



Family  
Focused  
Treatment  
Association

**PROGRAM  
STANDARDS  
FOR  
TREATMENT  
FAMILY CARE  
2019**



# PROGRAM STANDARDS FOR TREATMENT FAMILY CARE

FFTA | FAMILY FOCUSED TREATMENT ASSOCIATION | MAY 2019

The Family Focused Treatment Association (FFTA) is an agency-led organization of Treatment Foster Care and other treatment family care providers established in 1988 with an initial purpose of defining and refining the Treatment Foster Care practice.

FFTA's mission is to *strengthen agencies that provide family focused treatment services*, whether those services are provided within treatment foster care, kinship, adoptive or biological families.

FFTA carries out its mission through the provision of program standards, cutting-edge resources, technical assistance, professional development opportunities, and other resources to help agencies achieve positive outcomes for children and youth served in family-based treatment homes. FFTA encourages research and evaluation, and inspires the development of evidence-informed practices. FFTA also monitors and advocates for federal legislation and public policy that support the development of quality services and effective programming for vulnerable children and youth.

The Association's membership is comprised of agencies throughout North America operating treatment family care programs. Organizations that are not direct service providers but that have an interest in the field hold affiliate membership status. FFTA is assisted by recognized researchers and policy makers in the fields of child welfare and children's mental health.

Much of the Association's work takes place through its committee structure. FFTA encourages participation by individuals from member agencies or others interested in our work. FFTA committees include:

- Conference
- Diversity
- Editorial
- Fund Development
- Kinship
- Membership
- Public Policy
- Research

Chapter development also has been an important Association achievement. Chapters are groupings of four or more FFTA agency members that meet regularly and share a common geographic or interest base. The chapters have been a great resource, allowing members to network with other providers to discuss topics ranging from public policy and creative programming to standards and training.

FFTA and its member agencies share certain core values and principles that lie at the heart of Treatment Family Care and shape its development and evolution. FFTA and its members believe in:

- Children and youth having the right to a permanent family.
- Normalization as a treatment principle, the power of family living as a normalizing influence, and the importance of implementing reasonable and prudent parent standards.
- The inherent need and right of all children and youth to have emotional, relational, and legal permanence with a family. Toward that end, family reunification, adoption, legal custody and/or guardianship, or other permanent, stable family living arrangements are essential to well-being.
- The ability to take the core skills, knowledge and experience we have learned in providing treatment foster care and adapt them to any treatment family home.
- The important role that kin play in the formation of identity and self-worth, and relationships that impart a sense of family belonging to children and youth.
- Children in out-of-home care with treatment needs can have those needs met by relatives or those with whom they have a family-like relationship, with access to the full array of training, services, and supports available through treatment family care to help them stay safe, achieve permanency, and thrive.
- Embracing diversity, equity and inclusion as organizational values, which is critical to the success and well-being of our children and families.
- Agencies having access to research, training, self-assessment, policy and practice resources that empower them to work cross-culturally.
- The fundamental importance of the systematic evaluation of services and their effects.
- Doing “whatever it takes” to maximize a young person’s opportunity to live successfully in a family and community.

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## PURPOSE OF THE FFTA STANDARDS

The FFTA Program Standards are designed to assist agencies in the development of quality Treatment Family Care services for children, youth, and families. Some current practitioners will meet all the standards immediately. Others will require time and resources to do so. Some programs may need time to make programmatic adjustments and will need financial resources to implement these changes. Without sufficient resources, the standards become extremely difficult to achieve.

Treatment Foster Care and the broader Treatment Family Care service as discrete models have paralleled the development and maturation of actual programs. An information base, including conceptual writings, surveys, and limited evaluation research, has grown with the size and number of programs describing themselves as providing Treatment Family Care. Given the reported efficiency, opportunity for normalization, and economy of the model, its expansion and evolution are likely to continue. While Treatment Foster Care and Treatment Family Care will continue to evolve, there is both the need and the capacity to continue to operationalize its definition in the form of standards. It is our belief that this task may best be accomplished by those who have developed and continue to operate Treatment Family Care Programs.

Setting standards for Treatment Family Care is not intended to limit innovation or further development of the service delivery model. In fact, the evolution of Treatment Family Care as a model is the result of innovation and creativity. Therefore, it is important to recognize that these Standards will not cover all successful variations on the Treatment Family Care theme. Subsequent revisions will be needed to reflect the evolution of practice and the accumulation of empirical evidence. Communication with the FFTA Board of Directors, Chapters and Committees is welcomed as these Standards are implemented and evaluated, and as the boundaries of Treatment Foster Care and Treatment Family Care expand.

The Family Focused Treatment Association encourages states, provinces, and accrediting bodies to adopt or adapt these Program Standards as a means of creating quality assurance processes. FFTA looks forward to continued work with associations, state and provincial governments, and accrediting bodies in developing and evaluating quality services for children, youth, and families.

The Standards have continued to influence child welfare and child behavioral health practice by providing a basis for development of criteria for accreditation used by national accrediting organizations. Although national accreditation bodies have made use of the Standards, the Standards are not intended to duplicate the criteria of those accrediting bodies.

The Standards provide direction for public agencies that develop programs and contracts for Treatment Family Care, and assist agencies in the private sector who provide Treatment Family Care. The Standards continue to be referenced in field research and by the public sector.

States and provinces have their own rules, regulations, policies, and standards for Treatment Family Care programs in their jurisdictions with content that is either more or less stringent than the FFTA Standards.

In recognition of the fact that the federal government from time to time enacts legislation that directs changes in practice in the United States, the revised Standards incorporate some facets of those directives without pretending to be the authoritative source on those requirements.

