Indiana Department of Child Services
Service Standard
Stabilization and Diagnostic Services
Effective October 21, 2016

I. Service Description

This service standard applies to the programs and services provided to children placed in residential programs contracted with DCS and approved under the program service category of Stabilization and Diagnostic Services (SDS). This program provides crisis intervention, stabilization, and diagnostic and evaluation services to children referred by DCS and/or probation. Diagnostic and evaluation services are provided either via the comprehensive Diagnostic and Evaluation process described in the DCS service standard, or, at the option of the Placing Agency, through a selected and approved analysis of information, which is less comprehensive in scope and pertinent to a more limited problem area. The target population for this service is children for whom the presence of disruptive behavior is a barrier to their placement in settings in which they can receive programs and services. Examples of these behaviors include physical aggression, self-harming, destruction of property, and a high risk of elopement. The presence of these behaviors also is a barrier to their achievement of permanency. The Placing Agency may not have comprehensive information about the child's history or the circumstances underlying the behaviors at the time of placement. For some children, Stabilization and Diagnostic Services serve as a means of identification of the type of placement which would be most appropriate to the child's needs and of preparing the child for placement in that setting. Stabilization and Diagnostic Services also serves as a preemptive measure to deter unnecessary placement in residential services. A stay in a program with Stabilization and Diagnostic services is not to exceed 60 days, absent further request/approval of the Placing Agency.

II. Program Components

Providers will be expected to adopt and utilize the conceptual elements as described below as a part of the delivery of Stabilization and Diagnostic Services:

A. Crisis Intervention and Stabilization - Services designed to assist and support children who are experiencing acute distress, and to improve the stability of the child by the transition of the child who is in crisis back to pre-crisis function and restoring equilibrium. This may be accomplished by use of short-term crisis oriented interventions; by use of behavior management techniques, and by the interaction of the child in the therapeutic trauma informed milieu. Crisis Intervention includes crisis assessment, planning, medication management, and counseling specific to the crisis.

B. Trauma Informed Environment of Care - Maintenance of an organizational structure and services framework that involves understanding, recognizing, and responding to the effects of trauma and an understanding of potential paths for recovery. The trauma informed environment of care also must emphasize physical, psychological and emotional safety designed to rebuild a sense of control and empowerment to the child. The trauma informed environment of care must include maintenance of an organizational structure and interventions that do not expose the child to re-traumatization. See Section III.F.4. related to Trauma-Informed Care.

C. Diagnostic and Evaluation – Programs must meet the service standard for Diagnostic and Evaluation programs, and be prepared to provide Diagnostic and Evaluation services in a manner consistent with this service standard. The Diagnostic and Evaluation should be completed by the 30th day of care.

D. Skills Building Program – Programs must utilize a process oriented skills building approach, which must be at least a "promising practice"[1]. Providers must utilize a standardized skills building program or programs designed to provide the child with a set of ideas and actions which create a framework for solving problems and which are intended to teach the child to deal with problems or situations through learned models of resolution. Skills to be targeted could include the following: self-management, self-efficacy, emotional regulation, relaxation, dealing with the stages of grief/loss, change management, information processing/thinking, cognitive behavioral skill building, social skill building, independent living skills, personal responsibility, and other skills that facilitate the child's attainment of permanence.

III. Service Delivery

Stabilization and Diagnostic Services must meet the following requirements in service delivery:

A. Licensure - Programs must meet requirements of 465 IAC 2-9 or 2-11, which require licensure as a child caring institution or private secure facility. Programs must document with their licensing consultant the waiver of sections of 465 IAC 2-9-60 and 465 IAC 2-11-60 with regard to Education. SDS Programs must meet 465 IAC 2-10-60 as indicated below.

B. Emergency Referrals - Programs must be accessible for evaluation/consideration of children for admission 24 hours per day/7 days per week, and will provide DCS with appropriate contact information for emergency referrals. Programs will receive Individual Child Placement Referrals pursuant to their contract with the Department of Child Services, and must comply with the terms of that contract.

