SERVICE STANDARD

INDIANA DEPARTMENT OF CHILD SERVICES

VISITATION SUPERVISION

I. Service Description

A. It is the fundamental right for children to visit with their parents and siblings.

B. The relationship developed by the child with the parent is one of bonding, dependency, and being nurtured, all of which must be protected by the emotional well-being of the child.

C. It is of extreme importance for a child not to feel abandoned in placement by either the child's parents or by other siblings, and for a child to be reassured that no harm has befallen either parent or siblings when separation occurs.

D. Visitation facilitation as identified by DCS/Probation will be provided between parents/children/siblings and/or others who have been separated due to a substantiated allegation of abuse or neglect or involvement with juvenile probation.

E. Visitation allows the child an opportunity to reconnect and reestablish the parent/child/family relationship in a safe environment.

F. It is an excellent time for parents to learn and practice new concepts of parenting and to assess their own ability to parent through interaction with the child.

G. Supervised visitation allows DCS/Probation to assess the relationship between the child and parent and to assist the parent in strengthening their parenting skills and developing new skills.

H. The role of the visitation provider is to protect the integrity of the visit and to provide a positive atmosphere where parents and children may interact in a safe, structured environment.

I. Visitation may be held in a visitation facility; neutral sites such as parks, fast food restaurants with playground, or shopping malls; child's own home or relative's home; foster home; or other location as deemed appropriated by the referring agency and other parties involved in the child's case taking into consideration the child's physical safety and emotional well-being.

J. The level and frequency of supervision required for visitation and how the supervision is handled will depend upon the purposes for which it is required.

K. Supervision of visits should be consistent with identified case issues and supportive of case goals.

L. Some of the major purposes of supervision include:

1. Protective, when there is reason to believe there are ongoing safety concerns
2. Ongoing assessment to determine when and if the child can safely return home
3. Support of ongoing family treatment by teaching and demonstrating parenting skills to parents and caregivers

II. Service Delivery

A. In order for positive and productive visitation to occur, the below items should be included on the service referral discussed with the referral source as a part of intake:

1. Desired/allowable location of visits (such as facility, neutral space, foster home, own home, etc.)
2. Length of visits, number of visits requested per week
3. Placement of the child and contact information
4. Approved participants, including contact information and relationship to the child.
    a) There should be no additional participants without prior approval of the FCM/PO
5. Restricted participants (including copies of any protective orders)
6. Level of supervision requested (fully supervised or intermittently supervised)
    a) The level of supervision should be collaboratively assessed on an ongoing basis with the referral source.
    b) See Level of Supervision Guide within this standard for further guidance.
7. Expectations of the parents or other approved person(s) regarding age appropriate preparation.
    a) This may include bottle feeding, meals/snacks and water, change of clothes if needed, diaper and wipes.
    b) Other considerations include sunscreen, outdoor activity supplies, funds for activities, and planning for restroom breaks.
    c) The duration of the visit must also be considered.
8. Restricted activities. This may include swimming, skating, trampolines, restricted activities based on health concerns, etc.
9. Consequences when parents do not attend visits as planned and agreed upon.
    a) This may include no showing or being consistently late or consistently leaving early, including review of the cancelation and tardy policy.

10. Circumstances under which visits may be limited or terminated.
    a) This may include if parent or child has head lice, parent is under the influence of mood altering substances, parent's intimidating or threatening behavior, inability of parent to manage children's behavior in structured setting, etc.
11. Any criminal, mental health, and safety information of all children and visiting parties.
    a) This may include any physical and/or emotional safety concerns and any known flight risks.
12. Ratio of direct workers and clients based on client need and/or number of referred participants
13. The approved DCS Visitation Plan (agreed to Visitation schedule) and the court ordered visitation schedule
14. Any other information pertinent to the visits

B. In the event the preceding information is incomplete, it is the responsibility of the visitation provider to obtain the information from the referring worker.

C. Upon receiving the referral from DCS/Probation, the agency will contact all parties to set up the visits, taking into consideration the ability of the parent to attend based on work schedules and the foster parent or relative caregiver's ability to ensure attendance of the child.

D. Every attempt must be made for visitation with the child's parent, guardian, or custodian to occur within 48 hours of the child's removal from the home

E. For all other visitation referrals, visitation must be scheduled within five (5) days.

F. All cancelled visits by the parent or visit facilitator must be reported within 48 hours to the referring agency indicating who cancelled and the reason for the cancellation.

