

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
COMMUNITY PARTNERS FOR CHILD SAFETY
Effective 7/1/2019

I. Community Partners for Child Safety Description

Community Partners for Child Safety (CPCS) provides child abuse and neglect prevention services in every region in the state. CPCS collaborates with other community resources within each region to create a coordinated prevention network. Families will be able to access prevention services through self-referral or referral from another community agency. Participation in services is voluntary. CPCS also provides Community Liaisons for direct services to connect families to resources to strengthen the family unit and prevent child abuse and neglect.

Contracted CPCS agencies work with the DCS Regional Services Council to identify needs within the region and the community resources available. These resources could include, but are not limited to: local DCS offices, hospitals, faith-based organizations, schools, First Steps, Head Start, and Healthy Families Indiana. In general, each region and community defines its own needs and resources as updated through the DCS Biennial Regional Services Strategic Plans or other needs assessment strategies.

II. Service Delivery Requirements

- Project Manager:
 - Develop partnerships with community agencies
 - Oversee the implementation of services
 - Ensure the fidelity of evidence based practices used by the agency
- Community Liaison:
 - Assess families entering the program
 - Provide direct, home-based services
 - Refer families to community resources
 - Provide on-call crisis intervention
- Parent Partner
 - Lead peer group meetings
 - Act as a spokesperson for the program/agency
 - Mentor other families in CPCS
 - Participate in governance of the program
 - Facilitate community family activities

Assessments

Providers will use the North Carolina Family Assessment Scale (NCFAS) for assessing families and measuring growth over time. The NCFAS will be completed at intake, at termination after a family has engaged in at least four (4) but not more than eight (8) face-to-face contacts, or after the family has engaged in its eighth face-to-face contact. In addition to the NCFAS, providers will also utilize a substance use screening tool to be used

DCS will offer the required trainings on the NCFAS as requested.

Within the first 20 days of the family agreeing to services, an assessment must be completed, with the family and input of other team members, to determine the family's needs.

1. The provider should include the following domains in the assessment in addition to the NCFAS:
 - (1) Housing history and current arrangement
 - (2) Criminal history
 - (3) Substance Use Screening Tool
 - (a) For example, UNCOPE or CAGE
 - (b) National Center on Substance Use and Child Welfare
<https://ncsacw.samhsa.gov/resources/daily-practice-client.aspx>
 - (4) Trauma Domain
 - (a) Parental history of childhood trauma (ACEs)
 - (b) Child history of trauma
 - (c) How trauma has impacted life functioning
 - (d) Prior child welfare involvement
2. The NCFAS and additional assessment items shall guide the recommendations for treatment and/or services.
3. Recommendations regarding the family's needs including service needs, risks, and goals should be included in the treatment/service plan.
4. A copy of the assessments must be retained in the service provider's case file for the client.

Evidence Based Practices (EBP)

CPCS agencies must use a practice model that rests along a continuum of evidence informed to evidence based when providing direct services for families, and 50% of all direct services provided must be rated as an evidence based practice (supported or well supported). For community based child abuse prevention programs, evidence-based practice (EBP) is defined as the integration of the best available research with child abuse prevention program expertise within the context of the child, family, and community characteristics, culture, and preferences. These approaches to prevention are validated by some form of documented scientific evidence. An evidence based practice model must have four pieces to be included¹:

1. A book or manual that describes administration;
2. Meet requirements for inclusion in the topic area;
3. Outcomes of research studies must be published in a peer-reviewed journal;
4. Outcome measures are reliable/valid.

Evidence based practices eligible to be used by CPCS agencies can be found at the California Evidence-Based Clearinghouse for Child Welfare (www.cebc4cw.org) and FRIENDS (<https://friendsnrc.org/evidence-based-practice-in-cbcap>) websites.

Direct Service Component:

- All services are voluntary.
- Community Liaisons must meet the evidence based model requirements to provide EBP services to the family.

¹ Material/Image/Information obtained from the California Evidence-Based Clearinghouse for Child Welfare (CEBC) at www.cebc4cw.org.

- With the assistance of the Community Liaisons, families must develop a family service plan:
 - Families must identify at least one (1), but no more than three (3) goals;
 - Plan must be solution focused;
 - A family meeting may be developed in which all persons chosen by the family should attend to plan and develop the goal(s) and service plan.
- Ten (10) days after achieving all goals, new goals should be added for the family or the family should be discharged.
- Staff must be available on call for crisis intervention and referral, if needed.
- Short term counseling may be provided.
 - Individuals providing counseling services must meet the minimum qualifications and supervision expectations as outlined in the DCS Community Based (Intervention) service standard for Counseling.

