

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
SEXUALLY HARMFUL/REACTIVE YOUTH

I. Service Description

- A. This service standard applies to services provided to families and children involved with the Department of Child Services and/or Probation. All referred cases shall follow a continuum that provides the following:
 - 1. Assessment under the appropriate category
 - a) Assessment for youth under 12 years old who engaged in sexually reactive behavior, risky to self, or harmful behaviors
 - b) Sexual risk assessment for youth ages over 12 years old and youth involved with the juvenile or CHINS legal system
 - 2. Referral for the appropriate level of treatment/services
- B. Additional collateral information from DCS/Probation may be helpful to complete the assessment:
 - 1. Summary of allegations
 - 2. Previous testing
 - 3. Treatment plans
 - 4. Other relevant historical information
 - 5. Goal of the referred assessment- what can be learned?
- C. Specific treatment is necessary for youth who engage in sexually abusive behavior.
- D. This standard is designed to improve the public safety by reducing the risk of reoccurring sexually abusive behavior.
- E. The standard requires interventions that are evidence based practices and address the individual needs of the youth and their families.
- F. This service standard relies on standards from the Association of Treatment of Sexual Abusers (hereby referred to as ATSA) that reflect current research and best practices. The standards of the association are described in Practice Guidelines, Assessment, Intervention and Management with Adolescents Who Have Engaged in Sexually Abusive Behavior.
 - 1. Up to date Practice Guidelines can be obtained via ATSA (<http://www.atsa.com/>) or IN-AJSOP.
 - 2. It is the responsibility for those fulfilling the services listed below to have made themselves aware and knowledgeable on the current ATSA Adolescent Practice Guidelines, Assessment, Intervention and Management of Adolescents Who Have Engaged in Sexually Abusive Behavior.

II. Service Delivery

- A. The location of service varies, depending on the payer source:
 - 1. For DCS, services are provided face-to-face in the counselor's office or other setting.
 - 2. For MCO, the service setting is either outpatient or office setting.
 - 3. For MRO, the service must be provided at the client's home or other location outside the clinic setting.
- B. Services must include 24 hour crisis intake, intervention and consultation seven (7) days a week.
- C. The provider must initiate contact with the family within five (5) business days of the referral.
- D. Polygraphs are not endorsed by DCS, as it is not best practice in working with juveniles.
 - 1. DCS is aligned with ATSA guidelines that state there is no research to address utilizing polygraphs with juveniles; therefore, polygraphs should not be utilized with juveniles.
 - 2. DCS Referrals: A polygraph is not a component provided within the referral. If a polygraph is court ordered a separate polygraph referral must be created by request to the DCS Child Welfare Services Division.
 - 3. Probation Referrals: The polygraph component will remain within the service referral.
- E. The provider will respond with the full written report within fourteen (14) business days from the date of the assessment.
- F. The provider must notify the referring worker of each no-show before the end of the next business day.
- G. Services must include ongoing risk assessment and monitoring of progress.
- H. Services must provide short and long term goals with measurable outcomes based on recommendation on the risk and needs assessment for sexual offenders.
Services include:
 - 1. Monthly reports
 - 2. Treatment goals
 - 3. Requested supportive and/or court appearances including hearings and/or appeals
 - 4. Requested testimony and/or court appearances including hearings and/or appeals
 - 5. Case conferences/staffing
 - 6. CFTM, if requested to attend by the DCS local office/Probation
- I. The provider must respect confidentiality.
 - 1. Failure to maintain confidentiality may result in immediate termination of the service agreement.