G. Guidelines for Visitation:
1. Prior to the first visitation and as needed thereafter, each participant should receive guidelines for visits which include the list of items under the referral process section above, as well as agency policies regarding:
    a) Tardy, ending the visit early, no show, and cancellation
    b) Weapons, fireworks, and other prohibited items determined by each agency
    c) The use of non-physical redirection/discipline methods.
        (1) Physical forms of discipline are prohibited.
    d) Authorized visitors pertinent to the parent/caregiver
    e) Drugs, tobacco, and alcohol
    f) Appropriate language and verbal behavior

H. Level of Supervision Guide

Level of Supervision	Definition	Justification for level of Supervision
Fully Supervised in Facility	The visitation facilitator should be actively monitoring (watching and listening) parent child interactions throughout the entirety of the visit.	• Conditions in the parent's home or community may threaten the safety of the child or visit supervisor. • Parent has not engaged in services that create safety in their home or community. • Parent has failed to demonstrate safe and appropriate parenting skills
Fully Supervised in Community (parent home, relative home or resource home, other areas of the community such as parks, malls, stores, schools, etc.)	The visitation facilitator should be actively monitoring (watching and listening) parent child interactions throughout the entirety of the visit.	• Allows the parent to demonstrate the ability to manage child behaviors and exercise parenting skills in less structured environments. • Allows parents and child to have more natural settings to demonstrate learned skills and change (School events, sporting activities, parks, doctor, therapies).
Intermittent Supervision in Facility	The visitation facilitator is not directly supervising the children and family at all times. The number and length of check ins will fluctuate based on the family's progress.	• While home and community conditions may be unsafe, direct supervision of parent/child interactions is not necessary for the duration of the visit. • Parent is able to provide structure, safe discipline, and age appropriate activities for the children during visits.
Intermittent Supervision in Home/Community (parent home, relative home or resource home, other areas of the community such as parks, malls, stores, schools, etc.)	The visitation facilitator is not directly supervising the children and family at all times. The number and length of check ins will fluctuate based on the family's progress.	• Parent has engaged in services that create safety in their home or community. • Direct supervision of parent/child interactions in the home or community is not necessary for the duration of the visit. • Parent is able to provide structure, safe discipline, and age appropriate activities for the children during visits.
Unsupervised	Visit between parent and child occur in the home or community without the need for supervision.	• Parent is able to provide a safe environment for the child during visits. • Parent has completed and been successful in services and can articulate how change has occurred for their family. • Parent is able to provide structure, safe discipline, and age appropriate activities for the children during visits.

I. Visitation Observation and Reporting

1. Professional and/or paraprofessional staff will assist the family by strengthening, teaching, demonstrating, role modeling appropriate skills, and monitoring in, but not limited to the following areas:
    a) Establishing and/or strengthening the parent-child relationship
    b) Instructing parents in child care skills such as feeding, diapering, administering medication if necessary, and/or proper hygiene
    c) Teaching positive affirmations and praising when appropriate
    d) Providing instruction about child development stages, current and future
    e) Teaching age-appropriate discipline
    f) Teaching positive parent-child interaction through conversation and play
    g) Providing opportunities for snack and meal prep with children present
    h) Responding to child's questions and requests.
        (1) Including teaching safety regarding age-appropriate toys, climbing, running, jumping, or other safety issues depending on the environment.
    i) Managing needs of children of differing ages at the same time
    j) Helping parents gain confidence in meeting their child's needs
    k) Visit planning
    l) Teaching age appropriate activities to encourage child development and resiliency
    m) Identifying and assessing potentially stressful situations between parent and their children
    n) Giving parents an opportunity to demonstrate their willingness to complete their case plan

J. At each visit, the visitation facilitator will accurately document for the referring agency the following information:

1. Outcome of the visit (visit held, visit not held)
2. Name of the visitation facilitator
3. Date, location, and level of supervision of visit
4. Participants in attendance at the visit
5. Time of arrival and departure of all parties for the visit
6. Greetings and departure interaction between parent and child
7. Positive interactions between parent and child
8. Planned activities by the parent for the visit
9. Interventions required, if any, and parent's response to direction provided with regard to interventions

10. Ability and willingness of parent to meet the child's needs as requested by child or facilitator
11. Tasks given to the parent to be completed prior to or at the next visit
12. Pertinent information, issues, or concerns regarding the child's placement
13. Quality of Face-to-Face visits:
    a) To determine the quality of the visit please select how the parent(s)/caregiver(s) did each of the following: Always (Strong), Often (Adequate), Occasionally (Limited), or Rarely/Never (Destructive):
        (1) Demonstrated parental role
        (2) Demonstrated knowledge of child's development
        (3) Responded appropriately to child's verbal and nonverbal signals
        (4) Put child's needs ahead of his/her own
        (5) Showed empathy towards child
        (6) Focused on the child when preparing for visits and during interactions

