

SERVICE STANDARD

INDIANA DEPARTMENT OF CHILD SERVICES

TRANSITION FROM RESTRICTIVE PLACEMENT (TRP)

I. Service Description

- A. TRP is a provision of services to assist children in a more restrictive placement to a less/least restrictive placement.
- B. The purpose of the program is to prevent a return of the youth to a more restrictive setting/placement.
- C. TRP must include the following kinds of services to the youth and family:
- D. Therapeutic/clinical interventions to address the service needs of the youth and family.
- E. Therapeutic interventions must be based on an evidence-based model such as:
 - A. Functional Family Therapy (FFT)
 - B. Multi-systematic Therapy (MST)
 - C. Parenting With Love and Limits
 - D. Similar program
- F. Home-based services including but not limited to the following:
 - 1. Home assessment
 - 2. Child development education
 - 3. Educational transition services
 - 4. Vocational services
 - 5. Drug/alcohol screening and monitoring
 - 6. Conflict management
 - 7. Addiction education
 - 8. Group therapy
 - 9. Coordination of services
 - a) Special emphasis on education and employment services
 - 10. Emergency/crisis services
 - 11. Parenting education/training
 - 12. Family communication
 - 13. Assistance with transportation
 - 14. Family reunification
 - 15. Family assessment
 - 16. Community referrals and follow up
 - 17. Behavior modification
 - 18. Budgeting/money management
 - 19. Other services deemed appropriate based on youth and family needs

II. Service Delivery

- A. Services must include 24-hour access to crisis intervention seven days per week
 - 1. May be provided in family home, community site, or in the office
- C. Services must include ongoing risk assessment and monitoring family/parental progress
- D. Services must include development of goals with measurable outcomes
- E. Provider must complete an intake interview with the family within five (5) calendar days after the receipt of the referral or notify referral source if client does not respond to meeting requests.
- F. Provider must maintain monthly contact with the youth's referring agency during the time the youth is in the more restrictive placement to ensure that the transition plan remains consistent between agencies
- G. Provider must participate in an initial meeting with the youth's FCM or probation officer, youth, and family within 48 hours of release
- H. DCS will be responsible for CANS assessments for CHINS youth
- I. For JD/JS youth, the provider must complete the Child and Adolescent Needs and Strengths (CANS) assessment within 30 days of transition from the more restrictive placement
 - 1. If not completed at the time of discharge
 - 2. Repeat every six months thereafter
- I. If no CANS completed prior to admission to the restrictive placement:
 - 1. Service provider is responsible to complete within 2 weeks of placement in a less restrictive placement
- J. Provider must conduct a minimum of two (2) face to face visits per week with the youth during the first thirty (30) days of release from the more restrictive placement
 - 1. The level of supervision after that period of time will be determined by the team
 - 2. Must never be less than one (1) face to face visit per week
- K. The provider may require the youth to submit at least one (1) random drug screen within fourteen (14) days of changing from a more restrictive placement
 - 1. When appropriate and requested by Probation Officer or Family Case Manager
 - 2. May be done through probation or another approved vendor
- L. Provider must maintain frequent contact with the FCM/Probation officer
 - 1. Notify in writing any non-compliance issues
 - 2. Develop a recommendation for the FCM/Probation Officer as to a suitable therapeutic intervention
- M. Services must be family focused and child centered

1. Focus on strengths and build upon them
- N. Services include:
1. Intensive in-home skill building and after-care linkage
 2. Providing monthly progress reports in a format approved by the court
 3. Participation in Child and Family Team Meetings
 4. Presence at court hearing and providing testimony when requested by DCS
- O. Provider will recommend to the referring agency any other services (therapy is common)
1. Recommendations for additional services not covered in the service standard should be made in writing to the FCM or Probation Officer
 2. Additional services require a separate referral and should not be started until a referral has been received
- P. Staff must respect confidentiality
1. Failure to do so may result in immediate termination of the service agreement
- Q. The caseload of the therapist/case manager will include no more than twelve (12) workload units
1. All youth in service are weighted at one (1) workload unit

III. Target Population

- A. Services must be restricted to the following eligibility category:
1. Note that Transition from Restrictive Placement (TRP) can be provided to CHINS or Probation youth you are transitioning out of residential or group home placements
 2. TRP services may begin while a youth is still in a residential or group home placement if that youth will be transitioning within 30 days
 3. For JD/JS youth who are committed to the Department of Corrections, service may begin within 60 days of the scheduled or anticipated discharge

IV. Goals and Outcomes

- A. Goal 1: To improve the transition for youth back to their home by providing therapeutic services to the youth and family.
1. Outcome Measure 1: Based on the CANS Assessment, 100% of participants will have an individualized service plan developed.
 2. Outcome Measure 2: 90% of families will actively participate in services during the youth's period of placement.

