SERVICE STANDARD

INDIANA DEPARTMENT OF CHILD SERVICES

DOMESTIC VIOLENCE SURVIVOR AND CHILD INTERVENTION SERVICES

I. Service Description

A. Definition of Domestic Violence (Indiana Coalition Against Domestic Violence [ICADV] Definition)
   1. A pattern of assaultive or coercive behavior, including physical, sexual, or psychological attacks, as well as economic coercion, that adults or adolescents use against an intimate partner.

B. Intimate partners include spouse, former spouse, those living or having lived as if a spouse, those having a child in common, those having a past or current sexual relationship, or a past or current dating relationship.

C. The targeted population for Domestic Violence services includes both survivors and children.

D. Services may be provided comprehensively with service delivery including the survivor and child.

E. The provider is responsible for the reporting and coordinating of services to all populations.

F. Domestic Violence intervention services provided by DCS/Probation are not intended to exist in isolation, but as only one component of a coordinated community response to domestic violence.

G. Services shall maintain cooperative working relationships with local programs (domestic violence, batterers' programs, survivor programs, shelters, law enforcement, advocates, legal services, etc.).

H. Services shall be structured, goal-oriented, time-limited individual/group services and casework/victim advocacy services.

I. Services will be provided by a direct worker and/or counselor. Services provided may include the following:
   1. Educational and skills-based support group for survivor and/or child
   2. Assistance with transportation
   3. Coordination of services
   4. Advocacy (which includes goal setting, case management, supportive services)
   5. Safety planning
   6. Crisis intervention
   7. Community referrals and follow up

8. Family/Child assessment
9. Child development education
10. Domestic violence education
11. Parenting education with or without children present
12. Budgeting and money management
13. Participation in Child and Family Team meetings
14. Family reunification
15. Individual and family services
16. Cognitive behavioral strategies
17. Family of origin/Intergenerational issues
18. Family structure and organization (internal boundaries, relationships, roles, socio-cultural history)
19. Substance abuse screening
20. Potential screening for traumatic brain injury of the victim using a tool such as the OSU TBI Interview form and referral for medical treatment
21. Housing stability
22. Self-Sufficiency

II. Service Delivery

A. Child safety and ending violence takes precedence over saving relationships.
   1. The service focus shall be on child safety, survivor safety, and increasing the survivor and child's functioning, both emotionally and physically.

B. The provider must be available to respond for crisis intervention as needed.

C. Service will be provided within the context of the Department of Child Services' practice model with involvement in Child and Family Team meetings.
   1. The provider will develop a service plan based on the provider's assessment, and the agreements reached in the Child and Family Team meeting as convened by DCS/Probation.
   2. Service plans for survivors and children must be developed separately from service plans developed for batterers.

D. The provider will work with the FCM/Probation Officer on conducting safe Child and Family Team Meetings/case conferences and developing safe plans during those meetings.
   1. The provider will provide any necessary follow up with the survivor afterwards to ensure safety.

E. Services must be available to participants who have limited daytime availability.
   1. The provider must identify a plan to engage the survivor in the process, and a plan to specifically engage non-cooperative participants, including those who believe they have no problems to address or believe they are not involved in a domestically violent relationship.

F. Provider must respect confidentiality of survivors and children.
   1. Failure to maintain confidentiality may result in immediate termination of the agreement.
   2. A breach of confidentiality, even if unintended, can result in increased risk of harm for the survivor and/or children.

G. The provider shall establish a written policy requiring that all staff have a duty to warn and protect survivors, partners, children and others against whom the batterer has made a threat of violence.

H. Services include providing any allowable subpoenaed/court ordered testimony and/or court appearances (to include hearings or appeals) with a signed release.
   1. IC-35-37-6-1 states that communications between victims of DV and victim advocates are confidential, even if certain third parties are present when information is exchanged.
   2. Victim advocates cannot give testimony without victim consent in court proceedings, including CHINS.

