

**SERVICE STANDARD**  
**INDIANA DEPARTMENT OF CHILD SERVICES**  
**SPECIALIZED SERVICES**

**I. Service Description**

- A. This service standard applies to services provided to families and children involved with the Department of Child Services and/or Probation.
- B. Providers will maintain compliance with federal and state laws. Providers will follow what service was proposed in RFP.
- C. If changes need to be made, discussion will happen with DCS prior to making changes
- D. If using evidence based practices or best practices, providers will follow those to fidelity of the model.
- E. The family will be the focus of service, and services will focus on the strengths of the family and build upon these strengths.
- F. Members of the client family, which may include foster parents, are to be defined in consultation with the family and approved by DCS/Probation.
  - 1. This may include persons not legally defined as part of the family.
  - 2. Approved family members will be documented as those listed on the authorizing DCS/Probation referral and subsequent written documents.
- G. Services will be time-limited and focused on limited objectives derived directly from the established DCS/Probation case plan or Informal Adjustment.
- H. Services must include development of short and long-term family goals with measurable outcomes that are consistent with the DCS case plan.
- I. Services must be family centered and child focused. Services may include intensive in-home skill building and must include after-care linkage.
- J. Services include providing monthly progress reports; requested supportive documentation such as case notes, social summaries, etc.; and requested testimony and/or court appearances including hearings and/or appeals; case conferences/staffing.
- K. Monthly reports are due by the 10<sup>th</sup> of each month following the month of service. Staff must respect confidentiality. Failure to maintain confidentiality may result in immediate termination of the service agreement.
- L. Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life style choices, and complex family interactions and be delivered in a neutral-valued culturally-competent manner.

## **II. Service Delivery**

- A. Providers will maintain compliance with federal and state laws. Providers will follow what service was proposed in RFP. If changes need to be made, discussion will happen with DCS prior to making changes.
- B. For Residential Treatment Services
  - 1. Residential Treatment Services under Specialized Services may include placement of children with their parents in the program.
  - 2. All activities in these programs should include appropriate supervision and care of the children while in these programs as well as the needed support for the parents to complete their parenting as independently as possible.
  - 3. Providers should complete a bio-psychosocial assessment, consistent with the Substance Use Disorder Assessment service standard, on referred clients.
    - a) It is strongly encouraged providers utilize the most current American Society of Addiction Medicine Criteria (ASAM) when determining the appropriate level of care and creating a discharge plan.
    - b) Individuals shall be accepted into the program within 5 days.
  - 4. Providers shall give priority to pregnant women and intravenous drug abuse populations.
    - a) The provider shall establish and utilize a referral system if the provider has insufficient capacity to provide services to women who are pregnant.
    - b) The provider will notify the Department of Mental Health and Addiction (DMHA) if immediate access to services, for a woman who is pregnant cannot be arranged.
      - (1) Interim services, including referral for prenatal care, will be provided to each woman who is pregnant awaiting commencement into detoxification services for forty-eight (48) hours or more. This shall continue until such time services are fully commenced.
  - 5. Interim services shall be provided to individuals who use intravenous drugs and wait for commencement into detoxification service for forty-eight (48) hours or more. This shall continue to until such time services are fully commenced. The length of stay in the program shall be based on level of need.
    - a) Minimum length of stay being 10 days and maximum length of stay being 30 calendar days.

- b) The service provider, in collaboration with the referral source, must identify a plan to engage the client and motivate non-cooperative clients including those who believe they have no problems to address.
  - c) The service provider must work with special needs clients, such as those who are mentally ill or developmentally delayed.
6. Services are planned and organized with addiction professionals and clinicians providing multiple treatment service components for the rehabilitation of the referred individual's substance use disorder.
7. The treatment team will collaborate with the referral source throughout the treatment duration, including, but not limited to: discharge planning and coordination.
8. The service provider must deliver and assure a continuum of care for all clients.
9. Due to the chronic nature of addiction, treatment involves multiple interventions and requires constant monitoring.
- a) The treatment provider shall follow all requirements of 440 IAC 7.5-2-8 with regards to treatment planning
  - b) In addition, an individualized Recovery/Treatment Plan must be developed that considers the client's:
    - (1) Age
    - (2) Gender
    - (3) Ethnic background
    - (4) Cognitive development and functioning and
    - (5) Clinical issues.
  - c) Recovery/Treatment Plans for referred individuals should connect substance use and how it affects child safety.
  - d) Recovery/Treatment Plans shall provide a framework for measuring success and progress.
  - e) Recovery/Treatment Plans should include goals and objectives that address the issues identified in the substance use assessment.
    - (1) The goals and objectives in the Recovery/Treatment Plan should be partially based on:
      - (a) Functional assessment of each resident's daily living
      - (b) Socialization
      - (c) Coping skills
      - (d) Result of a structured evaluation and observation of behavior.

