Service Standards – Updated July 1st, 2016

Service Standard – June 30, 2015	Revision/Clarification
All Service Standards	**Section, Billable Units- Interpretation, Translation and Sign Language Services updated definition**
ADOPTION	
Child Preparation	
Family Preparation	Service Description language updated (July 1, 2016) Billable units updated (July 1, 2016)
HOMEBASED FAMILY CENTERED SERVICES	
Home-Based Family Centered Casework Services	Qualification language for supervisor updated. Shadowing Policy Added 11/2/2015 Qualification language for supervisor updated. Clarifying language added to Bachelors level supervisor and Clinical Consultation (March 1, 2016)
Home-Based Family Centered Therapy Services	Qualification language updated (June 30, 2015) Qualification language updated (March 1, 2016)
Homemaker/Parent Aid	
Comprehensive Home Based Services	Qualification language corrected, residential transition time frame added (October 2, 2014) Direct/Indirect Service time clarification/revision (January 27, 2015) Qualification language updated (June 30, 2015) Qualification language updated (March 1, 2016)
Family Centered Treatment	Qualification language corrected, residential time frame added (October 2, 2014) Direct/Indirect Service time clarification/revision (January 27, 2015) Qualification language updated (June 30, 2015) Qualification language updated (March 1, 2016)
RESOURCE PARENT SERVICES	

Support Group Services for Resource Families	
OTHER SERVICES	
CHINS Parent Support Services	
Counseling	Qualification language updated (June 30, 2015) Qualification language updated (March 1, 2016)
Cross-System Care Coordination	Service Delivery updated (March 1, 2016) Billable Units updated (March 1, 2016)
Diagnostic and Evaluation Services	
Domestic Violence - Batterer Intervention Services	
Domestic Violence - Survivor and Child Intervention Services	Qualification language updated (June 30, 2015) Qualification language updated (March 1, 2016)
Father Engagement Programs	
Functional Family Therapy	Qualification language updated (June 30, 2015) Qualification language updated (March 1, 2016)
Parent Education	Section VII Billable Units- removal of language "Includes crisis intervention and other goal directed interventions via telephone with the identified client family". (October 2, 2014)
Parenting / Family Functioning Assessment	Qualification language updated (June 30, 2015) Qualification language updated (March 1, 2016)
Sex Offender Treatment	Qualification language updated (June 30, 2015) Qualification language updated (March 1, 2016)
Transition from Restrictive Placement	Qualification language updated (June 30, 2015) Qualification language updated (March 1, 2016)
Tutoring/Literacy Classes	
Visitation Facilitation-Parent/Child/Sibling	Qualification language updated. 11/2/2015
ADDICTIONS	

Support Group Services for Resource Families	
OTHER SERVICES	
CHINS Parent Support Services	
Counseling	Qualification language updated (June 30, 2015) Qualification language updated (March 1, 2016)
Cross-System Care Coordination	Service Delivery updated (March 1, 2016) Billable Units updated (March 1, 2016)
Diagnostic and Evaluation Services	
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Transition from Restrictive Placement	Qualification language updated (June 30, 2015) Qualification language updated (March 1, 2016)
Tutoring/Literacy Classes	
Visitation Facilitation-Parent/Child/Sibling	Qualification language updated. 11/2/2015
ADDICTIONS	

Drug Testing and Supplies	Section I Service Description – added language: "When indicated by the referral source, Synthetic Marijuana will not undergo the screening process and will only undergo the confirmation testing to insure accurate results." And "The vendor shall also ensure that all screens are observed by an individual of the same gender as the client." Section V Billable Units – added components: Instant Urine (Provider Administered), Instant Saliva Swab (Provider Administered), Instant Saliva Swab (DCS Administered), and Instant Urine Kit Only (October 2, 2014)
Random Drug Testing	Section II Service Delivery – added language: "When indicated by the referral source, Synthetic Marijuana will not undergo the screening process and will only undergo the confirmation testing to insure accurate results." And "The vendor shall also ensure that all screens are observed by an individual of the same gender as the client." (October 2, 2014)
Detoxification Services	Section II Service Delivery – changed drug screen panel and added language: "The vendor shall also ensure that all screens are observed by an individual of the same gender as the client." And "Minimum of substances tested should include Alcohol, Amphetamines, Barbiturates, Benzodiazepines, Cocaine, Cannabis, Opiates, Methadone, Oxycodone, Tramadol, Buprenorphine, Synthetic Marijuana, Bath Salts, Methamphetamine and other drugs indicated by client's history." (October 2, 2014)
Residential Substance Use Treatment	Section II Service Delivery – changed drug screen panel and added language: "The vendor shall also ensure that all screens are observed by an individual of the same gender as the client." And "Minimum of substances tested should include Alcohol, Amphetamines, Barbiturates, Benzodiazepines, Cocaine, Cannabis, Opiates, Methadone, Oxycodone, Tramadol, Buprenorphine, Synthetic Marijuana, Bath Salts, Methamphetamine and other drugs indicated by client's history." (October 2, 2014) Reports added under Billable units (June 24, 2015)

Substance Use Disorder Assessment	Section II Service Delivery – added language: "All sample collections drug screens will be observed sample collections screens. The vendor shall also ensure that all screens are observed by an individual of the same gender as the client. Minimum of substances tested should include Alcohol, Amphetamines, Barbiturates, Benzodiazepines, Cocaine, Cannabis, Opiates, Methadone, Oxycodone, Tramadol, Buprenorphine, Synthetic Marijuana, Bath Salts, Methamphetamine and other drugs indicated by client's history. Other substances not listed that the client may report a history of using may also be tested. The agency will be expected to provide reports that state the minimum level necessary to detect the presence of each substance, the level of substance detected, and the chain of custody documentation. Assurance must be given for accurate results even if the confirmation process is the only means to ensure accurate results due to the screening process providing inaccurate results." Section VII Billable Unit – changed Drug Screen language to "Actual cost of the screens. " (October 2, 2014)
Substance Use Outpatient Treatment	Section II Service Delivery – changed drug screen panel and added language: "The vendor shall also ensure that all screens are observed by an individual of the same gender as the client." And "Minimum of substances tested should include Alcohol, Amphetamines, Barbiturates, Benzodiazepines, Cocaine, Cannabis, Opiates, Methadone, Oxycodone, Tramadol, Buprenorphine, Synthetic Marijuana, Bath Salts, Methamphetamine and other drugs indicated by client's history." (October 2, 2014)
PROBATION SERVICES (primarily)	
Day Reporting/Treatment	Qualification language updated (June 30, 2015) Qualification language updated (March 1, 2016)
Truancy Termination	

CMHC Only	
Med-Adult Intensive Resiliency Services (AIRS)	Added (January 12, 2014)
Med-Assessment for MRO	Added (January 12, 2014)
Med-Child and Adolescent Intensive Resiliency Services (CAIRS)	Added (January 12, 2014)
Med-Medication Training and Support	Added (January 12, 2014)
Med-Peer Recovery Services	Added (January 12, 2014)
START Treatment Coordinator	Added (January 12, 2014)
START Family Mentor	Added (January 12, 2014)

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SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
ADOPTION - CHILD PREPARATION

I. Service Description

This preparation is to assist the local Department of Child Services (DCS) in assessing the adoption readiness of children in the custody of the State of Indiana. Upon assessment, the contractor will work to prepare the child(ren) for adoption. The child should be counseled about what adoption will mean to them, and make it clear that an adoptive family is a permanent family. This explanation also necessitates the painful realization that the biological family ties may be severed prior to the adoption.

Preparation of children or adolescents for adoptive placement may include but is not limited to the following areas:

1) Reconstruction and interpretation of child's history
2) Weaving together the child's background so s/he understands their own unique life experience
3) Grief and loss issues with biological and foster families (and others)
4) Loyalty issues
5) What adoption means

6) Listening to an adoptive child speak of their experience and feelings
7) Sharing of feelings
8) Knowing the difference between adoption and foster care

Supportive Services

Offering supportive services to the child and current care takers to help the child transition from a foster home to an adoptive placement. These services can be done in the foster home, in individual sessions or in group sessions.

Every child referred for child preparation services will begin a Lifebook or continue working on an existing Lifebook. The Lifebook is a means of documenting the child's life to date and is created for and with the child with the assistance of the child's case manager, therapist, foster parent, CASA, and/or other individuals in the child's life. It is designed to capture memories and provide a chance to recall people and events in the child's life to allow a sense of continuity. The Lifebook also serves as a focal point to explore painful issues with the child that need to be resolved.

II. Target Population

1) Children who are free for adoption.
2) Children who have a permanency plan of adoption.
3) Children who have termination of parental rights initiated with an expected plan of adoption.

III. Goals and Outcome Measures

Goal #1

Ensure that children in Indiana's custody are adequately prepared for adoption.

Outcome Measures

1) 100% of children referred for child preparation will complete an initial assessment which is to include a service plan within 30 days of the referral
2) 100% of children will have initiated a Lifebook within 60 days of the referral.

3) 100% of the local DCS offices referring a child for adoption preparation will receive written monthly reports and a discharge report within 15 days of the completion of the service.

Goal #2

Increase the child's understanding of adoption.

Outcome Measures

1) 90% of the children prepared over the age of 4 will verbalize their understanding and acceptance of the adoption process.
2) 95% of the children prepared ages 4 to 10 will be able to draw a version of an adopted family.
3) 95% of the children prepared over the age 10 will describe their ideal adoptive family.
4) 100% of the children prepared will have a Lifebook completed with their input.

Goal #3

Successful transition for the child and family to increase the probability of a successful adoption.

Outcome Measures

1) 90% of the children prepared will move into an adoptive home
2) 95% of adoptions will be finalized within one year of placement.

Goal #4

DCS and child satisfaction with services

Outcome Measure

1) 95% of children over the age of 10 will indicate comfort with the adoption process to the county through a satisfaction survey.
2) DCS satisfaction will be rated 4 and above on the Service Satisfaction Report.

IV. Minimum Qualifications

Direct Worker:

Bachelor's degree in social work, psychology, sociology, or a directly related human service field.

Supervisor:

Master's degree in social work, psychology, or directly related human services field.

Supervision/consultation is to include not less than one (1) hour of face to face supervision/consultation per 20 hours of direct client services provided, nor occur less than every two (2) weeks.

Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral valued culturally competent manner.

In addition the worker must have:

- Knowledge of family of origin/intergenerational issues and child development.
- Knowledge of separation and loss issues
- Knowledge of child abuse/neglect and trauma and how these impact behavior and development.
- Knowledge of community resources, especially adoption friendly services in the communities' families reside.
- Staff must respect confidentiality. Failure to maintain confidentiality may result in immediate termination of the service agreement.
- Services must demonstrate respect for socio-cultural values, personal goals, life style choices, and complex family interactions and be delivered in a culturally competent fashion.

V. Billable Units

Hourly rate up to 24 hours (*additional hours must be approved by the referring DCS*):

The hourly rate includes face to face contact with the identified client, collateral contacts; report writing, travel time, professional time involved preparing the assessment report. This also includes support on behalf of the child which includes review of the child's case file; preparation for contacts; preparation of life book; transporting the child to various places of interest related to the child's past and time in foster care while in the provision of services; taking pictures as important to the child to reconstruct a timeline related to placements, people, pets, place of birth, etc.

Interpretation, Translation and Sign Language Services

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

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

The location of and cost of Interpretation, Translation, and Sign Language Services are the responsibility of the Service Provider. 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. 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. Providers can use DCS contracted agencies and request that they be given the DCS contracted rate but this is not required. 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. 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.

Group

Services include group goal directed work with clients. To be billed per group hour.

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

Court

The provider of this service may be requested to testify in court. 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. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. 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.

VI. Case Record Documentation

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.

VII. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS. Providers must initiate a re-authorization for services to continue beyond the approved period.

VIII. Adherence to the DCS Practice Model

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. 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.

IX. Trauma Informed Care

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/): 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. 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?" 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. 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

Trauma Specific Interventions: (modified from the SAMHSA definition)

- The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
- 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)
- 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.

X. Cultural and Religious Competence.

Provider must respect the culture of the children and families with which it provides services. 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. 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. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth. The guidebook can be found at:
http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf

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. 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.

XI. Child Safety

Services must be provided in accordance with the Principles of Child Welfare Services. Please note: All services (even individual services) are provided through

the lens of child safety. 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. 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. 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.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
FAMILY PREPARATION/HOME STUDY

I. Service Description

Pursuant to IC 31-19-8-5, all Family Preparation providers contracted with DCS must be a Licensed Child Placing Agency (LCPA). Preparation of the adoptive home study for prospective families should follow the outline provided by the referring DCS, from the State Child Welfare Policies from July 1, 2015 through June 30, 2016. Contractors should commit to obtaining certification in the Structured Analysis Family Evaluation (SAFE) format. Starting July 1, 2016 all contractors will be required to use SAFE for all adoption home studies. (www.SAFEhomestudy.org)

Providers should collect information, evaluate the family and home, then make a recommendation as to the appropriateness and ability of the prospective adoptive parent(s) to meet the needs of children in Indiana's custody as a result of abuse or neglect. The assessment criteria must include but not be limited to the following areas:

1) Home study should address specific children if a child has been identified to be placed
2) Child Behavior Challenges Checklist
3) Reference forms completed by four (4) of which one (1) may be a relative
4) Financial profile
5) Medical Report for Foster Care/Adoption
6) Application for Adoptive Family
7) Background check for all persons in the household:
    a. See State Child Welfare Policies for details and directions.
8) Consent to Release of Information for prospective Adoptive family
9) Outline for Adoptive Family Preparation Summary

Family Assessment
The Family Assessment Process includes the initial contact with a family, the application, several home visits at convenient times for the parent(s) including evenings and weekends if necessary. The process may include but is not limited to the following:

- processing the family's references, medical information forms, financial forms and all other necessary state forms
- creating with the family, family genograms, eco-map, etc
- preparing other members of the household who will affect the success of an adoption because of their relationship to the family, such as a live-in grandparent or a relative who is always at the home during the day
- using the challenges checklist as a learning tool to review common challenges the children have with the family and to gauge the families degree of acceptance of the child's needs/challenges and to help the family self-evaluate to determine how such needs/challenges will impact the family now and in the future as well as if special needs adoption is for them
- assists the family with pre-placement family support services and
- serving as advocate for the family throughout the adoption process

The Family Preparation should include the family's feelings about adoption and experiences with parenting as well as pertinent issues specific to adoption. Preparation should also prepare adoptive parents in understanding the commitment they are making to provide a permanent home for the child or children they will be including in their family whether young children, adolescents, or sibling groups. The contractor will engage in a dialogue with family members, providing information on all aspects of child abuse and neglect, including an explanation about how trauma impacts child development, typical resulting behaviors, and common characteristics of children in the system. The contractor should assist the family in planning and foreseeing what is needed for their own specific successful parenting of these children and should discuss with the family how traditional disciplinary methods of time outs, groundings and loss of privileges may not be appropriate or effective with this population. The contractor will explore with the family the types of children that they feel able to parent and the specific special needs with which they can work.

The contractor will also make a recommendation about the family's appropriateness for special needs adoption and their ability to meet the needs of children in Indiana's custody. Any issues revealed during the home study process should be addressed & resolved prior to submission of the home study to SNAP Council. The contractor should only present a family to SNAP Council when the contractor can endorse that family without reservation. The assessment criteria must include but not be limited to specific children to be placed in the home, if a child has already been identified for the home.

Pre-Adoptive Families

When the family preparation is complete, the contractor will share with the family a copy of the proposed summary and add the family's comments to the summary document and submit the entire case file to the referring DCS worker. The contractor will also provide a copy to the Regional Special Needs Adoption Program (SNAP) Specialist for the county of residence. The contractor will then present the family preparation at the adoption team meeting. The SNAP council team will recommend if the family is appropriate for consideration to adopt a special needs child. Families will be added to a database of approved families and their information will be shared with the other SNAP Specialists.

The contractor may accompany the selected family to interview(s) for a specific child(ren) to offer support and feedback on the appropriateness of that particular child's placement in their family.

- Family assessment services must be completed within 60 days of receipt of the referral or within a time frame specified by DCS at the time of referral.
- Staff must respect confidentiality. Failure to maintain confidentiality may result in immediate termination of the service agreement.
- Services must demonstrate respect for socio-cultural values, personal goals, lifestyle, choices, and complex family interactions and be delivered in a culturally competent fashion.
- Services will be arranged at the convenience of the family and to meet the specific needs of the family.

II. Target Population

1) Families who are willing to parent a child or a sibling group of children, in Indiana's custody.
2) Families for whom adoptive home study update has been requested by the DCS.
3) ICPC requests for studies of Indiana families as potential placement for relative children from other states.

III. Goals and Outcome measures

Goal #l
Provide adoption home studies for families interested in adopting special needs children in a timely manner.
Outcome Measures

1) 95% of families referred will have their home study completed within 60 days of the referral.

2) 95% of families, who are approved by the SNAP Council, will not need additional work done or will have the recommended additions or changes completed within 30 days as recommended by the Council.

Goal #2
Ensure that the local SNAP Specialist are aware of each prepared and waiting family
Outcome Measures

1) 95% of families with completed home studies will be sent to SNAP Council Team for approval within 30 days of the completion of the home study.
2) 100% of prepared adoptive families, who are in need of recruitment, will be presented at SNAP Council Team for approval.

Goal #3
Increase the number of adoptions of children.
Outcome Measures

1) 95% of families prepared for adoption will have an understanding of the special needs of a child(ren) that is being blended into their family through adoptive placement.

Goal #4
DCS and family awareness of available services
Outcome Measure

1) 95% of families will report an understanding of the adoption process to the SNAP Specialist.
2) 100% of families will be made aware of post adoptive services available to them.
3) DCS satisfaction will be rated level 4 and above on the Service Satisfaction Report.

Goal #5

Contracted agency staff will obtain Structured Analysis Family Evaluation (SAFE) certification no later than June 30, 2016 and may implement upon certification. SAFE Implementation will be required as of July 1, 2016.

IV. Minimum Qualifications

Direct Worker:
Bachelor's degree in social work, psychology, sociology, or a directly related human service field and three years experience in adoption.

Supervisor:
Master's degree in social work, psychology, or directly related human services field.

Supervision/consultation is to include not less than one (1) hour of face to face supervision/consultation per 20 hours of direct client services provided, nor occur less than every two (2) weeks.

Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral valued culturally competent manner.

In addition to:

- Knowledge of family of origin/intergenerational issues
- Separation and loss issues
- Knowledge of adoption specific issues and the needed characteristics for families to parent these children differently
- Knowledge of child abuse/ child neglect and how these impact behavior and development.
- Knowledge of community resources, especially adoption friendly services in the communities where families reside.

V. Billable Units

Hourly rate up to 20 hours (*additional hours must be approved by the referring DCS or SNAP*):

The hourly rate includes face to face contact with the identified client/family members and professional time involved preparing the assessment report. Includes collateral contacts, case conferencing, follow up with the family, SNAP Team presentation at Statewide Council; and travel.

Hourly rate (*up to 4 hours for adoptive home study updates and additional hours must be approved by the referring DCS or SNAP*):

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

Interpretation, Translation and Sign Language Services

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

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

The location of and cost of Interpretation, Translation, and Sign Language Services are the responsibility of the Service Provider. 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. 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. Providers can use DCS contracted agencies and request that they be given the DCS contracted rate but this is not required. 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. 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.

Court: The provider of this service may be requested to testify in court. 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. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. 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.

Reports: If the services provided are not funded by DCS, the "Reports" hourly rate will be paid. A referral for "Reports" must be issued by DCS in order to bill.

VI. Case Record Documentation

Case record documentation for service eligibility must include:

1) A completed, signed, and dated DCS/ Probation referral form authorizing services.
2) Documentation of contacts regarding foster parent interest in adopting children in their care or other children available. OR Documentation of all contacts with potential adoptive family and a record of services provided with goals and objectives of the services and dates of service.
3) Documentation includes a copy of the written home studies for all prospective families following the outline in the Child Welfare Policies.

VII. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS. In the event a service provider receives verbal or email authorization to provide services from DCS an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS. Providers must initiate a re-authorization for services to continue beyond the approved period.

VIII. Adherence to the DCS Practice Model

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. 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. Trauma Informed Care

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/):
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. 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?" 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. 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

Trauma Specific Interventions: (modified from the SAMHSA definition)

- The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
- 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)
- 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.

XI. Cultural and Religious Competence.

Provider must respect the culture of the children and families with which it provides services. 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. 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. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth. The guidebook can be found at: http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf

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. 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.

XII. Child Safety

Services must be provided in accordance with the Principles of Child Welfare Services. Please note: All services (even individual services) are provided through the lens of child safety. 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. 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. 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.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
HOME-BASED FAMILY CENTERED CASEWORK SERVICES

I. Services Description

Provision of home-based casework services for families involved with DCS/Probation. Home-based casework is also available for pre-adoption and post-adoption services for adoptive families at risk or in crisis. These in-home services should be high quality, family centered, and culturally competent. They should be effective in reducing maltreatment, improving caretaking and coping skills, enhancing family resilience, supporting healthy and nurturing relationships, and children's physical, mental, emotional and educational well-being. Home-Based Casework Services should help to safely maintain children in their homes (or foster home); prevent children's initial placement or reentry into foster care; preserve, support, and stabilize families; and promote the well-being of children, youth, and families. Home-based Caseworker Services (HCS) provides any combination of the following kinds of services to the families as approved by DCS/Probation:

- Home visits
- Participation in DCS Case planning
- Supervised visitation **
- Coordination of services
- Conflict management
- Emergency/crisis services
- Child development education
- Domestic violence education
- Parenting education/training
- Family communication
- Facilitate transportation*
- Participation in Child and Family Team meetings
- Family reunification/preservation
- Reactive Attachment Disorder (RAD) support
- Foster family support
- Advocacy
- Family assessment
- Community referrals and follow-up
- Develop structure/time management
- Behavior modification
- Budgeting/money management
- Meal planning/preparation
- Parent training with children present

- Monitor progress of parenting skills
- Community services information
- Develop long and short-term

* HCS transport limited to client goal-directed, face-to-face 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.)

**Supervised Visits will be billed separately from other services within this standard and will consist of work within the scope of this service standard. The "Visitation Monthly Progress Report" form must be used to report the supervised visitation portion of the services provided. The "Monthly Progress Report" will be used for the remainder.

II. Service Delivery

1) Service provision must occur with face-to-face contact with the family within 48 hours of referral.
2) Services must include 24 hour crisis intake, intervention, and consultation seven days a week and must be provided primarily in the family's home. Limited services may also be provided at a community site.
3) Services must include ongoing risk assessment and monitoring family/parental progress.
4) The family will be the focus of service, and services will focus on the strengths of the family and build upon these strengths. Members of the client family, which may include foster parents, are to be defined in consultation with the family and approved by DCS/Probation. This may include persons not legally defined as part of the family. Approved family members will be documented as those listed on the authorizing DCS/Probation referral and subsequent written documents.
5) Services will be time-limited and focused on limited objectives derived directly from the established DCS/Probation case plan or Informal Adjustment.
6) Services must include development of short and long-term family goals with measurable outcomes that are consistent with the DCS case plan.
7) Services must be family centered and child focused.
8) Services may include intensive in-home skill building and must include after-care linkage.
9) Services include providing monthly progress reports; requested supportive documentation such as case notes, social summaries, etc.; and requested testimony and/or court appearances including hearings and/or appeals; case conferences/staffing. Monthly reports are due by the 10th of each month following the month of service.
10) Staff must respect confidentiality. Failure to maintain confidentiality may result in immediate termination of the service agreement.
11) Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life style choices, and complex family interactions and be delivered in a neutral-valued culturally-competent manner.
12) The caseload of the HCS will include no more than 12 active families at any one time.

13) Services will be provided within the context of the DCS practice model or Probation plan with involvement in Child and Family Team (CFT) meetings if invited. A treatment plan will be developed based on assessment by the provider and agreements reached in the Child and Family Team meetings and/or documented in the authorizing referral.

14) Each family receives comprehensive services through a single HCS acting within a team, with team back up and agency availability 24 hours a day, 7 days a week.

15) DCS may choose to select a standardized tool for evaluating family functioning. Services will include administration of this tool at the initiation of services as well as periodically during service provision.

III. Medicaid

For those families and children not eligible for Medicaid Rehabilitation Option, this service will be paid by DCS. For eligible families and children, some services may be provided through Medicaid Rehabilitation Option (MRO) with the remaining services paid by DCS. 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 health care needs of the MRO eligible client, and therefore may be billable to MRO. The service standard is not a Medicaid standard and includes services that are not billable to Medicaid. It is the responsibility of the contracted service provider to be knowledgeable about the Medicaid billing requirements and comply with them, including provider qualifications and any pre-authorization requirements and further, to appropriately bill those services in particular cases where they may be reimbursed by Medicaid. The Services not eligible for MRO may be billed to DCS.

IV. Crisis Service

"Safely Home Families First" is the Indiana Department of Child Services (DCS) Initiative for 2011. Our goal is to keep as many children "Safely Home" with their caretakers when possible. When removal of a child is necessary, then placement should be with "Families First." Placing children with relatives is the next healthiest action to take, regarding meeting a child's safety needs as well as their emotional needs. Crisis services may be necessary to prevent the removal of the child(ren). The family centered practice of the home based services is the best avenue to provide crisis services.

These crisis services are for families who have children at imminent risk of removal. Imminent risk is defined as: Immediate threat of injury or harm to a child when ***no interventions*** have occurred to protect the child. Goal is to resolve the immediate crisis, prevent removal of the child, and to transition and/or link the family to needed services.

Criteria for service:

- The crisis intervention provider must be available for contact 24/7.
- The provider must have a crisis intervention telephone number.
- The FCM will notify the Provider of a crisis situation and require a 1 hour response on the part of the provider.
- One (1) hour response time required. (No more than 1 hour from phone call to provider to a face to face contact with the family by the provider.)
- Referrals would be for families who are not currently receiving home based services (Home Based Casework, Home Based Therapy, Homemaker, or Homebuilders). Crisis Intervention services to existing clients in Home Based Services are already included as part of the service standards.
- Crisis Intervention includes, but is not limited to, crisis assessment, planning and counseling specific to the crisis. Most interventions are expected to be in the home.
- Crisis payment is for the "incident only". The "incident" for payment purposes for the provider will start at the time of a face to face contact with the client and end when that face to face contact ends.
- A Crisis Report shall be electronically sent to the FCM within 24 hours. This report should document the start time and end time of the intervention. It shall report the assessment of the situation and recommendations for services, if any.
- The referral for this service will be after the incident and will include ongoing services if deemed necessary.

V. When DCS is not paying for services:

A billable unit of "Reports" has been developed for providers who service DCS families without DCS payment for these services (Medicaid, insurances, self-pay) but DCS wants a report from the provider on the progress of the family. The referral process has been set up to authorize reports and court components on the DCS referral form in these incidences. **DCS will only pay for reports when DCS is not paying for these services.** If the services provided are not funded by DCS, the report rate per hour will be paid for the necessary reports on a referral form issued by DCS. Court testimony will be paid per appearance if requested on a referral form issued by DCS. In order to be paid for a court appearance a subpoena or written request from DCS should be on file.

VI. Target Population

Services must be restricted to the following eligibility categories:

1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
2) Children and their families which have an Informal Adjustment (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.

Services billable to MRO are for Medicaid eligible clients with a qualifying diagnosis and level of need.

VII. Goals and Outcomes

Goal #1

Maintain timely intervention with the family and regular and timely communication with referring worker.

Objectives:

1) HCS or back-up is available for consultation to the family 24-7 by phone or in person.

Fidelity Measures:

1) 95% of all families that are referred will have face-to-face contact with the client within 48 hours of receipt of the referral or inform the current Family Case Manager/Probation Officer if the client does not respond to requests to meet.
2) 95% of families will have a written treatment plan prepared and sent to the current Family Case Manager/Probation Officer following receipt of the referral within 30 days of contact with the client.
3) 100% of all families will have monthly written summary reports prepared and sent to the current Family Case Manager/Probation Officer by the 10th of the month following the services.

Goal #2 Clients will achieve improved family functioning.

Objectives:

1) Goal setting, and service planning are mutually established with the client and Home Based Caseworker within 30 days of the initial face-to-face intake and a written report signed by the Home Based Caseworker and the client is submitted to the current FCM/ Probation Officer.

Client Outcome Measures:

1) 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

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. (To be measured/evaluated by DCS/Probation staff)
3) 90% of the individuals/families that were intact prior to the initiation of service will remain intact throughout the service provision period.
4) If DCS elects to implement a standardized tool for evaluating family functioning, a related outcome measure will be added.

Goal #3 DCS/ Probation and clients will report satisfaction with services.

Outcome Measures:

1) DCS/ Probation satisfaction will be rated 4 and above on the Service Satisfaction Report.
2) 90% of clients will rate the services "satisfactory" or above on a satisfaction survey developed by the service provider, unless one is distributed by DCS/Probation to providers for their use with clients Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.

VIII. Minimum Qualifications

Services provided will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral-valued culturally-competent manner.
Providers are to respond to the on-going individual needs of staff by providing them with the appropriate combination of training and supervision. The frequency and intensity of training and supervision are to be consistent with "best practices" and comply with the requirements of each provider's accreditation body. Supervision should include individual, group, and direct observation modalities and can utilize teleconference technologies. Under no circumstances is supervision to be less than one (1) hour of supervision per 25 hours of face-to-face direct client services provided, nor occur less than every two (2) weeks (Clinical Consultation time applies when the supervisor is present, refer to clinical consultation section under supervisor qualifications).

Must possess a valid driver's license and the ability to use a private car to transport self and others, and must comply with the state policy concerning minimum car insurance coverage.

Direct Worker:
Bachelor's degree in social work, psychology, sociology, or a directly-related human service field from an accredited college. Other Bachelor's degrees will be accepted in combination with a minimum of five years experience working directly with families in the child welfare system. Must possess a valid driver's license and the ability to use private car to transport self and others, and must comply with the state policy concerning minimum car insurance coverage.

In addition to the above:

- Knowledge of child abuse and neglect, and child and adult development
- Knowledge of community resources and ability to work as a team member
- Belief in helping clients change their circumstances, not just adapt to them
- Belief in adoption as a viable means to build families
- Understanding regarding issues that are specific and unique to adoptions such as loss, mismatched expectations and flexibility, loss of familiar surroundings, customs and traditions of the child's culture, entitlement, gratification delaying, flexible parental roles and humor.

Supervisor:
Qualifications for Home Based Casework Supervision

Master's or Doctorate degree in social work, psychology, or directly-related human services field from an accredited college and completion of DCS Supervision Qualification Training requirements specified for Masters level supervisors.
Or
A Bachelors Degree in social work, psychology, or directly-related human service field from an accredited college with five years experience delivering home-based child welfare or home based probation services under a DCS community based contract with one year experience under the home based casework service standard and completion of DCS Supervisor Qualification Training requirements specified for Bachelors level supervisors. The individual must have a minimum of 6 months of experience with current agency or must have provided supervision under the service standard for at least 1 year at a different agency. All staff who are supervised by a bachelor's level supervisor must have clinical consultation a minimum of quarterly. This consultation can be provided in a group format. Supervisors should be present during clinical consultation, as this time can apply toward the minimum staffing requirements required for supervision.
Or
Master's degree in social work, psychology, marriage and family therapy, or related human service field, and 2 years related clinical experience with a clinical license issued by the Indiana Social Worker, Marriage and Family Therapist, or Mental Health Counselor Board, as one of the following: 1) Clinical Social Worker, 2) Marriage and Family Therapist, 3) Mental Health Counselor.

Supervision Training Criteria
All providers providing supervision must adhere to the DCS Supervisor Qualification Training. The DCS Supervisor Qualification training outlines a training criteria. These trainings can be completed by the agencies own training program if it meets the competencies or utilize DCS resources to train staff. The link for the Supervisor Qualification Training can be found at http://www.in.gov/dcs/3493.htm .

Qualifications for Clinical Consultation (applicable when the supervisor meets the requirements at a Bachelor's Degree level, refer above)

Master's degree in social work, psychology, marriage and family therapy, or related human service field, and 2 years related clinical experience with a clinical license issued by the Indiana Social Worker, Marriage and Family Therapist, or Mental Health Counselor Board, as one of the following: 1) Clinical Social Worker, 2) Marriage and Family Therapist, 3) Mental Health Counselor. All staff who are supervised by a bachelor's level supervisor must have clinical consultation staffed a minimum of quarterly. This consultation can be provided in a group format. Bachelors level Supervisor should be present during clinical consultation with direct staff, this time is applicable to minimum supervision requirements.

The supervisor must meet the minimum criteria outlined below for:
Supervision, Case Staffing, and Shadowing.

Supervision

Supervisors must respond to the on-going individual needs of staff by providing them with the appropriate combination of training and supervision. The frequency and intensity of training and supervision are to be consistent with "best practices" and comply with the requirements of each provider's accreditation body. Supervision should include individual, group, and direct observation modalities and can utilize teleconference technologies. Under no circumstances is supervision to be less than one (1) hour of supervision per 25 hours of face-to-face direct client services provided, nor occur less than every two (2) weeks.

Shadowing Criteria

All agencies must have policies that require regular shadowing (by supervisor) of all staff at established intervals based on staff experience and need.
Shadowing must be provided in accordance with the policy. The agency must provide clear documentation that shadowing has occurred.

Individuals providing supervision under this service standard on 11/1/15 will have until 6/30/16 to complete the DCS Supervision Qualification Training. All training requirements must be met within the last 3 years. New staff hired as supervisors on or after 11/1/15 must have DCS Supervision Qualification Training prior to providing supervision.

IX. . Billable Unit

Medicaid: Services through the Medicaid Rehab Option (MRO) may be Case Management and/or Skills Training & Development. Medicaid shall be billed when appropriate.

- Medically necessary behavioral health care Skills Training and Development services for the MRO will be paid per 15 minute unit for Individual and Family per 15 minute unit for group.

- Medically necessary behavioral health care Case Management for the MRO child will be paid per 15 minute unit. Case Management services should not exceed those included in the MRO package.

Billing Code	Description
T1016 HW	Case Management, each 15 minutes
H2014 HW	Skills Training and Development , per 15 minutes
H2014 HW HR	Skills Training and Development, per 15 minutes (family/couple, consumer present)
H2014 HW HS	Skills Training and Development, per 15 minutes (family/couple, without consumer present)
H2014 HW U1	Skills Training and Development , per 15 minutes (group setting)
H2014 HW HR U1	Skills Training and Development , per 15 minutes (group setting, family/couple, with consumer present)
H2014 HW HS U1	Skills Training and Development , per 15 minutes (group setting, family/couple, without consumer present)

DCS holds overall Case Management responsibility. In order to assist DCS with the coordination of medically necessary behavioral health care needs of the MRO client, CMHC's may provide case management services with this specific focus.

DCS Funding: Those services not deemed medically necessary for the Medicaid eligible client, including services to other referred members of the family that are not related to the behavior health care needs of the eligible client, will be billed to DCS per face-to-face hour as outlined below. These billable units will also be utilized for services to referred clients who are not Medicaid eligible and for those providers who are unable to bill Medicaid. .

Face to face time with the client:
(Note: Members of the client family are to be defined in consultation with the family and approved by the DCS. This may include persons not legally defined as part of the family)

- Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.

- Includes Child and Family Team Meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family.
- Includes in-vehicle (or in-transport) time with client provided it is identified as goal-directed, face-to-face, and approved/specified as part of the client's intervention plan (e.g. housing/apartment search, etc.).
- Includes crisis intervention and other goal-directed interventions via telephone with the identified client family.
- Includes time spent completing any DCS approved standardized tool to assess family functioning.

Reminder: Not included are routine report writing and scheduling of appointments, collateral contacts, travel time and no shows. These activities are built into the cost of the face- to-face rate and shall not be billed separately.

Supervised Visit:
** Time spent supervising visits will be billed separately from other services within this standard and will consist of work within the scope of this service standard. The rate will be the same as the face-to-face rate, but will include only time spent face-to-face supervising the visit. Any other billable time as defined in the face-to-face rate, should be billed under the face-to-face rate.

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

(Note on Intermittent supervised visitation: when DCS requests the provider to check in intermittently - at least once per hour - , the provider can bill in increments of 30 minutes for each check-in, provided that the total amount of time billed should not exceed the total length of the visit.)

Interpretation, Translation and Sign Language Services
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. 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. 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). Sign Language should be done in the language familiar to the family.
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. 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. No side comments or conversations between the Interpreters and the clients should occur.
The location of and cost of Interpretation, Translation, and Sign Language Services are the responsibility of the Service Provider. 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. 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. Providers can use DCS contracted agencies and request that they be given the DCS contracted rate but this is not required. 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. 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.

Court
The provider of this service may be requested to testify in court. 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. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. 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.

Reports
If the services provided are not funded by DCS, the "Reports" hourly rate will be paid. A referral for "Reports" must be issued by DCS in order to bill.

Crisis Intervention/Response
Crisis Intervention includes, but is not limited to, crisis assessment, planning and counseling specific to the crisis. Most interventions are expected to be in the home. Crisis payment is for the "incident only". The "incident for payment purposes for the provider will start at the time of a face to face contact with the client and end when that face to face contact ends. An hourly rate will be paid.

X. Case Record Documentation

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.

XI. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

XII. Adherence to the DCS Practice Model

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. 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.

XIII. Trauma Informed Care

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/):
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. 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?" 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. 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

Trauma Specific Interventions: (modified from the SAMHSA definition)

- The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
- 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)

- 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.

XIV. Cultural and Religious Competence.

Provider must respect the culture of the children and families with which it provides services. 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. 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. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth. The guidebook can be found at: http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf

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. 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

Services must be provided in accordance with the Principles of Child Welfare Services. Please note: All services (even individual services) are provided through the lens of child safety. 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. 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. 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.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
HOME-BASED FAMILY CENTERED THERAPY SERVICES

I. Service Description

This service standard applies to services provided to families and children involved with the Department of Child Services and/or Probation. These in-home services should be high quality, family centered, and culturally competent.

Provision of structured, goal-oriented, time-limited therapy in the natural environment of families who need assistance recovering from physical, sexual, emotional abuse, and neglect. Other issues, including substance abuse, mental illness, personality/behavior disorder, developmental disability, dysfunctional family of origin, and current family dysfunction, may be addressed in the course of treating the abuse/neglect.

Professional staff will provide family and/or individual therapy including one or more of the following areas:

- Family of origin/intergenerational issues
- Family organization (internal boundaries, relationships, roles)
- Stress management
- Self-esteem
- Communication skills
- Conflict resolution
- Behavior modification
- Parenting skills/Training
- Substance abuse
- Crisis intervention
- Strengths based perspective
- Adoption issues
- Participation in Child and Family Team meetings
- Sex abuse
- Goal setting
- Family structure (external boundaries, relationships, socio-cultural history)
- Problem solving
- Support systems
- Interpersonal relationships
- Therapeutic supervised visitation**
- Family processes (adaptation, power authority, communications, META rules)
- Cognitive behavioral strategies
- Brief therapy
- Family reunification/preservation

- Grief and loss
- Domestic violence education
- Reactive Attachment Disorder (RAD) support

**Supervised Visits will be billed separately from other services within this standard and will consist of work within the scope of this service standard. The "Visitation Monthly Progress Report" form must be used to report the supervised visitation portion of the services provided. The "Monthly Progress Report" will be used for the remainder.

II. Service Delivery

1) Services must include 24 hour crisis intake, intervention, and consultation seven days a week and must be provided primarily in the family's home. Limited services may also be provided at a community site.
2) Services must include ongoing risk assessment and monitoring family/parental progress.
3) The family will be the focus of service and services will focus on the strengths of the family and build upon these strengths. Members of the client family, which may include foster parents, are to be defined in consultation with the family and approved by DCS/Probation. This may include persons not legally defined as part of the family. Approved family members will be documented as those listed on the authorizing DCS/Probation referral and subsequent written documents.
4) Services will be time-limited and focused on limited objectives derived directly from the established DCS/Probation case plan or Informal Adjustment.
5) Services must include development of short and long-term family goals with measurable outcomes.
6) Services must be family focused and child centered.
7) Services may include intensive in-home skill building and must include after-care linkage.
8) Services include providing monthly progress reports; requested supportive documentation such as case notes, social summaries, etc.; and requested testimony and/or court appearances including hearings and/or appeals; case conferences/staffing.
9) Staff must respect confidentiality. Failure to maintain confidentiality may result in immediate termination of the service agreement.
10) Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life style choices, and complex family interactions and be delivered in a neutral-valued culturally-competent manner.
11) The caseload of the Home-Based Family Centered Therapist (HBFCT) will include no more than 12 active families at any one time.
12) Services will be provided within the context of the DCS practice model or Probation plan with involvement in Child and Family Team (CFT) meetings if invited. A treatment plan will

be developed based on agreements reached in the Child and Family Team meetings and/or documented in the authorizing referral.

13) Each family receives comprehensive services through a single HBFCT acting within a team, with team back up and agency availability 24 hours a day, 7 days a week.
14) DCS may choose to select a standardized tool for evaluating family functioning. Services will include administration of this tool at the initiation of services as well as periodically during service provision.

III. Medicaid

For those families and children not eligible for Medicaid Rehabilitation Option, this service will be paid by DCS. For eligible families and children, some services may be provided through Medicaid Rehabilitation Option (MRO) with the remaining services paid by DCS. 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 health care needs of the MRO eligible client, and therefore may be billable to MRO. The service standard is not a Medicaid standard and includes services that are not billable to Medicaid. It is the responsibility of the contracted service provider to be knowledgeable about the Medicaid billing requirements and comply with them, including provider qualifications and any pre-authorization requirements and further, to appropriately bill those services in particular cases where they may be reimbursed by Medicaid. The Services not eligible for MRO may be billed to DCS.

IV. Crisis Service

Safely Home Families First" is the Indiana Department of Child Services (DCS) Initiative for 2011. Our goal is to keep as many children "Safely Home" with their caretakers when possible. When removal of a child is necessary, then placement should be with "Families First." Placing children with relatives is the next healthiest action to take, regarding meeting a child's safety needs as well as their emotional needs. Crisis services may be necessary to prevent the removal of the child(ren). The family centered practice of the home based services is the best avenue to provide crisis services.

These crisis services are for families who have children at imminent risk of removal. Imminent risk is defined as: Immediate threat of injury or harm to a child when ***no interventions*** have occurred to protect the child. Goal is to resolve the immediate crisis, prevent removal of the child, and to transition and/or link the family to needed services.

Criteria for service:

The provider must have a crisis intervention telephone number.
The FCM will notify the Provider of a crisis situation and require a 1 hour response on the part of the provider.

One (1) hour response time required. (No more than 1 hour from phone call to provider to a face to face contact with the family by the provider.)
Referrals would be for families who are not currently receiving home based services (Home Based Casework, Home Based Therapy, Homemaker, or Homebuilders). Crisis Intervention services to existing clients in Home Based Services are already included as part of the service standards.

- Crisis Intervention includes, but is not limited to, crisis assessment, planning and counseling specific to the crisis. Most interventions are expected to be in the home.
- Crisis payment is for the "incident only". The "incident" for payment purposes for the provider will start at the time of a face to face contact with the client and end when that face to face contact ends.
- A Crisis Report shall be electronically sent to the FCM within 24 hours. This report should document the start time and end time of the intervention. It shall report the assessment of the situation and recommendations for services, if any.
- The referral for this service will be after the incident and will include ongoing services if deemed necessary.

V. When DCS is not paying for services:

A billable unit of "Reports" has been developed for providers who service DCS families without DCS payment for these services (Medicaid, insurances, self-pay) but DCS wants a report from the provider on the progress of the family. The referral process has been set up to authorize reports and court components on the DCS referral form in these incidences. **DCS will only pay for reports when DCS is not paying for these services.** If the services provided are not funded by DCS, the report rate per hour will be paid for the necessary reports on a referral form issued by DCS. Court testimony will be paid per appearance if requested on a referral form issued by DCS. In order to be paid for a court appearance a subpoena or written request from DCS should be on file.

Target Population

Services must be restricted to the following eligibility categories:

1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with 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) Any child who has been adopted and adoptive families.

Services billable to MRO are for Medicaid eligible clients with a qualifying diagnosis and level of need.

VI. Goals and Outcomes

Goal #1

Maintain timely intervention with the family and regular timely communication with referring worker.

Objectives:

1) HCS or back-up is available for consultation to the family 24-7 by phone or in person.

Fidelity Measures:

1) 95% of all families that are referred will have face-to-face contact with the client within 48 hours of receipt of the referral or inform the current Family Case Manager/Probation Officer if the client does not respond to requests to meet.
2) 95% of families will have a written treatment plan prepared and sent to the current Family Case Manager/Probation Officer following receipt of the referral within 30 days of contact with the client.
3) 95% of all families will have monthly written summary reports prepared and sent to the current Family Case Manager/Probation Officer by the 10th of the month following the services.

Goal #2

Clients will achieve improved family functioning.

Objectives:

1) Goal setting, and service planning are mutually established with the client and Home Based Therapist within 30 days of the initial face-to-face intake and a written report signed by the Home Based Therapist and the client is submitted to the current FCM/ Probation Officer.

Client Outcome Measures:

1) 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

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. (To be measured/evaluated by DCS/Probation staff)
3) 90% of the individuals/families that were intact prior to the initiation of service will remain intact throughout the service provision period
4) If DCS elects to implement a standardized tool for evaluating family functioning, a related outcome measure will be added.

Goal #3

DCS/ Probation and clients will report satisfaction with services.

Outcome Measures:

1) DCS/ Probation satisfaction will be rated 4 and above on the Service Satisfaction Report.
2) 90% of clients will rate the services "satisfactory" or above on a satisfaction survey developed by the service provider, unless one is distributed by DCS/Probation to providers for their use with clients Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.

VII. Minimum Qualifications

MRO:

Providers must meet the either of the following qualifications:

- Licensed professional, except for a licensed clinical addiction counselor
- Qualified Behavioral Health Professional (QBHP)

DCS Direct Worker:

Direct workers under this standard must meet one of the following minimum qualifications:

1) Master's or Doctorate degree with a current license issued by the Indiana Behavioral Health and Human Services Licensing Board as one of the following: 1) Social Worker, 2) Clinical Social Worker, 3) Marriage and Family Therapist, 4) Mental Health Counselor 5) Marriage and Family Therapist Associate and 6) Mental Health Counselor Associate.

2) Master's degree with a temporary permit issued by the Indiana Behavioral Health and Human Services Licensing Board as one of the following: 1) Social Worker, 2) Clinical

Social Worker, within 90 days of providing services under this contract (Please note: In order to obtain a temporary license, the individual must register for the exam) and,

a. 2 years related clinical experience, or
b. completion of the DCS approved training program

Note: In order to obtain a temporary license, the individual must first register for the licensure exam and may have additional requirements for temporary licensure. Please contact the Indiana Professional Licensing Board for additional instructions for obtaining a temporary license.

3) Master's degree and a submitted application for 1) Marriage and Family Therapist Associate, or 2) Mental Health Counselor Associate within 90 days of providing services under this contract. The individual must obtain licensure as a Marriage and Family Therapist Associate or Mental Health Counselor Associate within 12 months of providing services under this contract. The individual must also have:

   a. 2 years related clinical experience, or
   b. completion of the DCS approved training program

4) Master's degree in a related human service field plus 2 years related clinical experience and working under a DCS Community Based Contract on July 1, 2015.

Note: Individuals who hold a Master's degree that is applicable toward licensure, must become licensed as indicated in #2 & 3 above. Providers should not employ any new staff who are not license eligible.

Must possess a valid driver's license and the ability to use a private car to transport self and others, and must comply with the state policy concerning minimum car insurance coverage.

In addition to the above:

- Knowledge of family of origin/intergenerational issues
- Knowledge of child abuse/neglect
- Knowledge of child and adult development
- Knowledge of community resources
- Ability to work as a team member
- Belief in helping clients change, to increase the level of functioning, and knowledge of strength-based initiatives to bring about change
- Belief in the family preservation philosophy
- Knowledge of motivational interviewing
- Skillful in the use of Cognitive Behavioral Therapy

- Skillful in the use of evidence-based strategies

Supervisor:

Master's or Doctorate degree in social work, psychology, marriage and family, or related human service field, with a current license issued by the Indiana Behavioral Health and Human Services Licensing Board as one of the following: 1) Clinical Social Worker, 2) Marriage and Family Direct Worker, 3) Mental Health Counselor.

Services provided will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral-valued culturally-competent manner.

Providers are to respond to the on-going individual needs of staff by providing them with the appropriate combination of training and supervision. The frequency and intensity of training and supervision are to be consistent with "best practices" and comply with the requirements of each provider's accreditation body. Supervision should include individual, group, and direct observation modalities and can utilize teleconference technologies. Under no circumstances is supervision/consultation to be less than one (1) hour of supervision/consultation per 25 hours of face-to-face direct client services provided, nor occur less than every two (2) weeks.

VIII. Billable Units

Medicaid: Services through the Medicaid Rehab Option (MRO) may be Behavioral Health Counseling and Therapy. Medicaid shall be billed when appropriate.

- Medically necessary behavioral health care services for MRO will be paid per 15 minute unit for Individual and Family per 15 minute unit for group.

Billing Code	Title
H0004 HW	Behavioral health counseling and therapy, per 15 minutes
H0004 HW HR	Behavioral health counseling and therapy, per 15 minutes (family/couple, with consumer present)

H0004 HW HS	Behavioral health counseling and therapy, per 15 minutes (family/couple, without consumer present

DCS Funding: Those services not deemed medically necessary for the Medicaid eligible client, including services to other referred members of the family that are not related to the behavior health care needs of the eligible client, will be billed to DCS per face-to-face hour as outlined below. These billable units will also be utilized for services to referred clients who are not MRO eligible and for those providers who are unable to bill Medicaid. .

Face to face time with the client:

(Note: Members of the client family are to be defined in consultation with the family and approved by the DCS. This may include persons not legally defined as part of the family)

- Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
- Includes crisis intervention and other goal-directed interventions via telephone with the identified client family
- Includes Child and Family Team Meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family.
- Includes in-vehicle (or in-transport) time with client provided it is identified as goal-directed, face-to-face, and approved/specified as part of the client's intervention plan (e.g. housing/apartment search, etc.).
- Includes time spent completing any DCS approved standardized tool to assess family functioning.

. **Reminder:** Not included are routine report writing and scheduling of appointments, collateral contacts, travel time and no shows. These activities are built into the cost of the face- to-face rate and shall not be billed separately.

Therapeutic Supervised Visit:

** Time spent supervising visits will be billed separately from other services within this standard and will consist of work within the scope of this service standard. The rate will be the same as the face-to-face rate, but will include only time spent face-to-face supervising the visit. Any other billable time as defined in the face-to-face rate, should be billed under the face-to-face rate.

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

(Note on Intermittent supervised visitation: when DCS requests the provider to check in intermittently - at least once per hour - , the provider can bill in increments of 30 minutes for each check-in, provided that the total amount of time billed should not exceed the total length of the visit.)

Interpretation, Translation and Sign Language Services

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

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

The location of and cost of Interpretation, Translation, and Sign Language Services are the responsibility of the Service Provider. 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. 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. Providers can use DCS contracted agencies and request that they be given the DCS contracted rate but this is not required. 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. 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.

Court

The provider of this service may be requested to testify in court. 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. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. 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

Reports

If the services provided are not funded by DCS, the "Reports" hourly rate will be paid. A referral for "Reports" must be issued by DCS in order to bill.