There is a fine line between “best practices” and standards. FFTA intends these Standards to be guideposts for the field with the hope that programs that do not meet all the Standards will aspire to do so.

Although there is awareness that programs can operate without meeting the FFTA Standards, FFTA believes that the Standards define the essence of Treatment Family Care.

Special recognition must be given to the Standards Committee, chapters, member agencies, work groups, advisors, and the Board of Directors for their hard work, diligence, and commitment to providing input to the Standards. Because of their expertise, knowledge, and thoughtful input, an outstanding tool has been developed for building and maintaining quality programs and services for children, youth, and families.

## HISTORY OF THE FFTA STANDARDS

The development of the initial Program Standards for Treatment Foster Care began in the fall of 1989. Leaders in the field of Treatment Foster Care held regional meetings throughout the United States and Canada, discussing and debating specific standards. Reports from these regional sessions were collected, summarized, and distributed to member agencies for further regional discussions. Input from the final round of regional meetings in the fall of 1990 was discussed and summarized by the FFTA Board of Directors in December 1990, and a draft was prepared for consideration by member agency directors at their meeting in Washington, D.C. in March 1991. Based on their recommendations, a final draft was completed and distributed to members, FFTA advisors, and other key individuals in the United States and Canada. The landmark publication of the “Program Standards for Treatment Foster Care” occurred in April 1991.

In the fall of 1993, FFTA began to review the Standards to determine their efficacy and to make additions and revisions to the original document. A process similar to the one implemented in 1990 was used in gathering input from a broad base of experienced agency members. The process began by asking chapters and regional working groups to reflect on the results of agency self-assessments of compliance with the Standards. The development of formal FFTA regional chapters in the United States and Canada assisted greatly in the processing and dissemination of infor-

mation and ideas ranging from the organization of the document to the wording of specific standards. After multiple reviews, recommendations, and committee input, a final draft of the revised Standards was approved at the May 1995 Board meeting in Cincinnati, Ohio. Distribution of the revised Standards throughout North America was initiated in August 1995 in concert with the FFTA Annual Conference in St. Louis.

In recognition of the continuing need for and application of the Standards, in 2002 the Board of Directors called for another revision of the Standards. The resulting updated Standards, published in 2004, reflected a new understanding of key components of Treatment Foster Care while honoring the time-tested wisdom of previous versions. The process of collecting input from those with experience in the field benefited from the use of online discussions that provided a broad segment of member agencies the opportunity to participate in interactive dialogue around specific areas of content.

In 2013, the Board again approved an update and revision of the Standards. Drawing on earlier methods of gathering input from experts in the field, including online discussions and in-person focus groups, that revision reflected the expertise and experience of Treatment Foster Care professionals, administrators, public officials, and Treatment Parents as well as research into public child welfare policies and accreditation standards.

In 2018, the Board approved another update to the FFTA Standards to integrate a focus on children living with kin. This update reflects the increasing interest among FFTA agencies to meet the treatment needs of children in kin settings, an interest that stems from a belief that living with kin can minimize the trauma associated with separation from parents. In fact, research finds that children experience better outcomes with kin across three major domains: improved placement stability, higher levels of permanency, and decreased behavior problems. This update for children living with kin reflects the understanding that kin have some different needs than non-kin, given their

pre-existing relationship to the child and his or her parents, and other factors that are detailed in the Standards. It also recognizes that children living with kin have the right to the same level of supports and services as those in non-kin families. It's important to note that this update does not change the core standards for treatment foster care, but rather presents key considerations when the family receiving services is a kin family.

## **FFTA'S EXPANDED FOCUS ON TREATMENT FAMILY CARE**

This Standards update also reflects several changes in FFTA and its members. In 2016, after thoughtful consideration, FFTA changed its name from the Foster Family-based Treatment Association to the Family Focused Treatment Association. This decision was made in response to the changing needs of children, youth, and families, and the programmatic changes and service expansions that FFTA members were making to meet these changing needs. When FFTA was first established, many FFTA members were solely operating treatment foster care programs. Today, FFTA members are providing a broader array of services that include treatment foster care, regular foster care, family preservation, kinship care, reunification, adoption, behavioral health, and more. As such, members have moved from exclusively addressing the treatment needs of children in foster families, to addressing the treatment needs of children and youth in all families, whether those families are treatment foster, adoptive, kinship, relative or bio families. At the same time FFTA has witnessed how the key components and interventions used in treatment foster care are being adapted to and used in other family-based treatment homes.

While treatment foster care remains at the heart of FFTA's work, the Association's expanded view of "treatment family care" is more aligned with the changing needs of children and families, and FFTA members'

programs and services. Thus, this newest version of the Standards references both "treatment foster care" and "treatment family care", depending on the service standard.

In 2019 and 2020, the FFTA Board of Directors will direct a full review and subsequent revision of the Standards that will reflect this expanded vision of treatment family care, as well as updates on innovative practices; new requirements recently enacted in federal legislation; practices that embody racial, ethnic, religious, and gender equity and inclusion; and other updates that incorporate emerging practices in the field.

## **ORGANIZATION OF THE DOCUMENT**

The document flows from a broad framework of Program-related standards to standards more directly related to those served by Treatment Foster Care and Treatment Family Care. The document is organized as follows:

### **Section I — Program**

### **Section II — Treatment Parents**

### **Section III — Children, Youth, and Their Families**

Much thought and discussion occurred regarding the organization of the Standards. The entire context for Treatment Family Care is important for the sensitive and effective delivery of services. The child, the child's immediate family and extended family, the community, the Treatment Family (including Foster and Kinship Families), Program Staff, and Program supports are all parts of the "whole" that is Treatment Family Care.