- f) The Recovery/Treatment Plan will be completed and shared with the referral source within 7 business days from client's admission into treatment in order to facilitate the continuum of care following the client's discharge from residential treatment.
10. Residential treatment services must be based on a written, cohesive, and clearly stated philosophy and treatment orientation that includes the following standards (per 440 IAC 9-2-8):
- a) There must be evidence that the philosophy is based on literature, research, and proven practice models.
  - b) Services must be provided utilizing evidence-based interventions and programs that are supported or well-supported.
  - c) Approved programs may be found at:
    - (1) The California Evidence: [www.cebc4cw.org](http://www.cebc4cw.org);
    - (2) Substance Abuse and Mental Health Services Administration (SAMHSA): [www.nrepp.samhsa.gov](http://www.nrepp.samhsa.gov);
    - (3) The Office of Juvenile Justice and Delinquency Prevention: <http://ojjdp.ncjrs.gov>.
    - (4) Other program requests may be utilized with prior written approval from DCS Central Office.
    - (5) Requests should be submitted to the Child Welfare Plan [childwelfareplan@dcs.in.gov](mailto:childwelfareplan@dcs.in.gov).
  - d) The services must be client-centered.
  - e) The services must consider client preferences and choices.
  - f) There must be a stated commitment to quality services.
  - g) The residents must be provided a safe, alcohol-free, and drug-free environment.
  - h) The individual environment must be as homelike as possible.
  - i) The provider must provide transportation or ensure access to public transportation in accordance with the recovery plan.
  - j) The services must provide flexible alternatives with a variety of levels of supervision, support, and treatment as follows:
  - k) Service flexibility must allow movement toward the least restrictive environment but allow increases in intensity during relapses or cycles of relapse.
  - l) The service provider must deliver and assure a continuum of care for all clients.
  - m) An agency cannot terminate a referred individual from services because of a need for a higher level of care:

- (1) Without making a good faith effort to continue to provide adequate, safe, and continuing treatment at the current level.
- (2) Unless the resident is transferred to another agency that provides the continuum of care needed.
- n) The treatment services must be carried out in residences that meet all life safety requirements and are licensed or certified as appropriate.
- o) Residential services shall include specific functions that shall be made available to clients based upon the individual Recovery/Treatment Plan.
  - (1) These functions include the following:
    - (a) Crisis services, including access to more intensive services, within twenty-four (24) hours of problem identification;
    - (b) Case management services, including access to medical services, for the duration of treatment, provided by a case manager or primary therapist and
    - (c) Access to psychiatric or addictions treatment as needed.

11. Drug Testing

- a) Drug testing plays an important role in maintaining a drug-free therapeutic environment in residential treatment.
- b) Drug Testing shall be utilized during the course of treatment.
- c) The treatment provider will use best practice recommendations when considering the testing frequency and specific time for testing.
- d) Per American Society of Addiction Medicine (ASAM) drug testing guidelines, residents should be asked to provide a sample for drug testing after returning from any passes.<sup>2</sup>
- e) The total number and frequency of drug tests is at the provider's discretion and is included in the daily treatment rate (per diem).
- f) All sample collections drug tests will be observed sample collections.
  - (1) Urine drug tests will be observed by an individual of the same gender as the client.
  - (2) Gender of the client is defined as the gender listed on the client's government issued identification.

- (a) Provider staff must be aware and sensitive to the sexual and/or gender orientation of clients. If applicable, provider staff should provide information to the client regarding changing their government issued identification, accessible at <https://www.in.gov/bmv/2564.htm>
- g) Minimum of substances tested should include:
  - (1) Alcohol
  - (2) Amphetamines
  - (3) Barbiturates
  - (4) Benzodiazepines
  - (5) Cocaine
  - (6) Cannabis
  - (7) Opiates
  - (8) Methadone
  - (9) Oxycodone
  - (10) Tramadol
  - (11) Buprenorphine
  - (12) Synthetic Marijuana
  - (13) Fentanyl
  - (14) Methamphetamine
  - (15) Other drugs indicated by client's history
- h) The agency will be expected to provide reports to the referral source that state the minimum level necessary to detect:
  - (1) The presence of each substance,
  - (2) The level of substance detected and
  - (3) The chain of custody documentation.
- i) Assurance must be given for accurate results even if the confirmation process is the only means to ensure accurate results, due to the testing process providing inaccurate results.
- j) Any presumptive positive test must go through the confirmation process.
- k) The vendor shall ensure proper legal chain-of-custody procedures are maintained and comply with departmental procedure, state and federal laws.
  - (1) The vendor shall also ensure complete integrity of each specimen tested and the respective test results.
  - (2) Receiving, transfer and handling of all specimens by personnel shall be fully documented using the proper chain-of-custody.

- l) A laboratory participating in DCS/Probation drug testing must comply with:
  - (1) All applicable Federal Department of Health and Human Service requirements and are subsumed:
    - (a) Substance Abuse and Mental Health Services Administration (SAMHSA)
    - (b) College of American Pathology (CAP)
    - (c) Clinical Laboratory Improvement Act (CLIA) requirements.
- m) The vendor shall notify the local Department of Child Services Office/Probation Officer (PO) of testing results via email or fax on vendor letterhead
  - (1) The results will be sent by U.S. mail to the referring county.
  - (2) The vendor shall gain approval from DCS or Probation for any changes in the results notification system.
- n) The referring agency will be notified of positive test results within 72 hours of the lab receipt of the sample specimen.
- o) The referring agency will be notified of negative test results within 24 hours of the lab receipt of the sample specimen.