Community Component:

- Participate in the local DCS Regional Services Council meetings.
- CPCS agencies will collaborate with other local agencies to develop a network of community resources that will support families.
- Participate in community events and outreach to build new relationships and support local prevention efforts such as
 - Developing contacts and partnering with local community agencies, including schools, police and fire departments, hospitals, local government, existing providers that offer child and family services, other prevention providers;
 - Establishing a presence within the community;
- Create opportunities to build a volunteer pool, specifically parents served by the CPCS program(s) previously.
- Develop opportunities for additional funding and financial support.
- The Kids First Trust Fund provides funds for the Community Partners for Child Safety program. KFTF Board requests that CPCS providers:
 - Promote the purchase of Kids First license plates;
 - Promote direct donations to the Kids First Trust Fund;
 - Utilize the Communication kit provided by the KFTF Board;

The donation portal and communication kit can be found at <https://www.in.gov/dcs/2456.htm>

Subcontracting Component:

- A percentage of funding (not more than 30% of the Region's allocation) may be utilized for other prevention services.
 - This funding will be allocated to be subcontracted for services that meet the prevention priority needs identified by the Regional Services Council.
 - Regional Services Councils may reduce the percentage for other prevention services and allocate additional funds to CPCS services. However, Regional Services Councils may not increase above 30% for other prevention services.
 - CPCS agencies may submit a proposal to the Regional Services Council to utilize funding for a program operated within its agency that focuses on prevention services that falls outside the Direct Service and Community components listed above.
- CPCS agencies will issue Requests for Proposals to identify services that meet regional prevention priority needs. The CPCS agency will select provider(s) to meet the stated need based on the RFP process and with approval from the Regional Services Council.

- CPCS agencies will provide quarterly reports on outcomes to the Regional Services Council.
- CPCS agencies will administer the prevention funds for the region and by doing so may collect up to 7.5% of the subcontracted amount in administration fees.

NOTE: The Community Partner for Child Safety agency is responsible for selecting subcontractors to provide prevention services, for monitoring services provided by the subcontractors, and ensuring the subcontractors are in compliance with all DCS contractual terms and conditions.

III. Target Population

A. Services must be restricted to the following eligibility categories:

- 1) Children and families for whom DCS does not currently have an open, on-going case.
 - a. Special permission can be given by the DCS Prevention staff to provide CPCS services to a family with an open, on-going DCS case. Requests should be sent to the DCS Prevention staff detailing why these services are in the best interest of the family.
 - i. CPCS must inform any family that has an open DCS assessment upon entering CPCS services that CPCS services may end if DCS opens a case. See special permission above.
 - b. Older youth, who are participating in Collaborative Care and have children not involved in a DCS case, may be eligible for CPCS services.
- 2) Families that have been referred by a community resource or who self-referred due to a determination that, with timely, effective, and appropriate prevention support services, family functioning can be improved and child abuse and neglect prevented.
- 3) Families that do **not** meet the criteria for Healthy Families Indiana participation, or if the local Healthy Families Indiana site is at capacity. Special permission must be given by the DCS Prevention staff to provide CPCS services to a family also being served by Healthy Families Indiana and services must be delivered in a coordinated manner to prevent duplication.
- 4) If the Juvenile Probation Department has an open case on a child, and that child is placed outside of the home, the family can receive CPCS services if there are other children still in the home.

Note: Community Partners for Child Safety services shall not be used as a substitute for other DCS funded Community Based or Concrete Services available to open DCS and Juvenile Probation cases.

B. For purposes of evaluation, upon completion of services people/families will be classified in one of three categories of services:

- 1) Information and referral (I&R)
 - a. A referred family that requests only to speak with the agency in order to get their questions answered or for a referral to another community service shall be documented as I&R.
- 2) Short Term. (7 or fewer face-to-face contacts)
- 3) Long Term with services ending within 180 days. (8 or more face-to-face contacts)

Note: Any family served more than 180 days must be reviewed with DCS Prevention staff to determine if voluntary services should continue.

IV. Goals

Goal #1 - Prevent families from entering the DCS child abuse and neglect system by improving family functioning.

1. 90% of referred families will receive information about Community Partners within five (5) business days of referral.
2. 90% of families accepting services will have a minimum of short term service that consists of at least one referral to a community partner and/or community resource.
3. 50% of referrals to CPCS will engage in Direct Services
 - a. Direct Services are defined as having a face-to-face contact, a signed family consent form, a completed initial assessment, and at least one identified goal.
4. 95% of the families participating in Direct Services will have a service plan that identifies at least one (1) but not more than three (3) goals.
5. 90% of families with eight (8) or more face-to-face contacts will have a second assessment of family functioning with the North Carolina Family Assessment Scale – General (NCFAS) due at the 8th face-to-face contact
 - a. If the family terminates prior to the 8th face-to-face contact, but has at least four (4) face-to-face contacts, CPCS staff will complete the second administration of the NCFAS.
 - b. 75% of families with eight (8) or more face-to-face contacts will demonstrate improvement in family functioning as measured by the NCFAS.
6. 90% of families will accomplish at least one goal as identified in the family service plan.
7. 95% of families with eight (8) or more face-to-face contacts will not have a substantiated child abuse or neglect assessment within twelve (12) months after discharge from CPCS services.