I. Supervision/consultation is to include not less than one (1) hour of face-to-face supervision/consultation per 20 hours of direct client services provided, nor occur less than every two (2) weeks.

J. Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral-valued culturally-competent manner.

K. Child Services
   1. An initial safety assessment shall occur within 24 hours upon receipt of DCS/Probation referral.
      a) A full assessment (including written domestic violence service plans) will be completed and a summary sent to the referring worker within 10 days of face-to-face intake with the client/family. The full assessment will be kept in the provider file.
      b) The full assessment shall include, but is not limited to: safety and risk factors for the child, child abuse/neglect, food/shelter/clothing, the parent/child relationships, screening for other co-occurring issues (substance abuse, mental health issues, behavioral issues, social impairment, educational impairment, etc.).
   2. Comprehensive safety plans that are age and developmentally appropriate will be developed with the child.
      a) The child must be willing and able to use the plan, and have the ability to opt out of any step in the plan if needed.)
      b) Plans at a minimum will include:
         (1) Input from the non-abusive parent
         (2) Input from the child when appropriate

(3) Identification of safe places to go inside/outside of the home during violence

(4) Identification of where to meet if exiting the home is necessary

(5) Identification of how and when to use the phone for help

(6) Identification of how to stay safe during an argument/violence

3. The provider shall develop a comprehensive domestic violence service plan based on the assessment.
   a) Plans, at a minimum, will identify the needs of the child, set goals for the child, and establish a timeline for the accomplishment of goals in plan.
4. Advocacy and support services shall be provided as needed and as consistent with the assessment.
   a) These services shall include, but are not limited to, crisis intervention, links to community resources, Court Appointed Special Advocate (CASA)/ Guardian Ad Litem (GAL), information, and referral.
5. Services should be provided in the method consistent with the assessment and comprehensive domestic violence service plan and may include:
   a) Individual or group services
   b) Play services
   c) Group play services
   d) Family services
   e) Support groups
   f) Casework/victim advocacy services
6. Group services for children, if provided, are to occur in weekly sessions at least one (1) hour in length.
   a) The number of weekly sessions will be determined by the provider and DCS/Probation based on the child's individual needs.
   b) Class size shall contain a minimum of three (3) participants and is not to exceed twelve (12) participants.
7. Group curriculum will be age appropriate and shall include, but is not limited to:
   a) Promoting safe discussion of experiences with violence;
   b) Helping the child understand that violence is not their fault and/or the fault of the survivor;
   c) Helping the child understand and cope with their emotional responses to domestic violence;

d) Helping children identify, label, process, and express their feelings;

e) Exploring the child's attitudes and beliefs about families and family violence

L. Survivor Services

1. An initial safety assessment to address imminent risk and safety concerns shall occur within 24 hours upon receipt of DCS/Probation referral.
2. A full assessment (including written domestic violence service plans) will be completed and a summary sent to the referring worker within 10 days of face-to-face intake with the client/family. The assessment shall include
3. Additional comprehensive safety planning and screening which at a minimum will include:
   - a) Strategies to increase the safety of themselves and their children,
   - b) A list of emergency contacts,
   - c) Access to critical legal, financial, and medical documents, medications, and relocation or shelter services.
4. Based on the findings of the full assessment, a comprehensive domestic violence service plan to address the immediate and ongoing needs and risk factors of the survivor will be developed and will include, but not limited to:
   - a) Safety and risk factors for the survivor and his/her child(ren),
   - b) Emergency medical/dental care, legal assistance, food/shelter/clothing, parenting needs
   - c) Parent/child relationship, and screening for other co-occurring issues (substance abuse, mental health issues, traumatic brain injury etc.)
5. Set goals for the survivor, establish a timeline for the accomplishment of goals in plan, and identify and promote the use of informal and community supports and community resources.