Crisis Intervention/Response

Crisis Intervention includes, but is not limited to, crisis assessment, planning and counseling specific to the crisis. Most interventions are expected to be in the home. Crisis payment is for the "incident only". The "incident for payment purposes for the provider will start at the time of a face to face contact with the client and end when that face to face contact ends. An hourly rate will be paid.

Child Parent Psychotherapy (CPP)

Parent/child focused relationship based intervention for infants 0-5 years of age whom have experienced a traumatic event such as a car accident, domestic violence, death or murder of a parent. The treatment is home based and focuses on the attachment between the caregiver and the child. It helps to promote normal development of the child and connects the caregiver to the meanings of the child's behavior

IX. Case Record Documentation

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.

X. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation.

Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

XI. Adherence to the DCS Practice Model

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. 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.

XVI. Trauma Informed Care

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/):
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. 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?" 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. 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

Trauma Specific Interventions: (modified from the SAMHSA definition)

- The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
- 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)
- 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.

XVII. Cultural and Religious Competence.

Provider must respect the culture of the children and families with which it provides services. 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. 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. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth. The guidebook can be found at: http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf

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. 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.

XVIII. **Child Safety**

Services must be provided in accordance with the Principles of Child Welfare Services. Please note: All services (even individual services) are provided through the lens of child safety. 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. 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. 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.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
HOMEMAKER / PARENT AID

I. Service Description

Homemaker/parent aid provides assistance and support for parents who are unable to appropriately fulfill parenting and/or homemaking functions. Paraprofessional staff assists the family through advocating, teaching, demonstrating, monitoring, and/or role modeling new, appropriate skills for coping with the following areas in an effort to build self-sufficiency:

- Time management
- Care of children (Life Skills Training not the provision of Child Care)
- Child development
- Health care
- Community resources (referrals)
- Transportation *
- Supervise visitation with child(ren)**
- Identify support systems
- Problem solving
- Family reunification/preservation
- Resource management/Budgeting
- Child safety
- Child nutrition
- Home management
- Parenting skills
- Housing
- Self esteem
- Crisis resolution
- Parent/child interaction
- Supervision

*****Homemaker transportation limited to client goal-directed, face-to-face 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)

**Supervised Visits will be billed separately from other services within this standard and will consist of work within the scope of this service standard. The "Visitation Monthly Progress Report" form must be used to report the supervised visitation portion of the services provided. The "Monthly Progress Report" will be used for the remainder.

II. Service Delivery

Services will be provided in the family's home, a community site, or in the office (if approved by DCS/Probation), and in the course of assisting with transportation, accompanying the parent(s) during errands, job search, etc.

1) Services must be compatible with the established DCS/Probation case plan and authorized by the DCS/Probation referral.
2) Transportation can be provided in the course of assisting the client to fulfill the case plan or informal adjustment program, or as part of learning a particular task as specified in the service components, such as visitation, medical appointments, grocery shopping, house/apartment hunting, etc.
3) Staff must respect confidentiality. Failure to maintain confidentiality may result in immediate termination of the service agreement.
4) Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral-valued culturally-competent manner.
5) Services will include any requested testimony, for court appearances (to include hearings or appeals), or when requested participate in Child and Family Team (CFT) meetings. (To ensure provider participation, DCS/Probation will give the service provider at least two working days notice in advance of CFT meeting.)
6) Services to provide monthly reports outlining progress toward treatment goals. Reports should utilize the DCS approved monthly report form and provided to the Family Case Manager or Probation officer by the 10th day of the month following the month the service was provided.
7) Services to families will be available 24 hours per day, 7 days per week.
8) Services will focus on the strengths of families and build upon those strengths. Members of the client family, which may include foster parents, are to be defined in consultation with the family and approved by DCS/Probation. This may include persons not legally defined as part of the family and should be listed as part of the referral document or subsequent written documents from the referral source.
9) One (1) full-time homemaker/parent aid can have a caseload of no more than 12 active families at any one time.
10) DCS may choose to select a standardized tool for evaluating family functioning. Services will include administration of this tool at the initiation of services as well as periodically during service provision.

III. Crisis Service

Safely Home Families First" is the Indiana Department of Child Services (DCS) Initiative for 2011. Our goal is to keep as many children "Safely Home" with their caretakers when possible. When removal of a child is necessary, then placement should be with "Families First." Placing children with relatives is the next healthiest action to take, regarding meeting a child's safety needs as well as their emotional needs. Crisis services may be necessary to prevent the removal

of the child(ren). The family centered practice of the home based services is the best avenue to provide crisis services.

These crisis services are for families who have children at imminent risk of removal. Imminent risk is defined as: Immediate threat of injury or harm to a child when ***no interventions*** have occurred to protect the child. Goal is to resolve the immediate crisis, prevent removal of the child, and to transition and/or link the family to needed services.

Criteria for service:

The crisis intervention provider must be available for contact 24/7.
The provider must have a crisis intervention telephone number.
The FCM will notify the Provider of a crisis situation and require a 1 hour response on the part of the provider.
One (1) hour response time required. (No more than 1 hour from phone call to provider to a face to face contact with the family by the provider.)
Referrals would be for families who are not currently receiving home based services (Home Based Casework, Home Based Therapy, Homemaker, or Homebuilders). Crisis Intervention services to existing clients in Home Based Services are already included as part of the service standards.

- Crisis Intervention includes, but is not limited to, crisis assessment, planning and counseling specific to the crisis. Most interventions are expected to be in the home.
- Crisis payment is for the "incident only". The "incident" for payment purposes for the provider will start at the time of a face to face contact with the client and end when that face to face contact ends.
- A Crisis Report shall be electronically sent to the FCM within 24 hours. This report should document the start time and end time of the intervention. It shall report the assessment of the situation and recommendations for services, if any.
- The referral for this service will be after the incident and will include ongoing services if deemed necessary.

IV. When DCS is not paying for services:

A billable unit of "Reports" has been developed for providers who service DCS families without DCS payment for these services (Medicaid, insurances, self-pay) but DCS wants a report from the provider on the progress of the family. The referral process has been set up to authorize reports and court components on the DCS referral form in these incidences. **DCS will only pay for reports when DCS is not paying for these services.** If the services provided are not funded by DCS, the report rate per hour will be paid for the necessary reports on a referral form issued by DCS. Court testimony will be paid per appearance if requested on a referral form issued by DCS. In order to be paid for a court appearance a subpoena or written request from DCS should be on file.

V. Target Population

Services must be restricted to the following eligibility categories:

1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
2) Children and their families which have an Informal Adjustment (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.

VI. Goals and Outcome Measures

Goal #1

Maintain timely intervention with family regularly, and timely communication with DCS/Probation worker.

Objective:

1) Homemaker/Parent Aid or backup is available for consultation to the family 24/7 by phone or in person.

Outcome Measure/Fidelity Measure:

1) 95% of all families that are referred will have face-to-face contact with the client within 5 days of the receipt of the referral. Provider will inform the current/referring Family Case Manager/Probation Officer if the client does not respond to requests to meet within that time period.
2) 95% of families will have a written plan prepared regarding expectations of the family and homemaker/parent aid and sent to the current Family Case Manager/Probation Officer following receipt of the referral within 30 days of contact with the client.
3) 100% of all families will have monthly written summary reports prepared and sent to the current Family Case Manager or Probation Officer.

Goal #2

Improved family functioning including development of positive means of managing crisis.

Objective:

1) Service delivery is grounded in best practice strategies and building skills based on a strength perspective to increase family functioning.

Outcome Measure/Fidelity Outcome:

1) 67% of the families that have a child in substitute care prior to the initiation of service will be reunited by the closure of the service provision period.
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 through the service provision period.
3) 90% of the individuals/families that were intact prior to the initiation of service will remain intact throughout the service provision period.
4) Scores will be improved on the state approved, standardized needs and strengths assessment instruments used by the referring DCS or Probation.
5) If DCS elects to implement a standardized tool for evaluating family functioning, a related outcome measure will be added.

Goal #3

Maintain satisfactory services to the children and family

Objective

1) DCS/Probation and clients will report satisfaction with services.

Outcome Measure/Fidelity Measure:

1) DCS/Probation satisfaction with services will be rated 4 and above on the Service Satisfaction Report.
2) 90% of clients will rate the services "satisfactory" or above on a satisfaction survey developed by the service provider, unless one is distributed by DCS/Probation to providers for their use with clients Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.

VII. Minimum Qualifications
Homemaker/Parent Aid:

A high School diploma or GED and is at least 21 years of age. Must possess a valid driver's license and the ability to use private car to transport self and others, and must comply with state policy concerning minimum car insurance coverage.

Qualities:

Ability to work as a team member

Ability to work independently

Patience

Nonjudgmental

Emotional maturity

Knowledge of child development

Knowledge of community resources

Belief that change is possible

Strong organizational skills

Exercise sound judgment

Belief in family preservation philosophy

Knowledge of child abuse and neglect

Thorough and empathetic communication skills

Supervisor:

Bachelor's Degree in social work, psychology, sociology, or a directly related human service field from an accredited college.

Providers are to respond to the on-going individual needs of staff by providing them with the appropriate combination of training and supervision. The frequency and intensity of training and supervision are to be consistent with "best practices" and comply with the requirements of each provider's accreditation body. Supervision should include individual, group, and direct observation modalities and can utilize teleconference technologies. Under no circumstances is supervision/consultation to be less than one (1) hour of supervision/consultation per 25 hours of face-to-face direct client services provided, nor occur less than every two (2) weeks.

Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral-valued culturally-competent manner.

VIII. Billable Units

Face-to-face time with the client

(Note: Members of the client family are to be defined in consultation with the family and approved by the DCS/Probation. This may include persons not legally defined as part of the family.)

- Includes client-specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
- Includes crisis intervention and other goal-directed interventions via telephone with the identified client family.
- Includes scheduled Child and Family Team meetings or case conferences (including crisis case conferences via telephone) initiated or approved by the DCS/Probation for the purposes of goal-directed communication regarding the services to be provided to the client/family. All cases conferences billed, including those via telephone, must be documented in the case notes.
- Includes in-vehicle (or in-transport) time with client provided it is identified as goal-directed, face-to-face, and approved/specified as part of the client's intervention plan (e.g. housing/apartment search, etc.).
- Includes time spent completing any DCS approved standardized tool to assess family functioning.

Reminder: Not included are routine report writing and scheduling of appointments, collateral contacts unless ordered by DCS/Probation, travel time, and no shows. These activities are built into the cost of the face-to-face rate and shall not be billed separately.

Supervised Visit:

Time spent supervising visits will be billed separately from other services within this standard and will consist of work within the scope of this service standard. The rate will be the same as the face-to-face rate, but will include only time spent face-to-face supervising the visit. Any other billable time as defined in the face-to-face rate, should be billed under the face-to-face rate.

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

(Note on Intermittent supervised visitation: when DCS requests the provider to check in intermittently - at least once per hour - , the provider can bill in increments of 30 minutes for each check-in, provided that the total amount of time billed should not exceed the total length of the visit.)

Interpretation, Translation and Sign Language Services

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

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

The location of and cost of Interpretation, Translation, and Sign Language Services are the responsibility of the Service Provider. 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. 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. Providers can use DCS contracted agencies and request that they be given the DCS contracted rate but this is not required. 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. 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.

Court

The provider of this service may be requested to testify in court. 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. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. 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.

Reports

If the services provided are not funded by DCS, the "Reports" hourly rate will be paid. A referral for "Reports" must be issued by DCS in order to bill.

Crisis Intervention/Response

Crisis Intervention includes, but is not limited to, crisis assessment, planning and counseling specific to the crisis. Most interventions are expected to be in the home. Crisis payment is for the "incident only". The "incident for payment purposes for the provider will start at the time of a face to face contact with the client and end when that face to face contact ends. An hourly rate will be paid.

IX. Case Record Documentation

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.

X. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

XI. Adherence to the DCS Practice Model

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. 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.

XII. Trauma Informed Care

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/):
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. 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?" 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. 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

Trauma Specific Interventions: (modified from the SAMHSA definition)

- The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
- 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)
- 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. Cultural and Religious Competence.

Provider must respect the culture of the children and families with which it provides services. 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. 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. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth. The guidebook can be found at: http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf

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. 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

Services must be provided in accordance with the Principles of Child Welfare Services. Please note: All services (even individual services) are provided through the lens of child safety. 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. 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. 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.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
COMPREHENSIVE HOME BASED SERVICES

I. Services Description

Provision of comprehensive and intensive home based services for families involved with DCS/Juvenile Probation to address the short and long term behavioral health care needs. This service shall be for the entire family. The service shall include assessment of child/parent/family resulting in an appropriate service/treatment plan that is based on the assessed need and congruent with the DCS case plan. These in-home services must be evidence based models or promising practices, family centered, and culturally competent. Fidelity to the chosen evidence based model should be documented.

Examples of therapeutic interventions that are evidence-based models such as:

- Trauma-Focused Cognitive Behavioral Therapy,
- Alternative for Families Cognitive Behavioral Therapy,
- Cognitive Behavioral Therapy,
- Motivational Interviewing,
- Child Parent Psychotherapy,
- Parent Child Interactive Therapy,
- ABA, or
- Other DCS approved treatment models

Additional evidence-based programs are outlined at:

·The California Evidence- Based Clearinghouse at www.cebc4cw.org or

·The National Registry for Evidence Based Programs-SAMHSA (Substance Abuse and Mental Health Services Administration) at www.nrepp.samhsa.gov or

·The Office of Juvenile Justice and Delinquency Prevention at http://ojjdp.ncjrs.gov

The service shall be all inclusive (as defined below) and must aim at improving long term outcomes for children and their families by providing services that are effective in reducing maltreatment, improving caretaking and coping skills, enhancing family resilience, supporting healthy and nurturing relationships, and children's physical, mental, emotional and educational well-being. Additionally, the Home-Based Service must monitor and address any safety concerns for the child(ren). The intervention must be strength-based and family driven with the family participating in identifying the focus of services.

Additionally, the provider must provide intensive safety planning and crisis response services 24 hours a day/7 days per week/365 days a year.

II. Inclusive Service Model

The service shall be all inclusive to meet the needs of the family. There should not be a need for DCS to contract/refer the child(ren) or family for additional services as the service provided shall be all inclusive to meet the needs of the family. The service includes but is not limited to assessment of service need, home based casework services, homemaker services, visitation supervision, parent engagement services, parent education, and transportation assistance. Home based therapeutic services may be included, but it is not required. Examples of services that may be outside of the services provided under this Service Standard include: Translation Services, Diagnostic and Evaluation Services, Residential Substance Use Treatment services, Detoxification Services and other medical services, Substance Use Outpatient Treatment. Given the dynamic range of evidence-based models and promising/research-informed practices that may fall under this service standard, there may be some variation in what is considered outside the "all inclusive" services. To avoid confusion regarding services payable in addition to the Comprehensive Home Based Services per diem, provider must actively communicate with the assigned DCS family case manager to determine which services are appropriate for the family and are consistent with model or practice in place.

If the requested/required supervised visitation needs exceed what is thought to be reasonable as part of the comprehensive service, the provider must complete the Comprehensive Visitation Appeal form to request additional supervised visitation billable units.

III Quality Service Reviews

In order to ensure providers are offering services in accordance with the DCS practice model, providers should be trained in the Quality Service Review process and participate in the regional Quality Service Reviews. This information will be valuable to your agency in understanding the Practice Model and quality standards in which the system is measured. Understanding quality expectations will assist your agency in planning and implementing services.

The Comprehensive Home-based Service Standard requires only that one person from each agency participate in the QSR as a shadow for each region they serve. If your agency is interested in completing the entire training process that is permitted, but is not required.

The agency will need to select one individual from within the agency to participate in the QSR. That person will need to attend a 2 day training on the QSR Protocol and process. Following training, providers will be required to attend QSR in the regions in which they provide services through the comprehensive contract. Providers will participate in the QSR as a shadow reviewer. Each QSR is scheduled for two consecutive days, beginning at 8am and ending no later than 8pm. An agency will need to select a minimum of one representative to participate in the QSR in each region they provide comprehensive services in. This could be the same person for all regions or a different person for each region. Each person participating in the QSR must first complete the two day training.

Providers will not be penalized if the available reviewer positions are full. The provider should simply wait for the next QSR round for the Region. The agency needs to shadow in each region that they provide services. The Service Standard requires only that the individual shadow in each region that service is provided. The cost of participation in the QSR is included in the comprehensive service rate. Therefore, individuals who participate in the QSR should inquire about reimbursement for travel and lodging from their provider agency.

IV. . Target Population

All clients served must be restricted to the following eligibility categories:

● Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.

●Children and their families which have an Informal Adjustment (IA) or the children have the status of CHINS or JD/JS.

●Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.

Note: The specific service model chosen to be used under this Service Standard may require a more focused population. However, all clients served under this Service Standard must fit within the above eligibility categories.

V. Goals and Outcomes

Goal #1 Maintain timely intervention with the family and regular timely communication with referring worker.

Objectives:

1) Staff is available for consultation to the family 24-7 by phone or in person.

Fidelity Measures:

1) 95% of all families that are referred will have face-to-face contact with the client within 48 hours of receipt of the referral or inform the current Family Case Manager/Probation Officer if the client does not respond to requests to meet.

2) 95% of families will have a written treatment plan prepared and sent to the current Family Case Manager/Probation Officer following receipt of the referral within 30 days of contact with the client.

3) 95% of all families will have monthly written summary reports prepared and sent to the current Family Case Manager/Probation Officer by the 10th of the month following the services.

Goal #2 Clients will achieve improved family functioning.

Objectives:

1) Goal setting, and service planning are mutually established with the client and Direct Worker within 30 days of the initial face-to-face intake and a written report signed by the Direct Worker and the client is submitted to the current FCM/Probation Officer.
Client Outcome Measures:
1) __% 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.
2) __% 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. (To be measured/evaluated by DCS/Probation staff)
3) __% of the individuals/families that were intact prior to the initiation of service will remain intact throughout the service provision period.
4) __% of the children/youth involved with an open JD/JS case will have no occurrences of reoffending throughout the service provision period.
5) __% of those individuals/families with a successful case closure will not have a further incident of abuse or neglect at 12 months post discharge.
6) __% of those children/youth with a successful case closure will not have any occurrences of reoffending at 12 months post discharge.

Goal #3 DCS/Probation and clients will report satisfaction with services.
Outcome Measures:
1) DCS/ Probation satisfaction will be rated 4 and above on the Service Satisfaction Report.
2) 90% of clients will rate the services "satisfactory" or above on a satisfaction survey developed by the service provider, unless one is distributed by DCS/Probation to providers for their use with clients.

VI. Minimum Qualifications
The program shall be staffed by appropriately credentialed personnel who are trained and competent to complete the service as required by state law. At a minimum, the following would apply.
Case Manager:
Bachelor's Degree in social work, psychology, sociology, or a directly related field. Other Bachelor's degrees will be accepted in combination with a minimum of five years experience working directly with families in the child welfare system.
Must possess a valid driver's license and the ability to use private car to transport self and others, and must comply with the state policy concerning minimum car insurance coverage.
In addition to the above:
- Knowledge of child abuse and neglect, and child and adult development
- Knowledge of community resources and ability to work as a team member

· Belief in helping clients change their circumstances, not just adapt to them
· Belief in adoption as a viable means to build families
· Understanding regarding issues that are specific and unique to adoptions such as loss, mismatched expectations and flexibility, loss of familiar surroundings, customs and traditions of the child's culture, entitlement, gratification delaying, flexible parental roles and humor

Therapist:
Therapist under this standard must meet one of the following minimum qualifications:

1) Master's or Doctorate degree with a current license issued by the Indiana Behavioral Health and Human Services Licensing Board as one of the following: 1) Social Worker, 2) Clinical Social Worker, 3) Marriage and Family Therapist, 4) Mental Health Counselor 5) Marriage and Family Therapist Associate and 6) Mental Health Counselor Associate.
2) Master's degree with a temporary permit issued by the Indiana Behavioral Health and Human Services Licensing Board as one of the following: 1) Social Worker, 2) Clinical Social Worker, within 90 days of providing services under this contract (Please note: In order to obtain a temporary license, the individual must register for the exam) and,
   a. 2 years related clinical experience, or
   b. completion of the DCS approved training program

Note: In order to obtain a temporary license, the individual must first register for the licensure exam and may have additional requirements for temporary licensure. Please contact the Indiana Professional Licensing Board for additional instructions for obtaining a temporary license.

3) Master's degree and a submitted application for 1) Marriage and Family Therapist Associate, or 2) Mental Health Counselor Associate within 90 days of providing services under this contract. The individual must obtain licensure as a Marriage and Family Therapist Associate or Mental Health Counselor Associate within 12 months of providing services under this contract. The individual must also have:
   a. 2 years related clinical experience, or
   b. completion of the DCS approved training program
4) Master's degree in a related human service field plus 2 years related clinical experience and working under a DCS Community Based Contract on July 1, 2015.

Note: Individuals who hold a Master's degree that is applicable toward licensure, must become licensed as indicated in #2 & 3 above. Providers should not employ any new staff who are not license eligible.

Must possess a valid driver's license and the ability to use a private car to transport self and others, and must comply with the state policy concerning minimum car insurance coverage.

In addition to the above:

- Knowledge of family of origin/intergenerational issues
- Knowledge of child abuse/neglect
- Knowledge of child and adult development
- Knowledge of community resources
- Ability to work as a team member
- Belief in helping clients change, to increase the level of functioning, and knowledge of strength-based initiatives to bring about change
- Belief in the family preservation philosophy
- Knowledge of motivational interviewing
- Skillful in the use of Cognitive Behavioral Therapy
- Skillful in the use of evidence-based strategies

Support Staff:
Support staff may be used to supplement the professional staff when approved as part of the model or a supplement to the model. These staff must be trained in the basic principles of the chosen model and their practice must be coordinated and directed by the direct professional staff.

Supervisor Tier 1, 2, 4
Master's or Doctorate degree in social work, psychology, marriage and family, or related human service field, with a current license issued by the Indiana Behavioral Health and Human Services Licensing Board as one of the following: 1) Clinical Social Worker, 2) Marriage and Family Direct Worker, 3) Mental Health Counselor.
Services provided will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral-valued culturally-competent manner.
Providers are to respond to the on-going individual needs of staff by providing them with the appropriate combination of training and supervision. The frequency and intensity of training and supervision are to be consistent with "best practices" and comply with the requirements of each provider's accreditation body. Supervision should include individual, group, and direct observation modalities and can utilize teleconference technologies. Under no circumstances is supervision/consultation to be less than one (1) hour of supervision/consultation per 25 hours of face-to-face direct client services provided, nor occur less than every two (2) weeks.
Supervisor Tier 3 and 5

Master's or Doctorate degree in social work, psychology, or directly-related human services field from an accredited college.
Services provided will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral-valued culturally-competent manner.
Providers are to respond to the on-going individual needs of staff by providing them with the appropriate combination of training and supervision. The frequency and intensity of training and supervision are to be consistent with "best practices" and comply with the requirements of each provider's accreditation body. Supervision should include individual, group, and direct observation modalities and can utilize teleconference technologies. Under no circumstances is supervision/consultation to be less than one (1) hour of supervision/consultation per 25 hours of face-to-face direct client services provided, nor occur less than every two (2) weeks.
Note: When treatment/service models chosen and/or Indiana licensure/certification bodies require a higher level of staffing qualifications than above, those qualification requirements shall be followed. It is the responsibly of the provider to maintain staff with the skills necessary to effect change in the families that will be referred. This responsibility includes the supervision and training of the staff. Providers are to respond to the on-going individual needs of staff by providing them with the appropriate combination of training and supervision. The frequency and intensity of training and supervision are to be consistent with "best practices" and comply with the requirements of each provider's accreditation body and the Evidence Based Practice Model or Promising Practice Model that is being provided. Supervision may include individual, group, and direct observation modalities and can utilize teleconference technologies.
Staff must possess a valid driver's license and must comply with the state policy concerning minimum car insurance coverage.

VII. Reporting

Providers will be required to prepare, maintain, and provide any statistical reports, program reports, other reports, or other information as requested by DCS relating to the services provided. These monthly reports are due by the 10th of the month following service.

DCS will require an electronic reporting system which will include documenting time and services provided to families. This information must be entered into KidTraks within 48 hours of providing the service to the family. DCS may also adopt a standardized tool for evaluating family functioning. Services will include administration of this tool at the initiation of services as well as periodically during service provision.

VIII. Billable Unit

Per Diem rate: The per diem will start the day of the first face to face contact after recommendation for acceptance into this program is approved by DCS. The per diem rate will be all inclusive of the services outlined in Section III above.

	Tier 1	**Tier 2**	**Tier 3**	**Tier 4**	**Tier 5**
Weekly Hours:	8 Hours Time	8 Hours Time	8 Hours Time	5 Hours Time	5 Hours Time
Primary Worker:	Therapist	Bachelors	Bachelors	Bachelors	Bachelors
Minimum Face to face Therapy Hours per week	3 over a minimum of 2 face to face contacts	1	0	1	0
Minimum Face to Face Case Management hours per week	0	2 over a minimum of 2 face to face contacts	3 over a minimum of 2 face to face contacts	1	2 over a minimum of 2 face to face contacts
Case Load for primary staff:	5	5	5	8	8
Team structure	· Therapist-primary · Support staff	· Case Manager – primary · Therapist · Support staff - optional	· Case Manager-primary · Support Staff-optional	· Case Manager-primary · Therapist	· Case Manager-primary · Support Staff
Direct vs. Indirect hours	180 hours/ 6 months	180 hours/ 6 months	180 hours/ 6 months	120 hours / 6 month	120 hours / 6 month

Note: all tiers are required to meet the 80%Direct vs 20% Indirect hours of service requirement over the intervention.	80% Direct= 144 hours 20% indirect= 36 hours *Calculation allows for a maximum of 1 hour of direct support per week, remaining time is a calculated total of the primary workers time across the intervention.	80% Direct=144 20% indirect =36 *Calculation allows for a maximum of 1 hour of direct support per week remaining time is a calculated total of the primary workers time across the intervention.	80% Direct =144 20% Indirect=36 *Calculation allows for a maximum of 2 hours of direct support per week, remaining time is a calculated total of the primary workers time across the intervention .	80% Direct = 96 20% Indirect=24	80% Direct = 96 20% Indirect=24 * Calculation allows for a maximum of 1 hour of direct support per week, remaining time is a calculated total of the primary workers time across the intervention

<u>Direct service (minimum 80%) includes</u>:

●Family specific face to face contact with the identified family during which services are defined in the applicable service standard are performed. Members of the client family are to be defined in consultation with the family and approved by the DCS office. This may include persons not legally defined as part of the family.

●Includes in-vehicle (or in transport) time with client provided it is identified as goal directed, face-to-face, and approved/specified as part of the family's intervention plan

●Includes crisis intervention and other goal-directed interventions via telephone with the identified family

●Includes time spent completing any DCS approved standardized tool with the family to assess family functioning

●Supervised visitation is included in the minimum direct service hours if it includes a therapeutic component and/or modeling and coaching the parent to improve parenting skills

Indirect service (maximum 20%) includes:

●Routine report writing

●Travel time

●Court attendance when requested

●Comprehensive case management including stakeholder/referral/collateral contact. Contact with referring/community stakeholders or collateral for the purpose of case coordination, updating, planning, case staffing, child and family team meetings, court, or other information shared for the advancement and benefit of the family to complete the identified service plan goals

●Clinical service/treatment planning/case assessment. Examples of allowable components include development of clinical service components necessary for provision of services, service treatment plan development, clinical case assessment and planning, necessary case coordination documentation as required by DCS, other specific assessment tools as defined by DCS, review of video session if required by the EBP model, discharge planning/documentation

●Supervision – time allotted for supervision is dedicated to case staffing/assessment/planning specific to the client/family

Interpretation, Translation and Sign Language Services

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

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

The location of and cost of Interpretation, Translation, and Sign Language Services are the responsibility of the Service Provider. 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. 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. Providers can use DCS contracted agencies and request that

they be given the DCS contracted rate but this is not required. 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. 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.

Supervised Visitation

If the requested/required supervised visitation needs of the referred family, exceed what is reasonable as part of the comprehensive service, the provider can reuest additional fee for service Supervised Visitation hours to be added. Providers must complete the Comprehensive Visitation Appeal form to request additional supervised visitation billable hours and submit to the local Regions Services Coordinator or Probation Service Consultant for processing. Referrals for additional supervised visitation will be referred for a maximum of 30 days. All addition supervised visitation must be approved by Central Office, not all requests will be approved. DCS has determined that the services that are provided under this service standard are not appropriate to be billed to Medicaid.

IX. Case Record Documentation

Comprehensive providers will be required to enter service logs and into the KidTraks system, including uploading of fidelity documents. Entries should be made within 48 hours of service completion.

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.

X. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. DCS will have the option to put the referral on hold or terminate the family's referral at an earlier date due to changes in family status or loss of engagement.

If a child is the only child participating in services and there are no other siblings, and that child is in residential placement, the child must be transitioning to a less restrictive placement within the next 30 days for the referral to be made.

Provider to contact Family Case Manager after missed appointments. After three unsuccessful face to face contacts, the provider must notify the Family Case Manager and billing must be suspended until successful face to face contact is made. Family Case Manager should be contacted to evaluate the need for early termination of the referral.

Providers must initiate a re-authorization for services to continue beyond the approved period. All comprehensive referrals are created for 1 year and include 185 units. Once the 185 units have run out, requests for continued services must be processed in central office and require approval. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

● Referral must be accepted within the KidTraks vendor portal within 72 hours
● Provider has 24 hours to contact the referral source if unable to accept the referral based upon lack of capacity
●Providers will see the family within 48 hours of referral,

XI Adherence to the DCS Practice Model

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

XII. Core Competency - Trauma Informed Care

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/):
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. 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?" 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. 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.

Trauma Specific Interventions: (modified from the SAMHSA definition)

●The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.

●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)
●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. Cultural and Religious Competence.

Provider must respect the culture of the children and families with which it provides services. 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. 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. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth. The guidebook can be found at:
http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf

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. 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

Services must be provided in accordance with the Principles of Child Welfare Services. Please note: All services (even individual services) are provided through the lens of child safety. 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. 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. 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.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
FAMILY CENTERED TREATMENT

I. Services Description

Family Centered Treatment® (FCT) was developed as a model of treatment designed for use in the provision of intensive in home services. FCT is owned by the Family Centered Treatment Foundation Inc. (FCTF); a nonprofit corporation devoted to furthering the effectiveness of family preservation services. FCT origins derive from practitioners' efforts to find simple, practical, and common sense solutions for families faced with forced removal of their children from the home due to their delinquent behavior or dissolution of the family due to both external and internal stressors and circumstances. This service shall be for the entire family, culturally competent, and shall include assessment of child/parent/family resulting in an appropriate service/treatment plan that is based on the assessed need and congruent with the DCS case plan.

FCTF is the owner of the evidenced-based family preservation treatment model FCT, and the related training program, Wheels of Change©. FCTF licenses provider agencies that meet the stringent criteria necessary to provide Family Centered Treatment. A readiness assessment is implemented by FCTF to determine if the applicant agency meets the criteria. When agencies procure licensure as a provider of FCT, FCTF provides the Wheels of Change online and field based competency training program, supervisor certification and training process, fidelity oversight of the implementation of FCT, and ongoing fidelity & program evaluation related to FCT. Upon written agreement by an organization and FCTF to provide FCT, the provisional status of the organization or sites will commence. For additional information regarding FCT, Wheels of Change, and the process to become a provider, follow the link: http://familycenteredtreatment.com/

The service must aim at improving long term outcomes for children and their families by providing services that are effective in reducing maltreatment, improving caretaking and coping

skills, enhancing family resilience, supporting healthy and nurturing relationships, and children's physical, mental, emotional and educational well-being through family value changes. Additionally, the FCT Service provider must monitor and address any safety concerns for the child(ren). FCT service providers must adhere to State and Federal laws requiring the reporting of suspected abuse and neglect. The intervention must be strength-based with the family participating in identifying the focus of services.

Additionally, the provider must provide intensive safety planning and crisis response services 24 hours a day/7 days per week.

The provider must advise the referral source within 24 hours of receipt of the referral as to whether or not the provider has the capacity to serve the family. There will be at a minimum of two face to face contacts per week with the family by the provider clinician commencing within 48 hours of the referral.

There will be 185 hours of service during the six months of service provision consisting of 80 percent direct face-to-face service between clinician and the family and 20 percent indirect service.

Direct service (minimum 80%) includes:
●Family specific face to face contacts with the identified family during which services are defined in the applicable service standard are performed. Members of the client family are to be defined in consultation with the family and approved by the DCS office. This may include persons not legally defined as part of the family.
●Includes in-vehicle (or in transport)time with client provided it is identified as goal directed, face-to-face, and approved/specified as part of the family's intervention plan
●Includes crisis intervention and other goal-directed interventions via telephone with the identified family
●Includes time spent completing any DCS approved standardized tool to with the client/s to assess family functioning
●Supervised visitation is included in the minimum direct service hours if it includes a therapeutic component and/or modeling and coaching the parent to improve parenting skills

Indirect service (maximum 20%) includes:
●Routine report writing
●Travel time
●Court attendance when requested
●Comprehensive case management including stakeholder/referral/collateral contact. Contact with referring/community stakeholders or collaterals for the purpose of case coordination, updating, planning, case staffing, child and family team meetings, court, or other information

shared for the advancement and benefit of the family to complete the identified service plan goals
●Clinical service/treatment planning/case assessment. Examples of allowable components include development of clinical service components necessary for provision of services, service treatment plan development, clinical case assessment and planning, necessary case coordination documentation as required by DCS, other specific assessment tools as defined by DCS, review of video session if required by the EBP model, discharge planning/documentation
●Supervision – time allotted for supervision is dedicated to case staffing/assessment/planning specific to the client/family

II. Trauma Specific Interventions: (modified from the SAMHSA definition) Trauma Informed Care

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/):
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. 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?" 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. 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

Trauma Specific Interventions: (modified from the SAMHSA definition)

●The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
●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)
●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.

III. Inclusive Service Model

The service shall be all inclusive to meet the needs of the family. There should not be a need for DCS to contract/refer the child(ren) or family for additional services as the service provided shall be all inclusive to meet the needs of the family. The service includes but is not limited to assessment of service need, home based therapeutic services, home based casework services, homemaker services, visitation supervision, parent engagement services, parent education, transportation assistance.

Examples of services that may be outside of the services provided under this Service Standard include: Diagnostic and Evaluation Services (Clinical Interview and Assessment, Psychological Testing, Neuropsychological Testing, Psychiatric Services), Residential Substance Use Treatment services, Detoxification Services and other medical services, Substance Use Disorder Outpatient Treatment.

To avoid confusion regarding services payable in addition to the Family Centered Services per diem, Provider must actively communicate with the assigned DCS family case manager to determine which services are appropriate for the family and are consistent with model or practice in place. Provider must then confirm cancellation of extraneous services and confirm documentation of any DCS supervisor-approved additional services to be paid outside the per diem.

IV. . Quality Service Reviews

In order to ensure providers are offering services in accordance with the DCS practice model, providers should be trained in the Quality Service Review process and participate in the regional Quality Service Reviews. This information will be valuable to your agency in understanding the Practice Model and quality standards in which the system is measured. Understanding quality expectations will assist your agency in planning and implementing services.
The Comprehensive Home-based Service Standard requires only that one person from each agency participate in the QSR as a shadow for each region they serve. If your agency is interested in completing the entire training process that is permitted, but is not required.
The agency will need to select one individual from within the agency to participate in the QSR. That person will need to attend a 2 day training on the QSR Protocol and process. Following training, providers will be required to attend QSR in the regions in which they provide services through the comprehensive contract. Providers will participate in the QSR as a shadow reviewer. Each QSR is scheduled for two consecutive days, beginning at 8am and ending no later than 8pm. An agency will need to select a minimum of one representative to participate in the QSR in each region they provide comprehensive services in. This could be the same person for all regions or a different person for each region. Each person participating in the QSR must first complete the two day training.

Providers will not be penalized if the available reviewer positions are full. The provider should simply wait for the next QSR round for the Region. The agency needs to shadow in each region that they provide services
After shadowing the QSR process, individuals would be able to complete the process of becoming a Qualified Mentor. This process would include the 2 day training, the shadow, 2 lead experiences, a 2 hour webinar on how to be a mentor and then the individual would mentor a mentor. At that point the person would be qualified. However, this is not necessary. The Service Standard requires only that the individual shadow in each region that service is provided.
The cost of participation in the QSR is included in the comprehensive service rate.

V. Target Population

All clients served must be restricted to the following eligibility categories:
1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with CHINS status.
2) Children which have status of CHINS or JD/JS.
3) Children with the status of CHINS or JD/JS and their Foster/Kinship families (as defined by the family) with whom they are placed.

VI. Goals and Outcomes

Goal #1 Maintain timely intervention with the family, regular timely communication with referring worker (a minimum of bi-weekly).

Objectives:
1) Staff is available for consultation to the family 24-7 by phone or in person.
Fidelity Measures:
1) 95% of all families that are referred will have face-to-face contact with the client within 48 hours of receipt of the referral or inform the current Family Case Manager/Probation Officer if the client does not respond to requests to meet.
2) 95% of families will have a written treatment plan prepared and sent to the current Family Case Manager/Probation Officer following receipt of the referral within 30 days of contact with the client.
3) 95% of all families will have monthly written summary reports prepared and sent to the current Family Case Manager/Probation Officer by the 10th of the month following the services.

Goal #2 Clients will achieve improved family functioning and demonstrate value changes.

Objectives:

1) Goal setting, and service planning are mutually established with the client and Direct Worker within 30 days of the initial face-to-face intake and a written report signed by the Direct Worker and the client is submitted to the current FCM/Probation Officer.

Client Outcome Measures:1) 65% of the families that have a child in residential care prior to the initiation of service will be reunited within four to six weeks of the service referral.
2) 95% 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. (To be measured/evaluated by DCS/Probation staff)
3) 70% of the individuals/families that were intact prior to the initiation of service will remain intact throughout the service provision period.
4) 65% of the children/youth involved with an open JD/JS case will have no occurrences of reoffending throughout the service provision period.
5) 60% of those individuals/families with a successful case closure will not have a further incident of abuse or neglect at 12 months post discharge.
6) 60% of those children/youth with a successful case closure will not have any occurrences of reoffending at 12 months post discharge.

Goal #3 DCS/Probation and clients will report satisfaction with services.

Outcome Measures:
1) DCS/ Probation satisfaction will be rated 4 and above on the Service Satisfaction Report conducted via survey monkey.
2) 90% of clients will rate the services "satisfactory" or above on a satisfaction survey developed and offered to all clients by the service provider, unless one is distributed by DCS/Probation to providers for their use with clients.

VII. Minimum Qualifications
The program shall be staffed by appropriately credentialed personnel who are trained and competent to complete the service as required by state law and the FCT model. At a minimum, the following apply:

FCT Therapist:

1) Master's or Doctorate degree with a current license issued by the Indiana Behavioral Health and Human Services Licensing Board as one of the following: 1) Social Worker, 2) Clinical Social Worker, 3) Marriage and Family Therapist, 4) Mental Health Counselor 5) Marriage and Family Therapist Associate and 6) Mental Health Counselor Associate.

2) Master's degree with a temporary permit issued by the Indiana Behavioral Health and Human Services Licensing Board as one of the following: 1) Social Worker, 2) Clinical

Social Worker, within 90 days of providing services under this contract (Please note: In order to obtain a temporary license, the individual must register for the exam) and,

a. 2 years related clinical experience, or

b. completion of the DCS approved training program

Note: In order to obtain a temporary license, the individual must first register for the licensure exam and may have additional requirements for temporary licensure. Please contact the Indiana Professional Licensing Board for additional instructions for obtaining a temporary license.

3) Master's degree and a submitted application for 1) Marriage and Family Therapist Associate, or 2) Mental Health Counselor Associate within 90 days of providing services under this contract. The individual must obtain licensure as a Marriage and Family Therapist Associate or Mental Health Counselor Associate within 12 months of providing services under this contract. The individual must also have:

   a. 2 years related clinical experience, or

   b. completion of the DCS approved training program

4) Master's degree in a related human service field plus 2 years related clinical experience and working under a DCS Community Based Contract on July 1, 2015.

Note: Individuals who hold a Master's degree that is applicable toward licensure, must become licensed as indicated in #2 & 3 above. Providers should not employ any new staff who are not license eligible.

Must possess a valid driver's license and the ability to use a private car to transport self and others, and must comply with the state policy concerning minimum car insurance coverage.

In addition to the above:

- Knowledge of family of origin/intergenerational issues
- Knowledge of child abuse/neglect
- Knowledge of child and adult development
- Knowledge of community resources
- Ability to work as a team member
- Belief in helping clients change, to increase the level of functioning, and knowledge of strength-based initiatives to bring about change
- Belief in the family preservation philosophy
- Knowledge of motivational interviewing
- Skillful in the use of Cognitive Behavioral Therapy
- Skillful in the use of evidence-based strategies

Supervisor:

Master's or Doctorate degree in social work, psychology, marriage and family, or related human service field, with a current license issued by the Indiana Behavioral Health and Human Services Licensing Board as one of the following: 1) Clinical Social Worker, 2) Marriage and Family Direct Worker, 3) Mental Health Counselor.

It is the responsibly of the provider to maintain staff with the skills necessary to effect change in the families that will be referred through adherence to the FCT model. This responsibility includes the supervision and training of the staff. There will be one supervisor dedicating 100% of their time supervising no more than nine clinicians (FCT or other clinicians). FCT clinicians will provide services for no more than 5 cases which will account for 100% of their time. Clinicians can carry a mix of FCT and non FCT cases. Each FCT case on the caseload would be the equivalent of 20% of a clinician's time. (Traditional low intensity cases should be considered 8%, Comprehensive Tier 1, 2, and 3 are 20%, Comprehensive Tier 4 and 5 are 12.5%.) Clinician caseloads should not exceed 100%. The intensity of the cases should always be considered when determining the case load size. Providers are to respond to the on-going individual needs of staff by providing them with the appropriate combination of training and supervision. The frequency and intensity of training and supervision are to be consistent with "best practices" and comply with the requirements of the FCT model. The provider must have the capacity to hold weekly team meetings for all team members. Supervision may include individual, group, and direct observation modalities and can utilize teleconference technologies.

Support Worker:

Bachelor's Degree in social work, psychology, sociology, or a directly related field. These staff must be trained in the basic principles of the FCT model and their practice must be coordinated and directed by the direct professional staff. There will be one Support Worker per every three clinicians.

Staff must possess a valid driver's license.

VIII. Reporting

Providers will be required to prepare, maintain, and provide any statistical reports, program reports, other reports, or other information as requested by DCS relating to the services provided. These monthly reports are due by the 10th of the month following service.DCS will require an electronic reporting system which will include documenting time and services provided to families. DCS may also adopt a standardized tool for evaluating family functioning. Services will include administration of this tool at the initiation of services as well as periodically during service provision.

IX. . Billable Unit

Per Diem rate: The per diem will start the day of the first face to face contact after the recommendation for acceptance into this program is approved by DCS. There will be a minimum of 2 multi-hour face-to-face contacts with the family per week during the first two phases of the service. The per diem rate will be all inclusive of the services outlined in Section III above.

Interpretation, Translation and Sign Language Services

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

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

The location of and cost of Interpretation, Translation, and Sign Language Services are the responsibility of the Service Provider. 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. 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. Providers can use DCS contracted agencies and request that they be given the DCS contracted rate but this is not required. 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. 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.

Supervised Visitation

If the requested/required supervised visitation needs of the referred family, exceed what is reasonable as part of the comprehensive service, the provider can reuest additional fee for service Supervised Visitation hours to be added. Providers must complete the Comprehensive Visitation Appeal form to request additional supervised visitation billable hours and submit to the local Regions Services Coordinator or Probation Service Consultant for processing. Referrals for additional supervised visitation will be referred for a maximum of 30 days. All addition supervised visitation must be approved by Central Office, not all requests will be approved. DCS has determined that the services that are provided under this service standard are not appropriate to be billed to Medicaid.

X. Case Record Documentation

FCT providers will be required to enter service logs and phase dates into the KidTraks system, including uploading of fidelity documents. Entries should be made within 48 hours of service completion.

Case record documentation for service eligibility must include:

10) A completed, and dated DCS/ Probation referral form authorizing services
11) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for these documents from referral source.
12) Safety issues and Safety Plan Documentation
13) Documentation of Termination/Transition/Discharge Plans
14) 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
15) 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
16) Progress/Case Notes Must Document: Date, Start Time, End Time, Participants, Individual providing service, and location
17) 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
18) Supervision Notes must include:

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

XI. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by DCS/Probation.
The referral must be accepted within the KidTraks vendor portal within 72 hours. Referral must be accepted within the KidTraks vendor portal within 72 hours. Provider has 24 hours to contact the referral source if unable to accept the referral based upon lack of capacity. The family must be seen face to face, within 48 hours of referral.

DCS will have the option to put the referral on hold or terminate the family's referral at an earlier date due to changes in family status or loss of engagement.

If a child is the only child participating in services and there are no other siblings, and that child is in residential placement, the child must be transitioning to a less restrictive placement within the next 30 days for the referral to be made.

Provider is to contact Family Case Manager after missed appointments. After three unsuccessful face to face contacts, the provider must notify the Family Case Manager and billing must be suspended until successful face to face contact is made. Family Case Manager should be contacted to evaluate the need for early termination of the referral.

Providers must initiate a re-authorization for services to continue beyond the approved period. All comprehensive referrals are created for 1 year and include 185 units. Once the 185 units have been billed, any necessary extensions should be requested through central office.

XII. Adherence to the DCS Practice Model

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

Trauma Informed Care

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/):
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. 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?" 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. 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

Trauma Specific Interventions: (modified from the SAMHSA definition)

- The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
- 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)
- 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. Cultural and Religious Competence.

Provider must respect the culture of the children and families with which it provides services. 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. 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. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth. The guidebook can be found at: http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf

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. 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**

Services must be provided in accordance with the Principles of Child Welfare Services. Please note: All services (even individual services) are provided through the lens of child safety. 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. 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. 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.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES

RESOURCE FAMILY SUPPORT SERVICES

I. Service Description

Home Based Services

Face-to-face home-based caseworker services to preserve, support, and stabilize foster family home placements, and to promote the well-being of children, youth, and families.

Home-based caseworker will provide any combination of the following kinds of services to the families as approved by DCS/Probation:

- Home visits
- Coordination of services
- Conflict management
- Emergency/crisis services
- Child development education
- Developmental/behavioral effects of trauma education
- Parenting education/training
- Parent training with children present
- Monitor progress of parenting skills
- Family communication
- Foster family support
- Community services information
- Community referrals and follow-up
- Develop structure/time management
- Reactive Attachment Disorder (RAD) support

Target Population
Licensed resource families supervised by DCS.

DCS intends to develop specialized services targeting relative caregivers. Until such time, licensed and unlicensed relative caregivers may be referred to this service.

II. Goals and Outcome Measures

Goal #1

Timely and on-going intervention with family

Outcome Measures

- 95% of all families that are referred will have face to face contact with the family within five (5) days of the referral
- 95% of all families will have monthly written summary reports prepared and sent to the referring worker

Goal #2

Minimize the number of disrupted foster care placements (foster, pre-adoptive)

Outcome Measures

- 95% of foster parents will participate in supportive services that are recommended and available
- 95% of foster families and foster children requiring supportive services will maintain their placements

Goal #3

DCS and foster family satisfaction with services

Outcome Measures

- DCS satisfaction will be rated 4 and above on the Service Satisfaction Report.
- 95% of families will rate the services "satisfactory" or above on a satisfaction survey developed by the service provider, unless one is distributed by DCS/Probation to providers for their use with clients. Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.

III. Minimum Qualifications

Direct Worker:

Bachelor's degree in social work, psychology, sociology, or a directly-related human service field from an accredited college. Must possess a valid driver's license and the ability to use private car to transport self and others, and must comply with the state policy concerning minimum car insurance coverage.

In addition to the above:

- Knowledge of child abuse and neglect, and child and adult development
- Knowledge of community resources and ability to work as a team member
- Belief in helping clients change their circumstances, not just adapt to them
- Belief in adoption as a viable means to build families
- Understanding regarding issues that are specific and unique to adoptions such as loss, mismatched expectations and flexibility, loss of familiar surroundings, customs and traditions of the child's culture, entitlement, gratification delaying, flexible parental roles and humor

Supervisor:

Master's or Doctorate degree in social work, psychology, or directly-related human services field from an accredited college.

Services provided will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral-valued culturally-competent manner.

Providers are to respond to the on-going individual needs of staff by providing them with the appropriate combination of training and supervision. The frequency and intensity of training and supervision are to be consistent with "best practices" and comply with the requirements of each provider's accreditation body. Supervision should include individual, group, and direct observation modalities and can utilize teleconference technologies. Under no circumstances is supervision/consultation to be less than one (1) hour of supervision/consultation per 25 hours of face-to-face direct client services provided, nor occur less than every two (2) weeks.

IV. Billable Units Face to Face Time With the Client

<u>Face-to-Face time with the client</u>

(Note: Members of the client family are to be defined in consultation with the family and approved by the DCS. This may include person not legally defined as part of the family.)

- Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed

- Includes crisis intervention and other goal directed interventions via telephone with the identified client family
- Includes Child and Family Team Meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family

Reminder: Not included is routine report writing and scheduling of appointment, collateral contacts, court time, travel time and no shows. These costs are built into the cost of the face to face rate and shall not be billed separately.

Interpretation, Translation and Sign Language Services

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

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

The location of and cost of Interpretation, Translation, and Sign Language Services are the responsibility of the Service Provider. 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. 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. Providers can use DCS contracted agencies and request that they be given the DCS contracted rate but this is not required. 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. 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.

V. Case Record Documentation

Case record documentation for service eligibility must include:

1) A completed, and dated DCS/ Probation referral form authorizing services
2) Safety issues and Safety Plan Documentation
3) 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
4) Progress/Case Notes Must Document: Date, Start Time, End Time, Participants, Individual providing service, and location
5) 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

VI. Service Access

Services must be accessed through a Referral for Child Welfare Services Form. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS. Providers must initiate a reauthorization for services to continue beyond the approved time period.

Note: All services must be pre-approved through a Referral for Child Welfare Services Form from the referring DCS. In emergency situations, services may begin with a verbal approval but must be followed by a written referral within five (5) days. It is the responsibility of the service provider to obtain the written referral.

VII. Adherence to the DCS Practice Model

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

VIII. Trauma Informed Care

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/):
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. 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?" 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. 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

Trauma Specific Interventions: (modified from the SAMHSA definition)

- The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
- 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)
- 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.

IX. Cultural and Religious Competence.

Provider must respect the culture of the children and families with which it provides services. 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. 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. Services to youth who identify as LGBTQ must also

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

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. 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.

X. **Child Safety**

Services must be provided in accordance with the Principles of Child Welfare Services. Please note: All services (even individual services) are provided through the lens of child safety. 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. 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. 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.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
SUPPORT GROUP SERVICES FOR RESOURCE FAMILIES

I. Service Description

The Support Group Coordinator will provide face-to-face support group services to local resource parents. Support group services should be provided no less than quarterly, but may be provided as frequently as monthly. Monthly phone or email contact should be made with resource parents for the purposes of coordinating services and identifying pertinent support group topics. The Coordinator will record the topic(s) of discussion and keep a sign-in sheet for each support group meeting. Child care should be provided if requested by families attending support group meetings. Anyone providing childcare must pass criminal history and CPS checks.

