

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
FUNCTIONAL FAMILY THERAPY

I. Service Description

- A. FFT is a short-term, high quality intervention program with an average of 12 to 14 sessions over three to five months. FFT works primarily with 11- to 18-year-old youth who have been referred for behavioral or emotional problems by the juvenile justice, mental health, school or child welfare systems. Services are conducted in both clinic and home settings, and can also be provided schools, child welfare facilities, probation and parole offices/aftercare systems and mental health facilities. A major goal of FFT is to improve family communication and supportiveness while decreasing the intense negativity.
- B. Other goals include helping family members adopt positive solutions to family problems and developing positive behavior and parenting strategies.
- C. Further information on FFT can be found at <http://www.fftinc.com> or <http://www.functionalfamilytherapy.com/>
- D. FFT is designed to increase efficiency, decrease costs, and enhance the ability to provide service to more youth by:
 - 1. Targeting risk and protective factors that can change and then programmatically changing them;
 - 2. Engaging and motivating families and youth so they participate more in the change process;
 - 3. Entering each session and phase of intervention with a clear plan and by using proven techniques for implementation; and
 - 4. Constantly monitoring process and outcome.

II. Service Delivery

- A. The program is conducted by FFT trained family therapists through the flexible delivery of services by one and two person teams to clients in the home and clinic settings, and at time of re-entry from residential placement.
- B. Service providers must adhere to the principles of the FFT model.
- C. FFT requires as few as 8-12 hours of direct service time for commonly referred youth and their families, and generally no more than 26 hours of direct service time for the most severe problem situations.
- D. Sessions are spread over a three (3) month period or longer if needed by the family.
- E. Therapists must engage the family (as many members as reasonably feasible) through a face-to-face contact within 14 days of the referral and obtain their willingness to participate.
- F. FFT emphasizes the importance of respecting all family members on their own terms as they experience the intervention process.
- G. Therapists must be relationally sensitive and focused, as well as capable of clear structuring, in order to produce significantly fewer drop-outs and lower recidivism.
- H. Empirically grounded and well-documented, FFT has three (3) specific intervention phases. Each phase has distinct goals and assessment objectives, addresses different risk and protective factors, and calls for particular skills from the therapist providing treatment. The phases consist of:
 - 1. Phase 1: Engagement and Motivation:
 - a) During the initial phases, FFT applies reframing and related techniques to impact maladaptive perceptions, beliefs, and emotions to emphasize within the youth and family, factors that protect youth and families from early program drop out.
 - b) This produces increasing hope and expectation of change, decreasing resistance, increasing alliance and trust, reduced oppressive negativity within the family and between the family and community, increased respect for individual differences and values, and motivation for lasting change.
 - 2. Phase 2: Behavior Change
 - a) This phase applies individualized and developmentally appropriate techniques such as communication training, specific tasks and technical aids, basic parenting skills, and contracting and response-cost techniques.
 - 3. Phase 3: Generalization

- a) In this phase, Family Case Management is guided by individualized family functional needs, their interaction with environmental constraints and resources, and the alliance with the therapist to ensure long-term support changes.
 - b) FFT links families with available community resources and FFT therapists intervene directly with the systems in which a family is embedded until the family is able to do so itself.
- I. Each of these phases involves both assessment and intervention components:
 - 1. Family assessment focuses on characteristics of the individual family members, family relational dynamics, and the multi-systemic context in which the family operates.
 - a) The family relational system is described in regard to interpersonal functions and their impact on promoting and maintaining problem behavior.
 - 2. Intervention is directed at accomplishing the goals of the relevant treatment phase.
- J. Assessment and Intervention examples within each phase:
 - 1. Engagement and Motivation:
 - a) Assessment is focused on determining the degree to which the family or its members are negative and blaming.
 - b) The corresponding intervention would target the reduction of negativity and blaming.
 - 2. Behavior Change:
 - a) Assessment would focus on targeting the skills necessary for more adaptive family functioning.
 - b) Intervention would be aimed at helping the family develop those skills in a way that matched their relational patterns.
 - 3. Generalization:

- a) Assessment focuses on the degree to which the family can apply the new behavior in broader contexts.
 - b) Interventions would focus on helping generalize the family behavior change into such contexts.
- K. Program certification must be obtained and maintained through utilizing Functional Family Therapy certified trainers to train a site supervisor and therapists.
- L. Program fidelity must be maintained through adherence to using a sophisticated client assessment, tracking, and monitoring system and clinical supervision requirements.