Based on consensus, the document starts with Program, leads into Treatment Parents, and concludes with Children, Youth, and Their Families. This order does not imply greater significance of any one part over the whole.

Other facts about the revised standards include:

- The terms “family” and “parent,” when used without modifiers, are intended to refer to the family members of children and youth, such as biological or adoptive, nuclear, or extended family members.
- The term “kin” refers to a child’s extended family member(s), including kin who are related to the child by blood, marriage, or adoption, as well as those who are not related but have a significant “family-like” relationship to the child.
- The terms “Treatment Family” and “Treatment Parent” are used in reference to members of a Treatment Foster Family, which may include kin.
- To ease reference, individual standards are numbered in straight sequence from the beginning of the document through the end, regardless of the section, subsection, or page on which they appear.
- These Standards continue to focus on services to children and youth with serious emotional and behavioral disturbances. It is recognized that at a conceptual level most of the Standards will apply to a variety of “special needs” populations, including children and youth with medically fragile conditions.

## INTRODUCTION

A Treatment Family Care Program is a family-based, service delivery approach providing individualized treatment for children, youth, and their families. Treatment is delivered through an integrated constellation of services with key interventions and supports provided by Treatment Parents, who are trained, supervised, and supported by qualified Program Staff.

The term “Program” implies a discrete organizational entity with clearly stated purposes and means of achieving them, and which are logically described

and justified within the framework of a consistent treatment philosophy. As a program, Treatment Family Care is agency-led and team-oriented. It is not simply the provision of higher payment and more training to Treatment Parents for work with more difficult children and youth. Nor is it solely the addition of therapeutic resources external to the Treatment Family Home.

Individualized treatment is the coordinated provision of services and use of procedures designed to produce a planned outcome in a person’s behavior, attitude, or general condition based on a thorough assessment of possible contributing factors. Because treatment is individualized, each child, youth, and family receive flexible services over time to meet their changing needs.

Treatment typically involves teaching adaptive, pro-social skills and responses that equip young people and their families with the means to deal effectively with the unique conditions or individual circumstances that have created the need for treatment. The term “individualized treatment” presumes stated, measurable goals based on a professional assessment, a set of written procedures for achieving those goals, and a process for assessing the results. Treatment accountability requires that goals and objectives be time-limited and outcomes systematically monitored.

Individualized treatment requires a commitment to cultural competence by Treatment Family Care Programs. Programs must mandate in policy and reinforce in training and development of all Program Staff and Treatment Parents respect for and nurturance of each child’s unique culture, language, socioeconomic status, race, ethnic background, religion, gender, political affiliation, gender identity, sexual orientation, and ability.

As part of an individualized approach to treatment, there might be levels of care within the Treatment Family Care Program with children’s level of treatment and movement between levels determined by the

intensity of their treatment needs. A change in level of care within the Program should not necessitate a transfer to a different Treatment Home. Program factors that may be modified depending on level of care include ratio of cases to worker, frequency of contact between the Program's Caseworker and Treatment Parents, and level of in-home services.

When it is determined that a child needs less intensive treatment within the framework of the Treatment Family Care Program, that change may be referred to as a "step down" in treatment level or treatment interventions provided at a continuation level. There also should be recognition that movement may be bi-directional and that a "step up" in level of service may be required if the child's behaviors intensify or become more serious.

Programs may provide both Treatment and Non-Treatment Family Care services so that a child who no longer requires a treatment level of care can move to a non-treatment level and remain in the Program to benefit from continuity of relationships. During the ongoing treatment planning and revision process, Program Staff, Treatment Parents, or public agency caseworkers/legal representatives may suggest a change in level of care based on the child's changing treatment needs. A change in level of care should always be based on a change in treatment needs rather than being an automatic change dictated by time spent in the Program. It is the responsibility of Program Staff to provide input into decisions regarding level of care that may be made by another professional or entity and to advocate for the level that best meets the needs of the child.

Treatment Family Care is family-based. The Treatment Family is viewed as the primary treatment setting, with Treatment Parents trained and supported to implement key elements of treatment in the context of family and community life while promoting the goals of permanency planning for children and youth in their care. Although their role is central to the service delivery approach, Treatment Parents do not carry primary or exclusive responsibility for the

design of treatment plans. This task is a team function carried out under the clinical direction of qualified Program Staff.

Treatment Family Care serves children and youth whose unique needs require out-of-home care. This may include out-of-home care with their kin. Although many Treatment Family Care programs focus on services to children and youth with serious emotional and behavioral disturbance, the term "unique needs" may apply to any clinical problem or disability whether of an emotional, behavioral, medical, delinquent, intellectual, or developmental nature.

In addition to providing treatment for specific problems or conditions, Treatment Family Care seeks to promote permanence for every child in out-of-home care. Permanence can take many forms, including return to family, adoption, and guardianship/legal custody. Long-term foster care is not considered an acceptable permanence plan, nor is letting a child "age out" of the foster care system, transitioning to adulthood in a manner that is not thoroughly planned and leaves the youth lacking permanent connections. During the period in which permanence is promoted, it is imperative that children and youth be provided with as much stability as possible, with no or few moves between homes and as few changes in staff as possible.

Treatment Family Care Programs also serve the families of children and youth and seek to involve children, youth, and families in treatment planning and decision making as key members of the treatment team. Family involvement requires an unwavering commitment to promoting a service that is culturally competent and respectfully embraces cultural diversity. This includes the recognition that promoting family reunification can be facilitated by Treatment Family Care that is delivered in the child's and family's community. Treatment Family Care Programs actively support and enhance children's relationships with their parents, siblings, and other family members throughout the period of placement regardless of permanency goal unless such efforts are expressly and legally proscribed.



