

**SERVICE STANDARD**  
**INDIANA DEPARTMENT OF CHILD SERVICES**  
**SUPERVISED PARENTING TIME**

**I. Service Description**

- A. Parenting or Family Time is the fundamental right of parents and children.
- B. Supervised Parenting Time is not an elective service and should never be used as reward or punishment.
  - 1. Parenting Time is essential for child well-being and frequent family time correlates with successful reunification of families.
- C. Supervised Parenting Time may be provided for adults and their children who have been separated due to substantiated allegation of abuse or neglect, or involvement in juvenile probation.
  - 1. This could also include sibling visitations, or any court ordered participants.
- D. Under this Standard, provider will monitor and supervise visits between parents and their children, to ensure child safety and encourage the ongoing attachment between the parent and the child.
- E. The provider is responsible for coordinating, scheduling, as well as ensuring the integrity of the supervised parenting time.
- F. Provider will work with the referring worker, and with the Child and Family Team (CFT) to develop a Visitation Plan that includes considerations for transportation needs of the parents and child's current caregivers.
- G. The provider will monitor and supervise throughout the visit, intervening, if necessary, to ensure child safety and well-being, as well as coaching and modeling nurturing parenting approaches.
- H. Supervised Parenting Time should take place in the most home-like setting as possible, based on the nature of family involvement, current safety level assessment, children's and caregivers' needs, and identified permanency goals.
- I. The level of supervision and ongoing goals of parenting time will be determined and adjusted through the Visitation Plan as developed by the CFT.
- J. CFT should also determine the most appropriate location of family time, with input from the provider.
- K. The goal of Supervised Parenting Time is to support parent/child bond, while promoting timely reunification.
  - 1. With that in mind, the duration and frequency of Parenting Time should gradually increase, while the level of supervision should decrease until successful reunification can occur.

## II. Service Delivery

- A. It is important for both the child(ren) and parents that the initial visit takes place as soon as possible after removal.
  - 1. DCS Policy requires the initial visit to take place within 48 hours from removal.
  - 2. At the time the referral is received, the initial supervised parenting time visit after removal should have already occurred, supervised by local DCS staff or another individual, approved by DCS.
  - 3. Provider will ensure that the next visit occurs within 5 days of acceptance of referral, or sooner, depending on the established schedule or court orders.
- B. The provider will initiate coordinating of Supervised Parenting Time upon acceptance of a referral from the Department of Child Services.
  - 1. Based on the directions included in the referral, applicable court orders and availability of all parties, the provider will schedule the first visit.
- C. Provider will collaborate with the CFT to develop a thorough Visitation Plan that specifies the most appropriate location of visits, provides frequency and duration of Parenting Time that fosters ongoing parent-child attachment and well-being, considering the age(s) of the child(ren), needs and availability of the provider, parents, children and their current caregivers.
- D. With the Child and Family Team, provider will also ensure that transportation needs are considered and built into the [Visitation Plan \(see Policy 8.13\)](#)
- E. Transportation ([per DCS policy](#))
  - 1. The FCM should engage the CFT to help resolve any transportation issues that make parent-child visits difficult.
  - 2. Sources of transportation may include the child's relatives, family friends, faith-based transportation services, etc.
  - 3. If alternative transportation cannot be acquired and the cost of paid transportation would cause the child's family undue hardship, DCS will pay for the most cost-efficient means of local transportation.
- F. Safety should be the primary consideration for all Supervised Parenting Time episodes.
  - 1. The provider will continually assess and monitor the child(ren)'s safety, regardless of the type of visit referral.
  - 2. Any observed safety threats must be addressed immediately through direct intervention or redirection.
    - a) The concerns MUST also be immediately reported to the DCS Local Office, preferably by calling the Family Case Manager (FCM) or Family Case Manager Supervisor (FCMS).

