

**SERVICE STANDARD**  
**INDIANA DEPARTMENT OF CHILD SERVICES**  
**SUBSTANCE USE OUTPATIENT TREATMENT**

**I. Service Description**

- A. This service standard applies to families and children involved with the Department of Child Services and/or Probation.
- B. 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.
- C. A variety of scientifically based approaches to substance use recovery exists.
  - 1. Recovery prescribed for all clients must be evidence-based.
  - 2. Substance use recovery must include behavioral therapy (such as counseling, cognitive therapy, or psychotherapy), medications, or their combination.
  - 3. Effective recovery attends to multiple needs of the individual, not just his or her substance use.
  - 4. To be effective, recovery must address the individual's substance use and any associated medical, social, psychological, vocational, and legal problems.
- D. Parental substance use can potentially place a child's welfare at risk.
  - 1. A parent who engages 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.
  - 2. During the course of recovery, it is imperative the treatment provider assesses the safety of the child(ren) periodically and takes into consideration where the parent is in their recovery and how their actions might impact the safety and well-being of the child(ren).
- E. Important Note: A face-to-face multi-axial clinical assessment must take place prior to admission to an outpatient program (See Substance Use Disorder Assessment Service Standard).

**II. Service Delivery**

- A. Services must be available to clients who have limited daytime availability.
- B. 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 problem to address, as well as working with special needs clients, such as those who have mental health issues or are developmentally delayed.

- C. Services must be provided utilizing evidence-based interventions and programs that are promising, supported or well-supported.
1. Approved programs may be found at:
    - a) The California Evidence: [www.cebc4cw.org](http://www.cebc4cw.org)
    - b) Substance Abuse and Mental Health Services Administration (SAMHSA): [www.nrepp.samhsa.gov](http://www.nrepp.samhsa.gov)
    - c) The Office of Juvenile Justice and Delinquency Prevention: <http://ojjdp.ncjrs.gov>.
    - d) Other program requests may be utilized with prior written approval from DCS Central Office.
    - e) Requests should be submitted to the Child Welfare Plan Inbox- [childwelareplan@dcs.in.gov](mailto:childwelareplan@dcs.in.gov).
- D. For each client referred by DCS, the vendor shall provide written monthly reports, utilizing the standard DCS monthly report form, available on the DCS website: <https://www.in.gov/dcs/3159.htm>.
1. Written monthly reports are due by the 10<sup>th</sup> of each month following the reporting month, and should be received by the referring worker.
- E. Upon successful completion of treatment, the provider shall submit a discharge plan to the referring worker to include the client's response to treatment and aftercare plan.
1. The discharge plan will provide the client's linkage to recovery support, client's identified strengths, as well as treatment/recovery goals that were developed in collaboration with client.
  2. The discharge plan will include a narrative discussing overall progress related to treatment plan goals, with specific examples to illustrate progress.
  3. The discharge plan will include specific steps the client has agreed to take to continue their individualized recovery goals.
- F. Services are planned and organized with addiction professionals and clinicians providing multiple recovery service components for the rehabilitation of substance use/opioid use disorder in a group setting.
- G. Due to the chronic nature of addiction, treatment involves multiple intervention and requires constant monitoring.
1. The treatment provider shall follow all requirements of 440 IAC 4.4-2-4.5 with regards to treatment planning.
- H. An individualized Recovery Plan must be developed that considers the client's age, gender, ethnic background, cognitive development and functioning, and clinical issues.
1. Recovery Plans for DCS clients should connect substance use and how it affects child safety.

