

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
DIAGNOSTIC AND EVALUATION

I. Service Description

- A. Diagnostic and assessment services will be provided as requested by the referring worker for parents, family members, and children due to intervention of the Department of Child Services. The intervention is due to:
 - 1. Alleged physical, sexual, or emotional abuse or neglect
 - 2. The removal of children from the care and control of their parents
 - 3. Children alleged to be a delinquent child or adjudicated a delinquent child
- B. When either a psychological or emotional problem is suspected to be contributing to the behavior of an adult or child or interfering with a parent's ability to parent, they should be referred for an initial bio-psychosocial assessment by the Family Case Manager/Probation Officer.
- C. If an Attachment and Bonding Assessment, a Trauma Assessment, or psychiatric consultation/medication evaluation or either psychological or neuropsychological testing is necessary to answer a specific question, testing may be included in the evaluation after a consultation with the Family Case Manager and Clinical Consultant to clarify the rationale for testing.
- D. The results of the evaluation including the diagnostic impression and treatment recommendations will be forwarded to the Family Case Manager/Probation Officer to assist the family in remedying the problems that brought the family to the attention of child protective services and/or probation.

II. Service Delivery

- A. Clinical Interview and Assessment
 - 1. The purpose of the Clinical Interview and Assessment is to provide a clinical snapshot of the referred client and to generate recommendations to address identified needs.
 - 2. The Clinical Interview and Assessment will have the following completed and summarized in a report:
 - a) Bio-psychosocial assessment (including initial impression of parent functioning)
 - b) Diagnosis (if applicable) for the referred client per 405 IAC 5-20-8 (3), a physician, psychiatrist, or HSPP must certify the diagnosis. Record of a certification by the qualified individual must be provided if a diagnosis is included
 - c) Summary of recommended services and service approach

3. The completed report will utilize the DCS standardized “Clinical Interview and Assessment” report format, or an equivalent format to include all of the information above and is approved by the referring DCS Local Office.
 - a) The report should be completed with a summary to DCS within fourteen (14) calendar days of referral.
4. The service provider may recommend Attachment and Bonding Assessment, Trauma Assessment, Psychological Testing, Psycho-Sexual Assessment, Neuropsychological Testing, and/or psychiatric consultation/medication evaluation as a result of the bio-psychological assessment.
 - a) If Attachment and Bonding Assessment, Trauma Assessment, Psychological Testing, or Neuropsychological testing is recommended, the service provider should include in the report the specific issues/questions the testing should address.
 - b) A new referral under this Service Standard will be required for these services and must be approved by the Family Case Manager/Probation Officer prior to initiation of additional testing.

B. Attachment and Bonding Assessment

1. An Attachment and Bonding Assessment is used to determine the quality and nature of a child’s bond or attachment to a particular person or persons. This might include:
 - a) Biological parents
 - b) Resource parents
 - c) Guardians
 - d) Prospective adoptive parents
 - e) Relatives
 - f) Siblings
2. The assessment may be used as one piece of information when making decisions about a child’s placement options.
3. Information obtained from the Attachment and Bonding Assessment is focused on the needs of the child, as well as ways to foster relationships and improve attachment quality. It is used specifically to:
 - a) Identify secure vs. insecure attachment patterns
 - b) Predict the impact on a child of continuing to be in the current situation as opposed to other placement alternatives
 - c) Assist a parent or caregiver in learning about their own strengths and weaknesses, as well as ways to improve their parenting style based on the needs of the child
 - d) Assess the future potential and needs of the caregiver-child relationship

- e) Determine the most appropriate parenting style/skills/qualities for substitute caregivers
- 4. The clinician will respond with a written report with recommendations of service within fourteen (14) days from the date of assessment.
- 5. At a minimum, the Attachment and Bonding Assessment should include the following components:
 - a) Social history of the child and caregiver(s)/sibling(s)
 - b) Developmental history of the child
 - c) Direct observation of the child with his/her caregiver/sibling using the following 9 episode standardized format (Boris, Neil W., Sarah S. Hinshaw-Fuselier, Anna T. Smyke, Michael S. Scheeringa, Sherryl S. Heller, and Charles H. Zeanah. "Comparing Criteria for Attachment Disorders: Establishing Reliability and Validity in High-Risk Samples." *Journal of the American Academy of Child & Adolescent Psychiatry* 43, no. 5 (2004): 568-77).