III. Assessments & Treatment

- A. Assessment for youth under 12 years old who engaged in sexually reactive behavior, risky to self, or harmful behaviors.
 - 1. When the assessment should be done
 - a) Youth under age of 12 who have harmed others in a sexual manner should be evaluated under this category.
 - b) This will allow the evaluator to assess if behaviors are trauma related or there is a risk for ongoing sexual behaviors.
 - 2. Sexual Risk Assessment
 - a) At a minimum, the sexual risk assessment for youth under 12 years old should include the following components:
 - (1) A statement of informed consent
 - (2) A minimum of one (1) collateral contact shall be completed in order to collect information regarding the client's sexual behaviors and past trauma.
 - (a) Members of the client's informal or formal support can serve as collateral contacts to verify client's history.
 - (b) Local DCS office/Probation staff will count as a collateral contact if additional information is obtained from them.
 - (3) Youth, family, and community strengths
 - (4) Cognitive functioning
 - (5) Social/developmental history
 - (6) Current individual functioning
 - (7) Current and historic family functioning
 - (8) Delinquency and conduct/behavioral issues
 - (9) Substance use and abuse
 - (10) Psychosexual assessment
 - (11) Mental health assessment
 - (12) Sexual history
 - (13) Trauma history
 - (14) Community risk and protective factors;
 - (15) Awareness of victim impact
 - (16) Dynamic Safety Plan
 - (17) Quality and availability of informal supervision
 - (18) Addresses needs for safety specific to the referred youth
 - b) Needs tools if applicable:
 - (1) Latency Age-Sexual Adjustment and Assessment Tool (LA-SAAT) - Assessment of Risk and Needs for Continued Sexually Troubled Behavior
 - (a) The LA-SAAT is an instrument designed to shape structured professional judgement (SPJ) in

assessing the risk for continued sexually troubled behavior in pre-adolescent males, aged 8-12, who have engaged in sexual behavior that appears inappropriate due to age or the nature and/or extent of the sexual behavior.

- (b) For children who have behaved in sexually problematic or sexually abusive behavior.
- (c) It is not designed to be used to evaluate younger children, adolescents, adults, or females.

(2) Or other clinically approved/ATSA approved tool

- 3. Conclusion of the Assessment should include:
 - a) Statement of concerns/vulnerabilities/risks by life domains (at least home, school, and community)
 - b) Recommendation concerning the level of restrictiveness for the youth
 - c) Statement of amenability to interventions of the youth and family
 - d) Statement of protective factors
 - e) Statement of needs for youth and family
 - f) Recommendations for intervention to address the needs of youth and family
 - g) Recommendations of critical individuals in the family and community to support interventions
 - h) Statements of specific responsivity factors
 - i) Recommendations for strategies to address responsivity factors
- 4. Tools used in the report
 - a) Practitioners who conduct risk and needs assessments of youth who have sexually abused must use one or more of the most empirically supported, independently evaluated measures in addition to structured clinical judgment.
 - b) Practitioners will determine through the assessment if trauma assessment tools should be utilized or if there is a need for needs/risk tool to be utilized.
 - c) As newly developed tools become available, practitioners should evaluate relevant professional literature to determine research support before using them.
 - d) Clinicians who administer and interpret results must meet the qualification of the testing tools being utilized.

B. Sexual Risk Assessment for youth over 12 years old and youth involved with the juvenile or CHINS legal system

- 1. When an assessment should be done:
 - a) When there is definitive information that the adolescent engaged in sexually abusive behavior. This includes, but is not limited to the following:

- (1) The agency responsible for investigating allegations of sexually abusive behavior determined the behavior occurred and substantiated the findings of such.
 - (2) The behavior has been substantiated by the appropriate jurisdictional investigative agency.
 - (3) The adolescent has been adjudicated by the court on a sex-abuse related offense.
 - (4) The sexually abusive behavior was directly observed by a reliable, responsible, source.
 - (5) The youth admits to having engaged in sexually abusive behavior.
- b) Practitioners should:
- (1) Take into account the adolescents current legal status and the ways in which that status may influence the nature, scope, or validity of the assessment.
 - (2) Recognize assessments cannot prove or disprove that sexual abuse has occurred, that it is not the role of an assessment, and an assessment cannot predict with certainty whether such behavior will or will not reoccur.
 - (3) Educate referral sources accordingly.
- c) Risk and Needs Assessment:
- (1) The preferred practice to complete the Risk and Needs Assessment is post-adjudication; however, there are situations that warrant consideration of a pre-adjudication assessment, such as:
 - (a) The legal professionals involved in the case are seeking information to assist in formulating a plea agreement or to support moving a plea agreement forward.
 - (b) The judge is seeking additional information prior to accepting to a proposed plea agreement.
 - (c) The court is withholding the charge, providing the adolescent an opportunity for treatment, resulting in no formal action on the offense.