- b) If unable to be reached, email can be sent to the FCM and FCMS. Observed safety threats noted, must also be detailed in visit narrative.
  - c) If the immediate safety threat cannot be resolved (for example, the parent is significantly impaired during visit) or it constitutes an emergency, the specific supervised visit shall be terminated and DCS Family Case Manager must be contacted for further guidance regarding current Visitation Plan.
- G. Supervised Parenting Time can only be suspended through a court order.
- H. If the provider also transports the child or children, as part of the Supervised Parenting Time referred services:
  - 1. The provider is responsible for ensuring the children are transported in proper child passenger restraints, in accordance with current state law and best practice recommendations.
  - 2. The provider will ensure that proper child restraint (car seat) is available at the time of transport.
  - 3. The provider agency is responsible to ensure staff member transporting children adequately trained in child passenger safety regulations and proper child restraint (car seat) installation, as well as proper fit to ensure safe travel.
  - 4. Please see DCS Provider Training Requirements, Module IV, Staff Who Transport Clients: <https://www.in.gov/dcs/service-standards/dcs-service-provider-training-requirements/>
- I. Levels of Supervision (all supervised parenting time will be referred under one of the following levels)
  - 1. Standard Supervision
    - a) There are no significant safety threats regarding the nature of the parent-child relationship or attachment.
    - b) There is a need for continuous monitoring, modeling of nurturing parenting practices, with occasional redirection, or intervention if necessary.
    - c) The provider will ensure child safety and protect the integrity of the visit, as well as documenting the details of Supervised Parenting Time.

2. Enhanced Supervision

- a) There is a need for ongoing intervention and structured parenting instruction throughout a significant portion of the total parenting time.
  - (1) This could include children with complex medical needs.
- b) Providers are strongly encouraged to select and consistently utilize an evidence-based practice or parenting curriculum to instruct and coach the parent/caregiver in nurturing parenting practices that promote positive attachment and overall well-being of the child(ren).
- c) Evidence based practices or curricula used must be appropriate for the age, developmental stage of the child/ren and the abilities of the parents.
  - (1) These interventions and/or education must be documented in the visit report.
- d) If an evidence-based practice is utilized during this level of Supervised Parenting Time, it must be relevant to parenting and family functioning in the child welfare setting.
  - (1) Some examples of common EBPs that might be appropriate to utilize for this purpose are:
    - (a) Motivational Interviewing
    - (b) Nurturing Parenting
    - (c) Positive Parenting Practices (Triple P)
    - (d) Safe Care
    - (e) Parents as Teachers Trust Based Relational Intervention (TBRI)
    - (f) This is NOT an exhaustive list, other models can be used
      - (i) There are other structured coaching and parenting models that might be appropriate, however, have not been rated or fully evaluated yet (Visit Coaching is an example)
      - (ii) To obtain approval to utilize a model that is not rated as an EBP, please email [childwelfareplan@dcs.in.gov](mailto:childwelfareplan@dcs.in.gov)
- e) Regardless of the model utilized, providers must follow best practice strategies and approaches.

- (1) The Child Welfare Information Gateway outlines key program characteristics and parent training strategies.
- f) The key program characteristics include the following:
  - (1) strength-based focus
  - (2) family centered practice
  - (3) individual and group approaches
  - (4) qualified staff
  - (5) targeted service groups
  - (6) and clear program goals and continuous evaluation.
- g) Parent Training Strategies include the following:
  - (1) encourage peer support
  - (2) involve fathers
  - (3) promote positive family interaction
  - (4) use interactive training techniques
  - (5) provide opportunities to practice new skills.

### 3. Therapeutic Supervision

- a) A trained clinician facilitates this type of supervised Parenting Time for vulnerable children and their families.
  - (1) Skilled clinician will assist the visiting parents in better understanding the physical and emotional needs of their child through skill building, psychoeducation, as well as clinical consultations before or debriefing sessions after the visit time.
  - (2) If a clinician is already working with any of the participants, they should be considered first and foremost to provide this service.
    - (a) If there are other clinicians working with the referred family members, the clinician facilitating the visitations must communicate with those parties.
- b) Visits at this level is best for families who require primarily therapeutic interventions to have safe and meaningful interactions.