2. Recovery Plans shall provide a framework for measuring success and progress.
  3. Recovery Plans should include goals and objectives that address the issues identified in the substance use assessment.
  4. The goals should follow the SMART principle (Specific, Measurable, Attainable, Relevant, and Time bound).
  5. The client's Recovery Plan should include the treatment planning component, but should be more holistic in nature, encompassing other aspects of client's recovery, such as lifestyle and behavioral changes to support the healing process, increase well-being, and reduce the risk of relapse.
- I. 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.
1. All concerns regarding child safety will be immediately reported to the DCS Intake Hotline or the Family Case Manager.
- J. The following questions, based on the Screening an Assessment for Family Engagement Retention and Recovery (SAFERR) principles, are to be utilized in assessing child safety.
1. Where are your children at the time you use alcohol and/or drugs?
  2. Have you ever worried that you would not be able to take care of your children while you were using drugs and/or alcohol?
  3. 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?
  4. 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?
    - a) When do your children eat their meals and what are examples of food they often eat?
  5. Has anyone ever reported you to the child welfare system in the past?
  6. 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:
    - a) Is the child in someone else's care when the client uses drugs and/or alcohol?
    - b) Does the client have sober relatives/friends they can utilize when they are not sober and cannot care for their children?
    - c) How does the client keep the child safe when they are using drugs and/or alcohol?
    - d) Determine the willingness of the parent to accept and participate in treatment and if the parent acknowledges they have a substance use disorder.

- K. Drug testing plays an important role as a tool in supporting client recovery.
1. Drug testing in substance use disorder treatment should be used as a therapeutic component of treatment, rather than a punitive tool.
  2. Drug test results should be addressed as part of therapy and testing should be used to monitor the effectiveness of a patient's treatment plan.
  3. The treatment provider will use best practice recommendations when considering drug testing frequency and specific time for testing.
  4. Per American Society of Addiction Medicine (ASAM) drug testing guidelines, at the beginning of treatment, patients should be tested more frequently and the frequency of testing should decrease as the patient becomes more stable in their recovery.
  5. It is recommended patients in early recovery be tested at least weekly and, as they progress in treatment and testing decreases in frequency, it should not be less than monthly.<sup>1</sup>
  6. The total number and frequency of drug tests is at the provider's discretion; however, all testing should be in compliance with the following uniform rules and guidelines:
    - a) All sample collection drug tests will be observed sample collection tests.
    - b) The vendor will ensure that all urine drug tests are observed by an individual of the same gender as the client.
    - c) Gender of the client is defined as the gender listed on the client's government issued identification.
      - (1) Provider staff must be aware and sensitive to the sexual and/or gender orientation of clients.
      - (2) If applicable, provider staff should provide information to the client regarding changing their government issued identification, accessible at <https://www.in.gov/bmv/2564.htm>.
    - d) Minimum of substances tested should include:
      - (1) Alcohol
      - (2) Amphetamines
      - (3) Barbiturates
      - (4) Benzodiazepines
      - (5) Cocaine
      - (6) Cannabis
      - (7) Opiates
      - (8) Methadone
      - (9) Oxycodone
      - (10) Tramadol

- (11) Buprenorphine
  - (12) Synthetic Marijuana
  - (13) Fentanyl
  - (14) Methamphetamine
  - (15) Other drugs indicated by client's history
7. 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.
    - a) Assurance must be given for accurate results even if the confirmation process is the only means to ensure accurate results due to the testing process providing inaccurate results.
  8. The vendor shall ensure proper legal chain-of-custody procedures are maintained and comply with departmental procedure, state, and federal law.
    - a) The vendor shall ensure complete integrity of each specimen tested and the respective test results.
    - b) Receiving, transfer, and handling of all specimens by personnel shall be fully documented using the proper chain-of-custody.
  9. The referring agency will be notified of positive test results within 72 hours of the lab receipt of the sample specimen.
  10. Negative test results will be provided within 24 hours of the test.
- L. Substance Use Disorder Treatment for Adolescents
1. Providers offering treatment for Substance Use Disorder to clients less than eighteen (18) years of age shall pay particular attention and care to accommodate the special and unique needs of this population, including:
    - a) The type of setting
    - b) Treatment format and frequency
    - c) Drug testing consideration
    - d) Family involvement
  2. Programing for adolescents shall utilize research-based approaches and treatment modalities that have been shown to be effective in treating this population.
  3. As research shows the substantial prevalence of SUD and psychiatric comorbidity in adolescents, providers are highly encouraged to make arrangements of recommended services that address the mental health needs of the adolescent concurrently.