Support group services will be designed to assist resource families in strengthening their relationships with foster children placed in their homes, as well as to promote positive relationships between foster families and the local DCS Family Case Managers and Regional Foster Care Specialists. Support group services will also focus on enhancing placement stability, and promoting foster families' willingness and ability to foster special needs children and older youth that come into care. The Coordinator will collaborate with the Regional Foster Care Specialist(s) to invite prospective foster parents to the monthly support group meeting, in order for them to gain insight and information regarding the foster care program.

II. Target Population

1) All foster and kinship parents licensed by the referring county DCS office.

2) Court ordered substitute caregivers and adoptive parents.

III. Goals and Outcome Measures

<u>Goal #1</u>

Retention of the current number of foster parents that are licensed

Outcome Measures

1) 90% retention of currently licensed foster families that continue to reside in the county.

2) 70% of licensed foster families participate in support meetings at least one time per year.

Goal #2

Develop an environment where foster families believe they are being heard and respected for the work they do.

Outcome Measures

1) 100% of foster families can report their belief that the DCS respects the work they do.

2) 10% increase in the number of foster families willing to accept special needs children and older youth based on the support received.

Goal #3

DCS and foster family satisfaction with services

Outcome Measures

1) DCS satisfaction will be rated 4 and above on the Service Satisfaction Report.

2) 94% of the families who have participated in Foster Family Support Services will rate the services "satisfactory" or above.

IV. Minimum Qualifications

Coordinator:

Bachelor's degree in social work, psychology, sociology, or a directly related human service field or hold an active foster home license.

The Coordinator must:

• Possess clear oral and written communication skills

• Possess the ability to play the role of a mediator when necessary

• Possess the ability to confront in a positive manner and provide constructive criticism when necessary

• Demonstrate insight into human behavior

• Demonstrate emotional maturity and exercise sound judgment

• Be nonjudgmental

• Be a self starter

• Exhibit the ability to work independently

• Exhibit the ability to work as a team member

• Have strong organizational skills

• Must respect confidentiality. Failure to maintain confidentiality may result in immediate termination of the service agreement.

• Demonstrate respect for socio-cultural values, personal goals, life style choices, and complex family interactions and be delivered in a culturally competent fashion.

Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral valued culturally competent manner.

V. Billing Units

Support Group

Per support group. A minimum of 3 foster parents must be in attendance in order to bill for this service.

Interpretation, Translation and Sign Language Services

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

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

The location of and cost of Interpretation, Translation, and Sign Language Services are the responsibility of the Service Provider. 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. 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. Providers can use DCS contracted agencies and request that they be given the DCS contracted rate but this is not required. 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. 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.

VI. Case Record Documentation

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.

VII. Service Access

Service can only be accessed by licensed foster families, prospective foster families, or adoptive families as identified by DCS either verbally or in written form.

VIII. Adherence to the DCS Practice Model

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

IX. Trauma Informed Care

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/):
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. 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?" 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. 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

Trauma Specific Interventions: (modified from the SAMHSA definition)

- The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
- 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)
- 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.

X. Cultural and Religious Competence.

Provider must respect the culture of the children and families with which it provides services. 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. 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. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth. The guidebook can be found at: http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf

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. 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.

XI. Child Safety

Services must be provided in accordance with the Principles of Child Welfare Services. Please note: All services (even individual services) are provided through the lens of child safety. 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. 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. 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.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
CHINS PARENT SUPPORT SERVICES

I. Services Description

The CHINS Parent Support Worker (CPSW) will provide support services to parents who have children in foster care, this includes absent parents, and parents whose children were previously in foster care and remain a CHINS. The CPSW will assist families in strengthening the relationship with their children and promoting positive relationships between the families and the local DCS family case managers and others involved in their children's case. In the case of the absent parent the CPSW may help in the location, engaging and support of the absent parent. The CPSW may be contracted to provide services on a part time or full time basis depending on the needs of the county.

The CPSW will facilitate a monthly/bi-monthly support group for parents to allow group discussion regarding concerns related to their children and assist in maintaining and strengthening the skills of participating families. Individual family support may be provided for those families who are unable to function appropriately or understand the material in the group setting. Individual support of families can be for the caretaker or the absent parent.

Family support group meetings must provide:

1) information regarding the CHINS legal process including court procedures, parental participation requirements, court ordered services, visitation with the children, reimbursement of cost for services, and other aspects related to the legal process;
2) the expectations of the family related to participation in court ordered services and visitation with the children, attendance at court, appropriate dress for court, and other aspects related to the legal process;
3) information regarding the parent's rights and the CHINS proceedings, the length of time children may be in care prior to a permanency procedure, and termination of parental rights, family team meetings and their procedures
4) role of the Court Appointed Special Advocate or Guardian ad Litem,
5) interactive activities including pre and post tests related to the CHINS process, parental rights, parental participation, reimbursement for cost of services, permanency, termination of parental rights and other issues related to CHINS case to assist in the learning process and to ensure that learning is taking place,
6) an informal environment for parents to discuss issues that brought them to the attention of the DCS and develop suggestions that may assist in resolving these issues as a group, and;
7) educational programs using speakers recruited from the local professional community to assist and educate the families in areas such as:

- abuse and neglect,

- increasing parenting skills,
- substance abuse,
- anger management,
- advocacy with public agencies including the children's schools, and;
- issues of interest to the parents related to their needs and the needs of their children.

II. Target Population

Services must be restricted to the following eligibility categories:

- Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with CHINS status.
- Children and their families which have the status of CHINS.

III. Goals and Outcomes

Goal #1

Educate parents regarding CHINS process and help them to understand the expectations of the involved parent.

Outcome Measures

1) 90% of parents participating can increasingly verbalize their rights and expectations related to the CHINS proceedings measured through pre/post surveys.

Goal #2

Improved family functioning including the development of positive means of managing crisis. Develop an environment where families feel they are being heard.

Outcome Measures

1) 67% of the families that have a child in substitute care prior to the initiative of service will be reunited by closure of the service provision period.
2) 90% of the individuals/families will not be the subjects of "substantiated" abuse or neglect throughout the service provision period.
3) 90% of the individuals/families that were intact prior to the initiation of service will remain throughout the service provision period.
4) 90% of families participating will provide input and make recommendations at the meetings.

Goal #3

DCS/Probation clients will report satisfaction with services provided.

Outcome Measures

1) DCS/Probation satisfaction will be rated 4 and above on the Service Satisfaction Report.

2) 90% of the families who have participated in Family Support Services will rate the services "satisfactory" or above on a satisfaction survey developed by the service provider, unless DCS/Probation distributes one to providers for their use with clients. Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.

IV. Minimum Qualifications

Direct Worker:
Bachelor's Degree in social work, psychology, sociology, or a directly related human service field.

Supervisor:
Master's degree in social work, psychology, or directly related human services field or a Bachelors degree in social work, psychology, or a directly related service field with 5 years child welfare experience.

The CPSW must:

- Possess clear oral and written communication skills
- Possess the ability to play the role of a mediator when necessary
- Possess the ability to address concerns/issues others in a positive manner and provide constructive feedback when necessary
- Demonstrate insight into human behavior
- Demonstrate emotional maturity and exercise sound judgment
- Be non-judgmental
- Be a self starter
- Have strong organizational skills
- Must respect confidentiality. (Failure to maintain confidentiality may result in immediate termination of the service agreement.)

Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral valued culturally competent manner.

V. Billable Unit

Face to face time with the client:
(Note: Members of the client family are to be defined in consultation with the family and approved by the DCS. This may include persons not legally defined as part of the family)

- Includes client specific face-to-face contact with the identified client/family

during which services as defined in the applicable Service Standard are performed.

- Includes crisis intervention and other goal directed interventions via telephone with the identified client family.
- Includes Child and Family Team Meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family.

Group
Services include group goal directed work with clients. To be billed per group hour.

Reminder: Not included are routine report writing and scheduling of appointments, collateral contacts, travel time and no shows. These activities are built into the cost of the face- to-face rate and shall not be billed separately.
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

Interpretation, Translation and Sign Language Services
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. 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. 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). Sign Language should be done in the language familiar to the family.
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. 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. No side comments or conversations between the Interpreters and the clients should occur.
The location of and cost of Interpretation, Translation, and Sign Language Services are the responsibility of the Service Provider. 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. 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. Providers can use DCS contracted agencies and request that they be given the DCS contracted rate but this is not required. 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. 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.

Court

The provider of this service may be requested to testify in court. 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. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. 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.

VI. Case Record Documentation

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.

VII. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period.

VIII. Adherence to the DCS Practice Model

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. 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.

IX. Trauma Informed Care

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/):
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. 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?" 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. 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

Trauma Specific Interventions: (modified from the SAMHSA definition)

- The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
- 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)
- 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.

X. Cultural and Religious Competence.

Provider must respect the culture of the children and families with which it provides services. 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. 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. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth. The guidebook can be found at: http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf

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. 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.

XI. Child Safety

Services must be provided in accordance with the Principles of Child Welfare Services. Please note: All services (even individual services) are provided through the lens of child safety. 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. 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. 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.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
COUNSELING

I. Service Description

This service standard applies to services provided to families and children involved with the Department of Child Services and/or Probation. These services include the provision of structured, goal-oriented therapy for families affected by physical abuse, sexual abuse, emotional abuse, or neglect. Other issues, including substance abuse, dysfunctional families of origin, etc., may be addressed in the course of treating the abuse or neglect. In addition, counseling may be provided to address family or youth issues that resulted in the involvement of juvenile probation.

Professional staff provides individual, group, and/or family counseling with emphasis on one or more of the following areas:

- Initial Assessment
- Conflict resolution
- Behaviors modification
- Identify systems of support
- Interpersonal relationships
- Communication skills
- Substance abuse awareness/family dynamics *
- Parenting skills
- Anger management
- Supervised therapeutic visits**
- Problem solving
- Stress management
- Goal-setting
- Domestic violence issues
- School problems
- Family of origin/inter-generational issues
- Sexual abuse – victims and caretakers of sexual abusers

*Substance abuse Counseling/Treatment must be done under the Service Standard "Substance Abuse Treatment" due to the specific legal qualifications of the provider, not under this counseling service standard.

**Supervised Visits will be billed separately from other services within this standard. The "Visitation Monthly Progress Report" form must be used to report the supervised visitation portion of the services provided. The "Monthly Progress Report" will be used for the remainder.

II. Service Delivery

1) Services are provided at a specified (regularly scheduled) time for a limited period of time.
2) Service Settings:
   a. For services billable to DCS, services are provided face-to-face in the counselor's office or other setting.

b. For services billable to Medicaid Clinic Option, the service setting is either outpatient or office setting.
c. For services billable to Medicaid Rehabilitation Option, the service must be provided at the client's home or other at other locations outside the clinic setting.

3) Services will be based on objectives derived from the family's established DCS/Probation case plan, Informal Adjustment, taking into consideration the recommendations of the Child and Family Team (CFT) and authorized by DCS/Probation referral, and subsequent written documents.
4) The counselor will be involved in Child and Family Team Meetings (CFTM) if invited.
5) Counselor must respect confidentiality. Failure to maintain confidentiality may result in immediate termination of the service agreement.
6) Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral-valued, culturally competent manner.
7) Services include providing any requested testimony and/or court appearances, including hearings and/or appeals.
8) Services must be provided at a time convenient for the family.
9) Services will be time-limited.
10) Written reports will be submitted monthly to provide updates on progress and recommendation for continuation or discontinuation of treatment. The DCS approved "Monthly Progress Report" form will be used.

III. Medicaid

For those families and children not eligible for Medicaid Rehabilitation Option, this service will be paid by DCS. For eligible families and children, some services may be provided through Medicaid Rehabilitation Option (MRO) or Medicaid Clinic Option (MCO) with the remaining services paid by DCS. 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 health care needs of the MRO eligible client, and therefore may be billable to MRO. Other services for Medicaid clients may be covered under MCO. The service standard is not a Medicaid standard and includes services that are not billable to Medicaid. It is the responsibility of the contracted service provider to be knowledgeable about the Medicaid billing requirements and comply with them, including provider qualifications and any pre-authorization requirements and further, to appropriately bill those services in particular cases where they may be reimbursed by Medicaid. The Services not eligible for MRO or MCO may be billed to DCS.

IV. When DCS is not paying for services:

A billable unit of "Reports" has been developed for providers who service DCS families without DCS payment for these services (Medicaid, insurances, self-pay) but DCS wants a report from

the provider on the progress of the family. The referral process has been set up to authorize reports and court components on the DCS referral form in these incidences. **DCS will only pay for reports when DCS is not paying for these services.** If the services provided are not funded by DCS, the report rate per hour will be paid for the necessary reports on a referral form issued by DCS. Court testimony will be paid per appearance if requested on a referral form issued by DCS. In order to be paid for a court appearance a subpoena or written request from DCS should be on file.

V. Target Population

Services must be restricted to the following eligibility categories:

1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with Informal Adjustment (IA) or CHINS status.
2) Children and their families which have an IA or the children have the with a status of CHINS, and/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.
   Services billable to MRO are for Medicaid eligible clients with a qualifying diagnosis and level of need. Services billable to MCO are for Medicaid eligible clients.

VI. Goals and Outcome Measures

Goal #1
Maintain timely intervention with family and regular and timely communication with current Family Case Manager or Probation Officer.

Objectives
1) Therapist or backup is available for consultation to the family 24-7 by phone or in person.

Fidelity Measures:
1) 95% of all families that are referred will have face-to-face contact with the client within 5 days of receipt of the referral or inform the current Family Case Manager or Probation Officer if the client does not respond to requests to meet.
2) 95% of families will have a written treatment plan prepared and sent to the current Family Case Manager/Probation Officer within 30 days of the receipt of the referral.
3) 100% of all families will have monthly written summary reports prepared and sent to the current Family Case Manager/Probation Officer. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.

Goal #2
Improved family functioning including development of positive means of managing crisis.

Objectives
1) 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.

Client Outcome Measures:
1) 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.
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. (To be measured/evaluated by DCS/Probation staff)
3) 90% of the individuals/families that were intact prior to the initiation of service will remain intact throughout the service provision period.

Goal #3
DCS/Probation and clients will report satisfaction with services provided.

Outcome Measures:
1) DCS/Probation satisfaction will be rated 4 and above on the Service Satisfaction Report.

2) 90% of the clients will rate the services "satisfactory" or above on a satisfaction survey developed by the service provider, unless DCS/Probation distributes one to providers for their use with clients. Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.

VII. Minimum Qualifications

Counselor/Direct Worker:

MCO billable:
- Medical doctor, doctor of osteopath; licensed psychologist
- Physician or HSPP-directed services provided by the following: licensed clinical social worker, licensed marital and family therapist; licensed mental health counselor; a person holding a master's degree in social work, marital and family therapy or mental health counseling; an advanced practice nurse.

MRO billable:
Providers must meet the either of the following qualifications:
- Licensed professional, except for a licensed clinical addiction counselor

- Qualified Behavioral Health Professional (QBHP).

DCS billable:
Counselor
Counselors under this standard must meet one of the following minimum qualifications:

1) Master's or Doctorate degree with a current license issued by the Indiana Behavioral Health and Human Services Licensing Board as one of the following: 1) Social Worker, 2) Clinical Social Worker, 3) Marriage and Family Therapist, 4) Mental Health Counselor 5) Marriage and Family Therapist Associate and 6) Mental Health Counselor Associate.

2) Master's degree with a temporary permit issued by the Indiana Behavioral Health and Human Services Licensing Board as one of the following: 1) Social Worker, 2) Clinical Social Worker, within 90 days of providing services under this contract (Please note: In order to obtain a temporary license, the individual must register for the exam) and,
   a. 2 years related clinical experience, or
   b. completion of the DCS approved training program

   Note: In order to obtain a temporary license, the individual must first register for the licensure exam and may have additional requirements for temporary licensure. Please contact the Indiana Professional Licensing Board for additional instructions for obtaining a temporary license.

3) Master's degree and a submitted application for 1) Marriage and Family Therapist Associate, or 2) Mental Health Counselor Associate within 90 days of providing services under this contract. The individual must obtain licensure as a Marriage and Family Therapist Associate or Mental Health Counselor Associate within 12 months of providing services under this contract. The individual must also have:
   a. 2 years related clinical experience, or
   b. completion of the DCS approved training program

4) Master's degree in a related human service field plus 2 years related clinical experience and working under a DCS Community Based Contract on July 1, 2015.

Note: Individuals who hold a Master's degree that is applicable toward licensure, must become licensed as indicated in #2 & 3 above. Providers should not employ any new staff who are not license eligible.

Supervision:

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 as one of the following: 1) Clinical Social Worker 2) Marriage and Family Therapist 3) Mental Health Counselor.

Supervision/consultation is to include not less than one (1) hour of face-to-face supervision/consultation per 20 hours of direct client services provided, nor occur less than every two (2) weeks.

Providers are to respond to the on-going individual needs of staff by providing them with the appropriate combination of training and supervision. The frequency and intensity of training and supervision are to be consistent with "best practices" and comply with the requirements of each provider's accreditation body. Supervision should include individual, group, and direct observation modalities and can utilize teleconference technologies. Under no circumstances is supervision/consultation to be less than one (1) hour of supervision/consultation per 25 hours of face-to-face direct client services provided, nor occur less than every two (2) weeks.

In addition to the above:

- Knowledge of child abuse and neglect, and child and adult development,
- Knowledge of community resources and ability to work as a team member;
- Beliefs in helping clients change their circumstances, not just adapt to them,
- Belief in adoption as a viable means to build families.
- Understanding regarding issues that are specific and unique to adoptions, such as loss, mismatched expectations and flexibility, entitlement, gratification delaying, flexible parental roles, and humor.

Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral-valued culturally-competent manner.

VIII. Billable Units

Medicaid:

It is expected that the majority of the individual, family and group counseling provided under this standard will be based in the clinic setting. Some group counseling may occur in the community. In these instances, the units may be billable through MRO. Medicaid shall be billed when appropriate.

Services through the **MCO** may be Outpatient Mental Health Services. Medicaid shall be billed first for eligible services under covered evaluation and management codes, including those in the 90000 range.

Services through the Medicaid Rehab Option **(MRO)** may be **group** Behavioral Health Counseling and Therapy**.**

Billing Code	**Title**
H0004 HW U1	Behavioral health counseling and therapy (group setting), per 15 minutes
H0004 HW HR U1	Behavioral health counseling and therapy, per 15 minutes (family/couple, group setting, with consumer present)
H0004 HW HS U1	Behavioral health counseling and therapy, per 15 minutes (family/couple, group setting, without consumer present

DCS funding: Those services not deemed medically necessary for the Medicaid eligible client, including services to other referred members of the family that are not related to the behavior health care needs of the eligible client, will be billed to DCS per face-to-face hour as outlined below. These billable units will also be utilized for services to referred clients who are not Medicaid eligible and for those providers who are unable to bill Medicaid.

Face to face time with the client **(Individual and Family each have a face to face rate):** (Note: Members of the client family are to be defined in consultation with the family and approved by the DCS. This may include persons not legally defined as part of the family)

- Includes client-specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed
- Includes crisis intervention and other goal-directed interventions via telephone with the identified client family.
- Includes Child and Family Team Meetings or case conferences including those via telephone initiated or approved by the DCS/Probation for the purposes of goal-directed communication regarding the services to be provided to the client/family

Reminder: Not included are routine report writing and scheduling of appointments, collateral contacts, travel time and no shows. These activities are built into the cost of the face- to-face rate and shall not be billed separately

Supervised Visit:

** Time spent supervising visits will be billed separately from other services within this standard. The rate will be the same as the face-to-face rate, but will include only time spent face-to-face supervising the visit. Any other billable time as defined in the face-to-face rate, should be billed under the face-to-face rate.

Per person per group hour
Services include group goal directed work with clients. To be billed per client per hour attended. 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

Interpretation, Translation and Sign Language Services
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. 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. 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). Sign Language should be done in the language familiar to the family.
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. 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. No side comments or conversations between the Interpreters and the clients should occur.
The location of and cost of Interpretation, Translation, and Sign Language Services are the responsibility of the Service Provider. 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. 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. Providers can use DCS contracted agencies and request that they be given the DCS contracted rate but this is not required. 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. 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.

Court
The provider of this service may be requested to testify in court. 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. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. 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.

Reports
If the services provided are not funded by DCS, the "Reports" hourly rate will be paid. A referral for "Reports" must be issued by DCS in order to bill.

IX. Case Record Documentation

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.

X. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

XI. Adherence to the DCS Practice Model

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. 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.

XII. Trauma Informed Care

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/):
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. 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?" 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. 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

Trauma Specific Interventions: (modified from the SAMHSA definition)

- The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
- 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)
- 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. Cultural and Religious Competence.

Provider must respect the culture of the children and families with which it provides services. 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. 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. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth. The guidebook can be found at: http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf

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. 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**

Services must be provided in accordance with the Principles of Child Welfare Services. Please note: All services (even individual services) are provided through the lens of child safety. 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. 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. 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.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
CROSS-SYSTEM CARE COORDINATION
(Revised 3/1/2016)

I. Services Description

The provision of services is for youth and families with complex needs that are involved in multiple care systems and are involved with the Department of Child Services and/or Juvenile Probation. Cross-system care coordination is designed to facilitate child and family teams comprised of youth, families, their natural support persons, local systems, agencies, and community members. These teams design individualized service and resource plans based on the needs of the youth.

Services in this system of care should be comprehensive, incorporating a broad range of services and supports, individualized, provided in the least restrictive, appropriate setting coordinated at the system and service delivery levels involve youth and families as full partners and emphasize early identification and intervention. Core values of a system of care are, that services are child centered and family driven, community based and culturally competent.

The services provided are comprehensive and will include cross-system coordination, case management, safety and crisis planning, comprehensive strength-based discovery and assessment, activities of daily living training, assistance to the FCM in the facilitation of the child and family team process, and family and child centered care.

This service is based on the belief that children and their families are remarkably resilient and capable of positive development when provided with community-centered support, truly defined by what is in the best interest of the child. It is meant to provide a single comprehensive system of care that allows children and families in the child welfare and/or juvenile probation system(s) with complex needs to receive culturally competent, coordinated, and uninterrupted care.

The services provided to the clients and covered in the per child allotment rate will include all services necessary to meet the child's safety, permanency and wellbeing needs and addresses criminogenic risk factors. They include but are not limited to the following:

1) Case Management Services

2) Behavioral Health Services

- Behavior Management Services
- Crisis Intervention
- Day Treatment
- Evaluation / Testing Services
- Family Assessment
- Family Therapy
- Group Therapy [referred youth and/or parent(s)]
- Individual Therapy [referred youth and/or parent(s)]
- Parenting/ Family Skills Training Groups
- Special Therapy
- Substance Abuse Therapy- Group
- Substance Abuse Therapy- Individual
- Drug Screens [referred youth and/or parent(s)]
- Family Preservation – home based services

2) Mentor Services

- Clinical Mentor
- Educational Mentor
- Life Coach/ Independent Living Skills Mentor
- Parent and Family Mentor
- Recreational/Social Mentor
- Supported Work Environment
- Tutor

3) Other Services

- Consultation with Other Professionals
- Team Meetings
- Transportation
- Supervised Visitation
- Diagnostic and Evaluation services for parents

4) Psychiatric Services

- Assessments Outpatient
- Medication Follow-up/ Psychiatric Review

5) Respite Services

- Crisis Respite
- Planned Respite

6) Supervision Services

- Community Supervision
- Intensive Supervision

7) All Out of Home Placements
8) Services to meet the needs of children with complex medical needs or developmental delays.
9) Goods and services related to increased child wellbeing.

Family based services are included in the per diem if the referred child is participating in the service or if the service is to address the child's safety, permanency, or wellbeing needs. Outpatient substance use disorder services for parents are included in the rate, however residential services for parents, individual services for siblings, and sex offender treatment for adults are not included. Siblings who do not meet the target population will receive individual services only if they are included on the referral.

All services provided under contracts for Cross System Care Coordination should be provided in accordance with any applicable service standard. For example, counseling services must be provided in accordance with the Counseling service standard.

If mentoring services are being provided under this service standard, the Cross Systems Care Coordination provider must have a DCS approved service standard or policy related to the provision of this service.

II. Service Delivery

1) The Care Coordinator has the specific responsibilities for the following:

- Evaluates and interprets referral packet information and completes a strength based assessment with child and family and the Child and Adolescent Needs and Strengths Assessment (CANS).
- Collaborate with the Family Case Manager (FCM)/Probation Officer in convening the family members, service providers and other child and family team members to form a collaborative plan of care with clearly defined goals. Utilizes the CANS and IYAS (Indiana Youth Assessment System) as a basis for developing the plan for appropriate treatment.
- Addresses need for and develops, revises and monitors crisis plan with family and team members.
- Ensures that parent and family involvement is maintained throughout the service period so that families have continual voice and choice in their care.
- Maintains ongoing dialogue with the family and providers to assure that the philosophy of care is consistent and that there is progress toward service goals. Evaluates the progress and makes adjustments as necessary.
- Assures care is delivered in a manner consistent with strength-based, family centered, and culturally competent values, offers consultation and education to all

providers regarding the values of the model, monitors progress toward treatment goals and
assures that all necessary data for evaluation is gathered and recorded.

- Maintains central file consisting of treatment summaries, payment and resource utilization records, case notes, legal documents and releases of information.
- Facilitates the closing of the case and oversees transition to any ongoing care.
- Uses resources and available flex funding to assure that services are based specifically on the needs of the child and family.
- Able to deliver strength based, family centered, culturally competent services.
- Able to interpret psychiatric, psychological and other evaluation data, and use that information in the formation of a collaborative plan of care.
- Able to complete all documentation using a computerized clinical record.
- Able to utilize creativity, flexibility and optimism about the strengths of children and their
families.

2) Providing agency receives referrals 24 hours a day, 7 days a week. There is a verbal determination between the referring worker and the agency that services are warranted, and there is agency availability for the service before the referral is sent.
3) The initial face- to- face contact with the family must occur no later than 48 hours following receipt of the completed referral or as requested by the referring worker. Stabilization services must be provided as necessary to meet the safety needs of the family.
4) An abbreviated assessment to determine the needs of the youth and family and is mutually established between the referral source and care coordinator within 14 days of completed referral. Goal setting and service planning are mutually established between the youth, caregiver, care coordinator, providers and referral source based upon the comprehensive assessment within 21 days of the completed referral. The provider must contact any service providers already serving the family at the time of CSCC referral and make arrangements to continue any needed services by transitioning responsibility for payment to the Cross System Care Coordination provider within 14 days of referral. The provider should collaborate with the Family Case Manager to ensure any services being changed or canceled are transitioned as necessary to meet the needs of the family.
5) Each family receives access to services through a single care coordinator acting within a team, with supports available 24 hours a day 7 days a week.
6) Regular assessment of needs and strengths of the youth and family will be completed and discussed within the Child and Family team to guide decision making on services and supports for the youth and family. System-related concerns and directives are included in these team discussions as well.
7) Safety is of paramount importance. If there are concerns about safety within the home there is an obligation for the care coordinator and the current worker to communicate to address all safety concerns, and document safety steps taken to resolve the issues. If any incidences

occur, the care coordinator is to notify the current worker immediately of the situation.
8) Confidentiality must be maintained. Failure to maintain confidentiality may result in termination of the service agreement.
9) After a 12 day period of no face-to-face contact with the child or youth, billing should be suspended until successful face-to-face contact is made.

III. Target Population

Services are restricted to cases where existence of complex needs has been documented within the following eligibility categories:

5) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
6) Children and their families which have an Informal Adjustment (IA) or the children have the status of CHINS or JD/JS.
7) Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.

Within the population listed above, Cross Systems Care Coordination will specifically target children who have a need for increased support, training of caregivers and monitoring due to one or more of the following:

- mental health issues and/or developmental delays/intellectual disabilities/autism and are in residential placements or at risk of residential placements (but do not qualify for the Medicaid funded services, Medicaid Rehabilitation Option and/or Children's Mental Health Wraparound Services)
- significant substance abuse issues in conjunction with mental health issues
- sexually maladaptive behaviors
- significant medical issues
- legal issues within the delinquency system in addition to child welfare system involvement
- significant criminogenic risk and needs

DCS may expand the target as necessary to ensure families and children receive the supports and services necessary to meet their needs.

IV. Goals and Outcomes

Goals and Outcomes will be established during the contract negotiation.

V. Minimum Qualifications

Clinical Consultant:

Master's Degree in Social Work, Psychology, Marriage and Family Therapy, or related Human Services field; and,
A current license issued by the Indiana Social Worker, Marriage and Family Therapist and Mental Health Counselor Board as one of the following:

- Clinical Social Worker
- Marriage and Family Therapist
- Mental Health Counselor

The Clinical Consultant must staff each case a minimum of monthly with the Care Coordinator and the supervisor.

Supervisor:
If the Clinical Consultant is not the supervisor of the Care Coordinator, the following are minimum requirements for the Direct Supervisor:

- Master's degree in social work, psychology, or directly-related human services field from an accredited college and 2 years of experience in delivering child welfare services or probation services, OR

- Bachelor's degree in social work, psychology, sociology, or a directly-related human service field from an accredited college and 5 years of experience delivering child welfare services or probation services. Must have a minimum of one year of the above experience must be in the Cross System Care Coordination.

Care Coordinator:
Bachelor's degree in social work, psychology, sociology, or a directly-related human service field from an accredited college and 3 years of experience in a human service field. Other Bachelor's degrees will be accepted in combination with a minimum of five years experience working directly with families in the child welfare system. Must possess a valid driver's license and the ability to use private car to transport self and others, and must comply with the state policy concerning minimum car insurance coverage.
In addition to the above:

- Specialized training in care coordination
- Knowledge of child abuse and neglect, and child and adult development
- Knowledge of community resources
- Ability to facilitate a team as well as work as a team member
- Belief in helping clients change their circumstances, not just adapt to them
- Belief in adoption as a viable means to build families
- Understanding regarding issues that are specific and unique to adoptions such as loss, mismatched expectations and flexibility, loss of familiar surroundings, customs and

traditions of the child's culture, entitlement, gratification delaying, flexible parental roles and humor

VI. Billable Units

Billable units will be based on a per diem rate based on four levels of service:

- Intensive – Youth in Residential Treatment, Day Treatment or Group Home placements
- Intervention – Youth at risk for Residential Treatment placements
- Early Intervention – Youth with functional impairments across multiple life domains but who are currently functioning appropriately in the community
- Noneligible sibling

The per diem will start the day of the first face to face contact after recommendation for acceptance into this program is approved by DCS. Referrals will be made for 6 month time periods and the tier of service will remain unchanged for that time period. In situations where an exception is necessary, the provider will work through the Regional Services Coordinator to request an adjustment. After a 12 day period of no face-to-face contact made by the care coordinator with the child or youth, billing should be suspended until successful face-to-face contact is made.

Interpretation, Translation and Sign Language Services

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

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

The location of and cost of Interpretation, Translation, and Sign Language Services are the responsibility of the Service Provider. 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. 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. Providers can use DCS contracted agencies and request that they be given the DCS contracted rate but this is not required. 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. 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.

VII. Case Record Documentation

Providers will be required to enter service logsinto the KidTraks system. Entries should be made within 48 hours of service completion.

Case record documentation for service eligibility must include:

19) A completed, and dated DCS/ Probation referral form authorizing services
20) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for these documents from referral source.
21) Safety issues and Safety Plan Documentation
22) Documentation of Termination/Transition/Discharge Plans
23) 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
24) 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
25) Progress/Case Notes Must Document: Date, Start Time, End Time, Participants, Individual providing service, and location
26) When applicable Progress/Case notes may also include:
    l. Service/Treatment plan goal addressed (if applicable-
    m. Description of Intervention/Activity used towards treatment plan goal
    n. Progress related to treatment plan goal including demonstration of learned skills
    o. Barriers: lack of progress related to goals
    p. Clinical impressions regarding diagnosis and or symptoms (if applicable)
    q. Collaboration with other professionals

r. Consultations/Supervision staffing
s. Crisis interventions/emergencies
t. Attempts of contact with clients, FCMs, foster parents, other professionals, etc.
u. Communication with client, significant others, other professionals, school, foster parents, etc.
v. Summary of Child and Family Team Meetings, case conferences, staffing

27) 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. Reporting

Providers will be required to prepare, maintain, and provide any statistical reports, program reports, other reports, or other information as requested by DCS relating to the services provided. These monthly reports are due by the 10th of the month following service.

DCS will require an electronic reporting system which will include documenting time and services provided to families. DCS may also adopt a standardized tool for evaluating family functioning. Services will include administration of this tool at the initiation of services as well as periodically during service provision.

IX. . Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. DCS will have the option to put the referral on hold or terminate the family's referral at an earlier date due to changes in family status or loss of engagement.

The provider is to contact the Family Case Manager after missed appointments. After three unsuccessful face to face contacts, the provider must notify the Family Case Manager and billing must be suspended until successful face to face contact is made. Family Case Manager should be contacted to evaluate the need for early termination of the referral.

● Referral must be accepted within the KidTraks vendor portal within 72 hours
● Provider has 24 hours to contact the referral source if unable to accept the referral based upon lack of capacity
●Providers will see the family within 48 hours of referral

X. Adherence to the DCS Practice Model

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

XI. Core Competency - Trauma Informed Care

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/):
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. 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?" 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. 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.

Trauma Specific Interventions: (modified from the SAMHSA definition)

●The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
●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)
●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. Cultural and Religious Competence.

Provider must respect the culture of the children and families with which it provides services. 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. 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. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth. The guidebook can be found at: http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf

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. 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.

XIII. Child Safety

Services must be provided in accordance with the Principles of Child Welfare Services. Please note: All services (even individual services) are provided through the lens of child safety. 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. 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. 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.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
DIAGNOSTIC AND EVALUATION SERVICES

I. Service Description

Diagnostic and assessment services will be provided as requested by the referring worker for parents, other family members, and children due to intervention of the Department of Child Services because of alleged physical, sexual, or emotional abuse or neglect, the removal of children from the care and control of their parents, and/or children alleged to be a delinquent child or adjudicated a delinquent child. When either a psychological or emotional problem is suspected to be contributing to the behavior of an adult or child or interfering with a parent's ability to parent, they should be referred for an initial bio-psychosocial assessment by the Family Case Manager/Probation Officer. If an attachment and bonding assessment, a trauma assessment, a psychiatric consultation/medication evaluation or either psychological or neuropsychological testing is necessary to answer a specific question, testing may be included in the evaluation after a consultation with the Family Case Manager (FCM) and Clinical Service Specialist to clarify the rationale for testing. The results of the evaluation including diagnostic impression and treatment recommendations will be forwarded to the Family Case Manager to assist the family in remedying the problems that brought the family to the attention of child protective services and/or probation.

II. Service Delivery

Clinical Interview and Assessment

The purpose of the Clinical Interview and Assessment is to provide a clinical snapshot of the referred client and to generate recommendations to address identified needs. The Clinical Interview and Assessment will have the following completed and summarized in a report:

- Bio-psychosocial assessment (including initial impression of parent functioning)
- Diagnosis (if applicable) for the referred client per 405 IAC 5-20-8 (3), a physician, psychiatrist or HSPP must certify the diagnosis. Record of certification by qualified individual must be provided if a diagnosis is included.
- Summary of Recommended Services and Service Approach

1. The completed report will utilize the DCS standardized "Clinical Interview and Assessment" report format. The report should be completed with a summary to DCS within 14 calendar days of referral.
2. The service provider may recommend attachment and bonding assessment, trauma assessment, psychological testing, psycho-sexual assessment, neuro-psychological testing and/or psychiatric consultation/medication evaluation as a result of the bio-psychological assessment. If attachment and bonding assessment, trauma assessment, psychological testing or neuropsychological testing is recommended, the service provider should include in the report the specific issues/questions the testing should address. A new referral under this service standard will be required for these services and must be approved by DCS/ PO prior to initiation of additional testing.

Attachment and Bonding Assessment

An attachment and bonding assessment is used to determine the quality and nature of a child's bond or attachment to a particular person or persons. This might include biological parents, foster parents, guardians, prospective adoptive parents, relatives or siblings. The assessment may be used as one piece of information when making decisions about a child's placement options. Information obtained from the attachment and bonding assessment is focused on the needs of the child, as well as ways to foster relationships and improve attachment quality. It is used specifically to:

- Identify secure vs. insecure attachment patterns;
- Predict the impact on a child of continuing to be in the current situation as opposed to other placement alternatives;
- Assist a parent or caregiver in learning about their own strengths and weaknesses, as well as ways to improve their parenting style based on the needs of the child;
- Assess the future potential and needs of the caregiver-child relationship; and
- Determine the most appropriate parenting style/skills/qualities for substitute caregivers.

The clinician will respond with a written report with recommendation of services within 14 days from the date of assessment. At a minimum, the attachment and bonding assessment should include the following components:

- Social history of the child and caregiver(s)/sibling(s).

- Developmental history of the child; and
- Direct observation of the child with his/her caregiver/sibling using the following 9 episode standardized format (Boris NW, Hinshaw-Fuselier S, Smyke AT, Scheeringa MS, Heller SS, Zeanah CH (2004), Comparing criteria for attachment disorders: establishing reliability and validity in high-risk samples. J Am Acad Child Adolesc Psychiatry 43: 568–577):

Episode	Duration	Description
1	5 minutes	The clinician observes parent-child "free pay." Note especially familiarity, comfort, and warmth in the child as he/she interact with attachment figure.
2	3 minutes	The clinician talks with, then approaches, then attempts to engage the child in play. Most young children exhibit some reticence, especially initially, about engaging with an unfamiliar adult.
3	3 minutes	The clinician picks up child and shows him/her a picture on the wall or looks out window with the child. This increases the stress for the child. Again, note the child's comfort and familiarity with this stranger.
4	3 minutes	The caregiver picks up the child and shows him/her a picture on the wall or looks out window with the child. In contrast to stranger pick up, the child should feel obviously more comfortable during this activity.
5	1 minutes	The child is placed between the caregiver and a stranger, and a novel (e.g., scary/exciting) remote control toy is introduced. The child should seek comfort preferentially from the parent. If interested rather than frightened, the child should share positive affect with the parent.
6	3 minutes	The clinician leaves the room. This separation should not elicit much of a reaction in the child because the clinician is a stranger.
7	1 minutes	The clinician returns. Similarly, the child should not be much affected by the stranger's return.
8	3 minutes	The caregiver leaves the room. The child should definitely take notice of the caregiver's departure, although not necessarily exhibit obvious distress. If the child is distressed, then the clinician should be little comfort to the child.
9	1 minutes	The caregiver returns. The child's reunion behavior with the caregiver should be congruent with separation behavior. That is, distressed children should seek comfort and non-distressed children should re-engage positively with the caregiver by introducing them to a toy or activity or talking with them about what occurred during the separation.

Note: Other research-based observation models may be used but they require **written approval from the DCS Central Office prior to use.**

<u>Trauma Assessment</u>

Many people involved with DCS have experienced trauma and meet the clinical criteria for PTSD. However, many who do not meet the full criteria for PTSD still suffer significant posttraumatic symptoms that can have an adverse impact on their behavior, judgment, educational performance and ability to connect with caregivers. A comprehensive trauma assessment helps determine which intervention will be most beneficial.

At a minimum, the trauma assessment should include the following components:

- Social history of the client
- Developmental history of the client;
- Trauma history, including all forms of traumatic events experience directly or witnessed by the client;
- Use of at least one standardized clinical measure to identify types and severity of symptoms the client has experienced. Examples include the UCLA PTSD Index for DSM-IV, Trauma Assessment for Adults- Self Report (TAA), the Trauma Symptoms Checklist for Children (TSCC), the Trauma Symptoms Checklist for Young Children (TSCYC), the Child Sexual Behavior Inventory (CSBI), and the Clinician-Administered PTSD Scale for Children and Adolescents (CAPS-CA)
- Integration of DCS CANS scores; and
- Recommendations for evidence-based, trauma-informed treatment, as appropriate.

The clinician will respond with a written report with recommendation of services within 14 days from the date assessment.

Psychological Testing

The psychologist will conduct applicable psychological testing as recommended during the Clinical Interview and Assessment and approved by DCS. The psychologist will respond with a written report that clearly outlines the findings of the psychological test within 30 days from the completion of the psychological test. The detailed written report should include, but not limited to, defining any applicable diagnosis with appropriate treatment recommendations and considerations, present functioning of the referred individual, and description of the referred individual's history. In addition to the written report, the psychologist (or another appointed staff member) will notify (via email) the referring local DCS office within 48 hours that the psychological testing has been completed.

At DCS's request, the psychologist may attend a Child and Family Team Meeting for the purpose of debriefing the team on the psychological evaluation findings and providing guidance for treatment to address the findings.

Neuropsychological Testing

The psychologist will conduct applicable neuropsychological testing as recommended during the Clinical Interview and Assessment and approved by the Clinical Specialist/Probation Officer. The psychologist will respond with a written report within 30 days from the date of appointment.

Medication Evaluation

If psychiatric consultation/medication evaluation is recommended, the psychiatrist will see the client within 14 days from the date of referral and complete a written report within 30 days from the date of evaluation.

Ongoing Medication Monitoring

Ongoing medication monitoring will be provided as needed based on the results of the Medication Evaluation.

Child Hearsay Evaluation

An evaluation completed by a psychiatrist, physician, or psychologist to determine if participation in court proceedings would create a substantial likelihood of emotional or mental harm to the child. This evaluation is intended for youth under the age of 14, or a child at least 14 and younger than 18 that has a substantial disability attributable to impairment of general intellectual functioning or adaptive behavior that is likely to continue indefinitely, and is for use in CHINS or Termination of Parental Rights proceedings. Child Hearsay is governed by Indiana Statute.

The Child Hearsay Evaluation should address IC 31-34-13-3 (2) (i): Childs participation in the court proceedings (testifying) creates likelihood of Emotional or Mental Harm to the child. It is also possible to be asked to address IC 31-34-13-3 (2) (iii): Is the child incapable of understanding the nature and obligation of an oath? The Child Hearsay Evaluation should NOT address IC 31-34-13-3 (1): Whether the child's statements meet sufficient indications of reliability (used in criminal cases not CHINS/TPR). The evaluation is also NOT to make recommendations about what services the child and/or parents need. This is done through other Diagnostic & Evaluation Services.

IC 31-34-13-3Requirements for admissibility of statements or videotapes
Sec. 3. A statement or videotape described in section 2 of this chapter is admissible in evidence in an action to determine whether a child or a whole or half blood sibling of the child is a child in need of services if, after notice to the parties of a hearing and of their right to be present:
(2) The child:
(A) Testifies at the proceeding to determine whether the child or a whole or half blood sibling of the child is a child in need of services;
(B) was available for face-to-face cross-examination when the statement or videotape was made; or
(C) Is found by the court to be unavailable as a witness because:

(i) A psychiatrist, physician, or psychologist has certified that the child's participation in the proceeding creates a substantial likelihood of emotional or mental harm to the child;
(iii) The court has determined that the child is incapable of understanding the nature and obligation of an oath.

The main component in this evaluation is to gather information to make the determination of the probability of emotional or mental harm to the child if they testify in Court. This is done through a Clinical Interview and Assessment with the child. The evaluator also has the option of using testing tools as deemed appropriate. Examples of tools include but are not limited to: Problem Behavior Checklist; Children's Manifest Anxiety Scales; Child Behavior Checklist for ages 6-18 and for ages 1.5 to 5; Trauma Symptom Checklist for Children; House Tree Person; Children's Incomplete Sentences; Stoner Incomplete Sentences for Children; Coloring Sheet of Faces; Kinetic Drawings; RAT-2.

The Child Hearsay Evaluation needs to be completed within 14 days after the referral is made and the Final Evaluation Report needs to be provided to the referral source within 21 days from the referral. In some instances, the Court may need this evaluation to be completed more quickly. This would be included on the referral.

III. When DCS is not paying for services:
A billable unit of "Reports Writing/Court Testimony Only" has been developed for providers who service DCS families without DCS payment for these services (Medicaid, insurance, self-pay) but DCS requests a report or Court Testimony from the provider on the family. The referral process has been set up to authorize reports and court appearance components on the DCS referral form in these incidences. If the services provided are not funded by DCS, the report rate per hour for the necessary reports on a referral form issued by DCS. Court Testimony will be paid per appearance if requested on the referral form issued by DCS. In order to be paid for a court appearance a subpoena or written request from DCS should be on file.

IV. . Target Population
Service must be restricted to the following eligibility categories:

1. Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with Informal Adjustment (IA) or Children In Need of Services (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.

V. Goals and Outcomes

Goal # 1: Timely receipt of evaluations.
Objective:

1). Service provider to submit written report to the referring Family Case Manager (FCM) or Probation Officer (PO) within the designated time frames of completion of evaluation.

Outcome Measure/Fidelity Measure:

1) 95% of the evaluation reports will be submitted to the referring Family Case Manager/Probation Officer within specified service delivery time frames.

Goal #2: Obtain appropriate recommendations based on information provided.
Objective:

1) Service provider to submit written recommendations of appropriate services to address the needs as identified on the assessment or the symptoms of the identified diagnosis.

Outcomes Measure/Fidelity Measure:

1) 100% of reports will meet information requested by the referring Family Case Manager /Probation Officer.
2) 100% of reports will include recommendations for treatment, needed services Indicate no further need for services.

Goal #3: Client satisfaction surveys.
Objective:

1) Client satisfaction of service provided.

Outcome Measure/Fidelity Measure:

1) DCS and/or Probation satisfaction will be rated 4 and above on the Service Satisfaction Report.
2) A random sample of Satisfaction Surveys will be completed at the conclusion of services.

VI. Minimum Qualifications:

Clinical Interview and Assessment Reimbursed by DCS:
Diagnosis and assessment may be done by the following staff:
Masters degree in social work, psychology, marriage and family therapy, or related human services field.
The Diagnosis must be signed off by:

- A Health Services Provider in Psychology (HSPP) psychologist or
- A licensed psychiatrist

Clinical Interview and Assessment Reimbursed by Medicaid:

Must meet Medicaid requirements.

Attachment and Bonding Assessment Reimbursed by DCS
Administration and interpretation must meet the requirements of the testing tool being utilized.

Child Hearsay Evaluation
Per Indiana Statute, the evaluation must be completed by a psychiatrist, a physician, or a psychologist.

Trauma Assessment Reimbursed by DCS
Administration and interpretation must meet the requirements of the testing tool being utilized.

Psychological & Neuropsychological Testing Reimbursed by DCS:
Test Interpretation

Diagnosis and assessment may only be done independently by a Health Services Provider in Psychology (HSPP) or physician.

Test Administration

The following practitioners may **administer** psychological testing under the direct supervision of a HSPP or physician:

(A) A licensed psychologist
(B) A licensed independent practice school psychologist.
(C) A person holding a Master's degree in psychology or mental health field and one (1) of the following:
  (i) at least one (1) year of supervised experience in testing under physician or HSPP psychologist at the performance site on the tests to be used including instruction on administration and scoring and practice assessment with non-patients and final approval to administer the specific instruments by a physician or HSPP psychologist at the performance site; or
  (ii) A certified specialist in psychometry (CSP)
(D) Status as a psychology intern enrolled in an American Psychological Association (APA)- approved internship program.
(E) A psychology resident enrolled in an APA-approved training program or APPIC recognized internship or post-doctoral program.
(F) An individual certified by a national organization in the Administration and scoring of psychological tests.

The physician and HSPP are responsible for the interpretation and reporting of the testing performed.

The physician and HSPP must provide direct supervision and maintain documentation to support the education, training, and hours of experience for any practitioner providing services under their supervision. A cosign by the physician or HSPP is required for services rendered by one of the lower level practitioners.

Psychological & Neuropsychological Testing reimbursed by Medicaid:

Subject to prior authorization by the office or its designee, Medicaid will reimburse for neuropsychological and psychological testing when provided by a physician or an HSPP. The services are provided by one (1) of the following practitioners:

(A) A physician
(B) An HSPP
(C) The following practitioners may only **administer** neuropsychological and psychological testing under the direct supervision of a physician or HSPP:
1. A licensed psychologist
2. A licensed independent practice school psychologist
3. A person holding a Master's degree in a mental health field and one(1) of the following:
   (a) A certified specialist in psychometry (CSP)
   (b) two thousand (2000) hours of experience, under direct supervision of a physician or HSPP, in administering the type of test being performed.

The physician and HSPP are responsible for the interpretation and reporting of the testing performed. The physician and HSPP must provide direct supervision and maintain documentation to support the education, training, and hours of experience for any practitioner providing services under their supervision. A co-signature by the physician or HSPP is required for services rendered by one of practitioners listed in sub-division (C).

Medication Evaluation and Ongoing Medication Management:

(A) Physician
(B) Advanced Practice Nurses (Nurse Practitioners or Certified Nurse Specialists) with a:
1) Master or doctoral degree in nursing with a major psychiatric or mental health nursing
2) from an accredited school of nursing

If working as an Authorized Health Professional Staff must:
1) be an Advance Practice Nurse as described above
2) and prescriptive authority

3) must work within the scope of his/her license and have a supervisory agreement with a licensed physician.

VII. Billable Unit

Medicaid:

It is expected that the diagnostic and evaluation services provided under this service standard will be based in the clinic setting. Medicaid shall be billed when appropriate. Services will be billable by utilizing the 90000 codes.

The medically necessary parts of the clinical interview and assessment should be billed as appropriate through Medicaid. For more information on Medicaid Billing, please refer to Chapter 8 of the Indiana Health Coverage Program Manual (direct link is file://fss00it6/HOME/CFarzetta/Downloads/chapter08%20(5).pdf) Any additional time spent face to face with the client or caregiver gathering DCS required non-medically necessary information, that would not typically be part of a clinical intake or assessment, may be billed to DCS (up to 1.5 hours). Time spent completing the DCS required standardized form may be billed to DCS up to a total of 1.5 hours.

DCS Funding:

Those services not billable under Medicaid may be billed to DCS as follows:

Clinical Interview and Assessment: Hourly rate- Face to Face time with a client, plus a maximum of 1.5 hour may be billed for report writing.

Attachment and Bonding Assessment: Hourly rate- includes face-to-face time with the client, as well as time spent:

- administering, scoring, and interpreting psychological tests;
- collecting current diagnostic collateral information;
- reviewing treatment records and other collateral information related to the referral question; and
- writing the report (maximum of one hour to be billed).

Trauma Assessment: Hourly rate- includes face-to-face time with the client, as well as time spent:

- administering, scoring, and interpreting psychological tests;
- collecting current diagnostic collateral information;
- reviewing treatment records and other collateral information related to the referral question; and
- writing the report (maximum of one hour to be billed).

Psychological Testing: Hourly rate- includes face-to-face time with the client, as well as time spent:

- administering, scoring, and interpreting psychological tests;
- collecting current diagnostic collateral information;
- reviewing treatment records and other collateral information related to the referral question; and
- writing the report (maximum of one hour to be billed).

Neuropsychological Testing: Hourly rate- includes Face to Face with the client and time spent administering, scoring, and interpreting testing, plus a maximum of 1 hour may be billed for report writing.

Medication Evaluation: Hourly rate- Face to face with the client, plus a maximum of ½ hour may be billed for report writing.

Ongoing Medication Monitoring: Hourly rate- Face to face with the client.

Child Hearsay Evaluation- Hourly face to face time with the youth while completing the Clinical Interview and the administration and interpretation of the testing tools selected by the Evaluator. An additional 1 hour can be billed for writing the report.