- (1) This level of service should be based on clinical needs
- c) Therapeutic supervision might be indicated for:
  - (1) Parents who cannot have unsupervised access to their children due to history of severe abuse or neglect where the parent-child relationship has been significantly negatively affected
  - (2) Parents who do not have an established relationship with their child(ren) due to prior absence
- d) Standard supervision or enhanced supervision-level may also be considered to supplement the therapeutic supervision, depending on the total number of hours of supervised parenting time that is indicated weekly for a specific family.

#### J. Supervised Parenting Time Preparation

- 1. Upon receipt of a valid, complete referral from the Department of Child Services, the provider will:
  - a) Review the referral for specific instructions regarding necessary monitoring details and potential safety concerns as well as to determine the appropriate and safe visit location.
  - b) Provider will then consult with the referring worker, regarding other specific circumstances, such as transportation and scheduling needs of all parties.
- 2. The provider shall then schedule a family time preparation session with the referred (parents) to be conducted prior to the initial family visit.
  - a) During the session, the provider will obtain as much information as possible about the child(ren), their needs and preferences.
  - b) This session should also focus on
    - (1) discussing the goals of family time
    - (2) setting realistic expectations
    - (3) suggesting positive parenting strategies
    - (4) structuring the upcoming visit
      - (a) meal planning
      - (b) additional visitors
      - (c) transitional objects, etc.
  - c) In instances where the child has been in resource care for more than three weeks, work with the Family Case Manager to include the resource parent in this portion of preparation.
    - (1) Resource Parent information may be included in the other pertinent information in the referral, or you may reach out to the FCM to determine if this step is applicable.

K. Visitation and Progression Plans

1. Within a week of receiving the referral, the provider should become actively involved in collaboration with the Child and Family Team to develop a thorough Visitation Plan.
  - a) Provider should remain involved in adjusting the plan as the permanency goals progress.
2. Visitation plans should be progressive toward an end goal of the parent's ability to independently supervise children without the intervention of a third party.
3. With the goal of gradually increasing the duration and frequency of parenting time, while reducing the level of supervision, the following stages of supervision levels should be considered in terms of “progression plan” over the course of Supervised Parenting Time referral:

<b>SUPERVISION LEVEL:</b>	<b>Full Supervision</b>	<b>Intermittent/Low Supervision</b>	<b>Unsupervised time</b>
DESCRIPTION	The provider monitoring the family will always remain in the presence of the child/ren and with ability to hear all conversations between parent and child.	The provider will only be present for a portion of the visit. The family will have some time alone, away from the facilitator.	Parent(s) can be alone with the child. No supervisor is present during the visit. This could be a day or overnight visit.
SAFETY ASSESSMENT:	High level of concern assessed for the safety of the child during a visit	Low level of concern assessed for the child safety. Continued need for parental coaching and skill-building. Typically takes place immediately prior to fully unsupervised time and is a <b>time-limited</b> part of the overall transition plan, approved by the Child and Family Team and leading towards reunification.	Typically takes place immediately prior to reunification, when no safety concerns are determined to exist preventing the parent to spend time alone with their child. Additional safety planning guidelines might be in place.
LOCATION CONSIDERATIONS	Most restrictive locations are typically considered at the initial stages, such as DCS or provider agency office. If deemed safe, community settings or parent’s home should also be considered.	Less restrictive settings, such as community outings, special events, kinship placement or parent’s home may be selected	Typically, the least restrictive setting, such as parent’s home or kinship placement home will be selected as location.

L. Virtual Supervised Parenting Time

1. Under some circumstances, it could be determined that in-person supervised parenting time is not indicated.
  - a) It could be due to public health considerations or distance from the parent's home (another state or significant drive time).
  - b) Virtual Supervised Parenting Time can also be used to supplement in person supervised visits
  - c) It may also be the best form of supervised parenting time for incarcerated parents when other options are not practical or available.
  - d) In such instances, virtual supervised parenting time can be used to ensure continued contact and continued attachment between parent and child.
2. Virtual Supervised Parenting Time requires thorough preparation and additional considerations made to ensure the time is beneficial and appropriate for the age and development of the child.
  - a) These visits will typically be shorter in duration and meaningful activities should be planned to engage the child in a positive way.
3. Approval of virtual supervised parenting time must be provided by the Child and Family Team, or a court order.
4. Additional guidance on managing virtual parenting time can be found on this page:

<https://www.childwelfare.gov/topics/management/workforce/virtualpractice/>

M. Reporting

1. It is essential that the reporting narrative is thorough so that the reader can get a clear picture of what occurred during the parenting time session.
  - a) The narrative needs to also be descriptive enough to help determine adjustments to Visitation Plan and monitor progression towards reunification.