III. Target Population

- A. Services must be restricted to the following eligibility categories:
 - 1. Children and their families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with Informal Adjustment (IA) or CHINS status.
 - 2. Children and their families which have an IA or the children have the status of CHINS or JD/JS.
 - 3. Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.
 - 4. All adopted children and adoptive families.

IV. Goals and Outcomes

- A. Goal 1: Services are provided timely as indicated in the service description above.
 - 1. Outcome Measure: 100% of referred children and families are engaged in services within fourteen (14) days of referral.
 - 2. Outcome Measure: 100% of children and families being served have an assessment completed at the beginning of each phase.
 - 3. Outcome Measure: 100% of children and families being served have a clear plan developed immediately following the assessment.
 - 4. Outcome Measure: 100% of progress reports are provided to the current worker every month.
- B. Goal 2: Improved family functioning is indicated by no further incidence of the presenting problem.
 - 1. Objective: Service Delivery is grounded in best practice strategies, using such approaches as cognitive behavioral strategies, motivational interviewing, change processes, and building skills based on a strength perspective to increase family functioning.
 - a) Outcome Measure: 67% of the families that have a child in substitute care prior to the initiation of service will be reunited by closure of the service provision period.

- b) Outcome Measure: 90% of the children and 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.
 - c) Outcome Measure: 90% of children and families that were intact prior to the initiation of service will remain intact throughout the service provision period.
- C. Goal 3: DCS/Probation and clients will report satisfaction with services provided.
 - 1. Outcome Measure: Probation/DCS Satisfaction will be rated 4 and above on the Service Satisfaction Report.
 - 2. Outcome Measure: 90% of clients will rate services “satisfactory” or above on satisfaction surveys developed by the service provider, unless DCS/Probation distributes one to providers for their use with clients.
 - a) Providers are to survey a minimum of twelve (12) clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.

V. Minimum Qualifications

- A. Direct Worker:
 - 1. Master’s or Doctorate degree with a current license issued by an Indiana Behavioral Health and Human Services Licensing Board
 - 2. Master’s degree with a temporary permit issued by the Indiana Behavioral Health and Human Services Licensing Board
 - 3. Master’s degree in a related human service field and employed by an organization that is Nationally Accredited by the Joint Commission, Council on Accreditation, or the Commission on Accreditation of Rehabilitation Facilities. That individual must also:
 - a) Complete a minimum of 24 post-secondary semester hours or 36 quarter hours in the following coursework:
 - (1) Human Growth & Development
 - (2) Social & Cultural Foundations
 - (3) Group Dynamics, Processes, Counseling, and Consultation
 - (4) Lifestyle and Career Development
 - (5) Sexuality
 - (6) Gender and Sexual Orientation
 - (7) Issues of Ethnicity, Race, Status, & Culture
 - (8) Therapy Techniques
 - (9) Family Development & Family Therapy
 - (10) Clinical/Psychiatric Social Work
 - (11) Group Therapy

- (12) Psychotherapy
 - (13) Counseling Therapy & Practice
 - b) The individual must complete the Human Service Related Degree Course Worksheet. For auditing purposes, the worksheet should be completed and placed in the individual's personnel file. Transcripts must be attached to the worksheet.
 - c) Note: Individuals who hold a Master or Doctorate degree that is applicable towards licensure, the individual must become licensed as indicated in #1 and #2 above.
- B. Supervisor:
- 1. Master's degree in Social Work, Psychology, or Marriage and Family or related human service field with a current license issued by the Indiana Behavioral Health and Human Services Licensing Board
- C. Both Direct Worker and Supervisor must complete FFT Certified Training prior to serving clients under this standard.
- 1. The FFT links can be found under Service Description.
- D. Shadowing Criteria
- 1. All agencies must have policies that require regular shadowing (by supervisor) of all staff at established intervals based on staff expertise and need.
 - 2. Shadowing must be provided in accordance with the policy.
 - 3. The agency must provide clear documentation that shadowing has occurred.
- E. Supervision/Consultation is to include not less than one (1) hour of individual face-to-face supervision/consultation per 20 hours of direct client services provided, nor occur less than every two (2) weeks.
- F. Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, lifestyle choices, as well as complex family interactions.
- 1. Services will be delivered in a neutral valued, culturally competent manner.

