SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
Behavioral Health Services in a Residential Setting
(Effective 1/15/2014)

I. Service Description

This service standard applies to services provided to children placed in a residential setting. These services include the provision of structured, goal-oriented therapy for children and families affected by physical abuse, sexual abuse, emotional abuse, and/or neglect. It is expected that other behavioral/emotional issues will 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.

II. Service Delivery

Therapeutic Services

Residential providers will be expected to adopt and utilize evidence-based treatments that best suit the needs of the target populations they serve. Programs may choose a range of evidence-based models; however, given that a majority of youth placed by DCS in residential treatment programs have experienced trauma, all providers will be required to utilize Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) as a core competency. Approval of the Deputy Director of Placement Support and Compliance is required to utilize any other evidence-based, trauma-informed practice instead of TF-CBT.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) was developed specifically to treat children and adolescents who have experienced traumatic events, including child abuse, domestic violence, natural disasters, rape, and exposure to community violence. TF-CBT combines elements of cognitive-behavioral, attachment, humanistic, empowerment and family therapy models. It includes several core treatment components designed to be provided in a flexible manner to address the unique needs of each child and family. Initially developed to address the trauma associated with child sexual abuse, there is strong scientific evidence that TF-CBT works in treating the symptoms associated with a wide array of traumatic experiences in children, adolescents and their parents.

Providers should consult The National Child Traumatic Stress Network at http://www.NCTSN.org for background information and instructions for implementing TF-CBT.

Therapeutic Services: Youth with Sexually Maladaptive Behaviors:
Treatment must include individual, group and family components for sex offenders including the following:

1. Risk and needs assessment: 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) or other risk assessment tool approved by the Department of Child Services.
2. 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.

3. Core treatment modules through group therapy including: psycho-education 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.
4. 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.
5. Establishing 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 when s/he is outside the treatment setting: in the home, school and community. The provider will help prepare this network to provide monitoring 24 hours a day.
6. Relapse prevention if appropriate.
7. Polygraph testing if appropriate.
8. Family support services.
9. Compliance monitoring and reporting.

Therapeutic Services: Youth with Substance Use Disorders:
An individualized recovery plan must be developed that considers the client's age, ethnic background, cognitive development and functioning, and clinical issues. 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. 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.
Service providers must adopt and utilize evidence-based treatments which focus not only on the behavior associated with the substance use disorder, but also any underlying trauma which may be contributing to the disorder.

Diagnostic and Evaluation Services:
1. If the child is placed in a short term diagnostic and evaluation program, the provider should complete a comprehensive diagnostic evaluation. The diagnostic evaluation should incorporate and integrate information from multiple disciplines, including the nursing assessment, psychiatric evaluation, educational assessment, biopsychosocial assessment and psychological testing, as appropriate. Collateral data is also collected, and includes but is not limited to interviews with service providers, treatment records of inpatient and outpatient care, and information with family members. Neuropsychological tests and medication evaluation should also be completed as necessary. The diagnostic evaluation will integrate all data into a summary of the issues creating barriers to reunification, explain the psychological diagnosis, and will provide recommendations for treatment

Other Behavioral Health Services:
1. Crisis Intervention services: The service is defined as an unscheduled, immediate, short-term treatment intervention provided by a master's- level therapist to a client who is experiencing a psychiatric or behavioral crisis. Crisis intervention services are designed to stabilize the person in crisis, prevent further deterioration, and provide immediate indicated treatment in the least restrictive setting.
2. Therapeutic Visitation: The service is defined as a planned, structured visitation between the child and his/her parent/guardian, family member or alternate caretaker, as outlined in the DCS case plan or ordered by the court. Therapeutic visitations are supervised by a master's-level therapist and are designed to a) assist children and their families in maintaining or reestablishing relationships that are healthy and safe for the child or b) assist children in the transition to different family structures, while providing for the safety of the child.

3. Periodic Reassessment: This service is defined as completion of an updated bio-psychosocial assessment, or other specialized assessment, by a master's-level therapist, as requested by DCS or required by state licensure and/or accreditation standards.
4. Polygraphs should be provided as appropriate for those children/youth in programs targeting treatment for Sexually Maladaptive Youth.
5. Drug screens should be provided as appropriate for those children/youth in drug treatment programs.