Episode	Duration	Description
1	5 minutes	The clinician observes parent-child "free play." Note especially familiarity, comfort, and warmth in the child as he/she interact with attachment figure.
2	3 minutes	The clinician talks with, then approaches, then attempts to engage the child in play. Most young children exhibit some reticence, especially initially, about engaging with an unfamiliar adult.
3	3 minutes	The clinician picks up child and shows him/her a picture on the wall or looks out window with the child. This increases the stress for the child. Again, note the child's comfort and familiarity with this stranger.
4	3 minutes	The caregiver picks up the child and shows him/her a picture on the wall or looks out window with the child. In contrast to stranger pick up, the child should feel obviously more comfortable during this activity.
5	1 minutes	The child is placed between the caregiver and a stranger, and a novel (e.g., scary/exciting) remote control toy is introduced. The child should seek comfort preferentially from the parent. If interested rather than frightened, the child should share positive affect with the parent.
6	3 minutes	The clinician leaves the room. This separation should not elicit much of a reaction in the child because the clinician is a stranger.
7	1 minutes	The clinician returns. Similarly, the child should not be much affected by the stranger's return.
8	3 minutes	The caregiver leaves the room. The child should definitely take notice of the caregiver's departure, although not necessarily exhibit obvious distress. If the child is distressed, then the clinician should be little comfort to the child.

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1 minutes The caregiver returns. The child's reunion behavior with the caregiver should be congruent with separation behavior. That is, distressed children should seek comfort and non-distressed children should re-engage positively with the caregiver by introducing them to a toy or activity or talking with them about what occurred during the separation.

Note: Other research-based observation models may be used but they require **written approval from the DCS Central Office prior to use.**

C. Trauma Assessment

1. Many people involved with DCS have experienced trauma and meet the clinical criteria for Post-Traumatic Stress Disorder (PTSD). However, many who do not meet the full criteria for PTSD still suffer significant posttraumatic symptoms that can have an adverse impact on:
 - a) Behavior
 - b) Judgement
 - c) Educational performances
 - d) Ability to connect with caregivers
2. A comprehensive Trauma Assessment helps determine which intervention will be most beneficial.
3. At a minimum, the Trauma Assessment should include the following components:
 - a) Social history of the client
 - b) Developmental history of the client
 - c) Trauma history, including all forms of traumatic events experienced directly or witnessed by the client
 - d) Use of at least one standardized clinical measure to identify types and severity of symptoms the client has experienced. Examples include:
 - (1) UCLA PTSD Index for DSM-IV
 - (2) Trauma Assessment for Adults-Self Report (TAA)
 - (3) The Trauma Symptoms Checklist for Children (TSCC)
 - (4) The Trauma Symptoms Checklist for Young Children (TSCYC)
 - (5) The Child Sexual Behavior Inventory (CSBI)
 - (6) Clinician-Administered PTSD Scale for Children and Adolescents (CAPS-CA)
 - e) Integration of DCS CANS scores
 - f) Recommends for evidence-based, trauma-informed treatment, as appropriate
 - g) The clinician will respond with a written report with recommendations of services with fourteen (14) days from the date of assessment.

D. Psychological Testing

1. The psychologist will conduct applicable psychological testing as recommended during the Clinical Interview and Assessment and approved by DCS.
2. The psychologist will respond with a written report that clearly outlines the findings of the psychological test within thirty (30) days from the completion of the psychological test.
3. The detailed written report should include, but not limited to:
 - a) Defining any applicable diagnosis with appropriate treatment recommendations and considerations
 - b) Present functioning of the referred individual
 - c) Description of the referred individual's history
4. In addition to the written report, the psychologist (or another appointed staff member) will notify via email the referring local DCS office within 48 hours that the psychological testing has been completed.
5. At DCS's request, the psychologist may attend a Child and Family Team Meeting for the purpose of debriefing the team on the psychological evaluation findings and providing guidance for treatment to address the findings.