6. Advocacy and support services shall be provided as needed and as consistent with the assessment and comprehensive domestic violence service plan.
    a) These services shall include, but are not limited to:
        (1) Housing assistance
        (2) Emergency medical/dental
        (3) Legal advocacy
        (4) Job training/employment
        (5) Safety plan
        (6) Transportation
        (7) Links to educational resources and community resources, information, and referral
7. Services should be provided in the method consistent with the assessment and comprehensive domestic violence service plan and may include individual, group and/or family services, case management, and advocacy services.
8. Group services, if provided, occur in weekly sessions at least one (1) hour in length.
    a) Number of weekly sessions will be determined by the provider and DCS based on the survivors' individual needs.
    b) Class size shall be a minimum of three (3) and is not to exceed 20 participants.
9. Group curriculum shall include, but is not limited to:
    a) Helping the survivors explore their attitudes and beliefs about families and family violence;
    b) Helping the survivors understand that violence is not their fault and they have no control over the violence;
    c) Helping the survivors understand the dynamics of domestic violence and aspects of power and control;
    d) Helping the survivors understand the impact of family violence on their children's development;
    e) Enhancing survivors' parenting skills and appropriate discipline methods;
    f) Enhancing the survivors' skills to safely co-parent with the offending parent on issues dealing with the child(ren) in common,
        (1) In circumstances where face-to-face contact is necessary when safety and/or orders of protection are not prohibitive(visitations, school/athletic events etc.)

10. If clinical services are identified as a need, and the agency does not provide that service, the agency shall notify the FCM, who may refer for additional services.
    a) If the agency has a clinician on staff, the clinician must adhere to qualifications below.

III. Target Population

A. 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 and their families which have an Informal Adjustment 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.

IV. Goals and Outcomes

A. Goal #1: Improve Safety of Survivors
   1. Outcome Measure 1: 100% of survivors have a detailed safety plan.
   2. Outcome Measure 2: 90% of survivors will report increased knowledge of resources that they can seek to meet their family’s basic needs (for example, housing assistance, transportation, medical care, food assistance and other forms of financial assistance).
   3. Outcome Measure 3: 90% of survivors will report increased confidence in their ability to access resources that can support their family’s basic needs.
   4. Outcome Measure 4: 90% of survivors report having an increased understanding of their legal rights.
   5. Outcome Measure 5: 90% of survivors report they know how and to access resources that meet their needs and feel empowered to do so.

B. Goal #2: To Enhance Skills of Children Who are exposed to Domestic Violence
   1. Outcome Measure 1: 100% of children report they know that the violence is not their fault.
   2. Outcome Measure 2: 90% of children will have identified effective coping mechanisms to deal with emotional responses to domestic violence.
   3. Outcome Measure 3: 90% of engaged youth will report that services improved their physical safety.

C. Goal #3: Improved functioning included development of positive means of managing crisis

1. Objective: Service delivery is grounded in best practice strategies, using such approaches as cognitive behavioral strategies, motivational interviewing, change processes, and building skills based on a strength perspective to increase family functioning.
    a) Outcome Measure 1: 100% of survivors report an increased knowledge and understanding of the effects of domestic violence on their children.
    b) Outcome Measure 2: 90% of survivors report an increased understanding of parenting skills and appropriate discipline.
    c) Outcome Measure 3: 90% of survivors report an increased knowledge on how to safely co-parent with the offending parent on issues dealing with the child(ren) in common.
    d) Outcome Measure 4: 67% of the families that have a child in substitute care prior to the initiation of service will be reunited by closure of the service provision period
    e) Outcome Measure 5: 90% of the survivor/children units that were intact prior to the initiation of service will remain intact throughout the service provision period.

D. Goal #4: DCS/Probation and clients will report satisfaction with services

1. Outcome Measure 1: 80% of the families who have participated in Domestic Violence Services will rate the services "satisfactory" or above on a satisfaction survey developed by the service provider, unless DCS/Probation distributes one to providers for their use with clients. 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.
2. Outcome Measure 2: DCS/Probation satisfaction will be rated 4 or above on the Service Satisfaction Report.

