Department of Children's Services

Delegated Authority Procured Services
For Existing and Potential Vendors

FY2024-25 Service Description Guideline & Criteria

DCS, Office of Child Health

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FY 2024-25 Service Description Guideline and Criteria

Contents

Alcohol and Drug Assessment

This assessment will be provided by one of the following:

- a Licensed Mental Health Professional (Master's or above) or
- a Licensed Alcohol and Drug Abuse Counselor (LADAC either Level I or II) or
- an individual supervised by a licensed mental health professional or a LADAC II. The assessment will be signed by the supervising professional, who is responsible for the interpretation of the test results. Examiners will practice within the scope of their license.

The Alcohol and Drug Assessment Report will consist of:

- Referral question(s)
- Referral source
- Background information
- Assessment procedures
- Relevant test procedures
- Assessment results
- Interpretation of results
- Summary and recommendations

This assessment:

- Will be initiated within ten working days from the date on which the individual or their parent or other legal representative requests services and completed within thirty working days of the initiation of the assessment.
- Is appropriate for children or youth who have suspected alcohol or drug use. These evaluations are useful in determining placement and treatment needs.
- Will consist of a review of relevant history. A clinical interview with the child or youth and caregivers will be conducted and the validity of the information given will be assessed.
- Will include at least one standardized instrument with proven validity and reliability for assessing alcohol and drug usage.

The report will include recommendations for treatment and address whether the treatment can be received on an outpatient or residential basis. The safety of the child or youth will be considered in making these recommendations.

Alcohol and Drug Case Management (Non-Clinical)

Alcohol & Drug Case Management is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality cost-effective outcomes. Alcohol & Drug Case Management focuses on provision of consistent direct support, skills training, obtaining, and coordinating services and resources, and maximizing strengths and recovery outcomes. The provider is licensed by the Tennessee Department of Mental Health and Substance Abuse Services (DMHSAS) as an Out-Patient Mental Health Facility.

Services include:

- Documented Case Management Assessment and Service Plan
- The Service Plan has measurable goals with clear outcomes identified as long- or short term

with anticipated date of accomplishment and action steps to accomplish each goal.

- staff availability for 24/7 on-call crisis response
- A plan of crisis prevention/resolution
- Flexibility which meets the needs and schedule of the child and family as determined in the CFTM.
- A minimum of four (4) face to face encounters each month with the family and two (2) with other systems such as school, therapist, or judicial/legal authorities. Each family encounter is at least 30 minutes in duration. Transport or travel time, documentation time or phone contact are not considered face-to-face contact.
- Ensures coordination and continuity of care, developing collaborative relationships with treating psychiatrists, nurses, PCPs, therapists, inpatient providers, and educators for all family members.
- Documentation of all services provided. Monthly Reports should be provided by the 5th day of the following month.
- The case manager to family ratio will not exceed 1:15.
- Expected outcomes include:
    - Increased:
        - participate in recovery services,
        - time in school,
        - social contacts and
        - child/youth and family satisfaction
    - Decreased:
        - number of positive drug screens,
        - frequency of relapse,
        - crisis episodes,
        - number of services required and
        - family stress
- Alcohol & Drug case managers will have at least a bachelor's degree in a related field mental health or behavioral science field and under the direct supervision of a A&D CM supervisor with at least a master's level license in counseling, psychology, social work, or nursing or are licensed as through the Board of Alcohol and Drug Abuse Counselors. A&D CM clinical supervision occurs at least twice biweekly and documented.
- Ongoing case management and social, medical, clinical, educational support services to support an individual who has achieved sobriety and re-integrate into society. Services can be provided individually, group and/or on a family basis. The individual receiving services may be in the home or living in an alternative location such as a halfway house designed to be a safe and drug-free environment.
- "Alcohol and Drug Halfway House Treatment Facility" means a transitional residential program providing services to service recipients with alcohol and/or drug abuse or dependency disorders with the primary purpose of establishing vocational stability and counseling focused on re-entering the community.
- "Alcohol and Drug Residential Rehabilitation Treatment Facility" means a residential program for service recipients at least 18 years of age, which offers highly structured services to service recipients with the primary purpose of restoring service recipients with alcohol and/or drug abuse or dependency disorders to levels of positive functioning and abstinence appropriate to the service recipient.

- Any assessment deemed self-report being completed whether it be A/D, mental health, or parenting should require a phone call to the referring agency to gather additional information as to the request of the assessment before the final report is completed and recommendations are made.

Alcohol and Drug Case Management (Clinical/Medical)

Specialized services to address substance abuse and the impact on the family requiring higher level psychological and/or medical interventions and oversight. The parent/caregiver's substance abuse is unstable enough to jeopardize the children/youth remaining in the family setting but not severe enough to require a more intense level of care, and outpatient services alone are not sufficient to meet the family's needs. The service can be provided in the home or office setting.

Service Description:

Evidence based intensive, home-based case management services designed to protect, treat, and support families. The child/youth's clinical status is unstable enough to jeopardize remaining in the family setting but not severe enough to require a more intense level of care and outpatient services alone are not sufficient to meet the family's needs. The provider is licensed by the Tennessee Department of Mental Health and Substance Abuse Services (DMHSAS) as an Outpatient Mental Health Facility.

Services include:

- Contact with the family within 24 hours of referral If contact has not been established within 5 (five) business days, provider contacts the referring agency for notification purposes.
- First face-to-face meeting within 24 hours
- Documented Case Management Assessment and Service Plan
- The Service Plan has measurable goals with clear outcomes identified as long- or short term with anticipated date of accomplishment and action steps to accomplish each goal.
- Staff availability for 24/7 on-call crisis response
- A plan of crisis prevention/resolution
- Flexibility which meets the needs and schedule of the child and family as determined in the CFTM.
- A minimum of three (3) face-to-face family/child contacts per week which includes at least one weekly contact with other systems with a minimum of 45 minutes per contact.
- Additional contacts made through a wraparound team of specialized treatment staff in partnership with the A&D case manager.
- Documentation of all service provided; Monthly Reports should be provided by the 5th day of the following month.
- Ensures coordination and continuity of care, developing collaborative relationships with treating psychiatrists, nurses, PCPs, therapists, inpatient providers, and educators for all family members.
- The case manager to family ratio will not exceed 1:5.
- Expected outcomes include:
    - Increased:
        - Participation in Recovery Services

        - In home care
        - Social integration
        - Family satisfaction
        - Regular school attendance
        - Other system support
    - Decreased:
        - Number of Positive Drug Screens
        - Frequency of Relapse
        - Out of home care or hospitalization
        - Level of care need
        - Symptoms and side effects

- Alcohol & Drug case managers will have at least a master's degree in a related field mental health or behavioral science field, are licensed as through the Board of Alcohol and Drug Abuse Counselors, and/or are licensed as a Registered Nurse with two years of experience in treatment of substance abuse disorders and under the direct supervision of a A&D CM supervisor with at least a master's level license in counseling, psychology, social work, or nursing. A&D CM clinical supervision occurs at least twice biweekly and documented.
- Ongoing case management and social, medical, clinical, educational support services to support an individual who has achieved sobriety and re-integrate into society. Services can be provided individually, group and/or on a family basis. The individual receiving services may be in the home or living in an alternative location such as a halfway house designed to be a safe and drug-free environment.
- Any assessment deemed self-report being completed whether it be A/D, mental health, or parenting should require a phone call to the referring agency to gather additional information as to the request of the assessment before the final report is completed and recommendations are made.

Alcohol and Drug Treatment

This evidence-based treatment* of alcohol and drug abuse and dependence is provided by an independently licensed mental health professional who has had appropriate training and/or supervision in alcohol and drug treatment or is a Licensed Alcohol and Drug Abuse Counselor I or II, or by a non-licensed staff member who is supervised by an independently licensed mental health professional or a Licensed Alcohol and Drug Abuse Counselor II. The service can be provided in the home or office setting and can be delivered on an individual, group, or family basis. Services provide intervention, support, and referral for children and family members who are impacted by alcohol and drug issues.

Anger Management/Conflict Resolution

Evidence-based* education or clinical treatment which focuses on, at a minimum:

- Identification of Triggers and Physical and emotional signs
    - Identification of anger triggering stressors or situations
    - Physical and emotional signs of anger
- Acquisition of anger management skills and strategies
    - Logical assessment of situations
    - Appropriate expression of feelings and needs.

- Self-calming techniques
- Problem solving skills
- Communication skills

Assessment for Children with Sexual Behavior Problems (Ages 12 and under)

This assessment will be performed by a Licensed Mental Health Professional (Master's or above) who has received training in this type of assessment through opportunities such as conferences, trainings, academic work, practicum or internship, and direct supervision by a qualified assessor. DCS will review and assess the level of qualification of the person(s) who provided the training or supervision.

This Licensed Mental Health Professional generates and signs the report. If testing is administered by an individual other than the Licensed Mental Health Professional, that individual is either master's level mental health professional or is a Certified Psychological Assistant. The individual is identified, along with his/her training and qualifications. Tests are administered in accordance with the standards provided by the developer of the test.

The Assessment for Children with Sexual Behavior Problems Report includes information related to the following items (taken from the TDMHSAS Best Practice Guidelines):

- Referral question(s)
- Referral source
- Sources of Information
- History of sexual behavior problems
- History of abuse, neglect, and/or adverse childhood experiences
- Developmental History
- Family history
- Social History
- Psychiatric / Treatment History
- School History / Intellectual Functioning
- Medication History
- Any appropriate assessment or testing measures
- Results and Interpretation
- Summary and recommendations

This assessment is appropriate for young children who have been engaging in inappropriate sexual behavior. These evaluations are useful in determining placement and treatment needs.