2. Sexual Risk Assessment

- a) At a minimum, the sexual risk assessment on youth should include the following:
- (1) A statement of informed consent
 - (2) A minimum of one (1) collateral contact shall be completed in order to collect information regarding the client's sexual behaviors and past trauma.

- (a) Members of the client's informal or formal support system can serve as collateral contacts to verify client's history.
 - (b) Local DCS Office/Probation staff will count as a collateral contact if additional information is obtained from them.
 - (3) Youth, family, and community strengths
 - (4) Cognitive functioning
 - (5) Social/developmental history
 - (6) Current individual functioning
 - (7) Current and historic family functioning
 - (8) Delinquency and conduct/behavioral issues
 - (9) Substance use and abuse
 - (10) Sexual Assessment (including sexual interests)
 - (11) Mental health assessment
 - (12) Sexual history
 - (13) Trauma history
 - (14) Community risk and protective factors
 - (15) Awareness of victim impact
 - (16) Quality and availability of informed supervision
 - (17) Risk/Need estimate utilizing an appropriate tool listed below (See Section III.B.4)
3. Conclusion of the Assessment shall include:
- a) Statement of risk for continued sexually abusive behavior by environments (at least home, school, and community)
 - b) Recommendation concern level of restrictiveness for the youth
 - c) Statement of amenability to interventions of the youth and family
 - d) Statement of protective factors
 - e) Statement of needs for youth and family
 - f) Recommendations for intervention to address the needs of youth and family
 - g) Recommendations of critical individuals in the family and community to support interventions
 - h) Statement of specific responsivity factors
 - i) Recommendations for strategies to address responsivity factors
4. Tools used in the report
- a) Practitioners who conduct risk and needs assessments of youth who have sexually abused must use one or more of the most empirically supported, independently evaluated measures in addition to structured clinical judgement.
 - b) As newly developed tools become available, practitioners should evaluate relevant professional literature to determine research support before using them.

- c) Clinicians who administer and interpret results must meet the qualification of the testing tools being utilized.
- d) Examples of tools to be used:
 - (1) PROFESOR- Protective + Risk Observations for Eliminating Sexual Offense Recidivism
 - (a) PROFESOR is a structured checklist to assist professionals to identify and summarize protective and risk factors for adolescents and emerging adults (individuals aged 12-25) who have offended sexually.
 - (b) PROFESOR is intended to assist with planning interventions that can help individuals to enhance their capacity for sexual and relationship health and thus, eliminate sexual recidivism.
 - (c) PROFESOR is not intended to predict risk.
 - (i) Indeed it is critical to stress that there is currently no empirical support to suggest that the PROFESOR could inform predictions of future sexual offending.
 - (2) MEGA- Multiplex Empirically Guided Inventory of Ecological Aggregates for Assessing
 - (a) To be used for sexually abusive children and adolescents, between the ages of 4-19
 - (b) MEGA is a scientifically based questionnaire that determines the level of risk for coarse sexual improprieties and/or risk for sexually abusive behaviors
 - (c) MEGA can be applied to both adjudicated and non-adjudicated youth
 - (d) MEGA can be applied to males and females in addition to lower functioning individuals
 - (3) MIDSAs-Multidimensional Inventory of Development, Sex, and Aggression
 - (a) MIDSAs is a computerized self-report inventory that assesses all domains found important in the treatment and management of sexually aggressive behavior.
 - (b) The MIDSAs gathers extensive data on the developmental antecedents that contribute to the onset and continuance of sexual and aggressive behavior.
 - (c) The MIDSAs is a psychological assessment tool that was designed specifically to identify important

target domains for therapeutic intervention with individuals who have been sexually coercive. It is intended to serve as a risk management instrument.