K. Additionally the following items apply:
1. Visitation staff must respect confidentiality.
    a) Failure to maintain confidentiality may result in immediate termination of the service agreement.
2. If inappropriate behavior occurs with either parent in a visit that affects the ability of the visit to continue or the safety of the child, the current worker will be notified immediately after the cancelation of the visit.
3. Services must demonstrate respect for sociocultural values, personal goals, lifestyle choices, and complex family interactions and be delivered in a culturally competent fashion.
4. Attendance at case conferences may be required as well as testimony and/or court appearances at review of permanency hearings for the child.
5. Documentation of incidents in visitations which are or could be considered subjective must be followed by examples of the situation for clarification.
    a) The documentation of the visit must be provided to the current FCM/PO within three (3) business days of the visit.
    b) Phone calls shall be immediate for safety or recommendations for terminated visits.
6. Provider understands that documentation may be shared by DCS/Probation with the child's parents, resource parents, or other placement of the child, the child's therapist, and other parties in the case to assist in decision making regarding decreased or increased levels of supervision and reunification.

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 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.

IV. Goals and Outcomes

A. Goal #1: Ensure that all children removed from their parents have the opportunity to visit their parents/siblings on a regular basis.

1. Outcome Measure: 100% of the families referred will have the first face-to-face visit with their children within 48 hours of the child's removal from the home.
2. Outcome Measure: 100% of the families referred will have visitation set up and occurring with the frequency and duration requested by DCS/Probation within 5 business days of receipt of the referral.

B. Goal #2: Strengthen and increase the parent's ability to provide for the emotional and physical needs as well as the safety of their children.

1. Outcome Measure: 85% of parents served will demonstrate an increased ability to recognize and respond appropriately to their children's cues by case closure.
2. Outcome Measure: 85% of the parents will actively reinforce positive behavior and address negative behavior.
3. Outcome Measure: 90% of parents will arrive with previously requested items by the visit facilitator for the children such as diapers, food, etc., and be prepared to provide a meal or snack if expected.

C. Goal #3: Provide accurate and timely information in the child's case so that informed decisions may be made regarding reunification and permanency for the child.

1. Outcome Measure: 98% of visitation reports will be received by DCS/Probation within 3 business days of the visitation or immediately (by phone or email) when inappropriate behavior occurs, followed by an individual visitation report.
    a) Written reports will be completed on the DCS approved visitation report forms.

2. Outcome Measure: 94% of the families referred will have completed visitation facilitation services will rate the services "satisfactory" or above on a satisfaction survey developed by the service provide, unless DCS/Probation distributes one to providers for their use with clients.
    a) Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in the larger number) randomly selected from each county served).

V. Minimum Qualifications

A. Paraprofessional Level Direct Worker

1. Providers are encouraged to hire Staff who have shared life experience and are familiar with the communities where they will be working
2. High school diploma or GED
3. Must be at least 21 years of age.
4. The Direct Worker 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.

B. Paraprofessional Level Supervisor

1. Providers are encouraged to hire Supervisors who have shared life experience and are familiar with the communities where they will be working
2. Supervisors must meet the requirements of "direct worker" as stated above
3. Supervisors who possess Bachelor's or Master's degrees (accredited university) must have at least 2 years of full-time employment experience providing direct services to children & families that includes providing services to families that need assistance in the protection and care of their children
4. Supervisors who possess an Associate Degree, High School Diploma, or GED, must have at least 6 years of full-time employment providing direct services to children & families that includes providing services to families that need assistance in the protection and care of their children

C. Supervision
   1. Individual Supervision for each family must occur at least every two weeks

D. Shadowing
   1. All agencies must have policies that require regular shadowing (by supervisor) of all staff at established intervals based on staff experience and need.
   2. The agency must provide clear documentation that shadowing has occurred.

E. Bachelor's Level Direct Worker
   1. Providers are encouraged to hire Direct Workers who have shared life experience and are familiar with the communities where they will be working
   2. The Direct Worker must have one of the following:
      a) Bachelor's, or Master's degree from an accredited university
      b) High School Degree, GED, or Associate Degree
         (1) If the Direct Worker possesses an Associate Degree, High School Diploma, or GED, they must also have:
         (2) At least 4 years full time employment experience providing direct services to children & families that includes providing services to families that need assistance in the protection and care of their children
   3. Direct Workers must be trained and competent to complete the service as required by federal and State of Indiana law.
   4. Direct Workers must be credentialed according to the requirements of the evidence-based model(s) used.
   5. Direct Workers must carry appropriate caseloads. No member of the treatment team (excluding support staff) may carry a caseload greater than what is allowed by the model being delivered, provided that the caseload shall never be greater than 12.
   6. The Direct Worker 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.