E. Neuropsychological Testing

1. The psychologist will conduct applicable neuropsychological testing as recommended during the Clinical Interview and Assessment and approved by the Clinical Consultant/Probation Officer.
2. The psychologist will respond with a written report within thirty (30) days from the date of appointment.

F. Medication Evaluation

1. If psychiatric consultation/medication evaluation is recommended, the psychiatrist will see the client within fourteen (14) days from the date of referral and complete a written report within thirty (30) days from the date of evaluation.

G. Ongoing Medication Monitoring

1. Ongoing medication monitoring will be provided as needed based on the results of the Medical Evaluation.

H. Child Hearsay Evaluation

1. An evaluation completed by a psychiatrist, physician, or psychologist to determine if participation in court proceedings would create a substantial likelihood of emotional or mental harm to the child.

2. This evaluation is intended for youth under the age of fourteen (14), or a child at least fourteen (14) and younger than eighteen (18) that has a substantial disability attributable to impairment of general intellectual functioning or adaptive behavior that is likely to continue indefinitely, as is for use in CHINS or Termination of Parental Rights proceedings.
3. Child Hearsay is governed by Indiana statute.
4. The Child Hearsay Evaluation should address IC 31-34-13-3 (2) (i): Child participation in court proceedings (testifying) creates likelihood of Emotional or Mental Harm to the child.
5. It is also possible to be asked to address IC 31-34-13-3 (2) (iii): Is the child incapable of understanding the nature and obligation of an oath?
6. The Child Hearsay Evaluation should NOT address IC 31-34-13-3 (1): Whether the child's statements meet sufficient indications of reliability (used in criminal cases not CHINS/TPR).
7. The Child Hearsay Evaluation is NOT to make recommendations about what services the child and/or parents need. This is done through other Diagnostic and Evaluation services.
8. IC 31-34-13-3 Requirements for admissibility of statements or videotapes. Section 3: A statement or videotape described in section 2 of this chapter is admissible in evidence in an action to determine whether a child or a whole or half-blood sibling of the child is a child in need of services if, after notice to the parties of a hearing and of their right to be present:
 - a) The child;
 - b) Testifies at the proceedings to determine whether the child or a whole or half-blood sibling or the child is a child in need of services;
 - c) Available for a face-to-face cross-examination when the statement or videotape was made; or
 - d) Found by the court to be unavailable as a witness because:
 - (1) A psychiatrist, physician, or psychologist has certified that the child's participation in the proceedings creates a substantial likelihood of emotional or mental harm to the child;
 - (2) The court has determined that the child is incapable of understanding the nature and obligation of an oath.
9. The main component in this evaluation is to gather information to make the determination of the probability of emotional or mental harm to the child if they testify in Court.
 - a) This is done through a Clinical Interview and Assessment with the child.

10. The evaluator also has the option of using testing tools as deemed appropriate. Examples of tools include but are not limited to:
 - a) Problem Behavior Checklist
 - b) Children's Manifest Anxiety Scales
 - c) Child Behavior Checklist for rages 6-19 and for ages 1.5 to 5.
 - d) Trauma Symptom Checklist for Children
 - e) House Tree Person
 - f) Children's Incomplete Sentences
 - g) Stoner Incomplete Sentences for Children
 - h) Coloring Sheets of Faces
 - i) Kinetic Drawings
 - j) RAT-2
11. The Child Hearsay Evaluation needs to be completed within fourteen (14) days after the referral is made and the final evaluation report needs to be provided to the referral source within twenty one (21) days from the referral.
 - a) In some cases, the court may need this evaluation to be completed more quickly. This will be included in the referral.

