SERVICE STANDARD

INDIANA DEPARTMENT OF CHILD SERVICES

SOBRIETY TREATMENT AND RECOVERY TEAMS (START) PROGRAM

TREATMENT COORDINATOR

I. Service Description

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

B. This service applies to families who 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 opening of a new case.

C. 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.

D. 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, promote children remaining in the home, and increasing permanency outcomes.

II. Service Delivery

A. The START team will consist of a Family Case Manager (FCM), Family Mentor, Treatment Coordinator, and DCS Supervisor.

B. The START Treatment Coordinator is employed by the local Community Mental Health Center.

C. The START Treatment Coordinator has several responsibilities, including the following:

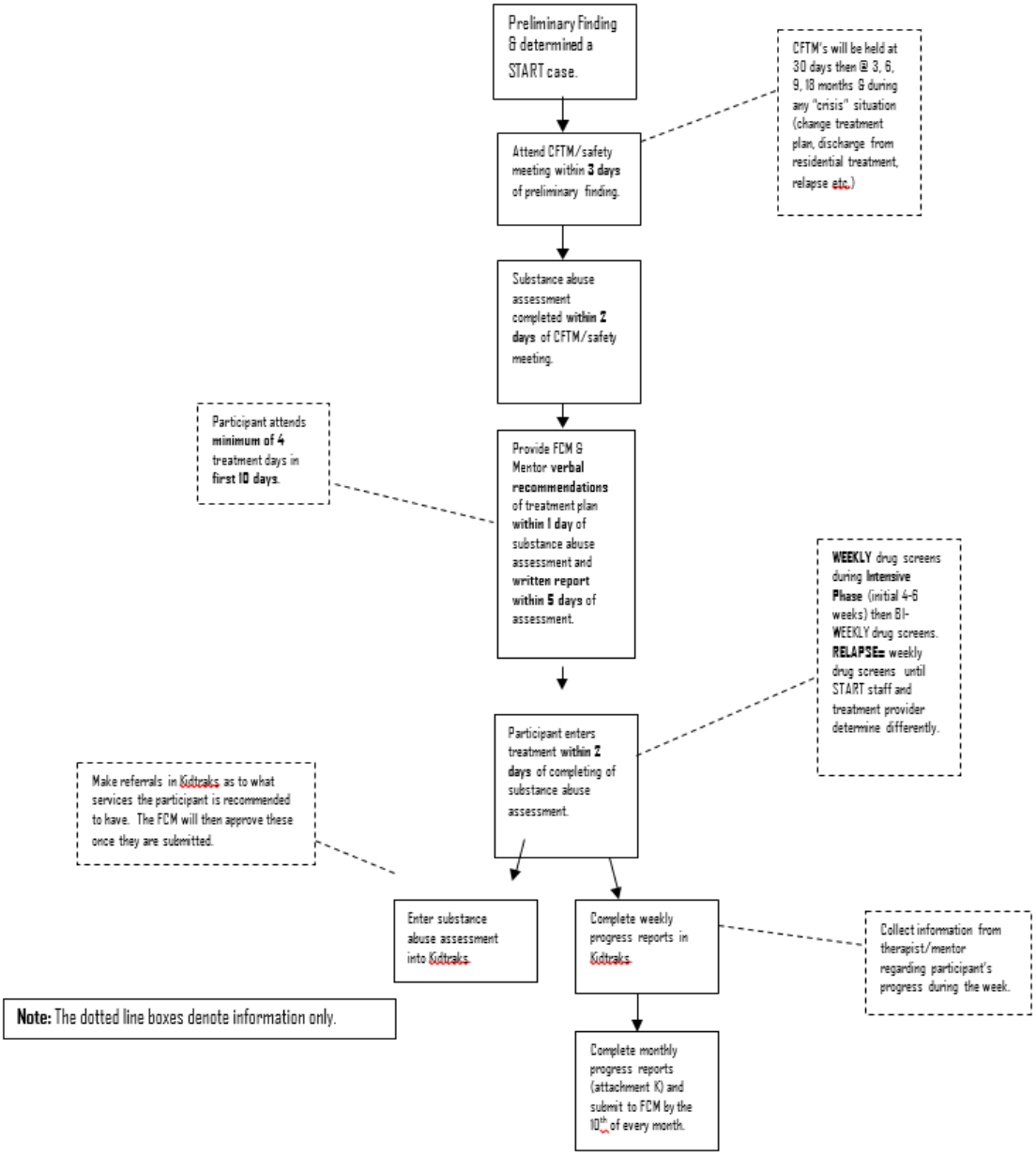
1. Completes the assessment for treatment, makes recommendations, and coordinates treatment services.
2. Utilizes all addiction services, inside and outside the agency, to ensure treatment needs are met.
3. Ability to work on a multi-disciplinary team and effectively communicate with all parties involved with the client.
    a) The minimum contact of the START Treatment Coordinator with the Family Mentor and FCM is once per week, per case.

