for in FACS to confirm that a TPR did, in fact, occur?
    - **Next steps/Action taken:** This report will be shared with the internal IDHS "Intake Advisory Council", made up of CSIU staff/sups, field staff/sups, and IDHS child protective service help desk staff. The group will discuss recommendations and decide what, if any, action needs to occur.
- **Recommendation:** The CPC would like to conduct an additional review to look at the actual "assessments" related to these intakes, particularly those FAs that changed pathways, to determine if there were indications at intake to suggest these were not appropriate for a FA. If trends do become evident (i.e., things at intake that appear "predictive" of reassignment), the CPC would like the IDHS to consider changes to the intake screening tool.
    - **Next steps/Action taken:** IDHS CJA Program Manager will explore options for a future review by the CPC in the coming year.
- **Recommendation:** The IDHS should look closer at how ID/DD screening occurs during the assessment process and consider additional ways to support families of children with disabilities in getting appropriate screening and service referrals.
    - **Next steps/Action taken:** IDHS is currently mandated by federal law (Child Abuse Prevention and Treatment Act or CAPTA) to refer all children 0-3 with a "substantiated" case of abuse for ID/DD screening. The way this has been done is primarily through an automated referral system to Early Access. The IDHS and the IDOE (Iowa Department of Education) are currently exploring ways to better engage families in this process.
- **Recommendation:** The IDHS should work towards increasing consistency on system lookups, particularly for intakes done Afterhours.
    - **Next steps/Action taken:** This report will be shared with the internal IDHS "Intake Advisory Council", made up of CSIU staff/sups, field staff/sups, and IDHS child protective service help desk staff. The group will discuss recommendations and decide what, if any, action needs to occur.
- **Recommendation:** The IDHS should explore issues of substance abuse and domestic violence (as these were the most prevalent concerns in FAs) and whether there are indications of "imminent danger" in some cases that make them inappropriate for a FA.
    - **Next steps/Action taken:** As a result of this concern brought up by a number of reviewers, IDHS staff reviewed all FAs to determine the number/percentage of the 25 randomly chosen cases that included

allegations of domestic violence and/or substance abuse (to determine the true extent of these issues in FA intakes) and the findings indicated that:

- **Domestic Violence:** 16 of the 25 FAs chosen at random specifically included allegations of violence between adult caretakers (64%). The vast majority of these were IPV (Intimate Partner Violence) situations, although one allegation included a physical altercation between a mother and grandmother.
- **Substance Abuse:** 7 of the 25 FAs chosen at random specifically included allegations of substance abuse (28%). However, in also looking at the narrative "Additional Information" sections of the 25 intakes, another 7 indicated some form of concern by the reporter of possible drug and/or alcohol abuse, even if not rising to the level of being an allegation itself. Therefore substance abuse was, at minimum, mentioned in 14 of the 25 intakes or 56%.
- **One or both:** In total, all but 4 of the 25 cases (88%) included concerns of domestic violence and/or substance, either within the allegation itself or within the additional information section.

o **Next steps/Action taken:** The IDHS is aware of the common issues and family dynamics that often correlate with the majority of child abuse cases (i.e., mental illness, substance abuse, and domestic violence). In order to address some of these things, the IDHS has done the following:

- The IDHS recently implemented the Safe & Together Model, a perpetrator pattern based, child centered, and survivor strengths approach to working with domestic violence. All field staff have received this training and CSIU staff will be receiving soon.
- The IDHS continues to look at how the term "imminent danger" is defined and how it is used in practice and convened an internal workgroup on the topic in 2015.
- The IDHS is currently reviewing additional tools and guidance and is in the process of developing training for field staff to assist in the screening process for issues related to mental illness, substance abuse, and domestic violence.

IDHS INTAKE REVIEW TEAM LEADS

- Lisa Bender/Roxanne Riesberg – Adult, Children and Family Services
- Jason Geyer –Social Work Administrator (CSIU)
- Michelle Gonzalez – Quality Improvement Coordinator
- Jana Rhoads – Field Operations Support Unit/Training

IDHS FIELD SUPERVISORS & CPC MEMBER TEAMS

- Megan Christner, Eastern Service Area
    - CPC Members: Regina Butteris & Jerry Foxhoven
- Chad Hargin, Des Moines Service Area
    - CPC Members: Cheryll Jones & Barbara Small
- Travis Heaton, Western Service Area
    - CPC Members: Resmiye Oral & Chaney Yeast
- Suzanne Laurence, Centralized Service Intake Unit (CSIU)
    - CPC Members: Kenneth McCann & Beverly Saboe
- Heather Lietz, Cedar Rapids Service Area
    - CPC Members: RaeAnn Barnhart & James Hennessey
- Doug Sedgwick, Northern Service Area
    - CPC Members: Sylvia Lewis & Stephen Scott