For purposes of these Standards, Treatment Parents can be foster parents or kinship caregivers who are caring for children and youth with treatment needs in and as part of a treatment family care program.

Kin Note: Treatment foster care programs provided with kin require special considerations. These considerations are noted throughout this document and reflect the reality that kin often step up during times of crisis, and that engaging and supporting kin is different from working with non-kin. Kin require different types of support than non-kin because they often begin care of children with little notice or preparation, may need help navigating relationships with the children's birth parents and other family members, and often do not have access to training and benefits that non-kin may receive. Agencies should make every effort to ensure their treatment programs are responsive to these considerations given that the benefits of living with kin outweigh any challenges the agency may face in addressing their needs.

It's important to note that states and localities have very different policies and practices governing placement with kin, and the benefits and supports kin receive to care for the child. This includes a number of states that place children with kin as an alternative to foster care and states that place "children at-risk of foster care" with kin to avoid the need of state custody care, such as foster care. Children living with kin who are not in foster care may also have treatment needs that can be met through the specialized services and supports that are provided by treatment foster care programs. FFTA encourages agencies to explore partnerships with their public agencies to meet the treatment needs of these children.

## SECTION 1

# PROGRAM

## INTRODUCTION

A Treatment Family Care Program is created when services and supports are organized in a coherent manner for a common purpose. It is the program context that creates and supports the framework necessary for effective service delivery. A clear Program Statement, a commitment to measuring Program Performance, and attention to Program Staff qualifications, roles, and supports are all required to define a Treatment Family Care Program. Standards related to these three areas are detailed in this section.

### PROGRAM STATEMENT

As a human service organization with accountability to children, youth, Treatment Parents, funders, regulating bodies, and community partners, a Treatment Family Care Program shall develop a Program Statement that describes its administrative structure, policies, and procedures. In addition to content areas required by a licensing, accrediting, or other administrative authority, the Program Statement shall include the following:

**1. PROGRAM STATEMENT** — Any entity operating a Treatment Family Care Program shall have a written Program Statement that describes its mission, organizational structure, purpose, services, philosophies, methods, goals, and evaluation procedures of the program that are culturally relevant, trauma informed, and age and developmentally appropriate. The Program Statement shall include:

**a. Program Purpose and Goals:** A statement describing why the Program was created and a list of specific goals of the Program.

**b. Treatment Philosophy:** A statement describing the Program's treatment philosophy and the specific treat-

ment modalities it employs. The treatment philosophy should affirm a focus on all aspects of the child's development, including physical, social, emotional, cognitive, cultural, and spiritual, and affirm a strength-based, trauma-specific approach to treatment.

**c. Services:** A precise and detailed description of the services the Program provides.

**d. Population Served:** A description of the population served, including the age range, sex, gender, and population of persons served by your agency, including, but not limited to: children; youth, nonminor dependents; persons with physical or developmental disabilities; or serious behavioral challenges or mental disorders.

**e. Admission Policy:** A list of criteria for admission as well as procedures that provide for timely processing of referrals and notification of the referral source. The policy also must outline steps and requirements for admission. The policy will prohibit discriminatory selection processes while delineating reasons the Program might decline referrals based on criteria such as capacity, service contract requirements, limitations to provide necessary services, or ability to ensure the safety and protection of others.

**f. Staffing:** A statement outlining a staffing pattern, including staff qualifications, that allows for the intensity of service required in Treatment Family Care. The agency must demonstrate sufficient, qualified professional staff to provide 24/7 crisis response and support, ongoing service planning, treatment oversight, and case management, and that designates an individual responsible for Program administration.

**g. Culturally Relevant Services:** A policy that addresses cultural diversity and cultural competence. Cultural

competence recognizes, affirms, fosters, and values the strengths of individuals, families, and communities and protects and preserves the worth and dignity of each person. To be culturally relevant, individuals, agencies, and systems must integrate and transform their awareness of assumptions, values, biases, and knowledge about themselves and others to respond respectfully and effectively across diverse cultures, languages, socioeconomic statuses, races, ethnic backgrounds, religions, genders, political affiliations, gender identities, sexual orientations, and abilities.

Every Program shall have a plan for developing and maintaining the cultural competence of the Program that acknowledges and values diversity in respect to culture, language, socioeconomic status, race, ethnic background, religion, gender, political affiliation, gender identity, sexual orientation, and ability and provides for:

- Recruitment of Program Staff and Treatment Parents who share or have an understanding of the cultural background of the population served.
- Priority for placement with and/or connections to kin to help children maintain connections with their racial, ethnic, and cultural identities.
- Training of Program Staff and Treatment Parents to increase knowledge and understanding of the history, traditions, language and communication styles, values, family and social systems, and social customs of the populations served that reflects understanding of the diversity between and within cultures, including those associated with diverse nationalities, ethnicities, and religions. Staff and Treatment Parents shall also receive training pertaining to sexual orientation, gender expression and identity, privilege, racial inequities, and implicit bias.
- Staff development plans that encourage staff to increase awareness of how their own personal and cultural values, beliefs and biases affect their work with Treatment Parents and with children and youth in care.

- Use of treatment approaches and models that are compatible with the values and cultural styles of the populations served.
- A commitment to using community resources, including informal networks and natural helpers, that provide opportunities for reinforcement of the cultural and religious values of the population served.
- Awareness of the dynamics of interaction between diverse cultures.
- Monitoring of the Program's cultural competence in Program Evaluation and Continuous Quality Improvement efforts.

**h. Family Connections:** A policy statement that commits Program Staff and Treatment Parents to practices that respect and promote positive connections to the child's biological, kin, or adoptive family and that preserve and promote cultural or ethnic identity.

