SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
SUBSTANCE TREATMENT AND RECOVERY TEAMS (START) PROGRAM
FAMILY MENTORS

I. Service Description

A. The Indiana Department of Child Services (DCS) intends to contract with Community Mental Health Centers throughout the state to implement Sobriety Treatment and Recovery Teams (START) to provide assistance and support to parents who are in need of addictions treatment.

B. This service applies to families who:
   1. Have a new DCS case
   2. Have at least one child age 0-5 years and intervention by DCS is needed due to substantiation of child abuse/neglect
   3. Resulting from the parent's substance use disorder.

C. The parent(s) will be paired with a Family Mentor who will support and guide the family through the recovery and DCS process.

D. The goals of START are to:
   1. Promote sobriety for the parent(s)
   2. Ensure quick access to treatment
   3. Improve the function and stability of the family unit
   4. Ensure child safety
   5. Promote children remaining in the home, increasing permanency outcomes

E. The Family Mentor will work with the parent(s) in creating connections to the community for long-term recovery support.

II. Service Delivery

A. The START team will consist of a:
   1. Family Case Manager (FCM)
   2. Family Mentor
   3. Treatment Coordinator
   4. DCS Supervisor
   5. Any other service provider that is actively involved with the family.

B. The Family Mentor is a paraprofessional and an individual who:
   1. Has been in long term recovery
      a) Minimum of 3 years sobriety.

C. The Family Mentor was involved with DCS and/or criminal justice system in some capacity in the past.

D. The role of the Family Mentor is to work closely with the family to help the family deal with the challenges of recovery, DCS and accessing community resources.

E. The Family Mentor will be employed by the Community Mental Health Center
   1. Their home office will be located in a DCS office
   2. This is where most of the services outlined in the service standard can be

performed.

F. The Family Mentor and FCM will share the same START caseload.

G. The FCM and Family Mentor will partner together to ensure the family is:
   1. Receiving necessary resources
   2. Accessing treatment
   3. Following guidelines and developing a support system.

H. The FCM and Family Mentor are to work in close contact with one another
   1. Minimum contact of once per week per case shared.

I. The Family Mentor will be responsible for:
   1. Attending the initial Child and Family Team Meeting (CFTM)
   2. Transporting the parent(s) to the drug and alcohol assessment
   3. Transporting the parent(s) the first 4 days of treatment

J. The Family Mentor will attend all subsequent CFTM's and may be required to attend and/or testify in Court regarding the case.

K. Family Mentors will participate in a minimum of bi-weekly case staffing with DCS staff and will participate in other meetings as required.

L. The Family Mentor will communicate with the Treatment Coordinator on a continual basis
   1. Minimum of once per week per case

M. Adherence to the model fidelity documents for client contact, both in-home and out-of-home, shall be followed by the Family Mentor and listed as follows:

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N. The Family Mentor will need to be able to effectively engage a family in services and follow the DCS practice model.

O. Throughout the life of the case, the Family Mentor will assist with the ongoing assessment of the child's safety, well-being and permanency.

P. The Family Mentor will reference and follow the current safety plan in place regarding the child.

Q. Any concerns regarding the safety and well-being of a child will immediately be reported to the FCM and/or the DCS Supervisor.

R. Family Mentors will receive training by DCS regarding the practice model, court and court testimony.

S. Family Mentors will participate in other training modules as required and deemed appropriate.

T. The Family Mentor will assist the family through advocating, teaching, demonstrating, monitoring, coaching and/or role modeling new appropriate skills for coping with the following areas in an effort to build self-sufficiency:

1. Identify community/recovery supports (i.e. identify support meetings in community, help secure a sponsor etc.)
2. Attend a support meeting with client
3. Track the client's attendance for the recommended number of support meetings per week
4. Assist the FCM in identifying the client's needs and appropriate referrals
5. Help client identify the benefits to participating in the treatment program
6. Engage client in treatment
7. Develop a recovery plan
8. Identify triggers and ways to work through them
9. Identify alternative activities to maintain sobriety
10. Develop client self wellness goals
11. Work on client driven life goals, short & long term (i.e. education/treatment/employment)
12. Create a budget to gain financial stability
13. Teach &/or model life skills (i.e. opening a bank account; filling out a job application etc.)
14. Locate safe housing
15. Coach on advocating for self
16. Help identify client's strengths and develop self esteem
17. Develop structure/time management skills
18. Coach through crisis/emergency situations effectively
19. Facilitate transportation

a) Transportation limited to client goal-related, face-to-face activities as approved/specified as part of the case plan or

goals/objectives identified at the Child and Family Team Meeting (e.g. housing/apartment search, etc.)