---

<sup>1</sup><https://www.asam.org/resources/guidelines-and-consensus-documents/drug-testing>

4. Integrated care, targeting both the substance use disorder and any co-occurring psychiatric disorders, has been proven to be most effective in treatment of adolescents.<sup>2</sup>
5. As some delay in cognitive and social-emotional development is often associated with substance use during adolescence, SAMHSA (Substance Abuse and Mental Health Services Administration) recommends that treatment identify such delays and their connections to academic performance, self-esteem, and social interactions.<sup>3</sup>
6. Programs should make every effort to engage and involve the adolescent client's family because of its possible role in the origins of the problem and the ability to change the youth's environment.
  - a) As part of family-oriented treatment, caregivers should receive education regarding addiction dynamics and its effects on family functioning, as well as skills training to enhance the caregiver's parenting capacity.
7. Providers should consider adolescent brain development when devising treatment schedule and frequency.
  - a) More frequent sessions that are shorter in duration are highly recommended.
  - b) Use of group therapy is well suited to adolescents, who tend to rely heavily on peer examples and approval.
  - c) Before beginning the drug testing process with an adolescent, providers will explain drug testing protocols in full and ensure the adolescent has the opportunity to provide informed consent to testing.

---

<sup>2</sup> Treating Mental Health and Substance Use Disorders in Adolescents: What Is on the Menu?; Stanley Brewer<sup>1</sup> & Mark D. Godley<sup>2</sup> & Leslie A. Hulvershorn (Curr Psychiatry Rep (2017) 19: 5; DOI 10.1007/s11920-017-0755-0)

<sup>3</sup> <https://www.ncbi.nlm.nih.gov/books/NBK64350/>

### III. Addiction Services

- A. Addiction Counseling (Individual Setting) – designed to be a less intensive alternative to IOT
1. Please Note: If a client fails to show for a scheduled treatment session, the provider must notify the referred source for each no-show before the end of the next business day
  2. Documentation must support how Addiction Counseling benefits the client, including when the client is not present.
  3. Addiction Counseling requires face-to-face contact with the client and/or family members or non-professional caregivers
  4. Addiction Counseling consists of regularly scheduled sessions at a frequency determined by the clinician.
  5. Addiction Counseling may include the following:
    - a) Education on addiction disorders
    - b) Skills training in communication, anger management, stress management, relapse prevention, and any other skills identified in the treatment plan.
  6. Addiction Counseling goals are rehabilitative in nature.
  7. For a client less than eighteen (18) years of age, Addiction Counseling must be provided in an age-appropriate setting.
  8. Addiction Counseling must be individualized, based on the goals developed with the client and included in the Recovery/Treatment Plan.
  9. Drug tests shall be utilized as part of treatment and used to monitor the effectiveness of the client's treatment plan.
    - a) Providers will use best practice recommendations to determine the timeframes and frequency of testing.
    - b) ASAM (American Society for Addiction Medicine) drug testing guidelines are highly recommended as best practice reference.
  10. Case management and referrals to available community services will be included as part of treatment.
  11. Exclusions:
    - a) Clients with withdrawal risk or symptoms whose needs cannot be managed at this level of care, or who need detoxification services.
    - b) Clients at imminent risk of harm to self or others.
    - c) Addiction Counseling may not be provided for professional caregivers.
    - d) Addiction Counseling sessions that consist of education services only will NOT be reimbursed.
- B. Addiction Counseling (Group Setting) – designed to be a less intensive alternative to IOT