3. 90% of the youth will have a minimum of 2 face to face visits each week from their direct worker/therapist during the first 30 days following their placement from a more restrictive placement to a less restrictive placement.
- B. Goal #2: To reduce routine barriers by providing direct assistance with transition issues.
1. Outcome Measure 1: 90% of all participants will have a state-issued ID or driver's license by the completion of the program.
 2. 90% of all participants will actively participate in an education program.
 3. 100% of participants not involved in an educational program will be employed and/or participating in a formal employment assistance program.
- C. Goal #3: TO develop a system of community supports for each youth that will continue after the completion of the program.
1. Outcome Measure 1: 100% of the youth in the program will establish as least one community-based support that will continue to provide assistance and/or direction following completion of the program.
 2. Outcome Measure 2: 85% of youth will maintain their placement in a less restrictive setting at 6 month follow up.
- D. Goal #4: Maintain satisfactory services to the children and family
1. Outcome Measure 1: DCS/Probation satisfaction with services will be rated 4 and above on the Service Satisfaction Report.
 2. 90% of clients will rate the services 'satisfactory' or above on a satisfaction survey developed by the service provider, unless one is distributed by DCS/Probation to providers for their use with clients.
 3. Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.

V. Minimum Qualifications

- A. MCO:
1. Medical doctor
 2. Doctor of osteopath
 3. Licensed psychologist
 4. Qualified Behavioral Health Professional (QBHP)
- B. MRO:
1. Licensed professional
 - a) Except for a licensed clinical addictions counselor
 2. Qualified Behavioral Health Professional (QBHP)

C. DCS:

1. Direct Worker:

- a) Bachelor's degree in Psychology or Sociology, or Social Work
- b) Master's degree in Psychology, Sociology, Social Work; OR
- c) Bachelor's or Master's degree in a directly related human services field. as evidenced by:
 - (1) Completion of a minimum of 39 semester/58 quarter hours in the following coursework:
 - (a) Human Growth and Development
 - (b) Social and Cultural Foundations
 - (c) Lifestyle and Career Development
 - (d) Sexuality
 - (e) Gender and Sexual Orientation
 - (f) Ethnicity, Race, Status, and Culture
 - (g) Psychology
 - (h) Sociology
 - (i) Social Work
 - (j) Criminology
 - (k) Ethics and Philosophy
 - (l) Physical and Behavioral Health
 - (m) Family Relationships
 - (n) Advocacy and Mediation
 - (o) Case Management
 - (p) Resources and Systems
 - (q) Social Policy
 - (r) Community Planning and Relations
 - (s) Crisis Intervention
 - (t) Substance Use
 - (u) Counseling and Guidance
 - (v) Educational Studies

- (2) The individual must complete the Human Service Related Degree Course Worksheet.
 - (a) For auditing purposes, the worksheet should be completed and placed in the individual's personnel file.
 - (b) Transcripts must be attached to the worksheet.
 - (3) Coursework must be completed at a satisfactory level, no less than a C- for any quarter or semester grade in applicable coursework.
 - d) Other non-Human Service related Bachelor's degrees will be accepted:
 - (1) Minimum of two years-experience
 - (a) Providing a service to families that need assistance in the protection and care of their children and/or providing skills training, development, and habilitation.
 - (i) Experience gained by an employee in which the employee was not qualified to complete the work at the current or previous employer does not count toward the required two (2) year experience in combination with a Bachelor's degree.
5. The individual must possess a valid driver's license and the ability to use a private car to transport self and others, and must comply with the state policy concerning minimum car insurance coverage.
 6. In addition to the above:
 - a) Knowledge of child abuse and neglect, and child and adult development
 - b) Knowledge of community resources and ability to work as a team member
 - c) Belief in helping clients change their circumstances, not just adapt to them
 - d) Belief in adoption as a viable means to build families
 - e) Understanding regarding issues that are specific and unique to adoptions such as loss, mismatched expectations and flexibility, loss of familiar surroundings, customs and traditions of the child's culture, entitlement, gratification delaying, flexible parental roles, and humor.

