

**SERVICE STANDARD**  
**INDIANA DEPARTMENT OF CHILD SERVICES**  
**RESIDENTIAL SUBSTANCE USE TREATMENT**

**I. Service Description**

- A. This service standard applies to families with children involved with the Department of Child Services (DCS) and/or Probation.
- B. Services may be provided for adult clients with a substance-related disorder and with:
  - 1. Minimal manageable medical conditions;
  - 2. Minimal withdrawal risk;
  - 3. Or emotional, behavioral cognitive conditions that will not prevent the client from benefiting from this level of care.
- C. Residential treatment programs are characterized by:
  - 1. Offering 24-hour supervised living with a highly structured treatment program
  - 2. Includes individual, group, and family counseling.
  - 3. Offering crisis intervention and case management services.
  - 4. Including access to medical services.
- D. Residential treatment is most appropriate for clients who have been determined, upon assessment, to meet at least one of the following:
  - 1. To need a higher level of treatment prior to receiving outpatient treatment.
  - 2. Clients who have been unsuccessful in outpatient treatment.
  - 3. Or those who meet residential level of care per American Society of Addiction Medicine (ASAM) Patient Placement Criteria<sup>1</sup>.
- E. Residential treatment is comprehensive and intensive.
- F. The focus of residential treatment is to give the client the tools to begin a substance-free lifestyle.
- G. The program must be licensed, certified and properly designated by The Division of Mental Health and Addictions (DMHA).
- H. The program shall be staffed by appropriately credentialed personnel who are trained and competent to implement residential programming.

**II. Service Delivery**

- A. Providers should complete a bio-psychosocial assessment, consistent with the Substance Use Disorder Assessment service standard, on referred clients.

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<sup>1</sup> <https://www.asam.org/resources/the-asam-criteria/about>

- B. It is strongly encouraged providers utilize the most current American Society of Addiction Medicine Criteria (ASAM) when determining the appropriate level of care and creating a discharge plan.
- C. Individuals shall be accepted into the program within 5 days.
- D. Providers shall give priority to pregnant women and intravenous drug abuse populations.
  - 1. The provider shall establish and utilize a referral system if the provider has insufficient capacity to provide services to women who are pregnant.
  - 2. The provider will notify the Department of Mental Health and Addiction (DMHA) if immediate access to services, for a woman who is pregnant cannot be arranged.
    - a) Interim services, including referral for prenatal care, will be provided to each woman who is pregnant awaiting commencement into detoxification services for forty-eight (48) hours or more. This shall continue until such time services are fully commenced.
- E. Interim services shall be provided to individuals who use intravenous drugs and wait for commencement into detoxification service for forty-eight (48) hours or more. This shall continue to until such time services are fully commenced. The length of stay in the program shall be based on level of need.
  - 1. Minimum length of stay being 10 days and maximum length of stay being 30 calendar days.
  - 2. The service provider, in collaboration with the referral source, must identify a plan to engage the client and motivate non-cooperative clients including those who believe they have no problems to address.
  - 3. The service provider must work with special needs clients, such as those who are mentally ill or developmentally delayed.
- F. Services are planned and organized with addiction professionals and clinicians providing multiple treatment service components for the rehabilitation of the referred individual's substance use disorder.
- G. The treatment team will collaborate with the referral source throughout the treatment duration, including, but not limited to: discharge planning and coordination.
- H. The service provider must deliver and assure a continuum of care for all clients.
- I. Due to the chronic nature of addiction, treatment involves multiple interventions and requires constant monitoring.
  - 1. The treatment provider shall follow all requirements of **440 IAC 7.5-2-8** with regards to treatment planning
  - 2. In addition, an individualized Recovery/Treatment Plan must be developed that considers the client's:
    - a) Age
    - b) Gender
    - c) Ethnic background
    - d) Cognitive development and functioning and
    - e) Clinical issues.