**i. Children's and Youth's Rights:** A policy that is provided to children and youth upon admission, both written and verbally explained in developmentally appropriate language. The policy must delineate the rights of children and youth in the Program, including: Full compliance with and incorporation of Foster Children/Youth Personal Rights required by the states wherein the agency serves.

- Safety – Freedom from all physical, sexual, and emotional abuse and neglect.
- Basic Needs – The right to receive wholesome food and nourishment; adequate clothing and other necessities of daily life; routine medical services, including dental and vision services; and appropriate mental health care services.
- Humane Treatment – The right to privacy; freedom from corporal punishment, denial or threat of denial of contact with parents or other family members, threats of removal from the treatment home,

threats of physical harm, denial or threats of denial of basic needs (including meals), meaningless work as punishment, and emotionally demeaning or humiliating actions or consequences.

- **Respectful Treatment** – The right to respect for cultural and religious preferences and access to religious worship services of their choice; the right to be free from discrimination and harassment and to receive fair treatment regardless of the child’s culture, language, socioeconomic status, race, ethnic background, religion, gender, political affiliation, gender identity, sexual orientation, and ability; and the right to live in a safe, comfortable home where he or she is treated with respect.
- **Connection to Kin** – The right to have kin considered as a placement option, and if placement is not possible, the right to maintain ongoing kin connections.
- **Communication** – The right to contact family members, kin, caseworkers, attorneys, and foster youth advocates and to conduct private conversations via telephone or social media (unless contraindicated for safety or treatment reasons or prohibited by court order).
- **Education** – The right to attend school and participate in developmentally appropriate extracurricular, cultural, social, and personal enrichment activities.
- **Normalcy** – The right to be involved in activities in accordance with reasonable and prudent parent standards.
- **Grievance Process** – A specific process for handling complaints or grievances by the child or others regarding violation of the rights specified. Upon admission, children and youth shall receive written information about grievance procedures in developmentally appropriate language with verbal explanations by Program Staff. The Program must designate someone other than the Treatment Parents or the Program Caseworker to investigate any grievance

related to violation of youth rights. Any variation from the rights specified in the statement must be documented in the treatment plan and explained to the child, to the child’s legal representative, and to the child’s family when family contact is part of the treatment plan. The Program shall track and maintain records of child grievances and investigations of alleged misconduct toward children and youth in the Program as part of a program audit policy and risk management review.

**j. Foster Parent Rights:** A policy that is provided to Treatment Parents during preservice training (or in the case of children living with kin, at the time the family becomes involved with the program) in writing and accompanied by verbal explanation. The policy must delineate the rights of Treatment Parents, including:

- **Respectful Treatment** – Treatment Parents will be treated with dignity, respect, trust, and consideration as valued members of the treatment team.
- **Programmatic Support** – The Program will provide access to program staff 24 hours a day, 7 days a week.
- **Reimbursement** – The Program will provide written information regarding Treatment Parent reimbursement and will reimburse in a timely manner according to the written plan. Information regarding potential changes in reimbursement, such as through moving the child to a higher or lower intensity of care over time, shall be provided to the Treatment Parents prior to placement of a child, or in the case of children living with kin, at the time the family becomes involved with the program.
- **Placement Decisions** – The Program will provide pre-placement information regarding the needs of children and youth in the match process for placement in the Treatment Family’s home. This includes information about behavioral problems, health history, educational status, cultural and family background, results of assessments and evaluations, and

any other information known to the Program at the time the child is placed. At any point that further information becomes available, the Program must share that information with the Treatment Family immediately. Treatment Parents shall have input into decisions determining whether the child would be an appropriate placement for them. The Program shall inform the Treatment Parents of court hearings and of decisions made by the courts or the child's legal representative that affect the placement of the child.

Kin note: For programs that are engaging kin as Treatment Parents when the child is already living in the home, the Program should not assume that the kin caregiver is already aware of the treatment needs of the child. Therefore, any information available about the child's background and needs should be disclosed to kin at the start of the family's involvement with the Program. A thorough assessment of the caregiver's needs should also be completed to ensure access to the right level of supports to maintain the child's placement in their home.

- **Treatment** – Treatment Parents will be part of the treatment planning process, with their opinions and suggestions carrying the same weight as those of the other treatment team members.
- **Respite** – Treatment Parents will have access to adequate respite.

Kin note: Kin Treatment Parents also need respite, but may not want to leave the child with someone they don't know. The agency should have a process that allows kin Treatment Parents to designate other members of the extended family network as respite providers, and a procedure to assess the proposed respite provider for their capacity to provide safe respite care in a manner that is consistent with the treatment plan.

- **Training** – The Program will provide the training and support necessary for Treatment Parents to provide care and treatment specific to the needs of children and youth in their home; the Program will

provide ongoing supervision regarding implementation of the treatment process.

- **Grievance Process** – The Program will provide access to a fair and impartial grievance process to address licensure, case management decisions, and delivery of service issues. Treatment Parents shall have timely access to the Program's appeals process and shall be free from acts of retaliation when exercising the right to appeal.
- **Maltreatment Allegations** – When a Treatment Parent or anyone in the household is accused of maltreatment of children or youth, the Program will ensure the safety of all children in its care while also advocating on behalf of the Treatment Parent or family member for a speedy and fair investigatory process. Unless prohibited by the rules of the investigating body, the Program shall inform the Treatment Parent in person and in writing of maltreatment allegations. The Program shall provide to the Treatment Parents information about the investigatory process, including the Treatment Family's rights and responsibilities. A written notification of any report in which a finding is not indicated shall be provided to a Treatment Parent within five days of the agency's receipt of that decision.

**k. Missing Children or Youth:** A policy that outlines the Program's practices and protocols should a child or youth run away or be deemed missing.

