

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
FAMILY PRESERVATION SERVICES (Per Diem Model)

I. Service Description

- A. Family Preservation Services are services designed to work with families who have had a substantiated incident of abuse and/or neglect, where the Indiana Department of Child Services (DCS) believes the child(ren) can remain in the home with their caregiver(s) with the introduction of appropriate services to the family.
1. “Caregiver” is broadly defined to include:
 - a) Birth parent(s)
 - b) Adoptive parent(s)
 - c) Relative caregiver(s)
 - d) Fictive kinship caregiver(s)
 - e) Other caregiver(s) who has been providing care and housing to the child(ren) and who has been deemed to be appropriate by DCS.
 2. These services may also be utilized in the absence of a substantiated abuse or neglect allegation if the case is an in-home CHINS or Informal Adjustment (IA). This service shall be for the entire family.
- B. This service shall be for the entire family.
1. The service shall include assessment of child/parent/family resulting in an appropriate service/treatment plan that is based on the assessed need.
 2. The clear goal for these services is to preserve the family and avoid removal of the child(ren), provided it is safe for the child(ren) to remain with their identified caregiver(s).
- C. All services delivered under this standard must have as a foundation at least one evidence-based practice that is classified at a minimum as a “Promising Practice” on the California Evidence-Based Clearinghouse (CEBC) (<http://www.cebc4cw.org/>).
1. Models that are classified on the CEBC as “Supported” or “Well-Supported” may also be used.
 2. No practice that is classified as “Fails to Demonstrate Effect” or “Concerning Practice”, or that is not listed at all on the CEBC may be utilized, except for concrete assistance which is defined below.
- D. Providers (“Providers” or “Service Providers”) must be able to document adherence to the evidence-based practice(s) that they are utilizing and be able to show that staff delivering these practices have had adequate training/certification/credentials (as required by the model being utilized).

- E. Services must be comprehensive and individualized to families' unique needs.
- F. Examples of therapeutic interventions that are evidence-based models include:
 - 1. Trauma-Focused Cognitive Behavioral Therapy
 - 2. Alternative for Families Cognitive Behavioral Therapy
 - 3. Cognitive Therapy/Cognitive Behavioral Therapy
 - 4. Motivational Interviewing
 - 5. Child Parent Psychotherapy
 - 6. Parent Child Interactive Therapy
 - 7. This is not a comprehensive list of models that may be utilized for this service standard.
 - a) Please see the California Evidence-Based Clearinghouse for other models that meet the above-stated criteria described in subsection I.C above
- G. These services must be home-based and must monitor and address any safety concerns for the child(ren).
 - 1. The interventions must be strength-based and family-driven with the family actively participating in identifying the focus of services.
 - 2. While these services require home visits to ensure safety (minimum home-visiting requirements are listed below), other settings (i.e., office, schools, etc.) may be utilized if the evidence-based model being used requires these settings, provided that the mandatory weekly home visit to assess home safety has occurred.
- H. The Provider must provide intensive safety planning and crisis response services 24 hours a day/7 days per week/365+ days a year. Provider will be expected to speak directly with either a family case manager (FCM), a supervisor, local office director (LOD), or the DCS hotline at 800-800-5556 to report any identified safety concerns.
- I. Any identified safety concerns must be reported to DCS immediately.
- J. The service shall be all inclusive (as defined below) and must aim at preserving the family by addressing any present safety and supervision concerns.
 - 1. All family members (provided it is age-appropriate for children to do so) should be involved in treatment planning and establishment of goals.
 - a) The overarching goal for these services is to preserve families by addressing and resolving identified safety and supervision concerns.
 - 2. DCS must also be involved in the creation of treatment plans and safety plans.
 - a) It is expected that Providers of this service will be actively engaged in the DCS Practice Model and attend scheduled Child and Family Team Meetings (CFTMs) whenever requested (see "Adherence to DCS Practice Model" section below).

- b) Through the teaming process DCS should participate in the continuous development of family goals.
- K. Providers, in order to ensure safety of the child(ren), must visit the child(ren) and identified caregivers in the home at a minimum of one time per week or more frequently if requested by DCS.
 - 1. The entire home must be assessed for safety during these visits.
 - 2. Documentation of this must occur and be reflected in the required monthly reports.
 - 3. Any safety concerns found must be immediately reported to DCS in accordance with subsection I.I above.
- L. Providers must submit their initial assessment and safety plan within 7 days of their first face-to-face visit to the FCM.
 - 1. Submissions should be made via upload to KidTraks
- M. If, during the course of service delivery, it becomes necessary to formally and indefinitely remove the child(ren) due to unresolvable safety concerns, the referral for Family Preservation Services will end, effective the date of the removal.