Hourly services may be billed in 15 minute increments, partial units are rounded to the nearest quarter using the following guidelines:

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

Medication: Billed at Actual Cost. The provider must access all sample medication resources and other medication sources (e.g. MAP) and pharmaceutical companies that provide free or reduced cost medications prior to billing DCS. Documentation of these efforts must be maintained in the case file.

Child and Family Team Meetings

Includes only Child and Family Team Meetings or case conferences initiated or approved by DCS or Probation for the purposes of debriefing the team on the psychological evaluation findings and providing guidance for treatment to address the findings. Provider must receive a written request from the referral source in order bill for CFTM attendance.

Court: The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing **after receiving a written request (email or subpoena) of the agency's representative from DCS/Probation to appear in court**, and can be billed per appearance per family. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. **Maximum of 1 court appearance per day/per case.** 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.

Reports/Court Testimony Only: If the services provided **are not funded by DCS**, the "Report Writing" hourly rate will be paid; the "Court Testimony" per appearance rate will be paid. A referral for "Report Writing/Court Testimony" must be issued by DCS in order to bill.

Interpretation, Translation and Sign Language Services

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

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

The location of and cost of Interpretation, Translation, and Sign Language Services are the responsibility of the Service Provider. 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. 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. Providers can use DCS contracted agencies and request that they be given the DCS contracted rate but this is not required. 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. 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.

VIII. Case Record Documentation

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

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation, an approved DCS referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approval period.

X. Adherence to the DCS Practice Model

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. 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. Trauma Informed Care

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/):
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. 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?" 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. 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

Trauma Specific Interventions: (modified from the SAMHSA definition)

- The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
- 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)
- 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. Cultural and Religious Competence.

Provider must respect the culture of the children and families with which it provides services. 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. 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. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth. The guidebook can be found at: http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf

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. 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.

XIII. Child Safety

Services must be provided in accordance with the Principles of Child Welfare Services. Please note: All services (even individual services) are provided through the lens of child safety. 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. 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. 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.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
DOMESTIC VIOLENCE BATTERERS INTERVENTION SERVICES

A Batterers Intervention Program (BIP), Certified by the Indiana Coalition Against Domestic Violence (ICADV), shall be utilized by DCS as a preferred contract provider of services for domestic violence offenders/batterers in keeping with I.C. 35-50-9. If a contract service provider is needed in an area in which an ICADV Certified BIP is not available, the service provider must adhere to the DCS standards listed below.

I. Service Description

Definition of Domestic Violence (Indiana Coalition Against Domestic Violence [ICADV] definition) - A pattern of assaultive or coercive behavior, including physical, sexual, or psychological attacks, as well as economic coercion, that adults or adolescents use against an intimate partner. Intimate partners include spouse, former spouse, those living or having lived as if a spouse, those having a child in common, those having a past or current sexual relationship, or a past or current dating relationship.

The batterer or offending parent may be selected for service delivery of Domestic Violence Batterers Intervention Services. Batterers' intervention services shall not exist in isolation, as it

represents only one component of a coordinated community response to domestic violence. Services shall maintain cooperative working relationships with local programs (domestic violence programs and shelters, survivor programs, law enforcement, courts, advocates, legal services, etc.). Services shall focus on victim safety, batterer accountability and community collaboration, in that order. Services should be non-abusive, support change, and hold program clients accountable for their behavior.

II. Service Delivery

Group is the only method of services for the batterer. Group sessions will be for same-gendered participants only. All service must follow the ICADV approved policies and procedures for BIP service delivery as listed below:

1) The provider and the agency operating the program will not provide couples counseling involving the batterer until after the batterer/participant has successfully completed the program, and not thereafter if facilitators and advocates have reason to be concerned about the victim or child safety.
2) As a condition of program completion, each participant must attend a minimum of 26 weekly sessions, consisting of at least 1.5 hours each. Three of these sessions can be used for the orientation/intake, mid-point/check-in and for the exit/program termination interviews.
3) A minimum of 24 of the 26 sessions will be group sessions.
4) Class size should not exceed 18.
5) The provider will establish objective criteria for program completion that will be enforced uniformly.
6) All on-going batterers' groups shall be conducted by qualified personnel.
7) The provider will have an established procedure for notification of victim/survivor/partner about expulsion and/or completions.
8) Any communication regarding program completion must include the following statement: *Program completion does not guarantee the absence of future violence or abusive behavior.*
9) The batterer may pursue other service methods after satisfactory completion of group services as determined and documented by BIP provider staff. The batterer should only be included in marital/couples or family services if the batterer has done extensive work to change violent behavior and there is proof of progress. The batterer should not be included in marital/couples or family services if there is reason to be concerned about the survivor/child's safety or wellbeing.
10) Services must be available to participants who have limited daytime availability.
11) Provider must respect confidentiality unless otherwise specified by the client-provider contract. Failure to maintain confidentiality may result in immediate termination of the service agreement between DCS and the provider.

Provider shall conduct intake with batterer within 5 days after referral by DCS. Intake shall include but is not limited to:

- Acknowledgment of Batterer's past and current use of physical and sexual violence, including other abusive behaviors, within and outside of intimate relationships
- Substance abuse screening
- Screening for history of mental illness or trauma
- Identification of current threats or ideations of homicide

Substance abuse, addictions, and/or mental illness counseling/treatment is not an appropriate intervention for domestic violence and may not be substituted for the program. If intake indicates the need for substance abuse or mental health assessment or treatment, it shall be done separately and not in conjunction with batterer's intervention. Information from the intake should be provided to the Family Case Manager or Probation Officer along with any recommendations for additional services.

Providers shall require batterers to sign a contract as outlined in the ICADV Policies and Procedures for Services to Batterers. The provider shall require batterers to sign an explicit, written waiver of confidentiality at the time of intake, which will give the provider permission to make reports, to testify, to otherwise communicate as needed, and to reveal file and other information regarding the batterer to each of the following:

1) Indiana Department of Child
2) The referral source, if legally mandated; The court, prosecutor, police, probation and child protective agency of the referring county; The victim/partner/survivor or her/his designated advocate; Administrative and professional personnel who need information for record-keeping, monitoring, or professional development.
3) Any entity or person to whom the provider is legally bound to report suspected abuse or neglect of a child or protected adult;
4) Any person to whom the provider must report in order to fulfill its duty to warn or protect.

The waiver may include a specified end date, but an exception must be included in the text of the waiver that extends the waiver beyond the end date where necessary in order to prevent the participant from avoiding legal consequences for criminal or violent acts or in order for the provider to respond to a court subpoena for information or testimony.

Curriculum Content

1) The central focus of any provider curriculum will remain on participant responsibility and accountability for their beliefs and actions. It will actively challenge all abusive behaviors or victim blaming.

2) Any provider curriculum used or developed by provider programs will be based on ICADV-approved curriculum.
3) Provider curriculum should reflect an awareness of cultural diversity.

Program Monitoring
Provider will establish a written working agreement with a local independent domestic violence program or advocate. The local domestic violence program or advocate will be referred to as the "monitor". This written agreement will include all necessary elements as per ICADV Policies and Procedures.

The provider will develop guidelines for BIP participant expulsion reflecting ICADV policies so that decisions are uniform and predictable and so that discrimination does not occur against any participant based on race, class, age, physical handicap, religion, educational level, ethnicity, national origin, sexual orientation, or gender. Batterers may be re-enrolled in group on an individual basis at the provider's discretion in consultation with the referring FCM.

Partner Contact

Definition: "Partner contact" refers to any mail, phone, e-mail, or face-to-face contact, direct or indirect, with any partner, victim, survivor, ex-partner/victim/survivor, or child of a program participant, before, during, or after his/her enrollment in the program. Providers shall follow guidelines established by ICADV.

The provider shall establish a written policy requiring that all staff have a duty to warn and protect victims, partners, children and others against whom the batterer has made a threat of violence. This policy will detail the criteria for determining when a duty to warn arises, and the procedures staff are expected to follow.

Batterer services must work in collaboration with local programs that serve survivors of domestic violence, law enforcement, the Indiana Coalition Against Domestic Violence and the Resource Center (ICADV) and others. Collaboration shall include: Measuring effectiveness of the services by outcome measures and being an active participant in local coordinated community response efforts.

III. When DCS is not paying for services:

A billable unit of "Reports" has been developed for providers who service DCS families without DCS payment for these services (Medicaid, insurances, self-pay) but DCS wants a report from the provider on the progress of the family. The referral process has been set up to authorize reports and court components on the DCS referral form in these incidences. **DCS will only pay**

for reports when DCS is not paying for these services. If the services provided are not funded by DCS, the report rate per hour will be paid for the necessary reports on a referral form issued by DCS. Court testimony will be paid per appearance if requested on a referral form issued by DCS. In order to be paid for a court appearance a subpoena or written request from DCS should be on file.

IV. . Target Population

Services must be restricted to cases where domestic violence has been documented within the following eligibility categories:

1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
2) Children and their families which have an Informal Adjustment (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.

V. **Goals and Outcomes**

Goal #1 BIP participants will not continue to engage in assaultive or coercive behavior, including physical, sexual, or psychological attacks as well as economic coercion against an intimate partner.

Outcome Measures

1) 90% of participants will acknowledge use of power and control in their relationship.
2) 70% of program participants have no further involvement with the DCS or criminal justice system related to domestic violence for a 12 month period beginning with program enrollment.
3) 80% of referrals will complete the full program.

Fidelity Measures:

Program fidelity/abiding by “best practices” is perhaps the best predictor of successful outcomes and provides an effective indirect measure. An audit undertaken by a DCS employee or designee may be conducted to assure program accountability. Programs must clearly link daily practices to the following program fidelity issues:

1) 90% of the supportive services (shelters, law enforcement, courts, advocates, legal agencies etc.) have a cooperative working relationship with the provider.
2) 100% of the BIP provider staff focus on victim safety as evidenced by adherence to appropriate policies and procedures of the provider agency.

3) 100% of program participants have an opportunity to participate in same-gender group sessions within 15 days of the referral.
4) 75% of programs are available to participants who have limited daytime availability.
5) 100% of groups are conducted by qualified personnel (see qualification section).
6) 100% of the BIP referrals are offered a 26-week group curriculum for batterers.
7) 80% of referrals have a provider contact attempted within 72 hours of referral and outcome of contact is documented.
8) 100% of program participants sign an agreement/contract as outlined by ICADV Policies and Procedures for BIP providers.
9) 100% of BIP providers will require staff to warn and protect victims, partners, children and others when and if the batterer has made a threat of violence as evidenced by adherence to appropriate policies and procedures of the provider agency.

VI. Minimum Qualifications

A. Initial Qualifications

Please note that as of the time of RFP release, ICADV was in the process of reviewing and updating BIP qualification standards. In order to remain aligned with the ICADV standards, the DCS service standards and qualifications may be updated when the ICADV updated standards are finalized.

Individuals must meet one of the following ICADV criteria in order to be deemed a qualified service provider by DCS:

1) Co-Facilitator: To qualify to co-facilitate a class or group session with a qualified Supervisor/Trainer or Facilitator, an individual must show:
    a. Evidence of 60 hours of formal training approved by ICADV. A minimum of 40 hours of this training must be specific to domestic violence. The remaining 20 hours shall include evidence of training in each of the following areas of group facilitation skills, cultural diversity, substance abuse, and mental health.
    b. Evidence of observing a minimum of 26 different ICADV-approved sessions.

2) Facilitator: To qualify to facilitate an individual must show:
    a. Evidence of meeting all the requirements of a Co-facilitator.
    b. 100 hours of formal training approved by ICADV. A minimum of 60 hours of this training must be specific to domestic violence. The remaining 40 hours shall include evidence of training in each of the following areas of group facilitation skills, cultural diversity, substance abuse, and mental health.
    c. Evidence of co-facilitating a minimum of 26 additional sessions with a Supervisor/Trainer.

3) Supervisor: To qualify to supervise an individual must show:
    a. Evidence of meeting all the requirements of a Facilitator.
    b. 120 hours of formal training approved by ICADV. A minimum of 80 hours of this training must be specific to domestic violence. The remaining 40 hours shall include evidence of training in each of the following areas of group facilitation skills, cultural diversity, substance abuse, and mental health.
    c. Evidence of facilitating a minimum of 26 additional sessions as a Facilitator under a Supervisor/Trainer.

4) Trainer: To qualify to train staff or others related to work, an individual must show:
    a. Evidence of fulfilling the requirements of a Supervisor.
    b. Evidence of a minimum of 3 years experience as a supervisor (or the equivalent thereof).
    c. Evidence of successfully completing the "train the trainer" offered by ICADV

VII. Billable Units

Face to face time with the client

- Includes client specific face-to-face contact with the identified client/family during which the intake (including applicable screening), midpoint individual session, and discharge sessions are conducted.

Per Person Per Group
Services include group goal directed work with clients. To be billed per client per hour attended.

Per Person Per Group (licensed master's level staff)
Services include group goal directed work with clients. To be billed per client per hour attended. Group is facilitated by someone with a Master's degree in social work, psychology, marriage and family therapy, or related human service field with a clinical license issued by the Indiana Social Worker, Marriage and Family Therapist or Mental Health Counselor Board, as one of the following: 1) Clinical Social Worker 2) Marriage and Family Therapist 3) Mental Health Counselor.

Reminder: Not included are routine report writing and scheduling of appointments, collateral contacts, travel time and no shows. These activities are built into the cost of the group rate and shall not be billed separately.

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

Child and Family Team Meetings
Includes only Child and Family Team Meetings or case conferences initiated or approved by the DCS or Probation for the purposes of goal directed communication regarding the services to be provided to the client/family.

Interpretation, Translation and Sign Language Services
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. 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. 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). Sign Language should be done in the language familiar to the family.
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. 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. No side comments or conversations between the Interpreters and the clients should occur.
The location of and cost of Interpretation, Translation, and Sign Language Services are the responsibility of the Service Provider. 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. 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. Providers can use DCS contracted agencies and request that they be given the DCS contracted rate but this is not required. 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. 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.

Court
The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a written request (email or subpoena) from DCS

or subpoena to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. 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.

Reports
If the services provided are not funded by DCS, the "Reports" hourly rate will be paid. A referral for "Reports" must be issued by DCS in order to bill.

Therapeutic DV Batterer Intervention
Alternative approaches (e.g., therapeutic) with special approval from DCS.

VIII. Case Record Documentation

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

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period.

X. Adherence to the DCS Practice Model

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. 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. Trauma Informed Care

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/):
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. 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?" 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. 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

Trauma Specific Interventions: (modified from the SAMHSA definition)

- The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
- 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)
- 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. Cultural and Religious Competence.

Provider must respect the culture of the children and families with which it provides services. 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. 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. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth. The guidebook can be found at: http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf

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. 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.

XIII. Child Safety

Services must be provided in accordance with the Principles of Child Welfare Services. Please note: All services (even individual services) are provided through the lens of child safety. 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. 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. 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.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
DOMESTIC VIOLENCE SURVIVOR AND CHILD INTERVENTION SERVICES

I. Service Description

Definition of Domestic Violence (Indiana Coalition Against Domestic Violence [ICADV] Definition) – A pattern of assaultive or coercive behavior, including physical, sexual, or psychological attacks, as well as economic coercion, that adults or adolescents use against an intimate partner. Intimate partners include spouse, former spouse, those living or having lived as if a spouse, those having a child in common, those having a past or current sexual relationship, or a past or current dating relationship.

The targeted population for Domestic Violence services includes both survivors and children. Services may be provided comprehensively with service delivery including the survivor and child. The provider is responsible for the reporting and coordinating of services to all populations. Domestic Violence intervention services provided by DCS/Probation are not intended to exist in isolation, but as only one component of a coordinated community response to domestic violence. Services shall maintain cooperative working relationships with local programs (domestic violence, batterers' programs, survivor programs, shelters, law enforcement, advocates, legal services, etc.). Services shall be structured, goal-oriented, time-limited individual/group services and casework/victim advocacy services.

Services provided may include the following:

- Educational and skills-based support group for survivor and/or child
- Assistance with transportation
- Coordination of services
- Advocacy (which includes goal setting, case management, supportive services)
- Safety planning
- Crisis intervention
- Community referrals and follow up
- Family/Child assessment
- Child development education
- Domestic violence education
- Parenting education with or without children present
- Budgeting and money management
- Participation in Child and Family Team meetings
- Family reunification
- Individual and family services

- Cognitive behavioral strategies
- Family of origin/Intergenerational issues
- Family structure and organization (internal boundaries, relationships, roles, socio-cultural history)
- Substance abuse screening

II. Service Delivery

1) Child safety and ending violence takes precedence over saving relationships. The service focus shall be on child safety, survivor safety, and increasing the survivor and child's functioning, both emotionally and physically.
2) The provider must be available to respond for crisis intervention as needed.
3) Service will be provided within the context of the Department of Child Services' practice model with involvement in Child and Family Team meetings. The provider will develop a service plan based on the provider's assessment, and the agreements reached in the Child and Family Team meeting as convened by DCS/Probation. Service plans for survivors and children will be developed separately from service plans developed for batterers.
4) Services must be available to participants who have limited daytime availability. The provider must identify a plan to engage the participant in the process, and a plan to work with non-cooperative participants, including those who believe they have no problems to address.
5) Provider must respect confidentiality. Failure to maintain confidentiality may result in immediate termination of the agreement.
6) The provider shall establish a written policy requiring that all staff have a duty to warn and protect survivors, partners, children and others against whom the batterer has made a threat of violence.
7) Services include providing any subpoenaed/court ordered testimony and/or court appearances (to include hearings or appeals).
8) Supervision/consultation is to include not less than one (1) hour of face-to-face supervision/consultation per 20 hours of direct client services provided, nor occur less than every two (2) weeks.
9) Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral-valued culturally-competent manner.

A. Child Services

1) Provider assessment shall occur within 24 hours upon receipt of DCS/Probation referral. Children will receive an initial assessment of needs when DCS/Probation indicates imminent risk/immediate safety concerns. A full assessment(including written domestic

violence service plans) will be completed and sent to the referring worker within 10 days of face-to-face intake with the client/family.

2) Assessments shall include, but are not limited to: safety and risk factors for the child; child abuse/neglect; food/shelter/clothing; the parent/child relationships; screening for other co-occurring issues (substance abuse, mental health issues, behavioral issues, social impairment, educational impairment, etc.).
3) A child safety plan shall be developed. (Note: the child must be willing and able to use the plan, and have the ability to opt out of any step in the plan if needed.) Comprehensive safety plans that are age and developmentally appropriate will be developed. Plans at a minimum will include: input from the non-abusive parent and be age appropriate; input from the child when appropriate; identification of safe places to go inside/outside of the home during violence; identification of where to meet if exiting the home is necessary; identification of how and when to use the phone for help; and identification of how to stay safe during an argument/violence.
4) The provider shall develop a comprehensive domestic violence service plan based on the assessment. Plans, at a minimum, will identify the needs of the child, set goals for the child, and establish a timeline for the accomplishment of goals in plan.
5) Advocacy and support services shall be provided as needed and as consistent with the assessment. These services shall include, but are not limited to, crisis intervention, links to community resources, Court Appointed Special Advocate (CASA)/ Guardian Ad Litem (GAL), information, and referral.
6) Services should be provided in the method consistent with the assessment and comprehensive domestic violence service plan and may include: individual or group services, play services, group play services, family services, support groups, and casework/victim advocacy services.
7) Group services for children, if provided, are to occur in weekly sessions at least one (1) hour in length. The number of weekly sessions will be determined by the provider and DCS/Probation based on the child's individual needs. Class size shall contain a minimum of three (3) participants and is not to exceed twelve (12) participants.
8) Group curriculum will be age appropriate and shall include, but is not limited to: promoting safe discussion of experiences with violence; helping the child understand that violence is not their fault and/or the fault of the survivor; helping the child understand and cope with their emotional responses to domestic violence; helping children identify, label, and express their feelings; exploring the child's attitudes and beliefs about families and family violence; and teaching children how to effectively manage their own anger.

B. Survivor Services

1) Provider assessment shall occur within 24 hours upon receipt of DCS/Probation referral. Survivors will receive an initial assessment of needs when DCS/Probation indicates imminent risk/immediate safety concerns. A full assessment (including written domestic

violence service plans) will be completed and sent to the referring worker within 10 days of face-to-face intake with the client/family.

2) A comprehensive domestic violence safety plan will be developed based on the assessment. Survivor safety plans at a minimum will include: strategies to increase the safety of themselves and their children; a list of emergency contacts; access to critical legal, financial, and medical documents; medications; and relocation or shelter services.

3) Assessments shall include, but are not limited to, safety and risk factors for the survivor and his/her child(ren), emergency medical/dental care, legal assistance, food/shelter/clothing, parenting needs and the parent/child relationship, and screening for other co-occurring issues (substance abuse, mental health issues, etc.).

4) The provider shall develop a comprehensive domestic violence service plan based on the assessment. Plans, at a minimum, will identify the needs of the survivor, set goals for the survivor, establish a timeline for the accomplishment of goals in plan, and identify and promote the use of informal and community supports and community resources.

5) Advocacy and support services shall be provided as needed and as consistent with the assessment and comprehensive domestic violence service plan. These services shall include, but are not limited to, housing assistance, emergency medical/dental, legal advocacy, job training/employment, safety plan, transportation, links to educational resources and community resources, information, and referral.

6) Services should be provided in the method consistent with the assessment and comprehensive domestic violence service plan and may include individual, group and/or family services, case management, and advocacy services.

7) Group services, if provided, occur in weekly sessions at least one (1) hour in length. Number of weekly sessions will be determined by the provider and DCS based on the survivor's individual needs. Class size shall be a minimum of three (3) and is not to exceed 20 participants.

8) Group curriculum shall include, but is not limited to, helping the survivors understand their attitudes and beliefs about families and family violence; helping the survivors understand that violence is not their fault and they have no control over the violence; helping the survivors understand the dynamics of domestic violence and aspects of power and control; helping the survivors understand the impact of family violence on their children's development; enhancing survivors' parenting skills and appropriate discipline methods; and enhancing the survivors' skills in interacting with the batterer on issues dealing with the best interest of the child, in circumstances where face-to-face contact is

necessary when safety and/or orders of protection are not prohibitive(visitations, school/athletic events etc.).

9) If clinical services are identified as a need, and the agency does not provide that service, the agency shall notify the FCM, who may refer for additional services. If the agency has a clinician on staff, the clinician must adhere to qualifications below.

III. When DCS is not paying for services:

A billable unit of "Reports" has been developed for providers who service DCS families without DCS payment for these services (Medicaid, insurances, self-pay) but DCS wants a report from the provider on the progress of the family. The referral process has been set up to authorize reports and court components on the DCS referral form in these incidences. **DCS will only pay for reports when DCS is not paying for these services.** If the services provided are not funded by DCS, the report rate per hour will be paid for the necessary reports on a referral form issued by DCS. Court testimony will be paid per appearance if requested on a referral form issued by DCS. In order to be paid for a court appearance a subpoena or written request from DCS should be on file.

IV. . Target Population

Services must be restricted to cases where domestic violence has been documented within the following eligibility categories:

1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
2) Children and their families which have an Informal Adjustment (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.

V. Goals and Outcomes

Goal #1: To Improve Safety of Survivors

Outcome Measures:

1) 100 % of survivors know how to plan for their continued safety.
2) 90 % of survivors report having an increased understanding of their legal rights.
3) 90 % of survivors report they know how to access resources that meet their needs.

Goal #2: To Enhance Skills of Children Who are Exposed to Domestic Violence

Outcome Measures:

1) 100% of children report they know that the violence is not their fault.
2) 90% of children will have identified effective coping mechanisms to deal with emotional responses to domestic violence.
3) 90% of children will have identified strategies to effectively manage their own anger.

Goal #3: Improved functioning including development of positive means of managing crisis

Objectives:

1) 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.

Client Outcome Measures:

1) 100 % of survivors report an increased knowledge and understanding of the effects of domestic violence on their children.
2) 90% of survivors report an increased understanding of parenting skills and appropriate discipline.
3) 90% of survivors report an increased knowledge on how to interact with the batterer on issues dealing with the best interest of the child.
4) 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
5) 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. (To be measured/evaluated by DCS/Probation staff)
6) 90% of the individuals/families that were intact prior to the initiation of service will remain intact throughout the service provision period.
7) If DCS elects to implement a standardized tool for evaluating family functioning, a related outcome measure will be added.

Goal #4: DCS/Probation and clients will report satisfaction with services

Outcome Measures:

1) 90 % of the families who have participated in Domestic Violence Services will rate the services "satisfactory" or above on a satisfaction survey developed by the service provider, unless DCS/Probation distributes one to providers for their use with clients. Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.

2) DCS/Probation satisfaction will be rated 4 or above on the Service Satisfaction Report.

Program Fidelity Measures

Program fidelity and abiding by best practice standards are a good predictor of successful outcomes and provides an effective indirect measure. An audit undertaken by a DCS employee or DCS designee may be conducted to assure program accountability and quality. Programs must clearly link daily practices to the following program fidelity issues:

1) 90% of families receive their first contact (telephone, mail or face-to-face) no later than the end of the first day following receipt of a referral from DCS/Probation.
2) 100% of referrals that are not seen within 24 hours of referral will be reported to the referral source.
3) 90% of required written domestic violence service plans/assessments will be completed and sent to the referring worker within 10 days of face-to-face intake with the client/family.
4) 90% of the community supportive services (BIP providers, law enforcement, courts, advocates, legal agencies, etc.) have a cooperative working relationship with the provider.
5) 100% of provider staff focus on child/victim safety as evidenced by adherence to appropriate provider policies and procedures.
6) 100% of program activities are carried out by qualified staff (see Qualifications).
7) 90% of programs are available to participants who have limited daytime availability.
8) 100% of provider staff are required to warn and protect children and victims and others when and if the batterer has made a threat of violence.
9) 100% of clients (children and victims) will have a comprehensive domestic violence service plan developed.
10) 100% of children referred and engaged in the program will have a developmentally-appropriate safety plan developed by provider staff.
11) 100% of clients will be able to access a provider staff in the event of an emergency, 7 days a week, 24 hours a day.

VI. Minimum Qualifications

Direct Worker:
Services may be provided as needed by personnel with a Associates degree in social work, psychology, sociology, or a directly related human services field and/or 2 years working with families in a social service setting. Worker should have knowledge of current Indiana state law and best practices regarding domestic violence.

Supervisor of Direct Worker:

Bachelor's degree in social work, psychology, marriage and family, or a related human services field. Minimum 4 years professional field experience in a social service setting. Or Master's degree in social work, psychology, marriage and family, or a related human services field. Minimum 2 years professional field experience in family violence services. Supervisor should have knowledge of current Indiana state law and best practices regarding domestic violence.

Counselor

Counselors under this standard must meet one of the following minimum qualifications:

1) Master's or Doctorate degree with a current license issued by the Indiana Behavioral Health and Human Services Licensing Board as one of the following: 1) Social Worker, 2) Clinical Social Worker, 3) Marriage and Family Therapist, 4) Mental Health Counselor 5) Marriage and Family Therapist Associate and 6) Mental Health Counselor Associate.

2) Master's degree with a temporary permit issued by the Indiana Behavioral Health and Human Services Licensing Board as one of the following: 1) Social Worker, 2) Clinical Social Worker, within 90 days of providing services under this contract (Please note: In order to obtain a temporary license, the individual must register for the exam) and,
    a. 2 years related clinical experience, or
    b. completion of the DCS approved training program

   Note: In order to obtain a temporary license, the individual must first register for the licensure exam and may have additional requirements for temporary licensure. Please contact the Indiana Professional Licensing Board for additional instructions for obtaining a temporary license.

3) Master's degree and a submitted application for 1) Marriage and Family Therapist Associate, or 2) Mental Health Counselor Associate within 90 days of providing services under this contract. The individual must obtain licensure as a Marriage and Family Therapist Associate or Mental Health Counselor Associate within 12 months of providing services under this contract. The individual must also have:
    a. 2 years related clinical experience, or
    b. completion of the DCS approved training program

4) Master's degree in a related human service field plus 2 years related clinical experience and working under a DCS Community Based Contract on July 1, 2015.

Note: Individuals who hold a Master's degree that is applicable toward licensure, must become licensed as indicated in #2 & 3 above. Providers should not employ any new staff who are not license eligible.

Supervisor of Counselor:

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 as one of the following: 1) Clinical Social Worker 2) Marriage and Family Therapist 3) Mental Health Counselor.

Supervision/consultation is to include not less than one (1) hour of face-to-face supervision/consultation per 20 hours of direct client services provided, nor occur less than every two (2) weeks.

Providers are to respond to the on-going individual needs of staff by providing them with the appropriate combination of training and supervision. The frequency and intensity of training and supervision are to be consistent with "best practices" and comply with the requirements of each provider's accreditation body. Supervision should include individual, group, and direct observation modalities and can utilize teleconference technologies. Under no circumstances is supervision/consultation to be less than one (1) hour of supervision/consultation per 25 hours of face-to-face direct client services provided, nor occur less than every two (2) weeks.

In addition to the above:

- Knowledge of child abuse and neglect, and child and adult development,
- Knowledge of community resources and ability to work as a team member;
- Beliefs in helping clients change their circumstances, not just adapt to them,
- Belief in adoption as a viable means to build families.
- Understanding regarding issues that are specific and unique to adoptions, such as loss, mismatched expectations and flexibility, entitlement, gratification delaying, flexible parental roles, and humor.

Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral-valued culturally-competent manner.

VII. Billable Units

If agency administers clinical services, there may be two face to face units: Direct Worker and Counseling.

Face to face time with the client:

(Note: Members of the client family are to be defined in consultation with the family and approved by the DCS. This may include persons not legally defined as part of the family)

- Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
- Includes Child and Family Team Meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family.
- Includes crisis intervention and other goal-directed interventions via telephone with the identified client family.

Reminder: Not included are routine report writing and scheduling of appointments, collateral contacts, travel time and no shows. These activities are built into the cost of the face- to-face rate and shall not be billed separately.

Group

Services include group goal directed work with clients. To be billed per group hour.
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
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Interpretation, Translation and Sign Language Services
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. 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. 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). Sign Language should be done in the language familiar to the family.
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. 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. No side comments or conversations between the Interpreters and the clients should occur.
The location of and cost of Interpretation, Translation, and Sign Language Services are the responsibility of the Service Provider. 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. 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. Providers can use DCS contracted agencies and request that they be given the DCS contracted rate but this is not required. 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. 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.

Court
The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a written request (email or subpoena) from DCS or subpoena to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. 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.

Reports
If the services provided are not funded by DCS, the "Reports" hourly rate will be paid. A referral for "Reports" must be issued by DCS in order to bill.

VIII. Case Record Documentation

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

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period.

X. Adherence to the DCS Practice Model

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. 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. Trauma Informed Care

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/):
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. 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?" 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. 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

Trauma Specific Interventions: (modified from the SAMHSA definition)

- The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
- 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)
- 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. Cultural and Religious Competence.

Provider must respect the culture of the children and families with which it provides services. 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. 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. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth. The guidebook can be found at:

http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf

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. 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.

XIII. **Child Safety**

Services must be provided in accordance with the Principles of Child Welfare Services. Please note: All services (even individual services) are provided through the lens of child safety. 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. 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. 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.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
FATHER ENGAGEMENT PROGRAMS

I. Service Description

The Indiana Department of Child Services (DCS) intends to contract with providers throughout the state to implement fatherhood programming to provide assistance and support to fathers whose children are involved with the Department of Child Services. Providers will work actively with DCS employees to successfully engage fathers in services that will improve safety, stability, well-being and permanency for their children. Providers will assist fathers in strengthening the relationship with their children and promoting positive relationships between the families and the local DCS family case managers and others involved in their children's case.

II. Service Delivery

- The direct worker shall make efforts to make periodic visits to DCS offices to network with FCM's and attend CFTM's when requested. The provider will secure and maintain a working relationship with the Family Case Managers and other relevant DCS staff to provide a liaison between the fathers and DCS. When Family Case Managers have exhausted all known diligent search efforts and inquiries, providers will assist in locating and engaging fathers (including those who may be incarcerated or who live out of state).

- The provider will actively engage referred fathers with the goal of increasing their involvement in the DCS case.

- The provider will conduct intake interviews, and collect demographic and other outcome data for reporting purposes. Services must include ongoing monitoring of father/parental progress.

- The provider will work collaboratively with DCS, other contracted service providers, community organizations, and individuals to develop, maintain, and provide appropriate programming for fathers whose children are involved in the child welfare system.

- The provider will possess a clear understanding of male learning styles and male help seeking behaviors and will practice effective techniques for father engagement through a non-judgmental, holistic viewpoint regarding father/child relationship, focusing on the child in the context of the family.

- Refers participants, when indicated, to community resources and other organizations.

- Promotes community awareness regarding the value of engaging fathers of children involved in the child welfare process, through presentation and written materials.

- Develop a working relationship with local child support enforcement offices and staff members in order to be of mutual assistance in helping obtain appropriate financial support of children.

- Services will be provided at times convenient for or necessary to meet the family's need, not according to a specified work week schedule.

- Services will be provided in home, in the community environment, in the DCS office, and/or the providers' office.

- Services will be based on the family's established DCS Case Plan/Disposition or Informal Adjustment, while taking into consideration the recommendation of the Child and Family Team as applicable.

- Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life style choices, and complex family interactions and be delivered in a neutral, valued, culturally competent manner.

- The provider will coordinate and provide Fatherhood Programming utilizing a DCS approved educational curricula such as *Bringing Back The Dads*, *National Partnership for Community Leadership*, *Bridges Out of Poverty* (any other curricula must have prior approval). The Programming can be provided through the use of group or one-on-one sessions. All curricula must include child support enforcement education and financial responsibility education. In addition, the Fatherhood Programming and other individual work with the father, may provide any combination of the following kinds of services:
    - ➢ information regarding the CHINS legal process including court procedures, parental participation requirements, court ordered services, visitation with the children, reimbursement of cost for services, and other aspects related to the legal process;
    - ➢ the expectations of the family related to participation in court ordered services and visitation with the children, attendance at court, appropriate dress for court, and other aspects related to the legal process;
    - ➢ information regarding the parent's rights and the CHINS proceedings, the length of time children may be in care prior to a permanency procedure, and termination of parental rights, family team meetings and their procedures
    - ➢ role of the Court Appointed Special Advocate or Guardian ad Litem,

- ➢ an informal environment for fathers to discuss issues that brought them to the attention of the DCS and develop suggestions that may assist in resolving these issues as a group, and;
- ➢ educational programs using speakers recruited from the local professional community to assist and educate the fathers in areas such as:
- ➢ abuse and neglect,
- ➢ increasing parenting skills,
- ➢ substance abuse,
- ➢ anger management,
- ➢ advocacy with public agencies including the children's schools, and;
- ➢ issues of interest to the parents related to their needs and the needs of their children.
- ➢ coaching and information to develop attitudes and social skills needed for improved family relations and personal responsibility.
- ➢ After consultation with the Family Case Manager, providers will make concerted, organized and systematic efforts to connect children with their incarcerated father (if applicable), through video conferencing, face to face contact, correspondence and by telephone, unless the court has determined that visiting would put the child in danger.
- ➢ Supports fathers and paternal relatives in court and Child and Family Team Meetings by providing transportation and/or transportation voucher when appropriate.

III. When DCS is not paying for services:

A billable unit of "Reports" has been developed for providers who service DCS families without DCS payment for these services (Medicaid, insurances, self-pay) but DCS wants a report from the provider on the progress of the family. The referral process has been set up to authorize reports and court components on the DCS referral form in these incidences. **DCS will only pay for reports when DCS is not paying for these services.** If the services provided are not funded by DCS, the report rate per hour will be paid for the necessary reports on a referral form issued by DCS. Court testimony will be paid per appearance if requested on a referral form issued by DCS. In order to be paid for a court appearance a subpoena or written request from DCS should be on file.

IV. Target Population

Services must be restricted to the following eligibility categories:

- Fathers of children who have substantiated cases of abuse and/or neglect and will likely develop into an open case an IA or CHINS status.
- Fathers of children which have an Informal Adjustment (IA) or the children have the status of CHINS.

V. Goals and Outcome Measures

Goal #1
Timely initiation of services with the fathers.
Outcome Measures

1) 95% of all non-incarcerated fathers referred with a valid contact and/or address will receive a telephone call or a drop by contact attempt within 5 working days of referral.
2) 75% of all fathers referred will have face to face contact within 10 working days of the referral.

Goal#2
Timely receipt of electronic outcome reports.
Outcome Measures
100% of reports will be received timely.

- The monthly report will include a summary of services to each father as well as the father's involvement with the child (ren) and father's parental progression as evidence by visitation supervised and unsupervised with child (ren), participation in Child and Family Team Meetings, fathers involvement in the DCS case plan, established paternity and if the father is paying child support. The summary will also include engagement in fatherhood curriculum and/or successfully/unsuccessful completion of referral sources will be provided to the referring FCM monthly.
- An approved data sharing process, documenting services for each referred father, will be electronically forwarded to Central Office designated email address: researchevaluation@dcs.in.gov

Goal #3
Engage fathers in services that will reduce barriers to safety, stability, well-being and permanency for their children.
Outcomes Measures

1) 60% of all fathers referred will become actively engaged in the DCS open case as evidenced by visitation with their children, participation in CFTM, and the DCS Case Plan.
2) 100% of referred fathers, who received a face to face contact, will have a paternal genogram created and sent to FCM within 30 days of first face to face contact. Genogram's will be created using guidance found at http://www.in.gov/dcs/files/Family_Network_Diagram.pdf

Goal #4

Coordinate efforts between the department of corrections and/or local detention facilities, child welfare agencies, and the courts to ensure the incarcerated father is notified of court proceedings regarding the care and custody of their child (ren) when appropriate.
Outcome Measures

1) 60% of incarcerated fathers will become actively engaged in the DCS open case as evidenced by contact with their children via email, visitation, phone, or video communication.

Goal# 5
DCS/Probation and clients will report satisfaction with services.

Outcome Measures:
1) DCS/ Probation satisfaction will be rated 4 and above on the Service Satisfaction Report.
2) 90% of clients will rate the services "satisfactory" or above on a satisfaction survey developed by the service provider, unless one is distributed by DCS/Probation to providers for their use with clients.

VI. Minimum Qualifications

Direct Worker:
Bachelor's degree in social work, psychology, sociology, or a directly-related human service field from an accredited college. Other Bachelor's degrees will be accepted in combination with a minimum of five years experience working directly with families in the child welfare system. Must possess a valid driver's license and the ability to use private car to transport self and others, and must comply with the contract requirements concerning minimum car insurance coverage.
In addition to the above:

- Knowledge of child abuse and neglect, and child and adult development
- Knowledge of community resources and ability to work as a team member
- Belief in helping clients change their circumstances, not just adapt to them
- Belief in adoption as a viable means to build families
- Understanding regarding issues that are specific and unique to adoptions such as loss, mismatched expectations and flexibility, loss of familiar surroundings, customs and traditions of the child's culture, entitlement, gratification delaying, flexible parental roles and humor

Supervisor:
Master's or Doctorate degree in social work, psychology, or directly-related human services field from an accredited college.

Services provided will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral-valued culturally-competent manner.

Providers are to respond to the on-going individual needs of staff by providing them with the appropriate combination of training and supervision. The frequency and intensity of training and supervision are to be consistent with "best practices" and comply with the requirements of each provider's accreditation body. Supervision should include individual, group, and direct observation modalities and can utilize teleconference technologies. Under no circumstances is supervision/consultation to be less than one (1) hour of supervision/consultation per 25 hours of face-to-face direct client services provided, nor occur less than every two (2) weeks.

VII. Billing Units

- **Face to face time with the client:**

(Note: Members of the client family are to be defined in consultation with the family and approved by the DCS. This may include persons not legally defined as part of the family)

  - Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
  - Includes Child and Family Team Meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family.
  - Includes no more than 5 hours of time spent locating fathers including making telephone calls, attempted face-to-face contacts, collateral contacts, or completing online searches.
  - Billing for additional collateral contacts can be approved by DCS when attempting to locate and/or engage an incarcerated client or client living out of state.

- **Group**

  A minimum of 3 father's must be in attendance in order to bill for group. Services include group goal directed work with clients. To be billed per group hour.

Reminder: Not included are routine report writing and scheduling of appointments, collateral contacts, travel time and no shows. These activities are built into the cost of the face- to-face rate and shall not be billed separately.

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

- **Interpretation, Translation and Sign Language Services**

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

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

The location of and cost of Interpretation, Translation, and Sign Language Services are the responsibility of the Service Provider. 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. 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. Providers can use DCS contracted agencies and request that they be given the DCS contracted rate but this is not required. 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. 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.

- **Court**

  The provider of this service may be requested to testify in court. 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. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day per client. 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.

- **Reports**

  If the services provided are not funded by DCS, the "Reports" hourly rate will be paid. A referral for "Reports" must be issued by DCS in order to bill.

- **JPAY**
  To enhance communication with DOC incarcerated fathers. Services include: email communication, inbound video grams, and video visits. Agencies will partner with JPAY and will be reimbursed actual cost.

  JPAY will be approved during a CFTM, and CFTM minutes must authorize the request, along with the appropriate level of communication.

VIII. Case Record Documentation

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.
10) Child and Family Team Meeting Minutes authorizing usage of JPAY.
11) Paternal Genogram and documentation of when it was sent to referral source.

IX. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS staff. In the event a service provider receives verbal or email authorization to provide services from DCS an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS. Providers must initiate a re-authorization for services to continue beyond the approved period.

X. Adherence to the DCS Practice Model

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. 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.

IX. Trauma Informed Care

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/):
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. 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?" 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. 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

Trauma Specific Interventions: (modified from the SAMHSA definition)

- The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
- 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)
- 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.

X. Cultural and Religious Competence.

Provider must respect the culture of the children and families with which it provides services. 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. 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. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth. The guidebook can be found at: http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf

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. 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.

XI. Child Safety

Services must be provided in accordance with the Principles of Child Welfare Services. Please note: All services (even individual services) are provided through the lens of child safety. 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. 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. 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.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
FUNCTIONAL FAMILY THERAPY

I. Services Description

Functional Family Therapy (FFT) is an empirically-grounded, family-based intervention program for acting-out youth between 11-18, whose problems range from conduct disorder to alcohol/ substance abuse, and their families. A major goal of Functional Family Therapy is to improve family communication and supportiveness while decreasing the intense negativity. Other goals include helping family members adopt positive solutions to family problems, and developing positive behavior change and parenting strategies. Further information on FFT can be found at http://www.fftinc.com , http://www.ncjrs.org/pdffiles1/ojjdp/184743.pdf or http://www.functionalfamilytherapy.com/

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

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. Service providers must adhere to the principles of the FFT model. 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. Sessions are spread over a 3-month period or longer if needed by the family. 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. FFT emphasizes the importance of respecting all family members on their own terms as they experience the intervention process. 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.

Empirically grounded and well-documented, FFT has three 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:

- **Phase 1: Engagement and Motivation**
  During these initial phases, FFT applies reframing and related techniques to impact maladaptive perceptions, beliefs, and emotions and to emphasize within the youth and family, factors that protect youth and families from early program dropout. 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.

- **Phase 2: Behavior Change**
  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.

- **Phase 3: Generalization**
  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 of changes. 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.

Each of these phases involves both assessment and intervention components. Family assessment focuses on characteristics of the individual family members, family relational dynamics, and the multi-systemic context in which the family operates. The family relational system is described in regard to interpersonal functions and their impact on promoting and maintaining problem behavior. Intervention is directed at accomplishing the goals of the relevant treatment phase. For example, in the engagement and motivation phase, assessment is focused on determining the degree to which the family or its members are negative and blaming. The corresponding intervention would target the reduction of negativity and blaming. In behavior change, assessment would focus on targeting the skills necessary for more adaptive family functioning. Intervention would be aimed at helping the family develop those skills in a way that matched their relational patterns. In generalization, the assessment focuses on the degree to which the family can apply the new behavior in broader contexts. Interventions would focus on helping generalize the family behavior change into such contexts.

Program certification must be obtained and maintained through utilizing Functional Family Therapy certified trainers to train a site supervisor and therapists. Program fidelity must be maintained through adherence to using a sophisticated client assessment, tracking and monitoring system and clinical supervision requirements.

III. Target Population

Services must be restricted to the following eligibility categories:

1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
2) Children and their families which have an Informal Adjustment (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 Outcome Measures

Goals #1 Services are provided timely as indicated in the service description above.

Outcome Measures:

1) 100% of referred children and families are engaged in services within 14 days of referral.
2) 100% of children and families being served have an assessment completed at the beginning of each phase.
3) 100% of children and families being served have a clear plan developed immediately following the assessment.
4) Progress reports are provided to the current worker. Monthly.

Goal #2 Improved family functioning as indicated by no further incidence of the presenting problem

Objective:

1) 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.

Outcome Measures:

1) 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.
2) 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.
3) 90% of children and families that were intact prior to the initiation of service will remain intact throughout the service provision period.
4) Scores will be improved on the Risk Assessment instruments in ICWIS used by the referring DCS or Youth Level of Service Inventory (YSLI) used by referring Juvenile Probation Officer.

Goal #3 DCS/Probation and clients will report satisfaction with services provided.

Outcome Measures:

1) Probation/DCS satisfaction will be rated 4 and above on the Service Satisfaction Report.

2) 90% of clients will rate services "satisfactory" or above on satisfaction survey developed by the service provider, unless DCS/Probation distributes one to providers for their use with clients. Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.

V. Minimum Qualifications

Direct Worker:

Direct workers under this standard must meet one of the following minimum qualifications:

1) Master's or Doctorate degree with a current license issued by the Indiana Behavioral Health and Human Services Licensing Board as one of the following: 1) Social Worker, 2) Clinical Social Worker, 3) Marriage and Family Therapist, 4) Mental Health Counselor 5) Marriage and Family Therapist Associate and 6) Mental Health Counselor Associate.

2) Master's degree with a temporary permit issued by the Indiana Behavioral Health and Human Services Licensing Board as one of the following: 1) Social Worker, 2) Clinical Social Worker, within 90 days of providing services under this contract (Please note: In order to obtain a temporary license, the individual must register for the exam) and,

   a. 2 years related clinical experience, or

   b. completion of the DCS approved training program

   Note: In order to obtain a temporary license, the individual must first register for the licensure exam and may have additional requirements for temporary licensure. Please contact the Indiana Professional Licensing Board for additional instructions for obtaining a temporary license.

3) Master's degree and a submitted application for 1) Marriage and Family Therapist Associate, or 2) Mental Health Counselor Associate within 90 days of providing services under this contract. The individual must obtain licensure as a Marriage and Family Therapist Associate or Mental Health Counselor Associate within 12 months of providing services under this contract. The individual must also have:

a. 2 years related clinical experience, or
b. completion of the DCS approved training program

4) Master's degree in a related human service field plus 2 years related clinical experience and working under a DCS Community Based Contract on July 1, 2015.

Note: Individuals who hold a Master's degree that is applicable toward licensure, must become licensed as indicated in #2 & 3 above. Providers should not employ any new staff who are not license eligible.

Supervisor:

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 as one of the following: 1) Clinical Social Worker 2) Marriage and Family Therapist 3) Mental Health Counselor.

Both Direct Worker and Supervisor must complete FFT certified training

(See the links listed in the FFT Service Description.)

Supervision/consultation is to include not less than one (1) hour of face to face supervision/consultation per 20 hours of direct client services provided, nor occur less than every two (2) weeks.

Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral valued culturally competent manner.

VI. Billable Unit

Face to face time with the client:

(Note: Members of the client family are to be defined in consultation with the family and approved by the DCS. This may include persons not legally defined as part of the family)

• Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.

• Includes Child and Family Team Meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family.

• Includes crisis intervention and other goal-directed interventions via telephone with the identified client family.

Reminder: Not included are routine report writing and scheduling of appointments, collateral contacts, travel time and no shows. These activities are built into the cost of the face- to-face rate and shall not be billed separately.

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

Interpretation, Translation and Sign Language Services

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

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

The location of and cost of Interpretation, Translation, and Sign Language Services are the responsibility of the Service Provider. 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. 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. Providers can use DCS contracted agencies and request that they be given the DCS contracted rate but this is not required. 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. 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.

Court

The provider of this service may be requested to testify in court. 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. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. 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.

VII. Case Record Documentation

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.

VIII. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

IX. Adherence to the DCS Practice Model

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. 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. Trauma Informed Care

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/):
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. 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?" 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. 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

Trauma Specific Interventions: (modified from the SAMHSA definition)

- The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
- 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)
- 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.

XI. Cultural and Religious Competence.

Provider must respect the culture of the children and families with which it provides services. 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. 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. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth. The guidebook can be found at: http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf

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. 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.

XII. Child Safety

Services must be provided in accordance with the Principles of Child Welfare Services. Please note: All services (even individual services) are provided through the lens of child safety. 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. 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. 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.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
PARENT EDUCATION

I. Service Description

Parenting education is the provision of structured, parenting skill development experiences. Education regarding parenting, discipline and child development is a means to provide parents whose children are "at risk" or have been abused or neglected with tools to assist them in the lifelong task of disciplining, understanding, and loving their children. Family-centered parent training programs include family skills training and family activities to help children and parents take advantage of concrete social supports. A combination of individual and group parent training is the most effective approach when building skills that emphasize social connections and parents' ability to access social supports. However, the individual approach is most effective when serving families in need of specific or tailored services.

The following evidence-based programs are approved for use:

- Parent-Child Interaction Therapy (PCIT)
- STAR Parenting Program
- Systematic Training for Effective Parenting (STEP)
- Strengthening Families Program (SFP)
- Incredible Years; Parent-Child Interaction Therapy (PCIT)
- Parent Management Training-Oregon Model (PMTO)
- Positive Parenting Practices (Triple P)
- Parents as Teachers-Born to Learn
- Safe-Care
- Nurturing Program
- Active Parenting
- Effective Black Parenting by the Center for the Improvement of Child Caring
- 1-2-3 Magic
- Parenting with Love and Limits

Other Parent Education programs may be used but they require **written approval from the DCS Central Office.** Additional evidence-based programs are outlined at: The California Evidence-Based Clearinghouse at www.cebc4cw.org or the National Registry for Evidence Based Programs-SAMHSA (Substance Abuse and Mental Health Services Administration) at www.nrepp.samhsa.gov or the Office of Juvenile Justice and Delinquency Prevention at http://ojjdp.ncjrs.gov

The Child Welfare Information Gateway (www.childwelfare.gov/pubs/issue_briefs/parented) outlines key program characteristics and parent training strategies. Providers should review this issue brief incorporate these characteristics and strategies where possible. The key program characteristics include:

- strength-based focus
- family centered practice
- individual and group approaches
- qualified staff
- targeted service groups
- clear program goals and continuous evaluation

Parent Training Strategies include:

- Encourage Peer Support
- Involve Fathers
- Promote Positive Family Interaction
- Use Interactive Training Techniques
- Provide Opportunities to Practice New Skills

In-home assessments

When the model does not have prescribed in-home assessment procedures, the following shall be considered as a minimum standard:

An in-home assessment should be completed with the parent(s) and children before participation in the program, during program participation, as well as at program completion. These assessments should identify but are not limited to the following areas that impact the relationship of the parent/child:

- Appropriate developmental expectations-parent/child
- Empathy towards children's needs
- Use of corporal punishment
- Use of role reversal-child/parent
- Lack of family cohesion
- Lack of family expressiveness
- Lack of family independence

Postprogram assessments should indicate that parents significantly changed their parenting behavior and child-rearing attitudes following program completion. These changes should

include having more appropriate developmental expectations, increased empathy toward children's needs, decreased use of corporal punishment, and decreased use of role reversal.