III. Target Population

- A. Services 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 Informal Adjustment (IA) or Children in Need of services (CHINS) status.
 2. Children and their families which have an 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: Timely receipt of evaluations.
 1. Objective: Service provider to submit written report to the referring Family Case Manager (FCM) or Probation Officer (PO) within the designated timeframes of completion of evaluation.
 - a) Outcome Measure/Fidelity Measure: 95% of the evaluation reports will be submitted to the referring Family Case Manager/Probation Officer within specified service delivery timeframes.
- B. Goal #2: Obtain appropriate recommendations based on information provided.

1. Objective: Service provider to submit written recommendations of appropriate services to address the needs as identified on the assessment or the symptoms of the identified diagnosis.
 - a) Outcome Measure/Fidelity Measure: 100% of reports will meet information requested by the referring Family Case Manager/Probation Officer.
 - b) 100% of reports will include recommendations for treatment, needed services, indicate no further need for services.
- C. Goal #3: Client satisfaction surveys.
 1. Objective: Client satisfaction of service provided
 - a) Outcome Measure/Fidelity Measure: DCS and/or Probation will be rated 4 and above on the Service Satisfaction Report
 - b) A random sample of Satisfaction Surveys will be completed at the conclusion of services.

V. Minimum Qualifications

- A. Clinical Interview and Assessment Reimbursed by DCS
 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
 - b) Master's degree with a temporary permit issued by the Indiana Behavioral Health and Human Services Licensing Board
 - 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. That individual must also:
 - (1) Complete a minimum of 24 post-secondary semester hours or 36 quarter hours in the following coursework:
 - a. Human Growth & Development
 - b. Social & Cultural Foundations
 - c. Group Dynamics, Processes, Counseling and Consultation
 - d. Lifestyle and Career Development
 - e. Sexuality
 - f. Gender and Sexual Orientation
 - g. Issues of Ethnicity, Race, Status & Culture
 - h. Therapy Techniques
 - i. Family Development & Family Therapy
 - j. Clinical/Psychiatric Social Work

- k. Group Therapy
- l. Psychotherapy
- m. Counseling Theory & Practice

- d) Individual must complete the Human Service Related Degree Course Worksheet. For auditing purposes, the worksheet should be completed and placed in the individual's personnel file. Transcripts must be attached to the worksheet.
- e) **Note:** Individuals who hold a Master or Doctorate degree that is applicable toward licensure, must become licensed as indicated in #1 & 2 above.
- f) 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.
- g) In addition to the above:

- (1) Knowledge of family of origin/intergenerational issues
 - (2) Knowledge of child abuse/neglect
 - (3) Knowledge of child and adult development
 - (4) Knowledge of community resources
 - (5) Ability to work as a team member
 - h) Belief in helping clients change, to increase the level of functioning, and knowledge of strength-based initiatives to bring about change
 - (1) Belief in the family preservation philosophy
 - (2) Knowledge of motivational interviewing
 - (3) Skillful in the use of Cognitive Behavioral Therapy
 - a. Skillful in the use of evidence-based strategies
- B. Clinical Interview and Assessment Reimbursed by Medicaid
 - 1. Must meet Medicaid requirements.
- C. Attachment and Bonding Assessment Reimbursed by DCS
 - 1. Administration and interpretation must meet the requirements of the testing tool being utilized.
- D. Child Hearsay Evaluation
 - 1. Per Indiana Statute, the evaluation must be completed by a psychiatrist, a physician, or a psychologist.
- E. Trauma Assessment Reimbursed by DCS
 - 1. Administration and interpretation must meet the requirements of the testing tool being utilized.
- F. Psychological & Neuropsychological Testing Reimbursed by DCS
 - 1. Test Interpretation: Diagnosis and assessment may only be done independently by a Health Services Provider in Psychology (HSPP) or physician.
 - 2. Test Administration: The following practitioners may administer psychological testing under the direct supervision of a HSPP or physician:
 - a) A licensed psychologist
 - b) A licensed independent practice school psychologist
 - c) A person holding a Master's degree in psychology or mental health field and one (1) of the following:
 - (1) At least one (1) year of supervised experience in testing under physician or HSPP psychologist at the performance sites on the tests to be used including instruction on administration, scoring, and practice assessment with non-patients and final approval to administer the specific instruments by a physician or HSPP psychologist at the performance site; or

- (2) A certified specialist in psychometry (CSP)
- d) Status as a psychology intern enrolled in an American Psychological Association (APA) approved internship program.
- e) A psychology resident enrolled in an APA approved training program or APPIIC recognized internship or post-doctoral program.
- f) An individual certified by a national organization in the administration and scoring of psychological tests.