C. Treatment Plan - As the Stabilization and Diagnostic Services may be utilized in an emergency situation, the program shall assess each child's situation within twenty-four (24) hours or on the next working day of admission and shall develop a written Care Plan, which is consistent with the care plan required in Emergency Shelter Care programs. Then, within 7 days following the admission of the child, a Treatment Plan which is consistent with the Treatment Plan required by 465 IAC 2-9 or 465 IAC 2-11 shall be developed in conjunction with the placing agency and/or with the parents or guardian.
    1. When warranted, a Safety Pan, which describes maladaptive behaviors which may be displayed by the child and appropriate ways in which staff should respond, must be developed. When possible, the Safety Plan should be developed prior to the admission of the child.
    2. The Treatment Plan must identify the services and interventions that will be provided for the child, including the specific goals and objectives related to the services the child will receive during his/her stay.

D. Family Engagement - To the greatest extent possible, the program must involve the family, care-givers and significant others in the assessment of the child and in planning for services the child will receive.

E. Education - Programs must meet the minimum educational requirements of a child caring institution providing emergency shelter care found in 465 Ind. Admin. Code § 2-10-60.

F. Staffing –
    1. Program Director – The program must have a full time director that meets the qualifications of the program directed as listed in 465 IAC 2-9-48 or 465 IAC 2-11-48.

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[1] Promising practice - Programs rated as having promising outcomes or higher on the National Registry of Evidence Based Programs and Practices, http://nrepp.samhsa.gov

2. Qualifications - Persons providing services related to skills building must meet the requirements of the case-worker position as described in 465 IAC 2-9 and 2-11. Persons who work directly with children must be competent in utilizing techniques of a standardized program for crisis intervention/prevention. Persons providing crisis counseling services must meet the requirements for billing Medicaid, and at a minimum will be under the supervision of a licensed masters-level therapist.
3. Ratios - The ratio of skills building instructors/team leaders to children shall range between 1:4 and 1:8. The ratio of caseworkers (as described in 465 IAC 2-9 and 2-11) to children shall range between 1:6 and 1:8. The ratio of direct care staff to children shall range between 1:4 and 1:6.
4. Trauma-Informed Care – Staff must have a core competency in Trauma Informed Care as defined by the National Center for Trauma Informed Care (http://www.samhsa.gov/nctic/)

   "Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives. NCTIC facilitates the adoption of trauma-informed environments in the delivery of a broad range of services including mental health, substance use, housing, vocational or employment support, domestic violence and victim assistance, and peer support. In all of these environments, NCTIC seeks to change the paradigm from one that asks, "What's wrong with you?" to one that asks, "What has happened to you?" When a human service program takes the step to become trauma-informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma affects the life of an individual seeking services. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization."

G. Documentation – Programs must provide to the referral source on a bi-weekly basis (every two weeks) the following[2]:
   1. Summary of participation and response to process/skills building groups,
   2. Summary of participation in and response to therapy, if appropriate, and
   3. Overview of the child's behavior.

H. Discharge Planning – Programs must engage the Placing Agency in discharge planning at the time of completion of the Diagnostic and Evaluation[3]. The written comprehensive diagnostic evaluation will integrate data from all sources into a diagnostic impression summary and will include client strengths, barriers to permanence, prognosis and recommendations for treatment[4]. Providers should recommend placement types and restrictions, supports needed for transition and maintenance of stability within the placement, and other recommendations to assist in furthering progress for the child.

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[2] The required Monthly Progress Report fulfills this obligation on weeks where the Progress Report is provided to the Placing Agency.

[3] If a full Diagnostic and Evaluation is not completed, the discharge planning should begin no later than 30 days prior to discharge and at the conclusion of the analysis of any specific problems identified at placement.

[4] Review the service standard for Diagnostic and Evaluation for a full listing of required components in the written comprehensive diagnostic evaluation, located at http://in.gov/dcs/3320.htm.

I. Medical – In addition to meeting the requirements of 465 IAC 2-9-75 or 465 IAC 2-11-75 as applicable, programs must use a health evaluation checklist furnished by the Indiana State Department of Health to determine obvious health problems of the child at the time of admission. See 465 IAC 2-10-66.