An examination of family interaction patterns should identify several significant improvements at postprogram assessment, including family cohesion, family expressiveness, and family independence, whereas family conflict significantly decreased.

II. When DCS is not paying for services:

A billable unit of "Reports" has been developed for providers who service DCS families without DCS payment for these services (Medicaid, insurances, self-pay) but DCS wants a report from the provider on the progress of the family. The referral process has been set up to authorize reports and court components on the DCS referral form in these incidences. **DCS will only pay for reports when DCS is not paying for these services.** If the services provided are not funded by DCS, the report rate per hour will be paid for the necessary reports on a referral form issued by DCS. Court testimony will be paid per appearance if requested on a referral form issued by DCS. In order to be paid for a court appearance a subpoena or written request from DCS should be on file.

III. Target Population

Services must be restricted to the following eligibility categories:

- Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
- Children and their families which have an Informal Adjustment (IA) or the children have the status of CHINS or JD/JS.
- Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed
- All adopted children and adoptive families.

IV. Goals and Outcome Measures

Goal #1 Maintain timely intervention with the family and regular timely communication with DCS/Probation

Objectives:

1) Direct worker or backup is available for consultation to the family 24/7 by phone or in person.

Goal #2 Strengthen and increase the parent's ability to provide for the emotional, physical, and safety needs of their children.

Outcome Measures

1) 75% of the parents referred to program will complete the services.
2) 90% of the parents completing the program will show a demonstrated increase in skills during the in home postprogram assessment.
3) 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.
4) 90% of the individuals/families will not be the subjects of a new investigation resulting in the assignment of a status of "substantiated" abuse of neglect throughout the service provision period.
5) 90% of the individuals/families that were intact prior to the initiation of service will remain intact throughout the service provision period.

Goal #3

DCS/Probation and clients will report satisfaction with services provided.

Outcome Measures:

1) DCS or Probation satisfaction will be rated 4 and above on the Service Satisfaction Report.
2) 90% of the families who have completed Parent Education services will rate the services "satisfactory" or above on a satisfaction survey developed by the service provider, unless DCS/Probation distributes one to providers for their use with clients. Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.

V. Minimum Qualifications

Providers must meet the minimum qualifications guidelines of the chosen model. When qualifications are not prescribed in the model, the following shall be considered minimum qualifications:

Direct worker:

A high School diploma or GED and is at least 21 years of age. Must possess a valid driver's license and the ability to use private car to transport self and others, and must comply with state policy concerning minimum car insurance coverage.

Supervisor:

Bachelor's Degree in social work, psychology, sociology, or a directly related human service field.

Direct worker and Supervisor must have direct training in the Parent Education curriculum they are teaching.

In addition to:

- Knowledge of child abuse and neglect
- Knowledge of child and adult development and family dynamics
- Ability to work as a team member
- Strong belief that people can change their behavior given the proper environment and opportunity
- Belief in helping families to change their circumstances, not just adapt to them.

Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral valued culturally competent manner.

VI. Billable Units

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

- Includes client-specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
- Includes scheduled Child and Family Team meetings or case conferences (including crisis case conferences via telephone) initiated or approved by the DCS/Probation for the purposes of goal-directed communication regarding the services to be provided to the client/family.
- All case conferences billed, including those via telephone, must be documented in the case notes. **Reminder:** Not included is routine report writing and scheduling of appointments, collateral contacts, travel time and no shows. These activities are built into the cost of the face to face rate and shall not be billed separately.

Group

Group will be defined as at least 3 clients (who are DCS or Probation referrals and are from no less than two different referred families. If there are less than 3 clients from at least two DCS/Probation referrals, the payment would be the face to face rate for each referral.

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

Interpretation, Translation and Sign Language Services

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

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

The location of and cost of Interpretation, Translation, and Sign Language Services are the responsibility of the Service Provider. 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. 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. Providers can use DCS contracted agencies and request that they be given the DCS contracted rate but this is not required. 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. 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.

Court

The provider of this service may be requested to testify in court. 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. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. 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.

Reports

If the services provided are not funded by DCS, the "Reports" hourly rate will be paid. A referral for "Reports" must be issued by DCS in order to bill.

VII. Case Record documentation

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.
10) Documentation of regular contact with the referred families/children.
11) Signed attendance sheet for each group session.

VIII. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorization required by the Medicaid program.

IX. Adherence to the DCS Practice Model

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. 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. Trauma Informed Care

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/):
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. 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?" 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. 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

Trauma Specific Interventions: (modified from the SAMHSA definition)

- The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
- 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)
- 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.

XI. Cultural and Religious Competence.

Provider must respect the culture of the children and families with which it provides services. 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. 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. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth. The guidebook can be found at: http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf

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. 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.

XII. Child Safety

Services must be provided in accordance with the Principles of Child Welfare Services. Please note: All services (even individual services) are provided through the lens of child safety. 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. 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. 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.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
PARENTING / FAMILY FUNCTIONING ASSESSMENT

I. **Service Description**

Parenting/family functioning assessment is an in home evaluation which includes standardized test instrument(s) to identify the strengths and needs of the family. The service is most appropriately used when the needs of the family are so complex that a traditional assessment completed by a Family Case Manager is not able to determine the services necessary to improve the family's functioning. These families tend to have multiple caregiver ratings on the CANS of 2 or higher which indicates complex needs.

II. Service Delivery

Testing and Interviews Required

- Parenting/family functioning assessment must include an interview with the adults and children being assessed in their current home environment;
- Completion by adults of standardized test(s) to include a parenting inventory (such as Parent-Child Relationship Inventory; Adult Adolescent Parenting Inventory-2; Family Assessment Device, Version 3; Family Assessment Measure Version III (FAM-III); and/or the Child Abuse Potential Inventory and /or another Standard Risk Assessment Instrument;
- Observation of the parent(s) relationship with the child(ren); tour of the proposed home environment noting any needs or challenges.
- Review of other information sources to verify family's reported history (e.g., previous DCS history, collateral contacts).

Parenting and family functioning assessments shall include at least two separate appointments held on different days, when possible, to be scheduled at the convenience of the client (to include evenings and weekends).

Written Report

All written reports must include the recommendations regarding services/treatment at the beginning of the report followed by information relating to specific categories. The written assessment must be prepared to include the following:

1) identifying information,
2) history of significant events, medical history, history of the children (including educational history),
3) family socio-economic situation, including income information of the parents and child(ren)
4) family composition, structure, and relationships
5) family strengths and skills
6) family motivation for change
7) description of home environment,
8) summary of any testing completed,
9) summary of collateral contacts,
10) assessment of relationship between parent(s),and child(ren), and
11) assessor's assessment of the client's ability to safely parent the children,
12) client's understanding of the current situation.

If assessing parents in separate households, a separate written report must be provided on each parent. The report must also include current issues that jeopardize reunification with either parent if separate as well as a description of ongoing issues that need to be addressed even if the children remain in the home or are returned to the home.

If the provider suspects substance use, the provider should notify the Family Case Manager immediately if children are present and within 24 hours if children are not present in the home.

Services include providing any requested testimony and/or court appearances, including hearings and/or appeals.

Failure to maintain confidentiality may result in immediate termination of the service agreement.

III. When DCS is not paying for services:

A billable unit of "Reports" has been developed for providers who service DCS families without DCS payment for these services (Medicaid, insurances, self-pay) but DCS wants a report from the provider on the progress of the family. The referral process has been set up to authorize reports and court components on the DCS referral form in these incidences. **DCS will only pay for reports when DCS is not paying for these services.** If the services provided are not funded by DCS, the report rate per hour will be paid for the necessary reports on a referral form issued by DCS. Court testimony will be paid per appearance if requested on a referral form issued by DCS. In order to be paid for a court appearance a subpoena or written request from DCS should be on file.

IV. . Target Population

Services must be restricted to the following eligibility categories;

1) Children and families who have substantiated cases of abuse and/or neglect, and will likely develop into an open case with Informal Adjustment (IA) or CHINS status;
2) Children and their families which have an IA or the children with a status of CHINS, and/or JD/JS;
3) Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed;
4) Any child who has been adopted, and adoptive families

V. Goals and Outcomes

Goal #1 Timely receipt of report (service must commence within 3 working days of receipt of the referral).

Outcome Measures:

1) 90% of the evaluation reports will be submitted to the referring DCS Family Case Manager or Probation Officer within 30 days of referral.

Goal #2 Obtain appropriate recommendations based on information provided.

Outcome Measures:

1) 100% of reports will meet information requested by DCS.

2) 100% of reports will include recommendations for treatment and needed services.

Goal #3 DCS and client satisfaction with service provided.

Outcome Measures:

1) DCS satisfaction will be rated 4 and above on the Service Satisfaction Report.

2) 90% of the families who have completed Parent Education services will rate the services "satisfactory" or above on a satisfaction survey developed by the service provider, unless DCS/Probation distributes one to providers for their use with clients. Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.

Minimum Qualifications

Direct Worker:

Direct workers under this standard must meet one of the following minimum qualifications:

1) Master's or Doctorate degree with a current license issued by the Indiana Behavioral Health and Human Services Licensing Board as one of the following: 1) Social Worker, 2) Clinical Social Worker, 3) Marriage and Family Therapist, 4) Mental Health Counselor 5) Marriage and Family Therapist Associate and 6) Mental Health Counselor Associate.

2) Master's degree with a temporary permit issued by the Indiana Behavioral Health and Human Services Licensing Board as one of the following: 1) Social Worker, 2) Clinical Social Worker, within 90 days of providing services under this contract (Please note: In order to obtain a temporary license, the individual must register for the exam) and,
   a. 2 years related clinical experience, or
   b. completion of the DCS approved training program

   Note: In order to obtain a temporary license, the individual must first register for the licensure exam and may have additional requirements for temporary licensure. Please contact the Indiana Professional Licensing Board for additional instructions for obtaining a temporary license.

3) Master's degree and a submitted application for 1) Marriage and Family Therapist Associate, or 2) Mental Health Counselor Associate within 90 days of providing services under this contract. The individual must obtain licensure as a Marriage and Family Therapist Associate or Mental Health Counselor Associate within 12 months of providing services under this contract. The individual must also have:
   a. 2 years related clinical experience, or
   b. completion of the DCS approved training program

4) Master's degree in a related human service field plus 2 years related clinical experience and working under a DCS Community Based Contract on July 1, 2015.

Note: Individuals who hold a Master's degree that is applicable toward licensure, must become licensed as indicated in #2 & 3 above. Providers should not employ any new staff who are not license eligible.

In addition to the above:

- Knowledge of child abuse and neglect, and child and adult development,
- Knowledge of community resources and ability to work as a team member;
- Beliefs in helping clients change their circumstances, not just adapt to them,
- Belief in adoption as a viable means to build families.
- Understanding regarding issues that are specific and unique to adoptions, such as loss, mismatched expectations and flexibility, entitlement, gratification delaying, flexible. Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral valued culturally competent manner.

VII. Billable Units

Parenting/Family Functioning Assessment: per hour. Includes time face to face with the client/family, time spent administering, scoring, and interpreting testing. Plus a maximum of 1 hour may be billed for writing the report.

Reminder: Not included is scheduling of appointments, collateral contacts, travel time and no shows. These activities are built into the hourly rate and shall not be billed separately.

Hourly services may be billed in 15 minute increments, partial units are rounded to the nearest quarter using the following guidelines:

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

Court: The provider of this service may be requested to testify in court. 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. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. 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.

Reports

If the services provided are not funded by DCS, the “Reports” hourly rate will be paid. A referral for “Reports” must be issued by DCS in order to bill.

Interpretation, Translation and Sign Language Services

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

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

The location of and cost of Interpretation, Translation, and Sign Language Services are the responsibility of the Service Provider. 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. 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. Providers can use DCS contracted agencies and request that they be given the DCS contracted rate but this is not required. 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. 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.

VIII. Case Record Documentation

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

Services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the vent a service provider receives verbal or email authorization to provide services from DCS/Probation, an approved DCS referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

X. Adherence to the DCS Practice Model

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. 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. Trauma Informed Care

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/):
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. 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?" 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. 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

Trauma Specific Interventions: (modified from the SAMHSA definition)

- The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
- 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)
- 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. Cultural and Religious Competence.

Provider must respect the culture of the children and families with which it provides services. 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. 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. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth. The guidebook can be found at:

http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf

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. 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.

XIII. Child Safety

Services must be provided in accordance with the Principles of Child Welfare Services. Please note: All services (even individual services) are provided through the lens of child safety. 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. 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. 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.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
SEX OFFENDER TREATMENT

I. Service Description

This service standard applies to services provided to families and children involved with the Department of Child Services and/or Probation.

Sex offender specific treatment is designed to improve public safety by reducing the risk of reoccurring sexually based offenses. It is an intervention carried out in a specialized program containing a variety of cognitive behavioral and psycho-educational techniques that are designed to change offense supportive beliefs and attributions, improve handling of negative emotions, teach behavioral risk management, and promote pro-social behavior. Because programming will rely on a containment approach, providers shall work closely with local service and treatment agencies to enhance the community's response to sexual offending. Along with sexual offender specific treatment, containment teams shall be established for each referral in order to ensure

consistency in service delivery and decision-making and foster collaboration. Programming will provide services to children and their families who are referred by the Department of Child Services and/or the local Juvenile Probation Department.

All referred cases shall follow a continuum that provides the following:

1) Risk and needs assessment for sexual offenders: **(emergency and non-emergency)** Assessments must include the following components: Youth, family and community strengths; cognitive functioning; social/developmental history; current individual functioning; current family functioning; delinquency and conduct/behavioral issues; substance use and abuse; psychosexual assessment; mental health assessment; sexual evaluation; community risk and protective factors; awareness of victim impact; external relapse prevention systems including informed supervision amenable to treatment and treatment recommendations. It must also include an assessment of risk using the ERASOR (Estimated Risk of Adolescent Sexual Offender Recidivism).

2) Containment Teams for offenders Traditional supervision practices do not adequately address the unique challenges and risks that sexually maladaptive youth pose to the community. Therefore it is expected that the provider will establish a "network" of family members, friends, teachers, coaches and any other community members or professionals who are committed to the success of the youth, to provide intensive monitoring of the youth in the home, school and community. This monitoring will occur 24 hours a day while the youth receives treatment.

3) Treatment must include individual, group and family components for sex offenders including the following:

a. Case-specific treatment components through individual therapy including addressing personal history of sexual victimization and behavioral techniques designed to modify deviant sexual arousal if appropriate

b. Core treatment modules through group therapy including: psychoeducation about the consequences of abusive behavior; increasing victim empathy, identifying personal risk factors, promoting healthy sexual attitudes and beliefs; social skills training; sex education; anger management and relapse prevention as appropriate

c. Parent components including: engendering support for treatment and behavior change; encouraging supervision and monitoring; teaching recognition of risk signs and promoting guidance and support to their teenager.

d. Relapse prevention if appropriate

e. Polygraph testing if appropriate

f. Family support services

g. Compliance monitoring and reporting

II. Service Delivery

1) For DCS, services are provided face-to-face in the counselor's office or other setting. For MCO, the service setting is either outpatient or office setting. For MRO, the service must be provided at the client's home or other at other locations outside the clinic setting.
2) Services must include 24 hour crisis intake, intervention and consultation seven days a week.
3) Services must include ongoing risk assessment and monitoring of progress.
4) Services must provide short/long term goals with measurable outcomes based on recommendation based on risk and needs assessment for sexual offenders. Services include monthly reports, to include treatment goals; requested supportive documentation such as case notes, social summaries, etc.; and requested testimony and/or court appearances including hearings and /or appeals; case conferences/staffing; CFTM, if invited.
5) Staff must respect confidentiality. Failure to maintain confidentiality may result in immediate termination of the service agreement.

III. Medicaid

For those families and children not eligible for Medicaid Rehabilitation Option, this service will be paid by DCS. For eligible families and children, some services may be provided through Medicaid Rehabilitation Option (MRO) or Medicaid Clinic Option (MCO) with the remaining services paid by DCS. 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 health care needs of the MRO eligible client, and therefore may be billable to MRO. Other services for Medicaid clients may be covered under MCO. The service standard is not a Medicaid standard and includes services that are not billable to Medicaid. It is the responsibility of the contracted service provider to be knowledgeable about the Medicaid billing requirements and comply with them, including provider qualifications and any pre-authorization requirements and further, to appropriately bill those services in particular cases where they may be reimbursed by Medicaid.

IV. When DCS is not paying for services:

A billable unit of "Reports" has been developed for providers who service DCS families without DCS payment for these services (Medicaid, insurances, self-pay) but DCS wants a report from the provider on the progress of the family. The referral process has been set up to authorize reports and court components on the DCS referral form in these incidences. **DCS will only pay**

for reports when DCS is not paying for these services. If the services provided are not funded by DCS, the report rate per hour will be paid for the necessary reports on a referral form issued by DCS. Court testimony will be paid per appearance if requested on a referral form issued by DCS. In order to be paid for a court appearance a subpoena or written request from DCS should be on file.

V. Target Population

Services must be restricted to the following eligibility categories:

Youth, under the age of eighteen (18), experiencing sexually maladaptive behaviors, who are within the target populations described below:

1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
2) Children and their families which have an Informal Adjustment (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.

Services billable to MRO are for Medicaid eligible clients with a qualifying diagnosis and level of need. Services billable to MCO are for Medicaid eligible clients.

VI. Goals and Outcomes

Goal #1 Maintain timely intervention with family and regular and timely communication with current Family Case Manager or Probation Officer.

Objectives:

1) Therapist or backup is available for consultation to the family 24/7 by phone or in person.

Outcome Measures:

1) 95% of all families that are referred will have face-to-face contact with the client within 5 days of receipt of the referral or inform the current Family Case Manager or probation Officer if the client does not respond to requests to meet.

2) Emergency Assessments: 95% cases will include Initial recommendations being provided to the referring worker within 48 hours of the emergency assessment with a full assessment report to the worker within 72 hours of the emergency assessment (by email).

3) 95% of full assessment reports for nonemergency assessments must be available within fourteen calendar days of the referral (by email).

4) 95% of the initial treatment plans will including measurable goals, specific steps to be taken to meet those goals and estimated timeframes for completing each goal and must be sent to the referring worker within fifteen calendar days of the first face-to-face contact with the client (by email).

5) 100% of monthly progress must be completed and sent to the referring worker by email by the 10th of each month for the previous month. Reports must contain documentation of progress made since the previous report in each goal.

Goal #2 A Containment Team shall be implemented for each family referred to services. The Team approach will allow for families to participate in the decision making process regarding their family.

Outcome Measures:

1) 100% of all children/families referred for treatment will have a fully functional network in place within 60 days of the initial face-to-face contact and will thereafter meet monthly to review the adolescent's progress, strengths and needs. The meetings will have minutes prepared with action steps identified together with person(s) responsible for completing those steps. These minutes will be included with the monthly progress reports sent to the referring workers.

Goal #3 Youth participating in the program will have no behavioral issues and/or probation violations.

Outcome Measures:

1) 90% of youth participating in the program will not have any delinquency charges and/or probation violations during the treatment phase.

2) 75% of youth who successfully complete the program will not have any delinquency charges and/or probation violations within 12 months of completing the program.

3) 95% of youth who participate in the program will not be a perpetrator of child sexual abuse during the 12 months following program completion.

Goal #4 DCS/Probation and client will report satisfaction with services provided.

Outcome Measures:

1) DCS/Probation satisfaction will be rated 4 and above on the Service Satisfaction Report.

2) 90% of the clients will rate the services "satisfactory" or above on a satisfaction survey developed by the service provider, unless DCS/Probation distributes one to providers for their use with clients. Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.

VII. Minimum Qualifications

Service providers will only utilize professionals who are specifically trained and are licensed practitioners. Training can occur through the University of Louisville, KY, Ohio University, OH, the Indiana Association for Juvenile Sex Offender Practitioners, or an equivalent recognized credentialed authority. Further, staff members shall be knowledgeable of the dynamics surrounding child abuse/neglect, be knowledgeable of child and adult development and family dynamics, and also knowledgeable of community resources.

MCO:

- Medical doctor, doctor of osteopath, licensed psychologist
- Physician or HSPP-directed services provided by the following: licensed clinical social worker, licensed marital and family therapist; licensed mental health counselor; a person holding a master's degree in social work, marital and family therapy or mental health counseling; an advanced practice nurse

MRO:

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

DCS:

Direct workers under this standard must meet one of the following minimum qualifications:

1) Master's or Doctorate degree with a current license issued by the Indiana Behavioral Health and Human Services Licensing Board as one of the following: 1) Social Worker, 2) Clinical Social Worker, 3) Marriage and Family Therapist, 4) Mental Health Counselor 5) Marriage and Family Therapist Associate and 6) Mental Health Counselor Associate.

2) Master's degree with a temporary permit issued by the Indiana Behavioral Health and Human Services Licensing Board as one of the following: 1) Social Worker, 2) Clinical Social Worker, within 90 days of providing services under this contract (Please note: In order to obtain a temporary license, the individual must register for the exam) and,
    a. 2 years related clinical experience, or
    b. completion of the DCS approved training program

Note: In order to obtain a temporary license, the individual must first register for the licensure exam and may have additional requirements for temporary licensure. Please contact the Indiana Professional Licensing Board for additional instructions for obtaining a temporary license.

3) Master's degree and a submitted application for 1) Marriage and Family Therapist Associate, or 2) Mental Health Counselor Associate within 90 days of providing services under this contract. The individual must obtain licensure as a Marriage and Family Therapist Associate or Mental Health Counselor Associate within 12 months of providing services under this contract. The individual must also have:
    a. 2 years related clinical experience, or
    b. completion of the DCS approved training program

4) Master's degree in a related human service field plus 2 years related clinical experience and working under a DCS Community Based Contract on July 1, 2015.

Note: Individuals who hold a Master's degree that is applicable toward licensure, must become licensed as indicated in #2 & 3 above. Providers should not employ any new staff who are not license eligible.

VIII. Billing Units

Services through the **MCO** may be Outpatient Mental Health Services. Medicaid shall be billed first for eligible services under covered evaluation and management codes, including those in the 90000 range.

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

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

DCS funding: Those services not deemed medically necessary for the Medicaid eligible client, including services to other referred members of the family that are not related to the behavior health care needs of the eligible client, will be billed to DCS per face-to-face hour as outlined below. These billable units will also be utilized for services to referred clients who are not Medicaid eligible and for those providers who are unable to bill Medicaid.

- **Face to face time with the client:**
  (Note: Members of the client family are to be defined in consultation with the family and approved by the DCS/Probation. This may include persons not legally defined as part of the family)

  - Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
  - Includes crisis intervention and other goal directed interventions via telephone with the identified client family.
  - Includes Child and Family Team Meetings or case conferences including those initiated or approved by the DCS/Probation for the purposes of goal- directed communication regarding the services to be provided to the client/family.

  Reminder: Not included is routine report writing and scheduling of appointments, collateral contacts, travel time and no shows. These activities are built into the cost of the face to face rate and shall not be billed separately.

Hourly Services may be billed in 15 minute increments, partial units are rounded to the nearest quarter 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

Court: The provider of this service may be requested to testify in court. 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. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. 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.

Reports

If the services provided are not funded by DCS, the "Reports" hourly rate will be paid. A referral for "Reports" must be issued by DCS in order to bill.

Interpretation, Translation and Sign Language Services

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

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

The location of and cost of Interpretation, Translation, and Sign Language Services are the responsibility of the Service Provider. 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. 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. Providers can use DCS contracted agencies and request that they be given the DCS contracted rate but this is not required. 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. 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.

Polygraphs

Polygraphs must be purchased from a licensed provider. Polygraphs are a unit rate and the provider must tell what their rates are as part of their proposal. The intent of the polygraph is for the sex offender only.

Per person per group hour

Services include group goal directed work with clients. To be billed per person per group hour .

VIII. Case Record Documentation

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.
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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.
10) Written reports regarding each assessment;
11) Written minutes regarding each containment team meeting.

IX. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation, an approved DCS referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

X. Adherence to the DCS Practice Model

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

XI. Trauma Informed Care

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/):
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. 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?" 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. 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

Trauma Specific Interventions: (modified from the SAMHSA definition)

- The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
- 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)
- 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. Cultural and Religious Competence.

Provider must respect the culture of the children and families with which it provides services. 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. 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. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth. The guidebook can be found at:
http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf

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. 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.

XIII. Child Safety

Services must be provided in accordance with the Principles of Child Welfare Services. Please note: All services (even individual services) are provided through the lens of child safety. 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. 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. 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.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
TRANSITION FROM RESTRICTIVE PLACEMENTS (TRP)

I. Services Description

TRP is a provision of services to assist children in a more restrictive placement to a less/least restrictive placement. The purpose of the program is to prevent a return of the youth to a more restrictive setting/placement. TRP must include the following kinds of services to the youth and family:

Therapeutic/clinical interventions to address the service needs of the youth and family. Therapeutic interventions must be based on an evidence-based model such as Functional Family Therapy (FFT), Multi-systemic Therapy (MST), Parenting with Love and Limits (PLL), or similar program.

Home-based services including but not limited to the following:

- Home assessment
- Child development education
- Educational transition services
- Vocational services
- Drug/alcohol screening & monitoring
- Conflict management
- Addiction Education
- Group Therapy
- Coordination of services, with special emphasis on education and employment services
- Emergency/crisis services
- Parenting education/training
- Family communication
- Assistance with transportation
- Family reunification
- Family assessment
- Community referrals and follow-up
- Behavior modification
- Budgeting/money management
- Other services as deemed appropriate based on the needs of the youth and family

II. Service Delivery

1) Services must include 24-hour access to crisis intervention seven days a week and may be provided in the family's home, at a community site, or in the office.

2) Services must include ongoing risk assessment and monitoring family/parental progress.

3) Services must include development of goals with measurable outcomes.

4) Provider must complete an intake interview with the family within five calendar days after receipt of the referral or notify referral source if client does not respond to meeting requests.

5) Provider must maintain monthly contact with the youth's referring agency during the time the youth is in the more restrictive placement to ensure that the transition plan remains consistent between agencies.

6) Provider must participate in an initial meeting with the youth's FCM or probation officer, youth, and family within 48 hours of release.

7) For JD/JS youth, the provider must complete the Child and Adolescent Needs and Strengths (CANS) assessment within 30 days of transition from the more restrictive placement, if not completed at the time of discharge from the more restrictive placement, and every six months thereafter. If no CANS assessment was completed prior to the youth being admitted to the more restrictive placement, the service provider is responsible for completing the assessment within 2 weeks of the placement in a less restrictive placement. (DCS will be responsible for CANS assessments for CHINS youth.)

8) Provider must conduct a minimum of two (2) face to face visits per week with the youth during the first thirty (30) days of release from the more restrictive placement. The level of supervision after that period of time will be determined by the team but will never be less than 1 face to face visit per week.

9) When appropriate and requested by the Probation Officer or Family Case Manager, the provider may require the youth to submit to at least one random drug screen within fourteen (14) days of changing from a more restrictive placement. This may be done through the local probation department or another approved vendor.

10) Provider must maintain frequent contact with the FCM/probation officer and notify the FCM/probation officer in writing of non-compliance issues. The provider must also develop a recommendation for the FCM/probation officer as to a suitable therapeutic intervention.

11) The family will be the focus of service and services will focus on the strengths of the family and build upon these strengths.

12) Services must be family focused and child centered.

13) Services must include intensive in-home skill building and after-care linkage.

14) Services include providing monthly progress reports in a format approved by the Court, participation in team meetings, and providing requested testimony and/or presence at court hearings.

15) Additionally, the provider will recommend to the referring agency any other services, such as therapy, which might be needed. Recommendations for additional services not covered in the service standard should be made, in writing, to the current FCM or probation officer. Additional services require a separate referral and should not be started until one has been received.

16) Staff must respect confidentiality. Failure to maintain confidentiality may result in immediate termination of the service agreement.

17) The caseload of the therapist/case manager will include no more than ten (10) workload units. All youth in service are weighted at 1 workload unit.

III. Target Population

Services must be restricted to the following eligibility category:

- Children with a status of CHINS and/or JD/JS who have been placed in a restrictive setting.

Note that Transition From Restrictive Placements (TRP) can be provided to CHINS or probation youth who are transitioning out of residential or group home placements. TRP services may begin while a youth is still in a residential or group home placement if that youth will be transitioning within 30 days.

For JD/JS youth who are committed to the Department of Corrections, this service may begin within 60 days of the scheduled or anticipated discharge.

IV. Goals and Outcomes

Goal #1 To improve the transition for youth back to their home by providing therapeutic services to the youth and family

Outcome Measures

1) Based on the CANS Assessment, 100% of participants will have an individualized service plan developed.

2) 90% of families will actively participate in services during the youth's period of placement.

3) 90% of the youth will have a minimum of 2 face to face visits each week from their direct worker/therapist during the first 30 days following their placement from a more restrictive to a less restrictive placement.

Goal #2 To reduce routine barriers by providing direct assistance with transition issues

Outcome Measures

1) 90% of all participants will have a state-issued ID or driver's license by the completion of the program.

2) 90% of all participants will actively participate in an education program.

3) 100% of participants not involved in an educational program will be employed and/or participating in a formal employment assistance program.

Goal #3 To develop a system of community supports for each youth that will continue after completion of the program.

Outcome Measures

1) 100% of the youth in the program will establish at least one community-based support that will continue to provide assistance and/or direction following completion of the program

2) 85% of youth will maintain their placement in a less restrictive setting at 6 month follow up.

Goal #4 Maintain satisfactory services to the children and family

Objective

1) DCS/Probation and clients will report satisfaction with services.

Outcome Measures

1) DCS/Probation satisfaction with services will be rated 4 and above on the Service Satisfaction Report.

2) 90% of clients will rate the services "satisfactory" or above on a satisfaction survey developed by the service provider, unless one is distributed by DCS/Probation to providers for their use with clients Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.

V. Minimum Qualifications

Therapist/Direct Worker:

MCO billable:

- Medical doctor, doctor of osteopath; licensed psychologist
- Physician or HSPP-directed services provided by the following: licensed clinical social worker, licensed marital and family therapist; licensed mental health counselor; a person holding a master's degree in social work, marital and family therapy or mental health counseling; an advanced practice nurse.

MRO billable:

Providers must meet the either of the following qualifications:

- Licensed professional, except for a licensed clinical addiction counselor
- Qualified Behavioral Health Professional (QBHP).

DCS billable:

Direct Worker:

A bachelor's degree in social work, psychology, sociology, or a directly related human service field is required.

Therapist:

Therapists under this standard must meet one of the following minimum qualifications:

1) Master's or Doctorate degree with a current license issued by the Indiana Behavioral Health and Human Services Licensing Board as one of the following: 1) Social Worker,

2) Clinical Social Worker, 3) Marriage and Family Therapist, 4) Mental Health Counselor 5) Marriage and Family Therapist Associate and 6) Mental Health Counselor Associate.

2) Master's degree with a temporary permit issued by the Indiana Behavioral Health and Human Services Licensing Board as one of the following: 1) Social Worker, 2) Clinical Social Worker, within 90 days of providing services under this contract (Please note: In order to obtain a temporary license, the individual must register for the exam) and,
    a. 2 years related clinical experience, or
    b. completion of the DCS approved training program

Note: In order to obtain a temporary license, the individual must first register for the licensure exam and may have additional requirements for temporary licensure. Please contact the Indiana Professional Licensing Board for additional instructions for obtaining a temporary license.

3) Master's degree and a submitted application for 1) Marriage and Family Therapist Associate, or 2) Mental Health Counselor Associate within 90 days of providing services under this contract. The individual must obtain licensure as a Marriage and Family Therapist Associate or Mental Health Counselor Associate within 12 months of providing services under this contract. The individual must also have:
    a. 2 years related clinical experience, or
    b. completion of the DCS approved training program

4) Master's degree in a related human service field plus 2 years related clinical experience and working under a DCS Community Based Contract on July 1, 2015.

Note: Individuals who hold a Master's degree that is applicable toward licensure, must become licensed as indicated in #2 & 3 above. Providers should not employ any new staff who are not license eligible.

Supervisor:

A 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 as one of the following: 1) Clinical Social Worker 2) Marriage and Family Therapist 3) Mental Health Counselor 4) Addictions Counselor is required.

Supervision/consultation is to include not less than one (1) hour of face to face

supervision/consultation per 20 hours of direct client services provided, and occur every two (2) weeks or more frequently.

The staff person must possess:

- Knowledge of community resources and ability to work as a team member.
- An understanding of issues specific to youth transitioning back into the community following a stay in restrictive placement.
- Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life style choices, and complex family interactions and be delivered in a neutral valued culturally competent manner.

VI. Billable Unit

Medicaid:

It is expected that the majority of the individual, family and group counseling provided under this standard will be based in the clinic setting. In these instances, the units may be billable through MCO. Medicaid shall be billed when appropriate.

Services through the **MCO** may be Outpatient Mental Health Services. Medicaid shall be billed first for eligible services under covered evaluation and management codes, including those in the 90000 range.

Services through the Medicaid Rehab Option **(MRO)** may be **group** Behavioral Health Counseling and Therapy, Case Management, and Skills Training and Development **.**

Billing Code	**Title**
H0004 HW U1	Behavioral health counseling and therapy (group setting), per 15 minutes
H0004 HW HR U1	Behavioral health counseling and therapy, per 15 minutes (family/couple, group setting, with consumer present)

H0004 HW HS U1	Behavioral health counseling and therapy, per 15 minutes (family/couple, group setting, without consumer present
T1016 HW	Case Management, each 15 minutes
H2014 HW	Skills Training and Development , per 15 minutes
H2014 HW HR	Skills Training and Development, per 15 minutes (family/couple, consumer present)
H2014 HW HS	Skills Training and Development, per 15 minutes (family/couple, without consumer present)
H2014 HW U1	Skills Training and Development , per 15 minutes (group setting)
H2014 HW HR U1	Skills Training and Development , per 15 minutes (group setting, family/couple, with consumer present)
H2014 HW HS U1	Skills Training and Development , per 15 minutes (group setting, family/couple, without consumer present)

DCS funding:

Those services not deemed medically necessary for the Medicaid eligible client, including services to other referred members of the family that are not related to the behavior health care needs of the eligible client, will be billed to DCS per face-to-face hour as outlined below. These billable units will also be utilized for services to referred clients who are not Medicaid eligible and for those providers who are unable to bill Medicaid.

If agency administers clinical services, there may be two face to face units: Direct Worker and Counseling.

Face to face time with the client:

(Note: Members of the client family are to be defined in consultation with the family and approved by the DCS. This may include persons not legally defined as part of the family)

• Includes client specific face-to-face contact with the identified client/family

during which services as defined in the applicable Service Standard are performed.

• Includes Child and Family Team Meetings or case conferences, or probation meetings initiated or approved by the DCS or Probation for the purposes of goal directed communication regarding the services to be provided to the client/family.

• Includes crisis intervention and other goal-directed interventions via telephone with the identified client family.

.**Reminder:** Not included are routine report writing and scheduling of appointments, collateral contacts, travel time and no shows. These activities are built into the cost of the face- to-face rate and shall not be billed separately.

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

Interpretation, Translation and Sign Language Services

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

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

The location of and cost of Interpretation, Translation, and Sign Language Services are the responsibility of the Service Provider. 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. 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. Providers can use DCS contracted agencies and request that they be given the DCS contracted rate but this is not required. 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. 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.

Court

The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a written request (email or subpoena) from DCS or subpoena to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. 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.

VII. Case Record Documentation

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.

VIII. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

IX. Adherence to the DCS Practice Model

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. 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. Trauma Informed Care

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/):
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. 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?" 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. 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

Trauma Specific Interventions: (modified from the SAMHSA definition)

- The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
- 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)
- 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.

XI. Cultural and Religious Competence.

Provider must respect the culture of the children and families with which it provides services. 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. 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. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth. The guidebook can be found at: http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf

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. 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.

XII. Child Safety

Services must be provided in accordance with the Principles of Child Welfare Services. Please note: All services (even individual services) are provided through the lens of child safety. 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. 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. 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.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
TUTORING/LITERACY CLASSES

I. Services Description

Tutoring/literacy and math services will be provided to raise the academic performance of school aged youth to a level consistent with state education standards.

Services shall be provided in a manner that is age and developmentally appropriate, and consistent with the child's academic ability and learning style, interpersonal characteristics and special needs. Children will be connected as appropriate with both formal and informal community supports, services and activities that promote their literacy skills. The child's characteristics such as race, culture, ethnicity, language and personal history including child abuse and neglect will be considered when choosing or designing program interventions, materials and curriculum. The provider will develop an education plan to address the child's literacy and math needs.

A variety of activities and lessons shall be available to afford choice. Activities and lessons shall promote literacy skills and academic development and should demonstrate well-planned, flexible and responsive services. Services should include regular use of external resources such as libraries, museums and community educational sites. Services may also incorporate the use of video games and computers. The use of television and videos shall be strictly limited to a minimal portion of the child's participation. Video games, computers, television and videos should be age and developmentally appropriate, supportive of the child's educational goals, and the child should be monitored at all times when using these resources.

The provider will develop a plan to engage the child, caregiver, and educator in the process. The plan will accommodate persons who are difficult to engage if necessary. The provider will clearly communicate and coordinate the child's education plan goals with the caregiver and educator and will periodically and frequently give updates and review progress with them.

II. Service Delivery

Treatment Modality

Tutoring/literacy and math services shall be provided through direct one-on-one sessions or in small groups of 2 to 4 children who are matched by ability. Services should occur in locations that that promote learning, are large enough to accommodate the group and teaching materials, allow the child to concentrate without being disturbed by others, and allow for meaningful and

direct assistance. Services may take place after school, on weekends and/or other times when school is not in session. Services should not conclude later than normal bedtime hours.

Tutoring/literacy and math services shall incorporate evidence-based strategies that improve student achievement. Sessions shall be divided into segments, including: 1) an opening activity to set the stage, 2) activities based on individual learning goals, 3) opportunities to develop and practice skills, and 4) a closing activity. All sessions shall include opportunities for the child to experience success and to progress. The provider should suggest home activities as appropriate.

Assessment

The provider will ensure the child receives an initial assessment in order to determine child specific learning needs no later than 10 days after being referred. 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. Assessments shall include the use of standardized tools to obtain a baseline measurement and will at a minimum identify the following:

- Learning disabilities and/or impairments in cognitive functioning due to child abuse, neglect, or involvement with child welfare services
- Academic strengths, weaknesses and needs
- Level of ability compared to actual grade/age level

Services will be provided within the context of the Department of Child Services' practice model with participation in Child and Family team meetings if invited. An education plan will be developed and based on the agreements reached by means of the assessment and Child and Family Team Meeting (CFTM). Services will be provided in coordination with the child's Individualized Education Plan (IEP) if present, and the provider shall participate in IEP conferences with educators.

Education Plan

Comprehensive education plans will be developed based on the assessment and will contain both long-term and short-term goals. Plans at a minimum will:

Include input from the child, caregiver and the educator.

Reflect underlying needs and goals.

Be tailored to the child's strengths, weaknesses, needs, available resources and unique circumstances.

Build on realistic possibilities and options

Identify strategies for lessening the effects of any disabilities and/or impairments in cognitive functioning.

Promote reading and math achievement at a level consistent with state education standards.

Be consistent with the child's Individualized Education Plan (IEP), if one is present

Support and/or build upon what the child is learning through their primary education program

Respond flexibly to the child's changing needs

The provider will evaluate the child's progress toward achieving identified goals and will regularly incorporate the use of standardized performance measurement tools to track progress and adjust tutoring/ literacy and math activities. The provider will assist the child and caregiver in realizing ways of generating and maintaining gains. The provider will document progress and participation.

Services must be available to participants who have limited daytime availability.

Services shall include providing any requested testimony and/or court appearances (to include hearing or appeals).

Provider must respect confidentiality. Failure to maintain confidentiality may result in immediate termination of the contract.

III. Target Population

Services must be restricted to the following eligibility categories:

1) Children who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.

2) Children who have an Informal Adjustment (IA) or the children have the status of CHINS or JD/JS.

3) All adopted children.

IV. Goals and Outcomes

Goal #1 Timely provision of services for the youth and regular and timely communication with referring worker.

Outcome Measures:

1) 95% of all youth referred will have face-to-face contact with the provider within 10 days of the referral.

2) 95% of all youth will have a written education plan within 30 days of the referral.

3) 100% of all youth will have monthly written summary reports prepared and sent to the referring worker.

Goal #2

Child has improved academic and/or literacy performance

Outcome Measures:

1) 90% of children improve academic and/or literacy performance as evidenced by pre and post-testing

2) 90% of children improve overall school performance as measured by grade point average or other standard indicators

3) 100% of children participate actively in the goals of their education plan as evidenced by provider documentation

Goal #3 DCS and youth satisfaction with services

Outcome Measures:

1) DCS satisfaction will be rated 4 and above on the Service Satisfaction Report.

2) 90% of the youth who have participated will rate the services "satisfactory" or above.

V. Minimum Qualifications

Direct Worker:

Tutoring services may be provided by workers with a Bachelor's degree or at least 60 hours of post secondary credit hours in education, social work, psychology, or a related field.

Supervisor:

A bachelor's degree in education, social work, psychology, or a related field and 5 years experience tutoring children is required. Knowledge of state education standards is required.

Supervision/consultation is to include not less than one (1) hour of face to face supervision/consultation per 20 hours of direct client service hours provided. These sessions should occur no less frequently than every two (2) weeks.

Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral valued culturally competent manner.

Worker Qualities:

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

- Engage, empower and communicate effectively, respectfully and empathetically with children and families from a wide range of backgrounds, cultures and perspectives.
- Develop plans to meet the child's literacy and tutoring needs.
- Recognize and identify the presence of cognitive impairments
- Collaborate with workers in other disciplines and access community resources
- Advocate for the child during Child and Family Team Meetings Individualized Case Plan (IEP) conferences

Providers working directly with children should be knowledgeable about:

- Child development
- Behavior management
- Learning disabilities
- Possible effects of child abuse and neglect on cognitive functioning
- The Individualized Education Plan (IEP) and its use in education
- Educational resources within the community
- Tutoring techniques

VI. Billable Unit

Face to face time with the client:

(Note: Members of the client family are to be defined in consultation with the family and approved by the DCS. This may include persons not legally defined as part of the family)

- Includes client specific face-to-face contact with the identified client/family
- during which services as defined in the applicable Service Standard are performed.
- Includes Child and Family Team Meetings or case conferences initiated or
- approved by the DCS for the purposes of goal directed communication regarding

- the services to be provided to the client/family.
- Includes crisis intervention and other goal-directed interventions via telephone with the identified client family.

Reminder: Not included are routine report writing and scheduling of appointments, collateral contacts, travel time and no shows. These activities are built into the cost of the face- to-face rate and shall not be billed separately.

Group

Services include group goal directed work with clients. To be billed per group hour.

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

Interpretation, Translation and Sign Language Services

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

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

The location of and cost of Interpretation, Translation, and Sign Language Services are the responsibility of the Service Provider. 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. 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. Providers can use DCS contracted agencies and request that they be given the DCS contracted rate but this is not required. 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. 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.

Court

The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a written request (email or subpoena) from DCS or subpoena to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. 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.

VII. Case Record Documentation

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) Documentation of Termination/Transition/Discharge Plans
4) 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
5) 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
6) Progress/Case Notes Must Document: Date, Start Time, End Time, Participants, Individual providing service, and location
7) 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

VIII. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

IX. Adherence to the DCS Practice Model

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. 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. Trauma Informed Care

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/):
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. 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?" 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. 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

Trauma Specific Interventions: (modified from the SAMHSA definition)

- The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
- 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)
- 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.

XI. Cultural and Religious Competence.

Provider must respect the culture of the children and families with which it provides services. 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. 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. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth. The guidebook can be found at: http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf

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. 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.

XII. Child Safety

Services must be provided in accordance with the Principles of Child Welfare Services. Please note: All services (even individual services) are provided through the lens of child safety. 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. 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. 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.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
VISITATION FACILITATION

I. Service Description

It is the fundamental right for children to visit with their parents and siblings. The relationship developed by the child with the parent is one of bonding, dependency, and being nurtured, all of which must be protected for the emotional well being of the child. It is of extreme importance for a child not to feel abandoned in placement by either the child's parents or by other siblings, and for a child to be reassured that no harm has befallen either parent or siblings when separation occurs.

Visit facilitation as identified by DCS/Probation will be provided between parents/children/siblings and/or others who have been separated due to a substantiated allegation of abuse or neglect or involvement with juvenile probation. Visitation allows the child an opportunity to reconnect and reestablish the parent/child/family relationship in a safe environment. It is an excellent time for parents to learn and practice new concepts of parenting and to assess their own ability to parent through interaction with the child. Supervised visitation allows the DCS/Probation to assess the relationship between the child and parent and to assist the parent in strengthening their parenting skills and developing new skills

The role of the visitation provider is to protect the integrity of the visit and provide a positive atmosphere where parents and children may interact in a safe, structured environment. Visitation may be held in a visitation facility; neutral sites such as parks, fast food restaurant with playground, or shopping malls; child's own home or relative's home; foster home; or other location as deemed appropriate by the referring agency and other parties involved in the child's case taking into consideration the child's physical safety and emotional well being.

II. Service Delivery

Referral process

In order for positive and productive visitation to occur, specific outlined below will be provided to the visitation provider by the child's family case manager or probation officer as part of the referral. Information may include:

1) desired/allowable location of visits (such as facility, neutral space, foster home, own, home, etc.), length of visits, number of visits requested per week,
2) placement of the child and contact information,
3) who may participate in visits with contact information and relationship to child,
4) who is restricted from visits,
5) level of supervision requested (such as in-room, drop-in during visit, audio monitored, video monitored, semi-supervised, unsupervised, etc),
6) what is expected of the parents or other approved person(s) regarding prior preparation related to bottle feeding, meals and snacks, change of clothes if needed, diapers and wipes, etc.,
7) restricted activities, if any, and
8) consequences when parents do not attend visits as planned and agreed upon (this may include no showing or being consistently late or consistently leaving early);
9) circumstances under which visits may be limited or terminated (such as parent or child has head lice, parent under influence of mood altering substance, parent's intimidating or threatening behavior, inability of parent to manage children's behavior in structured setting, etc.); and
10) any criminal, mental health, and safety information on all children and visiting parties
11) other information pertinent to the visits.
12) ratio of direct workers and clients.

In the event that the preceding information is incomplete, it is the responsibility of the visitation provider to obtain that information from the referring worker.

Upon receiving the referral from the DCS/Probation, the agency will contact all parties to set up the visits taking into consideration the ability of the parent to attend based on work schedules and the foster parent or relative caregiver ability to ensure attendance of the child. Every attempt must be made for visitation with the child's parent, guardian or custodian to occur within 48 hours of the child's removal from the home. For all other visitation referrals, visitation must be scheduled within 5 days. All cancelled visits by the parent or visit facilitator must be reported within 48 hours to the referring agency indicating who cancelled and the reason for cancellation.

Visit Observation and Reporting

Professional and/or paraprofessional staff will assist the family by strengthening, teaching, demonstrating, role modeling appropriate skills and monitoring in, but not limited to the following areas:

Establishing and/or strengthening the parent-child relationship

Responding to child's questions and requests

Teaching safety regarding age-appropriate toys, climbing, running, jumping, or other safety issues depending on the environment

Instructing parents in child care skills such as feeding, diapering, administering medication if necessary, proper hygiene
Teaching positive affirmations, praising when appropriate
Providing instruction about child development stages, current and future
Teaching age-appropriate discipline
Teaching positive parent-child interaction through conversation and play
Providing opportunities for snack and meal prep with children present

Managing needs of children of differing ages at the same time
Helping parents gain confidence in meeting their child's needs
Visit Planning
Teaching age appropriate activities that encourage child development and resiliency.
Identifying and assessing potentially stressful situations between parent and their children
Giving parents an opportunity to demonstrate their willingness to complete their case plan.

At each visit, the visitation facilitator will accurately document for the referring agency the following information:

1) date, location, and level of supervision of visit;
2) those in attendance at the visit;
3) time of arrival and departure of all parties for the visit;
4) greeting and departure interaction between parent and child/ren;
5) positive interactions between parent and child;
6) planned activities by the parent for visit;
7) interventions required, if any and parent's response to direction provided with regard to interventions;
8) ability and willingness of parent to meet child's needs as requested by child or facilitator;
9) tasks given to the parent to be completed prior to or at the next visit, etc.
10) pertinent information/issues/concerns regarding the child's placement

Additionally, the following items apply:

1) Visitation staff must respect confidentiality. Failure to maintain confidentiality may result in immediate termination of the service agreement.
2) The current worker will be notified by phone immediately when inappropriate behavior occurs with either parent in a visit that affects the ability of the visit to continue or the safety of the child.
3) Services must demonstrate respect for sociocultural values, personal goals, life style choices, and complex family interactions and be delivered in a culturally competent fashion.
4) Attendance at case conferences may be required as well as testimony and/or court appearances at review or permanency hearings for the child.

5) Documentation of incidents in visitations which are or could be considered subjective must be followed by examples of the situation for clarification. The documentation of the visit must be provided to the current FCM/PO within 3 days of the visit. Phone calls shall be immediate for safety or recommendations for terminated visits.
6) Provider understands that documentation may be shared by DCS/Probation with the child's parents, foster parents or other placement of the child, the child's therapist, and other parties in the case to assist in decision making regarding decreased or increased levels of supervision and reunification.

III. Target Population

Services must be restricted to the following eligibility categories:

- Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
- Children and their families which have an Informal Adjustment (IA) or the children have the status of CHINS or JD/JS.
- Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.

IV. Goals and Outcome Measures

Goal #1

Ensure that all children removed from their parents have the opportunity to visit their parents/siblings on a regular basis.

Outcome Measures

1) 100% of the families will have the first face-to-face visit with their child(ren) within 48 hours of the child's removal from the home.
2) 100% of the families will have visitation set up and occurring with the frequency and duration requested by DCS/Probation within 5 working days of receipt of the referral.

Goal # 2

Strengthen and increase the parent's ability to provide for the emotional and physical needs as well as the safety of their children.

Outcome Measures

1) 85% of parents served will demonstrate an increased ability to recognize and respond appropriately to their children's cues by case closure.
2) 85% of the parents will actively reinforce positive behavior and address negative behavior.

3) 90% of parents will arrive with previously requested items by the visit facilitator for the children such as diapers, food, etc. and be prepared to provide a meal or snack if expected.

Goal # 3

Provide accurate and timely information in the child's case so that informed decisions may be made regarding reunification and permanency for the child.

Outcome Measures

1) 98% of visitation reports will be received by the DCS/Probation within 3 days of the visitation or immediately (by phone) when inappropriate behavior occurs with either parent, followed up with a monthly report form. Written reports will be completed on the DCS approved visitation report forms.

Goal #4

DCS/Probation and clients will report satisfaction with services provided

Outcome Measures

1) DCS or Probation satisfaction will be rated 4 and above on the Service Satisfaction Report.
2) 94% of the families who have completed visitation facilitation services will rate the services "satisfactory" or above on a satisfaction survey developed by the service provider, unless DCS/Probation distributes one to providers for their use with clients. Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.

V. Minimum Qualifications

Direct Worker

A high school diploma and 5 years of social service experience (i.e. early childhood, teacher's aide, licensed day care worker)
OR

A non human service related Bachelor's degree and 3 years of social service experience (i.e. early childhood, teacher's aide, licensed day care worker)

OR

Bachelor's degree in social work, psychology, sociology, or a directly related human services field.