12. Discharge Plan

- a) The provider will develop a discharge plan with the referred individual regardless of treatment methodology.
- b) All attempts should be made by the provider to ensure a smooth transition to subsequent level of care.
- c) In order to ensure follow up, the discharge recommendations have to be shared verbally with the referral source within a minimum of 3 business days prior to client's discharge from the program.
  - (1) The written discharge plan will be completed for every client and provided to the referral source within 7 business day after client's discharge from treatment.
- d) The discharge plan should include the following domains:
  - (1) Any applicable diagnosis(s)
  - (2) Level of care provided during residential treatment episode
  - (3) Recommended level of care upon discharge
  - (4) Prescribed medication and dosage instructions at time of discharge
  - (5) Supports in place for referred individual
    - (a) Social, familial, communal, relapse prevention, sponsor, etc.

- (6) Strengths and limitations of referred individual
  - (7) Referral recommendations, to include, but not limited to:
    - (a) Psychological testing, psychiatrist consultation, medication evaluation, recovery support meetings, life skills etc.
  - (8) Discharge/termination reason
  - (9) Discharge/termination date
  - e) Best practice will have the referred individual transition to the next level on the continuum of care when it is immediately available
    - (1) If services for the next level of care are not immediately available, and there is a gap between discharge and continuing services, the provider will develop an interim plan to encourage and support the client's recovery process.
- C. For Services Provided to Sexually Harmful or Reactive Youth under Specialized Services
- 1. When the assessment should be done: Youth under age of 12 who have harmed others in a sexual manner. This will allow the evaluator to assess if behaviors are trauma related or there is a risk for ongoing sexual behaviors.
    - a) Sexual Risk Assessment
      - (1) At a minimum, the sexual risk assessment for youth under 12 years old should include the following components:
        - (a) A statement of informed consent
        - (b) A minimum of one (1) collateral contact shall be completed in order to collect information regarding the client's sexual behaviors and past trauma.
        - (c) Members of the client's informal or formal support can serve as collateral contacts to verify client's history.
        - (d) Local DCS office/Probation staff will count as a collateral contact if additional information is obtained from them.
        - (e) Youth, family, and community strengths
        - (f) Cognitive functioning
        - (g) Social/developmental history
        - (h) Current individual functioning
        - (i) Current and historic family functioning
        - (j) Delinquency and conduct/behavioral issues
        - (k) Substance use and abuse
        - (l) Psychosexual assessment



- (m) Mental health assessment
- (n) Sexual history
- (o) Trauma history
- (p) Community risk and protective factors;
- (q) Awareness of victim impact
- (r) Dynamic Safety Plan
- (s) Quality and availability of informal supervision
- (t) Addresses needs for safety specific to the referred youth

b) Needs tools if applicable:

(1) Latency Age-Sexual Adjustment and Assessment Tool (LA-SAAT) - Assessment of Risk and Needs for Continued Sexually Troubled Behavior

- (a) The LA-SAAT is an instrument designed to shape structured professional judgement (SPJ) in assessing the risk for continued sexually troubled behavior in pre-adolescent males, aged 8-12, who have engaged in sexual behavior that appears inappropriate due to age or the nature and/or extent of the sexual behavior.
- (b) For children who have behaved in sexually problematic or sexually abusive behavior.
- (c) It is not designed to be used to evaluate younger children, adolescents, adults, or females.

(2) Or other clinically approved/ATSA approved tool

c) Conclusion of the Assessment should include:

- (1) Statement of concerns/vulnerabilities/risks by life domains (at least home, school, and community)
- (2) Recommendation concerning the level of restrictiveness for the youth
- (3) Statement of amenability to interventions of the youth and family
- (4) Statement of protective factors
- (5) Statement of needs for youth and family
- (6) Recommendations for intervention to address the needs of youth and family
- (7) Recommendations of critical individuals in the family and community to support interventions
- (8) Statements of specific responsivity factors

- (9) Recommendations for strategies to address responsivity factors
- d) Tools used in the report
  - (1) Practitioners who conduct risk and needs assessments of youth who have sexually abused must use one or more of the most empirically supported, independently evaluated measures in addition to structured clinical judgment.
  - (2) Practitioners will determine through the assessment if trauma assessment tools should be utilized or if there is a need for needs/risk tool to be utilized.
  - (3) As newly developed tools become available, practitioners should evaluate relevant professional literature to determine research support before using them.
  - (4) Clinicians who administer and interpret results must meet the qualification of the testing tools being utilized.
- 2. Sexual Risk Assessment for youth over 12 years old and youth involved with the juvenile or CHINS legal system
  - a) When an assessment should be done: When there is definitive information that the adolescent engaged in sexually abusive behavior. This includes, but is not limited to the following:
    - (1) The agency responsible for investigating allegations of sexually abusive behavior determined the behavior occurred and substantiated the findings of such.
    - (2) The behavior has been substantiated by the appropriate jurisdictional investigative agency.
    - (3) The adolescent has been adjudicated by the court on a sex-abuse related offense.
    - (4) The sexually abusive behavior was directly observed by a reliable, responsible, source.
    - (5) The youth admits to having engaged in sexually abusive behavior.
  - b) Practitioners should:
    - (1) Take into account the adolescents current legal status and the ways in which that status may influence the nature, scope, or validity of the assessment.
    - (2) Recognize assessments cannot prove or disprove that sexual abuse has occurred, that it is not the role of an assessment, and an assessment cannot predict with certainty whether such behavior will or will not reoccur.
    - (3) Educate referral sources accordingly.