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

C. Treatment

1. Treatment must include individual and family components, and may include group components for sexually harmful youth including the following:
 - a) Case-specific treatment components through individual therapy including addressing personal history of sexual victimization and behavioral techniques designed to modify deviant sexual arousal if appropriate.
 - b) Core treatment modules through an optional group component including psychoeducation about the consequences of abusive behavior.
 - c) Increasing victim empathy
 - d) Identifying personal risk factors
 - e) Promoting healthy sexual attitudes and beliefs
 - f) Social skills training
 - g) Sex education
 - h) Problem solving skills
 - i) Parent components including:
 - (1) Engendering support for treatment and behavior change
 - (2) Encouraging supervision and monitoring
 - (3) Teaching recognition of risk signs
 - (4) Promoting guidance and support to their child
 - j) Dynamic safety planning
 - k) Family support services
 - l) Compliance monitoring and reporting
 - m) Individual must be trained (post-secondary) in evidence based trauma modality such as:
 - (1) Trauma Focused Cognitive Behavior Therapy (TF-CBT): Prior to serving the client, the individual must complete the minimum ten (10) hour online training. The individual must be actively working towards certification.
 - (2) Strategies for Trauma Awareness and Resilience (STAR): Prior to serving the client, the individual must complete STAR Level 1 Training (5 day in-person training).
 - (3) Other evidence based trauma modalities may be used but they require **written approval from the DCS Central Office.**
 - n) If reunification is the permanency plan, the team must have a CSAYC or practicum CSAYC working on the case to ensure the victim clarification process is handled within best practices. Victim clarification must be completed prior to reunification. Best practices will ensure safety throughout the clarification process, as well as how safety will be addressed during and after reunification.

- (1) Reunification and clarification steps/goals should be discussed in all team meetings.

IV. Target Population

- A. Services must be restricted to youth under the age of eighteen (18), experiencing sexually harmful/reactive behaviors, who are within the target population described below:
 1. Children and their families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with Informal Adjustment (IA) or CHINS status.
 2. Children and their families which have an IA or children with 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.

V. Goals and Outcomes

- A. Goal #1: Maintain timely intervention with family and regular and timely communication with current Family Case Manager or Probation Officer.
 1. Objective: Therapist or backup is available for consultation to the family 24/7 by phone or in person.
 2. Outcome Measures:
 - a) 95% of all families that are referred will have face-to-face contact with the client within five (5) business days of receipt of the referral or inform the current Family Case Manager or Probation Officer if the client does not respond to requests to meet
 - b) 95% of all emergency assessments will include initial recommendations, provided to the referring worker within 48 hours of the emergency assessment with a full assessment report to the worker within 72 hours of the emergency assessment (by email).
 - c) 95% of full assessment reports for nonemergency assessments must be available within fourteen (14) business days of the referral (by email).
 - d) 95% of the initial treatment plans will include measureable goals, specific steps to be taken to meet those goals, and estimated timeframes for completing each goal.
 - (1) The initial treatment plans must be sent to the referring worker within 7 business days of the first face-to-face contact with the client (by email).

- e) Outcome Measure: 100% of monthly progress reports must be completed and sent to the referring worker by the 10th of each month for the previous month. Reports must contain documentation of progress made for each goal since previous report.
- B. Goal #2: Youth participating in the program will have no behavioral issues and/or probation violations.
- 1. Outcome Measures:
 - a) 90% of youth participating in the program will not have any delinquency charges and/or probation violations during the treatment phase.
 - b) 75% of youth who successfully complete the program will not have any delinquency charges and/or probation violations within 12 (twelve) months of completing the program.
 - c) 95% of youth who participate in the program will not be a perpetrator of child sexual abuse during the 12 (twelve) months following program completion.
- C. Goal #3: DCS/Probation and client will report satisfaction with services provided.
- 1. Outcome Measures:
 - a) DCS/Probation satisfaction will be rated 4 and above on the Service Satisfaction Report.
 - b) 90% of the clients will rate the services “satisfactory” or above on a satisfaction survey developed by the service provider, unless DCS/Probation distributes one to provide for their use with clients.
 - (1) Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.