3. The physician and HSPP are responsible for the interpretation and reporting of the testing performed.

- a) The physician and HSPP must provide direct supervision and maintain documentation to support the education, training, and hours of experience for any practitioner providing services under their supervision.
- b) A cosign by the physician or HSPP is required for services rendered by one of the lower level practitioners.

G. Psychological & Neuropsychological Testing Reimbursed by Medicaid

- 1. Subject to prior authorization by the office or its designee, Medicaid will reimburse for psychological and neuropsychological testing when provided by a physician or HSPP. The services provided by one (1) of the following practitioners:

- a) A physician
- b) HSPP
- c) The following practitioners may only administer psychological neuropsychological testing under the direct supervision of a physician or HSPP:
 - (1) A licensed psychologist
 - (2) A licensed independent practice school psychologist
 - (3) A person holding a Master's Degree in a mental health field and one (1) of the following:
 - (a) A certified specialist in psychometry (CSP)
 - (b) Two thousand (2000) hours of experience, under direct supervision of a physician or HSPP, in administering the type of test being performed.

- 2. The physician and HSPP are responsible for the interpretation and reporting of the testing performed.
- 3. The physician and HSPP must provide direct supervision and maintain documentation to support the education, training, and hours of experience for any practitioner providing services under their supervision.
- 4. A co-signature by the physician or HSPP is required for services rendered by one of the practitioners listed in sub-division (c).

- H. Medical Evaluation and Ongoing Medication Management
 - 1. Physician
 - 2. Advanced Practice Nurses (Nurse Practitioners or Certified Nurse Specialists) with a:
 - a) Masters or Doctoral degree in nursing with a major psychiatric or mental health nursing
 - b) From an accredited school of nursing
 - 3. If working as an Authorized Health Professional Staff must:
 - a) Be an Advanced Practice Nurse
 - b) Prescriptive authority
 - c) Must work within the scope of his/her license and have a supervisory agreement with a licensed physician.

VI. Billable Unit

- A. Medicaid:
 - 1. It is expected that the diagnostic and evaluation services provided under this service standard will be based in the clinic setting.
 - 2. Medicaid shall be billed when appropriate. Services should be billable by utilizing the 90000 codes.
 - 3. The medically necessary parts of the Clinical Interview and Assessment should be billed as appropriate through Medicaid.
 - 4. For more information on Medicaid billing, please refer to Chapter 8 of the Indiana Health Coverage Program Manual:
<http://provider.indianamedicaid.com/media/23576/chapter08.pdf>
 - 5. Any additional time spent face to face with the client or caregiver gathering DCS required non-medically necessary information, that would not typically be part of a Clinical Intake or Assessment, may be billed to DCS (up to 1.5 hours).
 - 6. Time spent completing the DCS required standardized form may be billed to DCS up to a total of 1.5 hours.
- B. DCS Funding: Those services not billable under Medicaid may be billed to DCS as follows:
 - 1. **Clinical Interview and Assessment:** Hourly rate- includes Face-to-Face time with the client, as well as time spent:
 - a) Writing the report (maximum of 1.5 hour may be billed for report writing).
 - 2. **Attachment and Bonding Assessment:** Hourly rate- includes Face-to-Face time with the client, as well as time spent:
 - a) Administering, scoring, and interpreting psychological tests;
 - b) Collecting current diagnostic collateral information;