This assessment will consist of a review of relevant history, including details of the alleged sexual acting-out. The focus will be on the context of the behavior and family and environmental issues that may be impacting this behavior. A clinical interview with the child and caregivers will be conducted and the validity of the information given will be assessed. A brief Mental Status Examination, including an estimate of his or her level of intellectual functioning, is appropriate as part of the interview with the child.

Each assessment will include an evaluation of the child's sexual knowledge and knowledge of rules regarding appropriate sexual behavior.

Appropriate instruments for use in these assessments include:

- The Child Sexual Behavior Inventory (CSBI)
- The Child Sexual Behavior Checklist (CSBCL-2nd revision)

- The Weekly Behavior Report (WBR)
- Child Behavior Checklists (CBCL)
- Behavior Assessment System for Children (BASC)
- Trauma Symptom Checklist for Children (TSCC)

Other assessments may be acceptable if there is evidence of validity and reliability for assessing behavior problems in children in this age range.

The examiner uses other relevant standardized instruments to assess related behavior, and mental health issues, including cognitive functioning if indicated.

The report will include recommendations for treatment and address whether the treatment can be received on an outpatient or residential basis. The safety of the community and the victim/s will be considered in making these recommendations. If this child is placed in a home with other young children, the examiner may be asked to assist in developing a safety plan for the home.

The assessment will be initiated within 15 working days from the date on which the individual or their parent or other legal representative requests services and completed within thirty working days of the final interview of the person being evaluated.

Combined Mental Health and A&D Assessment

The purpose of combined mental health and A&D assessment is to gather information to determine if a mental illness to include any possible substance use disorder(s) exist and to develop a service plan to address the individual's needs. This assessment is appropriate for youth or adults with suspected or documented substance use concerns in combination with a need to assess mental health needs.
The combined Mental Health and A&D assessment will:

- Be provided by a licensed mental health professional or unlicensed (Master's or above) professional being supervised by a licensed mental health profession. When the assessment is provided by an unlicensed master's level mental health professional, the assessment will be supervised and signed by an independently licensed professional.
- Be initiated within ten working days from the date on which the individual or their parent or other legal representative requests services and completed within thirty working days of the initiation of the intake.
- Be culturally and age relevant.
- Document the presenting problem(s) as described by the individual.
- Review any medical or behavioral health records provided by the individual.
- Be inclusive of people who provide active support to the individual, if the individual so requests, or if the individual is under thirteen years of age.
- Document current physical health status, including any medications the individual is taking.
- Assess substance use and abuse:
    - Gather background information on substance use history (across the various classes of substances) including substance use frequency, duration of use, last use, history of withdrawal, longest period of abstinence , prior legal history, sanctions, negative consequences related to use and any information from collateral contacts.
    - Must include a standardized instrument with proven validity and reliability for assessing alcohol and drug usage.
    - Provide assessment results and interpretation of the results of the screen.

- Include sufficient clinical information to justify the provisional diagnosis using diagnostic and statistical manual (DSM-5) criteria. This is to include any applicable substance use disorder diagnoses.
- Identify risk of harm to self and others, including suicide/homicide. Note: A referral for provision of emergency/crisis services, will be made if indicated in the risk assessment; and
- Recommend a course of treatment and in the case of substance use concerns, address whether the A&D treatment can be received on an outpatient or residential basis and whether an assessment for medical detox is needed.

Comprehensive Trauma Assessment

The purpose of a comprehensive trauma assessment is to provide a thorough snapshot of the child/youth who has experienced trauma/s via an assessment of the traumatic event/s, how these events affect current level of functioning across all relevant domains, within the context of the current environment as well as treatment recommendations. The assessment should be conducted by, at minimum, a licensed master's level clinician or a master's level clinician under the supervision of a licensed provider, with the report signed by the independently licensed professional.

The comprehensive trauma assessment will include the following information:

- Description of trauma exposure
- PTSD symptoms
- Current trauma triggers
- Child's response to trauma including:
    - Effects on interpersonal relationships
    - Somatic symptoms
    - Social engagement
    - Academic performance
    - Behavioral symptoms
    - Affect dysregulation.
    - Dissociative symptoms
- Child's perception of the impact of trauma
    - A description of the child's narrative about how the trauma is currently affecting them. Consider factors such as whether they are minimizing their experience, level of insight into the current presentation and how it might be related to the trauma experience as well as the child's perspective on the future.
- Caregiver/family functioning
    - Provide a description of the family's narrative about the trauma including factors such as whether they are minimizing the trauma or are supportive, their understanding of the possible relationship between current presentation and traumatic experience/s as well as the family's expectations regarding future and how the effects of trauma can be resolved.
    - Assess whether the family is supportive of treatment and already engaged or willing to engage in treatment.
    - Assess presence of generational trauma.

- Risk and Protective factors of youth and family

The assessment is conducted through:

- Clinical interview with the youth
- Standardized Measures:
    - UCLA/Northshore
    - BASC-3 or similar standardized behavioral checklist that assesses for other mental health symptoms.
- Collateral information including review of DCS records, review of treatment, and INTERVIEWS with caregivers, teachers, and other adults involved in the youth's daily life that can speak to the youth's current functioning.

The assessment should also include:

- Thorough case conceptualization with synthesis and analysis of trauma, current functioning, and environmental factors.
- DSM Diagnoses
- Treatment recommendations

Co-occurring Alcohol and Drug/Mental Health Treatment

Alcohol & Drug Counseling is the evidence-based* treatment of substance abuse disorders along with accompanying/underlying mental illness, behavioral disorders or any other emotional/mental health conditions for individuals or families. This service is provided by a licensed or mental health professional (master's or above) that meets the definition of "Qualified Provider" in Department of Mental Health and Substance Abuse Services rule 0940-05-35. When the treatment is provided by a master's level professional, the treatment will be supervised by, and treatment notes signed by the independently licensed professional.

The service can be provided in the home or office setting and can be delivered on an individual, group, or family basis. Virtual sessions shall only occur in the event of an emergency.

Maintenance of documentation should be done in accordance with your licensing body's ethical guidelines. Monthly Reports should be provided by the 5th day of the following month.

Any assessment deemed self-report being completed whether it be A/D, mental health, or parenting should require a phone call to the referring agency to gather additional information as to the request of the assessment before the final report is completed and recommendations are made.

Intensive In-Home Family Services

Evidence based short term intensive, home-based case management services designed to protect, treat, and support families. The child/youth's clinical status is unstable enough to jeopardize remaining in the family setting but not severe enough to require a more intense level of care and outpatient services

alone are not sufficient to meet the family's needs. The provider is licensed by the Tennessee Department of Mental Health and Substance Abuse Services (DMHSAS) as an Outpatient Mental Health Facility.

Services include:

- Contact with the family within 24 hours of referral.
- First face-to-face meeting within 48 hours
- Documented Case Management Assessment and Service Plan
- The Service Plan has measurable goals with clear outcomes identified as long- or short term with anticipated date of accomplishment and action steps to accomplish each goal.
- Staff availability for 24/7 on-call crisis response
- A plan of crisis prevention/resolution
- Flexibility which meets the needs and schedule of the child and family as determined in the CFTM.
- A minimum of three (3) face-to-face family/child contacts per week which includes at least one weekly contact with other systems with a minimum of 45 minutes per contact.
- Documentation of all service provided.
- Ensures coordination and continuity of care, developing collaborative relationships with treating psychiatrists, nurses, PCPs, therapists, inpatient providers, and educators for all family members.
- The case manager to family ratio will not exceed 1:5.
- Expected outcomes include:
    - Increased:
        - In home care
        - Social integration
        - Family satisfaction
        - Regular school attendance
        - Other system support
    - Decreased:
        - Out of home care or hospitalization
        - Level of care need
        - Symptoms and side effects

Mental health case managers will have at least a bachelor's degree in a related field mental health or behavioral science field and under the direct supervision of a MHCM supervisor with at least a master's level license in counseling, psychology, social work, or nursing. MHCM clinical supervision occurs at least twice biweekly and documented.

Intensive Outpatient Alcohol and Drug Treatment

Compared to outpatient services, intensive outpatient treatment (IOT), also referred to as an intensive outpatient program (IOP), provides an increased frequency of contact and services. An agency wishing to provide IOT should be licensed with the Tennessee Dept. of Mental Health and Substance Abuse Services as an Alcohol and Drug Non-Residential Rehabilitation Treatment Facility. As such, all rules, and regulations for this type of facility must be followed. An individual wishing to provide IOT should be licensed by their discipline specific board through the Department of Health-Related Boards.

This evidence based treatment* of alcohol and drug abuse and dependence is provided by an independently licensed mental health professional who has had appropriate training and/or supervision in alcohol and drug treatment or is a Licensed Alcohol and Drug Abuse Counselor I or II, or by a non-licensed staff member who is supervised by an independently licensed mental health professional who has received training in this type of treatment through opportunities such as conferences, trainings, academic work, practicum or internship, and direct supervision by a qualified therapist or a Licensed Alcohol and Drug Abuse Counselor II. IOT programs must be based upon evidence-based practices. Each program must be supervised by an independently licensed professional with experience and training in the treatment of substance use disorders.