D. Attends the initial/safety Child and Family Team Meeting (CFTM) and ensure the client has an appointment for a substance disorder assessment at the end of the meeting.

1. Ensures the client is scheduled to attend a minimum of 4 treatment days within the first 10 days after the assessment.
2. Ensures drug screens are completed, according to the START model, track the result, communicate the results to DCS and address any barriers to completing the drug screens.
    a) Positive screens will be immediately communicated to the FCM and/or DCS Supervisor.
3. Attends any additional meetings regarding the case including, but not limited to, ongoing CFTMs.

E. The START Treatment Coordinator may be required to attend/testify in Court regarding the case.

F. Adherence to the model, fidelity documents for client contact shall be followed by the Treatment Coordinator.
    1. A diagram outlining this process can be found on the next page.


Preliminary Finding & determined a START case.
CFTM's will be held at 30 days then @ 3, 6, 9, 18 months & during any "crisis" situation (change treatment plan, discharge from residential treatment, relapse etc.)
Attend CFTM/safety meeting within 3 days of preliminary finding.
Substance abuse assessment completed within 2 days of CFTM/safety meeting.
Participant attends minimum of 4 treatment days in first 10 days.
Provide FCM & Mentor verbal recommendations of treatment plan within 1 day of substance abuse assessment and written report within 5 days of assessment.
WEEKLY drug screens during Intensive Phase (initial 4-6 weeks) then BI-WEEKLY drug screens. RELAPSE= weekly drug screens until START staff and treatment provider determine differently.
Participant enters treatment within 2 days of completing of substance abuse assessment.
Make referrals in Kidtraks as to what services the participant is recommended to have. The FCM will then approve these once they are submitted.
Enter substance abuse assessment into Kidtraks.
Complete weekly progress reports in Kidtraks.
Collect information from therapist/mentor regarding participant's progress during the week.
Complete monthly progress reports (attachment K) and submit to FCM by the 10th of every month.
Note: The dotted line boxes denote information only.

G. Throughout the life of the case, the START Treatment Coordinator will assist with the ongoing assessment of the child's safety, well-being, and permanency.

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

I. The START Treatment Coordinator will engage in the following list of activities, although other duties may be assigned as needed:

1. Complete Substance Use Disorder Assessment (as defined by the Service Standard for this service)
2. Complete an individualized treatment plan
3. Utilize all addiction services, inside and outside of the agency, to meet the client's needs
4. Educate outside service providers on the START model
5. Coordinate with residential/detoxification provider for a smooth transition into and out of the facility
6. Complete weekly reports
7. Complete monthly reports by the 10th day of each month
8. Attend initial and subsequent CFTMs
9. Attend any meetings pertinent to the START case
10. Attend and testify in court
11. Coordinate random drug screens on all clients per the START model and communicate those result to the FCM and/or Family Mentor
12. Conduct individual counseling sessions as needed and appropriate (Treatment Coordinator led treatment needs to performed under a separate referral)
13. Contact collateral contacts to complete assessment and weekly/monthly reports
14. Track client's progress in treatment and report any "no shows" to START Mentor/FCM immediately
15. Maintain consistent and transparent contact with all providers and team members involved in the case
16. Daily/weekly contact with the FCM/Family Mentor/DCS Supervisor
17. Follow fidelity measures of the START model
18. Attend all START meetings, including but not limited to Direct Line Meetings
19. Participate in START consultations with the State Designated START Administrator

J. Core Competency

1. 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.
2. The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their future.
3. The provider must demonstrate an understanding through the services provided of the interrelation between trauma and symptoms of trauma.
4. The provider will work in a collaborative way with the parent(s), extended family/friends, and other human services agencies in a manner that will empower the children and families.

III. Target Population

A. 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.

IV. Goals and Outcomes

A. Goal #1: The START Treatment Coordinator will assist with the ongoing assessment of the child's safety, well-being, and permanency.

1. Outcome Measure: 67% of the families that have a child in substitute care as of the ignition of START service will be reunited by closure of the service provision period.
2. Outcome Measure: 90% of the individuals/families will not be the subjects of a new investigation resulting in the assignment of a status of "substantiated" abuse or neglect throughout the service provision period.
3. Outcome Measure: 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.

B. Goal #2: The START Treatment Coordinator will ensure quick access to services, in accordance with the START fidelity measures and timeline, including making recommendations for service.

1. Outcome Measure: 95% of the time the START Treatment Coordinator will attend the initial CFTM with the family and engage the family in the assessment process.
2. Outcome Measure: 85% of the time, within 48 hours of the initial/safety CFTM, the START Treatment Coordinator will complete an assessment on the client.
3. Outcome Measure: 90% of the time the START Treatment Coordinator will provide verbal feedback to DCS within 1 (one) business day of the assessment and written recommendations for treatment within 5 (five) business days.
4. Outcome Measure: 80% of the time the START Treatment Coordinator will ensure the client begins treatment within 48 hours of the assessment.