E. Program Fidelity Measures

1. Program fidelity and abiding by best practice standards are a good predictor of successful outcomes and provides an effective indirect measure.
2. An audit undertaken by a DCS employee or DCS designee may be conducted to assure program accountability and quality.
3. Programs must clearly link daily practices to the following program fidelity issues:
    a) 90% of families receive their first contact (telephone, mail or face-to-face) no later than the end of the first day following receipt of a referral from DCS/Probation.
    b) 100% of referrals that are not seen within 24 hours of referral will be reported to the referral source.
    c) 90% of required written domestic violence service plans/assessments will be completed and a summary sent to the referring worker within 10 days of face-to-face intake with the client/family.
    d) 90% of the community supportive services (BIP providers, law enforcement, courts, advocates, legal agencies, etc.) have a cooperative working relationship with the provider.
    e) 100% of provider staff focus on child/victim safety as evidenced by adherence to appropriate provider policies and procedures.
    f) 100% of program activities are carried out by qualified staff (see Qualifications).
    g) 90% of programs are available to participants who have limited daytime availability.
    h) 100% of provider staff are required to warn and protect children and victims and others when and if the batterer has made a threat of violence.
    i) 100% of clients (children and victims) will have a comprehensive domestic violence service plan developed.
    j) 100% of children referred and engaged in the program will have a developmentally- appropriate safety plan developed by provider staff.
    k) 100% of clients will be able to access a provider staff in the event of an emergency, 7 days a week, 24 hours a day.

V. Minimum Qualifications

A. Direct Worker

1. Services may be provided as needed by personnel with a Associates degree in social work, psychology, sociology, or a directly related human services field and/or 2 years working with families in a social service setting.
2. Worker should have knowledge of current Indiana state law and best practices regarding domestic violence.
3. If the provider is a peer reviewed agency, the direct worker should follow the training requirements of ICADV.
4. If the provider is not a peer reviewed agency, director worker should have completed at least 20 hours of online or in person training through ICADV, End Violence Against Women International (EVAWI), or Office for Victims of Crime (OVCTTAC).
5. The 20 hours of trainings must include:
   - a) Through ICADV's online webinar archive: Dynamics of Domestic Violence aka DV 101 (90 minute webinar) icadvinc.org
   - b) Through the OVCTTAAC Resources (ovcttac.gov)—online training under web-based training
   - c) Sign up for the Victim Assistance Training Online for free. The following webinars are required:
     - (1) VAT Basics: Ethics (45 min)
     - (2) VAT Core Competencies and Skills: Confidentiality (60 min)
     - (3) VAT Core Competencies and Skills: Trauma Informed Care (30 min)
     - (4) VAT Crimes: Child Abuse (45 min)
     - (5) VAT Crimes: Intimate Partner Violence (45 min)
     - (6) VAT Specific Considerations: Children and Youth (60 min)
     - (7) VAT Specific Considerations: Victims with Mental Health Issues (30 min)
     - (8) VAT Specific Considerations: Victims with Substance Abuse Issues (45 min)

B. Supervisor of Direct Worker

1. Associates degree in social work, psychology, marriage and family, or a related human services field and 5 years of direct domestic violence provider experience

2. Bachelor’s degree in social work, psychology, marriage and family, or a related human services field. Minimum 4 years professional field experience in a social service setting.
3. Master's degree in social work, psychology, marriage and family, or a related human services field.
4. Minimum 2 years professional field experience in family violence services.
5. Supervisor should have knowledge of current Indiana state law and best practices regarding domestic violence.
6. Supervisor will also have completed at least 20 hours of training through ICADV, EVAWI, or the Office of Victims of Crime as listed above in direct worker if not a peer reviewed agency.
7. Providers are to respond to the on-going individual needs of staff by providing them with the appropriate combination of training and supervision.
    a) 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.
    b) Supervision should include individual, group, and direct observation modalities and can utilize teleconference technologies.
    c) 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.