1. Please Note: If a client fails to show for a scheduled treatment session, the provider must notify the referral source of each no-show before the end of the next business day.
2. Documentation must support how Addiction Counseling benefits the client, including when services are provided in a group setting and/or the client is not present.
3. Addiction Counseling requires face-to-face contact with the client and/or family members or non-professional caregivers.
4. Addiction Counseling consists of regularly scheduled sessions.
5. Addiction Counseling may include the following:
  - a) Education on addiction disorders
  - b) Skills training in communication, anger management, stress management, relapse prevention, and any other skills identified in the treatment plan.
6. Addiction Counseling must demonstrate progress toward and/or achievement of client Recovery goals identified in the Recovery Plan.
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 client less than eighteen (18) years of age receiving services.
10. Addiction Counseling must be individualized, based on the goals developed with client and included in the Recovery/Treatment Plan.
11. Drug tests shall be utilized as part of treatment and used to monitor the effectiveness of the client's treatment plan.
  - a) Providers will use best practice recommendations to determine the timeframes and frequency of testing.
  - b) ASAM (American Society for Addiction Medicine) drug testing guidelines are highly recommended as best practice reference.
12. Case management and referrals to available services will be included as part of treatment.

C. Intensive Outpatient Treatment (IOT)

1. Please Note: If a client fails to show for a scheduled treatment session, the provider must notify the referral source of each no-show before the end of the next business day.
2. 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.
3. IOT includes the following components:
  - a) Referral to 12 step programs, peers, and other community supports
  - b) Education on Addictions disorders



- c) Skills training in communication, anger management, stress management, and relapse prevention
  - d) Individual, group, and family therapy (provided by a licensed professional or QBHP Only)
- 4. IOT must be offered as a distinct service.
- 5. For a client less than eighteen (18) years of age, IOT must be provided in an age-appropriate setting.
- 6. IOT must be individualized, based on the goals developed with the client and included in the Recovery/Treatment Plan.
- 7. Access to additional support service (e.g. peer supports, case management, 12-step programs, aftercare/relapse prevention services, integrated Recovery, referral to other community supports) must be included, as needed.
- 8. The client is the focus of the service.
- 9. Documentation must support how the service benefits the client, including when the service is in the group setting.
- 10. Services must demonstrate progress toward or achievement of client recovery goals identified in the Recovery/Treatment Plan.
- 11. Service goals must be rehabilitate in nature.
- 12. Up to twenty (20) minutes of break time is allowed during each three consecutive hour sessions.
- 13. Drug tests shall be utilized as part of treatment and used to monitor the effectiveness of the client's treatment plan.
  - a) Providers will use best practice recommendations to determine the timeframes and frequency of testing.
  - b) ASAM (American Society for Addiction Medicine) drug testing guidelines are highly recommended as best practice reference.
- 14. Case management and referrals to available services will be included as part of treatment.
- 15. Exclusions:
  - a) Clients with withdrawal risk/symptoms whose needs cannot be managed at this level of care or who need detoxification services.
  - b) Clients at imminent risk of harm to self of others.
  - c) IOT will not be reimbursed for client receiving Group Addiction Counseling on the same day.
  - d) IOT sessions that consist of education services only are not reimbursable.
  - e) Any service that is less than 3 hours may not be billed as IOT, but may be billed as Group Addictions Counseling (if provider qualifications and program standards are met).

D. Specialized Recovery

1. 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 the individual's needs.
2. 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 individuals' ability to remain drug free (i.e. domestic violence, traumatic events, and/or childhood trauma).
3. Specialized Recovery can also include modalities of brief counseling therapy.