**l. Behavior Management:** A policy that affirms that the primary use of strength-based, trauma informed behavior management strategies is to teach pro-social, adaptive behaviors rather than simply reduce or eliminate undesirable behaviors; includes reference to use of positive reinforcement; ensures the rights of children and youth in the Program; incorporates trauma-based interventions, specifically addresses use of restrictive behavior management practices in the Program; and prohibits use of physical/manual restraint except when necessary to ensure the safety of the child or others in the environment and only as a last resort after other, nonrestrictive interventions fail

and in programs where such actions are not prohibited. The policy shall prohibit all corporal punishment.

- The policy shall be specific regarding either prohibiting or allowing use of physical/manual restraint. If physical/manual restraint is permitted in the program, parameters for use must be defined in the policy. Parameters must include circumstances of child behavior that would make use of restraint acceptable; procedural requirements for use of restraint; delineation of who can authorize, initiate, and carry out restraint; and requirements for reporting and documenting use of and tracking of restraint.
- Physical/manual restraint is not treatment, and treatment language such as “therapeutic hold” should not be used to describe an act of physical/manual restraint. The policy must be clear in specifying that physical/manual restraint is used only as a last resort to ensure the physical safety of the child or others in the environment. Physical/manual restraint cannot be used as a disciplinary action or for the convenience of Program Staff or Treatment Parents.
- Use of mechanical restraints, chemical restraint, isolation, and locked seclusion is not compatible with treatment in a family setting and shall be specifically prohibited. Although use of medication may be part of the treatment plan (see Program Statement n.), chemical restraint refers to use of medication to sedate the child for the purpose of preventing aggressive or self-destructive behaviors with the effect that the child is unable to respond to or function in the environment in a normal manner.
- Seclusion should not be confused with “time-out” procedures. Time-out is an acceptable behavioral management strategy used as a negative consequence and removes a child from pleasurable stimuli without confining the child in isolation. If time-out is used as a treatment intervention, the Program should provide specific procedures that

define implementation of age-appropriate time-out interventions and train Program Staff and Treatment Parents in the use of time-out.

- The policy must address Program interventions that are used to identify and de-escalate situations that could lead to use of restraint. Examples of non-restrictive crisis intervention responses by Staff include attending to nonverbal behaviors such as facial expressions and body language; respecting personal space; decreasing noise and activity level in the environment; attending to warning signs of aggression; maintaining calm demeanor and voice tone; eliminating peers from the environment; involving the child in the process of regaining control; using reflective questioning; and providing options for the child. Treatment planning and review must include review of frequency of restraint, if any, for individual children and youth and include strategies to avoid the need for use of any physical restraint.
- Program policy/procedures regarding use of physical/manual restraint must be in compliance with all applicable state, provincial, and federal/national laws and regulations as well as each Program’s accrediting body.
- If physical/manual restraint is permitted in the Program, the Program must provide for state, province, or nationally recognized training/certification in the use of restraint and in the implementation of treatment strategies designed to prevent behaviors that would require use of restraint. Staff and Treatment Parents must be trained to recognize medical conditions or signs of physical distress that would contraindicate use of restraint or signal the need to discontinue restraint. Training should be competency-based, and any Staff person or Treatment Parent authorized to use physical/manual restraint must have certification updated on a specified and regular schedule with all documentation of training retained in Program files.
- Quality improvement measures must track use of

restraint on a programmatic basis with recognition that frequent use of restraint may be an indicator of ineffective treatment planning or implementation, inadequate training of Program Staff or Treatment Parents, or placement of children and youth at an inappropriate level of treatment.

- All use of restraint should be reviewed in follow-up supervision within a specified time period.

**m. Medical Care:** A policy affirming that the child shall be informed of and involved in all medical decisions regarding him or her. This information should be delivered in a manner consistent with the child's developmental abilities and level of understanding. To the degree possible according to the child's age and development, his or her assent or consent shall be obtained when medical decisions are made, including decisions to begin or to continue the use of medication and invasive procedures.

**n. Medication:** A policy on the use of medication which commits the Program to the following principles and practices:

- The first line of intervention with children and youth should not involve the use of medications unless clear research evidence indicates otherwise for a particular condition. When psychotropic medications are prescribed by a physician, there must be a diagnosis specifically indicating "medical necessity," they should be used in concert with other interventions where such interventions may also contribute to remediation of the problem or safely reduce reliance on medication alone.
- In state or county jurisdictions which require it, the Program Policy must include procedures for securing necessary Juvenile Court orders, and subsequent required reauthorizations by the Juvenile Court.
- All prescribed medication shall be stored in a locked and secure location.

- Treatment Parents and relevant treatment team members shall be informed of side effects and trained in reporting side effects of any medication prescribed by a physician for use by children and youth in care.

- The Program's policy shall specify the approach for administering medication, the documentation requirements including medication logs, the frequency of medication reviews, and the process for obtaining informed consent if applicable.

**o. Emergency Care:** A written protocol for backup emergency care in the event that a child's placement in a Treatment Family is disrupted. Agencies should seek emergency caregivers in a family-based setting, preferably in the child's own family network, when making emergency care arrangements. Protocols should include the use of family team meetings that engage the Treatment Parent, the extended family network, and other resources to develop the least disruptive emergency care plan possible for the child.

**p. Allegations of Misconduct Toward Children and Youth:** A written protocol for investigating, responding to, and reporting allegations of misconduct toward children and youth, and fully conform to state law and applicable licensing regulations. The protocol must also be inclusive of sexual misconduct. The written protocol shall include a plan for the immediate protection of a child when there is suspicion that the child may be in danger. The protocol shall include the agency's obligation and intent to cooperate with all investigative bodies.