3. Risk and Needs Assessment:
  - a) The preferred practice to complete the Risk and Needs Assessment is post-adjudication; however, there are situations that warrant consideration of a pre-adjudication assessment, such as:
    - (1) The legal professionals involved in the case are seeking information to assist in formulating a plea agreement or to support moving a plea agreement forward.
    - (2) The judge is seeking additional information prior to accepting to a proposed plea agreement.
    - (3) The court is withholding the charge, providing the adolescent an opportunity for treatment, resulting in no formal action on the offense.
4. Sexual Risk Assessment
  - a) At a minimum, the sexual risk assessment on youth should include the following:
    - (1) A statement of informed consent
      - (a) A minimum of one (1) collateral contact shall be completed in order to collect information regarding the client's sexual behaviors and past trauma.
      - (b) Members of the client's informal or formal support system can serve as collateral contacts to verify client's history.
      - (c) Local DCS Office/Probation staff will count as a collateral contact if additional information is obtained from them.
    - (2) Youth, family, and community strengths
    - (3) Cognitive functioning
    - (4) Social/developmental history
    - (5) Current individual functioning
    - (6) Current and historic family functioning
    - (7) Delinquency and conduct/behavioral issues
    - (8) Substance use and abuse
    - (9) Sexual Assessment (including sexual interests)
    - (10) Mental health assessment
    - (11) Sexual history
    - (12) Trauma history
    - (13) Community risk and protective factors
    - (14) Awareness of victim impact
    - (15) Quality and availability of informed supervision
    - (16) Risk/Need estimate utilizing an appropriate tool

- b) Conclusion of the Assessment shall include:
  - (1) Statement of risk for continued sexually abusive behavior by environments (at least home, school, and community)
  - (2) Recommendation concern level of restrictiveness for the youth
  - (3) Statement of amenability to interventions of the youth and family
  - (4) Statement of protective factors
  - (5) Statement of needs for youth and family
  - (6) Recommendations for intervention to address the needs of youth and family
  - (7) Recommendations of critical individuals in the family and community to support interventions
  - (8) Statement of specific responsivity factors
  - (9) Recommendations for strategies to address responsivity factors
- c) Tools used in the report
  - (1) Practitioners who conduct risk and needs assessments of youth who have sexually abused must use one or more of the most empirically supported, independently evaluated measures in addition to structured clinical judgement.
  - (2) As newly developed tools become available, practitioners should evaluate relevant professional literature to determine research support before using them.
  - (3) Clinicians who administer and interpret results must meet the qualification of the testing tools being utilized.
  - (4) Examples of tools to be used:
    - (a) PROFESOR- Protective + Risk Observations for Eliminating Sexual Offense Recidivism
      - (i) PROFESOR is a structured checklist to assist professionals to identify and summarize protective and risk factors for adolescents and emerging adults (individuals aged 12-25) who have offended sexually.
      - (ii) PROFESOR is intended to assist with planning interventions that can help individuals to enhance their capacity for sexual and relationship health and thus, eliminate sexual recidivism.
      - (iii) PROFESOR is not intended to predict risk.

- (iv) Indeed it is critical to stress that there is currently no empirical support to suggest that the PROFESOR could inform predictions of future sexual offending.
- (b) MEGA- Multiplex Empirically Guided Inventory of Ecological Aggregates for Assessing
  - (i) To be used for sexually abusive children and adolescents, between the ages of 4-19
  - (ii) MEGA is a scientifically based questionnaire that determines the level of risk for coarse sexual improprieties and/or risk for sexually abusive behaviors
  - (iii) MEGA can be applied to both adjudicated and non-adjudicated youth
  - (iv) MEGA can be applied to males and females in addition to lower functioning individuals
- (c) MIDSAs-Multidimensional Inventory of Development, Sex, and Aggression
  - (i) MIDSAs are computerized self-report inventories that assess all domains found important in the treatment and management of sexually aggressive behavior.
  - (ii) The MIDSAs gather extensive data on the developmental antecedents that contribute to the onset and continuance of sexual and aggressive behavior.
  - (iii) The MIDSAs are psychological assessment tools that were designed specifically to identify important target domains for therapeutic intervention with individuals who have been sexually coercive. They are intended to serve as risk management instruments.
  - (iv) The MIDSAs are not risk actuarial and are not designed to be used for adjudication purposes.
  - (v) The MIDSAs have versions written specifically for juveniles. Adolescents with a fourth grade reading level can answer them.
  - (vi) Males and females can utilize the inventories.