2. Therapist:
 - a) Master's or Doctorate degree with a current license issued by the Indiana Behavioral Health and Human Services Licensing Board
 - b) Master's Degree with a temporary permit issued by the Indiana Behavioral Health and Human Services Licensing Board
 - c) Master's Degree in a related human service field and employed by an organization that is nationally accredited by the Joint Commission, Council on Accreditation or the Commission on Accreditation of Rehabilitation Facilities. The individual must also:
 - (1) Complete a minimum of 24 post-secondary semester hours or 36 quarter hours in the following coursework:
 - (a) Human Growth and Development
 - (b) Social and Cultural Foundations
 - (c) Group Dynamics, Processes, Counseling, and Consultation
 - (d) Lifestyle and Career Development
 - (e) Sexuality
 - (f) Gender and Sexual Orientation
 - (g) Issues of Ethnicity, Race, Status, and Culture
 - (h) Therapy Techniques
 - (i) Family Development and Family Therapy
 - (j) Clinical/Psychiatric Social Work
 - (k) Group Therapy
 - (l) Psychotherapy
 - (m) Counseling Theory and Practice
 - (2) Individual must complete the Human Service Related Degree Course Worksheet.
 - (a) For auditing purposes, the worksheet should be completed and placed in the individual's personnel file.
 - (i) Transcripts must be attached to the worksheet.
 - d) Individuals who hold a Master or Doctorate degree that is applicable toward licensure must become licensed as indicated in a and b above.
3. Supervisor
 - a) A Master's Degree in social work, psychology, or marriage and family or related human service field with a current license issued by the Indiana Behavioral Health and Human Services Licensing Board
 - b) Supervision/Consultation is to:

- (1) Include not less than one (1) hour face to face per 20 hours of direct client service provided
- (2) Occur every two (2) weeks or more frequently
- 4. In addition to the above, staff must possess:
 - a) Knowledge of community resources
 - b) Ability to work as a team member
 - c) Understanding of issues specific to youth transitioning back into the community following a stay in a more restrictive placement
- 5. Services will be conducted with behavior and language that demonstrates respect for:
 - a) Sociocultural values
 - b) Personal goals
 - c) Life style choices
 - d) Complex family interactions
 - e) Delivery of services in a neutral valued culturally competent manner

VI. Billable Units

- A. It is expected that the majority of the individual, family, and group counseling provided under this standard will be based in the clinic setting.
- B. In these instances, the units may be billable through MCO.
- C. Services through MCO may be Outpatient Mental Health Services.
- D. Medicaid shall be billed when appropriate.
 - 1. Bill first for eligible services under covered evaluation and management codes, including those in the 9000 range.
- E. Services through the Medicaid Rehab Option (MRO) may be group Behavioral Health Counseling and Therapy, Case Management, and Skills Training and Development.

| Billing Code | Title |
|---------------------|---|
| H0004 HW U1 | Behavioral health counseling and therapy (group setting), per 15 minutes |
| H0004 HW HR U1 | Behavioral health counseling and therapy, per 15 minutes (family/couple, group setting, with consumer present) |
| H0004 HW HS U1 | Behavioral health counseling and therapy, per 15 minutes (family/couple, group setting, without consumer present) |
| T1016 HW | Case Management, each 15 minutes |

| | |
|----------------|--|
| H2014 HW | Skills Training and Development , per 15 minutes |
| H2014 HW HR | Skills Training and Development, per 15 minutes (family/couple, consumer present) |
| H2014 HW HS | Skills Training and Development, per 15 minutes (family/couple, without consumer present) |
| H2014 HW U1 | Skills Training and Development , per 15 minutes (group setting) |
| H2014 HW HR U1 | Skills Training and Development , per 15 minutes (group setting, family/couple, with consumer present) |
| H2014 HW HS U1 | Skills Training and Development , per 15 minutes (group setting, family/couple, without consumer present) |

F. 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 behavior health care needs of the eligible client, will be billed to DCS per face-to-face hours as outlined below.
2. If agency administers clinical services, there may be two (2) face to face units:
 - a) Direct Worker
 - b) Counseling

G. Face-to-Face Time with Client

1. Members of the client family are to be defined in consultation with the family and approved by DCS.
 - a) This may include persons not legally defined as part of the family.
2. Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
3. Includes Child and Family Team Meetings or case conferences, or probation meetings initiated or approved by DCS or Probation for the

purposes of goal directed communication regarding the services to be provided to the client/family.