**q. Allegations of Misconduct Toward Others:** A written protocol for preventing, investigating, and responding to potential harm or danger to the Treatment Family or the community. Program Policy addressing the child/youth misconduct towards others must fully conform with all state laws and applicable licensing regulations. If the Program serves children and youth with histories of sexual, assaultive or other potentially dangerous behaviors, there must be requirements for safety plans that address restrictions, monitoring, and

supervision that are adequate to prevent children and youth in care from continuing patterns of sexual, assaultive or dangerous behavior that would place at risk other children and youth in the family, the school, or the community.

**r. Risk Management:** A policy statement describing the agency's risk management philosophy, practices, and prevention strategies. This policy must include: staff and Treatment Parent training; monitoring and documentation practices; critical incident response; and practice improvement practices.

**s. Confidentiality:** A policy statement on privacy and confidentiality of information, with specific procedures to safeguard child and family information that are compliant with the Health Insurance Portability and Accountability Act (HIPAA), as well as all state law and applicable licensing regulations and requirements. The statement shall provide for:

- A statement of potential consequences for violating HIPAA, and state and local confidentiality laws.
- Consent for Treatment forms that specify the content of the forms as well as the point at which the forms are to be signed.
- Requirements that Consent for Treatment forms be provided to and signed by the child's legal representative and that the forms explain the Program's confidentiality policies, permitted uses of child and family information, and the handling of confidential information under HIPAA requirements.
- Treatment Parents' access to all information regarding the child's history and to any other information from the case record that could impact the child's treatment plan or planning for services and interventions.
- Release of Information forms that include reference to authorizing signatures, specification of information to be released, dates the consent takes effect and expires, identification of the party

to whom the information is to be released, and identification of the party authorized to release the information.

- Maintenance of all disclosures in the case file.
- Access to the case record by the legal guardian.
- Procedures for addressing complaints regarding violations of privacy policies, documenting of complaints, and handling of complaints.
- Keeping sensitive demographic information, such as a child's religious affiliation, HIV status or other medical condition, sexual orientation, and gender identity, private without the youth's express consent to release the information.
- Sanctioning Program Staff and Treatment Parents who violate privacy policies, and protecting from retaliation Program Staff or Treatment Parents who raise issues about the Program's privacy practices.
- Written, informed consent for participation of children and youth, family members, Treatment Parents, or Program Staff in research and evaluation.
- A written statement specifying that the youth's exit from the foster home or even from foster care does not relieve Program Staff and Treatment Parents from the duty to abide by rules of confidentiality.

**t. Social Media:** A policy addressing the use of social media and unencrypted, web-based e-mail services and calendars. Social media may include websites and apps that allow Treatment Parents to share common struggles and post strategies for parenting children and youth in care. Program Staff and Treatment Parents will protect the rights of foster children and are prohibited from posting pictures, stories, or confidential identifying information about children and youth on social networking sites. Internet communi-

cations that contain identifying information regarding foster children or their families constitute a breach of privacy and confidentiality and are prohibited. Likewise, the policy on social media should provide guidance and structure for Treatment Parents to monitor the youth's use of social media. Information should also be provided to youth that will ensure their safety when using social media and the Internet to communicate with family members, friends and others. Guidelines for using social media to prevent the unintentional disclosure of sensitive information should also be provided.

Kin note: The agency's social media policy should consider the special circumstances of kin who may regularly post family pictures or stories, which may include children who are enrolled in the Treatment Family Care program. The policy should identify the difference between family-related items (such as family information not related to the child's treatment and experience in foster care) and treatment-related items (items that only concern the child's experience in foster care), and provide clear expectations around privacy and confidentiality for those items.

## PROGRAM PERFORMANCE

**2. SERVICE DELIVERY** — A Treatment Family Care Program shall establish processes for delivering effective, evidence-informed services across its target population. Such a system includes conducting timely and thorough assessments; implementing a goal-oriented and collaborative treatment planning process that includes transition planning to address children's permanency needs; delivering evidence-informed, strength-based services and interventions specifically tailored to each child's unique needs, strengths and culture; and establishing an agency-wide Continuous Quality Improvement process. The Program also must ensure that documentation by all Program Staff and Treatment Parents is accurate and complete.

**3. ASSESSMENT AND RECORDS** — To achieve sound placement decisions and planning for relevant treatment services to children and youth, Program staff

must receive and review the following case materials prior to a child's admission:

- a. Current case plan(s)
- b. Permanency plan
- c. Social history information
- d. Previous and current (within a year of referral date) psychological assessments
- e. School and educational information
- f. Medical information
- g. Previous placement history and outcomes
- h. Child's and family's strengths and needs, including skills, interests, talents, and other assets
- i. Documentation on the child's extended family network, including previous efforts to locate and engage kin as placement options or important connections for the child.

In addition to reviewing the records received, Program Staff must assess the child prior to admission by conducting a personal interview to begin the process of treatment planning. The individual interview is part of the admission process and should be used to identify the child's specific preferences, strengths, and capabilities from a holistic point of view. This facet of the assessment process should address the child's physical, cognitive, social, emotional, cultural, and spiritual/religious development from the child's own perspective. The assessment shall include optional questions about the child's sexual orientation and gender identity. Information from the interview should be used to inform treatment planning.