2. At each visit, the provider will accurately document the following:
  - a) Whether or not the visit occurred
    - (1) Justification for why a visit did not occur, as applicable
  - b) The name of the staff member facilitating the visit
  - c) Date, time, and location of the visit
    - (1) This should include specific start and end times
    - (2) Be specific regarding transportation, including travel start and end times (please refer to billable units section)
  - d) Participants in attendance at the visit
    - (1) Include mention of referred or expected participants who did not attend
  - e) Level of visitation utilized
    - (1) Include EBP as applicable
  - f) Greeting and departure interactions between parent/caregiver and child
  - g) Preparedness of the parent
    - (1) Directly related to discussions and agreements made during the prep meeting
  - h) Positive interactions between the parent(s) and child(ren)
  - i) Interventions required by provider
    - (1) Detail any occurrence and include how the parent responded to intervention
  - j) Observations of the parent(s) ability to meet the child(ren)s needs throughout the entirety of the visit
  - k) Other pertinent information, issues, or concerns related to the visit
3. [The individual visitation report](#) must be completed and sent to the DCS case manager within 72 hours of the completion of the visitation, or immediately by phone or email followed by an individual visitation report if inappropriate behavior occurs. Cancellation and no shows should be reported to the FCM as soon as possible.

### **III. Target Population**

- A. Service must be restricted to the following eligibility categories:
  1. Children and families who have substantiated cases of abuse and/or neglect and have been formally separated due to removal
  2. Children and their families where 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

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

- A. Goal #1: Ensure that all children removed from their parents have the opportunity to visit their parents/siblings on a regular basis.
  - 1. Outcome Measure 2: 100% of the families referred will have visitation set up and occurring with the frequency and duration requested by DCS/Probation within 5 business days of acceptance of the referral.
- B. Goal #2: Strengthen and increase the parent's ability to provide for the emotional and physical needs as well as the safety of their children
  - 1. Outcome Measure 1: 85% of parents served will demonstrate an increased ability to recognize and respond appropriately to their children's cues by case closure.
  - 2. Outcome Measure 2: 85% of the parents will actively reinforce positive behavior and address negative behavior.
  - 3. Outcome Measure 3: 90% of parents will arrive with previously requested items by the visit facilitator for the children such as diapers, food, etc., and be prepared to provide a meal or snack if expected.
- C. Goal #3: Provide accurate and timely information in the child's case so that informed decisions may be made regarding reunification and permanency for the child.
  - 1. Outcome Measure 1: 98% of visitation reports will be received by DCS/Probation within 3 business days of the visitation or immediately (by phone or email) when inappropriate behavior occurs, followed by an individual visitation report. a) Written reports will be completed on the DCS approved visitation report forms.
  - 2. Outcome Measure 2: 94% of the families referred will have completed visitation facilitation services will rate the services "satisfactory" or above on a satisfaction survey developed by the service provide, unless DCS/Probation distributes one to providers for their use with clients. a) Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in the larger number) randomly selected from each county served).