II. Inclusive Service Model

- A. The service shall be all-inclusive to meet the needs of the family.
 - 1. There should rarely be a need for DCS to refer the child(ren) or family for additional services.
 - a) Examples of services that may be outside of the services provided under this Service Standard include:
 - (1) Translation services
 - (2) Diagnostic and Evaluation services
 - (3) Residential Substance Use Treatment services
 - (4) Detoxification and other medical services
 - (5) Substance Use Outpatient Treatment
 - 2. To avoid confusion regarding services payable in addition to the Family Preservation Services per diem, Provider must actively communicate with the assigned FCM to determine which services are appropriate for the family and are consistent with the model(s) or practice(s) in place.

B. Concrete Assistance

1. Providers of this service will be expected to utilize the funds received from DCS through the course of their service delivery to address any concrete assistance needs that the family may have, if failing to address these needs would result in the child(ren) having to be removed from the home.
 - a) Examples of concrete assistance needs that may need to be met to prevent removal of the child(ren) from the home are:
 - (1) Overdue rent when the family is facing an eviction or other loss of housing.
 - (2) Past-due utilities that may result in electricity and/or gas to the home being suspended creating an unsafe or unsuitable living condition for the child(ren).
 - (a) Example: lack of heat during winter months, or water service being shut off
 - (3) Food or clothing insecurity.
 - (4) Other (this is not an all-inclusive list).
2. Whenever possible, Providers are encouraged to help the family identify and utilize available resources in their communities.
 - a. For example, families can be referred to food banks, trustee's offices, churches, etc. to meet their identified needs.
 - b. When this occurs, these should be opportunities to teach the family about the availability of these resources so families are knowledgeable and able to utilize them after the Family Preservation Provider is no longer working with the family.

C. This service includes but is not limited to:

1. Assessment of service need
2. Home-based casework services
3. Homemaker services
4. Parent engagement services
5. Parent Education
6. Transportation assistance

D. Providers are expected to follow fidelity to the model(s) they are utilizing and must document fidelity adherence.

E. If the child(ren) has to be formally and indefinitely removed from their caregiver(s), the referral for Family Preservation Services must end effective the date of the removal.

1. Providers must work with the DCS Local Office on canceling the Family Preservation referral and assist with transitioning the family/child(ren) to other appropriate services when this occurs.

2. If a child(ren) is removed from the home formally and indefinitely, but at least one child remains in the home, the child and family team (CFT) should discuss the appropriateness of continuing with Family Preservation Services. In the absence of a CFT, the Provider and DCS should discuss whether Family Preservation Services should continue.
- F. Short-term removals may not meet the criteria to end the Family Preservation Services referral, depending on circumstances.
1. An example of a short-term removal that may not necessitate the cancelation of Family Preservation Services is a removal that must occur for a parent to enter short-term detoxification services or time-limited residential or acute treatment.

III. Target Population

- A. All clients served must be restricted to the following eligibility categories:
1. Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
 - a) Given that the children have not been removed from their caregivers during the life of the current IA or CHINS case.
 2. Children and their families which have an Informal Adjustment (IA) or the children have the status of CHINS.
 - a) Given that the children have not been removed from the family targeted for preservation during the life of the current IA or CHINS case.
- B. Children who are not living with the targeted caregiver(s) for Family Preservation are ineligible for Family Preservation services.
1. If the child(ren) is in foster care or otherwise removed from the targeted caregiver(s), the child(ren) is not eligible for Family Preservation services.

IV. Goals and Outcomes

- A. Goal #1: Preservation of the referred family while ensuring the safety of the child(ren).
1. Objective: Providers will have clearly-developed treatment plans that target any apparent safety concerns including supervision and appropriate discipline.
 - a) Families, as well as DCS, will participate in the development of these plans.
 - b) Plans will be reviewed and updated regularly (at least one time per month) with input from the Child and Family Team. Updated plans will be sent to the referring worker each month included with the monthly report.