- (d) JSORRAT- Juvenile Sexual Offense Recidivism Risk Assessment Tool- II
  - (i) JSORRAT-II is an actuarial sexual recidivism risk assessment tool designed for male juveniles between ages of 12-17 who have been adjudicated guilty for a sexual offense.
  - (ii) The JSORRAT-II may be used experimentally in any state to tentatively inform treatment, programming, and other similar clinical decisions.
  - (iii) Use of the JSORRAT-II to advise forensic decisions (registration, community notification, and civil commitment) should be limited to states in which it has been validated or is currently being validated.
- (e) J-SOAP- Juvenile Sex Offender Assessment Protocol- II
  - (i) J-SOAP-II is a checklist whose purpose is to aid in the systematic review of risk factors that have been identified in the professional literature as being associated with sexual and criminal offending.
  - (ii) It is designed to be used with males ages 12-18 who have been adjudicated for sexual offenses, as well as non-adjudicated youth with a history of sexually coercive behavior.
- (f) J-RAT- The Juvenile Risk Assessment Tool
  - (i) The J-RAT is an instrument designed to shape structured professional judgement (SPJ) in assessment the risk of a sexual re-offense in adolescent males, ages 12-18 who have engaged in prior sexually abusive behavior.
  - (ii) It is not designed to be used to evaluate younger children, adults, or females.
- (g) Visit in-[ajsop.org](http://ajsop.org) for more details and up to date information tools.

5. Treatment

- a) Treatment must include individual and family components, and may include group components for sexually harmful youth including the following:
  - (1) Case-specific treatment components through individual therapy including addressing personal history of sexual victimization and behavioral techniques designed to modify deviant sexual arousal if appropriate.
  - (2) Core treatment modules through an optional group component including psychoeducation about the consequences of abusive behavior.
  - (3) Increasing victim empathy
  - (4) Identifying personal risk factors
  - (5) Promoting healthy sexual attitudes and beliefs
  - (6) Social skills training
  - (7) Sex education
  - (8) Problem solving skills
  - (9) Parent components including:
    - (a) Engendering support for treatment and behavior change
    - (b) Encouraging supervision and monitoring
    - (c) Teaching recognition of risk signs
    - (d) Promoting guidance and support to their child
  - (10) Dynamic safety planning
  - (11) Family support services
  - (12) Compliance monitoring and reporting
- b) Individual must be trained (post-secondary) in evidence based trauma modality such as:
  - (1) Trauma Focused Cognitive Behavior Therapy (TF-CBT): Prior to serving the client, the individual must complete the minimum ten (10) hour online training. The individual must be actively working towards certification.
  - (2) Strategies for Trauma Awareness and Resilience (STAR): Prior to serving the client, the individual must complete STAR Level 1 Training (5 day in-person training).
  - (3) Other evidence based trauma modalities may be used but they require **written approval from the DCS Central Office.**

- c) If reunification is the permanency plan, the team must have a CSAYC or practicum CSAYC working on the case to ensure the victim clarification process is handled within best practices. Victim clarification must be completed prior to reunification. Best practices will ensure safety throughout the clarification process, as well as how safety will be addressed during and after reunification.
    - d) Reunification and clarification steps/goals should be discussed in all team meetings.
  - D. Caregiver Education under Specialized Services
    - 1. Group
      - a) Group will be defined as at least 3 clients (who are DCS or Probation referrals and are from no less than two different referred families. If there are less than 3 clients from at least two DCS/Probation referrals, the payment would be the face to face rate for each referral. Specialized curriculum will follow as proposed in the RFP.

### **III. Target Population**

- B. Service must be restricted to the following eligibility categories:
  - 1. Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
  - 2. Children and their families which have an Informal Adjustment (IA) or the children have the status of CHINS or JD/JS.
  - 3. Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.
  - 4. All adopted children and adoptive families.

### **IV. Goals and Outcomes**

- A. Goal 1: Maintain timely intervention with the family and regular and timely communication with referring worker.
  - 1. 100% of cases will have a monthly report submitted to DCS/Probation by the 10<sup>th</sup> of the following month
  - 2. 95% of families will receive initial contact from the provider within 48 hours
- B. Goal 2: DCS/Probation and clients will report satisfaction with services
  - 1. DCS/ Probation satisfaction will be rated 4 and above on the Service Satisfaction Report.



1. 90% of clients will rate the services “satisfactory” or above on a satisfaction survey developed by the service provider, unless one is distributed by DCS/Probation to providers for their use with clients. Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.
- C. Goal 3: Clients in residential treatment will remain illicit substance free.
  1. 95% of clients who participate in residential treatment will remain drug free during the service provision period as indicated by the drug tests administered.
  2. 80% of clients will be enrolled in continuum of care upon discharge/terminations.
- D. Goal 4: Provide No-Show alert to FCM
  - a) 100% of no-show alerts will be provided to the referring worker immediately following each no show.
  - b) Notification must occur within 24 hours of occurrence.