## V. Minimum Qualifications

- A. Standard Supervision Direct Worker
  - 1. High School Diploma or equivalent
  - 2. Must be at least 21 years of age
  - 3. Must possess a valid driver's license
    - a) Must have the ability to use a private vehicle to transport self and others
    - b) Must comply with the state policy regarding minimum auto insurance coverage
  - 4. Providers are encouraged to hire staff who have shared life experience and are familiar with the communities they serve
- B. Standard Supervision Supervisor
  - 1. Supervisors must meet the requirements of the Direct Worker as stated in Section A
  - 2. Supervisors who possess a High School Diploma or equivalent, or who have an Associate's degree:
    - (1) Must have at least 6 years of full-time employment providing direct services to children and families
      - (a) This experience must include providing services to families that need assistance in the protection and care of their children
  - 3. Supervisors who possess a Bachelor's or Master's Degree from an accredited university:
    - (1) Must have at least 2 years of full-time employment experience providing direct services to children and families
      - (a) This experience must include providing services to families that need assistance in the protection and care of their children
  - 4. Individual Supervision
    - a) Supervision regarding each referred family must occur at least every two weeks
  - 5. Supervisor Shadowing
    - a) Providers must have policies that require regular shadowing of staff at established intervals based on staff experience and need
    - b) Provider must provide clear documentation in employee personnel file that the shadowing occurred
- C. Enhanced Supervision Direct Worker
  - 1. Must possess one of the following:
    - a) Bachelor's or Master's Degree from an accredited university

- b) High School Diploma or equivalent, or Associate's Degree
          - (1) This employee must also have at least 4 years full time employment experience providing direct service to children and families
            - (a) Experience must include service to families that need assistance in the protection and care of their children
  - 2. Worker must be trained and competent to complete the services as required by federal and State of Indiana law
  - 3. Worker must be credentialed according to the requirements of the evidence-based model(s) used
  - 4. Worker must carry appropriate caseloads
    - a) Caseloads shall never be greater than 12 active cases (cases that are seen at least weekly, are considered active), even if the EBP is not restrictive
  - 5. Worker must possess a valid driver's license
    - a) Must have the ability to use a private car to transport self and others
    - b) Must comply with the state policy regarding minimum auto insurance coverage
  - 6. Providers are encouraged to hire direct workers who have shared life experience and are familiar with the communities they serve
- D. Enhanced Supervision Supervisor
  - 1. Supervisors must meet the requirements of the Direct Worker as stated in Section A
  - 2. Supervisors who possess a High School Diploma or equivalent, or who have an Associate's degree:
    - (1) Must have at least 6 years of full-time employment providing direct services to children and families
      - (a) This experience must include providing services to families that need assistance in the protection and care of their children
  - 3. Supervisors who possess a Bachelor's or Master's Degree from an accredited university:
    - (1) Must have at least 2 years of full-time employment experience providing direct services to children and families
      - (a) This experience must include providing services to families that need assistance in the protection and care of their children

4. Individual Supervision
    - a) Supervision regarding each referred family must occur at least every two weeks
  5. Supervisor Shadowing
    - a) Providers must have policies that require regular shadowing of staff at established intervals based on staff experience and need
    - b) Provider must provide clear documentation in employee personnel file that the shadowing occurred
- E. Therapeutic Supervision Direct Worker
1. Direct workers under this standard must meet one of the following minimum qualifications:
    - a) Master's or Doctorate degree with a current license issued by the Indiana Behavioral Health and Human Services Licensing Board as one of the following:
      - (1) Social Worker
      - (2) Clinical Social Worker
      - (3) Marriage and Family Therapist
      - (4) Mental Health Counselor
      - (5) Marriage and Family Therapist Associate
      - (6) Mental Health Counselor Associate.
    - b) Master's degree with a temporary permit issued by the Indiana Behavioral Health and Human Services Licensing Board as one of the following:
      - (1) Social Worker
      - (2) Clinical Social Worker
      - (3) Marriage and Family Therapist
      - (4) Mental Health Counselor
    - c) Master's degree in a related human service field and employed by an organization that is nationally accredited by the Joint Commission, Council on Accreditation or the Commission on Accreditation of Rehabilitation Facilities
      - (1) That individual must also
        - (a) Complete a minimum of 24 post-secondary semester hours or 36 quarter hours in the following coursework:
          - (i) Human Growth & Development
          - (ii) Social & Cultural Foundations
          - (iii) Group Dynamics, Processes, Counseling and Consultation
          - (iv) Lifestyle and Career Development