3. Recovery/Treatment Plans for referred individuals should connect substance use and how it affects child safety.
  4. Recovery/Treatment Plans shall provide a framework for measuring success and progress.
  5. Recovery/Treatment Plans should include goals and objectives that address the issues identified in the substance use assessment.
    - a) The goals and objectives in the Recovery/Treatment Plan should be partially based on:
      - (1) Functional assessment of each resident's daily living
      - (2) Socialization
      - (3) Coping skills
      - (4) Result of a structured evaluation and observation of behavior.
  6. The Recovery/Treatment Plan will be completed and shared with the referral source within 7 business days from client's admission into treatment in order to facilitate the continuum of care following the client's discharge from residential treatment.
- J. Residential treatment services must be based on a written, cohesive, and clearly stated philosophy and treatment orientation that includes the following standards (per **440 IAC 9-2-8**):
1. There must be evidence that the philosophy is based on literature, research, and proven practice models.
  2. Services must be provided utilizing evidence-based interventions and programs that are supported or well-supported.
  3. Approved programs may be found at:
    - a) The California Evidence: [www.cebc4cw.org](http://www.cebc4cw.org);
    - b) Substance Abuse and Mental Health Services Administration (SAMHSA): [www.nrepp.samhsa.gov](http://www.nrepp.samhsa.gov);
    - c) The Office of Juvenile Justice and Delinquency Prevention: <http://ojjdp.ncjrs.gov>.
    - d) Other program requests may be utilized with prior written approval from DCS Central Office.
    - e) Requests should be submitted to the Child Welfare Plan Inbox-[childwelfareplan@dcs.in.gov](mailto:childwelfareplan@dcs.in.gov).
  4. The services must be client-centered.
  5. The services must consider client preferences and choices.
  6. There must be a stated commitment to quality services.
  7. The residents must be provided a safe, alcohol-free, and drug-free environment.
  8. The individual environment must be as homelike as possible.
  9. The provider must provide transportation or ensure access to public transportation in accordance with the recovery plan.

10. The services must provide flexible alternatives with a variety of levels of supervision, support, and treatment as follows:
  - a) Service flexibility must allow movement toward the least restrictive environment but allow increases in intensity during relapses or cycles of relapse.
  - b) The service provider must deliver and assure a continuum of care for all clients.
11. An agency cannot terminate a referred individual from services because of a need for a higher level of care:
  - a) Without making a good faith effort to continue to provide adequate, safe, and continuing treatment at the current level.
  - b) Unless the resident is transferred to another agency that provides the continuum of care needed.
12. The treatment services must be carried out in residences that meet all life safety requirements and are licensed or certified as appropriate.
13. Residential services shall include specific functions that shall be made available to clients based upon the individual Recovery/Treatment Plan.
  - a) These functions include the following:
    - (1) Crisis services, including access to more intensive services, within twenty-four (24) hours of problem identification;
    - (2) Case management services, including access to medical services, for the duration of treatment, provided by a case manager or primary therapist and
    - (3) Access to psychiatric or addictions treatment as needed.

K. Drug Testing

1. Drug testing plays an important role in maintaining a drug-free therapeutic environment in residential treatment.
2. Drug Testing shall be utilized during the course of treatment.
3. The treatment provider will use best practice recommendations when considering the testing frequency and specific time for testing.
4. Per American Society of Addiction Medicine (ASAM) drug testing guidelines, residents should be asked to provide a sample for drug testing after returning from any passes.<sup>2</sup>
5. The total number and frequency of drug tests is at the provider's discretion and is included in the daily treatment rate (per diem).
6. All sample collections drug tests will be observed sample collections.
  - a) Urine drug tests will be observed by an individual of the same gender as the client.
  - b) Gender of the client is defined as the gender listed on the client's government issued identification.

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<sup>2</sup> <http://eguideline.guidelinecentral.com/i/840070-drug-testing-pocket-guide/0?>  
<https://www.asam.org/resources/guidelines-and-consensus-documents/drug-testing>

- (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>
7. Minimum of substances tested should include:
  - a) Alcohol
  - b) Amphetamines
  - c) Barbiturates
  - d) Benzodiazepines
  - e) Cocaine
  - f) Cannabis
  - g) Opiates
  - h) Methadone
  - i) Oxycodone
  - j) Tramadol
  - k) Buprenorphine
  - l) Synthetic Marijuana
  - m) Fentanyl
  - n) Methamphetamine
  - o) Other drugs indicated by client's history
8. The agency will be expected to provide reports to the referral source that state the minimum level necessary to detect:
  - a) The presence of each substance,
  - b) The level of substance detected and
  - c) The chain of custody documentation.
9. Assurance must be given for accurate results even if the confirmation process is the only means to ensure accurate results, due to the testing process providing inaccurate results.
10. Any presumptive positive test must go through the confirmation process.
11. The vendor shall ensure proper legal chain-of-custody procedures are maintained and comply with departmental procedure, state and federal laws.
  - a) The vendor shall also ensure complete integrity of each specimen tested and the respective test results.
  - b) Receiving, transfer and handling of all specimens by personnel shall be fully documented using the proper chain-of-custody.
12. A laboratory participating in DCS/Probation drug testing must comply with:
  - (1) All applicable Federal Department of Health and Human Service requirements and are subsumed:
    - (a) Substance Abuse and Mental Health Services Administration (SAMHSA)
    - (b) College of American Pathology (CAP)
    - (c) Clinical Laboratory Improvement Act (CLIA) requirements.