E. Recovery Coaches

1. 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.
2. 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.
3. Recovery Coaches build on the client's strength, abilities, and resources.
4. Recovery Coaches work to decrease or stop substance use, increase the belief that recovery is possible, and increase life skills.
5. Recovery Coaches are to support positive changes made by the client and help the client overcome any obstacles that might inhibit the positive change.
6. Recovery Coaches work with the client on developing a Relapse Prevention Plan; develop means in dealing with past triggers and identifying healthy coping skills to deal with life stressors.
7. Recovery Coaches will primarily serve the clients in the home but may also serve the client in the community.
8. The goals of Recovery Coaches are to:
  - a) Decrease and/or eliminate substance use
  - b) Guide client through the recovery process
  - c) Assist clients in identifying their treatment goals
  - d) Increase client belief that recovery is possible and sustainable
  - e) Increase life skills, time management, and build healthy relationships
  - f) Empower client to advocate for themselves
9. Activities permitted under Recovery Coaching:
  - a) Identifying community/recovery supports

- b) Attend a support meeting with client
- c) Help identify client needs and benefits to the treatment program
- d) Engage the client into treatment
- e) Develop a recovery support plan
- f) Identify triggers and ways to work through them
- g) Identify alternative activities to maintain sobriety
- h) Develop client self-wellness goals
- i) Work on client-driven life goals, short and long term (e.g. education, treatment, and employment)
- j) Create a budget
- k) Teach and/or model life skills (e.g. opening a bank account, filling out a job application)
- l) Locate safe housing
- m) Coach on advocating for self
- n) Help identify client's strengths and develop self-esteem
- o) Develop structure/time-management goals
- p) Coach through crisis/emergency situations effectively
- q) Facilitate transportation and planning to be self-independent
- r) Participate in Child and Family Team Meetings
- s) Assist with coordinating services
- t) Identify a support system
- u) Develop problem-solving techniques
- v) Develop parenting skills
- w) Help understand child development and nutrition
- x) Assist with parent/child interactions
- y) Assist with understanding and implementing child safety
- z) Parenting sober: what that looks like through modeling and/or coaching with child and parent
- aa) Assist with family communication and rebuilding relationships
- bb) Education on Reactive Attachment Disorder (RAD), conflict management, domestic violence, mental health, and addiction

F. Medication-Assisted Treatment (MAT)

1. The use of medication-assisted treatment (MAT), in conjunction with psychosocial support and treatment is considered best practice for the treatment of opioid use disorders.
2. Clients should not be discouraged from using MAT as part of a substance abuse treatment plan.

3. If the client indicates the use of MAT (such as the use of Methadone, Buprenorphine, or Naltrexone), the provider will work with the client to complete a Release of Information form to obtain verification of the client's participation in MAT and to establish lines of communication, as well as with the MAT provider for the purpose of furthering the client's treatment/recovery goals.
  - a) Note: If a Release of Information is signed, both providers should share any positive drug test results, as well as other information pertinent, so that the most appropriate decisions regarding the treatment of the client can be made by each provider.

#### **IV. Target Population**

- A. 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 and/or JD/JS.
  3. Children with the status of CHINS or JD/JS and their Foster/Kinship families, with whom the children are placed.

#### **V. Goals and Outcomes**

- A. Vendors will have internal quality monitoring systems and procedures in place to track the quality and effectiveness of programming and service delivery.
- B. DCS may elect to conduct quality audits of contracted providers to ensure compliance with best practices and Service Standards.
- C. For Substance Use Disorder Outpatient Treatment Service Standard, DCS will use the following measures to monitor quality:
  1. Goal #1: Clients will be engaged in services timely and effectively.
    - a) Outcome Measure: 95% of referred clients will begin treatment within 10 business days of the referral.
    - b) Outcome Measure: 75% of referred clients will have stayed in treatment for 90 days or more.
  2. Goal #2: Recovery/Treatment Plan goals are developed from the substance use assessment.
    - a) Outcome Measure: 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.
      - (1) Recovery goals will be individualized, based on the assessment, with easy to evaluate outcomes.