20. Participate in Child and Family Team Meetings
21. Assist with coordinating services
22. Identify support system
23. Develop problem solving techniques
24. Help understand basic child development & nutrition
    a) Must be trained or knowledgeable in provider supported child development & nutrition curriculum.
25. Reference & reinforce current child safety plan when appropriate
26. Parenting sober: what that looks like through modeling &/or coaching (with child and parent)
27. Assist with family communication and rebuilding relationships
28. Assistance with accessing Child Care Vouchers
29. Assist the family in understanding addiction and the process of recovery
30. Help identify access to Healthcare/Medicaid Assistance
31. Supervise Visitation between parent/child
    a) Must be trained in supervising visits.
    b) Supervised visits will be billed separately from other services within this service standard and follow the Visitation Facilitation service standard.
    c) The 'Visitation Monthly Progress Report' form must be used to report the supervised visitation portion of the services provided.
    d) The 'Monthly Report' will be used for all other services outlined in this standard.
32. Assist client in organization and getting acclimated to being on a schedule

III. Target Population

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

1. Children and families who have new substantiated cases of child abuse and/or neglect which have an open case with Informal Adjustment (IA) or CHINS status:
    a) These families will also have substance use histories
    b) Each of the families shall have at least one child age 5 or under
    c) The family will be accepted into the program as determined by DCS

IV. Goals and Outcomes

A. Goal #1: The Family Mentor will engage the family in services in accordance with all START timelines.

1. Outcome Measure 1: 95% of the time, the Family Mentor will attend the initial CFTM
2. Outcome Measure 2: 95% of the time, the Family Mentor will transport the client to the drug and alcohol assessment
3. Outcome Measure 3: 90% of the time, the Family Mentor will transport the client to the first four initial treatment days
4. Outcome Measure 4: 100% of the time, the Family Mentor will notify the START Team if a client is in crisis or a suspected relapse situation.

B. Goal #2: The Family Mentor will assist with the ongoing assessment of the child's safety, well-being, and permanency
   1. Outcome Measure 1: 67% of the families that have a child in substitute care as of the initiation of START service will be reunited by closure of the service provision period.
   2. Outcome Measure 2: 90% of the individuals/families will not be the subjects of a new investigation resulting in the assignment of a status of "substantiated" abuse or neglect throughout the service provision period.
   3. Outcome Measure 3: 90% of the individuals/families that were intact prior as of the initiation of service will remain intact throughout the service provision period.
   4. Outcome Measure 4: If DCS elects to implement a standardized tool for evaluating family functioning, a related outcome measure will be added.

C. Goal #3: The Family Mentor will be responsible for connecting the family to the recovery community including building their support system.
   1. Outcome Measure 1: 80% of the time, the Family Mentor will attend the initial Community Support Meetings with the client (12 Steps, AA, NA, Celebrate Recovery, etc.)
   2. Outcome Measure 2: 90% of the time, the Family Mentor will collect, on a weekly basis, an attendance sheet from the client regarding the number of support meetings the client attended that week.
   3. Outcome Measure 3: 50% of the time, he Family Mentor will monitor the client's progress in obtaining a sponsor and will assist the client in obtaining/connecting to a sponsor if client does not already have one and monitor frequency of contact with the sponsor.

D. Goal #4: The Family Mentor will submit all required documentation and participate in DCS staffing.
   1. Outcome Measure 1: 95% of the time, the Family Mentor will attend monthly Local DCS Office staffing.
   2. Outcome Measure 2: 95% of the time, the Family Mentor will attend, at minimum, bi-weekly START Team supervision.

3. Outcome Measure 3: 90% of the time, the Family Mentor will enter all required contacts into the DCS approved electronic data system within 5 business days of the client contact.
4. Outcome Measure 4: 95% of the time, the Family Mentor will participate in other required meetings including CFTMs, court, and other related START meetings.

V. Minimum Qualifications

A. The Family Mentor is a paraprofessional with a minimum three years of sobriety and a solid foundation in their personal recovery.

B. Child protective services history is not required but preferred.
   1. The Family Mentor can either be a victim or perpetrator of child abuse or neglect.