4. Includes crisis intervention and other goal-directed interventions via telephone with the identified client family.
5. Not included:
 - a) Report writing
 - b) Scheduling of appointments
 - c) Collateral contacts
 - d) Travel time
 - e) No shows
 - f) All are built into cost of face-to-face rate and shall not be billed separately.
7. Hourly services may be billed in 15 minute increments, partial units are rounded to the nearest quarter 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)

H. Interpretation, Translation, and Sign Language Services

1. The location of and cost of Interpretation, Translation, and Sign Language Services are the responsibility of the Service Provider.
2. 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.
3. The referral from DCS must include the request for Interpretation services and the agencies' invoice for this service must be provided when billing DCS for the service.
4. Providers can use DCS contracted agencies and request that they be given the DCS contracted rate but this is not required.
5. 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.
6. 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.

I. Court

1. The provider of this service may be requested to testify in court.

2. A Court Appearance is defined as appearing for a court hearing after receiving a written or email request or subpoena from DCS to appear in court, and can be billed per appearance.
 3. If the provider appeared in court two different days, they could bill for 2 court appearances.
 - a) Maximum of one court appearance per day
 4. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.
- J. Reports
1. If the services provided are not funded by DCS, the 'Reports' hourly rate will be paid.
 1. DCS will only pay for reports when DCS is not paying for these services.
 2. A referral for 'Reports' must be issued by DCS in order to bill.
 - The provider will document the family's progress within the report.

VII. Medicaid

- A. For those families and children not eligible for Medicaid Rehabilitation Option, this service will be paid by DCS.
- B. For eligible families and children, some services may be provided through Medicaid Rehabilitation Option (MRO) with the remaining services paid by DCS.
- C. While the primary focus of these services is on the needs of the family, it is expected that some of these services will be deemed medically necessary to meet the behavioral healthcare needs of the MRO eligible client, and therefore may be billable to MRO.
- D. The service standard is not a Medicaid standard and includes services that are not billable to Medicaid.
- E. It is the responsibility of the contracted service provider to be knowledgeable about the Medicaid billing requirements and comply with them.
 1. Including Provider Qualifications
 2. Including Pre-Authorization
 3. Appropriately bill services in cases where they are Medicaid reimbursed
- F. Services not eligible for MRO may be billed to DCS
- G. Medicaid section is not included in all standards
 1. For those standards it is included, format should be changed from paragraph form to this outline form
 - a. Language is standard

VIII. Case Record Documentation (Some standards do not match this language – note differences for future edits)

- A. Case record documentation for service eligibility must include:

1. A completed, and dated DCS/ Probation referral form authorizing services
2. Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for these documents from referral source.
3. Safety issues and Safety Plan Documentation
4. Documentation of Termination/Transition/Discharge Plans
5. Treatment/Service Plan
 - a) Must incorporate DCS Case Plan Goals and Child Safety goals.
 - b) Must use Specific, Measurable, Attainable, Relevant, and Time Sensitive goal language
6. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.
 - a) Provider recommendations 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: Date, Start Time, End Time, Participants, Individual providing service, and location
8. When applicable Progress/Case notes may also include:
 - a) Service/Treatment plan goal addressed (if applicable-
 - b) Description of Intervention/Activity used towards treatment plan goal
 - c) Progress related to treatment plan goal including demonstration of learned skills
 - d) Barriers: lack of progress related to goals
 - e) Clinical impressions regarding diagnosis and or symptoms (if applicable)
 - f) Collaboration with other professionals
 - g) Consultations/Supervision staffing
 - h) Crisis interventions/emergencies
 - i) Attempts of contact with clients, FCMs, foster parents, other professionals, etc.
 - j) Communication with 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 and individuals present
 - b) Summary of Supervision discussion including presenting issues and guidance given.
- B. Comprehensive and FCT have REPORTING instead of Case Record Documentation

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.