3. Goal #3: Each client has an Individualized Recovery Plan on file, which has been updated to reflect client's progress and status changes.
  - a) Outcome Measure: Recovery Plan should identify long and short term goals attainable at 2, 4, and 6-month intervals and measurable by an expected performance or behavior.
  - b) Outcome Measure: Vendor shall maintain progress notes that provide details of client's functioning levels in terms of concrete behaviors and demonstrate growth and/or regression regarding the recovery process and lifestyle changes needed for the individual to remain drug free.
  - c) Outcome Measure: Monthly written reports, as prescribed by DCS, are on file for each client referred by DCS.
  - d) Outcome Measure: 90% of all monthly reports are submitted to DCS by the 10<sup>th</sup> day of the following month.
  - e) Outcome Measure: There is a Discharge Plan on file for each client who has successfully completed their treatment episode.
4. Goal #4: Client's drug test results will be provided to the referring worker in a timely fashion.
  - a) Outcome Measure: 100% of referring agencies will be notified of negative test results within 24 hours of laboratory receipt of sample specimen.
  - b) Outcome Measure: 100% of referring agencies will be notified of positive test results within 72 hours of laboratory receipt of sample specimen.
5. Goal #5: Provide No-Show alert to FCM.
  - a) Outcome Measure: 100% of no-show alerts will be provided to referral source, by the end of the next business day of the missed treatment session.
6. Goal #6: DCS and client satisfaction with services.
  - a) Outcome Measure: 90% of the families who have participated in outpatient treatment will rate the service as "satisfactory" or above on a satisfactory survey (or like tool) developed by the provider.
    - (1) Provides are to solicit feedback from a minimum of 12 clients or 20% of their caseload (whichever results in a larger number).
    - (2) Feedback should be collected in a random manner and be solicited from each county served.
  - b) Outcome Measure: Referral source satisfaction will be rated as "satisfactory" or above on a satisfaction (or like tool) developed by the provider.

## VI. Minimum Qualifications

- A. The program shall be staffed by appropriately-credentialed personnel who are trained and competent to complete SUD outpatient treatment as required by state law.
  - 1. Please refer to Indiana Administrative Code, Title 440 Division of Mental Health & Addictions: 1-11; Indiana Code (IC) 25-23.6-1-5.7, IC 25-23.6-1-5.9, IC 25-23.6-10.1-1 through 25-23.6-10.5-15.
- B. The program administrators will maintain their certification and credentialing by DMHA (Division of Mental Health & Addiction) and will ensure the direct service staff is appropriately credentialed at all times, as necessary to remain compliant with all ongoing certification requirements.
- C. The vendor shall notify DMHA regarding changes to credentialed staff, as required by DMHA Notification to DCS regarding any changes to the program's DMHA certification status or adverse action taken against vendor certification shall be sent to [ChildWelfarePlan@dcs.in.gov](mailto:ChildWelfarePlan@dcs.in.gov) within two (2) business days of the change.
- D. Recovery Coach Qualifications
  - 1. Recovery Coach:
    - a) Bachelor's Degree in Social Work, Psychology, Sociology, or directly related human service field from an accredited college.
    - b) Other Bachelor's Degree will be accepted in combination with a minimum of two (2) years-experience working directly with families in the child welfare system.
    - c) Individuals must possess a valid driver's license and have the ability to use a private car to transport self and others.
    - d) Individuals must comply with the contract requirements concerning minimum car insurance coverage.
    - e) In addition to the above:
      - (1) Official certification as a Recovery Coach is preferred; however, in lieu of the official certification, the individual may have extensive training in the area of substance abuse and addiction.
      - (2) Trained in Motivational Interviewing- preferred
      - (3) Trained in Trauma Informed Care- preferred
      - (4) Knowledge in addiction and how addiction impacts an individual and their family
      - (5) Knowledge in the stages of change and how to motivate an individual through the different stages
      - (6) Knowledge in the barriers individuals have in accessing and completing treatment