- A minimum of 9 hours or more per week.
- Services are provided over 3 to 5 days per week.
- Therapy may take the form of individual therapy, group-based interventions, or a combination of both.

Intensive Alcohol and Drug Case Management (Non-Clinical)

Evidence based intensive, home-based case management services designed to protect, treat, and support families. The child/youth's clinical status is unstable enough to jeopardize remaining in the family setting but not severe enough to require a more intense level of care and outpatient services alone are not sufficient to meet the family's needs. The provider is licensed by the Tennessee Department of Mental Health and Substance Abuse Services (DMHSAS) as an Outpatient Mental Health Facility.

Services include:

- Contact with the family within 24 hours of referral. If contact has not been established within 5 (five) business days, provider contacts the referring agency for notification purposes.
- First face-to-face meeting within 24 hours
- Documented Case Management Assessment and Service Plan
- The Service Plan has measurable goals with clear outcomes identified as long- or short term with anticipated date of accomplishment and action steps to accomplish each goal.
- Staff availability for 24/7 on-call crisis response
- A plan of crisis prevention/resolution
- Flexibility which meets the needs and schedule of the child and family as determined in the CFTM.
- A minimum of three (3) face-to-face family/child contacts per week which includes at least one weekly contact with other systems with a minimum of 45 minutes per contact.
- Additional contacts made through a wraparound team of specialized treatment staff in partnership with the A&D case manager.
- Documentation of all service provided Monthly Reports should be provided by the 5th day of the following month.
- .Ensures coordination and continuity of care, developing collaborative relationships with treating psychiatrists, nurses, PCPs, therapists, inpatient providers, Certified peer support and educators for all family members.
- The case manager to family ratio will not exceed 1:10
- Expected outcomes include:
    - Increased:

        - Participation in Recovery Services
        - In home care
        - Social integration
        - Family satisfaction
        - Regular school attendance
        - Other system support
    - Decreased:
        - Number of Positive Drug Screens
        - Frequency of Relapse
        - Out of home care or hospitalization
        - Level of care need
        - Symptoms and side effects

- Alcohol & Drug case managers will have at least a bachelor's degree in a related field mental health or behavioral science field and under the direct supervision of a A&D CM supervisor with at least a master's level license in counseling, psychology, social work, or nursing or are licensed as through the Board of Alcohol and Drug Abuse Counselors. A&D CM clinical supervision occurs at least twice biweekly and documented.
- Ongoing case management and social, medical, clinical, educational support services to support an individual who has achieved sobriety and re-integrate into society. Services can be provided individually, group and/or on a family basis. The individual receiving services may be in the home or living in an alternative location such as a halfway house designed to be a safe and drug-free environment.
- Any assessment deemed self-report being completed whether it be A/D, mental health, or parenting should require a phone call to the referring agency to gather additional information as to the request of the assessment before the final report is completed and recommendations are made.

Mental Health Assessment

The purpose of mental health assessment is to gather information to determine if a mental illness exists and to develop a service plan to address the individual's needs.
The intake evaluation will:

- Be provided by a licensed or mental health professional (Master's or above). When the assessment is provided by a master's level mental health professional, the assessment will be supervised and signed by an independently licensed professional.
- Be initiated within ten working days from the date on which the individual or their parent or other legal representative requests services and completed within thirty working days of the initiation of the intake.
- Be culturally and age relevant.
- Document the presenting problem(s) as described by the individual.
- Review any medical or behavioral health records provided by the individual.
- Be inclusive of people who provide active support to the individual, if the individual so requests, or if the individual is under thirteen years of age.
- Document current physical health status, including any medications the individual is taking.
- Assess substance use and abuse and treatment status.

- Include sufficient clinical information to justify the provisional diagnosis using diagnostic and statistical manual (DSM-5) criteria.
- Identify risk of harm to self and others, including suicide/homicide. Note: A referral for provision of emergency/crisis services, will be made if indicated in the risk assessment; and
- Recommend a course of treatment.

Mental Health Case Management

Mental Health Case Management is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality cost-effective outcomes. Mental Health Case Management focuses on provision of consistent direct support, skills training, obtaining, and coordinating services and resources, and maximizing strengths and recovery outcomes. The provider is licensed by the Tennessee Department of Mental Health and Substance Abuse Services (DMHSAS) as an Out-Patient Mental Health Facility.

Services include:

- Documented Case Management Assessment and Service Plan
- The Service Plan has measurable goals with clear outcomes identified as long- or short term with anticipated date of accomplishment and action steps to accomplish each goal.
- staff availability for 24/7 on-call crisis response
- A plan of crisis prevention/resolution
- Flexibility which meets the needs and schedule of the child/ family as determined in the CFTM.
- A minimum of two (2) face to face encounters each month with the family and two (2) with other systems such as school, therapist, or judicial/legal authorities. Each encounter is at least 15min in duration. Transport or travel time, documentation time or phone contact are not considered face-to-face contact.
- Ensures coordination and continuity of care, developing collaborative relationships with treating psychiatrists, nurses, PCPs, therapists, inpatient providers, and educators for all family members.
- Documentation of all service provided.
- The case manager to family ratio will not exceed 1:30.
- Expected outcomes include:
    - Increased:
        - time in school,
        - social contacts and
        - child/youth and family satisfaction
    - Decreased:
        - crisis episodes,
        - number of services required and
        - family stress
- Mental health case managers will have at least a bachelor's degree in a related field mental health or behavioral science field and under the direct supervision of a MHCM supervisor with at least a master's level license in counseling, psychology, social work, or nursing. MHCM clinical supervision occurs at least twice biweekly and documented.

Neuropsychological Assessment (Children and Youth)

This evaluation is performed only by a Tennessee Licensed Psychologist with appropriate training and expertise in this area, and the report is generated and signed by that Psychologist. If testing is administered by an individual other than the Licensed Psychologist, that individual is either pursuing licensure, a Certified Psychological Assistant, or an intern at an APA internship. The individual is identified, along with his/her training and qualifications. Tests are administered in accordance with the standards provided by the developer of the test.

The Neuropsychological Assessment Report will consist of:

- Referral question(s)
- Referral source
- Background information
- Assessment procedures
- Relevant test procedures
- Assessment results
- Interpretation of results
- Summary and recommendations

The Neuropsychological Assessment consists of a review of available information regarding the child/youth's developmental, medical, and behavioral, substance use, educational, familial, and social history.

Tests and procedures employed in a neuropsychological evaluation vary as a function of:

- Purpose of evaluation.
- Neurological intactness of the examinee.
- Thoroughness of the evaluation.

For a neuropsychological evaluation a battery of tests administered will include, at a **minimum**:

- Intelligence Tests.
- Personality Tests.
- Perceptual-Motor/Memory Tests

All testing will be performed using valid and reliable measures and include a statement as to validity of responses.

The summary will address the referral question(s) drawing support from the assessment findings. Recommendations regarding treatment, educational, and socialization needs, caretaker guidelines, and other factors as applicable will be included as well. Diagnostic impression on all axes of the most recent edition of the DSM is required.

The assessment will be initiated within 30 working days from the date on which the individual or their parent or other legal representative requests services and completed within thirty working days of the final interview of the person being evaluated.

Neuropsychological Assessment (adults)

This evaluation is performed only by a Tennessee Licensed Psychologist with appropriate training and expertise in this area, and the report is generated and signed by that Psychologist. If testing is

administered by an individual other than the Licensed Psychologist, that individual is either pursuing licensure, is a Certified Psychological Assistant or an intern at an APA internship. The individual is identified, along with his/her training and qualifications. Tests are administered in accordance with the standards provided by the developer of the test.

The Neuropsychological Assessment Report will consist of:

- Referral question(s)
- Referral source
- Background information
- Assessment procedures
- Relevant test procedures
- Assessment results
- Interpretation of results
- Summary and recommendations

The Neuropsychological Assessment consists of a review of available history regarding DCS involvement and referral concerns. The evaluation will include relevant history regarding developmental, medical, and behavioral, educational, substance use, and social functioning.

Tests and procedures employed in a neuropsychological assessment vary as a function of:

- Purpose of evaluation.
- Neurological intactness of the examinee.
- Thoroughness of the evaluation.

For a neuropsychological assessment a battery of tests administered will include, at a **minimum**:

- Intelligence Tests.
- Personality Tests.
- Perceptual-Motor/Memory Tests

All testing will be performed using valid and reliable measures and include a statement as to validity of responses.

The summary will address the referral question(s) drawing support from assessment findings. Recommendations regarding treatment and educational needs, caretaker strengths and deficits, and other factors as applicable will be included as well. Diagnostic impression on all axes of the most recent edition of the DSM is required.

The assessment will be initiated within 30 working days from the date on which the individual or their parent or other legal representative requests services and completed within thirty working days of the final interview of the person being evaluated.

Parenting Capacity Assessment

The Parenting Capacity Assessment is performed by a licensed mental health professional (Master's or above) with training in professional assessment practices and standards, which includes appropriate experience and supervision in parenting assessments. This Licensed Mental Health Professional generates and signs the report. If testing is administered by an individual other than the Licensed Mental Health Professional, that individual is either master's level mental health professional, or is a Certified Psychological Assistant. The individual is identified, along with his/her training and

qualifications. Tests are administered in accordance with the standards provided by the developer of the test.