2. Objective: Quick access to treatment
 - a) 90% of families will have a face-to-face contact with the service provider within 3 days of receipt of referral
- B. Goal #2: Family will have protective factors in place which help to keep children safe.
 1. These protective factors include:
 - a) Parental Resilience
 - b) Social Connections
 - c) Knowledge of Parenting and Child Development
 - d) Concrete Supports in Times of Need
 - e) Socially and Emotionally Competent Children
 2. Objective: To ensure providers discuss and target the development of these Protective Factors, providers must complete the Protective Factors Survey, 2nd Edition (PFS-2) (found here: <https://friendsnrc.org/protective-factors-survey/pfs-2/>) within 30 days of receiving the Family Preservation Services referral, and every 3 months thereafter, for as long as the provider is working with the family under the Family Preservation Services referral.
 - a) The supplemental Protective Factors surveys, including the PFS-2 Retrospective and PFS-2 Concrete Supports may also be used to help providers better assess referred families and target interventions, but their use is not required.
 - b) Please note, while providers are encouraged to use the PFS-2 to assist with measuring referred families' progress, the tool is best used to start conversations with families around these critical factors that are dynamic (changeable), and thus they should be treatment targets.
 - (1) The tool has acknowledged "ceiling effects", making progress using the tool alone difficult to measure (this is a reason for the introduction of the PFS-2 Retrospective survey).
 - (2) The purpose of using this tool on a regular basis is to ensure that providers focus on development of these factors in their work with referred families, which should predict more families being able to be safely preserved.
- C. Goal #3: The concrete assistance needs of families will be met, preventing the need to remove the child(ren) from the home due to lack of housing, food, transportation, clothing, etc.

1. Objective: Families will learn how to meet their own concrete assistance needs with the help of the contracted provider.
 - a) The provider will complete a budget with the family and help them prepare for their own needs.
 - b) The provider, when appropriate, will assist the family with applications for Supplemental Nutrition for Needy Families (SNAP), Women, Infant, and Children Program (WIC), Medicaid, subsidized housing, etc.
 2. Objective: Before removing a child(ren) due to anything related to the concrete needs of a family, the Child and Family Team will discuss the best course of action for that family given the presenting circumstance.
 - a) If the provision of concrete assistance is deemed appropriate and will prevent the need for the removal of the child(ren), the contracted provider must assist the family with the need using their per diem or other (non-DCS funded assistance such as the Trustee's office, the faith community, other family members, etc.)
- D. Goal #4: Children will be safe during and after the provision of Family Preservation Services.
1. Objective: 91.33% of families who actively engage in treatment for at least 3 months will not be the subject of a new substantiated report of abuse or neglect during service provision (while their DCS case is open).
 2. Objective: 91.5% of families who actively participated in and successfully completed services will not be named in a new substantiated report of abuse or neglect 12 months post discharge.

V. Minimum Qualifications

- A. The program shall be staffed by appropriately-credentialed personnel who are:
 1. Trained and competent to complete the service as required by federal and State of Indiana law.
 2. Credentialed according to the requirements of the evidence-based model(s) used.
 3. Carrying appropriate caseloads. No member of the treatment team (excluding support staff) may carry a caseload greater than what is allowed by the model being delivered, provided that the caseload shall never be greater than 12.
- B. Support Staff
 1. Support staff may be used to supplement the professional staff when approved as part of the model or to supplement the model.
 2. These staff must be trained in the basic principles of the chosen model and their practice must be coordinated and directed by the direct professional staff.

C. Supervision

1. Supervisors must possess a Master's or Doctorate degree in:
 - a) Social work
 - b) Psychology
 - c) Marriage and family
 - d) Related human service field
 - e) Must possess a current license issued by the Indiana Behavioral Health and Human Services Licensing Board
 - (1) Or be consistent with model expectations for supervision.
2. Supervision shall occur semi-monthly.
 - a) With at least one instance of supervision being one-on-one supervision between the worker and the supervisor
 - (1) The other minimally-required supervision may be in a group format.
 - b) Each supervision session must last for a minimum of one hour.
 - c) If the model being utilized requires a different frequency or format of supervision, fidelity to the model must be followed.

VI. Billable Units

A. Per Diem Rate

1. The per diem will start the day of the first face-to-face with the targeted caregiver(s).
2. The per diem will end the day of the closure of the case or the day the child(ren) is removed from the home.

B. Medicaid

1. For medically necessary services:
 - a) Medicaid or other third party payers may be utilized to treat the presenting condition.
 - b) Examples of medically necessary services include, but are not limited to:
 - (1) Substance Use Disorder Treatment
 - (2) Detoxification
 - (3) Acute hospitalization
2. The per diem rates are developed assuming that DCS will pay for the full cost of the services provided under the evidence-based models that form the foundation of the work with the family.
3. Providers should not bill Medicaid (or any other third party) for the services that DCS is providing, but Medicaid can be billed for any covered services that are provided outside of the DCS per diem model.