- (7) Knowledge of child abuse and neglect, child and adult development
  - (8) Knowledge of community resources, particularly the recovery community, and willingness to work as a team member.
  - (9) Belief in helping clients change their circumstances, not just adapt to them
2. Supervisor to Recovery Coach:
- a) Master's or Doctorate degree in Social Work, Psychology, or directly-related human services field from an accredited college.
  - b) Providers are to respond to the on-going individual needs of staff by providing them with the appropriate combinations of training and supervision.
  - c) 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.
  - d) Supervision should include individual, group, and direct observation modalities and can utilize teleconference techniques.
  - e) Under no circumstances is supervision/consultant to be less than one (1) hour of individual supervision/consultation per 25 hours of face-to-face direct client services provided, nor occur less than every two (2) weeks.
- E. Services provided will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as a complex family interactions.
- 1. Services will be delivered in a neutral-valued culturally-competent manner.

## **VII. Billable Units**

- A. 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.
- B. All providers that accept Medicaid shall follow the following procedures when billing for outpatient treatment services:
  - 1. After the agency receives prior approval from Medicaid then the agency must invoice Medicaid for the service.
  - 2. If Medicaid denies the claim and the agency invoices DCS, the Medicaid denial must be attached to the submitted invoice.

3. Failure to attach the denial may result in DCS denying the invoice.
- C. Community Mental Health Centers (CMHCs) and agencies that are qualified providers should utilize the Medicaid Eligibility Inquiry for patients with no health care coverage.
1. For invoices submitted to DCS with the statement, “client is not Medicaid eligible”, the qualified provider must attach the eligibility screen to the submitted DCS invoice.
  2. Failure to attach the eligibility screen may result in DCS denying the invoice.
- D. Services through MCO may be Outpatient Mental Health Services.
1. Medicaid shall be billed first for eligible services under covered evaluation and management codes, including those in the 90000 range.

<b>MRO Billing Code</b>	<b>Title</b>
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
H2014 HW	Skills training and development, per 15 minutes
T1016 HW	Case management, each 15 minutes



E. DCS Funding:

1. 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.
2. 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.
3. Addiction Counseling (Individual & Family)
  - a) Services billed per hour.
  - b) Note: Members of the client family are to be defined in consultation with the family and approved by DCS.
    - (1) This may include persons not legally defined as part of the family.
  - c) Includes client-specific goal-directed face-to-face contact with the identified client/family during which services are defined in this Service Standard are performed.
  - d) Includes Child and Family Team Meetings or case conferences initiated or approved by DCS for the purposes of goal-directed communication regarding the services to be provide to the client/family.
4. Addictions Counseling Group
  - a) Services include group goal directed work with clients.
  - b) Services to be billed per person per hour.
  - c) Note: Any group facilitated by Recovery Coaches shall be billed under Group component)
5. Intensive Outpatient Treatment
  - a) Services include goal-directed services as defined in this Service Standard.
  - b) Services to be billed per three hour session per person.
6. Recovery Coach
  - a) Note: Members of the client family are to be defined in consultation with the family and approved by DCS.
    - (1) This may include persons not legally defined as part of the family.
  - b) Includes client-specific face-to-face contact with the identified client/family, during which services (as defined in the applicable Service Standard) are performed.

- c) Includes Child and Family Team Meetings or case conferences initiated or approved by DCS for the purpose of goal-directed communication regarding the services to be provided to the client/family.
  - d) 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.)
    - (1) The Recovery Coach should not be utilized for transportation purposes only.
    - (2) The Recovery Coach should assist clients in becoming self-sufficient in their own transportation.
  - e) Includes crisis intervention and other goal-directed interventions via telephone with the identified client/family. Best practice would include a follow up face to face visit with the client family. Crisis over the phone is for extraordinary circumstances and should not be the mode to which ongoing services are provided.
  - f) Includes time spent completing any DCS-approved standardized tool to assess family functioning.
  - g) Any group facilitated by Recovery Coaches shall be billed under the Group component.
7. Reminder: Not included is routine report writing and scheduling of appointments, collateral contacts, travel time, and no shows.
- a) These activities are built into the cost of the face-to-face rate and shall not be billed separately. Travel time is only billable when the client is in the vehicle.
8. Services may be billed in 15 minute increments. Partial units are rounded to the nearest quarter hour using the following guidelines:
- a) 0 to 7 minutes- do not bill (0.00 hour)
  - b) 8 to 22 minutes- 1 fifteen minute unit (0.25 hour)
  - c) 23 to 37 minutes- 2 fifteen minute units (0.50 hour)
  - d) 38 to 52 minutes- 3 fifteen minute units (0.75 hour)
  - e) 53 to 60 minutes- 4 fifteen minute units (1.00 hour)
9. Interpretation, Translation, and Sign Language Services
- a) The location of and cost of interpretation, translation, and sign language services are the responsibility of the Service Provider.
  - b) 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.