The Parent Capacity Assessment will use a "minimal parenting standard" *, i.e., does the parent meet the basic safety and emotional needs of the child(ren).

The Parenting Capacity Assessment Report will consist of:

- Referral question(s)
- Referral source
- Background information
- Assessment procedures
- Relevant test procedures
- Assessment results
- Interpretation of results
- Summary and recommendations

Areas of Functional Parenting Skills to evaluate will include:

- Physical, cognitive, and social/emotional care needs of the child
- Physical/self-care, cognitive, and social/emotional personal competence of the parent

The assessment will include:

- Clinical interview of the parent
- Review of available information of the child and parent
    - Court records
    - DCS records
    - Past medical and behavioral assessments/evaluations and treatment records
- Observation of parent and child in a natural setting (unless "no contact" court order)
    - If not able to observe interaction, specify in the report why and the attempts made to fulfill this requirement of the assessment.
- Administration of relevant assessment instruments and parenting inventories
    - Child Abuse Potential Inventory
    - Parent Opinion Questionnaire
    - Other
- Interview collateral sources (can be by phone), for example:
    - Case worker (DCS, continuum, mental health)
    - Therapist (child's, parents', and/or family therapist)
    - Resource parent
- Administration of child assessment measures if indicated.

All testing will be performed using valid and reliable measures and include a statement as to validity of responses.

The summary and recommendations will address the referral question(s), strengths as well as weaknesses, and identify possible precipitants and maintaining variables for parent's problems drawing support from the assessment findings. The summary will also address limitations of the assessment. Recommendations will suggest interventions to address identified weaknesses and problems.

The assessment will be initiated within 15 working days from the date on which the individual or their parent or other legal representative requests services and completed within thirty working days of the final interview of the person being evaluated.

* For more information on "minimal parenting standard" see Budd, K. S., Connell, M., & Clark, J. R. (2011). *Best practices in forensic mental health assessment: Evaluation of parenting capacity in child protection*. New York: Oxford.

Psychoeducational Assessment (children and youth)

This evaluation is performed only by a Tennessee Licensed School Psychologist, a Licensed Psychologist or an independently Licensed Psychological Examiner, and the report is generated and signed by that individual. If testing is administered by an individual other than the Licensed Psychologist, that individual is either pursuing licensure or is a Certified Psychological Assistant. The individual is identified, along with his/her training and qualifications. Tests are administered in accordance with the standards provided by the developer of the test.

The Psychoeducational Assessment Report will consist of:

- Referral question(s)
- Referral source
- Background information
- Assessment procedures
- Relevant test procedures
- Assessment results
- Interpretation of results
- Summary and recommendations

The assessment consists of a review of available information regarding the child or youth's developmental, medical, and behavioral history. Educational review consists of a review of data from tests of intelligence and educational achievement, and at times, ratings tests of attention, behavior/emotions, and adaptive behavior.

The Psychoeducational Assessment will include:

- An individually administered full-length IQ test.
- An individually administered achievement test with multiple measures of reading, writing, mathematics, and, sometimes, language.
- Additional cognitive testing in areas not addressed by the IQ test (e.g., auditory/phonological processing, long-term retrieval, and retention).
- Rating scales to assess attention deficit/hyperactivity disorder and/or a computerized test of attention if attentional problems are indicated in the history, interview, and/or assessment.
- A measure(s) of adaptive behavior if low borderline or mentally deficient intellectual functioning is indicated.

All testing will be performed using valid and reliable measures and include a statement as to validity of responses.

The summary will address the referral question(s) drawing support from the assessment findings and resultant diagnoses. The summary will also include a statement indicating whether Tennessee standards for any special education disability have been met. Recommendations of specific educational

strategies, accommodations, methods, and interventions to address weaknesses in cognitive and academic abilities caretaker guidelines, and other factors as applicable will be included as well.

In addition to educational recommendations, recommendations for further assessment (e.g., medical evaluation) and other services (e.g., psychological counseling or therapy) may be appropriate. In some cases, assessment may indicate the child/youth does not appear capable of performing at a level consistent with meeting current goals (e.g., attending college, passing the HISET etc.). In these instances, recommendations for counseling and seeking alternative services would be appropriate.

The assessment will be initiated within 15 working days from the date on which the individual or their parent or other legal representative requests services and completed within thirty working days of the final interview of the person being evaluated.

Psychological Assessment (children and youth)

This assessment is performed only by a Tennessee Licensed Psychologist or independently licensed Psychological Examiner, and the report is generated and signed by that individual. If testing is administered by an individual other than the Licensed Psychologist, that individual is a master's level mental health professional, a Certified Psychological Assistant, or an intern at an APA internship. The individual is identified, along with his/her training and qualifications. Tests are administered in accordance with the standards provided by the developer of the test.

The Psychological Assessment Report will consist of:

- Referral question(s)
- Referral source
- Background information
- Assessment procedures
- Relevant test procedures
- Assessment results
- Interpretation of results
- Summary and recommendations

Evaluation consists of a review of available information regarding the child's developmental, medical, and behavioral health, substance use, educational, familial, and social history. At a minimum, an objective personality test is required for youth, 13 and up. If no standardized testing has been performed in the previous 12 months, the evaluation will include:

- Cognitive testing - a standardized intelligence scale, preferably the most recent edition of the Wechsler Intelligence Scale for Children
- Achievement screening such as the Wide Range Achievement Test or the Woodcock-Johnson.
- Behavior/personality assessment - standardized testing is encouraged, behavioral analysis may be sufficient.
- The assessment is initiated within 15 working days from the date on which the individual or their parent or other legal representative requests services and completed within thirty working days of the final interview of the person being evaluated.
- All testing will be performed using valid and reliable measures and include statements regarding the level of cooperation and motivation of the person being evaluated and validity of responses.
- The summary will address the referral question(s) drawing support from the assessment findings. A review of family systems is also encouraged.

- Recommendations regarding treatment, educational, and socialization needs, caretaker guidelines, and other factors as applicable will be included as well.

Psychological Assessment (adults)

This assessment is performed only by a Tennessee Licensed Psychologist or independently licensed Psychological Examiner, and the report is generated and signed by that individual. If testing is administered by an individual other than the Licensed Psychologist, that individual is either a master's level mental health professional, a Certified Psychological Assistant, or an intern at an APA internship. The individual is identified, along with his/her training and qualifications. Tests are administered in accordance with the standards provided by the developer of the test.

The Psychological Assessment Report will consist of:

- Referral question(s)
- Referral source
- Background information
- Assessment procedures
- Relevant test procedures
- Assessment results
- Interpretation of results
- Summary and recommendations

The assessment consists of a review of available history about DCS involvement and referral concerns. The evaluation will include relevant history about developmental, medical, educational, substance use, and social functioning. The evaluation will also include the following:

- Cognitive testing, preferably the Wechsler Intelligence Scale for Adults
- Achievement screening tests, such as the Wide Range Achievement Test
- Behavior/personality assessment

All testing will be performed using valid and reliable measures and include a statement as to validity of responses.

The summary will address the referral question(s) drawing support from assessment findings. Recommendations regarding treatment and educational needs, caretaker strengths and deficits, and other factors as applicable will be included as well. Diagnostic impression on all axes of the most recent edition of the DSM is required.

The assessment will be initiated within 15 working days from the date on which the individual or their parent or other legal representative requests services and completed within thirty working days of the final interview of the person being evaluated.

Psychosexual Assessment - Adolescent (Ages 13-17)

This assessment will be performed by a licensed or master's level mental health professional, who has received training in this type of assessment through opportunities such as conferences, trainings, academic work, practicum or internship, and direct supervision by a qualified assessor. DCS will review and assess the level of qualification of the person(s) who provided the training or supervision.

This Licensed Mental Health Professional generates and signs the report. If testing is administered by an individual other than the Licensed Mental Health Professional, that individual is either a master's level mental health professional or is a Certified Psychological Assistant. The individual is identified, along with his/her training and qualifications. Tests are administered in accordance with the standards provided by the developer of the test.

The Psychosexual Assessment Report will consist of:

- Referral question(s)
- Referral source
- Background information
- Assessment procedures
- Relevant test procedures
- Assessment results
- Interpretation of results
- Summary and recommendations

Consistent with the Tennessee practice guidelines, this type of specialized evaluation is limited to use with youth who:

- Have a child protective service finding of having perpetrated the abuse or
- Have been adjudicated in court on a sex related offense or
- There has been a direct observation of illegal sexual behavior/sexually abusive behavior by a reliable source or
- Admit to having engaged in sexually abusive behavior/illegal sexual behavior.

The assessment will consist of a review of relevant history, including details of the alleged sexual offense. A clinical interview with the offender and caregivers, if the offender is a minor, will be conducted and the validity of the information given will be assessed. A brief Mental Status Examination is appropriate as part of the interview with the offender.

Each assessment will include an evaluation of risk factors for re-offending sexually using one or more validated risk assessments such as:

- Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR)
- Juvenile Sex Offender Protocol – II (JSOP-II)

The use of additional instruments is recommended, such as the following:

- Sexual Adjustment Inventory Juvenile (SAI Juvenile)
- Multiphasic Sex Inventory – II

The examiner uses other relevant standardized instruments to assess related behavior, and mental health issues, including cognitive functioning if indicated.

The report will include recommendations for treatment and include information about the needed structure and supervision as well as intensity of interventions. The safety of the community and the victim/s will be considered in making these recommendations.