In addition, a direct worker must possess:

a) Knowledge of child abuse and neglect
b) Knowledge of child and adult development and family dynamics
c) An ability to work as a team member
d) A strong belief that people can change their behavior given the proper environment and opportunity
e) The belief in helping families to change their circumstances, not just adapt to them

Supervisor:

Master's degree in social work, psychology, or directly related human services field or a Bachelors degree in social work, psychology, or a directly related service field with 5 years child welfare experience.

Supervision/consultation is to include not less than one (1) hour of face to face supervision/consultation per 20 hours of direct client services provided, nor occur less than every two (2) weeks.

Billable Units

Face to face time with the client (Note: Members of the client family are to be defined in consultation with the family and approved by the referring agency. This may include persons not legally defined as part of the family)

- Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
- Includes crisis intervention and other goal directed interventions via telephone with the identified client family.
- Includes Child and Family Team Meetings or case conferences initiated or approved by the DCS/Probation (which can include telephone case conferences) either with or without the client, for the purposes of goal directed communication regarding the services to be provided to the client/family.

Reminder: Not included is routine report writing and scheduling of appointments, collateral contacts, travel time and no shows. These activities are built into the cost of the face to face rate and shall not be billed separately.

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	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

(Note on Intermittent supervised visitation: when DCS requests the provider to check in intermittently - at least once per hour - , the provider can bill in increments of 30 minutes for each check-in, provided that the total amount of time billed should not exceed the total length of the visit.)

Court

The provider of this service may be requested to testify in court. 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. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. 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.

Interpretation, Translation and Sign Language Services

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

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

The location of and cost of Interpretation, Translation, and Sign Language Services are the responsibility of the Service Provider. 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. 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. Providers can use DCS contracted agencies and request that they be given the DCS contracted rate but this is not required. 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. 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.

Case Record Documentation

Case record documentation for service eligibility must include:

1) A completed and dated DCS/ Probation referral form authorizing services
2) Documentation of regular contact with the referred families/children
3) Written progress reports no less than monthly or more frequently as prescribed by DCS/Probation and requested supportive documentation such as case notes, social summaries, etc. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent. The "Visitation Monthly Progress Report" form must be used to report the supervised visit.
4) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation

VIII. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period.

IX. Adherence to the DCS Practice Model

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. Providers will use the skills of engaging.

X. Trauma Informed Care

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/):
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. 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?" 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. 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

Trauma Specific Interventions: (modified from the SAMHSA definition)

- The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
- 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)
- 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.

XI. Cultural and Religious Competence.

Provider must respect the culture of the children and families with which it provides services. 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. 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. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth. The guidebook can be found at: http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf

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. 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.

XII. Child Safety

Services must be provided in accordance with the Principles of Child Welfare Services. Please note: All services (even individual services) are provided through the lens of child safety. 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. 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. 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.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
Children's Mental Health Initiative Services

I. Service Description

The Children's Mental Health Initiative (CMHI) is an initiative to provide services to children who do not have formal involvement with the child welfare system, but due to their behavioral health needs, require services to maintain safely in their home and community. When community services are not able to maintain the child at home, the CMHI may fund higher level out of home services. The CMHI provides services to children who are not eligible for Medicaid, but would otherwise meet the level of need to qualify for the Medicaid funded Children's Mental Health Wraparound Services. CMHI providers must be appropriately certified by the Division of Mental Health and Addictions to provide Children's Mental Health Wraparound (CMHW) Services. Services provided may include:

- Assessment for eligibility
- Wraparound Facilitation
- Habilitation
- Respite
- Family Support and Training for the Unpaid Caregiver
- Behavioral health services as defined under Medicaid Rehabilitation Option
- Behavioral health services as defined under Medicaid Clinic Option
- Other necessary client specific services

The minimum standards and qualifications for Wraparound Facilitation, Habilitation, Respite and Family Support and Training for the Unpaid Caregiver are located at http://www.in.gov/fssa/dmha/2766.htm Medicaid Rehabilitation Option services and Medicaid Clinic Option services are defined at http://provider.indianamedicaid.com. Other DCS referred services for the family may be provided utilizing the Department of Child Services Service

Standards located at http://www.in.gov/dcs/3159.htm Services under the Children's Mental Health Initiative are provided according to the Children's Mental Health Initiative Protocol.

Please note these critical differences between the Medicaid funded Children's Mental Health Wraparound Services and the Children's Mental Health Initiative:

1. DCS may expand the target population of the Children's Mental Health Initiative beyond that which is covered under the Children's Mental Health Wraparound Services.
2. DCS may determine that Wraparound Facilitation services should continue when the youth is in an out of home setting (hospital, residential facility, etc.)

II. Target Population

- Children who meet the qualifications for Children's Mental Health Wraparound services, but who are not Medicaid eligible.
- Other children who have been approved by DCS to receive services under the Children's Mental Health Initiative because they are a danger to themselves or others

Note: The Children's Mental Health Initiative is a voluntary service. The caregiver must be engaged in order to access services.

III. Goals and Outcomes

Goal #1: Children will be served in the least restrictive setting available to meet their needs.

The percentage of children being served in their own homes will continue to be monitored during the baseline period (pre-contract) and compared to the percentage of children being served in their own homes during each contract year.

Goal #2: Children will be served without formal involvement with the child welfare or probation systems.

90% of children served will not become involved with the child welfare or probation system through an open case (IA, CHINS, JD/JS) during the time the child is in CMHI services.

85% of children served will not become involved with the child welfare or probation system through an open case (IA, CHINS, JD/JS) during the time the child is in CMHI services or during the 6 month time period following following completion of services.

IV. Minimum Qualifications

The minimum qualifications for Wraparound Facilitation, Habilitation, Respite and Family Support and Training for the Unpaid Caregiver are located at http://www.in.gov/fssa/dmha/2766.htm Medicaid Rehabilitation Option services and Medicaid

Clinic Option services are defined at http://provider.indianamedicaid.com. Other DCS referred services for the family may be provided utilizing the Department of Child Services Service Standards located at http://www.in.gov/dcs/3159.htm

V. Billable Unit

Medicaid defined services may be billed to DCS when the service meets the criteria for Medicaid billing but the client is not eligible for Medicaid.
Those services provided under DCS service standards may be billed as defined in the applicable service standard.

Interpretation, Translation and Sign Language Services

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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. 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. No side comments or conversations between the Interpreters and the clients should occur.
The location of and cost of Interpretation, Translation, and Sign Language Services are the responsibility of the Service Provider. 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. 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. Providers can use DCS contracted agencies and request that they be given the DCS contracted rate but this is not required. 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. 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.

VI. Case Record Documentation

Case record documentation for service eligibility must include:
1) A completed, signed, and dated DCS/ Probation referral form authorizing services
2) Documentation of contact with the referred families/children through Case Notes which document: Date, Start Time, End Time, Participants,
Individual providing service, and location
3) Written progress reports no less than monthly or more frequently as prescribed by DCS and requested supportive documentation. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.
4) Copy of treatment plan

VII. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS staff. In the event a service provider receives verbal or email authorization to provide services from DCS an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by DCS.
Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

VIII. Adherence to the DCS Practice Model

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

IX. . Trauma Informed Care

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/):
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. 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?" 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. 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

Trauma Specific Interventions: (modified from the SAMHSA definition)

_ The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
_ 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)
_ 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.

X. Cultural and Religious Competence.
Provider must respect the culture of the children and families with which it provides services. 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. 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. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth. The guidebook can be found at:
http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf

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. 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.

XI. Child Safety
Services must be provided in accordance with the Principles of Child Welfare Services. Please note: All services (even individual services) are provided through the lens of child safety. 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. Continual assessment of child safety and communication with DCS is required. It is the responsibility of the service provider to report any safety concerns, per state statue, IC 31-33-5-1. 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.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
VOLUNTARY RESIDENTIAL SERVICES OVERSIGHT

I. Service Description

Voluntary Residential Services Oversight will be provided for children involved with the Children's Mental Health Initiative and/or Post Adoption Services who are: 1) at-risk of residential placement, to determine if the child needs to be treated in a more restrictive setting, and if so, to locate a placement that can meet the child's needs; and 2) currently in residential placement to assist DCS in determining if the needs of the child are being met by the current placement, and to assess and recommend alternative placement options that more suitably meet the child's individual needs.

Caseload size will be 15-20 children in residential plus children being evaluated for possible residential placement. DCS expects these clinicians to spend a significant amount of time in DCS central office, Indianapolis. Also, there will be substantial travel as children are located in facilities throughout the state.

These services will consist of, but are not limited to:

- Review all available assessments (including the CANS), medical and/or psychological recommendations, and staff case with the Wraparound Facilitator or Post Adoption Service Provider, family, and collateral contacts to determine if the child requires a more restrictive level of care.
- Recommend to DCS an appropriate level of care.
- Work with the placement facilities, Wraparound Facilitator/Post Adoption Service provider and parents to secure an appropriate placement for the child. Priority should be given to Medicaid paid services.
- Provide consultation to the placement facility to ensure the facility has all information to prepare an appropriate and thorough Prior Authorization request to Medicaid for

Psychiatric Residential Treatment Facility (PRTF) services or placement request to a State Operated Facility (SOF) and ensure appeals are occurring for any denials.

- Upon denial for PRTF or SOF, consult with facility, family members and others involved with youth to ensure an appropriate level of care is secured.
- In instances where the placement will be paid by the Department of Child Services (DCS), facilitate the Voluntary Placement Agreement between the caregiver and the DCS.
- Monitor service delivery by facilitating monthly team meetings to ensure the services are meeting the needs of the youth. Team meetings must include the parent/caregiver as well as appropriate clinical staff at the treatment facility.
- The youth must be visited face-to-face at least one time per month in the placement setting.
- Encourage and monitor family participation in services.
- Provide service documentation to DCS via monthly reports, critical incident reports, updated treatment plans, and monthly team meeting notes.
- Complete an updated CANS at 6 month intervals or at critical case junctures.
- Make monthly recommendations to DCS regarding the appropriate level of services for the youth.
- Coordinate with the caregiver/parent, placement provider, Wraparound Facilitator and/or Post Adoption Service provider to develop an appropriate discharge plan to transition the youth back to the community.
- Provide services in accordance to the Children's Mental Health Initiative Protocol.

II. Target Population

Children involved in the Children's Mental Health Initiative and/or Post Adoption Services, who are a danger to themselves or others and cannot be maintained safely in the community with the available services.

III. Goals and Outcomes

Goal #1: Children will be served in the least restrictive setting available to meet their needs.

The percentage of children being served in their own homes will continue to be monitored during the baseline period (pre-contract) and compared to the percentage of children being served in their own homes during each contract year.

Goal #2: Children will be served without formal involvement with the child welfare or probation systems.

90% of children served will not become involved with the child welfare or probation system through an open case (IA, CHINS, JD/JS) during the time the child is placed by the parents/caregiver out of the home.
85% of children served will not become involved with the child welfare or probation system through an open case (IA, CHINS, JD/JS) during the time the child is placed by the parents/caregiver out of the home or during the 6 month time period following the return home.

Goal #3: Residential services will be utilized primarily as crisis stabilization and not long term placement

Average and median length of stay during the baseline period (pre-contract) will be compared to that of children served during each contract year.

Goal #4: Medicaid funded residential services will be accessed for eligible children.

25% more residential stays will be funded by Medicaid.

Goal #5: Parent/Guardian/Caregiver will engage in services and follow the treatment plan.

Parent/guardian/caregiver will participate in 80% of all scheduled family treatment sessions.
Parent/guardian/caregiver will attend 100% of all monthly team meetings.
Parent/guardian/caregiver will participate in home passes 90% of the time as recommended by the treatment team.

IV. Minimum Qualifications

Master's or Doctorate degree in social work, psychology, marriage and family, or related human service field, with a current license issued by the Indiana Behavioral Health and Human Services Licensing Board as one of the following: 1) Clinical Social Worker, 2) Marriage and Family Direct Worker, 3) Mental Health Counselor.

V. Billable Unit

- Paid actual cost based on an approved budget.

VI. Case Record Documentation

Case record documentation for service eligibility must include:
1) A completed, signed, and dated DCS/ Probation referral form authorizing services
2) Documentation of regular contact with the referred families/children and placement provider through Case Notes which document: Date, Start Time, End Time, Participants, Individual providing service, and location
3) Written progress reports no less than monthly or more frequently as prescribed by

DCS and requested supportive documentation. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.
4) Copy of treatment plan

VII. Service Access
All services must be accessed and pre-approved through a referral form from the referring DCS staff. In the event a service provider receives verbal or email authorization to provide services from DCS an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by DCS.
Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

VIII. Adherence to the DCS Practice Model
Services must be provided according to the Indiana Practice Model, providers will build trustbased relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. 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

IX. . Trauma Informed Care
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/):
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. 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?" 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. 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

Trauma Specific Interventions: (modified from the SAMHSA definition)
_ The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
_ 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)
_ 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.

X. Cultural and Religious Competence.
Provider must respect the culture of the children and families with which it provides services. 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. 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. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth. The guidebook can be found at:

http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf

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. 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.

XI. Child Safety
Services must be provided in accordance with the Principles of Child Welfare Services. Please note: All services (even individual services) are provided through the lens of child safety. 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. Continual assessment of child safety and communication with DCS is required. It is the responsibility of the service provider to report any safety concerns, per state statue, IC 31-33-5-1. 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.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
DRUG TESTING AND SUPPLIES

I. Service Description

These services are designed for individuals who are suspected by DCS workers and Probation Officers of drug and/or alcohol use and require immediate testing. The drug test list includes Drugs of Abuse (illegal drugs), Therapeutic drugs (Prescription Drug-Painkillers, Mental Health Meds, etc.), and Designer drugs (i.e. Synthetic Marijuana). The vendor must provide all required supplies and courier services to transport all specimens, test results, and testing materials to and from any location within the referring county.

The types of drug screens included, but are not limited to, saliva/oral fluid, hair follicle, urine, blood and alcohol tests. DCS anticipates purchasing bulk saliva/oral fluid tests for administration by DCS staff. Other tests would need to be administered by provider or lab staff.

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 and providing certified copies of drug tests, if requested, up to 2 years after screening.

The vendor shall provide Initial Testing and Gas Chromatography/Mass Spectrometry Confirmation (GC/MS) Testing or other federally approved testing methods which may include LC/MS/MS or GC/MS/MS (when the Initial Tests indicate a positive result) for any location within the referring county.

The Vendor shall ensure proper legal chain-of-custody procedures are maintained and comply with departmental procedure, state and federal law. The vendor shall also ensure complete integrity of each specimen tested and the respective test results. Receiving, transfer and handling of all specimens by laboratory personnel shall be fully documented using the proper chain-of custody. The vendor shall also ensure that all screens are observed by an individual of the same gender as the client.

Testing shall not be conducted on any specimen without a legal chain-of-custody. All specimens found to be "Adulterated" or "Contaminated" shall be treated as an Invalid Specimen. Any specimen without a valid chain-of-custody is to be destroyed. The submitting location shall be notified in writing when a specimen has been rejected due to an invalid chain-of-custody or any other integrity problem. Monthly reports shall document how many random samples were taken minus how many "Adulterated" or "Contaminated" specimens there were for the month. (Note: This does not apply to oral fluid testing.)

Initial Testing

All sample collections drug screens will be observed sample collections screens. Minimum of substances tested should include Alcohol, Amphetamines, Barbiturates, Benzodiazepines, Cocaine, Cannabis, Opiates, Methadone, Oxycodone, Tramadol, Buprenorphine, Synthetic Marijuana, Bath Salts, Methamphetamine and other drugs indicated by client's history. Other substances not listed that the client may report a history of using may also be tested. The agency will be expected to provide reports that state the minimum level necessary to detect the presence of each substance, the level of substance detected, and the chain of custody documentation. Assurance must be given for accurate results even if the confirmation process is the only means to ensure accurate results due to the screening process providing inaccurate results.

For urine screens, testing for creatinine levels shall be conducted on all samples. The vendor shall also insure testing for total Cannabinoids per mg of creatinine using spectrophotometer technology. The Vendor shall insure testing for specific gravity on all samples with a creatinine level below 20 mg per deciliter. The Vendor shall also insure the administration of a nitrite test on any specimen that contains no creatinine and has a specific gravity test of 1.000.

Initial screening shall be conducted utilizing an enzyme immunoassay method. Testing should occur for the following substances utilizing the cut-off levels listed below:

DRUG	URINE	ORAL FLUID	HAIR LEVELS*
Amphetamines	*1000NG/ML*	*20NG/ML*	*500PG/MG*
Cannabinoids	*50NG/ML*	*1NG/ML*	*1PG/MG*
Benzodiazepines	*300NG/ML*	*10NG/ML*	*200PG/MG*

Methamphetamine (including ECSTACY(MDMA), ADAM (MDA)	*1000NG/ML*	*20NG/ML*	*500PG/MG*
Opiates	*2000NG/ML*	*10NG/ML*	*200PG/MG*
Cocaine	*300NG/ML*	*5NG/ML*	*500PG/MG*

**Hair uses = PG/MG = weight*
** For all other substances tested use recommended laboratory cutoff levels*

When indicated by the referral source, Synthetic Marijuana will not undergo the screening process and will only undergo the confirmation testing to insure accurate results.

All negative samples held by the laboratory will be retained for one week. A retention time extension may be requested based upon need. Confirmations will be completed on negative samples if requested.

Confirmation Testing

Confirmation Testing **shall** be conducted utilizing GC/MS or LC/MS/MS Technology on all samples initially testing POSITIVE. The following cut-off levels shall be utilized:

DRUG	URINE	ORAL FLUID	HAIR LEVELS*
Amphetamines	*500NG/ML*	*10NG/ML*	*300PG/MG*
Cannabinoids	*15NG/ML*	*.5NG/ML*	*.05PG/MG*
Benzodiazepines	*100NG/ML*	*1NG/ML*	*50PG/MG*
Methamphetamine (including ECSTACY(MDMA), ADAM (MDA)	*500NG/ML*	*10NG/ML*	*300PG/MG*
Opiates	*150NG/ML*	*5NG/ML*	*200PG/MG*
Cocaine	*150NG/ML*	*1NG/ML*	*50PG/MG*

**Hair uses = PG/MG = weight*
** For all other substances tested use recommended laboratory cutoff levels*

All positive samples shall be frozen and maintained for 365 days by the laboratory. A retention time extension may be requested based upon need.

In situations where the source of the Methamphetamine or Amphetamines is present, and the presence may come into question, the vendor must perform a d-1-isomer differentiation. This service is to be offered at
no additional cost to the Department of Child Services and performed when requested by DCS or Probation.

The vendor shall insure that all laboratories used for drug testing purposes must comply with all applicable Federal Department of Health and Human Service, and, under these federal requirements, are subsumed Substance Abuse and Mental Health Services Administration (SAMSHA) or The College of American Pathology (CAP), or Clinical Laboratory Improvement Act (CLIA) requirements.

Results Notification

The vendor shall notify the Department of Child Services and/or Probation of testing results via email or fax on vendor letterhead. The results will also be sent by U.S. mail to the referring agency as well. The vendor shall gain approval from DCS for any changes in the results notification system.

The referring agency will be notified of negative test results within 24 hours of the test. The specified time frame is from delivery to the testing laboratory to the time of notification. Positive test results will be provided within 72 hours of the lab receipt of the sample specimen.

For urine tests, diluted results must be reported on the result form.

Courier System

The vendor will coordinate all courier services to transport all specimens, test results, and testing materials to and from any location within the referring county. Deliveries shall be made during regular working days, normally between the hours of 8:00 am and 5:00pm unless otherwise indicated. The vendor shall be responsible for the cost of all courier services provided under the contract.

The vendor shall provide courier services that maintain the legal chain-of-custody, throughout the State of Indiana within 24 hours of request of pick up.

The vendor shall provide postage paid mailers or next day delivery services for utilization at any location that desires to use this method as an alternative to the courier services. This shall be at no additional charge to DCS.

The vendor's courier system shall provide documented, legal chain-of-custody throughout the State of Indiana which includes same day or next day delivery throughout Indiana.

Technical Support

A toll free 800 number will be available to all DCS local offices and Probation departments, in the State of Indiana to contact for technical support. Technical support staff and laboratory technicians shall be available during normal working hours via the 800 number, to provide technical assistance at no additional cost.

Supplies

The vendor shall provide the following supplies:
1) Sample containers
2) Specimen donor labels
3) Evidence security tape
4) Evidence bags
5) Evidence chain-of-custody forms with seals
6) Swabs
7) All supplies required for mailing or next day delivery
8) Any additional supplies necessary for referring specimens to the laboratory.

Note Regarding testing of Additional Substances:

A provider and/or the referral source may identify the need for screening of additional substances outside of what is specified above. This may be identified as a need in the entire region or for a specific client being referred.

If a contracted provider is proposing to test for additional substances to the already approved list of substances the provider shall submit an updated rate list to the Regional Child Welfare Services Coordinator to be approved by the Regional Services Counsel.

In the instance that the referral source has identified the need for testing of additional substances outside of what is specified above for a referred client, the provider will be expected to provide reports that state the minimum level necessary to detect the presence of each substance, the level of substance detected, and the chain of custody documentation. All testing levels (initial and confirmation) for additional substances outside of what is specified above shall be in compliance with Substance Abuse and Mental Health Administration (SAMHSA) regulations. All rates shall be billed at actual cost.

II. Target Population

Services must be restricted to the following eligibility categories:
1) Parent(s) of children for whom a DCS assessment has been initiated
2) Children and parent(s) who have substantiated cases of abuse and/or neglect

3) Children with a status of CHINS, and/or JD/JS
4) Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.
5) Minor children suspected of drug use prior to adjudication

III. Goals and Outcome Measures

Goal #1 Services are provided timely as indicated in the service description above.
Outcome Measures
1) 100% of courier services will be provided within a 24 hours of a request for pick up.
2) 100% of referring agencies will be notified of negative test results within 24 hours of laboratory receipt of sample specimen.
3) 100% of referring agencies will be notified of positive test results within 72 hours of laboratory receipt of sample specimen.

Goal #2 Services are provided as indicated in the service description above.
Outcome Measures
1)100% of proper legal chain-of-custody procedures will be maintained and will comply with Departmental Policy, State and Federal law.
2) 100% of all specimens will be tested for illegal drugs or prescription medication if the client does not have a valid prescription**.** Amphetamines Cannabinoids Benzodiazepines Opiates, Cocaine, and Methamphetamines utilizing the cut-off levels listed above.
3) 100% of supplies will be provided to referring counties upon request.

IV. . Qualifications

A laboratory participating in drug testing must comply with all applicable Federal Department of Health and Human Service, and, under these federal requirements, are subsumed Substance Abuse and Mental Health Services Administration (SAMHSA), or College of American Pathology (CAP), or Clinical Laboratory Improvement Act (CLIA) requirements.

V. Billable Units

Providers shall submit a rate list including the cost to provide the screens as defined in the required panel as well as including the cost for any drugs outside the panel that DCS may request. Providers do not have to provide all of the screening methods. Providers should be clear in their service and budget narrative as to if the rate for the screen includes the collection cost or if the proposal is for DCS administered screens. DCS anticipates purchasing

bulk saliva/oral fluid tests for administration by DCS staff. Other tests would need to be administered by provider or lab staff.

- **Oral Swabs (DCS Administered)**
- **Oral Swabs (Provider Administered)**
- **Urine Screens (Provider Administered)**
- **Hair Follicle Screens (Provider Administered)**
- **Blood Tests (Provider Administered)**
- **Alcohol Tests (Provider Administered)**
- **Instant Urine (Provider Administered)**
- **Instant Saliva Swab (Provider Administered)**
- **Instant Saliva Swab (DCS Administered)**
- **Instant Urine Kit Only**

NOTE: The provider cannot claim for the handling of rejected specimens or those otherwise unfit for testing.

• **Court**
The provider of this service may be requested to testify in court. 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. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. 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.

VI. Case Record Documentation

Case record documentation for service eligibility must include:

1) A completed, and dated DCS/ Probation referral form authorizing services
2) Receiving, transfer and handling of all specimens by laboratory personnel shall be fully documented using the proper chain-of-custody.

3) Documentation of notification of test results. Diluted results must be reported on the result form
4) The agency will be expected to provide reports that state the minimum level necessary to detect the presence of each substance, the level of substance detected, and the chain of custody documentation
5) All negative samples held by the laboratory will be retained for one week. A retention time extension may be requested based upon need.
6) All positive samples shall be frozen and maintained for 365 days by the laboratory. A retention time extension may be requested based upon need.

VII. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period.

VIII. Adherence to the DCS Practice Model

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. 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.

IX. Trauma Informed Care

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/):
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. 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?" 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. 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

Trauma Specific Interventions: (modified from the SAMHSA definition)

- The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
- 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)
- 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.

X. Cultural and Religious Competence.

Provider must respect the culture of the children and families with which it provides services. 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. 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. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth. The guidebook can be found at: http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf

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. 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.

XI. Child Safety

Services must be provided in accordance with the Principles of Child Welfare Services. Please note: All services (even individual services) are provided through the lens of child safety. 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. 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. 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.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
RANDOM DRUG TESTING

I. Service Description

Random screens are designed for individuals who may or may not meet the criteria for substance abuse and may or may not actively participate in drug treatment services. The drug test list includes drugs of abuse (illegal drugs), therapeutic drugs (prescription drug-painkillers, mental health medications, etc.), and designer drugs (i.e. synthetic marijuana). The provider has to have the ability to provide a maximum of three (3) screens per week as indicated by the referral form. It is expected the referring worker and provider agency will work together to develop a plan to determine the appropriate duration (up to 6 months) of each referral. The provider will adhere to the legal chain of custody on all confirmations so the test is admissible in court.

II. Service Delivery

The service provider must identify a plan to engage the client in the process, a plan to work with non-cooperative clients including those who believe they have no problems to address as well as working with special needs clients such as those who are mentally ill or developmentally delayed.

The types of drug screens include, but are not limited to, saliva drug screen/oral fluid based drug screen, hair follicle and urine.

Initial Testing

All sample collections drug screens will be observed sample collections screens. The vendor shall also ensure that all screens are observed by an individual of the same gender as the client. Minimum of substances tested should include Alcohol, Amphetamines, Barbiturates, Benzodiazepines, Cocaine, Cannabis, Opiates, Methadone, Oxycodone, Tramadol, Buprenorphine, Synthetic Marijuana, Bath Salts, Methamphetamine and other drugs indicated by clients history. Other substances not listed that the client may report a history of using may also be tested. The agency will be expected to provide reports that state the minimum level necessary to detect the presence of each substance, the level of substance detected, and the chain of custody documentation. When requested by the referral source, Synthetic Marijuana will not undergo the screening process and will only undergo the confirmation testing to insure accurate results.

For urine screens, testing for creatinine levels shall be conducted on all samples. The vendor shall also insure testing for total Cannabinoids per mg of creatinine using spectrophotometer technology. The Vendor shall insure testing for specific gravity on all samples with a creatinine level below 20 mg per deciliter. The Vendor shall also insure the administration of a nitrite test on any specimen that contains no creatinine and has a specific gravity test of 1.000.

Initial screening shall be conducted utilizing an enzyme immunoassay method. Testing should occur for the following substances utilizing the cut-off levels listed below:

DRUG	URINE	ORAL FLUID	HAIR LEVELS*
Amphetamines	*1000NG/ML*	*20NG/ML*	*500PG/MG*
Cannabinoids	*50NG/ML*	*1NG/ML*	*1PG/MG*
Benzodiazepines	*300NG/ML*	*10NG/ML*	*200PG/MG*
Methamphetamine (including ECSTACY(MDMA), ADAM (MDA)	*1000NG/ML*	*20NG/ML*	*500PG/MG*
Opiates	*2000NG/ML*	*10NG/ML*	*200PG/MG*
Cocaine	*300NG/ML*	*5NG/ML*	*500PG/MG*

**Hair uses = PG/MG = weight*
**For all other substances tested use recommended laboratory cutoff levels*

When requested by the referral source, Synthetic Marijuana will not undergo the screening process and will only undergo the confirmation testing to insure accurate results.

All negative samples held by the laboratory will be retained for one week. A retention time extension may be requested based upon need. Confirmations will be completed on negative samples if requested.

Confirmation Testing

Confirmation Testing **shall** be conducted utilizing GC/MS or LC/MS/MS Technology on all samples initially testing POSITIVE. The following cut-off levels shall be utilized:

DRUG	URINE	ORAL FLUID	HAIR LEVELS*
Amphetamines	*500NG/ML*	*10NG/ML*	*300PG/MG*
Cannabinoids	*15NG/ML*	*.5NG/ML*	*.05PG/MG*
Benzodiazepines	*100NG/ML*	*1NG/ML*	*50PG/MG*
Methamphetamine (including ECSTACY(MDMA), ADAM (MDA)	*500NG/ML*	*10NG/ML*	*300PG/MG*
Opiates	*150NG/ML*	*5NG/ML*	*200PG/MG*
Cocaine	*150NG/ML*	*1NG/ML*	*50PG/MG*

**Hair uses= PG/M= weight*

** For all other substance tested use recommended laboratory cutoff levels*

All positive samples shall be frozen and maintained for 365 days by the laboratory. A retention time extension may be requested based upon need.

In situations where the source of the Methamphetamine or Amphetamines is present, and the presence may come into question, the vendor must perform a d-1-isomer differentiation. This service is to be offered at no additional cost to the Department of Child Services and performed when requested by DCS or Probation.

The Vendor shall ensure proper legal chain-of-custody procedures are maintained and comply with departmental procedure, state and federal law. The vendor shall also ensure complete integrity of each specimen tested and the respective test results. Receiving, transfer and handling of all specimens by personnel shall be fully documented using the proper chain-of-custody.

The vendor shall insure that all laboratories used for drug testing purposes must comply with all applicable Federal Department of Health and Human Service, and, under these federal requirements, are subsumed Substance Abuse and Mental Health Services Administration (SAMSHA) or The College of American Pathology (CAP), or Clinical Laboratory Improvement Act (CLIA) requirements.

A letter to all referred clients will be required within three (3) calendar days of referral with instructions for contacting the agency immediately to begin screens. It is expected that the first screen will be collected within seven (7) calendar days of referral and each subsequent screen will be random. One or more toll free phone lines will be provided for clients to call daily to determine the day their screen is to be required. Agency must have a plan in place to modify the

phone messages every day by 5 a.m., instructing clients whether to report that day for a screen or call again the next day.

Note: It is expected that the referring worker and provider agency will work together to develop a plan to administer random testing for clients who do not have access to public transportation or telephone. In addition, the referring worker may also indicate the required number of random drug screens.

The agency shall update the referring worker, by phone or email, within ten (10) calendar days of the date the referral was sent regarding the status of the referral. Agencies should inform the referring worker of the date the client completed their first screen or, if the client has not contacted the agency to complete their first screen, a consultation with the referring worker should be held to determine the next steps of services.

Results Notification:

The vendor shall notify the local Department of Child Services Office/ Probation Officer (PO) of testing results via email or fax on vendor letterhead. The results will also be sent by U.S. mail to the referring county as well. The vendor shall gain approval from DCS or Probation for any changes in the results notification system.

The referring agency will be notified of positive test results within 72 hours of the lab receipt of the sample specimen. Negative test results will be provided within 24 hours of the test.

No-show alert forms will be provided by the contracted agency to the referring worker within 24 hours of the client's failure to show. Failure to show may result in an administrative discharge. Any client who is administratively discharged must request a new referral from the referring worker to begin receiving services again.

The DCS/Probation shall be notified in writing if the specimen has been rejected due to an invalid chain-of-custody or any other integrity problem.

For those employing urine tests diluted results must be reported on the result form.

Testing shall not be conducted on any specimen that does not have a legal chain-of-custody. All specimens found to be "Adulterated" shall be treated as an Invalid Specimen. Any specimen without a valid chain-of-custody is to be destroyed. The referring location shall be notified in writing when a specimen has been rejected due to an invalid chain-of-custody or any other integrity problem. Monthly reports shall document how many random samples were attempted and completed minus how many "Adulterated" specimens there were for the month.

Note Regarding testing of Additional Substances:

A provider and/or the referral source may identify the need for screening of additional substances outside of what is specified above. This may be identified as a need in the entire region or for a specific client being referred.

If a contracted provider is proposing to test for additional substances to the already approved list of substances the provider shall submit an updated rate list to the Regional Child Welfare Services Coordinator to be approved by the Regional Services Counsel.

In the instance that the referral source has identified the need for testing of additional substances outside of what is specified above for a referred client, the provider will be expected to provide reports that state the minimum level necessary to detect the presence of each substance, the level of substance detected, and the chain of custody documentation. All testing levels (initial and confirmation) for additional substances outside of what is specified above shall be in compliance with Substance Abuse and Mental Health Administration (SAHMSA) regulations.

III. Target Population

Services must be restricted to the following eligibility categories:
1) Parent(s) for whom a DCS assessment has been initiated.
2) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
3) Children and their families which have an Informal Adjustment (IA) or the children have the status of CHINS or JD/JS.
4) Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.
5) Minor children suspected of drug use prior to adjudication.

IV. Goals and Outcome Measures

Goal #1 Drug screen results will be provided to the referring worker in a timely fashion.
Outcome Measures

1) 100% of negative test results within 24 hours of laboratory receipt of sample.
2) 100% of positive test results within 72 hours of laboratory receipt of sample.

Goal #2 "No Show" alerts based on occurrence.
Outcome Measures

1) 100% of "No Shows" alerts will be provided to referring worker within 24 hours of the client's failure to show.

V. Minimum Qualifications

Sample collection does not require the services of a certified drug abuse counselor. The person providing this service must be trained in sample collection and the chain of custody procedures to document the integrity and security of the specimen from time of collection until receipt by the laboratory.

VI. Billable Units

Initial Screen

The provider needs to submit an all inclusive rate for the cost associated with conducting the screen. The proposal should include all costs from the drug screen supplies needed to do the screen to the result notifications. The proposed initial rate shall include an all inclusive rate for the drug screen panel, special requests and administrative cost to administer the screen. A separate rate shall be submitted for confirmation costs.

The provider cannot claim for the handling of rejected specimens or those otherwise unfit for testing.

The vendor shall ensure that the chain of custody procedure is followed to maintain the integrity and security of the specimen from time of collection until receipt by the laboratory.

Confirmation of Positive Test (lab processing)

The confirmation test is for those initial drug screens with a "Positive" result, all screens for synthetic marijuana, or negative screens with a DCS requested confirmation. The unit rate will include all cost associated with confirming the status of the initial drug screen and will include results notification. The vendor shall ensure that the chain of custody procedure is followed to maintain the integrity and security of the specimen from time of collection until receipt by the laboratory.

Interpretation, Translation and Sign Language Services

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

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. 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. No side comments or conversations between the Interpreters and the clients should occur.
The location of and cost of Interpretation, Translation, and Sign Language Services are the responsibility of the Service Provider. 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. 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. Providers can use DCS contracted agencies and request that they be given the DCS contracted rate but this is not required. 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. 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.

Court

The provider of this service may be requested to testify in court. 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. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day per referred family/client. 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.

VII. Case Record Documentation

Case record documentation for service eligibility must include:
1) A completed and dated DCS/ Probation referral form authorizing services
2) Documentation of regular contact with the referred families/children
3) Documentation of screen results notification sent to DCS.
4) "No Show" alerts will be provided to referring worker within 24 hours of the client's failure to show.
5) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation.

VIII. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period.

IX. Adherence to the DCS Practice Model

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. 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. Trauma Informed Care

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/):
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. 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?" 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. 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

Trauma Specific Interventions: (modified from the SAMHSA definition)

- The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
- 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)

- 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. Cultural and Religious Competence.

Provider must respect the culture of the children and families with which it provides services. 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. 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. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth. The guidebook can be found at: http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf

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. 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.

XIII. Child Safety

Services must be provided in accordance with the Principles of Child Welfare Services. Please note: All services (even individual services) are provided through the lens of child safety. 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. 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. 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.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
DETOXIFICATION SERVICES

I. Service Description

This service standard applies to families and children involved with the Department of Child Services and/or Probation. Services may be provided for clients of all ages in need of detoxification services. Detoxification is a process of treating individuals who are physically dependent on alcohol or drugs, and includes the period of time during which the body's physiology is adjusting to the cessation of substance use.

Three immediate goals of detoxification shall be included, to provide a safe withdrawal from the alcohol/drug(s) of dependence and enable the patient to become drug free, to provide withdrawal that is humane and protects the patient's dignity, and to prepare the patient for ongoing treatment of his or her alcohol and other drug dependence.

II. Service Delivery

The detoxification program must be state licensed and certified as well as supervised by a licensed physician. In addition, the program shall provide living accommodations in a structured environment for individuals who require twenty-four (24) hour per day supervision while withdrawing from toxic levels of consumption. Detoxification clients will be monitored by qualified, experienced staff 24 hours a day. Services will be available continuously twenty-four (24) hours a day, seven (7) days per week. Ambulatory detoxification may be provided on an outpatient basis as an alternative in limited situations. A caring staff, a supportive environment, sensitivity to cultural issues, confidentiality, and the selection of appropriate detoxification medication (if needed) are all important to providing humane withdrawal.

Clients will be accepted into the program within twenty-four (24) hours of the referral or sooner if an emergency exists. The type, length, and intensity of an individual's detoxification are determined by the severity of the addiction. Consultation with the Family Case Manager (FCM) and a new referral must be issued if length of stay is longer than two to six days.

All sample collections drug screens will be observed sample collections screens. The vendor shall also ensure that all screens are observed by an individual of the same gender as the client.

Minimum of substances tested should include Alcohol, Amphetamines, Barbiturates, Benzodiazepines, Cocaine, Cannabis, Opiates, Methadone, Oxycodone, Tramadol, Buprenorphine, Synthetic Marijuana, Bath Salts, Methamphetamine and other drugs indicated by client's history. Other substances not listed that the client may report a history of using may also be tested. The agency will be expected to provide reports that state the minimum level necessary to detect the presence of each substance, the level of substance detected, and the chain of custody documentation. Assurance must be given for accurate results even if the confirmation process is the only means to ensure accurate results due to the screening process providing inaccurate results.

A laboratory participating in DCS/Probation drug testing must comply with all applicable Federal Department of Health and Human Service, and, under these federal requirements, are subsumed Substance Abuse and Mental Health Services Administration (SAMHSA), or College of American Pathology (CAP), or Clinical Laboratory Improvement Act (CLIA) requirements.

The provider shall inform the referring worker, of the drug screen results within ten (10) calendar days of the initial test.

The provider will develop a recovery plan. The recovery plan should include client's mental health status at transition and recommendations for the next level of recovery support services, and substance use recovery resources. The recovery plan could include any needed recommendations for psychological testing, psychiatrist consultation and/or medication evaluation. A consultation with the Family Case Manager to obtain a new referral must be completed to refer client to the next level of care.

Best practice will have client transition only when the next step of the recovery plan is available immediately or in a short time frame.

III. When DCS is not paying for services:

A billable unit of "Reports" has been developed for providers who service DCS families without DCS payment for these services (Medicaid, insurances, self-pay) but DCS wants a report from the provider on the progress of the family. The referral process has been set up to authorize reports and court components on the DCS referral form in these incidences. **DCS will only pay for reports when DCS is not paying for these services.** If the services provided are not funded by DCS, the report rate per hour will be paid for the necessary reports on a referral form issued by DCS. Court testimony will be paid per appearance if requested on a referral form issued by

DCS. In order to be paid for a court appearance a subpoena or written request from DCS should be on file.

IV. . Target Population

Services must be restricted to the following eligibility categories:

1) Children and families who have substantiated cases of Use 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.

V. Goals and Outcomes

Goal #1: Maintain timely intervention with the family and regular and timely communication with referring worker.

Outcome Measures:

1) 90% of services initiated within 24 hours of the referral.
2) 100% of recovery reports will be submitted to the Family Case Manager or Probation Officer.
3) 100% of cases will include a consultation with the Family Case Manager Probation Officer to discuss the recommended next level of care.

Goal #2: Effective treatment for individuals

Outcome Measures:

1) 90% of clients will participate in continuing care upon completion of detoxification.

Goal #3 DCS/Probation and clients will report satisfaction with services provided

Outcome Measures:

1) 90% of the families who have participated in medical detoxification will rate the services "satisfactory" or above on a satisfaction survey developed by the service provider, unless DCS/Probation distributes one to providers for their use with clients. Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.

2) DCS/Probation satisfaction will be rated 4 and above on the Service Satisfaction Report.

VI. Qualifications

Licensed Physician:

A licensed physician by the professional licensing agency shall be identified as the program's medical director. The vendor shall be licensed and/or certified by the Indiana Division of Mental Health and Addiction according to state law.

VII. Billable Units

Medicaid:

Providers should bill Medicaid or private insurance when appropriate. For information on coverage of detoxification services and specific Medicaid Programs, please refer to the Indiana Health Coverage Programs (IHCP) Provider Manual located at www.indianamedicaid.gov.

DCS funding:

- **Detoxification Services (inpatient)**: For those not eligible for Medicaid a Per Diem rate will be paid for services as defined in this service standard. Detoxification Services will not be paid for services not deemed medically necessary.
- **Detoxification Services (outpatient)**: For those not eligible or Medicaid, a Per Diem rate will be paid or services as defined in this service standard. Detoxification Services will not be paid for service not deemed medically necessary.
- **Court:** The provider of this service may be requested to testify in court. 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. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. 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.
- **Reports**
  If the services provided are not funded by DCS, the “Reports” hourly rate will be paid. A referral for “Reports” must be issued by DCS in order to bill.

VIII. Case Record Documentation

1) A completed and dated DCS/ Probation referral form authorizing services
2) Written reports no less than 7 days from transition to next level of care. Case documentation shall show when report is sent.
3) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation.

IX. . Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

X. Adherence to the DCS Practice Model

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. 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.

XII. Trauma Informed Care

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/):
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. 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?" 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. 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

Trauma Specific Interventions: (modified from the SAMHSA definition)

- The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
- 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)
- 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.

XIV. Cultural and Religious Competence.

Provider must respect the culture of the children and families with which it provides services. 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. 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. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth. The guidebook can be found at: http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf

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. 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

Services must be provided in accordance with the Principles of Child Welfare Services. Please note: All services (even individual services) are provided through the lens of child safety. 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. 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. 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.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
RESIDENTIAL SUBSTANCE USE TREATMENT

Service Description

This service standard applies to families and children involved with the Department of Child Services (DCS) and/or Probation. Services may be provided for clients of all ages with a substance-related disorder and with minimal manageable medical conditions; minimal withdrawal risk; or emotional, behavioral cognitive conditions that will not prevent the client from benefiting from this level of care. Residential treatment programs are characterized by offering 24 hour supervised living with a highly structured treatment program that includes individual, group, and family counseling. Residential treatment is most appropriate for clients who are unsuccessful in outpatient. Residential treatment is comprehensive and intensive. The focus of residential treatment is to give the client the tools to begin a substance-free lifestyle. The program must be licensed and/or certified by The Division of Mental Health and Addictions. The program shall be staffed by appropriately credentialed personnel who are trained and competent to implement residential programming.

Service Delivery

The minimum length of stay in the program shall be 10 days and the maximum stay 21 days. The service provider must identify a plan to engage the client in the process, a plan to work with non-cooperative clients including those who believe they have no problems to address as well as working with special needs clients such as those who are mentally ill or developmentally delayed. Services are planned and organized with addiction professionals and clinicians providing multiple treatment service components for the rehabilitation of alcohol and drug abuse or dependence in a group setting.

An individualized recovery plan must be developed that considers the client's age, ethnic background, cognitive development and functioning, and clinical issues. Recovery plans should connect substance use and how it affects child safety. Attention to adverse experiences in the client in an attempt to break the cycle of child maltreatment. Recovery plans shall provide a framework for measuring success and progress. Recovery plans should also include goals and objectives. Goals shall be designed to address the issue(s) identified in the substance use assessment and include an achievable time frame. Objectives shall have an expected result. A recovery plan partially based on a functional assessment of each resident's daily living, socialization, and coping skills that is based on structured evaluation and observation of behavior.

Residential treatment services must be based on a written, cohesive, and clearly stated philosophy and treatment orientation and must include the following standards:
(1) There must be evidence that the philosophy is based on literature, research, and proven practice models.
(2) The services must be client centered.
(3) The services must consider client preferences and choices.
(4) There must be a stated commitment to quality services.
(5) The residents must be provided a safe, alcohol free, and drug free environment.
(6) The individual environment must be as homelike as possible.
(7) The services must provide transportation or ensure access to public transportation in accordance with the recovery plan.
(8) The services must provide flexible alternatives with a variety of levels of supervision, support, and treatment as follows:
(9) Service flexibility must allow movement toward the least restrictive environment but allow increases in intensity during relapses or cycles of relapse.
(10) The Residential services must provide continuous or reasonably incremental steps between levels.
(11) An agency cannot terminate a consumer from all services because of a need for more supervision, care, or direction without the agency making a good faith effort to continue to provide adequate, safe, and continuing treatment unless the
resident is transferred to another entity with continuing treatment provided to the resident by that entity.
(12) The treatment services must be carried out in residences that meet all life safety requirements and are licensed or certified as appropriate.
(13) Residential services shall include specific functions that shall be made available to consumers based upon the individual recovery plan. These functions include the following:
• Crisis services, including access to more intensive services, within twenty-four (24) hours of problem identification.
• Case management services, including access to medical services, for the duration of treatment, provided by a case manager or primary therapist.
• A consumer of Residential treatment services must have access to psychiatric or addictions treatment as needed.

All sample collections drug screens will be observed sample collections screens. The vendor shall also ensure that all screens are observed by an individual of the same gender as the client. Minimum of substances tested should include Alcohol, Amphetamines, Barbiturates, Benzodiazepines, Cocaine, Cannabis, Opiates, Methadone, Oxycodone, Tramadol, Buprenorphine, Synthetic Marijuana, Bath Salts, Methamphetamine and other drugs indicated by client's history. Other substances not listed that the client may report a history of using may also be tested. The agency will be expected to provide reports that state the minimum level necessary

to detect the presence of each substance, the level of substance detected, and the chain of custody documentation. Assurance must be given for accurate results even if the confirmation process is the only means to ensure accurate results due to the screening process providing inaccurate results.

The vendor shall ensure proper legal chain-of-custody procedures are maintained and comply with departmental procedure, state and federal law. The vendor shall also ensure complete integrity of each specimen tested and the respective test results. Receiving, transfer and handling of all specimens by personnel shall be fully documented using the proper chain-of-custody.
A laboratory participating in DCS/Probation drug testing must comply with all applicable Federal Department of Health and Human Service, and, under these federal requirements, are subsumed Substance Abuse and Mental Health Services Administration (SAMHSA), or College of American Pathology (CAP), or Clinical Laboratory Improvement Act (CLIA) requirements.

The vendor shall notify the local Department of Child Services Office/ Probation Officer (PO) of testing results via email or fax on vendor letterhead. The results will also be sent by U.S. mail to the referring county as well. The vendor shall gain approval from DCS or Probation for any changes in the results notification system.

The referring agency will be notified of positive test results within 72 hours of the lab receipt of the sample specimen. Negative test results will be provided within 24 hours of the test.

When DCS is not paying for services:

A billable unit of "Reports" has been developed for providers who service DCS families without DCS payment for these services (Medicaid, insurances, self-pay) but DCS wants a report from the provider on the progress of the family. The referral process has been set up to authorize reports and court components on the DCS referral form in these incidences. **DCS will only pay for reports when DCS is not paying for these services.** If the services provided are not funded by DCS, the report rate per hour will be paid for the necessary reports on a referral form issued by DCS. Court testimony will be paid per appearance if requested on a referral form issued by DCS. In order to be paid for a court appearance a subpoena or written request from DCS should be on file.

Target Population

In addition, services must be restricted to the following eligibility categories:
1. Children and families who have substantiated cases of child 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, and/or JD/JS
3. Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed

Goals and Outcome Measures

Goals #1 Recovery plan goals developed from the substance use assessment
Outcome Measure:
1) 90% of referred clients will have a recovery plan developed following the assessment with the recovery plan provided to the referring worker within 10 days of completion. Treatment goals will be individualized based on assessment with easy to evaluate outcomes. All goals will be developed with the expectation that the client will remain drug free.

Goal #2 Regularly modify and update the recovery plan to reflect client changes and progress
Outcome Measure:
1) 100% of Recovery plan should identify short term goals attainable at 10 to 21 days and measurable by an expected performance or behavior.
2) 90% of cases where the client successfully completes treatment will have a discharge plan submitted to the referring worker within 7 days of discharge. The discharge plan will include client's response to treatment and the aftercare plan.
3) 90% of cases where the client does not successfully complete treatment will have a recommendation report submitted to the referring worker within 7 days of termination of services.

Goal #3 Drug screens will be provided to the referring worker in a timely fashion.
Outcome Measures:

3) 100% of negative test results within 24 hours of laboratory receipt of sample.
4) 100% of positive test results within 72 hours of laboratory receipt of sample.

Goal #4 Clients will remain drug free.
Outcome Measures:
1) 95% of clients who participate in Residential treatment will remain drug free during the service provision period as indicated by routine drug screens.
2) 75% of clients who participate in Residential treatment will transition to a lower level of substance use treatment.
3) 60% of clients who participate in Residential treatment will remain drug free until DCS case closure as indicated by routine drug screens.

Goal #5 Provide No-show alert to FCM

Outcome Measures:
1) 100% of no-show alerts will be provided to referring worker immediately following each no-show.
Goal #6 DCS and client satisfaction with services
Outcome Measures:
1) DCS satisfaction will be rated 4 and above on the Service Satisfaction Report.
2) 80% of the clients who have completed substance use treatment services will rate the services "satisfactory" or above.

Qualifications

The program shall be staffed by appropriately credentialed personnel who are trained and competent to implement substance use treatment as outlined by state law. IC 25-23.6-10.5-9

Billable Units

Medicaid Funding: Medicaid shall be billed when appropriate.
Providers should bill Medicaid or private insurance when appropriate. For information on coverage of residential services and specific Medicaid Programs, please refer to the Indiana Health Coverage Programs (IHCP) Provider Manual located at www.indianamedicaid.gov.

Reports

If the services provided are not funded by DCS, the "Reports" hourly rate will be paid. A referral for "Reports" must be issued by DCS in order to bill.

DCS funding:

Residential Treatment
Those services not deemed appropriate to bill Medicaid eligible client, will be billed to DCS as a per diem rate for services as defined in this service standard.

Court Appearance
The provider of this service may be requested to testify in court. 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. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day per referred client/family. 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.

Case Record Documentation

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.

10) Documentation of progress notes that provide details of clients increase in performance and/or behavior that demonstrate growth and/or regression regarding the recovery process and lifestyle changes needed for the individual to remain drug free.
11) Recovery plan documenting short term goals attainable at 14 to 21 days and measurable by an expected performance or behavior.

Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation, an approved DCS referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period.

Adherence to the DCS Practice Model

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

Trauma Informed Care

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/):
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. 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?" 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. 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

Trauma Specific Interventions: (modified from the SAMHSA definition)

- The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
- 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)
- 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.

Cultural and Religious Competence.

Provider must respect the culture of the children and families with which it provides services. 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. 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. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth. The guidebook can be found at: http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf

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. 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.

Child Safety

Services must be provided in accordance with the Principles of Child Welfare Services. Please note: All services (even individual services) are provided through the lens of child safety. 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. 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. 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.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
SUBSTANCE USE DISORDER ASSESSMENT

I. Service Description

This service standard applies to families and children involved with the Department of Child Services and/or Probation. Services may be provided for clients of all ages in need of an assessment for substance use. The goal of the initial substance use assessment is to evaluate the client's substance use, the client's level of functioning and the appropriate entrance into substance use treatment services. The assessment shall screen for child safety and how parental substance use impacts the risk of harm to the child.