**V. Minimum Qualifications**

- A. Direct Worker
  1. Direct workers under this standard must meet one of the following minimum qualifications:
    - a) Bachelor’s degree in Psychology or Sociology, or Social Work
    - b) Master’s degree in Psychology, Sociology, Social Work; OR

- c) Bachelor's or Master's degree in a directly related human services field. as evidenced by:
  - (1) Completion of a minimum of 39 semester/58 quarter hours in the following coursework:
    - (a) Human Growth and Development
    - (b) Social and Cultural Foundations
    - (c) Lifestyle and Career Development
    - (d) Sexuality
    - (e) Gender and Sexual Orientation
    - (f) Ethnicity, Race, Status, and Culture
    - (g) Psychology
    - (h) Sociology
    - (i) Social Work
    - (j) Criminology
    - (k) Ethics and Philosophy
    - (l) Physical and Behavioral Health
    - (m) Family Relationships
    - (n) Advocacy and Mediation
    - (o) Case Management
    - (p) Resources and Systems
    - (q) Social Policy
    - (r) Community Planning and Relations
    - (s) Crisis Intervention
    - (t) Substance Use
    - (u) Counseling and Guidance
    - (v) Educational Studies
  - (2) The individual must complete the Human Service Related Degree Course Worksheet.
    - (a) For auditing purposes, the worksheet should be completed and placed in the individual's personnel file.
    - (b) Transcripts must be attached to the worksheet.
  - (3) Coursework must be completed at a satisfactory level, no less than a C- for any quarter or semester grade in applicable coursework.
- d) Other non-Human Service related Bachelor's degrees will be accepted:
  - (1) Minimum of two years-experience

- (a) Providing a service to families that need assistance in the protection and care of their children and/or providing skills training, development, and habilitation.
    - (i) Experience gained by an employee in which the employee was not qualified to complete the work at the current or previous employer does not count toward the required two (2) year experience in combination with a Bachelor's degree.
- 2. The individual must possess a valid driver's license and the ability to use a private car to transport self and others, and must comply with the state policy concerning minimum car insurance coverage.
- 3. In addition to the above:
  - a) Knowledge of child abuse and neglect, and child and adult development
  - b) Knowledge of community resources and ability to work as a team member
  - c) Belief in helping clients change their circumstances, not just adapt to them
  - d) Belief in adoption as a viable means to build families
  - e) Understanding regarding issues that are specific and unique to adoptions such as loss, mismatched expectations and flexibility, loss of familiar surroundings, customs and traditions of the child's culture, entitlement, gratification delaying, flexible parental roles, and humor.

B. Supervisor of Counselor

1. Supervisors under this standard must meet one of the following minimum qualifications:

- a) Master's or Doctorate degree in Social Work, Psychology, or directly related human services field from an accredited college and completion of DCS Supervision Qualification Training requirements specified for Masters level supervisors.
- b) Master's Degree in Social Work, Psychology, Marriage and Family Therapy, or related human services field, and two (2) years related clinical experience with a clinical license issued by the Indiana Social Worker, Marriage and Family Therapist, or Mental Health Counselor Board
- c) A Bachelor's Degree in Social Work, Psychology, or directly related human services field from an accredited college with five years-experience delivering home based child welfare or home based probation services with one year experience under the DCS Home Based Casework Service Standards (Community Partners, Father Engagement, or Home Based Family Centered Casework) and completion of DCS Supervisor Qualification Training requirements specified for Bachelor's level supervisors.

(1) The individual must have a minimum of 6 months of experience with the current agency or must have provided supervision under the service standard for at least 1 year at a different agency.

(2) All staff who are supervised by a bachelor's level supervisor must have clinical consultation a minimum of quarterly.

(a) This supervision can be provided in a group format.

(b) Supervisors should be present during clinical consultation, as this time can apply towards the minimum staffing requirements required for supervision.

C. Qualifications for SAY Case Manager

1. See Direct Worker Qualifications Above

D. Qualifications for Addictions Services shall mirror the standards from the DCS Residential Substance Abuse Services for the Residential Treatment Services.

1. The program shall be staffed by appropriately credentialed personnel who are trained and competent to implement substance use treatment as outlined by state law.

2. Reference: Indiana Code 25-23.6-10.5 and Article 7.5.

3. The program must be certified and properly designated by The Division of Mental Health and Addictions (DMHA).
  4. The program administrators will maintain their certification and credentialing by DMHA.
  5. Program administrators will ensure the direct service staff is appropriately credentialed at all times as necessary to remain compliant with all ongoing certification requirements.
  6. The vendor shall notify DMHA regarding changes to credentialed staff, as required by DMHA. Notification to DCS regarding any changes to the program's DMHA certification status or adverse action taken against vendor certification shall be sent to ChildWelfarePlan@dcs.IN.gov within 2 business days of the change
- E. Services provided will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions
  - F. Services will be delivered in a neutral-valued culturally-competent manner.
  - G. Providers are to respond to the on-going individual needs of staff by providing them with the appropriate combination of training and supervision.
  - H. The frequency and intensity of training and supervision are to be consistent with "best practices" and comply with the requirements of each provider's accreditation body.
  - I. Supervision should include individual, group, and direct observation modalities and can utilize teleconference technologies.
  - J. Under no circumstances is supervision/consultation to be less than one (1) hour of supervision/consultation per 25 hours of face-to-face direct client services provided, nor occur less than every two (2) weeks.
  - K. Shadowing Criteria
    - a. All agencies must have policies that require regular shadowing (by supervisor) of all staff at established intervals based on staff experience and need.
    - b. Shadowing must be provided in accordance with the policy. The agency must provide clear documentation that shadowing has occurred.