The assessment will be initiated within 15 working days from the date on which the individual or their parent or other legal representative requests services and completed within thirty working days of the final interview of the person being evaluated.

Psychosexual Assessment - Adult (Ages 18 and up)

This assessment will be performed by a licensed mental health professional (Master's or above) that has been approved by the Tennessee Sex Offender Treatment Board (TSOTB) to conduct Psychosexual Evaluations pursuant to TCA 39-13-702; 39-13-703; 39-13-704; and 39-13-705.

This Licensed Mental Health Professional generates and signs the report. If testing is administered by an individual other than the Licensed Mental Health Professional, that individual is either a master's level mental health professional or is a Certified Psychological Assistant. The individual is identified, along with his/her training and qualifications. Tests are administered in accordance with the standards provided by the developer of the test.

The Psychosexual Assessment Report will consist of:

- Referral question(s)
- Referral source
- Background information
- Review of relevant history, including details of the alleged sexual offense
- Clinical interview with assessment of the validity of information given.
- Brief mental status evaluation
- Assessment procedures
- Relevant test procedures
- Assessment results
- Interpretation of results
- Summary and treatment recommendations

A Psychosexual assessment is appropriate only if the examinee has been found guilty of a sex offense in court or DCS CPS has indicated them as a perpetrator. At times, this type of evaluation may be considered in the context of permanency planning.

Each assessment will include an evaluation of risk factors for re-offending sexually using one or more validated risk assessments such as:

- STATIC – 99R
- STATIC2002R
- Rapid Risk Assessment for Sex Offense Recidivism (RRASOR)

The use of addition assessment instruments may be used and is recommended. The use of an assessment of risk of general criminal behavior is also recommended. Tools designed for this purpose include:

- Have Psychopathy Checklist- Revised (PSL-R)
- Level of Service /Case Management Inventory (LSI/CMI)

The examiner may use other relevant standardized instruments to assess related cognitive functioning, behavior, and personality traits, particularly if these have a bearing on the sexual behaviors. Instruments such as behavior rating scales may be useful if the sexual behavior is seen as being related to poor impulse control.

The assessment will be initiated within 15 working days from the date on which the individual or their parent or other legal representative requests services and completed within thirty working days of the final interview of the person being evaluated.

Psychotherapy or Counseling

Psychotherapy or Counseling is the evidence-based* treatment of behavior disorders, mental illness, or any other emotional/mental health conditions for individuals or families. This service is provided by a licensed or mental health professional (Master's or above). When the treatment is provided by a master's level professional, the treatment will be supervised by, and treatment notes signed by the independently licensed professional.

The service can be provided in the home or office setting and can be delivered on an individual, group, or family basis.

Maintenance of documentation should be done in accordance with your licensing body's ethical guidelines.

Therapy or Counseling for Sex Offender Treatment

This service is defined as the evidence-based* therapy or counseling with case management linkages to community-based support services for treatment of sex offender issues. Youth who have completed a residential sex offender treatment program or whose sex offender issues do not warrant residential care are eligible. Adult sex offenders are eligible based on the permanency plan for the child/youth, but treatment must be provided from a provider on the Sex Offender Treatment Board approved provider list.

This treatment will be performed by a licensed or mental health professional (Master's or above) who has received training in this type of assessment through opportunities such as conferences, trainings, academic work, practicum or internship, and direct supervision by a qualified assessor. When the treatment is provided by a master's level professional, the treatment will be supervised by, and treatment notes signed by the independently licensed professional. DCS will review and assess the level of qualification of the person(s) who provided the training or supervision.

The service can be provided in the home or office setting and can be delivered on an individual, group, or family basis. The goal of treatment is to promote successful reunification and/or continued permanency for youth to age 19.

***Evidence Based Treatment as defined by:**

- **SAMSHA's Evidence-Based Practices Resource Center https://www.samhsa.gov/ebp-resource-center**
- **The California Evidence Based Clearinghouse for Child Welfare http://www.cebc4cw.org**

Applied Behavior Analysis (Children and Youth)

The assessment will be provided by a Board-Certified Behavior Analyst (BCBA) who is also an approved TennCare provider. A registered behavior technician (RBT) may provide ongoing direct intervention to the child/youth. Providers will adhere to the ABA Practice Guidelines put forth by the Council of Autism Service Providers (CASP), found at https://casproviders.org/asd-guidelines/

This service is provided in the youth's environment. This service will be approved on an emergency basis for up to then (10) hours at a time while TennCare approval is sought. The provider assists DCS in obtaining TennCare authorization.

Foreign Language Interpreter Services

Objective

To provide meaningful access to all programs and activities for persons with limited English proficiency who are involved with the Department on a custodial or non-custodial basis. Person with limited English proficiency is defined as individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English.

For children to be positively influenced by treatment programs, understand expectations, receive orientation, and receive basic educational instruction, DCS must be able to communicate with these children in their primary language through foreign language interpretation and/or English as Second Language (ESL) instruction.

Provider Requirements

Interpretation involves the immediate communication of meaning from one language (the source language) into another (the target language).

Provide information about the language interpreter(s):

- Qualifications (What specialized training have they received, or are they self-taught?)
- Experience (How long have they been a practicing interpreter? If not a practicing interpreter, have they interpreted before and, if so, in what situations?)
- Training on interpreter ethics and standards (Emphasizing confidentiality; impartiality; accuracy; avoidance of a conflict of interest)
- Certification (Are they certified by and/or an active member of any interpreter association?)
- Do they receive continuing education?
- Are they able to perform simultaneous interpretation (technique where the interpreter interprets at the same time as the speaker)? Are they able to do consecutive interpretation (where there is a pause between language conversions)?
- Do they specialize in law enforcement, medical, educational, or some other type of oral interpretation?
- Describe proposed process for complaints.
- Provide overview of your hiring practices including all pre-employment checks your organization does on employees/sub-contractors (background checks, drug screens, etc.). The overview should include any routine checks completed after hiring and how often those are completed.

Minimum Staff Qualifications

The interpreter must have command of at least two languages; he/she must be able to:

- Comprehend two languages as spoken and written, and
- Speak both languages, and
- Choose an expression in the target language that fully conveys and best matches the meaning of the source language.

Service Delivery Specifics

Role and Responsibilities of direct service staff
Faithfully and accurately convey the meaning of the source language orally, reflecting the style and cultural context of the source message, without omissions, additions, or embellishments.

Minimum Documentation to DCS
Upon completion of assignment, provide a summary report to the DCS Case Manager (and fiscal) that includes:

- Date referral was received by provider and date of assignment.
- Name of the interpreter providing the service.
- Case name and name of individual for whom interpreter services were provided.
- Duration of assignment (interpreter's arrival and departure time)
- What was the target language?
- A brief description of assignment.
- Interpreter must obtain DCS staff signature for each service event.

Homemaker Services

Objective
Homemaker Services assist a customer in maintaining a clean, healthy, and safe environment.

Provider Requirements
- Provide detailed job description detailing duties and responsibilities of the Homemaker (see examples below)
- Provide details about staff training and supervision.
- Include process for homemaker service requests and response time.
- Describe proposed process for complaints.
- Provide overview of your hiring practices including all pre-employment checks your organization does on employees (background checks, drug screens, etc.). The overview should include any routine checks completed after hiring and how often those are completed.

Minimum Staff Qualifications
- Must be at least 18 years of age, AND be a high school graduate or have completed the Hi-Set (GED)
- Valid driver's license
- Good communication skills
- Ability to follow written and oral directions.
- Promptly seek assistance when necessary
- Understanding of various cultures

Homemaker Expectations
- Ensure that all clients are treated fairly with kindness, dignity, and respect.
- Respect clients' personal property rights, maintaining clients' rights to privacy and confidentiality of client information.
- Follow established safety precautions in the performance of all duties and report all accidents and injury of yourself or clients to the agency director.

- Ensure that established infection control, universal precaution practices are maintained and followed when performing caregiver/homemaker duties.
- Report all hazardous conditions and equipment to the agency.

Service Delivery Specifics

Minimum Contact Requirements

Families are contacted within two working days of referral. Provider/Homemaker needs to have the capacity to be available five (5) out of seven (7) days to provide services to families, with a minimum of (1) full hour of direct in-home service and/or direct service in another appropriate location, agreed upon with the customer. The Provider/Homemaker will ensure services are available at times convenient to the family. Services must be culturally, intellectually, economically, socially, spiritually and gender sensitive to the family.

Minimum Expectations of Direct Service Staff Role and Responsibilities

The Homemaker is to follow the clients' service plan and teach/train the caregiver on the items below:

- Provide instruction on how to prepare meals, snacks and provide fluids.
- Instruct and demonstrate how to perform household chores: including cooking, monitoring food expiration dates, laundry, cleaning, making beds & changing linens, taking out garbage, and household maintenance.
- Instruct the parent on how to perform basic caretaking skills such as: providing and preparing a nutritious meal, hand washing and potty training.
- When possible, accompany client when grocery shopping and performing errands, to model and teach client budgeting techniques, buying the right amount and appropriate type of food.
- Assist the client in identifying risks and barriers and helping the client resolve problems, as they arise by, teaching client how to locate and use community resources.