- (v) Sexuality
  - (vi) Gender and Sexual Orientation
  - (vii) Issues of Ethnicity, Race, Status & Culture
  - (viii) Therapy Techniques
  - (ix) Family Development & Family Therapy
  - (x) Clinical/Psychiatric Social Work
  - (xi) Group Therapy
  - (xii) Psychotherapy
  - (xiii) Counseling Theory & Practice
- (b) Individual must complete the Human Service Related Degree Course Worksheet.
- (i) For auditing purposes, the worksheet should be completed and placed in the individual's personnel file.
  - (ii) Transcripts must be attached to the worksheet.
- (c) Must possess a valid driver's license
- (i) Must have the ability to use a private car to transport self and others
  - (ii) Must comply with the state policy concerning minimum car insurance coverage
- (d) In addition to the above:
- (i) Knowledge of family of origin/intergenerational issues
  - (ii) Knowledge of child abuse/neglect
  - (iii) Knowledge of child and adult development
  - (iv) Knowledge of community resources
  - (v) Ability to work as a team member
- (e) Belief in helping clients change, to increase the level of functioning, and knowledge of strength-based initiatives to bring about change
- (i) Belief in the family preservation philosophy
  - (ii) Knowledge of motivational interviewing
  - (iii) Skillful in the use of Cognitive Behavioral Therapy
  - (iv) Skillful in the use of evidence-based strategies

- F. Therapeutic Level Supervisor
  - 1. Master's or Doctorate degree in social work, psychology, marriage and family, or related human service field, with a current license issued by the Indiana Behavioral Health and Human Services Licensing Board as one of the following:
    - a) Clinical Social Worker
    - b) Marriage and Family Therapist
    - c) Mental Health Counselor

**VI. Billable Units**

- A. DCS Funding
  - 1. Members of the client family are to be defined in consultation with the family and approved by DCS
    - a) This may include persons not legally defined as part of the family
- B. Visit Supervision
  - 1. Includes client specific face-to-face (in person) contact with the identified client/family during which supervision services as defined in the applicable Service Standard are performed, unless otherwise approved by the CFT and/or local office, or court order for virtual interventions based on the needs of the family.
  - 2. The visit supervision preparation shall be billed at no more than 1 hour, preferably prior to visitation starting, but is allowable within 7 days of the visits starting.
  - 3. 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.
  - 4. Provider meetings initiated by the FCM for the purpose of goal directed communication regarding the client family.
  - 5. Visits that are approved by the CFT, local office or court ordered to be conducted virtually as outlined above
    - a) Must be billed using the virtual visitation billable unit

C. Intermittent Visit Supervision

1. Includes specific face to face (in person) supervision services performed at the identified Intermittent supervision level (see Service Delivery section above).
2. Intermittent visitation may be billed for the entire length of the visitation (start to stop time)
  - a) With a minimum of one drop in every hour beginning at the start time.
  - b) If the drop in is not completed every hour of the interment visitation time span, half of the total visitation time frame may be billed.
  - c) This minimum may be adjusted upon court order or written communication from the CFT or local office.
3. Transportation for intermittent supervised parenting time will be billed under the Transportation billable unit

D. Transportation

1. Includes in-vehicle (or in-transport) time with the client present, with the goal of providing parenting time between the client and the caregivers.
2. This should be identified in the Visitation Plan.
3. Travel time is only billable when the client is in the vehicle.
4. Billing of transportation for this purpose shall be billed under the transportation billable unit.

E. 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.

F. 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.
3. If the provider appeared in court two different days, they could bill for 2 court appearances.
  - a) *Maximum of 1 court appearance per day.*
4. 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.

G. 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
  - a) The provider will document the family's progress within the report

## VII. 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.
- B. Comprehensive and FCT have REPORTING instead of Case Record Documentation

### **VIII. Service Access**

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

**IX. 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.

**X. 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.

## **XI. 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.

## **XII. 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:  
<http://www.in.gov/dcs/3493.htm>
  - 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.

### **XIII. 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.

### **XIV. 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.