C. Criminal history will be considered on a case-by-case basis.

D. The ability to assist DCS with all practice model components is essential.
   1. Specifically, the Family Mentor will assist in teaming, engaging, assessing, planning, and intervening.

E. The Family Mentor must be able to take direction and collaborate with multiple agencies within the community, including:
   1. The contract agency
   2. DCS
   3. Court
   4. Attorneys
   5. Most importantly, a wide range of families

F. Self-awareness is a key component in being able to successfully do the job.
   1. The Family Mentor must be actively engaging in recovery activities in their own lives.

VI. Billable Units

A. Medicaid
   1. Family Mentors activities will be monitored by the contracting agency and any billable Medicaid activities are the responsibility of the contracting agency.
   2. The contracting agency is to be knowledgeable about the Medicaid billing requirements and comply with them.
      a) Including provider qualifications
      b) Including pre-authorization requirements.
   3. The contracting agency is responsible for billing those services when they may be reimbursed by Medicaid.

4. Those services not eligible for Medicaid Rehabilitation Option or Medicaid Clinic Option may be billed to the DCS office as outlined in the contract.

B. DCS Funding

1. DCS funding is provided as reimbursement for actual cost based on approved budget.
2. Contracted agencies will use approved invoicing process.

C. Interpretation, Translation, and Sign Language Services

1. The location of and cost of Interpretation, Translation, and Sign Language Services are the responsibility of the Service Provider.
2. If the service is needed in the delivery of services referred, DCS will reimburse the Provider for the cost of the Interpretation, Translation, or Sign Language service at the actual cost of the service to the provider.
3. The referral from DCS must include the request for Interpretation services and the agencies' invoice for this service must be provided when billing DCS for the service.
4. Providers can use DCS contracted agencies and request that they be given the DCS contracted rate but this is not required.
5. The Service Provider Agency is free to use an agency or persons of their choosing as long as the service is provided in an accurate and competent manner and billed at a fair market rate.
6. If the agency utilizes their own staff to provide interpretation, they can only bill for the interpretation services. The agency cannot bill for performing two services at one time.

D. Court

1. The provider of this service may be requested to testify in court.
2. A Court Appearance is defined as appearing for a court hearing after receiving a written or email request or subpoena from DCS to appear in court, and can be billed per appearance.
3. If the provider appeared in court two different days, they could bill for 2 court appearances.
    a) *Maximum of 1 court appearance per day.*
4. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.

E. Reports

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

VII. Medicaid

A. For those families and children not eligible for Medicaid Rehabilitation Option, this service will be paid by DCS.

B. For eligible families and children, some services may be provided through Medicaid Rehabilitation Option (MRO) with the remaining services paid by DCS.

C. While the primary focus of these services is on the needs of the family, it is expected that some of these services will be deemed medically necessary to meet the behavioral healthcare needs of the MRO eligible client, and therefore may be billable to MRO.

D. The service standard is not a Medicaid standard and includes services that are not billable to Medicaid.

E. It is the responsibility of the contracted service provider to be knowledgeable about the Medicaid billing requirements and comply with them.
    1. Including Provider Qualifications
    2. Including Pre-Authorization
    3. Appropriately bill services in cases where they are Medicaid reimbursed

F. Services not eligible for MRO may be billed to DCS

VIII. Case Record Documentation

A. Case record documentation for service eligibility must include:
    1. A completed, and dated DCS/ Probation referral form authorizing services
    2. Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for these documents from referral source.
    3. Safety issues and Safety Plan Documentation
    4. Documentation of Termination/Transition/Discharge Plans
    5. Treatment/Service Plan
        a) Must incorporate DCS Case Plan Goals and Child Safety goals.
        b) Must use Specific, Measurable, Attainable, Relevant, and Time Sensitive goal language

6. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.
    a) Provider recommendations to modify the service/ treatment plan
    b) Discuss overall progress related to treatment plan goals including specific examples to illustrate progress
7. Progress/Case Notes Must Document: Date, Start Time, End Time, Participants, Individual providing service, and location
8. When applicable Progress/Case notes may also include:
    a) Service/Treatment plan goal addressed (if applicable-
    b) Description of Intervention/Activity used towards treatment plan goal
    c) Progress related to treatment plan goal including demonstration of learned skills
    d) Barriers: lack of progress related to goals
    e) Clinical impressions regarding diagnosis and or symptoms (if applicable)
    f) Collaboration with other professionals
    g) Consultations/Supervision staffing
    h) Crisis interventions/emergencies
    i) Attempts of contact with clients, FCMs, foster parents, other professionals, etc.
    j) Communication with client, significant others, other professionals, school, foster parents, etc.
    k) Summary of Child and Family Team Meetings, case conferences, staffing
9. Supervision Notes must include:
    a) Date and time of supervision and individuals present
    b) Summary of Supervision discussion including presenting issues and guidance given.