Minimum Documentation to DCS

Provide bi-weekly summary reports to the DCS Case Manager (and fiscal) that includes:

- Dates of service delivery.
- A description of the service tasks performed.
- Name of the homemaker providing the service.
- Homemaker's arrival and departure time.
- Provider must obtain customer's signature for each service event.
- Staff and Family member observations
- Areas of concerns and follow-up plan

Bi-weekly service reports should be submitted to the DCS Case Manager within five (5) business days of the completion of the service, of the service weeks.

Parenting Education/Class Services

Objective

Parenting education is designed to promote well-being and strengthen families and communities to prevent child abuse and neglect.

- Parent education can be defined as any training, program, or other intervention that helps parents acquire skills to improve their parenting of and communication with their children, with the purpose of reducing the risk of child maltreatment and/or reducing child disruptive behaviors. Parent education may be delivered individually or in a group in the home, classroom, or other settings.
- Successful parent education programs help parents acquire and internalize parenting and problem-solving skills necessary to build a healthy family.

Provider Requirements

- Detail the evidence level for the proposed service. If the provider agency proposes a service for which there is not a specific evidence-based or evidence-informed practice available, the provider is to describe the core components of the service, how the existing science and evidence base informs the service. The provider should also detail the implementation of the service, and how the service will be assessed/ monitored for fidelity to the program design, as intended. For additional information on levels of evidence see http://www.cebc4cw.org/registry/ratings/
- Specify the Target population the provider intends to serve (i.e., Parents of children birth to 5, especially high-risk parents or parents of pre-teens and teens)
- Delivery setting and format (i.e., conducted in a community agency, in groups of 10–15 parents. Training includes discussions, problem-solving, skills training, role-play, and DVD vignettes of parent-child interactions)
- Duration (i.e., recommended for 1.5 hours per session for 4–8 weeks)
- Provide details about staff training and supervision.
- Include process for parent Education/Class service requests and response time.
- Describe proposed process for processing and addressing complaints.
- Provide overview of provider agency's hiring practices including all pre-employment checks the organization does on employees (background checks, drug screens, etc.). The overview should include any routine checks completed after hiring and how often those are completed.

Minimum Staff Qualifications

- Providers must meet the minimum qualifications required by the chosen model.
- Program staff should have a sound theoretical grounding as well as hands-on experience in the classroom or working with families and groups in different settings.
- When qualifications are not prescribed in the model, the following shall be considered minimum qualifications:
  - Bachelor's degree in social work, psychology or
  - An associate degree with one-year experience as a parenting educator

Additional Expectations for Direct Worker and Supervisor

- Staff should be able to provide culturally competent services consistent with the values of the family and community.
- Receive Direct Training in Parent Education Curricula used.
- Knowledge of Child Abuse and Neglect Prevention
- Knowledge of child and adult development and family dynamics

Service Delivery Specifics

- Participants are trained utilizing parent curriculum aimed at improving parenting skill and preventing maltreatment.

- Services will be conducted with behavior and language that demonstrates respect for sociocultural values, personal goals, lifestyle choices and complex family interactions.
- Use of interactive training techniques
- Opportunities provided for participants to practice new skills.
- Focus on family strengths and resilience.
- Procedures for tracking enrollment/participation of all participants
- Participants are assisted in identifying, learning about, and accessing community resources.

Minimum Documentation to DCS

Provide bi-weekly summary reports to the DCS Case Manager that includes:

- Contact notes documenting client contacts and participation in programming; pre and post testing.
- Sign-in sheets for class

Bi-weekly service reports should be submitted to the DCS Case Manager within five (5) business days of the completion of the service, of the service weeks.

Sign Language Interpreter Services

Objective

To provide sign language interpretation services to children/youth and families involved with the Department on a custodial or non-custodial basis with the purpose of bridging the communication gap between hearing and deaf/hard of hearing persons. Sign language interpretation service will help DCS provide meaningful access to all programs and activities for persons who are deaf/ hard of hearing and require communication using sign language.

Provider Requirements

Provide information about the sign language interpreter(s):

- Qualifications (What specialized training have they received, or are they a child of a deaf adult-CODA?)
- Experience (How long have they been a practicing interpreter? If not a practicing interpreter, have they interpreted before and, if so, in what situations?)
- Certification (Are they certified by and/or an active member of any interpreter association?)
- Do they receive continuing education?

Minimum Staff Qualifications

- Fluency in American Sign Language (ASL)
- Possess a high level of skill in the English language.
- Have knowledge of and adhere to The National Association of the Deaf (NAD) or Registry of Interpreters for the Deaf (RID) - Interpreter Code of Professional Conduct (emphasizing confidentiality; impartiality; accuracy; avoidance of a conflict of interest)

Service Delivery Specifics

Role and Responsibilities of direct service staff

- Interpreters strive to make the communication as clear as possible for both hearing and deaf or hard of hearing.

- They must convey thoughts and feelings as accurately as possible and never impose their own ideas.
- Interpreters relay information: they do not initiate or change it.

Minimum Documentation to DCS

Upon completion of assignment, provide a summary report to the DCS Case Manager (and fiscal) that includes:

- Date referral was received by provider and date of assignment.
- Name of the interpreter providing the service.
- Case name and name of individual for whom interpreter services were provided.
- Duration of assignment (interpreter's arrival and departure time).
- A brief description of assignment.
- Interpreter must obtain DCS staff signature for each service event.

Sitter Services

Objective

DCS utilizes sitters to attend to a hospitalized child, during medical or emergency situations where an assigned foster parent is not constantly available, as hospitals always require the presence of a guardian.

Additionally, DCS may use sitters to sit with children in transitional placement status in DCS offices or alternative community setting. In such instances, the sitter will be accompanied by one or more DCS staff.

Provider Requirements

- Provide a detailed job description detailing duties and responsibilities of the sitter.
- Detail what the agency is offering in the way of knowledge or training to prepare your sitters for a hospital experience and/or supervision of children/youth in a DCS office.
- Provide details about staff supervision.
- Include process for sitter service requests and response time.
- Describe proposed process for complaints.
- Provide overview of agency hiring practices including all pre-employment checks the organization does on employees (background checks, drug screens, etc.). The overview should include any routine checks completed after hiring and how often those are completed.

Minimum Staff Qualifications

- Direct service staff must be at least 18 years of age, AND be a high school graduate or have completed a GED/Hi-Set
- Supervisory staff may have a bachelor level degree OR the equivalent of 2 years of college level education or 2 years of related employment.
- Good oral and written communication skills
- Ability to follow written and oral directions.
- Previous childcare or medical experience
- Educated on and compliant with HIPAA regulations.
- Demonstrate knowledge of basic principles of child growth and development

Additional Sitter Requirements

- TB test, up to date on immunizations or titers indication immunity and yearly flu vaccine
- Understanding of various cultures
- All staff will comply with the most current version of DCS Policy 4.1 Employee Background Checks which can be found on the DCS website.
- Ability to work varying shifts.

Service Delivery Specifics

The provider needs to have the capacity to deliver service twenty-four (24) hours a day; this includes weekends and holidays. Services must be culturally, intellectually, economically, socially, spiritually and gender sensitive to the child and family.

Minimum Role and Responsibilities of direct service staff

- Monitor, support and assist the child/youth during custodial and non-custodial medical/emergency situations, as needed, following the directives of the guardian(s), hospital staff, or DCS staff when co-sitting at DCS office.
- Ask for a report from the attending nurse, regarding the child's identified care needs, visual, auditory, or language barriers, ambulation limitations, as well as any special considerations (NPO, suicide ideation, etc.).
- The child must be always observed and never left alone. To keep the child safe, sitters should be always alert, awake, and attentive to the child's needs. Use of a personal cell phone in the child's hospital room is not permitted. Individuals may bring personal reading material to utilize while the child is sleeping, pending all other duties have been completed.
- Be observant of the child's activity and behavior and communicate any concerns to the nurse or DCS worker who is on site.
- Ask the nurse for direction regarding what to report, to whom, and how.
- Recognize and access emergency assistance when needed.
- Ensure the child is treated fairly with kindness, dignity, and respect.
- Respect the child's personal property rights, maintaining child's rights to privacy and confidentiality of child information.
- Use standard precautions/infection control practices such as: 1) handwashing, gowning and gloving techniques 2) blood and body fluid precautions.
- Comply with all hospital rules, regulations, and nursing standards.

Minimum Documentation to DCS

Provide weekly summary reports to the DCS Case Manager (and fiscal) that includes:

- Date of service delivery.
- A description of the service tasks performed.
- Name of the sitter providing the service.
- Sitter's arrival and departure time.
- Sitter observations

Tutoring Services

Objective

Tutoring will be provided to raise the academic performance of school aged youth to a level consistent with the Tennessee Department of Education (TDOE) academic standards.

TDOE standards can be found at: https://www.tn.gov/education/instruction/academic-standards.html

Please be advised of the following tutoring guidelines enforced by the Department.

- Tutoring services are restricted to youth in state custody who are in danger of being left behind a grade due to placement moves/issues.
- A teacher employed in the same school the child attends cannot be paid for providing tutoring.
- Approval is given for a specific grade/age level.

Provider Requirements

- Provide a detailed job description detailing duties and responsibilities of the tutor.
- Indicate if the tutor can provide tutoring services in a foreign language (specify the language)
- Provide details about staff supervision.
- Include a process for tutor service requests and response time.
- Describe a proposed process for receiving and responding to complaints.
- Provide an overview of the agency's hiring practices, including all pre-employment checks the organization does on employees (background checks, drug screens, etc.). The overview should include any routine checks completed after hiring and should detail how often those checks are completed.