## **VI. Billable Units**

- A. DCS Funding
  1. Those services not deemed medically necessary for the Medicaid eligible client, including services to other referred members of the family that are not related to the behavior health care needs of the eligible client, will be billed to DCS per face-to-face hour as outlined below.

2. These billable units will also be utilized for services to referred clients who are not MRO eligible and for those providers who are unable to bill Medicaid.
  3. Face-To-Face Time with Client
  4. Members of the client family are to be defined in consultation with the family and approved by the DCS.
  5. This may include persons not legally defined as part of the family
  6. Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
  7. Includes crisis intervention and other goal-directed interventions via telephone with the identified client family
  8. Includes Child and Family Team Meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family.
  9. Includes in-vehicle (or in-transport) time with client provided it is identified as goal- directed, face-to-face, and approved/specified as part of the client's intervention plan (e.g. housing/apartment search, etc.).
  10. Travel time is only billable when the client is in the vehicle.
  11. Includes time spent completing any DCS approved standardized tool to assess family functioning.
  12. Not included are routine report writing and scheduling of appointments, collateral contacts, travel time and no shows.
  13. These activities are built into the cost of the face- to-face rate and shall not be billed separately.
- B. Services may be billed in 15 minute increments (unless paid on a per diem); partial units are rounded to the nearest quarter hour using the following guidelines:
1. 0 to 7 minutes – Do not bill (0.00 hour)
  2. 8 to 22 minutes – 1 fifteen minute unit (0.25 hour)
  3. 23 to 37 minutes – 2 fifteen minute units (0.50 hour)
  4. 38 to 52 minutes – 3 fifteen minute units (0.75 hour)
  5. 53 to 60 minutes – 4 fifteen minute units (1.00 hour)
- C. Interpretation, Translation, and Sign Language Services
1. The location of and cost of Interpretation, Translation, and Sign Language Services are the responsibility of the Service Provider.
  2. If the service is needed in the delivery of services referred, DCS will reimburse the Provider for the cost of the Interpretation, Translation, or Sign Language service at the actual cost of the service to the provider.

3. The referral from DCS must include the request for Interpretation services and the agencies' invoice for this service must be provided when billing DCS for the service.
4. Providers can use DCS contracted agencies and request that they be given the DCS contracted rate but this is not required.
5. The Service Provider Agency is free to use an agency or persons of their choosing as long as the service is provided in an accurate and competent manner and billed at a fair market rate.
6. If the agency utilizes their own staff to provide interpretation, they can only bill for the interpretation services. The agency cannot bill for performing two services at one time.

D. Court

1. The provider of this service may be requested to testify in court.
2. A Court Appearance is defined as appearing for a court hearing after receiving a written or email request or subpoena from DCS to appear in court, and can be billed per appearance.
6. If the provider appeared in court two different days, they could bill for 2 court appearances.
  - a) Maximum of 1 court appearance per day.
3. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.

E. Reports

1. If the services provided are not funded by DCS, the 'Reports' hourly rate will be paid

2. DCS will only pay for reports when DCS is not paying for these services
3. A referral for 'Reports' must be issued by DCS in order to bill
  - b) The provider will document the family's progress within the report

## **VII. Medicaid**

- A. For those families and children not eligible for Medicaid Rehabilitation Option, this service will be paid by DCS.
- B. For eligible families and children, some services may be provided through Medicaid Rehabilitation Option (MRO) with the remaining services paid by DCS.
- C. While the primary focus of these services is on the needs of the family, it is expected that some of these services will be deemed medically necessary to meet the behavioral healthcare needs of the MRO eligible client, and therefore may be billable to MRO.
- D. The service standard is not a Medicaid standard and includes services that are not billable to Medicaid.
- E. It is the responsibility of the contracted service provider to be knowledgeable about the Medicaid billing requirements and comply with them.
  1. Including Provider Qualifications
  2. Including Pre-Authorization
  3. Appropriately bill services in cases where they are Medicaid reimbursed
- F. Services not eligible for MRO may be billed to DCS

## **VIII. Case Record Documentation**

- A. Case record documentation for service eligibility must include:
  1. A completed, and dated DCS/ Probation referral form authorizing services
  2. Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for these documents from referral source.
  3. Safety issues and Safety Plan Documentation
  4. Documentation of Termination/Transition/Discharge Plans
  5. Treatment/Service Plan
    - a) Must incorporate DCS Case Plan Goals and Child Safety goals.
    - b) Must use Specific, Measurable, Attainable, Relevant, and Time Sensitive goal language
  6. Monthly reports are due by the 10<sup>th</sup> of each month following the month of service, case documentation shall show when report is sent.
    - a) Provider recommendations to modify the service/ treatment plan
    - b) Discuss overall progress related to treatment plan goals including specific examples to illustrate progress



7. Progress/Case Notes Must Document: Date, Start Time, End Time, Participants, Individual providing service, and location
8. When applicable Progress/Case notes may also include:
  - a) Service/Treatment plan goal addressed (if applicable-
  - b) Description of Intervention/Activity used towards treatment plan goal
  - c) Progress related to treatment plan goal including demonstration of learned skills
  - d) Barriers: lack of progress related to goals
  - e) Clinical impressions regarding diagnosis and or symptoms (if applicable)
  - f) Collaboration with other professionals
  - g) Consultations/Supervision staffing
  - h) Crisis interventions/emergencies
  - i) Attempts of contact with clients, FCMs, foster parents, other professionals, etc.
  - j) Communication with client, significant others, other professionals, school, foster parents, etc.
  - k) Summary of Child and Family Team Meetings, case conferences, staffing
9. Supervision Notes must include:
  - a) Date and time of supervision and individuals present
  - b) Summary of Supervision discussion including presenting issues and guidance given.