General Service Requirements

1. Services will be based on objectives derived from the established DCS/Probation case plan, CANS identified needs and strengths, taking into consideration the recommendations of the Child and Family Team (CFT), and subsequent written documents.
2. The counselor will be involved in Child and Family Team Meetings (CFTM) as requested.
3. Counselor 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 sociocultural 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 include providing any requested testimony and/or court appearances, including hearings and/or appeals.
6. When the case plan goal is reunification, family services must be provided to the family at a time convenient for the family.
7. Written reports will be submitted monthly to provide updates on progress and recommendations for continuation or discontinuation of treatment.

III. Medicaid

For those families and children not eligible for Medicaid, these services will be paid by DCS. For eligible children, some services may be provided through Medicaid Rehabilitation Option (MRO) or Medicaid Clinic Option (MCO) with the remaining services paid by DCS. The service standard is not a Medicaid service 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. 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 with a status of JD/JS and their families;
3. Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.

V. Minimum Qualifications

Staff providing services under this service standard must at a minimum meet the requirements to bill Medicaid (MRO or MCO). For "other behavioral health services", which are billable to DCS without first billing Medicaid, providers must meet the criteria outlined in the definition of each "other behavioral health service".

ADDITIONALLY FOR SEXUALLY MALADAPTIVE PROGRAMS: 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.

ADDITIONALLY FOR SUBSTANCE USE DISORDER TREATMENT: Service providers will only utilize professionals who are appropriately credentialed and who are trained and competent to implement substance use treatment as outlined by state law. IC 25-23.6-10.5-9

Training and Supervision
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 "best-practice" interventions for youth with commonly-occurring DSM-IV diagnoses;
- 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.

VI. Billable Units
Services will first be billed to Medicaid. If Medicaid denies the service, it may be billed to DCS:

- Individual Therapy – Includes client-specific face-to-face contact with the identified child during which services as defined in this Service Standard are performed. Billed to DCS per hour.
- Family Therapy – Includes client-specific face-to-face contact with the identified child and family during which services as defined in this Service Standard are performed. In circumstances where face to face service with the family is not possible, other modalities will be considered with written approval by the FCM or Probation Officer. Billed to DCS per hour.
- Group Therapy – Services include face to face group goal directed therapeutic work with children. To be billed per client per hour attended.
- Diagnostic and Evaluation Services—Services include face to face time with the child, collateral contacts with service providers and family members, scoring and report writing. Billed per hour.

These services are not billable to Medicaid and may be billed to DCS:

- **<u>Court Hearings</u>**
    - Court Attendance – 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 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 except travel time. The provider must have a written request from DCS or the Probation Officer in order to bill DCS for a court appearance.

    - Travel to and from Court – When DCS or the Probation Officer requests the therapist to attend court, DCS will pay the actual therapist's time traveling to and from court at a rate per hour.
- **Other behavioral health services:** The following other behavioral health services will be provided face-to-face by a master's level clinician paid by DCS per hour:
    - Crisis Intervention
    - Therapeutic Visitation
    - CFT Meeting Attendance
- **Other behavioral health services**: The following are paid at actual cost:
    - Polygraphs for Sexually Maladaptive Youth: Paid by DCS per polygraph at actual charge not to exceed $350.00.
    - Drug screens: Paid by DCS per drug screen at actual charge up to a rate of $15.00.
    - Translation or sign language: Services include translation for families who are non-English language speakers or hearing impaired and must be provided by a non-family member of the client. Dollar-for-dollar amount.

Services with hourly rates must 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

VII. Case Record Documentation

Case record documentation for service eligibility must include:

1. A DCS/ Probation Individual Child Placement Referral form authorizing services;
2. Documentation of regular contact with the referred families/children including a) the problem area addressed from the treatment plan, b) the intervention provided, c) the child/family's response to the intervention, and d) the plan for additional interventions.
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.
4. Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation.

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.