Minimum Staff Qualifications

Service provider must be a certified teacher, certified to teach the subject the individual is requesting to tutor.

Providers working directly with the youth will have the competencies and support needed to:

- Engage and communicate effectively and respectfully with youth and families from a wide range of backgrounds and cultures,
- Recognize and identify the presence of cognitive impairments,
- Collaborate with workers in other disciplines and access community resources, and
- Advocate for the child during Child and Family Team Meetings and Individualized Education Plans conferences.

Providers working directly with youth will be knowledgeable about:

- Child development
- Behavior management
- Learning disabilities
- The Individualized Education Plan (IEP) and its use in education
- Educational resources within the community
- Tutoring techniques

Service Delivery Specifics

- Tutoring services will be provided through direct one-on-one sessions or in small groups of 2 to 4 youth who are matched by ability.
- Services should take place in locations that promote learning, are large enough to accommodate the group, allow the youth to concentrate without being disturbed by others, and allow for direct assistance.

- Services will take place after school, on weekends, and/or other times when school is not in session.
- Services will not exceed two (2) hours per day.
- Services should not conclude later than normal bedtime hours.
- Tutoring services shall incorporate evidence-based strategies that improve student achievement.
- The provider should suggest home activities as appropriate.
- The provider should complete observation forms, if requested by DCS or local school system
- Providers should refer to TDOE academic standards for best practice guidance.
    - Information on academic standards can be found at: https://www.tn.gov/education/instruction/academic-standards.html

Assessment

- No later than 10 days after the referral is received by the provider, the provider will ensure the youth receives an initial assessment to determine the youth's academic strengths, weaknesses, needs and level of ability compared to actual grade/age level.
- The provider will make reasonable attempts to discover previous assessments and to utilize the findings of those assessments in conjunction with the provider's own assessment.

Minimum Documentation to DCS

Provide a weekly summary report to the DCS Case Manager (and fiscal) that includes:

- Date of service delivery
- Name of the tutor providing the service
- Tutor's arrival and departure time
- Indicate tutoring area/subject
- Documents the youth's level of participation and progress/improvement in the tutoring area

Interventions for Domestic/Intimate Partner Violence & Child Maltreatment

Programs designed to address violence and control issues of men or women who have been abusive in a domestic/intimate partner violence situation and by doing so have exposed their child(ren) to maltreatment, trauma, and/or neglect. Perpetrator accountability programs designed to help an individual recognize/acknowledge the negative impact that their violent and intimidating behaviors have on their children and other family members.

Interventions for Domestic/Intimate Partner Violence and Child Maltreatment can be defined as any educational/training, program, or other treatment approaches that utilize therapeutic strategies to help an individual recognize specific abusive, unhealthy, behaviors, take responsibility for, and stop or reduce their abusive behavior. Programs that also focus intervention efforts on teaching problem solving techniques, anger management, improved interpersonal skills and parenting skills.

- May include, but not limited to, a batterer's intervention program that has been certified by the domestic violence state coordinating council.
- May include a gender specific perpetrator accountability program that meets the service description/criteria outlined in this *Service Description Guideline and Criteria* document.

- Note: noncertified batterer's intervention program or perpetrator accountability programs Do Not substitute court-ordered batterer's intervention program that have been certified by the domestic violence state coordinating council.

Caring Dads Program

- The Caring Dads Group Program was designed as a seventeen-week, closed group model.
- Every Caring Dads Group Intervention must consist of fifteen group sessions and two individual sessions.
- Sessions must be substantively as outlined in the current edition of the Caring Dads manual.
- Sessions may be run once or twice a week for a total of 34 hours.
- After Session 3, the group must be run with a closed format (i.e., the same group of men must proceed through Sessions 4 through 17).
- The Caring Dads Group Program must not be advertised or administered as an alternative or replacement for court-ordered domestic violence perpetrator intervention.
- All Caring Dads Group Programs will be run exclusively by Accredited Caring Dads Facilitators
- Caring Dads Group entry must be preceded by an intake interview that includes an assessment of men's risk of continued abuse and of their suitability for participation.

Employment Readiness Program

Objective

To assist youth and young adults with obtaining and maintaining meaningful employment.

Provider Requirements

- Specify the target population the provider intends to serve (i.e. young adults in extension of foster care or teens in foster care)
- Service delivery setting and format (i.e., conducted in office setting, client residence, group setting, or one on one sessions)
- Duration (i.e., 1.5 hours per session for 8 weeks)
- Qualifications (What specialized training have they received)
- Provide overview of provider agency's hiring practice including all pre-employment checks the organization does on employees (background checks, drug screens, etc.). The overview should include any routine checks completed after hiring.
- Describe process for client complaints.

Minimum Staff Qualifications

- Providers must meet the minimum qualifications required by the chosen model.
- Staff must have the competence and support needed to engage and communicate effectively and respectfully with youth and young adults from a wide range of backgrounds, cultures, and traumatic experiences.

Minimum Contact Requirements

Provider needs to have the capacity to be available five (5) out of seven (7) days to provide employment related support to clients, with a minimum of (1) full hour of direct service. The Provider will ensure

services are available at time convenient to the youth/young adult. Services must be culturally, intellectually, socially, spiritually, and gender sensitive to the client.

Minimum Expectations of Direct Service Staff Role and Responsibilities

- Provide career exploration services to aid in the identifying of employment interest.
- Individualized employment services that are unique to youth with lived experience in foster care and their needs and current circumstances.
- Provide support to aid in the youth's ability to maintain employment.

Minimum Documentation to DCS

Provide monthly summary reports to the youth/young adults DCS or provider case manager that includes:

- Date of service delivery
- Description of the service and tasks performed.
- Document the youth/young adult's level of participation and progress towards obtaining employment (i.e., pre and posttest).

Provide semi-annual outcomes report to the Director of Independent Living of all clients served in the program.

Human Trafficking Prevention (up to 2-6 months)

Individual: Individualized, evidence-informed/evidence-based interventions with youth at high-risk of human trafficking based on education and empowerment of the youth to identify and minimize personal vulnerabilities, foster positive relationships, develop alternative coping skills and/or emotional regulation to reduce potential exploitation.

Group: Group-based and peer-to-peer evidence-informed/evidence-based interventions with youth at high-risk of human trafficking based on education and empowerment of the youth to identify and minimize personal vulnerabilities, foster positive relationships, develop alternative coping skills and/or emotional regulation to reduce potential exploitation.

Objective Prevention Services

- Intensive Strength-Based, Trauma-Informed, Evidence-Based/Evidence-Informed Interventions for youth, families and support systems including in the family home, when safe, residential facilities, and/or juvenile detention centers such as Trust-Based Relational Intervention
- Evidence-based and/or evidence-informed, trauma-informed education and empowerment interventions for youth identified as high-risk due to behaviors such as mental health issues, runaway episodes, delinquent acts (regardless of adjudication)
- Ability to identify youth who have been trafficked and has established referral process with anti-trafficking agencies.
- Frequency of contact – 2 times a week minimum
- Uses a validated screening tool to determine risk level.
- Ability to serve youth through transition into young adulthood including such programs such as Extension of Foster Care
- Connection with Positive Mentors/Mentorship programs

- Staff trained to recognize and address trauma-bonding with offender as well as managing boundaries between the youth and staff.
- Ratio: 1:15 youth

Personnel Qualifications

- Case Manager/Survivor Care Coordinator – minimum 2-year experience working with vulnerable populations and bachelor's degree in social work, Psychology, Social Sciences or similar field, or 5 years working with vulnerable populations experiencing trauma.
- Survivor Care Advocate – minimum 2-year experience working with vulnerable populations.
- Family Interventionist – minimum 2- year experience working with vulnerable populations and bachelor's degree in social work, Psychology, Social Sciences or similar field, or 5 years working with vulnerable populations experiencing trauma.
- Therapist – master's level or higher education level clinician with licensure or activity seeking licensure.
- Special Certifications for Direct Care Staff: 40-hour OVC training; trauma training.

Human Trafficking Assessment

Evaluation of a youth presenting one or more high-risk vulnerabilities often exploited by traffickers where there is no current disclosure of being trafficked through an extended screening process designed to educate and empower youth to understand the dynamics of trafficking. This process works jointly with multi-disciplinary partners to enhance service planning with current providers, identify necessity of specialized service provision, and share information of new disclosures/discoveries of human trafficking with partners.

Therapy or Counseling for Victims of Human Trafficking

This service is defined as the evidence-based or evidence-informed therapy or counseling for treatment of the complex trauma victims of human trafficking experience. Due to the frequent occurrence of delayed disclosure, it also applies to those identified as high-risk of human trafficking when no disclosure has been made. The service may be applied in addition to and in coordination with other community-based and/or residential therapies or counseling services and can be delivered on an individual, group or family basis.

Human Trafficking- Specialized Case Management (Youth)

Evidence-based and/or evidence-informed ongoing intensive long-term case management supporting youth at risk of or identified as being victims of human trafficking designed to support victims and those at risk of human trafficking through comprehensive, wrap-around services to mitigate victimization and reduce exploitation. Due to the nature and needs of the population, services may be provided in-person or remotely as well as community-based, supportive of residential programming, and/or be provided while the youth is on runaway status.

- History of working with the population served (3 years or more)
    - Youth disclosed victimization/self-identification.