13. The vendor shall notify the local Department of Child Services Office/ Probation Officer (PO) of testing results via email or fax on vendor letterhead
    - a) The results will be sent by U.S. mail to the referring county, as well
    - b) The vendor shall gain approval from DCS or Probation for any changes in the results notification system.
  14. The referring agency will be notified of positive test results within 72 hours of the lab receipt of the sample specimen.
  15. The referring agency will be notified of negative test results within 24 hours of the lab receipt of the sample specimen.
- L. Discharge Plan
1. The provider will develop a discharge plan with the referred individual regardless of treatment methodology.
  2. All attempts should be made by the provider to ensure a smooth transition to subsequent level of care.
  3. In order to ensure follow up, the discharge recommendations have to be shared verbally with the referral source within a minimum of 3 business days prior to client's discharge from the program.
    - a) The written discharge plan will be completed for every client and provided to the referral source within 7 business day after client's discharge from treatment.
  4. The discharge plan should include the following domains:
    - a) Any applicable diagnosis(s)
    - b) Level of care provided during residential treatment episode
    - c) Recommended level of care upon discharge
    - d) Prescribed medication and dosage instructions at time of discharge
    - e) Supports in place for referred individual
      - (1) Social, familial, communal, relapse prevention, sponsor etc.
    - f) Strengths and limitations of referred individual
    - g) Referral recommendations, to include, but not limited to:
      - (1) Psychological testing, psychiatrist consultation, medication evaluation, recovery support meetings, life skills etc.
    - h) Discharge/termination reason
    - i) Discharge/termination date
  5. Providers are not required to provide DCS with a monthly report.
  6. Best practice will have the referred individual transition to the next level on the continuum of care when it is immediately available
    - a) If services for the next level of care are not immediately available, and there is a gap between discharge and continuing services, the provider will develop an interim plan to encourage and support the client's recovery process.

### **III. Target Population**

- A. Service must be restricted to the following eligibility categories:
  - 1. Adult parents/caregivers who have substantiated cases of child abuse and/or neglect.
    - a) Likely to develop into an open case with Informal Adjustment or CHINS status.
  - 2. Parents/caregivers that have an active Informal Adjustment (IA) or whose children have the status of CHINS.
  - 3. Foster/Kinship adult caregivers with whom children with the status of CHINS or JD/JS are placed.

### **IV. Goals and Outcomes**

- A. Indiana Department of Child Services may elect to conduct quality audits of contracted providers to ensure compliance with best practice and service standards.
- B. For the Residential Substance Use Treatment Standard, DCS will use the following measures to monitor quality:
  - 1. Vendors will have internal quality monitoring systems and procedures in place to track qualifications and effectiveness of programming and service delivery.
  - 2. Goal #1: Recovery plan goals developed from the substance use assessment.
    - a) Outcome Measure 1: 90% of referred clients will have a Recovery/Treatment Plan developed following the assessment.
      - (1) Plan to be provided to the referring worker within 7 business days from client's admission into treatment.
      - (2) Treatment goals will be individualized based on the assessment.
        - (a) Attainable and realistic outcomes.
        - (b) All goals will be developed with the expectation that the client will remain illicit-substance free.
  - 3. Goal #2: Regularly modify and update the recovery/treatment plan to reflect client changes and progress
    - a) Outcome Measure 1: 100% of Recovery Plans should identify short term goals attainable within 30 days and measurable by an expected performance or behavior.
    - b) Outcome Measure 2: 100% of cases will have a Discharge Plan submitted to the referring worker within 7 business days of discharge.
      - (1) Discharge Plan will include client's response to treatment and the aftercare plan.