- c) The referral from DCS must include the request for Interpretation Services and the agency's invoice for this service must be provided when billing DCS for the service.
- d) Providers can use DCS contracted agencies and request that they be given the DCS contracted rate but this is not required.
- e) 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.
- f) 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.

10. Court

- a) The provider for this service may be requested to testify in court.
- b) 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.
- c) If the provider appeared in court two different days, they could bill for 2 court appearances.
  - (1) Maximum of 1 court appearance per day per referred case.
- d) The rate of the court appearance includes all costs associated with the court appearance; therefore, additional costs associated with the appearance cannot be billed separately.

11. Reports

- a) If the services provided are not funded by DCS, the "Reports" hourly rate will be paid.
- b) DCS will only pay for reports when DCS is not paying for these services.
- c) A referral for "Reports" must be issued by DCS in order to bill.
  - (1) The provider will document the family's progress within the report.

12. Drug Testing

- a) DCS utilizes a single contracted vendor for all provider-administered drug tests
- b) The contracted vendor then subcontracts with DCS community-based providers to provide drug tests.
- c) The contracted DCS drug-testing vendor will only reimburse providers for drug tests administered in accordance with the testing vendor referral.
- d) Individual community-based vendors may not bill DCS for administered drug tests.

## **VIII. Case Record Documentation**

- A. Case record documentation for service eligibility must include:
1. A completed, and dated DCS/Probation referral form authorizing services
  2. A copy of DCS/Probation Case Plan, Informal Adjustment documentation, or documentation of requests for these documents from referral sources
  3. Safety issues and Safety Plan documentation
  4. Documentation of Termination/Transition/Discharge Plans
  5. Treatment/Recovery Plan
    - a) Must incorporate DCS Case Plan Goals and Child Safety Goals
    - b) Must use SMART (Specific, Measurable, Attainable, Relevant, and Time Bound) goal language
  6. Monthly reports are due by the 10<sup>th</sup> of each month following the month of service- case documentation shall show when report was sent. Reports should include the following:
    - 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:
    - a) Date
    - b) Start time
    - c) End time
    - d) Participants
    - e) Individual providing service
    - f) Location
  8. When applicable, progress/case notes may also include:
    - a) Service/Treatment plan goal addressed
    - 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
    - f) Collaboration with other professionals
    - g) Consultation/Supervision staffing notes
    - h) Crisis intervention/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
  - b) Individuals present
  - c) Summary of supervision discussion, including presenting issues and guidance given

**IX. 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.

**X. 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.

**XI. 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.

## **XII. 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.

### **XIII. Training**

- A. Service provider employees are required to complete general training competencies at various levels.
- B. Levels are labeled in Modules (I-IV), and requirements for each employee are based on the employee's level of work with DCS clients.
- C. Training requirements, documents, and resources are outlined at:  
<http://www.in.gov/dcs/3493.htm>
  - 1. Review the **Resource Guide for Training Requirements** to understand Training Modules, expectations, and Agency responsibility.
  - 2. Review **Training Competencies, Curricula, and Resources** to learn more about the training topics.
  - 3. Review the **Training Requirement Checklist and Shadowing Checklist** for expectations within each module.

### **XIV. 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.

## **XV. 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.