IX. Service Access

A. All services must be accessed and pre-approved through a referral form from the referring DCS staff.

B. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required.

C. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS.

D. Providers must initiate a re-authorization for services to continue beyond the approved period.

E. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

X. Adherence to DCS Practice Model

A. Services must be provided according to the Indiana Practice Model, providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect.

B. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

XI. Interpreter, Translation, and Sign Language Services

A. All Services provided on behalf of the Department of Child Services must include Interpretation, Translation, or Sign Language for families who are non-English language speakers or who are hearing- impaired.

B. Interpretation is done by an Interpreter who is fluent in English and the non-English language and is the spoken exchange from one language to another.

C. Certification of the interpreter is not required; however, the interpreter should have passed a proficiency test in both the spoken and the written language in which they are interpreting.

D. Interpreters can assist in translating a document for a non-English speaking client on an individual basis, (i.e., An interpreter may be able to explain what a document says to the non-English speaking client).

E. Sign Language should be done in the language familiar to the family.

F. These services must be provided by a non-family member of the client, be conducted with respect for the socio- cultural values, life style choices, and complex family interactions of the clients, and be delivered in a neutral-valued culturally-competent manner.

G. The Interpreters are to be competent in both English and the non-English Language (and dialect) that is being requested and are to refrain from adding or deleting any of the information given or received during an interpretation session.

H. No side comments or conversations between the Interpreters and the clients should occur.

XII. Trauma Informed Care

A. Provider must develop a core competency in Trauma Informed Care as defined by the National Center for Trauma Informed Care—SAMHSA (http://www.samhsa.gov/nctic/):

1. Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives.
2. NCTIC facilitates the adoption of trauma-informed environments in the delivery of a broad range of services including mental health, substance use, housing, vocational or employment support, domestic violence and victim assistance, and peer support. In all of these environments, NCTIC seeks to change the paradigm from one that asks, "What's wrong with you?" to one that asks, "What has happened to you?"
3. When a human service program takes the step to become trauma-informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma affects the life of an individual seeking services.
4. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization

B. Trauma Specific Interventions: (modified from the SAMHSA definition)

1. The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
2. The provider must demonstrate an understanding, through the services provided, of the interrelation between trauma and symptoms of trauma (e.g., substance abuse, eating disorders, depression, and anxiety)
3. The provider will work in a collaborative way with child/family, extended family and friends, and other human services agencies in a manner that will empower child/family.

XIII. Training

A. Service provider employees are required to complete general training competencies at various levels.

B. Levels are labeled in Modules (I-IV), and requirements for each employee are based on the employee's level of work with DCS clients.

C. Training requirements, documents, and resources are outlined at: http://www.in.gov/dcs/3493.htm

1. Review the **Resource Guide for Training Requirements** to understand Training Modules, expectations, and Agency responsibility.

2. Review **Training Competencies, Curricula, and Resources** to learn more about the training topics.
3. Review the **Training Requirement Checklist** and **Shadowing Checklist** for expectations within each module.

XIV. Cultural and Religious Competence

A. Provider must respect the culture of the children and families with which it provides services.

B. All staff persons who come in contact with the family must be aware of and sensitive to the child's cultural, ethnic, and linguistic differences.

C. All staff also must be aware of and sensitive to the sexual and/or gender orientation of the child, including lesbian, gay, bisexual, transgender or questioning children/youth.

1. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook.
2. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth.
3. The guidebook can be found at: http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf

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

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

XV. Child Safety

A. Services must be provided in accordance with the Principles of Child Welfare Services.

B. All services (even individual services) are provided through the lens of child safety.

1. As part of service provision, it is the responsibility of the service provider to understand the child safety concerns and protective factors that exist within the family.
2. Continual assessment of child safety and communication with the Local DCS Office is required. It is the responsibility of the service provider to report any safety concerns, per state statue, IC 31-33-5-1.

C. All service plans should include goals that address issues of child safety and the family's protective factors. The monthly reports must outline progress towards goals identified in the service plans.