F. Bachelor's Level Supervisor

1. Providers are encouraged to hire Supervisors who have shared life experience and are familiar with the communities where they will be working
2. Supervisors must meet the requirements of "direct worker" as stated above
3. Supervisors who possess Bachelor's or Master's degrees (accredited university) must have at least 2 years of full-time employment experience providing direct services to children & families that includes providing services to families that need assistance in the protection and care of their children
4. Supervisors who possess an Associate Degree, High School Diploma, or GED, must have at least 6 years of full-time employment providing direct services to children & families that includes providing services to families that need assistance in the protection and care of their children

G. Supervision
1. Individual Supervision for each family must occur at least every two weeks

H. Shadowing
1. All agencies must have policies that require regular shadowing (by supervisor) of all staff at established intervals based on staff experience and need.
2. The agency must provide clear documentation that shadowing has occurred.

I. Therapeutic Level Direct Worker
1. Direct workers 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 & Culture
h. Therapy Techniques
i. Family Development & Family Therapy
j. Clinical/Psychiatric Social Work
k. Group Therapy
l. Psychotherapy
m. Counseling Theory & Practice

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

e) **Note:** Individuals who hold a Master or Doctorate degree that is applicable toward licensure, must become licensed as indicated in #1 & 2 above.

f) 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.

g) In addition to the above:

(1) Knowledge of family of origin/intergenerational issues
(2) Knowledge of child abuse/neglect
(3) Knowledge of child and adult development
(4) Knowledge of community resources
(5) Ability to work as a team member

h) Belief in helping clients change, to increase the level of functioning, and knowledge of strength-based initiatives to bring about change
(1) Belief in the family preservation philosophy
(2) Knowledge of motivational interviewing
(3) Skillful in the use of Cognitive Behavioral Therapy
a. Skillful in the use of evidence-based strategies

J. Therapeutic Level Supervisor

1. Master's or Doctorate degree in social work, psychology, marriage and family, or related human service field, with a current license issued by the Indiana Behavioral Health and Human Services Licensing Board as one of the following:
a) Clinical Social Worker
b) Marriage and Family Therapist
c) Mental Health Counselor

Billable Units

K. Face to Face

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 initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family.
4. Provider meetings initiated by the FCM for the purpose of goal directed communication regarding the client family.
5. Includes in-vehicle (or in-transport) time with the client provided it is identified as goal-directed, face-to-face, and approved/specified as part of the client's intervention plan (e.g. housing/apartment search, etc.).
    a) Travel time is only billable when the client is in the vehicle.
6. 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.

L. Services may be billed in 15 minute increments; partial units are rounded to the nearest quarter hour using the following guidelines:

1. 0 to 7 minutes – Do not bill (0.00 hour)
2. 8 to 22 minutes – 1 fifteen minute unit (0.25 hour)
3. 23 to 37 minutes -- 2 fifteen minute units (0.50 hour)
4. 38 to 52 minutes – 3 fifteen minute units (0.75 hour)
5. 53 to 60 minutes – 4 fifteen minute units (1.00 hour)
6. **Note on Intermittent supervised visitation**: when DCS requests the provider to check in intermittently - at least once per hour - , the provider can bill in increments of 30 minutes for each check-in, provided that the total amount of time billed should not exceed the total length of the visit.

M. 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.

N. 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.
4. Maximum of 1 court appearance per day.
1. 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.

O. Reports

1. If the services provided are not funded by DCS, the 'Reports' hourly rate will be paid.
2. A referral for 'Reports' must be issued by DCS in order to bill.

VI. 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
    c) Must include initial and ongoing assessments of needs including service needs, risks, and goals.
        (1) Must be provided within the first 30 days and should be reassessed and submitted at least every 90 days for the life of the referral.
6. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.
    d) Provider recommendations to modify the service/ treatment plan
    e) Discuss overall progress related to treatment plan goals including specific examples to illustrate progress
3. Progress/Case Notes Must Document: Date, Start Time, End Time, Participants, Individual providing service, and location
4. 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

5. Supervision Notes must include:

a) Date and time of supervision and individuals present

b) Summary of Supervision discussion including presenting issues and guidance given.

VII. 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.

VIII. 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.

IX. 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.

X. 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.

XI. 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.

XII. 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.

XIII. 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.