- c) Reviewing treatment records and other collateral information related to the referral question; and
 - d) Writing the report (maximum of one (1) hour to be billed).
 - 3. **Trauma Assessment:** Hourly rate- includes Face-to-Face time with the client, as well as time spent:
 - a) Administering, scoring, and interpreting psychological tests;
 - b) Collecting current diagnostic collateral information;
 - c) Reviewing treatment records and other collateral information related to the referral question; and
 - d) Writing the report (maximum of one (1) hour to be billed).
 - 4. **Psychological Testing:** Hourly rate- includes Face-to-Face time with the client, as well as time spent:
 - a) Administering, scoring, and interpreting psychological tests;
 - b) Collecting current diagnostic collateral information;
 - c) Reviewing treatment records and other collateral information related to the referral question; and
 - d) Writing the report (maximum of one (1) hour to be billed).
 - 5. **Neuropsychological Testing:** Hourly rate- including Face-to-Face time with the client, as well as time spent:
 - a) Administering, scoring, and interpreting testing; and
 - b) Writing the report (maximum of one (1) hour may be billed).
 - 6. **Medication Evaluation:** Hourly rate- including Face-to-Face time with the client, as well as time spent:
 - a) Writing the report (maximum of half hour (.5) may be billed).
 - 7. **Ongoing Medication Monitoring:** Hourly rate- including Face-to-Face time with the client.
 - 8. **Child Hearsay Evaluation:** Hourly rate- including Face-to-Face time with the youth while completing the Clinical interview, as well as time spent:
 - a) Administration and interpretation of the testing tools selected by the evaluator; and
 - b) Writing the report (maximum of one (1) hour may be billed).
- C. Hourly services may be billed in 15 minute increments, partial units are rounded to the nearest quarter using the following guidelines:

o 0-7 minutes	do not bill	0.00 hour
o 8-22 minutes	1 fifteen minute unit	0.25 hour
o 23-37 minutes	2 fifteen minute unit	0.50 hour
o 38-52 minutes	3 fifteen minute unit	0.75 hour
o 53-60 minutes	4 fifteen minute unit	1.00 hour

- D. Medication
 - 1. Billed at actual cost
 - 2. The provider must access all sample medication resources and other medication sources (e.g. MAP) and pharmaceutical companies that provide free or reduced cost medications prior to billing DCS.
 - 3. Documentation of these efforts must be maintained in the case file.
- E. Child and Family Team Meetings
 - 1. Includes only Child and Family Team Meetings or Case Conferences initiated or approved by DCS or Probation for the purpose of debriefing the team on the psychological evaluation and findings and providing guidance for treatment to address the findings.
 - 2. Provider must receive a written request from the referral source in order to bill for CFTM attendance.
- 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 request (email or subpoena) of the agency's representative from DCS/Probation to appear in court**, and can be billed per appearance per family.
 - 3. If the provider appeared in court two different days, they could bill for 2 court appearances.
 - a) *A maximum of one (1) court appearance per day/per case.*
 - 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/Court Testimony Only
 - 1. If the services provided are not funded by DCS, the "Report Writing" hourly rate will be paid; the "Court Testimony" per appearance rate will be paid.
 - 2. A referral for "Reporting Writing/Court Testimony" must be issued by DCS in order to bill.
- H. 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. Providers can use DCS contracted agencies and request that they be given the DCS contracted rate but this is not required.
4. 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.

5. 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.

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. A 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 be Specific, Measurable, Attainable, Relevant, and Time Sensitive goal language
 6. Monthly reports are due by the 10th 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:
 - a) Date
 - b) Start time
 - c) End time
 - d) Participants
 - e) Individual providing service
 - f) 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, resource parents, other professionals, etc.
 - j) Communication with client, significant others, other professionals, school, resource parents, etc.
 - k) Summary of Child and Family Team Meetings, case conferences, staffing
9. Supervision Notes must include:
- a) Date and time of supervision
 - b) Individuals present
 - c) Summary of supervision discussion including presenting issues and guidance given

VIII. Service Access

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

IX. Adherence to the 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. 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.

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.