VI. Minimum Qualifications

- A. MCO:
 - 1. Medical doctor, doctor of osteopath, or licensed psychologist
 - 2. Physician or HSPP-directed services provided by the following:
 - a) Licensed clinical social worker

- b) Licensed marital and family therapist
- c) Licensed mental health counselor
- d) Person holding a master's degree in social work, marital and family therapy, or mental health counseling
- e) Advanced practice nurse

B. MRO:

- 1. Licensed professional, except for a licensed addiction counselor
- 2. Qualified behavioral health professional (QBHP)

C. DCS: Direct Worker:

- 1. Master's or Doctorate degree with a current license issued by the Indiana Behavioral Health and Human Services Licensing Board
- 2. Master's degree with a temporary permit issued by the Indiana Behavioral Health and Human Services Licensing Board
- 3. 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:
 - a) Complete a minimum of 24 post-secondary semester hours or 36 quarter hours in the following coursework:
 - (1) Human Growth and Development
 - (2) Social and Cultural Foundations
 - (3) Group Dynamics, Processes, Counseling, and Consultation
 - (4) Lifestyle and Career Development
 - (5) Sexuality
 - (6) Gender and Sexual Orientation
 - (7) Issues of Ethnicity, Race, Status, and Culture
 - (8) Therapy Techniques
 - (9) Family Development and Family Therapy
 - (10) Clinical/Psychiatric Social Work
 - (11) Group Therapy
 - (12) Psychotherapy
 - (13) Counseling Theory and Practice
 - b) Individual must complete the Human Services 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.
 - c) Note: Individuals who hold a Master's or Doctorate degree that is applicable towards licensure, must become licensed as indicated in #1 and #2 above.

4. Licensed as a psychologist under IC 25-33 and acting within the scope of the individual's license.
- D. DCS: Supervisor
1. Master's degree in social work, psychology, or marriage and family or related human service field with a current license issued by the Indiana Behavioral Health and Human Services Licensing Board
 2. Supervision/consultation is to include not less than one (1) hour of individual face-to-face supervision/consultation per 20 hours of direct client services provided, nor occur less than every two (2) weeks.
 3. Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life style choices, complete family interactions.
 - a) Services will be delivered in a neutral valued culturally competent manner.
- E. Shadowing Criteria
1. All agencies must have policies that require regular shadowing (by supervisor) or all staff at established intervals based on staff experience and need.
 2. Shadowing must be provided in accordance with the policy.
 - a) The agency must provide clear documentation that shadowing has occurred.
- F. Service providers will only utilize professionals who are specifically trained and are licensed practitioners.
1. Training can occur through the Indiana Association for Juvenile Sex Offender Practitioners, or an equivalent recognized credentialed authority.
- G. If a provider is in active status of CSAYC field instruction and under clinical supervision of an individual who possess CSAYC, a service provider is eligible to provide services.
- H. Staff members shall be knowledgeable of the dynamics surrounding child abuse/neglect, child and adult development, family dynamics, and community resources.

VII. Billable Units

- A. It is the responsibility of the contracted service provider to be knowledgeable about the Medicaid billing requirements and comply with them, including provider qualifications and any pre-authorization requirements and further, to appropriately bill those services in particular cases where they may be reimbursed by Medicaid.
- B. Services through MCO may be Outpatient Mental Health Services.
1. Medicaid shall be billed first for eligible services under covered evaluation and management codes, including those in the 90000 range.

