SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
Behavioral Health Services in a Residential Setting
(Effective 7/1/2014)

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.

Therapeutic Services: Diagnostic and Evaluation:
For youth placed in a short-term diagnostic and evaluation (residential) program, the provider will complete a comprehensive diagnostic evaluation. The diagnostic evaluation should incorporate and integrate information from multiple disciplines and sources, including the biopsychosocial assessment, nursing assessment, psychiatric evaluation, education assessment and psychological testing. Collateral data is also collected and includes, but is not limited to, interviews with service providers, review of treatment records, and interviews with family members. Specialized testing, including substance abuse, neuropsychological and/or sexual risk assessments, may also be completed as necessary. 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.

The following components must be included in the written comprehensive diagnostic evaluation:

- Reason for Referral/Presenting Problem
- Summary of interventions, tests utilized
- Biopsychosocial Assessment
- Nursing assessment
- Individual Interview/Evaluation
- Family Interview/Evaluation (as appropriate)
- Psychiatric Evaluation

- Mental Status Exam
- Educational Evaluation, including at least one standardized intelligence test (e.g., WISC –IV) and at least one standardized achievement test (e.g., Woodcock Johnson)
- Personality Evaluation, including at least one standardized personality measure (e.g., MMPI – A, MACI, etc.). Projective measures may also be utilized.
- Assessment of Trauma, including at least one standardized trauma measure (e.g., Trauma Symptom Checklist), as well as an assessment of the impact of trauma on the youth's current functioning
- Behavior Rating Scales, including at least one standardized, comprehensive rating scale (e.g., BASC – II, CBCL, etc.) and symptom-specific rating scales, as appropriate (e.g., CDI, RCMAS, ISO-30, SASSI – A2, etc.)
- Specialty Rating Scales and/or Techniques, as related to the reason for referral and approved by DCS. Examples might include the ERASOR, Hare Psychopathy Checklist, Neuropsychological Testing, Clinical Polygraph, etc.
- Diagnostic Impression Summary (to include Prognosis)
- Full DSM – V Diagnosis
- Recommendations to address the following areas:
  - Level of care (placement)
  - Permanence (as applicable)
  - Considerations for potential caretakers
  - Medication management
  - Evidence-based therapies, prioritized to address primary diagnoses/symptoms first
  - Academic/school placement
  - Medical needs
  - Resiliency factors (e.g., sports, clubs, religious involvement, mentors, etc.)

As with other behavioral health services, it is our expectation that providers will first attempt to bill Medicaid. If Medicaid denies the service, DCS will reimburse the provider up to 32 units upon receipt of the written report. Additional units may be authorized (e.g., for specialized testing, additional interview time, etc.) with prior approval of the Clinical Services Specialist.

Providers will be expected to maintain a service log for each client billed under the Comprehensive Diagnostic Assessment code. This log should include the date, time (start time and end time), provider and type of service for each unit billed. Service logs will be reviewed by DCS Fiscal and Clinical staff during contract compliance audits. Allowable activities to be included under this standard will be as follows:

- face-to-face interview or assessment;
- collateral contact;
- review of records;
- test administration, scoring and interpretation; and
- report writing (maximum of 4 units).

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.
6. Intensive Behavioral Intervention (IBI): a highly specialized, individualized program of instruction and behavioral intervention. IBI is based upon a functional, behavioral and/or skills assessment of an individual's treatment needs. The primary goal of IBI is to reduce behavioral excesses, such as tantrums and acting out behaviors, and to increase or teach replacement behaviors that have social value for the individual and increase access to their community. Program goals are accomplished by the application of research based interventions.
    a. The following services may be billed to DCS when provided by a professional holding
        - at least a master's degree in applied behavior analysis; social work; psychology; counseling; or a related human service area of study approved by DCS, and
        - two years of experience developing and implementing intensive behavioral supports for children with developmental disabilities.
            1. Development of a Behavioral Support Plan, including a functional behavioral assessment through:
                - Direct observation of the child,
                - Review of records/assessments potentially associated with the unwanted behavior, and
                - Interviews with knowledgeable informants.
            2. Preparation and implementation of competency based training for all persons working with the child, including parents, regarding:
                - Best practices in working with children with developmental / intellectual disabilities,
                - General behavior management principles, and
                - Implementation of client specific behavioral support plans.
            3. Monitoring implementation of the Behavior Support Plan through:
                - Direct observation or interaction with the child to determine the effectiveness of the Behavior Support Plan and/or to gather information utilized to modify the Behavior Support Plan,
                - Direct observation of persons working with the child to determine the effectiveness of implementation of the plan and/or to gather information utilized to modify the Behavior Support Plan, and

- Utilization of modeling, coaching or other techniques with those persons to improve implementation of the Behavior Support Plan.

4. Assessing and updating the Behavior Support Plan including:
   - At least quarterly, review with the treatment team the Behavior Support Plan to determine the need for change, development of a new plan or to set new goals.
5. Working 1:1 with the child to provide structured, intensive behavioral training and to reinforce principles and approaches that are a part of the Behavioral Support Plan

b. The following services may be billed to DCS when provided by a professional with:
   - at least a bachelor's degree in applied behavior analysis; social work; psychology; counseling; or a related human service area of study approved by DCS, and
   - one year of experience working with individuals with developmental and/or intellectual disabilities.[1]

1. Monitoring the implementation of the Behavior Support Plan including:

   a. Direct observation of or interaction with the child and with the persons working with the child to determine the effectiveness of the Behavior Support Plan and/or to gather information utilized to modify the Behavior Support Plan;

   b. Utilization of modeling, coaching or other techniques with those persons to improve implementation of the Behavior Support Plan.

2. Assessing and updating the Behavior Support Plan including:

   a. objective measurement of progress through ongoing analysis of data collected

   b. production of at least monthly reports regarding the child's progress

   c. meeting at least quarterly with the interdisciplinary team to review the Behavior Support Plan, consider the need for change, develop a new plan, or set new goals.

3. Working 1:1 with the child to provide structured, intensive behavioral training and to reinforce principles and approaches that are a part of the Behavioral Support Plan.

<u>General Service Requirements</u>

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.

[1] These staff and activities should not be included in an agency's per diem rate that is set through the rate setting process set out in 465 IAC 2-16.

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:

- **Court Hearings**
    - 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 each billable contact with, or on behalf of, the identified client including: a) the date of contact, b) the start and stop time of the service provided, c) the provider's name and title, d) identification of the problem area addressed from the treatment plan, e) a description of the service type or intervention provided, f) a description of the child/family's response to the intervention, including any identified progress, barriers or setbacks, g) the plan for additional interventions, and h) the provider's signature with date and credential(s). It is also expected that the facility will have an internal tracking mechanism to ensure that each service is documented prior to billing DCS.

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.