

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
SUBSTANCE USE DISORDER ASSESSMENT

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 in need of an assessment for substance use.
- C. The goal of the initial substance use assessment is to evaluate the client's substance use, the client's level of functioning, and the appropriate entrance into substance use treatment services.
- D. The assessment shall screen for child safety and how parental substance use impacts the risk of harm to the child.

II. Service Delivery

- A. A face-to-face clinical interview must take place with each referred individual.
 - 1. The face-to-face interview may take place in a clinical setting or in the client's home with prior approval from the referring worker.
- B. The provider must be able to complete the initial assessment within 72 hours of the referral, if an emergency exists (defined as serious medical condition or pregnancy), or sooner, if the referring worker suspects the client is in need of detoxification services.
- C. For emergency assessments it is expected that the verbal report will be provided to the referring worker within 72 hours and a written report provided within 7 calendar days after the completion of the assessment with the client.
- D. For non-emergency assessments the provider should complete the initial assessment within 10 days of the referral and the written report will be received by the referring worker within 10 calendar days after the completion of the assessment with the individual.
- E. The provider must notify the referring worker of each no-show, including the initial assessment, before the end of the next business day.
 - 1. After three no-shows, a new referral from the referring worker must be sent to initiate new services.
- F. A multi-axial system must be used to develop a comprehensive bio-psychosocial assessment that will include a mental status examination at the time of the initial appointment.
- G. Recommendations regarding the client's needs must be provided on each assessment report and shall provide a summary of information gained for all domains within the bio-psychosocial assessment.

- H. Services must be available to clients who have limited daytime availability.
- I. The service provider must identify a plan to work with non-cooperative clients including those who believe they have no problems to address as well as working with special needs clients such as those who have mental health issues or are developmentally delayed.
- J. 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.
 - 1. Services will be delivered in a neutral-valued culturally-competent manner.

III. Comprehensive Bio-Psychosocial Assessment

- A. Presenting Problem:
 - 1. Description of the problem/issue that the client believes led to the referring agent to request the assessment.
- B. Substance Use History:
 - 1. In-depth drug and alcohol use history with information regarding onset, duration, frequency and amount of use, used substance(s), and primary drug used.
 - a) This section should include a description of previous treatment episodes the client engaged in and the outcomes of those treatment episodes.
 - 2. One of the following standardized assessment tools for drug/alcohol use shall be administered to accurately determine if further substance use assessment is indicated.
 - a) Providers should utilize a nationally accepted drug/alcohol screening instrument.
 - b) It is strongly encouraged for providers to utilize Addiction Society of Addiction Medicine Criteria (ASAM).
 - c) Examples of other acceptable screening tools include:
 - (1) Substance Use Subtle Screening Inventory (SASSI and SASSI-A2)
 - (2) Addiction Severity Index (ASI)
 - (3) Teen Addiction Severity Index (T-ASI)
 - (4) ASI Lite
 - (5) Drug Use Screening Test (DAST and DAST-20)
 - (6) CRAFFT Screening Test
 - (7) Brief Screener for Tobacco
 - (8) Alcohol and other Drugs (BSTAD)
 - (9) Drug Use Screening Inventory Revised (DUSI-R)

- (10) Other standardized tools may be used to best assess the specific needs of the client.
3. Incorporating information from collateral contact is strongly encouraged.
 - a) A minimum of one (1) collateral contact shall be contacted regarding the client's substance use and history.
 - b) Members of the client's informal and formal support system can serve as collateral contacts to verify client's history of substance usage.
 - c) Local DCS office/probation staff will count as collateral contact if additional information is obtained from them.
4. Drug Screen:
 - a) One (1) drug screen will be completed as part of the assessment.
 - b) All sample collections drug screens will be observed collection screens.
 - c) The vendor will ensure that all urine screens are observed by an individual of the same gender as the client.
 - a) 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. 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 the following:
 - (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) Methamphetamine
 - (14) Fentanyl
 - (15) Other drugs indicated by client's history
 - e) Other substances not listed that the client may report a history of using may also be tested.

- f) The agency will be expected to provide reports that state a minimum level necessary to detect the presence of each substance, the level of substance detected, and the chain of custody documentation.
 - g) Assurance must be given for accurate results even if the confirmation process is the only means to ensure accurate results due to the screening process providing inaccurate results.
5. Mental Health Status:
- a) The mental health examination will address at minimum the following:
 - (1) Existing diagnoses
 - (2) Client's mood
 - (3) Affect
 - (4) Memory processes
 - (5) Hallucinations
 - (6) Judgement
 - (7) Insight
 - (8) Impulse control
 - b) The exam should also include past psychiatric hospitalizations and any other past treatment episodes (i.e. outpatient, medication, etc.)
6. Physical Status:
- a) Description of client's physical health and medical status should cover the following items:
 - (1) Any current and chronic diagnoses
 - (2) Current symptoms
 - (3) Currently prescribed medications
 - (4) Past surgeries
 - (5) Allergies
7. Trauma:
- a) Describe any past trauma experienced by the client (i.e. abused/neglected as child, domestic violence, sexual assault, environmental trauma, etc.) and how has it impacted their life functioning
8. Life Domain:
- a) Within this topic, assessment should include information on clients:
 - (1) Criminal justice history (i.e. arrests, convictions, incarceration episodes, and current status)
 - (2) Education level and type
 - (3) Employment history and current status

- (4) Financial and housing situation/living arrangement
- (5) Current access to transportation
- b) Any physical or emotional disabilities, as well as accommodations needed should be listed here.
- c) Functional strengths of the client should be identified
 - (1) Some areas that may be explored are what they/other view as positives, their skills/abilities, goals, and interests.