II. Service Delivery

A face-to-face clinical interview must take place with each referred individual. The face-to-face interview may take place in a clinical setting or in the client's home with prior approval from the referring Family Case Manager. The provider must be able to complete the initial assessment within 72 hours of the referral, if an emergency exists, or sooner if the Family Case Manager suspects the client is in need of detoxification services. For emergency assessments, it is expected that a verbal report will be provided to the referring Family Case Manager within 72 hours and a written report provided within 7 days after the completion of the assessment with the client. For non-emergency assessments, it is expected that a written reports will be received by the referring Family Case Manager 10 days after the completion of the assessment with the individual. Recommendations regarding the client's needs must be provided on each assessment.

The following standardized assessment tools for drug/alcohol use may be administered to accurately determine if further substance use assessment is indicated: Substance Use Subtle Screening Inventory (SASSI), Addiction Severity Index (ASI) Teen Addiction Severity Index (T-ASI), ASI Lite, Addiction Society of Medicine Placement Patient Criteria Revised Version II (ASAM PPII), Drug Use Screening Test (DAST), Substance Use Relapse Assessment (SARA). Other standardized tools may be used to best assess the specific needs of the client.

A multi-axial system must be used to develop a comprehensive bio-psychosocial assessment to include a mental status examination at the time of the initial appointment.
All sample collections drug screens will be observed sample collections screens. The vendor shall also ensure that all screens are observed by an individual of the same gender as the client. Minimum of substances tested should include Alcohol, Amphetamines, Barbiturates, Benzodiazepines, Cocaine, Cannabis, Opiates, Methadone, Oxycodone, Tramadol,

Buprenorphine, Synthetic Marijuana, Bath Salts, Methamphetamine and other drugs indicated by client's history. Other substances not listed that the client may report a history of using may also be tested. The agency will be expected to provide reports that state the minimum level necessary to detect the presence of each substance, the level of substance detected, and the chain of custody documentation. Assurance must be given for accurate results even if the confirmation process is the only means to ensure accurate results due to the screening process providing inaccurate results.

Bio-Psychosocial Assessment must include:

A description of the presenting problem. Clinical Syndromes and/or other conditions that may be a focus of clinical attention. An in-depth drug and alcohol use history with information regarding onset, duration, frequency, and amount of use; substance(s) of use and primary drug of choice. Any associated medical, psychological and social history of the client, associated health, work, family, person, and interpersonal problems; driving record related to drinking or drug use; past participation in treatment programs. The assessment will also include client's attitude toward treatment.

Mental health examination must include:

Client's mood, affect, memory processes, hallucinations, judgment, insight, and impulse control.

Assessing for Child Safety:

Parental substance use can negatively impact child's safety. It is important to assess the risk of parental substance use to the child and immediately report the concerns to the DCS Intake Hotline or the Family Case Manager. During the assessment the provider shall inquire about who lives in the client's home, if the client has children and if so, then inquire about child safety. Clients who meet at least 1 of the following criteria shall be screened for child safety concerns:

- Client is a parent, male or female
- Client has caretaking responsibilities for a child
- Client has full or part-time care of their children

The following questions, based on The Screening and Assessment for Family Engagement Retention and Recovery (SAFEER) principles, are to be utilized in assessing child safety:

- Where are your children at the time you use alcohol and/or drugs?
- Have you ever worried that you would not be able to take care of your children while you were using drugs and/or alcohol?
- Has anyone ever told you they were worried about how you could take care of your children because of your drug and/or alcohol use?

- Have you ever had trouble getting your children food, clothing or a place to live, or had a hard time getting your kids to school because you were using? When do your children eat their meals and what are examples of food they often eat?
- Has anyone ever reported you to the child welfare system in the past?
- Are any other agencies involved with your family because of concerns about your children?

Follow-up questions regarding safety protective factors could be helpful in assessing the risk to child safety. Examples on assessing protective factors are as follows:

- Is the child in someone else's care when the client uses drugs and/or alcohol?
- Does the client have sober relatives/friends they can utilize when they are not sober and cannot care for the children?
- How does the client keep the child safe when they are using drugs and/or alcohol?
- Determine what the willingness of the parent is to accept and participate in treatment and if the parent acknowledges they have a substance use disorder.

Therapist Recommendations:

Following the assessment of each client, the service provider must make a recommendation which includes any necessary treatment as well as the treatment modality and length.

Recommendations will incorporate child safety. The provider will include services around parent education and support on how to parent sober. These services might include communication skills, child development, nurturing, setting boundaries, how to interact at an age appropriate level and how to handle children's behavior.

Services must be available to clients who have limited daytime availability. The service provider must identify a plan to work with non-cooperative clients including those who believe they have no problems to address as well as working with special needs clients such as those who have mental health issues or are developmentally delayed.

No-show alert forms will be provided by the contracted agency to inform the referring worker of the client's failure to attend the initial assessment. After three no-shows, a new referral from the referring worker must be sent to initiate new services.

Services will be conducted with behavior and language that demonstrates respect for sociocultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral-valued culturally-competent manner.

III. Medicaid

It is the responsibility of the contracted service provider to be knowledgeable about the Medicaid billing requirements and comply with them, including provider qualifications and any preauthorization requirements and further, to appropriately bill those services in particular cases where they may be reimbursed by Medicaid. The Services not eligible for MEDICAID REHABILITATION OPTION (MRO) or MEDICAID CLINIC OPTION (MCO) may be billed to DCS.

IV. . When DCS is not paying for services:

A billable unit of "Reports" has been developed for providers who service DCS families without DCS payment for these services (Medicaid, insurances, self-pay) but DCS wants a report from the provider on the progress of the family. The referral process has been set up to authorize reports and court components on the DCS referral form in these incidences. **DCS will only pay for reports when DCS is not paying for these services.** If the services provided are not funded by DCS, the report rate per hour will be paid for the necessary reports on a referral form issued by DCS. Court testimony will be paid per appearance if requested on a referral form issued by DCS. In order to be paid for a court appearance a subpoena or written request from DCS should be on file.

V. Target Population

Services must be restricted to the following eligibility categories:

- Children and families who have substantiated cases of child abuse and/or neglect and will likely develop into an open case with Informal Adjustment (IA) or CHINS status.
- Children and their families which have an IA or the children have the with a status of CHINS, and/or JD/JS;
- Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.

VI. Goals and Outcome Measures

Goal #1: Maintain timely assessment with the family.
Outcome Measures:
1) 100% of emergency referred clients will be assessed within 72 hours or sooner if a medical crisis exists.
2) 90% of non-emergency referred clients will assessed within 10 days of the initial referral.

Goal #2: Timely receipt of report to prepare for services/court and regular and timely communication with the referring worker.

Outcome Measures:
1) **For emergency assessment:** 100% of the verbal reports will be received by the referring worker with 72 hours of the assessment; the written report received by the referring worker 7 calendar days after the assessment with the individual.
2) **For non-emergency assessments:** 100% of the written reports will be received by referring worker 10 days after the completion of the assessment with the individual.

Goal #3: Recommendations relevant and based on documentation in the body of the report.
Outcome Measures:
1) 100% of recommendations prepared as a result of the assessment are appropriate based on interviews, observations, review of other records, and completion of test instruments.
2) 100% of no-show alerts will be provided to referring worker immediately following the clients (3) third no-show.

VII. Minimum Qualifications

Minimum Qualifications:
The program shall be staffed by appropriately credentialed personnel who are trained and competent to complete Substance Use Assessments as required by state law.

VIII. Billable Units

Medicaid:

Services through the **MEDICAID CLINIC OPTION** may be Outpatient Mental Health Services. Medicaid shall be billed first for eligible services under covered evaluation and management codes, including those in the 90000 range.

MRO

Billing Code	Title
H0015HW U1	Alcohol and/or other drug services; intensive outpatient (treatment program that operates at least three(3) hours/day and at least three(3) days/week and is based on an individualized treatment plan, including **assessment**, counseling; crisis intervention and activity therapies or education

DCS funding:

Those services not deemed medically necessary for the Medicaid eligible client, including services to other referred members of the family that are not related to the behavior health care needs of the eligible client, will be billed to DCS per face-to-face hour as outlined below. These billable units will also be utilized for services to referred clients who are not Medicaid eligible and for those providers who are unable to bill Medicaid.

- **Substance Use Assessment**
  Per hour. Includes time face to face with the client administering, scoring, and interpreting testing and writing of reports. Maximum of 1 hour report writing may be billed per assessment.

Reminder: Not included are scheduling of appointments, collateral contacts, travel time and no shows. These activities are built into the cost of the face-to-face rate and shall not be billed separately

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

Interpretation, Translation and Sign Language Services
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. 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. 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). Sign Language should be done in the language familiar to the family.
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. 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. No side comments or conversations between the Interpreters and the clients should occur.

The location of and cost of Interpretation, Translation, and Sign Language Services are the responsibility of the Service Provider. 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. 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. Providers can use DCS contracted agencies and request that they be given the DCS contracted rate but this is not required. 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. 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.

- **Drug Screens**
  Actual cost of the screens.

- **Court**
  The provider of this service may be requested to testify in court. 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. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. 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.

- **Reports**
  If the services provided are not funded by DCS, the "Reports" hourly rate will be paid. A referral for "Reports" must be issued by DCS in order to bill.

IX. Case Record Documentation

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) Written reports as defined in this service standard.

X. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

XI. Adherence to the DCS Practice Model

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. 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.

XII. Trauma Informed Care

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/):
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. 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?" 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. 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

Trauma Specific Interventions: (modified from the SAMHSA definition)

- The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
- 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)
- 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. Cultural and Religious Competence.

Provider must respect the culture of the children and families with which it provides services. 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. 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. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth. The guidebook can be found at: http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf

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. 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

Services must be provided in accordance with the Principles of Child Welfare Services. Please note: All services (even individual services) are provided through the lens of child safety. 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. 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. 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.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
SUBSTANCE USE OUTPATIENT TREATMENT

I. Service Description

This service standard applies to families and children involved with the Department of Child Services and/or Probation. Services may be provided for clients of all ages with a substance related disorder and with minimal manageable medical conditions; minimal withdrawal risk; or emotional, behavioral cognitive conditions that will not prevent the client from benefiting from this level of care. A variety of scientifically based approaches to substance use recovery exists. Recovery prescribed for all clients must be evidenced based. Substance use recovery can include behavioral therapy (such as counseling, cognitive therapy, or psychotherapy), medications, or their combination.

Effective recovery attends to multiple needs of the individual, not just his or her substance use. To be effective, recovery must address the individual's substance use and any associated medical, social, psychological, vocational, and legal problems.

Parental substance use can potentially place a child's welfare at risk. A child whose parent's engage in substance use may not have the capability to properly supervise the child and/or may inadvertently place the child in an unsafe environment due to their impaired capability to make decisions. During the course of recovery, it is imperative the treatment provider assesses the safety of the child periodically and takes into consideration where the parent is in their recovery and how might their actions impact the safety and well-being of the child.

A face-to-face multi-axial clinical assessment must take place prior to admission to an outpatient program. (See Substance Use Disorder Assessment Service Standards)

II. Service Delivery

Services must be available to clients who have limited daytime availability. The service provider must identify a plan to engage the client in the process, a plan to work with non-cooperative clients including those who believe they have no problems to address as well as working with special needs clients such as those who have mental health issues or developmentally delayed.

Services are planned and organized with addiction professionals and clinicians providing multiple Recovery service components for the rehabilitation of alcohol and drug use or dependence in a group setting.

An individualized Recovery Plan must be developed that considers the client's age, ethnic background, cognitive development and functioning, and clinical issues. Recovery Plans should connect substance use and how it affects child safety. Recovery Plans shall provide a framework for measuring success and progress. Recovery Plans should also include goals and objectives. Goals shall be designed to address the issue(s) identified in the substance use assessment and include an achievable time frame. Objectives shall have an expected result.

Child safety shall be addressed in the event of relapse by the client and how parental substance use impacts the risk of harm to the child. All concerns regarding child safety will be immediately reported to the DCS Intake Hotline or the Family Case Manager.

The following questions, based on The Screening and Assessment for Family Engagement Retention and Recovery (SAFEER) principles, are to be utilized in assessing child safety:

- Where are your children at the time you use alcohol and/or drugs?
- Have you ever worried that you would not be able to take care of your children while you were using drugs and/or alcohol?
- Has anyone ever told you they were worried about how you could take care of your children because of your drug and/or alcohol use?
- Have you ever had trouble getting your children food, clothing or a place to live, or had a hard time getting your kids to school because you were using? When do your children eat their meals and what are examples of food they often eat?
- Has anyone ever reported you to the child welfare system in the past?
- Are any other agencies involved with your family because of concerns about your children?

Follow-up questions regarding safety protective factors could be helpful in assessing the risk to child safety. Examples on assessing protective factors are as follows:

- Is the child in someone else's care when the client uses drugs and/or alcohol?
- Does the client have sober relatives/friends they can utilize when they are not sober and cannot care for the children?
- How does the client keep the child safe when they are using drugs and/or alcohol?
- Determine what the willingness of the parent is to accept and participate in treatment and if the parent acknowledges they have a substance use disorder.

All drug screens will be observed screens. The vendor shall also ensure that all screens are observed by an individual of the same gender as the client.
Minimum of substances tested should include Alcohol, Amphetamines, Barbiturates, Benzodiazepines, Cocaine, Cannabis, Opiates, Methadone, Oxycodone, Tramadol, Buprenorphine, Synthetic Marijuana, Bath Salts, Methamphetamine and other drugs indicated by

client's history. Other substances not listed that the client may report a history of using may also be tested. The agency will be expected to provide reports that state the minimum level necessary to detect the presence of each substance, the level of substance detected, and the chain of custody documentation. Assurance must be given for accurate results even if the confirmation process is the only means to ensure accurate results due to the screening process providing inaccurate results.

A laboratory participating in DCS/Probation drug testing must comply with all applicable Federal Department of Health and Human Service, and, under these federal requirements, are subsumed Substance Abuse and Mental Health Services Administration (SAMHSA), or College of American Pathology (CAP), or Clinical Laboratory Improvement Act (CLIA) requirements.

Addictions Counseling (Individual Setting) – is designed to be a less intensive alternative to IOT.

1. Documentation must support how Addiction Counseling benefits the client, including when the client is not present.
2. Addiction Counseling requires face-to-face contact with the client and/or family members or non professional caregivers.
3. Addiction Counseling consists of regularly scheduled sessions as needed.
4. Addiction Counseling may include the following:
- Education on addiction disorders.
- Skills training in communication, anger management, stress management, relapse prevention.

5. Addiction Counseling goals are rehabilitative in nature.
6. Addiction Counseling must be provided in an age appropriate setting for a client less than eighteen (18) years of age receiving services.
7. Addiction Counseling must be individualized.
8. Drug Screens shall be utilized as part of treatment or as requested by Family Case Manager.
9. Case management/referrals to available community services.

Exclusions:

1. Clients with withdrawal risk or symptoms whose needs cannot be managed at this level of care, or who need detoxification services.
2. Clients at imminent risk of harm to self or others.
3. Addiction Counseling may not be provided for professional caregivers.
4. Addiction Counseling sessions that consists of education services only will not be reimbursed.

<u>Addiction Counseling (Group Setting)</u> - is designed to be less intensive alternative to IOT.

1. Documentation must support how Addiction Counseling benefits the consumer, including when services are provided in a group setting and/or the consumer is not present.
2. Addiction Counseling requires face-to-face contact with the consumer and/or family members or non professional caregivers.
3. Addiction Counseling consists of regularly scheduled sessions.
4. Addiction Counseling is intended to be a less intensive alternative to IOT.
5. Addiction Counseling may include the following:
    - Education on addiction disorders.
    - Skills training in communication, anger management, stress management, relapse prevention.
6. Addiction Counseling must demonstrate progress toward and/or achievement of consumer Recovery goals identified in the IICP.
7. Addiction Counseling goals are rehabilitative in nature.
8. A licensed professional must supervise the program and approve the content and curriculum of the program.
9. Addiction Counseling must be provided in an age appropriate setting for a consumer less than eighteen (18) years of age receiving services.
10. Addiction Counseling must be individualized.
11. Drug Screens shall be utilized as a part of treatment or as requested by the Family Case Manager.
12. Case managements/referrals to available community services.

Exclusions:

1. Clients with withdrawal risk or symptoms whose needs cannot be managed at this level of care, or who need detoxification services.
2. Clients at imminent risk of harm to self or others.
3. Addiction Counseling may not be provided for professional caregivers.
4. Addiction Counseling sessions that consists of education services only will not be reimbursed.

<u>Intensive Outpatient Recovery (IOT</u>)

1. Regularly scheduled sessions, within a structured program, that are at least three (3) consecutive hours per day and at least three (3) days per week.
    a. IOT includes the following components:
        i. Referral to 12 step programs, peers and other community supports.
        ii. Education on Addictions disorders.

iii. Skills training in communication, anger management, stress management and relapse prevention.
iv. Individual, group and family therapy (provided by a licensed professional or QBHP Only)

b. IOT must be offered as a distinct service.
c. IOT must be provided in an age appropriate setting for a client age eighteen (18) and under.
d. IOT must be individualized.
e. Access to additional support services (e.g. peer supports, case management, 12-step programs, aftercare/relapse prevention services, integrated Recovery, referral to other community supports) as needed.
f. The client is the focus of the service.
g. Documentation must support how the service benefits the client, including when the service is in a group setting.
h. Services must demonstrate progress toward or achievement of client Recovery goals identified in the IICP.
i. Service goals must be rehabilitative in nature.
j. Up to twenty (20) minutes of break time is allowed during each three consecutive hour session.
k. Drug Screens shall be utilized as a part of treatment or as requested by Family Case Manager.
l. Referral to available community services is available.

Exclusions:

1. Clients with withdrawal risk/symptoms whose needs cannot be managed at this level of care or who need detoxification services.
2. Clients at imminent risk of harm to self or others.
3. IOT will not be reimbursed for clients receiving Group Addictions Counseling on the same day.
4. IOT sessions that consist of education services only are not reimbursable.
5. Any service that is less than three hours may not be billed as IOT, but may be billed as Group Addictions Counseling (if provider qualifications and program standards are met).

<u>Specialized Recovery:</u>

Substance use Recovery can also be provided through the use of individual sessions as needed and 1 to 1.5 hours of group weekly or more than once weekly group counseling session based on assessment of individual's needs. Services will be conducted as outlined in the counseling and group counseling section of this service standard, and can include gender specific group counseling to deal specifically with gender issues that may cause barriers to the individual's ability to remain drug free (i.e. domestic violence, traumatic events and/or childhood trauma).

Specialized Recovery can also include modalities of brief counseling therapy.

Recovery Coaches:

Utilization of Recovery Coaches in treatment can provide a strength-based approach in assisting the client in connecting with recovery community supports and community resources. The Recovery Coach does not provide the primary treatment for the substance use disorder, but rather complements the treatment and works in partnership with the client and primary treatment personnel. Recovery Coaches build on the client's strengths, abilities and resources. Recovery Coaches work to decrease or stop substance use, increase the belief that recovery is possible and increase life skills. Recovery Coaches are to support positive changes made by the client and help the client overcome any obstacles that might inhibit the positive change. Recovery Coaches work with the client on developing a Relapse Recovery Plan; develop means in dealing with past triggers and identifying healthy coping skills to deal with life stressors. Recovery Coaches will primarily serve the clients in the home but may also serve the client in the community. Recovery Coaches may engage in the following list of activities:

Identify community/recovery supports	Attend a support meeting with client	Help identify client needs and benefits to the treatment program	Engage client in treatment
Develop a recovery plan	Identify triggers and ways to work through them	Identify alternative activities to maintain sobriety	Develop client self wellness goals
Work on client driven life goals, short & long term (i.e. education/treatment/employment)	Create a budget	Teach &/or model life skills (i.e. opening a bank account; filling out a job application etc.)	Locate safe housing
Coach on advocating for self	Help identify client's strengths	Develop structure/time management skills	Coach through crisis/emergency situations effectively

	and develop self esteem		
Facilitate transportation	Participate in Child and Family Team Meetings	Assist with coordinating services	Identify support system
Develop problem solving techniques	Develop parenting skills	Help understand child development & nutrition	Assist with parent/child interaction
Assist with child safety, understanding & implementing	Parenting sober: what that looks like through modeling &/or coaching (with child and parent)	Assist with family communication and rebuilding relationships	Education on reactive attachment disorder (RAD)
Education on conflict management	Education on Domestic Violence	Education on Mental Health	Education on Addiction

The goals of Recovery Coaches are to:

1. Decrease and/or eliminate substance use
2. Guide client through the recovery process
3. Assist clients in identifying their treatment goals
4. Increase client belief that recovery is possible and sustainable
5. Increase life skills, time management and build healthy relationships
6. Empower client to advocate for themselves

III. Medicaid

It is the responsibility of the contracted service provider to be knowledgeable about the Medicaid billing requirements and comply with them, including provider qualifications and any preauthorization requirements and further, to appropriately bill those services in particular cases where they may be reimbursed by Medicaid.

IV. . When DCS is not paying for services:

A billable unit of "Reports" has been developed for providers who service DCS families without DCS payment for these services (Medicaid, insurances, self-pay) but DCS wants a report from the provider on the progress of the family. The referral process has been set up to authorize reports and court components on the DCS referral form in these incidences. **DCS will only pay for reports when DCS is not paying for these services.** If the services provided are not funded by DCS, the report rate per hour will be paid for the necessary reports on a referral form issued by DCS. Court testimony will be paid per appearance if requested on a referral form issued by DCS. In order to be paid for a court appearance a subpoena or written request from DCS should be on file.

V. Target Population

In addition, services must be restricted to the following eligibility categories:

1) Children and families who have substantiated cases of use 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 and/or JD/JS or
3) Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.

VI. Goals and Outcome Measures

Goals #1: Clients will be engaged in services.

1)_____% of referred clients will begin treatment within 10 business days of referral.
2)_____% of referred clients will have stayed in treatment for 90 days or more.

Goals #2: Recovery/Treatment plan goals are developed from the substance use assessment.
Outcome Measure:

1) 100% of referred clients will have a Recovery plan developed following the assessment with the Recovery plan provided to the referring worker within 10 days of completion. Recovery goals will be individualized based on assessment with easy to evaluate outcomes.

Goal #3: Regularly modify and update the Recovery Plan to reflect client changes and progress.
Outcome Measure:

1) Recovery Plan should identify long and short term goals attainable at 2, 4, and 6-month's intervals and measurable by an expected performance or behavior.
2) Vendor shall maintain progress notes that provide details of clients increase in

performance and/or behavior that demonstrate growth and/or regression regarding the recovery process and lifestyle changes needed for the individual to remain drug free.
3) Upon successful completion of recovery the provider shall submit a discharge plan to the referring worker to include client's response to recovery and aftercare plan.
4) Written reports, with no less than monthly or more frequently as prescribed by DCS. Written reports to DCS by the 10th of the month or more frequently, as prescribed by DCS.

Goal #4: Drug screens will be provided to the referring worker in a timely fashion.
Outcome Measures:

1) 100% of referring agencies will be notified of negative test results within 24 hours of laboratory receipt of sample specimen.
2) 100% of referring agencies will be notified of positive test results within 72 hours of laboratory receipt of sample specimen.

Goal #5: Provide No-show alert to FCM.
Outcome Measures:

1) 100% of no-show alerts will be provided to referring worker immediately following each no-show.

Goal #6: DCS and client satisfaction with services
Outcome Measures:

1) DCS satisfaction will be rated 4 and above on the Service Satisfaction Report.
2) 80% of the clients who have completed substance use recovery services will rate the services "satisfactory" or above.

VII. Minimum Qualifications

Medicaid Reimbursed

It is the responsibility of the contracted service provider to be knowledgeable about the Medicaid provider qualifications.

DCS Reimbursed

The program shall be staffed by appropriately credentialed personnel who are trained and competent to complete Substance Use Outpatient Treatment as required by state law.

Recovery Coaches

Bachelor's degree in social work, psychology, sociology, or directly-related human service field from an accredited college. Other Bachelor's degrees will be accepted in combination with a minimum of five years experience working directly with families in the child welfare system. Must possess a valid driver's license and the ability to use private car to transport self and others and must comply with the contract requirements concerning minimum car insurance coverage.
In addition to above:

- Official certification as a Recovery Coach is preferred; however, in lieu of the official certification, the individual may have extensive substance addictions training.
- Trained in motivational interviewing preferred.
- Trained in trauma informed care preferred.
- Knowledge in addictions and how addiction impacts an individual and their family.
- Knowledge in the stages of change and how to motivate an individual through the different stages.
- Knowledge in the barriers individuals have in accessing and completing treatment.
- Knowledge of child abuse and neglect, child and adult development.
- Knowledge of community resources, particularly the recovery community, and willingness to work as a team member.
- Belief in helping clients change their circumstances, not just adapt to them.

Supervisor to Recovery Coaches

Master's or Doctorate degree in social work, psychology or directly-related human services field from an accredited college.

Services provided will be conducted with behavior and language that demonstrate respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; service will be delivered in a neutral-valued culturally-competent manner.

Providers are to respond to the on-going individual needs of staff by providing them with the appropriate combination of training and supervision. The frequency and intensity of training and supervision are to be consistent with "best practice" and comply with the requirements of each provider's accreditation body. Supervision should include individual, group and direct observation modalities and can utilize teleconference technologies. Under no circumstance is supervision/consultation to be less than one (1) hour of supervision/consultation per 25 hours of face-to-face direct client services provided, no occur less than every two (2) weeks.

VIII. Billable Units

Medicaid

Services through the **MCO** may be Outpatient Mental Health Services. Medicaid shall be billed first for eligible services under covered evaluation and management codes, including those in the

90000 range.

MRO

Billing Code	Title
H2035 HW	Alcohol and/or other drug recovery program, per hours
H2035 HW HR	Alcohol and/or drug recovery program per hour (family/couple, consumer present)
H2035 HW HS	Alcohol and/or drug recovery program, per hour (family/couple, without consumer present)
H0005 HW	Alcohol and/or other drug services; group counseling by a clinician
H0005 HW HR	Alcohol and/or drug services; group counseling by a clinician (family/couple, consumer present)
H0005 HW HS	Alcohol and/or drug services; group counseling by a clinician (family/couple, without the consumer present)
H0015 HW U1	Alcohol and/or other drug services; intensive outpatient (recovery program that operates at least three (3) hours/day and at least three (3) days/week and is based on an individualized recovery plan, including assessment, counseling; crisis intervention and activity therapies or education

DCS Funding

Those services not deemed medically necessary for the Medicaid eligible client, including services to other referred members of the family that are not related to the behavior health care needs of the eligible client, will be billed to DCS per face-to-face hour as outlined below. These billable units will also be utilized for services to referred clients who are not Medicaid eligible and for those providers who are unable to bill Medicaid.

Addictions Counseling (Individual & Family): To be billed per hour

(Note: Members of the client family are to be defined in consultation with the family and approved by the DCS. This may include persons not legally defined as part of the family.

- Includes client specific goal directed face-to-face contact with the identified

client/family during which services as defined in this Service Standard are performed.

- Includes Child and Family Team Meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family.

Addictions Counseling Group

Services include group goal directed work with clients. To be billed per person per hour.

Intensive Outpatient Treatment

Services include goal directed services as defined in this Service Standard. Per three hour session per person.

> ***Reminder:*** *Not included is routine report writing and scheduling of appointments, collateral contacts, travel time and no shows. These activities are built into the cost of the face-to-face rate and shall not be billed separately.*
>
> *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*

Recovery Coach, Face-to-Face Time with Client

(Note: Members of the client 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.)

- Includes client specific face-to-face contact with the indentified client/family during which services are defined in the applicable service standard are performed.
- Includes Child and Family Team Meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family.
- Includes in-vehicle (or in transport) time with client provided it is identified as goal directed, face-to-face, and approved/specified as part of the client's intervention plan (i.e. housing/apartment search etc.).
- Includes crisis intervention and other goal-directed interventions via telephone with the identified client family.

- Includes time spent completing any DCS approved standardized tool to assess family functioning.

Court Appearance

The provider of this service may be requested to testify in court. 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. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day per referred case. 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.

Reports

If the services provided are not funded by DCS, the "Reports" hourly rate will be paid. A referral for "Reports" must be issued by DCS in order to bill.

Drug Screens

Actual cost of the screens.

Translation or sign language

Interpretation, Translation and Sign Language Services

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

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

The location of and cost of Interpretation, Translation, and Sign Language Services are the responsibility of the Service Provider. 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. 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. Providers can use DCS contracted agencies and request that they be given the DCS contracted rate but this is not required. 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. 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.

IX. Case Record Documentation

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.

X. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation, an approved DCS referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period.

XI. Adherence to the DCS Practice Model

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

XII. Trauma Informed Care

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/):
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. 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?" 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. 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

Trauma Specific Interventions: (modified from the SAMHSA definition)

- The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
- 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)
- 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. Cultural and Religious Competence.

Provider must respect the culture of the children and families with which it provides services. 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. 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. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth. The guidebook can be found at: http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf

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. 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

Services must be provided in accordance with the Principles of Child Welfare Services. Please note: All services (even individual services) are provided through the lens of child safety. 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. 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. 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.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
DAY REPORTING/TREATMENT PROGRAMS

I. Service Description

Day Treatment/Day Reporting programs provide intensive supervision to children exhibiting a pattern of delinquent behavior. The primary functions of Day Treatment/Day Reporting can include intensive supervision, utilization of a cognitive behavior change approach, and be utilized to prevent the removal of the child from the home, to increase community safety, and to improve family functioning.

Day Treatment/Day Reporting programs can vary in the intensity and length of supervision and service hours the child and family receive.

The Day Treatment service is designed to provide an environment in which each child can develop the skills necessary for successful living, and to alter the previous environment of the child so that newly acquired skills are encouraged and old inappropriate behaviors are discouraged. Family involvement is highly encouraged. The service also addresses the educational needs of the individual child, based on an assessment of their academic progress.

The day reporting service provides daily supervision and structured activities for youth who require more intensive oversight, as an alternative to secure detention. This program serves pre- or post-adjudicated youth.

Day Treatment

Providing agency receives referrals from the Department of Child Services FCM or the Probation Officer.

Upon receipt of a referral, the provider will respond to the referral source within two business days. Provider will conduct an interview with the child and family within 5 business days of the referral and notify the referralsource regarding acceptance into the program within 24 hours after the interview.

Service delivery can range from 1-180 days, at 4-10 hours per day. Service delivery may be extended beyond 180 days if approved by referral source. Programs must be open and available

for at least 20 hours each week, if a youth is in the program for at least 4 hours on a day, the Per Diem can be billed.

Services shall include, but are not limited to: Individualized educational planning, life skills training (including work readiness if appropriate), and community service projects.

Services shall also include a minimum of 6 hours per week of cognitive based instruction in a curriculum that demonstrates best practices of model programs. The use of role playing and interaction to teach new skills may be utilized. Services can address thinking errors, anger management, substance abuse, and other mental health needs identified by the provider and referral source.

Pre- and post-tests for evaluation and progress must be utilized.

Provider must also include a component that requires family involvement for a minimum of one hour per week. This may be in the form of a parenting support group or parenting instruction.

Provider will communicate progress to the referral source at least once per month in the form of a written progress report and monthly attendance in program, including number of contact hours. Provider will attend all Court review hearings and provide written progress reports to the Court at each review hearing.

Day Reporting

Providing agency receives referrals from the Department of Child Services FCM or Probation Officer.

Upon receipt of a referral, the provider will respond to the referral source within two business days. Provider will conduct an interview with the child and family within 5 business days of referral and will notify the referral source regarding admission status within 24 hours of the interview.

Service delivery can range from 1-180 days, at 4-10 hours per day. Service delivery may be extended beyond 180 days if approved by referral source. Programs must be open and available for at least 20 hours each week, if a youth is in the program for at least 4 hours on a day, the Per Diem can be billed.

Services shall include, but are not limited to: Intensive supervision, educational planning assistance, and community/recreational activities.

Provider will communicate progress to the referral source and monthly attendance in program, including number of contact hours performed. Provider will submit written progress reports to the referral source prior to each court hearing.

II. Target Population

Services must be restricted to the following eligibility categories:

1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.

2) Children and their families which have an Informal Adjustment (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.

III. Goals and Outcomes

Day Treatment

Goal #1: Reduce the risk of repetitive delinquent behavior.

Outcome Measures

1) 100% of children in the Day Treatment program will receive a minimum of 6 hours per week of cognitive based instruction required to successfully complete the program.

2) 50% of children will successfully complete the program with a reduction of the risk to re-offend based on a validated risk assessment tool.

Goal #2: Prevent removal from home or community.

Outcome Measures

1) 70% of parents will participate in required family activities as identified by the individual

program.

2) 70% of children who successfully complete the program will have exhibited improved family relationships.

3) 70% of families that were intact at the initiation of service will remain intact with no out-of-home, county paid placement for more than five days throughout the service provision period, and will have avoided out of home placement 6 months following service closure.

Goal #3: Enrollment in education programming

Outcome Measures

1) 100% of children will be enrolled in some type of educational programming during their involvement in the program.

2) 70% of children will be enrolled in an education program three months after program completion.

Goal # 4: Provide opportunities for the child to make meaningful contributions to their community.

Outcome Measures

1) 100% of children will be given opportunities to participate in employment, community, and recreational activities during their involvement in the program.

2) 70% of children will be employed or involved in community activities three months after program completion

Day Reporting

Goal #1: Provide supervision as an alternative to incarceration.

Outcome Measures

1) 75% of youth will not return to secure detention while in the program.

2) 100% of youth will receive intensive supervision and participate in other activities while in the program.

Goal # 2: Provide opportunities for the child to make meaningful contributions to their community.

Outcome Measures

1) 100% of children will be given opportunities to participate in employment, community, and recreational activities during their involvement in the program.

2) 70% of children will be employed or involved in community activities three months after program completion.

Goal #3: Enrollment in educational programming.

Outcome Measures

1) 100% of children will be enrolled in some type of educational programming during their involvement in the program.

2) 70% of children will be enrolled in an educational program three months after program completion.

IV. Minimum Qualifications

Direct Worker:

Program coordinator must hold a Bachelor's degree in criminal justice, sociology, psychology, social work or related field.

Therapeutic Services must be provided by an individual who meets one of the following minimum qualifications:

1) Master's or Doctorate degree with a current license issued by the Indiana Behavioral Health and Human Services Licensing Board as one of the following: 1) Social Worker, 2) Clinical Social Worker, 3) Marriage and Family Therapist, 4) Mental Health Counselor 5) Marriage and Family Therapist Associate and 6) Mental Health Counselor Associate.

2) Master's degree with a temporary permit issued by the Indiana Behavioral Health and Human Services Licensing Board as one of the following: 1) Social Worker, 2) Clinical Social Worker, within 90 days of providing services under this contract (Please note: In order to obtain a temporary license, the individual must register for the exam) and,
    a. 2 years related clinical experience, or
    b. completion of the DCS approved training program

Note: In order to obtain a temporary license, the individual must first register for the licensure exam and may have additional requirements for temporary licensure. Please contact the Indiana Professional Licensing Board for additional instructions for obtaining a temporary license.

3) Master's degree and a submitted application for 1) Marriage and Family Therapist Associate, or 2) Mental Health Counselor Associate within 90 days of providing services under this contract. The individual must obtain licensure as a Marriage and Family Therapist Associate or Mental Health Counselor Associate within 12 months of providing services under this contract. The individual must also have:
    a. 2 years related clinical experience, or
    b. completion of the DCS approved training program

4) Master's degree in a related human service field plus 2 years related clinical experience and working under a DCS Community Based Contract on July 1, 2015.

Note: Individuals who hold a Master's degree that is applicable toward licensure, must become licensed as indicated in #2 & 3 above. Providers should not employ any new staff who are not license eligible.

Supervision:

The Program Supervisor must hold a Master's degree in criminal justice, social work, psychology, Social Work or related field.

If therapeutic services are being provided, there must be supervision by someone who meets the following criteria:

Master's or Doctorate degree in social work, psychology, marriage and family, or related human service field, with a current license issued by the Indiana Behavioral Health and Human Services Licensing Board as one of the following: 1) Clinical Social Worker, 2) Marriage and Family Direct Worker, 3) Mental Health Counselor.

Supervision is to include not less than one (1) hour of face to face supervision/consultation per 20 hours of direct client services provided, and must occur every two (2) weeks or more frequently.

Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral valued culturally competent manner.

V. Billable Units

Per Diem cost for each client placed in the program. This per diem rate includes all costs of the

program. Programs must be open and available for at least 20 hours each week, if a youth is in the program for at least 4 hours on a day, the Per Diem can be billed. (There are two per diem units Day Reporting and Day Treatment.)

Translation or sign language
Interpretation, Translation and Sign Language Services

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

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

The location of and cost of Interpretation, Translation, and Sign Language Services are the responsibility of the Service Provider. 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. 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. Providers can use DCS contracted agencies and request that they be given the DCS contracted rate but this is not required. 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. 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.

VI. Case Record Documentation

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.

VII. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period.

VIII. Adherence to the DCS Practice Model

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. 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.

IX. Trauma Informed Care

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/):
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. 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?" 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. 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.

Trauma Specific Interventions: (modified from the SAMHSA definition)

- The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
- 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)
- 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.

X. Cultural and Religious Competence.

Provider must respect the culture of the children and families with which it provides services. 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. 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. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth. The guidebook can be found at: http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf

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. 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.

XI. Child Safety

Services must be provided in accordance with the Principles of Child Welfare Services. Please note: All services (even individual services) are provided through the lens of child safety. 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. 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. 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.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
TRUANCY TERMINATION

I. Services Description

The purpose of Truancy Termination services is to provide school drop-out prevention education, job readiness skills services, parent education, and family support services to youth and their families in order to reduce recidivism of delinquent youth and truants.

Family Support Services

Family support workers are to work with family members to identify reasons for youth's truancy and barriers to regular and positive school attendance as well as work with school personnel and Probation Officers to identify solutions and interventions necessary to ensure school attendance, increase the youth's involvement in the school, and improve academic performance.

Accomplishing these objectives may require the support worker to attend parent/teacher conferences and attend classes with the student. The support worker shall provide services in the areas of parent education and crisis intervention, including direct services. The support worker will be present as the court directs, including, but not limited to the initial hearing, where the worker will meet with the youth and family and complete the preliminary intake. The purpose of the preliminary intake is to gather basic information and provide a brief overview of the program.

The support worker is responsible for providing weekly written reports attending court hearing to provide testimony on progress, submitting monthly written progress reports regarding each family's circumstances, and monitoring school attendance, performance, and behavior. These reports shall reflect ongoing collaboration and cooperation among the family support workers, school social workers, and Probation Officers.

The family support workers shall conduct and complete comprehensive intake and assessment for each referral to create a Family Development Plan (FDP). The FDP will be shared with school social workers and Probation Officers. The family support worker will assist families with transportation to the program.

Training Modules

Training modules consist of six (6) weekly skills-based classes which the youth and parents are required to complete. The family support worker will assess progress of all program graduates, and identify youth and families who may benefit from additional training. Subsequent to the training an assessment of progress, including areas where additional improvement is needed should be made and any additional services recommended shared with school social workers, probation officers, and the court.

Youth Modules

The following youth modules of Skills Based programming will be taught:

- Personal Hygiene
- Truancy
- College Awareness
- Conflict Resolution
- Relationships (peer to peer and peer to parent)
- Substance Abuse
- Decision Making, Time Management, and Goal Setting

Parent Modules

The following parent modules of Skills Based programming will be taught:

- Role as a parent and self-esteem
- Understanding child growth and development/Sibling Rivalries
- Communication and listening skills/Relationships
- How to use effective discipline/Problem solving
- Anger management/Conflict resolution/Stress maintenance
- Teaching morals, values, and respect
- Financial Management

Subsequent to the completion of the training modules the family support worker shall continue to work with the school social workers, probation officers, and the court to monitor families' well-being to monitor school attendance. The support worker will conduct monthly activities designed to connect youth and families with positive sources of ongoing encouragement (i.e. carrier fairs, family dinners, age appropriate sports and/or entertainment events, etc.).

II. Target Population

Services must be restricted to the following eligibility categories:

- Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
- Children and their families which have an Informal Adjustment (IA) or the children have the status of CHINS or JD/JS.
- Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.
- All adopted children and adoptive families.

III. Goals and Outcomes

Goal #1 Ensure youth and parents participating in the program build skills in the module areas.

Outcome Measures

1) 85% of youth and parents referred by the Juvenile Court shall complete six (6) skills-based modules.

2) 85% of those families completing the modules shall demonstrate increased knowledge resulting from participation in the skills-based modules.

Goal #2 Increase regular school attendance of youth completing the program.

Outcome Measures

1) 75% of youth completing the six week modules will have 95% attendance during the service provision period.
2) 75% of youth will have 95% attendance during the period of time that begins at program completion and ends at 6 month follow up.

Goal #3 Juvenile Court and client satisfaction with services

Outcome Measures

1) Juvenile Probation/DCS staff satisfaction will be rated 4 and above on the Services Satisfaction Report.

2) 90% of clients will rate the services “satisfactory” or above on a satisfaction survey developed by the service provider, unless one is distributed by DCS/Probation to providers for their use with clients Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.

IV. Minimum Qualifications

Training Facilitator (Paraprofessional):

A high school diploma or GED and 21 years of age. Must possess a valid driver's license, the ability to transport self and others, and must have state minimum car insurance coverage in force at all times.

Family Support Worker:

Bachelor's Degree in social work, psychology, sociology, or a directly related human service field.

Supervisor (Professional):

Bachelor's Degree in social work, psychology, sociology, or directly related human service field plus three (3) years related experience.

Supervision/consultation is to include not less than one (1) hour of face-to-face supervision/consultation per twenty (20) hours of direct client services provided, nor occur less than every two (2) weeks.

V. Billable Unit

Face to face time with the client:

(Note: Members of the client family are to be defined in consultation with the family and approved by the DCS. This may include persons not legally defined as part of the family)

- Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
- Includes Child and Family Team Meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family.
- Includes crisis intervention and other goal-directed interventions via telephone with the identified client family.

Reminder: Not included are routine report writing and scheduling of appointments, collateral contacts, travel time and no shows. These activities are built into the cost of the face- to-face rate and shall not be billed separately.

Group (Effective 3/1/2012)

Group will be defined as at least 3 clients (who are DCS or Probation referrals and are from no less than two different referred families. If there are less than 3 clients from at least two DCS/Probation referrals, the payment would be the face to face rate for each referral.

Issue:

Question: The provider has 3 DCS/Probation clients referred from 2 different families. When cost allocating it, do they charge 1/3 or ½ (by client or referral)?

Answer: By number of referrals. Therefore, ½ charged to each referral, or ½ of the cost would be allocated to each family.

Question: What if there are less than 3 clients referred?

Answer: The payment would be by the Face to Face rate for each referral. Example, if the Face to Face rate is $50, then the claim would be for $50 for each referral.

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

Interpretation, Translation and Sign Language Services

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

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

The location of and cost of Interpretation, Translation, and Sign Language Services are the responsibility of the Service Provider. 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. 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. Providers can use DCS contracted agencies and request that they be given the DCS contracted rate but this is not required. 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. 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.

Court

The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a written request (email or subpoena) from DCS or subpoena to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. 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.

VI. Case Record Documentation

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.

VII. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

VIII. Adherence to the DCS Practice Model

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. 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.

IX. Trauma Informed Care

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/):
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. 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?" 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. 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

Trauma Specific Interventions: (modified from the SAMHSA definition)

- The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
- 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)
- 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.

X. Cultural and Religious Competence.

Provider must respect the culture of the children and families with which it provides services. 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. 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. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth. The guidebook can be found at:
http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf

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. 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.

XI. Child Safety

Services must be provided in accordance with the Principles of Child Welfare Services. Please note: All services (even individual services) are provided through the lens of child safety. 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. 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. 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.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
MED-ADULT INTENSIVE RESILIENCY SERVICES (AIRS)
(CMHC Only)
(Revised 6/8/11-Effective 7/1/15)

I. Services Description

This service standard applies to services provided to families and children involved with the Department of Child Services and/or Probation. Provision of services will be through Medicaid Rehabilitation Option (MRO) for MRO eligible adults and children only and will not be provided through DCS funding. (Exception made in payment for Court Appearance and Child and Family Team Meeting. See section VI – Billable Unit).

The service standard is not a Medicaid standard and includes services that are not billable to Medicaid. It is the responsibility of the contracted service provider to be knowledgeable about Medicaid billing requirements and comply with them, including provider qualifications and any pre-authorization requirements, and further, to appropriately bill those services in particular cases where they may be reimbursed by Medicaid. The DCS service model shall be used for this service standard. Adult Intensive Rehabilitative Services (AIRS) is a time-limited, non-residential service provided in a clinically supervised setting for consumers who require structured rehabilitative services to maintain the consumer on an outpatient basis. AIRS is curriculum based and designed to alleviate emotional or behavior problems with the goal of reintegrating the consumer into the community, increasing social connectedness beyond a clinical setting, and/or employment. AIRS may be provided for consumers at least eighteen (18) years of age with serious mental illness who need structured therapeutic and rehabilitative services; Have significant impairment in day-to-day personal, social and/or vocational functioning; do not require acute stabilization, including inpatient or detoxification services, and Are not at imminent risk of harm to self or others. AIRS may be provided to consumers less than eighteen (18) years of age, but not less than sixteen (16) years of age, with an approved prior authorization.

II. Service Delivery

- AIRS must be authorized by a physician or HSPP.
- Direct services must be supervised by a licensed professional.
- Clinical oversight must be provided by a licensed physician, who is on-site weekly and available to program staff when not physically present.
- Consumer goals must be designed to facilitate community integration, employment, and use of natural supports.
- Therapeutic services include clinical therapies, psycho-educational groups, and rehabilitative activities.
- A weekly review and update of progress occurs and must be documented in the consumer's clinical record.

- AIRS programs must be offered a minimum of two (2) hours and up to six (6) hours per day, three (3) to five (5) days per week, excluding time associated with formal educational or vocational services.
- AIRS must be provided in an age appropriate setting for a consumer age eighteen (18) and under.
- The consumer is the focus of the service.
- Documentation must support how the service benefits the consumer, including when provided in a group setting.
- Services must demonstrate movement toward or achievement of consumer treatment goals identified in the individualized integrated care plan.
- Service goals must be rehabilitative in nature.

Exclusions:

- AIRS will not be reimbursed for consumers who receive Individual or Group Skills Training and Development (H2014 HW or H2014 HW U1) on the same day.
- Services that are purely recreational or diversionary in nature, or that do not have therapeutic or programmatic content, are not reimbursable.
- Formal educational or vocational services.
- A consumer may not receive both CAIRS and AIRS on the same day.

III. When DCS is not paying for services:

A billable unit of "Reports" has been developed for providers who service DCS families without DCS payment for these services (Medicaid, insurances, self-pay) but DCS wants a report from the provider on the progress of the family. The referral process has been set up to authorize reports and court components on the DCS referral form in these incidences. **DCS will only pay for reports when DCS is not paying for these services.** If the services provided are not funded by DCS, the report rate per hour will be paid for the necessary reports on a referral form issued by DCS. Court testimony will be paid per appearance if requested on a referral form issued by DCS. In order to be paid for a court appearance a subpoena or written request from DCS should be on file.

IV. . Target Population

Services billable to MRO are for Medicaid eligible clients with a qualifying diagnosis and level of need.

In addition, services must be restricted to the following eligibility categories:

1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.

2) Children and their families which have an Informal Adjustment (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.

V. Goals and Outcomes

Goal #1
Maintain timely intervention with family and regular and timely communication with current Family Case Manager or Probation Officer.

Objectives
1) 100% of all families will have monthly written summary reports prepared and sent to the current Family Case Manager/Probation Officer by the 10th of each month following the month of service.

Goal #2
Improved family functioning including development of positive means of managing crisis.

Objectives
1) 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.

Client Outcome Measures:
1) 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.
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. (To be measured/evaluated by DCS/Probation staff)
3) 90% of the individuals/families that were intact prior to the initiation of service will remain intact throughout the service provision period.

Goal #3
DCS/Probation and clients will report satisfaction with services provided.
Outcome Measures:
1) DCS/Probation satisfaction will be rated 4 and above on the Service Satisfaction Report.
2) 90% of the clients will rate the services "satisfactory" or above on a satisfaction survey developed by the service provider, unless DCS/Probation distributes one to providers for their use with clients. Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.

VI. Qualifications
Services are provided through a behavioral health service provider that is enrolled as a

Medicaid provider that offers a full continuum of care as defined under IC 12-7-2-40.6 and 440 IAC 9. These providers may subcontract for services as appropriate.
Individual Provider Qualifications:

- Licensed professional
- Qualified Behavioral Health Professional
- Other Behavioral Health Professional

VII. Billable Unit

Medicaid:
Provision of services will be through Medicaid Rehabilitation Option (MRO) for MRO eligible adults and children only and will not be provided through DCS funding, except for court time and time spent attending the CFTM which can be billed to DCS. Medicaid shall be billed when appropriate.

Billing Code Title
H2012 HW HB U1
Behavioral health day treatment, per hour
Units = 1hour, provider must provide _ 45 minutes of service to round up.

DCS Funds:

Court: The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a request (either verbal or written) by DCS to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances -- maximum of 1 court appearance per day. 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.

Reports
If the services provided are not funded by DCS, the "Reports" hourly rate will be paid. A referral for "Reports" must be issued by DCS in order to bill.

CFTM: Child and Family Team Meeting: The provider of this service may be requested to participate in the CFTM. The provider may bill DCS per hour for this actual time spent in CFTM.

VIII. Case Record Documentation
Case record documentation for service eligibility must include:
1) A completed, signed, and dated DCS/ Probation referral form authorizing services

2) Documentation of regular contact with the referred families/children
3) Written reports no less than monthly or more frequently as prescribed by DCS/Probation. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.
4) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation

IX. . Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

X. Adherence to the DCS Practice Model

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

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
MED-ASSESSMENT FOR MRO
(CMHC Only)

I. Services Description

This service standard applies to services provided to children involved with the Department of Child Services and/or Probation. Provision of services will be through Medicaid Clinic Option (MCO), Medicaid Rehabilitation Option (MRO), and DCS Funding. The service standard is not a Medicaid standard and includes services that are not billable to Medicaid. It is the responsibility of the contracted service provider to be knowledgeable about the Medicaid billing requirements and comply with them, including provider qualifications and any pre-authorization requirements and further, to appropriately bill those services in particular cases where they may be reimbursed by Medicaid. The Services not eligible for MCO or MRO may be billed to DCS. The DCS service model shall be used for this service standard.

This service standard includes the Initial Assessment-Clinic, Initial Assessment- Home, and Redetermination. A client should only receive a referral for one of these assessments at any given time.

Initial Assessment:

The purpose of this initial assessment is to have the following completed and summarized in a report:

- DMHA approved assessment
- Bio-psychosocial assessment and
- Diagnosis (if applicable)
- Summary of CMHC Recommended Services

DCS will refer for an Initial Assessment-Clinic to be completed and billed to Medicaid Clinic Option (MCO). This assessment should be completed with a report to DCS within 7 calendar days unless the services will require prior authorization (the child is not eligible for a preauthorized service package). If a prior authorization for services is required, the assessment should be completed and a report returned to DCS within 17 days.

