

**SERVICE STANDARD**  
**INDIANA DEPARTMENT OF CHILD SERVICES**  
**CHILDREN'S MENTAL HEALTH INITIATIVE**

**I. Service Description**

- A. 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.
- B. When community services are not able to maintain the child at home, the CMHI may fund higher level out of home services.
- C. 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.
- D. CMHI providers must be appropriately certified by the Division of Mental Health and Addictions to provide Children's Mental Health Wraparound (CMHW) Services.
- E. Services provided may include:
  - 1. Assessment for eligibility
  - 2. Wraparound Facilitation
  - 3. Habilitation
  - 4. Respite
  - 5. Family Support and Training for the Unpaid Caregiver
  - 6. Behavioral health services as defined under Medicaid Rehabilitation Option
  - 7. Behavioral health services as defined under Medicaid Clinic Option
  - 8. Other necessary client specific services

**II. Service Delivery**

- A. The minimum standards and qualifications for Wraparound Facilitation, Habilitation, Respite, and Family Support Training for the Unpaid Caregiver are located at: <http://www.in.gov/fssa/dmha/2766.htm>
- B. Medicaid Rehabilitation Option services and Medicaid Clinic Option services are defined at <http://provider.indianamedicaid.com>.

- C. Other DCS referred services for the family may be provided utilizing the Department of Child Service Standards located at <http://www.in.gov/dcs/3159.htm>
- D. Services under the Children's Mental Health Initiative are provided according to the Children's Mental Health Initiative Protocol.
- E. 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.)

### **III. Target Population**

- A. Children who meet the qualifications for Children's Mental Health Wraparound services, but who are not Medicaid eligible.
- B. 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.
- C. The Children's Mental Health Initiative is a voluntary service.
  - 1. The caregiver must be engaged in order to access services.

### **IV. Goals and Outcomes**

- A. Goal #1: Children will be served in the least restrictive setting available to meet their needs.
  - 1. Outcome Measure: 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.

- B. Goal #2: Children will be served without formal involvement with the child welfare or probation systems.
  - 1. Outcome Measures:
    - a) 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.
    - b) 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 six (6) month time period following completion of services..

**V. Minimum Qualifications**

- A. 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>
- B. Medicaid Rehabilitation Option services and Medicaid Clinic Option services are defined at <http://provider.indianamedicaid.com>.
- C. 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>

**VI. Billable Units**

- A. 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.
- B. Those services provided under DCS service standards may be billed as defined in the applicable service standard.
- C. Interpretation, Translation, and Sign Language Services
  - 1. The location of and cost of Interpretation, Translation, and Sign Language Services are the responsibility of the Service Provider.
  - 2. If the service is needed in the delivery of services referred, DCS will reimburse the Provider for the cost of the Interpretation, Translation, or Sign Language service at the actual cost of the service to the provider.
  - 3. The referral from DCS must include the request for Interpretation services and the agencies' invoice for this service must be provided when billing DCS for the service.
  - 4. Providers can use DCS contracted agencies and request that they be given the DCS contracted rate but this is not required.
  - 5. The Service Provider Agency is free to use an agency or persons of their choosing as long as the service is provided in an accurate and competent manner and billed at a fair market rate.

6. If the agency utilizes their own staff to provide interpretation, they can only bill for the interpretation services. The agency cannot bill for performing two services at one time.

## **VII. Case Record Documentation**

- A. Case record documentation for service eligibility must include:
  1. A completed, signed, and dated DCS/Probation referral from authorizing services
  2. Documentation of contact with the referred families/children through Case Notes which document:
    - a) Date
    - b) Location
    - c) Start and end times
    - d) Participants
    - e) Individuals providing service
  3. Written progress reports no less than monthly or more frequently as prescribed by DCS and requested supportive documentation.
    - a) Monthly reports are due by the 10<sup>th</sup> of each month following the month of service.
    - b) Case documentation shall show when report is sent.
  4. Copy of treatment plan

## **VIII. Service Access**

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

## **IX. Adherence to DCS Practice Model**

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

## **X. Interpreter, Translation, and Sign Language Services**

- A. All Services provided on behalf of the Department of Child Services must include Interpretation, Translation, or Sign Language for families who are non-English language speakers or who are hearing- impaired.
- B. Interpretation is done by an Interpreter who is fluent in English and the non-English language and is the spoken exchange from one language to another.
- C. Certification of the interpreter is not required; however, the interpreter should have passed a proficiency test in both the spoken and the written language in which they are interpreting.
- D. Interpreters can assist in translating a document for a non-English speaking client on an individual basis, (i.e., An interpreter may be able to explain what a document says to the non-English speaking client).
- E. Sign Language should be done in the language familiar to the family.
- F. These services must be provided by a non-family member of the client, be conducted with respect for the socio- cultural values, life style choices, and complex family interactions of the clients, and be delivered in a neutral-valued culturally-competent manner.
- G. The Interpreters are to be competent in both English and the non-English Language (and dialect) that is being requested and are to refrain from adding or deleting any of the information given or received during an interpretation session.
- H. No side comments or conversations between the Interpreters and the clients should occur.

## **XI. Trauma Informed Care**

- A. Provider must develop a core competency in Trauma Informed Care as defined by the National Center for Trauma Informed Care—SAMHSA (<http://www.samhsa.gov/nctic/>):
  - 1. Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives.
  - 2. NCTIC facilitates the adoption of trauma-informed environments in the delivery of a broad range of services including mental health, substance use, housing, vocational or employment support, domestic violence and victim assistance, and peer support. In all of these environments, NCTIC seeks to change the paradigm from one that asks, "What's wrong with you?" to one that asks, "What has happened to you?"

3. When a human service program takes the step to become trauma-informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma affects the life of an individual seeking services.
  4. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization
- B. Trauma Specific Interventions: (modified from the SAMHSA definition)
1. The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
  2. The provider must demonstrate an understanding, through the services provided, of the interrelation between trauma and symptoms of trauma (e.g., substance abuse, eating disorders, depression, and anxiety)
  3. The provider will work in a collaborative way with child/family, extended family and friends, and other human services agencies in a manner that will empower child/family.

## **XII. Cultural and Religious Competence**

- A. Provider must respect the culture of the children and families with which it provides services.
- B. All staff persons who come in contact with the family must be aware of and sensitive to the child's cultural, ethnic, and linguistic differences.
- C. All staff also must be aware of and sensitive to the sexual and/or gender orientation of the child, including lesbian, gay, bisexual, transgender or questioning children/youth.
  1. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook.
  2. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth.
  3. The guidebook can be found at:  
<http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf>

- D. Efforts must be made to employ or have access to staff and/or volunteers who are representative of the community served in order to minimize any barriers that may exist.
- E. Contractor must have a plan for developing and maintaining the cultural competence of their programs, including the recruitment, development, and training of staff, volunteers, and others as appropriate to the program or service type; treatment approaches and models; and the use of appropriate community resources and informal networks that support cultural connections.

### **XIII. Child Safety**

- A. Services must be provided in accordance with the Principles of Child Welfare Services.
- B. All services (even individual services) are provided through the lens of child safety.
  - 1. As part of service provision, it is the responsibility of the service provider to understand the child safety concerns and protective factors that exist within the family.
  - 2. Continual assessment of child safety and communication with the Local DCS Office is required. It is the responsibility of the service provider to report any safety concerns, per state statute, IC 31-33-5-1.
- C. All service plans should include goals that address issues of child safety and the family's protective factors. The monthly reports must outline progress towards goals identified in the service plans.