#### **IX. Service Access**

- B. All services must be accessed and pre-approved through a referral form from the referring DCS staff.
- C. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required.
- D. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS.
- E. Providers must initiate a re-authorization for services to continue beyond the approved period.

#### **X. Adherence to DCS Practice Model**

- A. Services must be provided according to the Indiana Practice Model, providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect.

- B. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

## **XI. Interpreter, Translation, and Sign Language Services**

- A. All Services provided on behalf of the Department of Child Services must include Interpretation, Translation, or Sign Language for families who are non-English language speakers or who are hearing-impaired.
- B. Interpretation is done by an Interpreter who is fluent in English and the non-English language and is the spoken exchange from one language to another.
- C. Certification of the interpreter is not required; however, the interpreter should have passed a proficiency test in both the spoken and the written language in which they are interpreting.
- D. Interpreters can assist in translating a document for a non-English speaking client on an individual basis, (i.e., An interpreter may be able to explain what a document says to the non-English speaking client).
- E. Sign Language should be done in the language familiar to the family.
- F. These services must be provided by a non-family member of the client, be conducted with respect for the socio-cultural values, life style choices, and complex family interactions of the clients, and be delivered in a neutral-valued culturally-competent manner.
- G. The Interpreters are to be competent in both English and the non-English Language (and dialect) that is being requested and are to refrain from adding or deleting any of the information given or received during an interpretation session.
- H. No side comments or conversations between the Interpreters and the clients should occur.

## **XII. Trauma Informed Care**

- A. Provider must develop a core competency in Trauma Informed Care as defined by the National Center for Trauma Informed Care—SAMHSA (<http://www.samhsa.gov/nctic/>):
  - 1. Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives.
  - 2. NCTIC facilitates the adoption of trauma-informed environments in the delivery of a broad range of services including mental health, substance use, housing, vocational or employment support, domestic violence and victim assistance, and peer support. In all of these environments, NCTIC seeks to change the paradigm from one that asks, "What's wrong with you?" to one that asks, "What has happened to you?"

3. When a human service program takes the step to become trauma-informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma affects the life of an individual seeking services.
  4. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization
- B. Trauma Specific Interventions: (modified from the SAMHSA definition)
1. The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
  2. The provider must demonstrate an understanding, through the services provided, of the interrelation between trauma and symptoms of trauma (e.g., substance abuse, eating disorders, depression, and anxiety)
  3. The provider will work in a collaborative way with child/family, extended family and friends, and other human services agencies in a manner that will empower child/family.

### **XIII. Training**

- A. Service provider employees are required to complete general training competencies at various levels.
- B. Levels are labeled in Modules (I-IV), and requirements for each employee are based on the employee's level of work with DCS clients.
- C. Training requirements, documents, and resources are outlined at:
  1. Review the **Resource Guide for Training Requirements** to understand Training Modules, expectations, and Agency responsibility.
  2. Review **Training Competencies, Curricula, and Resources** to learn more about the training topics.
  3. Review the **Training Requirement Checklist** and **Shadowing Checklist** for expectations within each module.

### **XIV. Cultural and Religious Competence**

- A. Provider must respect the culture of the children and families with which it provides services.
- B. All staff persons who come in contact with the family must be aware of and sensitive to the child's cultural, ethnic, and linguistic differences.
- C. All staff also must be aware of and sensitive to the sexual and/or gender orientation of the child, including lesbian, gay, bisexual, transgender or questioning children/youth.

1. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook.
  2. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth.
  3. The guidebook can be found at:  
<http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf>
- D. Efforts must be made to employ or have access to staff and/or volunteers who are representative of the community served in order to minimize any barriers that may exist.
- E. Contractor must have a plan for developing and maintaining the cultural competence of their programs, including the recruitment, development, and training of staff, volunteers, and others as appropriate to the program or service type; treatment approaches and models; and the use of appropriate community resources and informal networks that support cultural connections.

## **XV. Child Safety**

- A. Services must be provided in accordance with the Principles of Child Welfare Services.
- B. All services (even individual services) are provided through the lens of child safety.
  1. As part of service provision, it is the responsibility of the service provider to understand the child safety concerns and protective factors that exist within the family.
  2. Continual assessment of child safety and communication with the Local DCS Office is required. It is the responsibility of the service provider to report any safety concerns, per state statute, IC 31-33-5-1.
- C. All service plans should include goals that address issues of child safety and the family's protective factors. The monthly reports must outline progress towards goals identified in the service plans.