If the family is not responsive within 3 days, the CMHC should contact the FCM to determine if the FCM wants to request the Initial Assessment to be completed in the home. If so, the FCM should complete a new referral for Initial Assessment-Home. In this instance, the Assessment time period of 7 calendar days would start over. (NOTE:
The time period on the referral will be for 6 months and will be used to authorize DCS match payment electronically for that time period.)

If, at the time the FCM makes the initial referral, the FCM believes there are circumstances which would prevent the family from going to the clinic, DCS may choose to refer for an Initial Assessment-Home to be completed in the family's home.
The Initial Assessment-Home unit would be paid by DCS funding.

Behavioral Health level of Need Redetermination
Redetermination Services are associated with the DMHA approved assessment required to determine level of need, assign an MRO service package and make changes to the Individualized Integrated Care Plan. The DMHA assessment tool must be completed at least every six (6) months for the purpose of determining the continued need for MRO services. Reassessment may occur when there is a significant event or change in consumer status.

II. Service Delivery

Initial Assessment:
1. Face-to face contact in a MCO approved setting is preferred.
a. CMHC will respond with a report in 7 calendar days from date of referral approval. If Prior Authorization is required, the CMHC will notify DCS and will respond with a report in 17 days.
b. The report will include the DMHA approved assessment, a Biopsychosocial assessment, the child's diagnosis (if applicable), and the MRO Service Package or authorized services.

Redetermination
1. The redetermination requires face-to-face contact with the consumer and may include face-to-face or telephone collateral contacts with family members or nonprofessional caretakers, which result in a completed redetermination.
2. The DMHA approved assessment tool must be completed at least every six months to determine the continued need for MRO services.
3. Reassessment may occur when there is a significant event or change in consumer status. Reimbursement is only available for one assessment per six months. .
4. CMHC will inform the referring worker of the need for a redetermination referral at least 14 days prior to the need for the approved referral.

III. Target Population
Assessments and Redeterminations are billable to Medicaid for Medicaid eligible clients. In addition, services must be restricted to the following eligibility categories:
1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
2) Children and their families which have an Informal Adjustment (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

Goal #1
To obtain an Initial Assessment that will result in the identification of the MRO service package if applicable.
Objective Measure
95% of Initial Assessments will be completed within the designated time frames.

V. Qualifications

Initial Assessment:
Subject to prior authorization by the office or its designee, Medicaid will reimburse physician or HSPP directed outpatient mental health services for group, family, and individual outpatient psychotherapy when such services are provided by one (1) of the following practitioners:
(A) A licensed psychologist.
(B) A licensed independent practice school psychologist.
(C) A licensed clinical social worker.
(D) A licensed marital and family therapist.
(E) A licensed mental health counselor.
(F) A person holding a master's degree in social work, marital and family therapy, or mental health counseling, except that partial hospitalization services provided by such person shall not be reimbursed by Medicaid.
(G) An advanced practice nurse who is a licensed, registered nurse with a master's degree in nursing with a major in psychiatric or mental health nursing from an accredited school of nursing.

Redetermination:
Services must be provided by individuals meeting DMHA training competency standards for the use of the DMHA-approved assessment tool.

VI. Billable Unit

Initial Assessment-MCO Clinic:
Initial Assessment-Clinic will be billed **per assessment** to clinic option for Medicaid eligible clients. Medicaid shall be billed when appropriate.

Medicaid Billing Code Description
90801 Diagnostic Interview

Initial Assessment-Clinic (DCS Paid):
Initial Assessment-**Clinic** will be paid **per assessment** by DCS for those clients who are not Medicaid eligible.

Initial Assessment-Home (DCS Paid):
Initial Assessment-Home will be paid **per assessment** by DCS.

Behavioral Health Level of Need Redetermination:
Services through the Medicaid Rehabilitation Option (MRO) include Behavioral Health level of Need Redetermination. Medicaid shall be billed when appropriate. DCS funds should not be billed for this service.
Medicaid Billing Code Description
H0031 HW Mental health assessment, by non physician

VII. Case Record Documentation

Case Record Documentation
Case record documentation for service eligibility must include:
1) A completed, signed, and dated DCS/ Probation referral form authorizing services
2) Documentation of regular contact with the referred families/children
3) Written reports no less than monthly or more frequently as prescribed by DCS/Probation. Monthly reports are due by the 10thof each month following the month of service, case documentation shall show when report is sent.
4) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation

VIII. Service Access
All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation, an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

IX. Adherence to the DCS Practice Model
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. 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.

NOTE: All services must be pre-approved through a referral form from the referring FCM or Probation Officer.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
MED-CHILD AND ADOLESCENT INTENSIVE RESILIENCY SERVICES
(CAIRS)
(CMHC Only)
(Revised 6/8/11-Effective 7/1/15)

I. Services Description

This service standard applies to services provided to families and children involved with the Department of Child Services and/or Probation. Provision of services will be through Medicaid Rehabilitation Option (MRO) for MRO eligible and children only and will not be provided through DCS funding. (Exception made in payment for Court Appearance and Child and Family Team Meeting. See section VI – Billable Unit) The service standard is not a Medicaid standard and includes services that are not billable to Medicaid. It is the responsibility of the contracted service provider to be knowledgeable about Medicaid billing requirements and comply with them, including provider qualifications and any pre-authorization requirements, and further, to appropriately bill those services in particular cases where they may be reimbursed by Medicaid. The DCS service model shall be used for this service standard.

Child and Adolescent Intensive Resiliency Services (CAIRS) is a time-limited, curriculum-based, non-residential service provided to children and adolescents in a clinically supervised setting that provides an integrated system of individual, family and group interventions based on an individualized integrated care plan. CAIRS is designed to alleviate emotional or behavioral problems with a goal of reintegration into age appropriate community settings (e.g., school and activities with pro-social peers).

CAIRS is provided in close coordination with the educational program provided by the local school district. CAIRS may be provided for consumers at least five (5) years of age and less than eighteen (18) years of age with severe emotional disturbance who: Need structured therapeutic and rehabilitative services; Have significant impairment in day-today personal, social and/or vocational functioning; Do not require acute stabilization, including inpatient or detoxification services; and Are not at imminent risk of harm to self or others.

II. Service Delivery

a. CAIRS must be authorized by a physician or HSPP.
b. Direct services must be supervised by a licensed professional.
c. CAIRS must be provided in close coordination with the educational program provided by the local school district.
d. Clinical oversight must be provided by a licensed physician, who is onsite weekly and available to program staff when not physically present.

e. Consumer goals and a transitional plan must be designed to reintegrate the consumer into the school setting.
f. Therapeutic services include clinical therapies, psycho-educational groups, and rehabilitative activities.
g. A weekly review and update of progress occurs and must be documented in the consumer's clinical record.
h. CAIRS must be provided in an age appropriate setting for a consumer age eighteen (18) and under receiving services.
i. CAIRS programs must be offered a minimum of two (2) hours and a maximum of four (4) hours per day, three (3) to five (5) days per week, excluding time associated with formal educational or vocational services.
j. CAIRS must be provided in an age appropriate setting for a consumer age eighteen (18) and under.
k. The consumer is the focus of the service.
l. Documentation must support how the service benefits the consumer, including when provided in a group setting.
m. CAIRS must demonstrate movement toward or achievement of consumer treatment goals identified in the individualized integrated care plan.
n. CAIRS goals must be rehabilitative in nature.

Exclusions:
i. Services that are purely recreational or diversionary in nature or have no therapeutic or programmatic content are not reimbursable.
ii. Formal educational or vocational services.
iii. CAIRS is not reimbursable for children less than five (5) years of age.
iv. CAIRS is not reimbursable for consumers age eighteen (18) and older, but less than twenty-one (21) years of age without an approved prior authorization.
v. CAIRS will not be reimbursed for consumers who receive Individual or Group Skills Training and Development (H2014 HW or H2014 HW UI) on the same day.
vi. A consumer may not receive both CAIRS and AIRS on the same day.

III. When DCS is not paying for services:
A billable unit of "Reports" has been developed for providers who service DCS families without DCS payment for these services (Medicaid, insurances, self-pay) but DCS wants a report from the provider on the progress of the family. The referral process has been set up to authorize reports and court components on the DCS referral form in these incidences. **DCS will only pay for reports when DCS is not paying for these services.** If the services provided are not funded by DCS, the report rate per hour will be paid for the necessary reports on a referral form issued by DCS. Court testimony will be paid per appearance if requested on a referral form issued by DCS. In order to be paid for a court appearance a subpoena or written request from DCS should be on file.

IV. . Target Population
Services billable to MRO are for Medicaid eligible clients with a qualifying diagnosis and level of need, and must meet the MRO target population definition as listed above.
In addition, services must be restricted to the following eligibility categories:
1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
2) Children and their families which have an Informal Adjustment (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.

V. Goals and Outcomes

Goal #1
Maintain timely intervention with family and regular and timely communication with current Family Case Manager or Probation Officer.

Objectives
1) 100% of all families will have monthly written summary reports prepared and sent to the current Family Case Manager/Probation Officer by the 10th of each month following the month of service.
2)

Goal #2
Improved family functioning including development of positive means of managing crisis.

Objectives
1) 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.

Client Outcome Measures:
1) 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.
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. (To be measured/evaluated by DCS/Probation staff)
3) 90% of the individuals/families that were intact prior to the initiation of service will remain intact throughout the service provision period.

Goal #3
DCS/Probation and clients will report satisfaction with services provided.
Outcome Measures:
1) DCS/Probation satisfaction will be rated 4 and above on the Service Satisfaction Report.
2) 90% of the clients will rate the services "satisfactory" or above on a satisfaction survey developed by the service provider, unless DCS/Probation distributes one to providers for their use with clients. Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.

VI. Qualifications
Services are provided through a behavioral health service provider that is an enrolled as a Medicaid provider that offers a full continuum of care as defined under IC 12-7-2-40.6 and 440 IAC 9. These providers may subcontract for services as appropriate. CAIRS may be provided in a facility provided by the school district.

Individual Provider Qualifications:
- Licensed professional
- Qualified Behavioral Health Professional
- Other Behavioral Health Professional

VII. Billable Unit

Medicaid:
Provision of services will be through Medicaid Rehabilitation Option (MRO) for MRO eligible children only and will not be provided through DCS funding, except for court time and time spent attending the CFTM which can be billed to DCS. Medicaid shall be billed when appropriate.

Billing Code Title
H2012 HW HA U1
Behavioral health day treatment, per hour
Units = 1hour, provider must provide _ 45 minutes of service to round up.

DCS Funds:

Court: The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a request (either verbal or written) by DCS to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. 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.

Reports
If the services provided are not funded by DCS, the "Reports" hourly rate will be aid. A referral for "Reports" must be issued by DCS in order to bill.

CFTM: Child and Family Team Meeting: The provider of this service may be requested to participate in the CFTM. The provider may bill DCS per hour for this actual time spent in CFTM.

VIII. Case Record Documentation
Case record documentation for service eligibility must include:
1) A completed, signed, and dated DCS/ Probation referral form authorizing services
2) Documentation of regular contact with the referred families/children
3) Written reports no less than monthly or more frequently as prescribed by DCS/Probation. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.
4) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation

IX. . Service Access
All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

X. Adherence to the DCS Practice Model
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. 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.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
MED-MEDICATION TRAINING AND SUPPORT
(CMHC Only)
(Revised 6/8/11-Effective 7/1/11)

I. Services Description

This service standard applies to services provided to families and children involved with the Department of Child Services and/or Probation. Provision of services will be through Medicaid Rehabilitation Option (MRO) for MRO eligible children only and will not be provided through DCS funding. (Exception made in payment for Court Appearance and Child and Family Team Meeting. See section VI – Billable Unit). The service standard is not a Medicaid standard and includes services that are not billable to Medicaid. It is the responsibility of the contracted service provider to be knowledgeable about Medicaid billing requirements and comply with them, including provider qualifications and any pre-authorization requirements, and further, to appropriately bill those services in particular cases where they may be reimbursed by Medicaid. The DCS service model shall be used for this service standard.

Individual:
Individual Medication Training and Support involves face-to-face contact with the consumer and/or family or non professional caregivers in an individual setting, for the purpose of monitoring medication compliance, providing education and training about medication, monitoring medication side effects, and providing other nursing or medical assessments. Medication Training and Support also includes certain related non face-to-face activities.

Group:
Medication Training and Support involves face-to-face contact with the consumer and/or family or non professional caregivers in a group setting, for the purpose of providing education and training about medications and medication side effects.

II. Service Delivery

Individual:
1. Face-to face contact in an individual setting with the consumer and/or family or non professional caregivers that includes monitoring self-administration of prescribed medications and monitoring side effects.
2. When provided in a clinic setting, Medication Training and Support may support, but not duplicate, activities associated with medication management activities available under the Clinic Option. When provided in residential treatment setting, Medication Training and Support may include components of medication management services.

3. Medication Training and Support may also include the following services that are not required to be provided face-to-face with the consumer:
i. Transcribing physician or AHCP medication orders.
ii. Setting or filling medication boxes.
iii. Consulting with the attending physician or Authorized Health Care Professional (AHCP) regarding medication – related issues.
iv. Ensuring linkage that lab and /or other prescribed clinical orders are sent.
v. Ensuring that the consumer follows through and received lab work and services pursuant to other clinical orders.
vi. Follow up reporting of lab and clinical test results to consumer and physician.
c. The consumer is the focus of the service.
d. Documentation must support how the service benefits the consumer, including when the consumer is not present.
e. Medication Training and Support must demonstrate movement toward and/or achievement of consumer treatment goals identified in the individualized integrated care plan.
f. Medication Training and Support goals are rehabilitative in nature.

Group:
1. Face-to-face contact in a group setting with the consumer and/or family or non professional caregivers that includes education and training on administration of prescribed medications and side effects, and/or conducting medication groups or classes.
2. When provided in residential treatment settings, Medication Training and Support may include components of medication management services.
3. Medication Training and Support must be provided in an age appropriate setting for a consumer less than eighteen (18) years of age receiving services.
4. The consumer is the focus of the service.
5. Documentation must support how the service benefits the consumer, including when the consumer is not present.
6. Medication Training and Support must demonstrate movement toward and/or achievement of consumer treatment goals identified in the individualized integrated care plan.
7. Medication Training and Support goals are rehabilitative in nature.

Exclusions:
1. If Clinic Option medication management, counseling, or psychotherapy is provided and medication management is a component, then Medication Training and Support may not be billed separately for the same visit by the same provider.
2. Coaching and instruction regarding consumer self-administration of medications is not reimbursable under Medication Training and Support, but may be billed as Skills Training and Development**.**
3. Medication Training and Support may not be provided for professional caregivers.

III. When DCS is not paying for services:
A billable unit of "Reports" has been developed for providers who service DCS families without DCS payment for these services (Medicaid, insurances, self-pay) but DCS wants a report from the provider on the progress of the family. The referral process has been set up to authorize reports and court components on the DCS referral form in these incidences. **DCS will only pay for reports when DCS is not paying for these services.** If the services provided are not funded by DCS, the report rate per hour will be paid for the necessary reports on a referral form issued by DCS. Court testimony will be paid per appearance if requested on a referral form issued by DCS. In order to be paid for a court appearance a subpoena or written request from DCS should be on file.

IV. . Target Population
Services billable to MRO are for Medicaid eligible clients with a qualifying diagnosis and level of need. In addition, services must be restricted to the following eligibility categories:
1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
2) Children and their families which have an Informal Adjustment (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.

V. Goals and Outcomes

Goal #1
Maintain timely intervention with the family and regular and timely communication with referring worker.

Objectives
1) Provider is available for consultation to the family 24-7 by phone or in person.

VI. Qualifications
Medication Training and Support must be provided within the scope of practice as defined by federal and state law.

- Licensed physician
- Authorized health care professional (AHCP)
- Licensed registered nurse (RN)
- Licensed practical nurse (LPN)
- Medical Assistant (MA) who has graduated from a (2) year clinical program.

VII. Billable Unit

Provision of services will be through Medicaid Rehabilitation Option (MRO) for MRO eligible children only and will not be provided through DCS funding. Medicaid shall be billed when appropriate.

Billing Code Title
H0034HW Medication Training and Support –Individual
H0034 HW HR Medication Training and Support--Family/Couple (Individual Setting), with the Consumer Present
H0034 HW HS Medication Training and Support--Family/Couple (Individual Setting), without the Consumer Present
H0034 HW U1 Medication Training and Support – Group
H0034 HW HR U1 Medication Training and Support--Family/Couple (Group Setting), with the Consumer Present
H0034 HW HS U1 Medication Training and Support--Family/Couple (Group Setting), without the Consumer Present
Services may be billed in 15 minute increments, partial units are rounded to the nearest quarter 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*

Child and Family Team Meeting (CFTM):
The provider of this service may be requested to participate in the CFTM..The provider may bill DCS for this actual time spent in CFTM.

Court: The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a request (either verbal or written) by DCS to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. 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.

Reports
If the services provided are not funded by DCS, the “Reports” hourly rate will be paid. A referral for “Reports” must be issued by DCS in order to bill.

VIII. Case Record Documentation
Case record documentation for service eligibility must include:
1) A completed, signed, and dated DCS/ Probation referral form authorizing services

2) Documentation of regular contact with the referred families/children
3) Written reports no less than monthly or more frequently as prescribed by DCS/Probation. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.
4) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation

IX. . Service Access
All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation, an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

X. Adherence to the DCS Practice Model
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. 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.
NOTE: All services must be pre-approved through a referral form from the referring FCM or Probation Officer.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
MED-PEER RECOVERY SERVICES
(CMHC Only)
(Revised 6/8/11-Effective 7/1/15)

I. Service Description

Provision of services will be through Medicaid Rehabilitation Option (MRO) for MRO eligible adults and children only and will not be provided through DCS funding. (Exception made in payment for Court Appearance and Child and Family Team Meeting. See section VI – Billable Unit) The service standard is not a Medicaid standard and includes services that are not billable to Medicaid. It is the responsibility of the contracted service provider to be knowledgeable about the Medicaid billing requirements and comply with them, including provider qualifications and any preauthorization requirements and further, to appropriately bill those services in particular cases where they may be reimbursed by Medicaid.

Peer Recovery Services are individual face-to-face services that provide structured, scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills.

II. Service Delivery

- Peer Recovery Services must be identified in the Individualized Integrated Care Plan (IICP) and correspond to specific treatment goals.
- The consumer is the focus of Peer Recovery Services
- Peer Recovery Services must demonstrate progress toward and/or achievement of consumer treatment goals identified in the IICP
- Peer Recovery Services are rehabilitative in nature
- Peer Recovery Services must be age appropriate for a consumer age eighteen
- (18) and under receiving services
- Documentation must support how the service specifically benefits the consumer
- Peer Recovery Services must be face-to-face and include the following components:
    - Assisting the consumer with developing self-care plans and other formal mentoring activities AIMed at increasing active participation in person-centered planning and delivery of individualized services
    - Assisting the consumer in the development of psychiatric advanced directives
    - Supporting day-to-day problem solving related to normalization and reintegration into the community
    - Education and promotion of recovery and anti-stigma activities associated with mental illness and addiction

III. When DCS is not paying for services:

A billable unit of "Reports" has been developed for providers who service DCS families without DCS payment for these services (Medicaid, insurances, self-pay) but DCS wants a report from the provider on the progress of the family. The referral process has been set up to authorize reports and court components on the DCS referral form in these incidences. **DCS will only pay for reports when DCS is not paying for these services.** If the services provided are not funded by DCS, the report rate per hour will be paid for the necessary reports on a referral form issued by DCS. Court testimony will be paid per appearance if requested on a referral form issued by DCS. In order to be paid for a court appearance a subpoena or written request from DCS should be on file.

IV. . Target Population

Services billable to MRO are for Medicaid eligible clients with a qualifying diagnosis and level of need. In addition, services must be restricted to the following eligibility categories:

1) Consumers age eighteen (18) and older
2) Peer Recovery Service may be provided to consumers ages sixteen (16) and seventeen (17) with an approved prior authorization.
3) Children and 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.
4) Children and their families which have an IA or the children have the with a status of CHINS, and/or JD/JS;
5) All adopted children and adoptive families.

V. Goals and Objectives

Goal #1

To become socialized, recover, develop self-advocacy, develop natural supports and maintain community living skills.

VI. Qualifications

Peer Recovery Services must be provided by individuals meeting DMHA training and competency standards for CRS (Certified Recovery Specialist). Individuals providing Peer Recovery Services must be under the supervision of a licensed professional or QBHP (Qualified Behavioral Health Professional).

VII. Billable Unit

Peer Recovery Services is included in adult packages only and is limited to 104 units for service package 3, 156 units for service packages 4, 208 units for service package 5, and 260 units for service package 5A. Prior Authorization is required for consumers requiring additional units of this service.

Provision of services will be through Medicaid Rehabilitation Option (MRO) for MRO eligible children only and will not be provided through DCS funding. Billing Code Title

H0038 HW Self help/peer services, per 15 minutes.

Exclusions:

- Peer Recovery Services that are purely recreational or diversionary in nature, or have no therapeutic or programmatic content, may not be reimbursed
- Interventions targeted to groups are not billable as Peer Recovery Services
- Activities that may be billed under Skills Training and Development or Case
- Management services are not billable as Peer Recovery Services
- Peer Recovery Services are not reimbursable for children under the age of sixteen (16)
- Peer Recovery Services that occur in a group setting are not reimbursable

DCS Funding:

Child and Family Team Meeting (CFTM): MRO provider of this service may be requested to participate in the CFTM. The MRO provider may bill DCS for the actual time spent in CFTM.

Court Appearance: The MRO provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a request (either verbal or written) by DCS to appear in court, and can be billed per appearance. Therefore, if the MRO provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. 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.

Reports
If the services provided are not funded by DCS, the "Reports" hourly rate will be paid.

A referral for "Reports" must be issued by DCS in order to bill.
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*

VIII. Case Record Documentation
Necessary case record documentation for service eligibility must include:
1) A completed, dated, signed DCS/Probation referral form authorizing service;
2) Documentation of regular contact with the referred families/children and referring agency;
3) Written reports no less than monthly or more frequently as prescribed by DCS.

Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.
4) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation.

IX. . Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation, an approved DCS referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES SUBSTANCE TREATMENT AND RECOVERY TEAMS (START) PROGRAM
TREATMENT COORDINATOR
(Effective July 1, 2015)

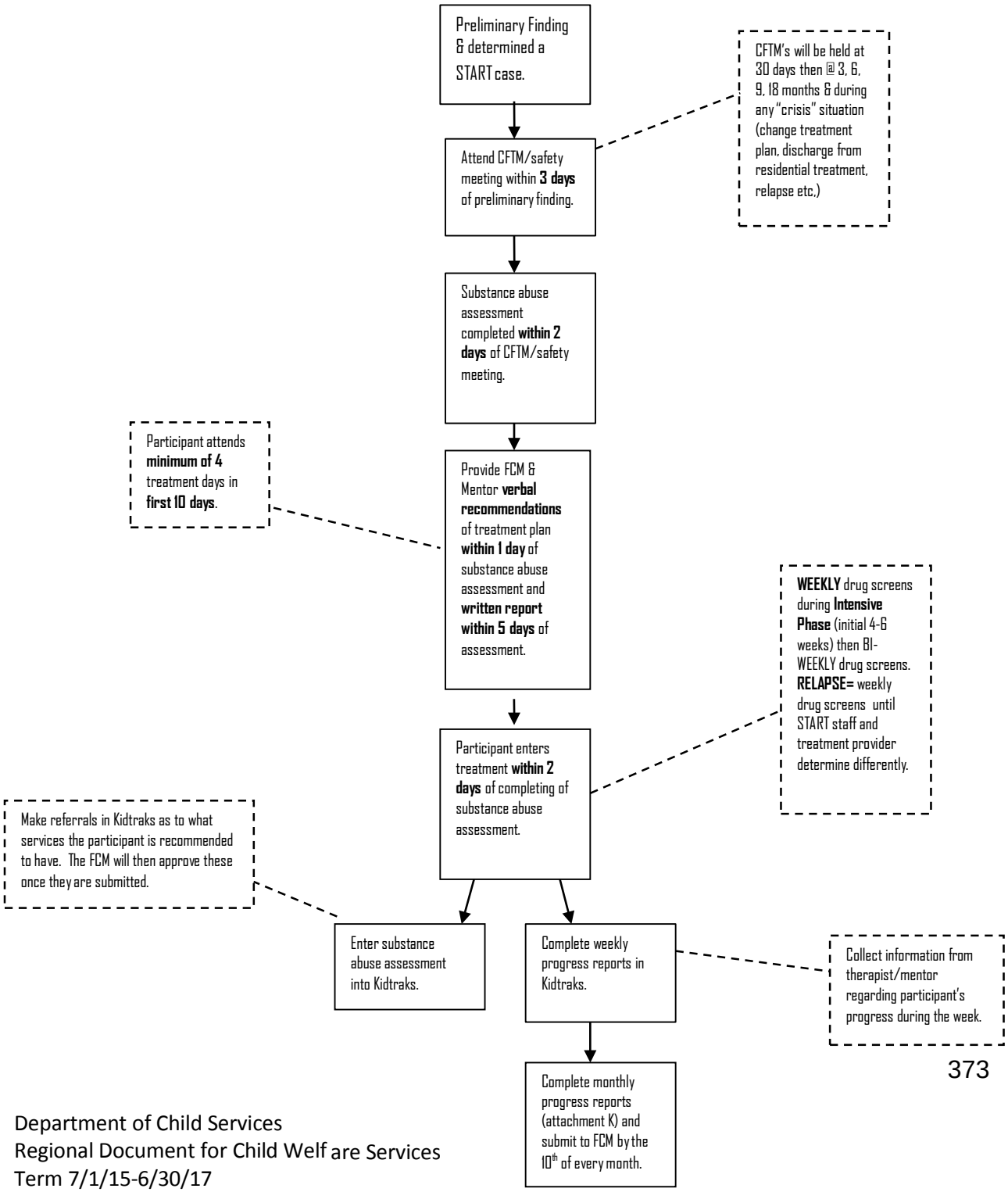
I. Services Description

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. This service applies to families who have at least one child age 0-5 years and intervention by DCS is needed due to substantiation of child abuse/neglect, resulting from the parent's substance addiction and resulted in the opening of a new case. The START Treatment Coordinator is responsible for overseeing all START client assessments for treatment, making recommendations for treatment, and coordinating all treatment services including recovery services. The goals of START are to promote sobriety for the parent(s), ensure quick access to treatment, improve the function and stability of the family unit, ensure child safety, and promote children remaining in the home, increasing permanency outcomes.

II. Service Delivery

The START team will consist of a Family Case Manager (FCM), Family Mentor, Treatment Coordinator and DCS Supervisor. The START Treatment Coordinator is employed by the local Community Mental Health Center. The START Treatment Coordinator completes the assessment for treatment, makes recommendations and coordinates treatment services. The Treatment Coordinator will utilize all addiction services, inside and outside the agency, to ensure treatment needs are met. The Treatment Coordinator will need to be able to work on a multi-disciplinary team and effectively communicate with all parties involved with the client. The minimum contact of the Treatment Coordinator with the Family Mentor and FCM is once per week per case. The START Treatment Coordinator will attend the initial/safety Child and Family Team Meeting (CFTM) and ensure the client has an appointment set for a substance disorder assessment at the end of the meeting. The Treatment Coordinator will ensure the client is scheduled to attend a minimum of 4 treatment days within the first 10 days after the assessment. The Treatment Coordinator will ensure drug screens are completed, according to the START model, track the results, communicate the results to DCS and address any barriers to completing the drug screens. Positive screens will be immediately communicated to the FCM and/or DCS Supervisor. The Treatment

Coordinator will attend any additional meetings regarding the case including, but not limited, to ongoing CFTM's. The START Treatment Coordinator may be required to attend/testify in Court regarding the case. Adherence to the model fidelity documents for client contact shall be followed by the Treatment Coordinator and listed as follows:



Note: The dotted line boxes denote information only.

Throughout the life of the case, the Treatment Coordinator will assist with the ongoing assessment of the child's safety, wellbeing and permanency. Any concerns regarding the safety and well-being of a child will immediately be reported to the FCM and/or the DCS Supervisor. The Treatment Coordinator may engage in the following list of activities, although other duties may be assigned as needed:

- Complete Substance Use Disorder Assessment (as defined by the service standard for this service)
- Complete an individualized treatment plan
- Utilize all addiction services, inside & outside of the agency, to meet client needs
- Educate outside service providers on the START model
- Coordinate with residential/detoxification provider for smooth transition into and out of the facility
- Complete weekly reports
- Complete monthly reports by the 10th of each month
- Attend initial and subsequent CFTM's
- Attend any meetings pertinent to the START case
- Attend and testify in Court
- Coordinate random drug screens of all clients per the START model and communicate those results to the FCM and/or Family Mentor
- Conduct individual counseling sessions as needed and appropriate (Treatment Coordinator led treatment needs to performed under a separate referral)
- Contact collateral contacts to complete assessment and weekly/monthly reports
- Track client's progress in treatment and report any "no shows" to START Mentor/FCM immediately
- Maintain consistent and transparent contact with all providers and team members involved in the case
- Daily/weekly contact with FCM/Mentor/DCS Supervisor
- Follow fidelity measures of the START model
- Attend all START meetings, including but not limited to Direct Line Meetings
- Participate in START consultations with State Designated START Administrator

III. Core Competency:

The START Treatment Coordinator will develop a core competency in Trauma Informed Care, Motivational Interviewing, treatment of co-occurring disorders, use of evidence based practices, gender sensitive treatments and the START model. The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their future. The provider must demonstrate an understanding, through the services provided, of the interrelation between trauma and symptoms of

trauma. The provider will work in a collaborative way with the parent(s), extended family and friends and other human services agencies in a manner that will empower the children/families.

IV. Minimum Qualifications

The Treatment Coordinator shall be appropriately credentialed personnel who are trained and competent to complete Substance Use Assessments/Treatment as required by state law.

In addition, the START Treatment Coordinator will have a minimum of a Master's Degree in social work, psychology, marriage and family therapy or related human service field, three (3) years experience in treating people with addictions and co-occurring mental health needs and have a clinical license issued by the Indiana Behavioral Health and Human Services Licensing Board, as one of the following: 1) Clinical Social Worker 2) Marriage and Family Therapist 3) Mental Health Counselor. The START Treatment Coordinator will need to be able to work cooperatively and collaboratively in a multi-discipline team. The START coordinator should be aware of different types of addiction services throughout the State of Indiana.
In addition to the above the START coordinator should have:

- Extensive knowledge of substance use and addiction
- Knowledge of family of origin/intergenerational issues
- Knowledge of child abuse/neglect
- Knowledge of child and adult development
- Knowledge of community resources
- Ability to work as a team member
- Belief in helping clients change, to increase the level of functioning
- Knowledge of strength-based initiatives to bring about change
- Belief in the family preservation philosophy
- Knowledge of motivational interviewing
- Skillful in the use of Cognitive Behavioral Therapy
- Skillful in the use of evidence-based strategies

Must possess a valid driver's license and the ability to use a private car, to transport self and
others, and must comply with the state policy concerning minimum car insurance coverage.

Supervisor:

Master's or Doctorate degree in social work, psychology, marriage and family, or related human service field, with a current license issued by the Indiana Behavioral Health and Human Services Licensing as one of the following: 1) Clinical Social Worker, 2) Marriage and Family Direct Worker, 3) Mental Health Counselor.

Services provided will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral-valued culturally-competent manner.

Providers are to respond to the on-going individual needs of staff by providing them with the appropriate combination of training and supervision. The frequency and intensity of training and supervision are to be consistent with "best practices" and comply with the requirements of each provider's accreditation body. Supervision should include individual, group, and direct observation modalities and can utilize teleconference technologies. Under no circumstances is supervision/consultation to be less than one (1) hour of supervision/consultation per 25 hours of ace-to-face direct client services provided, nor occur less than every two (2) weeks.

The supervisor will be knowledgeable on the START model and participate in consultation with the State Designated START Administrator. The supervisor will participate in START meetings, including but not limited to, Direct Line and Steering Committee.

Target Population

Services 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;
2) These families will also have substance use histories;
3) Each of the families shall have at least one child age 5 or under and
4) The family will be accepted into the program as determined by DCS.

V. Goals and Outcomes:

Goal #1: The Treatment Coordinator will assist with the ongoing assessment of the child's safety, wellbeing and permanency.

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) 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) 90% of the individuals/families that were intact prior as of the initiation of service will remain intact throughout the service provision period.

4) If DCS elects to implement a standardized tool for evaluating family functioning, a related outcome measure will be added.

Goal #2: The Treatment Coordinator will ensure quick access to services, in accordance with the START fidelity measures and timeline, making recommendations for service.

1) 95% of the time the Treatment Coordinator will attend the initial CFTM with the family and engage the family in the assessment process.
2) 85% of the time, within 48 hours of the initial/safety CFTM, the Treatment Coordinator will complete an assessment on the client.
3) 90% of the time the Treatment Coordinator will provide verbal feedback to DCS within 1 day of the assessment and written recommendations for treatment within 5 business days.
4) 80% of the time the Treatment Coordinator will ensure the client begins treatment within 48 hours of the assessment.

Goal #3: The Treatment Coordinator will be responsible for recommending a level of care using standard criteria such as ASAM or LOCUS, coordinating all treatment, creating a individualized treatment plan that will include services with a focus and intensity to provide the best possible outcomes for recovery from substance use and co-occurring mental health disorders. The Treatment Coordinator will supply all needed documentation regarding client's treatment to DCS.

1) 100% of the time the Treatment Coordinator will act as a liaison between the substance use providers and DCS, including agencies outside of the contract agency.
2) 95% of the time the Treatment Coordinator will ensure DCS receives weekly reports from the treatment provider for all clients served in the START program.
3) 95% of the time the Treatment Coordinator will ensure DCS receives monthly reports from the treatment provider, for all clients served in the START program, by the 10th of every month.

Goal #4: The Treatment Coordinator will ensure drug screens are completed, as a part of treatment, while adhering to the START fidelity measures and timeline.

1) 100% of the time the Treatment Coordinator will ensure the client is drug screened according to the fidelity of the START model: weekly during the initial treatment period, moving to bi-weekly after the initial treatment period or as decided by the team. If a positive screen is provided, while in the bi-weekly screening phase, the Treatment Coordinator will ensure the client moves to weekly drug screens until the START teams deems it appropriate to move to bi-weekly screens.

2) 100% of the time the Treatment Coordinator will immediately notify the START FCM and/or the DCS Supervisor if the client provides a positive drug screen. The confirmation of the positive drug screen will be received within 72 hours of sample collection.
3) 100% of the time the Treatment Coordinator will notify the START FCM and/or the DCS Supervisor, within 24 hours, if the client provides a negative drug screen.

VI. Case Record Documentation

Case record documentation for service eligibility must include:
1) A completed and dated DCS form authorizing services
2) Copy of DCS 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

VII. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS staff. In the event a service provider receives verbal or email authorization to provide services from DCS an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

VIII. Billable Units

Medicaid: Treatment Coordinator activities will be monitored by the contracting agency and any billable Medicaid activities are the responsibility of the contracting agency. The contracting agency is to be knowledgeable about the Medicaid billing requirements and comply with them, including provider qualifications and any pre-authorization requirements. The contracting agency is responsible for billing those services when they may be reimbursed by Medicaid. Those services not eligible for Medicaid Rehabilitation Option or Medicaid Clinic Option may be billed to the DCS office as outlined in the contract.
DCS Funding: DCS funding is provided as reimbursement for actual cost based on approved budget for time spent providing the services in this standard. Any treatment services performed under a separate referral should not be billed under this service standard (e.g. individual counseling). Contracted Agencies will use approved invoicing process.

IX. Trauma Informed Care

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/):

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. 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?" 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. 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.

Trauma Specific Interventions: (modified from the SAMHSA definition)

- The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
- 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).
- 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.

X. Cultural and Religious Competence.

Provider must respect the culture of the children and families with which it provides services. 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. 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. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth. The guidebook can be found at:
http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf

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. 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.

XI. Child Safety

Services must be provided in accordance with the Principles of Child Welfare Services. Please note: All services (even individual services) are provided through the lens of child safety. 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. 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. 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.

XII. Adherence to the DCS Practice Model

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

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
SUBSTANCE TREATMENT AND RECOVERY TEAMS (START) PROGRAM
FAMILY MENTORS
(Effective July 1, 2015)

I. Service Description

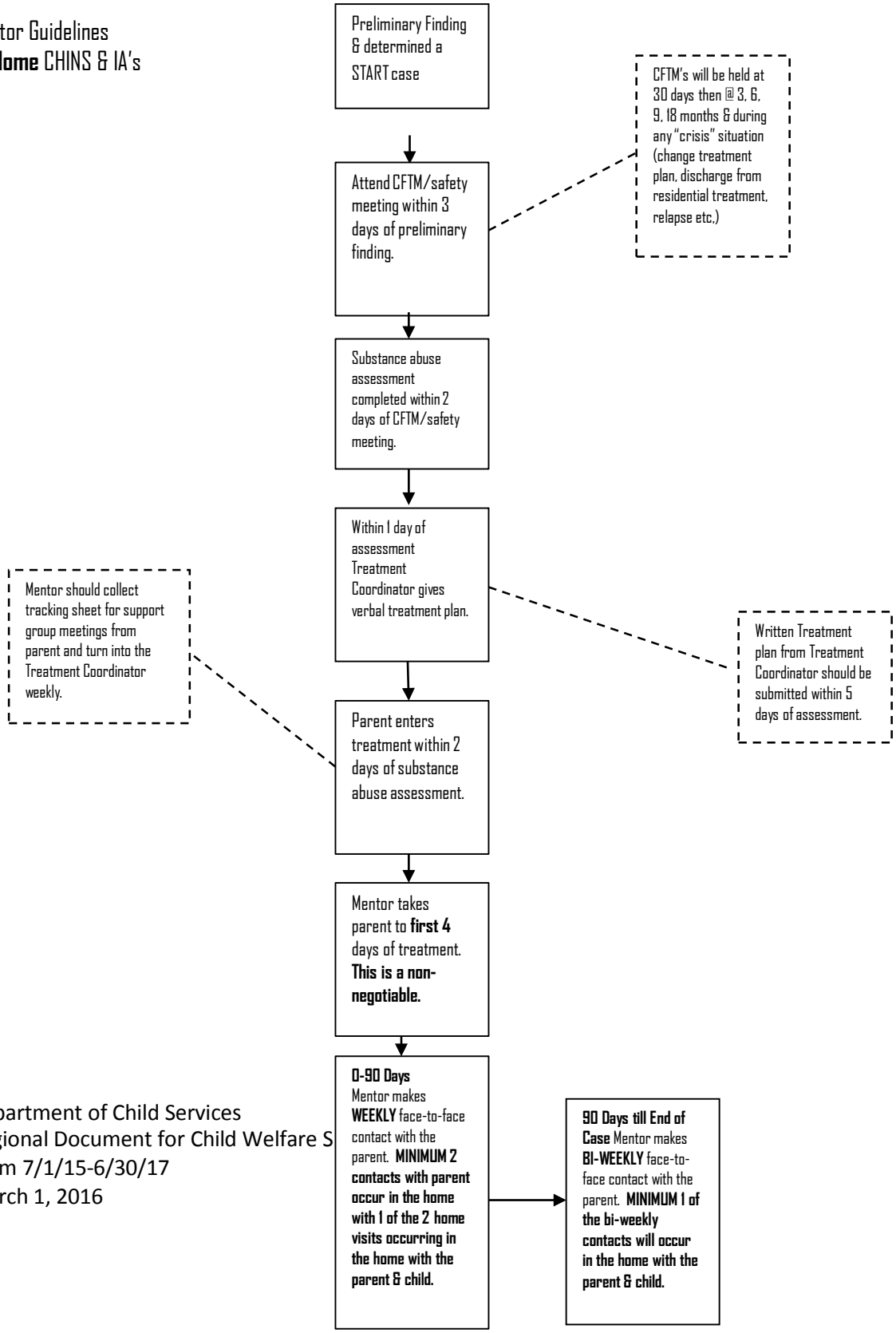
The Indiana Department of Child Services (DCS) intends to contract with Community Mental Health Centers throughout the state to implement Sobriety Treatment and Recovery Teams (START) to provide assistance and support to parents who are in need of addictions treatment. This service applies to families who have a new DCS case, at least one child age 0-5 years and intervention by DCS is needed due to substantiation of child abuse/neglect, resulting from the parent's substance use disorder. The parent(s) will be paired with a Family Mentor who will support and guide the family through the recovery and DCS process. The goals of START are to promote sobriety for the parent(s), ensure quick access to treatment, improve the function and stability of the family unit, ensure child safety, and promote children remaining in the home, increasing permanency outcomes. The Family Mentor will work with the parent(s) in creating connections to the community for long-term recovery support.

II. Service Delivery

The START team will consist of a Family Case Manager (FCM), Family Mentor, Treatment Coordinator, DCS Supervisor and any other service provider that is actively involved with the family. The Family Mentor is a paraprofessional and an individual who has been in long term recovery, with a minimum of 3 years sobriety. The Family Mentor was involved with DCS and/or criminal justice system in some capacity in the past. 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. The Family Mentor will be employed by the Community Mental Health Center but their home office will be located in a DCS office where most of the services outlined in the service standard can be performed. The Family Mentor and FCM will share the same START caseload. The FCM and Family Mentor will partner together to ensure the family is receiving necessary resources, accessing treatment, following guidelines and developing a support system. The FCM and Family Mentor are to work in close contact with one another, with a minimum contact of once per week per case shared. The Family Mentor will be responsible for attending the initial Child and Family Team Meeting (CFTM), will transport the parent(s) to the drug and alcohol assessment and the first 4 days of treatment. The Family Mentor will attend all subsequent CFTM's and may be required to attend and/or testify in Court regarding the case. Family Mentors

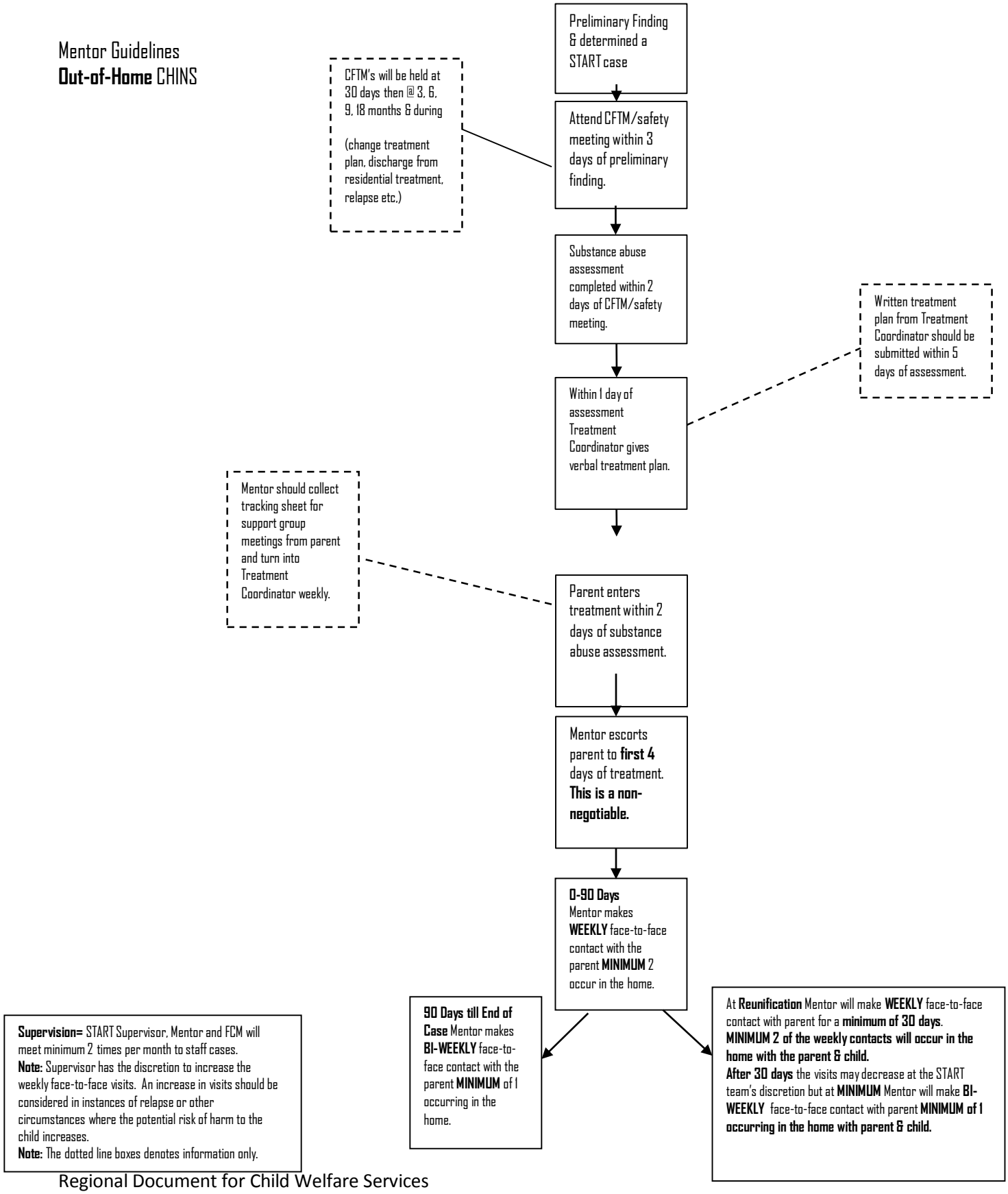
will participate in a minimum of bi-weekly case staffing with DCS staff and will participate in other meetings as required. The Family Mentor will communicate with the Treatment Coordinator on a continual basis with a minimum of once per week per case. Adherence to the model fidelity documents for client contact, both in-home and out-of-home, shall be followed by the Family Mentor and listed as follows:

Mentor Guidelines
In-Home CHINS & IA's



Supervision= START Supervisor, Mentor and FCM will meet minimum 2 times per month to staff cases.
Note: Supervisor has the discretion to increase the weekly face-to-face visits. An increase in visits should be considered in instances of relapse or other circumstances where the potential risk of harm to the child increases.
Note: The dotted line boxes denotes information only.

Mentor Guidelines
Out-of-Home CHINS



The Family Mentor will need to be able to effectively engage a family in services and follow the DCS practice model. Throughout the life of the case, the Family Mentor will assist with the ongoing assessment of the child's safety, wellbeing and permanency. The Family Mentor will reference and follow the current safety plan in place regarding the child. Any concerns regarding the safety and well-being of a child will immediately be reported to the FCM and/or the DCS Supervisor. Family Mentors will receive training by DCS regarding the practice model, court and court testimony. Family Mentors will participate in other training modules as required and deemed appropriate.

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:

- Identify community/recovery supports (i.e. identify support meetings in community, help secure a sponsor etc.)
- Attend a support meeting with client
- Track the client's attendance for the recommended number of support meetings per week
- Assist the FCM in identifying the client's needs and appropriate referrals
- Help client identify the benefits to participating in the treatment program
- Engage client in treatment
- Develop a recovery plan
- Identify triggers and ways to work through them
- Identify alternative activities to maintain sobriety
- Develop client self wellness goals
- Work on client driven life goals, short & long term (i.e. education/treatment/employment)
- Create a budget to gain financial stability
- Teach &/or model life skills (i.e. opening a bank account; filling out a job application etc.)
- Locate safe housing
- Coach on advocating for self
- Help identify client's strengths and develop self esteem
- Develop structure/time management skills
- Coach through crisis/emergency situations effectively
- Facilitate transportation**
- Participate in Child and Family Team Meetings
- Assist with coordinating services
- Identify support system
- Develop problem solving techniques
- Help understand basic child development & nutrition*
- Reference & reinforce current child safety plan when appropriate

- Parenting sober: what that looks like through modeling &/or coaching (with child and parent)
- Assist with family communication and rebuilding relationships
- Assistance with accessing Child Care Vouchers
- Assist the family in understanding addiction and the process of recovery
- Help identify access to Healthcare/Medicaid Assistance
- Supervise Visitation between parent/child***
- Assist client in organization and getting acclimated to being on a schedule

*Must be trained or knowledgeable in provider supported child development & nutrition curriculum.
**Transportation limited to client goal-directed, 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.).
***Must be trained in supervising visits. Supervised visits will be billed separately from other services within this standard and follow the Visitation Facilitation service standard. The "Visitation Monthly Progress Report" form must be used to report the supervised visitation portion of the services provided. The "Monthly Report" will be used for all other services outlined in this standard.

III. Target Population

Services must be restricted to the following eligibility categories:

5) 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;
6) These families will also have substance use histories;
7) Each of the families shall have at least one child age 5 or under and
8) The family will be accepted into the program as determined by DCS.

Goals and Outcomes

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

Outcome measures:

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

Goal #2: The Family Mentor will assist with the ongoing assessment of the child's safety, wellbeing and permanency.

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) 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) 90% of the individuals/families that were intact prior as of the initiation of service will remain intact throughout the service provision period.
4) If DCS elects to implement a standardized tool for evaluating family functioning, a related outcome measure will be added.

Goal #3: The Family Mentor will be responsible for connecting the family to the recovery community including building their support system.

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.) if the client is new to the Recovery Community.
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) 50% of the time, the 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.

Goal #4: The Family Mentor will submit all required documentation and participate in DCS staffing.

1) 95% of the time, the Family Mentor will attend monthly Local DCS Office staffing.
2) 95% of the time, the Family Mentor will attend, at a minimum, bi-weekly START Team supervision.
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) 95% of the time, the Family Mentor will participate in other required meetings including CFTMs, court, and other related START meetings.

IV. Minimum Qualifications:

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

- Child protective services history is not required but preferred. The Family Mentor can either be a victim or a perpetrator of child abuse or neglect.
- Criminal history will be considered on a case-by-case basis.
- The ability to assist DCS with all practice model components is essential. Specifically, the family mentor will assist in teaming, engaging, assessing, planning, and intervening.
- The Family Mentor must be able to take direction and collaborate with multiple agencies within the community including: the contract agency, DCS, the courts, attorneys, and most importantly, a wide range of families.
- Self awareness is a key component in being able to successfully do the job. The Family Mentor must be actively engaging in recovery activities in their own lives.

V. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS staff. In the event a service provider receives verbal or email authorization to provide services from DCS an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

VI. Billable Units

Medicaid: Family Mentors activities will be monitored by the contracting agency and any billable Medicaid activities are the responsibility of the contracting agency. The contracting agency is to be knowledgeable about the Medicaid billing requirements and comply with them, including provider qualifications and any pre-authorization requirements. The contracting agency is responsible for billing those services when they may be reimbursed by Medicaid. Those services not eligible for Medicaid Rehabilitation Option or Medicaid Clinic Option may be billed to the DCS office as outlined in the contract.
DCS Funding: DCS funding is provided as reimbursement for actual cost based on approved budget. Contracted Agencies will use approved invoicing process.

VII. Trauma Informed Care

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/):

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. 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?" 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. 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.

Trauma Specific Interventions: (modified from the SAMHSA definition)

- The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
- 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).
- 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.

VIII. Cultural and Religious Competence.

Provider must respect the culture of the children and families with which it provides services. 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. 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. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth. The guidebook can be found at:
http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf

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. 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.

IX. Child Safety

Services must be provided in accordance with the Principles of Child Welfare Services. Please note: All services (even individual services) are provided through the lens of child safety. 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. 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. 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.

X. Adherence to the DCS Practice Model

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