    - Multiple high-risk indicators are present without a self-disclosure including but not limited to those listed in the definition of Commercial Sexual Exploitation of a Minor in DCS Work Aid 1 (https://files.dcs.tn.gov/policies/chap14/WA1.pdf).
    - Demonstrated ability through relevant policies and practices to serve survivors regardless of race, gender, sexual orientation, nationality, legal status, language proficiency, etc.
- Ability to work within Residential Facilities and/or Detention Centers including:
    - Service provision within these facilities/centers.
    - Participation in discharge planning.
    - Continuation of services, or referral as appropriate, through next placement, reunification, and/or transition to young adulthood.
- Services Including:
    - Intensive Strength-Based, Trauma-Informed, Evidence-Based/Evidence-Informed Interventions for youth, families and support systems including in the family home when safe such as Trust-Based Relational Intervention.
    - After-Care services when youth step-down from facilities.
    - Ability to serve youth through transition into young adulthood including such programs such as Extension of Foster Care.
    - Connection with Positive Mentors/Mentorship programs.
    - Statewide and out-of-state referral network to prevent lapse of service provision.
    - Staff trained to recognize and address familial trafficking, intimate partner trafficking, cross-bonding with other trafficking victims, and trauma-bonding with offender as well as managing trauma-informed boundaries between the youth and all staff (i.e., CEO to custodians).
    - Ability to provide and/or secure safe transportation of survivors and/or family to safe locations/services.
    - 24/7 Crisis Response in-person or by phone (Hotline)
    - Ability to work within Residential Facilities and/or Detention Centers including:
        - Service provision within these facilities/centers.
        - Participation in discharge planning.
        - Continuation of services, or referral as appropriate, through next placement, reunification, and/or transition to young adulthood.
- Wrap-around Team which may include at least three of the below positions:
    - Case Manager/Survivor Care Coordinator – minimum 2-year experience working with vulnerable populations and bachelor's degree in social work, Psychology, Social Sciences or similar field, or 5 years working with vulnerable populations experiencing trauma.
    - Survivor Care Advocate – minimum 2- year experience working with vulnerable populations.
    - Family Interventionist – minimum 2-year experience working with vulnerable populations and bachelor's degree in social work, Psychology, Social Sciences or similar field, or 5 years working with vulnerable populations experiencing trauma.
    - Therapist – master's level or higher education level clinician with licensure or activity seeking licensure.
- Maintain a best practice ratio of 1:10 with consideration given to client capacity where the caseload is updated based on an evaluation of ability of staff to meet the need:
    - Includes factors such as drive-time to provide direct services, active involvement with criminal justice system, present escalated mental health.
- Frequency will be based on an assessment of client capacity with the following considerations:

- Initial frequency of once a week contact preferably in person
- No less than 1 to 2 times in-person a month with youth
- Documentation of Good Faith Efforts if no face-to-face contact

- Expected outcomes include:
  - Increased:
    - In home care
    - Social integration
    - Family satisfaction/re-unification/stabilization
    - Regular school attendance
    - Other system support
    - Resiliency skills and coping mechanisms
    - Pro-Social relationships with safe family, friends and/or community members
    - Compliance with medication/therapeutic services, as applicable
  - Decreased:
    - Out of home care or hospitalization
    - Level of care need
    - Symptoms and side effects
    - High Risk Factors such as
      - Runaway Episodes
      - Delinquency Behaviors
    - Vulnerabilities
    - Number of victimizations
    - Placement Disruptions
- Special Certifications for Direct Care Staff: 40-hour OVC training; trauma training

Human Trafficking- Two-Generational Case Management (Family)

Evidence-based and/or evidence-informed ongoing intensive case management focused on the non-offending caregivers, family and/or placement in the life of an identified victim of human trafficking and/or those at risk of being trafficked to ensure a safe, stable, and supportive environment for youth at risk of or identified as being victims of human trafficking regardless of their current living arrangement. A Two-Generational model provides education and empowerment to those in the life of a trafficked or high-risk youth to bolster clinical and therapeutic interventions through creating a trauma-informed environment for youth to return to upon completion of a treatment program.

Specimen Collection/Alcohol & Drug Testing

Objective

These services are designed for individuals who are suspected by DCS case managers or the courts of drug use/abuse and require immediate or scheduled testing through the analysis of urine, hair and/or nails to determine the presence/level or absence of drugs to provide information about a client's drug use/abuse behavior that can confirm or contradict what the agency and/or court has learned through other assessments and observations.

The drug test includes:

Drugs of Abuse
- Illegal drugs

Therapeutic drugs
- Prescription drug – Painkillers
- Mental Health medications

Designer drugs

The Department of Children's Services has five (5) different types of drug testing services that we procure:

- **Urine analysis (lab-based testing)**
  At a minimum, a 5 panel with Expanded Opiates test would qualify as a regular urine analysis. (Note- equivalent to DOT specimens)

- **Extended panel urine analysis (lab-based testing)**
  At a minimum, a 12-panel urine drug test would qualify as an extended urine analysis.

- **Hair Follicle analysis**
  At a minimum the Hair 5 Panel Drug Test with Expanded Opiates. There is a need for hair testing panels that test for Buprenorphine and/or Fentanyl.

- **Fingernail analysis**
  At a minimum the 5 panel fingernails and extended Opiates Test. There is a need for fingernail testing panels that test for Tramadol and/or Fentanyl.

- **Medical Review of Drug Screens**

Provider Requirements

- Providers with an on-site laboratory, provide information about any lab licenses and accreditations.
- What are the established cutoff levels and/or preset thresholds your laboratory uses to determine whether a drug test result is negative or positive?
- Outline your agency's staff training on the use of equipment and testing procedures.
- Describe your chain of custody protocol to help document the specimen's handling and storage.
- Services include providing any requested testimony and/or court appearances (to include hearing or appeals).
  - Including chain-of-custody and/or testing procedures/results on an as needed basis
  - Providing certified copies of drug tests, if requested up to 1 year after testing

Specimens are also examined for adulteration. The following are the standard, although not the only, indicators of adulterations that need to be checked for:

- Temperature
- Color/Appearance
- Nitrates
- Oxidants
- Specific Gravity
- pH Level
- Creatinine

Minimum Staff Skills & Qualifications

- The vendor and its drug testing analysts must comply with State and Federal licensing and certification requirements.
- Staff needs training to perform different drug testing procedures and to collect the different kinds of specimens.

Service Delivery Specifics

- DCS requires directly observed (visualization of the urine stream leaving the body and entering the screen cup) collections conducted by same gendered staff; vendor is to ensure specimen donor takes only the collection container into the collection site, to deter any intent to adulterate the specimen.
- Vendor displays efforts to provide as much privacy as possible, by using a single restroom environment or a large restroom stall.
- Vendor must provide all required supplies and courier services to transport all specimens, test results, and testing materials.
- Chain of custody documentation is critical to the integrity of the testing program. Possession of the specimen must always be accounted for. Changes in possession must be recorded.
- Service provider with an on-site laboratory must be available to receive/process urine and saliva specimens collected by DCS staff, in need of confirmatory testing through laboratory analysis. Such specimens will be submitted to the laboratory with a Case Service Request (CSR) completed within one (1) business day of the submission, when one of the following occur:
    - A drug screen will likely result in court action.
    - The individual submitting the specimen refutes the results in writing.
    - A court order requires it.
    - A DCS supervisor (i.e., Team Leader, Lead Investigator, Team Coordinator, or Investigation Coordinator) has reasonable suspicion to believe the drug screening process was adulterated or otherwise inaccurate.

<u>Minimum Role and Responsibilities of direct service staff</u>

- The specimen collector must:
    - Ask for positive photograph identification.
    - Ask each specimen donor about any type of medication taken and document the response.
    - Note any relevant observations concerning the specimen donor.
    - Note if the specimen donor is unable or refuses to submit a specimen.
- The individual receiving the specimen from the collector must sign and note the date and time.
- The tester must sign and note the date and time.

Minimum Documentation to DCS

Recording Test Results

Provide drug screen results sheet/form to DCS worker; sheet must contain:

- Date and time of testing
- Client's name clearly printed and signature (verify ID by requesting identification from the client)
- List of the substances tested for
- Name/signature and contact information of the individual receiving the specimen from the collector.
- Name/signature and contact information of staff person conducting the test.
- Note any type of medication taken as stated by client.
- Note any relevant observations concerning the client.
- Document if the client is unable or refuses to submit a specimen.
- Document any verbal admittance of drug use by the client.

Medical Review of Drug Screens

The Provider laboratory reports confirmed positive tests and/or any specimens with evidence of dilution, contamination, tampering or any question normally requiring a Medical Review Officer (MRO) opinion to the MRO for disposition.

Minimum Staff Skills & Qualifications for the Medical Review Officer

- Licensed as a medical doctor (MD) or Doctor of Osteopathic Medicine (DO)
- Knowledgeable about substance abuse disorders, plus clinical experience
- Knowledgeable of laboratory testing procedures and chain of custody collection procedures
- Certified by a nationally recognized MRO certification board.

Service Delivery Specifics for the Medical Review of Drug Screens

- The MRO may determine the need to re-test, re-collect, or otherwise modify the collection procedure to ensure adequate and appropriate testing.
- After the laboratory has returned a confirmed positive test result to the MRO, he/she attempts to contact the specimen donor within 24 hours to privately discuss any issues that might have affected the urine sample.
- The MRO interprets and evaluates positive test results in relation to the individual's medical history or other relevant biomedical information.