9. Child Safety:

- a) Parental substance use can negatively impact child's safety.
- b) It is important to assess the risk of parental substance use to the child and immediately report the concerns to the DCS Intake Hotline or the referring Family Case Manager.
- c) During the assessment the provider shall inquire about who lives in the client's home, if the client has children and if so, then inquire about child safety.
- d) Clients who meet at least 1 (one) of the following criteria shall be screened for child safety concerns:
 - (1) Client is a parent, male or female
 - (2) Client has caretaking responsibilities for a child
 - (3) Client has full or part-time care of their children
- e) The following questions, based on The Screening and 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? 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) Are any other agencies involved with your family because of concerns about your children?

- (7) Follow-up questions regarding safety protective factors could be helpful in assessing the risk to child safety. Examples of 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 what the willingness of the parent is to accept and participate in treatment and if the parent acknowledges they have a substance use disorder.

10. Therapist Recommendations:

- a) Following the assessment of each client, the service provider shall provide a detailed report to the referring worker, summarizing all information gained in each domain and make recommendations that include any necessary treatment, as well as the treatment modality and length.
- b) The recommendations will identify and incorporate the client's functional strengths.
- c) Recommendations for treatment will include goals that follow the SMART principle (Specific, Measurable, Attainable, Relevant, and Time Bound).
- d) Recommendations for treatment should incorporate language that encourages the client to engage with the recovery community and/or recovery support groups.
- e) Recommendations will incorporate child safety.

- f) The provider will include services around parent education and support on how to parent sober.
 - (1) The services might include communication skills, child development, nurturing, setting boundaries, how to interact at an age appropriate level, and how to handle children's behavior.

IV. Target Population

- A. Services must be restricted to the following eligibility categories:
 - 1. Children and families who have substantiated cases of child 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 or JD/JS.
 - 3. Children with the status of CHINS or JD/JS and their Foster Kinship families with whom they are placed.

V. Goals and Outcomes

- A. Goal #1: Maintain timely assessment with the family.
 - 1. Outcome Measure: 100% of emergency referred clients will be assessed within 72 hours or sooner if a medical crisis exists.
 - 2. Outcome Measure: 90% of non-emergency referred clients will be assessed within 10 days of the initial referral.
 - 3. Outcome Measure: 100% of referring workers will be notified of a client's no-show by the end of the following business day.
- B. Goal #2: Timely receipt of report to prepare for services/court and regular and timely communication with the referring worker.
 - 1. Outcome Measure for Emergency Assessment: 100% of the verbal reports will be received by the referring worker within 72 hours of the assessment; the written report received by the referring worker 7 calendar days after the assessment with the individual.
 - 2. Outcome Measure of Non-Emergency Assessment: 100% of the written reports will be received by the referring worker 10 calendar days after the completion of the assessment with the individual.
- C. Goal #3: Recommendations relevant and based on documentation in the body of the report.
 - 1. Outcome Measure: 100% of recommendations prepared as a result of the assessment are appropriate based on interviews, observations, review of other records, and completion of test instruments.

VI. Minimum Qualifications

- A. The program shall be compliant to Indiana Administrative Code 440 and staffed by appropriately credentialed personnel who are trained and competent to complete Substance Use Assessments as required by state law.
 - 1. References: Indiana Code (IC) 25-23.6-1-5.7; IC 25-23.6-1-5.9; IC 25-23.6-10.1 through 25-23.6-10.1-3 and IC 25.23.6-10.5-15.
- B. DCS will only permit Master level interns to complete substance use disorder assessments if they are co-facilitating the assessment with an appropriately credentialed individual.
- C. Administration and interpretation must meet the requirements of the standardized testing tool being utilized.
- D. All programs shall follow all regulations and be in compliance with the Department of Mental Health and Addictions.

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 preauthorization requirements and further, to appropriately bill for those services in particular cases where they may be reimbursed by Medicaid.
 - 1. The services not eligible for Medicaid Rehabilitation Option (MRO) or Medicaid Clinic Option (MCO) may be billed to DCS.
- B. Services through the Medicaid Clinic Option may be Outpatient Mental Health Services.
- C. Medicaid shall be billed first for eligible services under covered evaluation and management codes, including those in the 90000 range.

MRO Billing Code
H0015HW U1

Title
Alcohol and/or other drug services; intensive outpatient (treatment program that operates at least three(3) hours/day and at least three(3) days/week and is based on an individualized treatment plan, including **assessment**, counseling; crisis intervention and activity therapies or education

- D. 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.
- E. 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.
- F. DCS Funding
 - 1. Substance Use Assessment
 - a) Face to face hourly rate includes authorization of up to five (5) hours for time spent:
 - (1) Face to face time with the client
 - (2) Administering, scoring, and interpreting the assessment tools
 - (3) Collecting collateral information
 - (4) Reviewing treatment records and other collateral information
 - (5) Writing the report (maximum of 1.5 hours to be billed per assessment)
 - b) To exceed the maximum of five (5) units a prior request must be submitted to ChildWelfarePlan@dcs.in.gov with detailed information on the justification for additional units and how many units are being requested.
 - c) Reminder: Not included are scheduling of appointments, travel time, and no shows.
 - (1) These activities are built into the cost of the face-to-face and shall not be billed separately.
 - 2. 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)

3. 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.
4. Drug Screen
 - a) DCS utilizes a single contracted vendor for all provider administered drug screens.
 - b) The contracted vendor then subcontracts with DCS community based providers to provide drug screens.
 - c) The contracted DCS drug screening vendor will only reimburse providers for one (1) rug screen per assessment.
 - d) Individual community based vendors may not bill DCS for administered drug screens.
5. Court
 - a) The provider of 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) A maximum of 1 (one) court appearance per day.
 - 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.

6. 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.

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 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. Written reports as defined in this service standard.

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. Interpretation, 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 Trauma 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.