- C. Interpretation, Translation, and Sign Language Services
 - 1. The location of and cost of interpretation, translation, and sign language services are the responsibility of the Service Provider.
 - 2. If the translation, sign language, or interpretation service is needed in the delivery of Family Preservation 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 agency's invoice for this service must be provided when billing DCS for the service.
 - 4. Providers can use DCS contracted agencies and request that they be given the DCS contracted rate, but this is not required.
 - 5. The Service Provider is free to use an agency or persons of their choosing as long as the interpretation, translation, or sign language service is provided in an accurate and competent manner and billed at a fair market rate.

VII. Reporting

- A. Providers will be required to prepare, maintain, and provide any statistical reports, program reports, other reports, or other information as requested by DCS relating to the services provided.
- B. These monthly reports are due by the 10th of the month, unless requested earlier by DCS, following service provision.
- C. DCS will require an electronic reporting system which will include documenting time and services provided to families.
- D. DCS may, but is not obligated to, adopt and require Provider to use a standardized tool for evaluating family functioning.

VIII. Case Record Documentation

- A. Case record documentation for service eligibility must include:
 - 1. A completed, and dated DCS referral form authorizing services
 - 2. Copy of DCS case plan, informal adjustment documentation, or documentation of request 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 provision, unless requested earlier by DCS. Case documentation shall show when report is sent and include:
 - a) Provider recommendations to modify the service/treatment plan
 - b) Discuss overall progress related to treatment plan goals including specific examples to illustrate progress
7. Progress/Case Notes must document: date, start time, end time, participant(s), individual providing service, and location.
8. When applicable Progress/Case notes may also include:
 - a) Service/Treatment plan goal addressed (if applicable)
 - b) Description of intervention/activity used towards treatment plan goal
 - c) Progress related to treatment plan goal including demonstration of learned skills
 - d) Barriers: lack of progress related to goals
 - e) Clinical impressions regarding diagnosis and or symptoms (if applicable)
 - f) Collaboration with other professionals
 - g) Consultations/Supervision staffing
 - h) Crisis interventions/emergencies
 - i) Attempt to contact clients, FCMS, foster parents, other professionals, etc.
 - j) Communication with client, significant others, other professionals, school, foster parents, etc.
 - k) Summary of CFT meetings, case conferences, staffing
9. Supervision Notes must include:
 - a) Date and time of supervision and individuals present
 - b) Summary of supervision discussion including presenting issues and guidance given

IX. Adherence to DCS Practice Model

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

X. Interpreter, Translation, and Sign Language Services

- A. All Services provided on behalf of DCS 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 interpreter(s) is to be competent in both English and the non-English Language (and dialect) that is being requested and shall refrain from adding or deleting any of the information given or received during an interpretation session.
- H. No side comments or conversations between the interpreters and the clients should occur.

XI. Trauma Informed Care

- A. Prior to service initiation, provider must develop a core competency in Trauma Informed Care as defined by the National Child Traumatic Stress Network (<https://www.nctsn.org/trauma-informed-care/creating-trauma-informed-systems>).
- B. A service system with a trauma-informed perspective is one in which agencies, programs, and service providers:
 - 1. Routinely screen for trauma exposure and related symptoms.
 - 2. Use evidence-based, culturally responsive assessment and treatment for traumatic stress and associated mental health symptoms.
 - 3. Make resources available to children, families, and providers on trauma exposure, its impact, and treatment.
 - 4. Engage in efforts to strengthen the resilience and protective factors of children and families impacted by and vulnerable to trauma.
 - 5. Address parent and caregiver trauma and its impact on the family system.
 - 6. Emphasize continuity of care and collaboration across child-service systems.
 - 7. Maintain an environment of care for staff that addresses, minimizes, and treats secondary traumatic stress, and that increases staff wellness.
- C. These activities are rooted in an understanding that trauma-informed agencies, programs, and service providers:
 - 1. Build meaningful partnerships that create mutuality among children, families, caregivers, and professionals at an individual and organizational level.
 - 2. Address the intersections of trauma with culture, history, race, gender, location, and language.
 - 3. Acknowledge the compounding impact of structural inequity and are responsive to the unique needs of diverse communities.

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 the following link (or any designated successor link): <http://www.in.gov/dcs/3493.htm>
 - 1. Review the **Resource Guide for Training Requirements** to understand Training Modules, expectations, and Provider 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 into 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 (LGBTQ) 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 the following link (or any designated successor link):
<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. Provider 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.