Goal #2 – Ensure family and community satisfaction with services

1. DCS Regional Services Council will rate services as satisfactory.
2. 90% of families who have participated in prevention activities will rate the services as “satisfactory” or above using an annual client satisfaction survey. Providers are to survey a minimum of 12 clients or 20% of clients served (whichever results in a larger number) randomly selected from each county served. Clients should be contacted to complete the survey within 2 months of ending services.

Note: DCS is developing a satisfaction survey to be accessible in the DCS Prevention database.

Data Collection

1. CPCS agencies must enter all direct service client data and service data into the DCS approved database system. At minimum, CPCS agencies will be expected to gather the following information:
 - Date of referral
 - Date of consent
 - Date of assessment & assessment data

- Date(s) of face-to-face contact(s)
- Evidence Based Practices used
- Family goal(s)
- Date of goal completion
- Termination date and reason

Note: Due to evolving standards and requirements, expectations for data collection may change.

2. All data must be entered into the database within five (5) business days after the event has occurred. Data may include, but is not limited to case notes, assessments, and goal progress.
3. DCS will monitor participants who receive services for more than six (6) months within a rolling 12 month year, measuring from first to last contact and quality of service.

Quality Assurance

1. DCS staff may conduct site visits and case file reviews as a means of ensuring quality service provision.

V. Qualifications

Minimum Qualifications:

1. Project Managers
 - Masters’ Degree in Social Work or a related human services field and two (2) years of relevant experience, or
 - Bachelors’ Degree in Social Work or a related human services field and five (5) years of relevant experience

2. Community Liaisons

Direct workers under this standard must meet one of the following minimum qualifications:

a) Bachelor’s degree in Psychology or Sociology, or licensed Bachelor Degree Social Worker or licensed Social Worker with a Baccalaureate Degree

(1) A license is required unless a statutory licensure exemption in IC 25-23.6-4-2(a) is met.

b) Master’s degree in Psychology, Sociology, Social Work;

c) Bachelor’s or Master’s degree in a directly related human services field in which the individual must also:

(1) Complete a minimum of 39 semester/58 quarter hours in the following coursework:

(a) Human Growth and Development	(l) Physical and Behavioral Health
(b) Social and Cultural Foundations	(m) Family Relationships
(c) Lifestyle and Career Development	(n) Advocacy and Mediation
(d) Sexuality	(o) Case Management
(e) Gender and Sexual Orientation	(p) Resources and Systems
(f) Ethnicity, Race, Status, and Culture	(q) Social Policy
(g) Psychology	(r) Community Planning and Relations
(h) Sociology	(s) Crisis Intervention
(i) Social Work	(t) Substance Use

(j) Criminology (k) Ethics and Philosophy	(u) Counseling and Guidance (v) Educational Studies
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- (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.
- (c) Coursework must be completed at a satisfactory level, no less than a C- for any quarter or semester grade in applicable coursework listed above.
- (3) Other non-Human Service related Bachelor's degrees will be accepted in combination with a minimum of two years' experience providing a service to families that need assistance in the protection and care of their children and/or providing skills training, development, and habilitation.

- d) Associate's Degree in a related human services field and three (3) years working directly with families in a human services field, OR
- e) High School Diploma or equivalent and five (5) years working directly with families in a human services field.

Note: 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 years of experience in combination with educational requirements.

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.

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.

3. Parent Partners

- May be employed by the agency or receive a stipend.
- It is preferred that the parent partner has successfully completed the CPCS program, but not required.
- Criminal and child protection background check waivers will be considered on a case by case basis.

VI. Billable Units

Payment for services will be based on actual allowable costs. Agencies may bill up to 7.5% of subcontracting costs for administration fees. Agencies will bill monthly based on these payment points:

- .1 – Personnel
- .2 – Overhead/Indirect Costs (rent, utilities, etc)
- .3 – Office Equipment
- .4 – Office Supplies
- .5 – Travel & Training
- .6 – Concrete Funds
- .7 – Direct Services (if contracted)
- .8 – Community Outreach Services
- .9 – Administration Fees
- .10 – Subcontracted Services

VII. Adherence to the DCS Practice Model

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. 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.

Trauma Informed Care

A. Provider must develop a core competency in Trauma Informed Care as defined by the National Center for Trauma Informed Care (NCTIC) through 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.

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 and/or have access to staff and/or volunteers who are representative of the community served in order to minimize any barriers that may exist.

VIII. Child Safety

Services must be provided in accordance with the Principles of Child Welfare Services. Please note: All services (even individual services) are provided through the lens of child safety. 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. It is the responsibility of the service provider to report any safety concerns, per state statute, IC 31-33-5-1. All service plans should include goals that address issues of child safety and the family's protective factors.