VI. Billable Units

- A. Face to Face (Note: Members of the client's family are to be defined in consultation with the family and approved by DCS. This may include persons not legally defined as part of the family).
- 1. Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.

2. Includes Child and Family Team Meetings or case conferences initiated or approved by DCS for the purpose of goal directed communication regarding the services to be provided to the client/family.
 3. Includes crisis intervention and other goal-directed interventions via telephone with the identified client family.
 4. Reminder: Not included are routine report writing and scheduling of appointments, collateral contacts, travel time, and no shows.
 - a) These activities are built into the cost of the face-to-face rate and shall not be billed separately.
- B. Hourly services may be billed in 15 minute increments; partial units are rounded to the nearest quarter hour using the following guidelines:

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

C. Court

1. The provider of this service may be requested to testify in court.
2. A court appearance is defined as appearing for a court hearing after receiving a written request (email or subpoena) 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) A maximum of 1 (one) court appearance per day.
4. The rate of the court appearance includes all costs associated with the court appearance; therefore, additional costs associated with the appearance cannot be billed separately.

D. 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 agency's invoice for this service must be provided when billing DCS for the service.
4. Providers can use DCS contracted agencies and request that they be given the DCS contracted rate but this is not required.
5. The Service Provider 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. 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.
7. 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.

VII. Case Record Documentation

- A. Case record documentation for service eligibility must include:
 1. A completed, and dated DCS/Probation referral form authorizing services

2. Copy of DCS/Probation case plan, Informal Adjustment documentation, or documentation of requests for these documents from referral source
3. Safety issues and Safety Plan documentation
4. Documentation of Termination/Transition/Discharge Plans
5. Treatment/Service Plan
 - a) Must incorporate DCS Case Plan goals and child safety goals
 - b) Must use Specific, Measurable, Attainable, Relevant, and Time Sensitive goal language
6. Monthly reports are due by the 10th of each month following the month of service. Case documentation shall show when report is sent.
 - a) Provider recommendations to modify the service/treatment plan
 - b) Discuss overall progress related to treatment plan goals including specific examples to illustrate progress
7. Progress/Case notes must document the following:
 - a) Date
 - b) Start time
 - c) End time
 - d) Participants
 - e) Individual providing service
 - f) Location
8. When applicable, progress/case notes may also include:
 - a) Service/Treatment plan goal addressed (if applicable)
 - b) Description of Intervention/Activity used towards treatment plan goal
 - c) Progress related to treatment plan goal including demonstration of learned skills
 - d) Barriers: lack of progress related goals
 - e) Clinical impressions regarding diagnosis and/or symptoms (if applicable)
 - f) Collaboration with other professionals
 - g) Consultation/Supervision staffing
 - h) Crisis interventions/emergencies
 - i) Attempts of contact with clients, FCMs, resource families, other professionals, etc.
 - j) Communication with client, significant others, other professionals, school, resource families, etc.
 - k) Summary of Child and Family Team Meetings, case conferences, staffing
9. Supervision notes must include:

- a) Date and time of supervision and individuals present
- b) Summary of supervision discussion including presenting issues and guidance given

VIII. 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.

IX. Adherence to the DCS Practice Model

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

X. Interpretation, Translation, and Sign Language Services

- A. All Services provided on behalf of the Department of Child Services must include Interpretation, Translation, or Sign Language for families who are non-English language speakers or who are hearing-impaired.
- B. Interpretation is done by an Interpreter who is fluent in English and the non-English language and is the spoken exchange from one language to another.
- C. 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).
- D. Sign Language should be done in the language familiar to the family.
- E. 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.

XI. Trauma Informed Care

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

XII. Training

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

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

XIII. Cultural and Religious Competence

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

XIV. Child Safety

- A. Services must be provided in accordance with the Principles of Child Welfare Services.
- B. All services (even individual services) are provided through the lens of child safety.
 1. As part of service provision, it is the responsibility of the service provider to understand the child safety concerns and protective factors that exist within the family.

2. Continual assessment of child safety and communication with the Local DCS Office is required. It is the responsibility of the service provider to report any safety concerns, per state statute, IC 31-33-5-1.
- C. All service plans should include goals that address issues of child safety and the family's protective factors. The monthly reports must outline progress towards goals identified in the service plans.