SERVICE STANDARD

INDIANA DEPARTMENT OF CHILD SERVICES

VOLUNTARY RESIDENTIAL SERVICES OVERSIGHT

I. Service Description

A. Voluntary Residential Services Oversight will be provided for children involved with the Children's Mental Health Initiative and/or Post Adoption Services who are:

1. At-risk of residential placement
    a) To determine if the child needs to be treated in a more restrictive setting, and if so:
        (1) To locate a placement that can meet the child's needs
2. Currently in residential placement
    a) To assist DCS in determining if the needs of the child are being met by the current placement
    b) To assess and recommend alternative placement options that more suitably meet the child's individual needs.

B. Caseload size will be 15-20 children in residential plus children being evaluated for possible residential placement.

1. DCS expects these clinicians to spend a significant amount of time in DCS Central Office in Indianapolis.
2. There will be substantial travel as children are located in facilities throughout the state.

II. Service Delivery

A. These services will consist of, but are not limited to:

1. Review all available assessments (including the CANS), medical and/or psychological recommendations, and staff case with the Wraparound Facilitator or Post Adoption Service Provider, family, and collateral contacts to determine if the child requires a more restrictive level of care.
2. Recommend to DCS an appropriate level of care.
3. Work with the placement facilities, Wraparound Facilitator/Post Adoption Service provider and parents to secure an appropriate placement for the child. Priority should be given to Medicaid paid services.
4. Provide consultation to the placement facility to ensure the facility has all information to prepare an appropriate and thorough Prior Authorization request to Medicaid for
5. Psychiatric Residential Treatment Facility (PRTF) services or

placement request to a State Operated Facility (SOF) and ensure appeals are occurring for any denials.

6. Upon denial for PRTF or SOF, consult with facility, family members and others involved with youth to ensure an appropriate level of care is secured.
7. In instances where the placement will be paid by the Department of Child Services (DCS), facilitate the Voluntary Placement Agreement between the caregiver and the DCS.
8. Monitor service delivery by facilitating monthly team meetings to ensure the services are meeting the needs of the youth. Team meetings must include the parent/caregiver as well as appropriate clinical staff at the treatment facility.
9. The youth must be visited face-to-face at least one time per month in the placement setting.
10. Encourage and monitor family participation in services.
11. Provide service documentation to DCS via monthly reports, critical incident reports, updated treatment plans, and monthly team meeting notes.
12. Complete an updated CANS at 6 month intervals or at critical case junctures.
13. Make monthly recommendations to DCS regarding the appropriate level of services for the youth.
14. Coordinate with the caregiver/parent, placement provider, Wraparound Facilitator and/or Post Adoption Service provider to develop an appropriate discharge plan to transition the youth back to the community.
15. Provide services in accordance to the Children's Mental Health Initiative Protocol.

III. Target Population

A. Children who are involved in the Children's Mental Health Initiative and/or Post Adoption Services

1. Who are a danger to themselves or others
2. Who cannot be maintained safely in the community with the available services

IV. Goals and Outcomes

A. Goal #1: Children will be served in the least restrictive setting available to meet their needs.

1. Outcome Measure 1: The percentage of children being served in their own homes will continue to be monitored during the baseline period (pre-contract) and compared to the percentage of children being served in their own homes during each contract year.

B. Goal #2: Children will be served without formal involvement with the child welfare or probation systems.

1. Outcome Measure 1: 90% of children served will not become involved with the child welfare or probation system through an open case (IA, CHINS, JD/JS) during the time the child is placed by the parents/caregiver out of the home.

2. Outcome Measure 2: 85% of children served will not become involved with the child welfare or probation system through an open case (IA, CHINS, JD/JS) during the time the child is placed by the parents/caregiver out of the home or during the 6 month time period following the return home.

C. Goal #3: Residential services will be utilized primarily as crisis stabilization and not long term placement.

1. Outcome Measure 1: Average and medium length of stay during the baseline period (pre-contract) will be compared to that of children served during each contract year.

D. Goal #4: Medicaid funded residential services will be accessed for eligible children.

1. Outcome Measure 1: 25% more residential stays will be funded by Medicaid.

E. Goal #5: Parent/Guardian/Caregiver will engage in services and follow the treatment plan.

1. Outcome Measure 1: Parent/Guardian/Caregiver will participate in 80% of all scheduled family treatment sessions.
2. Outcome Measure 2: Parent/Guardian/Caregiver will attend 100% of all monthly team meetings.
3. Outcome Measure 3: Parent/Guardian/Caregiver will participate in home passes 90% of the time as recommended by the treatment team.

V. Minimum Qualifications

A. Master's or Doctorate degree in social work, psychology, marriage and family, or related human services field.

B. Current license issued by the Indiana Behavioral Health and Human Services Licensing Board

VI. Billable Units

A. Paid actual cost based on an approved budget.

VII. Case Record Documentation

A. Case record documentation for service eligibility must include:

1. A completed, and dated DCS/ Probation referral form authorizing services
2. Documentation of regular contact with the referred families/children and placement provider through Case Notes which document:
   a) Date
   b) Location
   c) Start Time
   d) End Time
   e) Participants
   f) Individual Providing Service
3. Written progress reports no less than monthly or more frequently as prescribed by DCS and requested supportive documentation.
   a) Monthly reports are due by the 10th of each month following the month of service.
   b) Case documentation shall show when report is sent.
4. Copy of treatment plan.

VIII. 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.

IX. 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.

X. 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.

XI. 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.

XII. 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.

XIII. 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.

XIV. 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 statue, 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.