8. 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) Beliefs in helping clients change their circumstances, not just adapt to them
    d) Understanding regarding issues that are specific and unique to domestic violence

C. Counselor
1. Counselors under this standard must meet one of the following minimum qualifications:
    a. Master’s or Doctorate degree with a current license issued by the Indiana Behavioral Health and Human Services Licensing Board as one of the following:
        (1) Social Worker

(2) Clinical Social Worker
(3) Marriage and Family Therapist
(4) Mental Health Counselor
(5) Marriage and Family Therapist Associate
(6) Mental Health Counselor Associate

b. Master's Degree with a temporary permit issued by the Indiana Behavioral Health and Human Services Licensing Board as one of the following:
   (1) Social Worker
   (2) Clinical Social Worker
   (3) Marriage and Family Therapist
   (4) Mental Health Counselor

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. That individual must also:
   (1) Complete a minimum of 24 post-secondary semester hours or 36 quarter hours in the following coursework:
      (a) Human Growth & Development
      (b) Social & 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 & Practice

d. Individual must complete the Human Services Related Degree Course Worksheet.
   (1) For auditing purposes, the worksheet should be completed and placed in the individual's personnel file.
   (2) Transcripts must be attached to the worksheet.

e. Individuals who hold a Master or Doctorate degree that is applicable toward licensure, must become licensed as indicated in 1 (a and b) above.

D. Supervisor of Counselor
   1. Master's degree in:

a. Social work
b. Psychology
c. Marriage and family therapy
d. OR related human service field
e. With a current license issued by the Indiana Behavioral Health and Human Services Licensing Board as one of the following:
    (1) Clinical Social Worker
    (2) Marriage and Family Therapist
    (3) Mental Health Counselor.

2. Providers are to respond to the on-going individual needs of staff by providing them with the appropriate combination of training and supervision.
3. 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.
4. Supervision should include individual, group, and direct observation modalities and can utilize teleconference technologies.
5. 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.
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. Beliefs 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, entitlement, gratification delaying, flexible parental roles, and humor.
7. Services will be conducted with behavior and language that demonstrates respect for socio- cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral-valued culturally-competent manner.

VI. Billable Units

A. If agency administers clinical services, there may be two face to face units – Direct Worker and Counseling

B. Face To Face

1. Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
2. Includes Child and Family Team Meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family.
3. Includes crisis intervention and other goal-directed interventions via telephone with the identified client family.
4. Not included are routine report writing and scheduling of appointments, collateral contacts, travel time and no shows.
   - a) These activities are built into the cost of the face- to-face rate and shall not be billed separately.

C. Group

1. Services include group goal directed work with clients. To be billed per group hour.
2. Services may be billed in 15 minute increments; partial units are rounded to the nearest quarter hour 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)

D. 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.

E. 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 1 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.

F. Reports

1. If the services provided are not funded by DCS, the 'Reports' hourly rate will be paid
2. DCS will only pay for reports when DCS is not paying for these services
3. A referral for 'Reports' must be issued by DCS in order to bill
   a) The provider will document the family's progress within the report

VII. When DCS is Not Paying For Services

A. A billable unit of "Reports" has been developed for providers who service DCS families without DCS payment for these services (Medicaid, insurances, self-pay) but DCS wants a report from the provider on the progress of the family.

B. The referral process has been set up to authorize reports and court components on the DCS referral form in these incidences.

C. DCS will only pay for reports when DCS is not paying for these services.

D. If the services provided are not funded by DCS, the report rate per hour will be paid for the necessary reports on a referral form issued by DCS.

E. Court testimony will be paid per appearance if requested on a referral form issued by DCS.

F. In order to be paid for a court appearance a subpoena or written request from DCS should be on file.

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. 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 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.