C. Services through the MRO may be Behavioral Health Counseling and Therapy.

Billing Code	Title
H0004 HW	Individual
H0004 HW HQ	Group
H0004 HW HR	Individual Setting with the Consumer Present
H0004 HW HS	Behavioral Health Counseling and Therapy
H0004 HW HR HQ	Behavioral Health Counseling and Therapy
H0004 HW HS HQ	Family/Couple Counseling and Therapy (Group Setting) without the Consumer Present

D. DCS Funding:

1. Those services not deemed medically necessary for the Medicaid eligible client, including services to other referred members of the family that are not related to the behavior health care needs of the eligible client, will be billed to DCS per face-to-face hour as outlined below.
2. These billable units will also be utilized for services to referred clients who are not Medicaid eligible, for those providers who are unable to bill Medicaid, and services that are not billable to Medicaid.
3. Face to Face time with the client: (Note: Members of the client family are to be defined in consultation with the family and approved by the DCS/Probation. This may include persons not legally defined as part of the family).
 - a) Includes the Risk Assessment, billed per hour. This includes time spent administering, scoring, and interpreting testing.
 - (1) A maximum of eight (8) hours can be billed for the Assessment.
 - b) Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
 - c) Includes crisis intervention and other goal directed intervention via telephone with the identified client family.
 - d) Includes Child and Family Team Meetings or case conferences including those initiated or approved by DCS/Probation for the purpose of goal-directed communication regarding the services to be provide to the client/family.

- e) Reminder: Not included is routine report writing and scheduling of appointments, collateral contacts, travel time, and no shows.
 - (1) These activities are built into the cost of the face-to-face rate and shall not be billed separately.
- 4. Hourly services may be billed in 15 minute increments, partial units are rounded to the nearest quarter using the following guidelines:
 - a) 0 to 7 minutes – Do not bill (0.00 hour)
 - b) 8 to 22 minutes – 1 fifteen minute unit (0.25 hour)
 - c) 23 to 37 minutes - 2 fifteen minute units (0.50 hour)
 - d) 38 to 52 minutes – 3 fifteen minute units (0.75 hour)
 - e) 53 to 60 minutes – 4 fifteen minute units (1.00 hour)
- 5. Per person per group hour
 - a) Services include group goal directed work with clients.
 - b) To be billed per person per group hour.
- 6. Polygraphs
 - a) Polygraphs must be purchased from a licensed provider.
 - b) Polygraphs are a unit rate and the provider must tell what their rates are as part of their proposal.
 - c) The intent of the polygraph is for sexually harmful youth only.
- 7. Interpretation, Translation, and Sign Language Services
 - a) The location of and cost of interpretation, translation, and sign language services are the responsibility of the Service Provider.
 - b) 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.
 - c) The referral from DCS must include the request for Interpretation Services and the agency's invoice for this service must be provided when billing DCS for the service.
 - d) Providers can use DCS contracted agencies and request that they be given the DCS contracted rate but this is not required.
 - e) 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.
 - f) 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.

8. Court

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

9. Reports

- a) If the services provided are not funded by DCS, the “Reports” hourly rate will be paid.
- b) DCS will only pay for reports when DCS is not paying for these services.
- c) A referral for “Reports” must be issued by DCS in order to bill.
 - (1) The provider will document the family’s progress within the report.

VIII. Case Record Documentation

- A. Case record documentation for service eligibility must include:
1. A completed, and dated DCS/Probation referral form authorizing services
 2. Copy of DCS/Probation case plan, Informal Adjustment documentation, or documentation of requests for these documents from referral source
 3. Safety issues and Safety Plan documentation
 4. Documentation of Termination/Transition/Discharge Plans
 5. Treatment/Service Plan
 - a) Must incorporate DCS Case Plan goals and child safety goals
 - b) Must use Specific, Measurable, Attainable, Relevant, and Time Sensitive goal language
 6. Monthly reports are due by the 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 the following:
 - 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 goals
 - e) Clinical impressions regarding diagnosis and/or symptoms (if applicable)
 - f) Collaboration with other professionals
 - g) Consultation/Supervision staffing
 - h) Crisis interventions/emergencies
 - i) Attempts of contact with clients, FCMs, resource families, other professionals, etc.
 - j) Communication with client, significant others, other professionals, school, resource families, 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
- 10. Written reports regarding each assessment