3. Goal #3: Drug tests will be provided to the referring worker in a timely fashion
  - a) Outcome Measure 1: 100% of negative test results within 24 hours of laboratory receipt of sample.
  - b) Outcome Measure 2: 100% of positive test results within 72 hours of laboratory receipt of sample.
4. Goal #4: Clients will remain illicit substance free.
  - a) Outcome Measure 1: 95% of clients who participate in residential treatment will remain drug free during the service provision period as indicated by the drug tests administered.
  - b) Outcome Measure 2: 80% of clients will be enrolled in continuum of care upon discharge/terminations.
5. Goal #5: Provide No-Show alert to FCM
  - a) Outcome Measure 1: 100% of no-show alerts will be provided to referring worker immediately following each no-show.
    - (1) Notification must occur within 24 hours of occurrence.
6. Goal #6: DCS and client satisfaction with services.
  - a) Outcome Measure 1: 90% of families who have participated in residential services will rate the service as 'satisfactory' or above on a satisfaction survey (or like tool).
    - (1) Tool is to be developed by provider.
    - (2) Providers are to solicit feedback from a minimum of 12 clients or 20% of their caseload, whichever results in a larger number.
    - (3) Feedback should be collected in a random manner and be solicited from each county served.
  - b) Outcome Measure 2: Referral source satisfaction will be rated as 'Satisfactory' or above on a satisfaction survey (or like tool).
    - (1) Tool is to be developed by provider.

## **V. Qualifications**

- A. The program shall be staffed by appropriately credentialed personnel who are trained and competent to implement substance use treatment as outlined by state law.
  1. Reference: Indiana Code 25-23.6-10.5 and Article 7.5.
- B. The program must be certified and properly designated by The Division of Mental Health and Addictions (DMHA).
  1. The program administrators will maintain their certification and credentialing by DMHA.
  2. Program administrators will ensure the direct service staff is appropriately credentialed at all times as necessary to remain compliant with all ongoing certification requirements



3. The vendor shall notify DMHA regarding changes to credentialed staff, as required by DMHA.
  - a) Notification to DCS regarding any changes to the program's DMHA certification status or adverse action taken against vendor certification shall be sent to [ChildWelfarePlan@dcs.IN.gov](mailto:ChildWelfarePlan@dcs.IN.gov) within 2 business days of the change.

## **VI. Billable Units**

### **A. Medicaid**

1. Providers will bill Medicaid or private insurance when appropriate.
2. For information on coverage of residential treatment services and specific Medicaid Programs, please refer to the Indiana Health Coverage Programs (IHCP) Provider Manual located at [www.indianamedicaid.gov](http://www.indianamedicaid.gov).
  - 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 those services in particular cases where they may be reimbursed by Medicaid.
3. After receiving prior authorization from Medicaid, the provider must invoice Medicaid for the stay.
  - a) If Medicaid denies the claim and the provider agency invoices DCS, the Medicaid denial must be attached to the submitted invoice.
  - b) Failure to attach the denial may result in DCs denying the invoice.
  - c) Denials due to improper/incorrect billing to Medicaid will not be accepted as a valid reason to invoice DCS.
4. CMHCs and agencies that are qualified providers will utilize the Medicaid Eligibility Inquiry for patients with no health care coverage.

### **B. DCS Funding**

1. Residential Treatment
  - a) For services deemed not appropriate to bill Medicaid:
    - (1) Services defined in this service standard will be invoiced as a Per Diem rate.
  - b) For invoices submitted to DCS with the statement "client is not Medicaid eligible," the qualified provider must attach the eligibility screen to the submitted DCS invoice.

- c) If Medicaid denies the claim and the provider agency invoices DCS, the Medicaid denial must be attached to the submitted invoice.
  - (1) Failure to attach the Medicaid denial or eligibility screen, where applicable, may result in DCS denying the invoice.
  - (2) Denials due to improper/incorrect billing to Medicaid will not be accepted as a valid reason to invoice DCS

C. 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.

D. 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.

E. 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

3. For the purpose of this service standard, 'reports' is defined as the Recovery/Treatment Plan and Discharge Plan

## **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. 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 SMART (Specific, Measurable, Attainable, Relevant, and Time Bound) goal language
    - c) Must include short-term goals attainable within 30 days and measurable by an expected performance or behavior
  6. Discharge report will be completed for every clients and provided to DCS within 7 business days after client's discharge from treatment
    - a) Report must meet all guidelines listed above in 'Service Delivery section of this standard
  7. Progress/Case Notes Must Document:
    - a) Date
    - b) Start Time
    - c) End Time
    - d) Participant
    - e) Individual providing service
    - f) 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.
10. Documentation of progress notes that provide details of client's increase in performance and/or behavior that demonstrate growth and/or regression regarding the recovery process and lifestyle changes needed for the individual to remain drug free

### **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 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.