C. Goal #3: The START Treatment Coordinator will be responsible for recommending a level of care using standard criteria such as ASAM or LOCUS, coordinating all treatment, creating an 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 START Treatment Coordinator will supply all needed documentation regarding client's treatment to DCS.

1. Outcome Measure: 100% of the time the START Treatment Coordinator will act as a liaison between the substance use providers and DCS, including agencies outside of the contract agency.
2. Outcome Measure: 95% of the time the START Treatment Coordinator will ensure DCS receives weekly reports from the treatment provider for all clients served in the START program.
3. Outcome Measure: 95% of the time the START 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.

D. Goal #4: The START Treatment Coordinator will ensure drug screens are completed, as a part of treatment, while adhering to the START fidelity measures and timeline.

1. Outcome Measure: 100% of the time the START Treatment Coordinator will ensure the client is drug screened according to the fidelity of the START model:
    a) Weekly during the initial treatment period, moving to bi-weekly after the initial treatment period, or as decided by the team.
    b) If a positive screen is provided, while in the bi-weekly screening process, the START 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. Outcome Measure: 100% of the time the START Treatment Coordinator will immediately notify the FCM and/or DCS Supervisor if the client provides a positive drug screen. The confirmation of the positive drug screen will be received within 72 hours of the sample collection.
3. Outcome Measure: 100% of the time the START Treatment Coordinator will notify the FCM and/or the DCS Supervisor, within 24 hours, if the client provides a negative drug screen.

V. Minimum Qualifications

A. START Treatment Coordinator

1. The START Treatment Coordinator shall be appropriately credentialed personnel who are trained and competent to complete Substance Use Assessment/Treatment as required by state law.
2. 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
3. The START Treatment Coordinator will need to be able to work cooperatively and collaboratively in a multi-disciplinary team.
4. The START Treatment Coordinator should be aware of different types of addiction services throughout the State of Indiana.
5. In addition to the above, the START Treatment Coordinator should have the following:
    a) Extensive knowledge of substance use and addiction
    b) Knowledge of family of origin/intergenerational issues
    c) Knowledge of child abuse/neglect
    d) Knowledge of child and adult development
    e) Knowledge of community resources
    f) Ability to work as a team member
    g) Belief in helping clients change, to increase the level of functioning
    h) Knowledge of strength-based initiatives to bring about change
    i) Belief in the family preservation philosophy
    j) Knowledge of Motivational Interviewing
    k) Skillful in the use of Cognitive Behavioral Therapy
    l) Skillful in the use of evidence based strategies
6. 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.

B. Supervisor

1. 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 Services Licensing as one of the following:
    a) Clinical Social Worker
    b) Marriage and Family Direct Worker
    c) Mental Health Counselor
2. 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.
    a) Services will be delivered in a neutral-valued culturally-competent manner.
3. Providers are to respond to the ongoing individual needs of staff by providing them with the appropriate combination of training and supervision.
    a) 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.
    b) Supervision should include individual, group, and direct observation modalities and can utilize teleconference technologies.
    c) 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.
4. The Supervisor will be knowledgeable on the START model and participate in consultation with the State Designated START Administrator.
    a) The supervisor will participate in START meetings, including but not limited to Direct Line and Steering Committee.

VI. Billable Units

A. Medicaid

1. The START Treatment Coordinator activities will be monitored by the contracting agency and any billable Medicaid activities are the responsibility of the contracting agency.
2. The contracting agency is to be knowledgeable about the Medicaid billing requirements and comply with them, including provider qualifications and any pre-authorization requirements.
3. The contracting agency is responsible for billing those services when they are may be reimbursed by Medicaid.

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

B. DCS Funding

1. DCS funding is provided as reimbursed by actual cost based on approved budget for time spent providing the services in this standard.
2. Any treatment services performed under a separate referral should not be billed under this service standard (e.g. individual counseling).
3. Contracted agencies will use approved invoicing process.

VII. Case Record Documentation

A. Case record documentation for service eligibility must include:

1. A completed and dated DCS form authorizing services
2. Copy of the DCS Case Plan, Informal Adjustment documentation, or documentation of requests for these documents from the 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 recommendation to modify the service/treatment plan
    b) Discuss overall progress related to treatment plan goals including specific examples to illustrate progress
7. Progress/Case Notes must document the following
    a) Date
    b) Start Time
    c) End Time
    d) Participants
    e) Individual providing the service
    f) Location
8. When applicable, Progress/Case notes may also include:
    a) Service/Treatment plan goal addressed (if applicable)
    b) Description of Intervention/Activity used towards treatment plan goal
    c) Progress related to treatment plan goal including demonstration of learned skills
    d) Barriers: lack of progress related to the 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 the 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 of supervision
b) Time of supervision
c) Individuals present for supervision
d) Summary of supervision discussion including presenting issues and guidance given

VIII. Service Access

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

XI. 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.

XII. Child Safety

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

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

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