IX. 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.

X. Adherence to DCS Practice Model

- A. Services must be provided according to the Indiana Practice Model, providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect.
- B. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

XI. Interpretation, Translation, and Sign Language Services

- A. All Services provided on behalf of the Department of Child Services must include Interpretation, Translation, or Sign Language for families who are non-English language speakers or who are hearing- impaired.
- B. Interpretation is done by an Interpreter who is fluent in English and the non-English language and is the spoken exchange from one language to another.
- C. Certification of the interpreter is not required; however, the interpreter should have passed a proficiency test in both the spoken and the written language in which they are interpreting.
- D. Interpreters can assist in translating a document for a non-English speaking client on an individual basis, (i.e., An interpreter may be able to explain what a document says to the non-English speaking client).
- E. Sign Language should be done in the language familiar to the family.
- F. These services must be provided by a non-family member of the client, be conducted with respect for the socio- cultural values, life style choices, and

complex family interactions of the clients, and be delivered in a neutral-valued culturally-competent manner.

- G. The Interpreters are to be competent in both English and the non-English Language (and dialect) that is being requested and are to refrain from adding or deleting any of the information given or received during an interpretation session.
- H. No side comments or conversations between the Interpreters and the clients should occur.

XII. Trauma Informed Care

- A. Provider must develop a core competency in Trauma Informed Care as defined by the National Center for Trauma Informed Care—SAMHSA (<http://www.samhsa.gov/nctic/>):
 - 1. Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives.
 - 2. NCTIC facilitates the adoption of trauma-informed environments in the delivery of a broad range of services including mental health, substance use, housing, vocational or employment support, domestic violence and victim assistance, and peer support. In all of these environments, NCTIC seeks to change the paradigm from one that asks, "What's wrong with you?" to one that asks, "What has happened to you?"
 - 3. When a human service program takes the step to become trauma-informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma affects the life of an individual seeking services.
 - 4. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization
- B. Trauma Specific Interventions: (modified from the SAMHSA definition)
 - 1. The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
 - 2. The provider must demonstrate an understanding, through the services provided, of the interrelation between trauma and symptoms of trauma (e.g., substance abuse, eating disorders, depression, and anxiety)
 - 3. The provider will work in a collaborative way with child/family, extended family and friends, and other human services agencies in a manner that will empower child/family.

XIII. Training

- A. Service provider employees are required to complete general training competencies at various levels.
- B. Levels are labeled in Modules (I-IV), and requirements for each employee are based on the employee's level of work with DCS clients.
- C. Training Requirements, documents, and resources are outlined at:
<http://www.in.gov/dcs/3493.htm>
 - 1. Review the **Resource Guide for Training Requirements** to understand Trauma Modules, expectations, and agency responsibility.
 - 2. Review **Training Competencies, Curricula, and Resources** to learn more about the training topics.
 - 3. Review the **Training Requirement Checklist** and **Shadowing Checklist** for expectations within each module.

XIV. Cultural and Religious Competence

- A. Provider must respect the culture of the children and families with which it provides services.
- B. All staff persons who come in contact with the family must be aware of and sensitive to the child's cultural, ethnic, and linguistic differences.
- C. All staff also must be aware of and sensitive to the sexual and/or gender orientation of the child, including lesbian, gay, bisexual, transgender or questioning children/youth.
 - 1. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook.
 - 2. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth.
 - 3. The guidebook can be found at:
<http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf>
- D. Efforts must be made to employ or have access to staff and/or volunteers who are representative of the community served in order to minimize any barriers that may exist.

- E. Contractor must have a plan for developing and maintaining the cultural competence of their programs, including the recruitment, development, and training of staff, volunteers, and others as appropriate to the program or service type; treatment approaches and models; and the use of appropriate community resources and informal networks that support cultural connections.

XV. Child Safety

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