For youth admitted to Treatment Family Care, an individual case record will be kept that includes the above information as well as the following:

- Personal identifying information such as a birth certificate
- A preadmission psychological evaluation (if available)
- The child's social and family history, including any family trees, genograms or other information about the child's extended family network, as well as information about efforts to locate and engage kin as placement options or important connections for the child
- Potentially sensitive demographic information, including religious affiliation, HIV status or other medical condition, sexual orientation, gender identity, history of sexual exploitation or sex trafficking as optional questions. Youth will be assured that such information will be kept private unless the youth gives express consent otherwise. Such information should be updated appropriately
- Educational history, including school reports and available standardized test results
- Medical information, including vision, hearing, and dental exam reports; current and previous medications; allergies; child's physical description; immunization records; medical history; and Medicaid, SSI, or Health Care numbers as applicable
- Authorizations for routine and emergency medical care, dental care, and other medical procedures
- Authorizations required by the Program's state/province, such as authorization for out-of-state/province travel, participation in special activities, and publicity releases
- Correspondence with/from other agencies involved with the child
- The Preliminary Treatment Plan
- The Comprehensive Treatment Plan

- Progress reports
- Case notes, including contacts with the child's family and extended family network
- Updates and reports from Treatment Parents
- Incident logs or records of serious behavior problems, illnesses, injuries, and traumas experienced and their impact on the child's current functioning and behavior
- Consent for Placement signed by legal custodian

**4. TREATMENT PLANNING** — Treatment planning is an ongoing process with several characteristics and products. A Preliminary Treatment Plan completed by the Program at the time of placement is needed to guide Treatment Parents' early assessment and relationship-building efforts and to describe specific responses to potential problems identified through the preadmission assessment. A more Comprehensive Treatment Plan is needed after placement to describe long-term treatment and permanency planning goals and the services to be provided to meet those goals. The Comprehensive Treatment Plan also must address specific trauma-informed interventions and strategies to be employed by Treatment Parents in the home to meet long-term goals related to permanency plans and to achieve short-term objectives related to meeting client needs, building strengths and enhancing client well-being. Significant revisions or extensions of these specific treatment strategies must be documented at least quarterly along with progress on long- and short-term goals.

Treatment planning should include a process for providing a child voice, choice and preference, when appropriate, from the outset and to increase and maximize that their involvement over time. The process likewise should involve the youth's family, kin and other significant relationships whenever possible and address strategies to promote reunification or permanency, and to enhance and maintain child-family relationships. Planning should extend beyond the period of a child's

tenure in Treatment Family Care to guide and stabilize transitions to subsequent settings and to maximize the transfer and maintenance of treatment gains. After-care services and discharge planning must be addressed as integral components of the treatment planning process.

NOTE: In some states or provinces, Programs may be limited in their ability to provide after-care services because of restrictions imposed by the public entity that serves as legal guardian for the children and youth in care. In such cases, the Program shall ensure a referral is made for needed after-care services.

Treatment and service planning standards are detailed below. It is recognized that state/provincial, Program, or accreditation guidelines may dictate plan requirements and content that differs in format from these Standards. Nevertheless, the recommendations regarding purpose, timelines, content, and participation are considered minimum standards.

**a. Preliminary Treatment Plan:** A preliminary, written treatment plan shall be completed at the time the child is placed in the treatment home. The plan shall describe specific tasks to be carried out by the treatment team during the first 30 days of placement. It shall describe strategies to ease the child's adjustment to the treatment home and to directly assess the child's strengths, skills, interests, and needs for treatment within the home. This preliminary plan should address short-term goals for the first 30 days of placement, identify potential problems likely to be encountered with the child, and specify how the treatment team is to respond to such problems. The Preliminary Treatment Plan must include a focus on the child's educational placement and adjustment to the school as well as the treatment home.

Kin Note: In the case of a child newly placed in the home with kin, the Preliminary Treatment Plan may also need to address some of the concrete supports needed by the kin family. Given that kin families have little preparation for the placement, these concrete needs may include furniture, clothing, access to government benefits, and other supports needed to provide stability for the child.

**b. Comprehensive Treatment Plan:** A written Comprehensive Treatment Plan shall be completed within 30 days of placement, or in the case where the child is already living in the home with kin, within 30 days of the kin family's involvement in the program. The primary goal of treatment planning is to promote the safety, well-being and permanency of the child. The Comprehensive Treatment Plan must be developed based on a comprehensive assessment process that identifies the child's needs and strengths, trauma history, unique values, culture, developmental stage, personal goals and expectations, aptitudes, and the community in which they reside. The plan must provide specific interventions needed for the child to achieve safety, well-being and permanency.

Essential elements of treatment planning include criteria for discharge, projected length of stay in the Program, permanency plan, and projected post-Treatment Family Care setting and after-care service recommendations. The permanency plan must include specific interventions and strategies necessary for the child to achieve family reunification, kin/relative placement, or, the acquisition of skills and resources needed to become a self-sufficient adult. The child's age and developmental abilities will determine the pacing and selection of skills.

The Comprehensive Treatment Plan shall also include strength-based, short-term treatment goals that are measurable and time-limited, along with specific interventions required for meeting these treatment goals. Each plan shall specify the person/people responsible for implementing interventions, and how progress toward goal achievement will be measured.

The plan shall identify and build on the child's strengths and needs as well as respond to presenting problems from a trauma-informed perspective. It shall assess the child's needs for services in major developmental areas. The plan shall describe goals and interventions necessary to promote pro-social, adaptive behavior; emotional well-being; cognitive development; interpersonal skills and relationships; community, family, and cultural connections; self-care;

daily living skills; and educational achievement. For older youth and those remaining in Treatment Family Care for longer periods, the plan shall address the development of skills necessary for successful transition to adulthood.

When the child's family is engaged in treatment, the plan shall outline goals and strategies for assisting the family to reach permanency. When the child's family is not engaged in treatment, the reason for the lack of engagement should be noted in the plan along with a strategy to put forth all reasonable efforts to include the family in treatment.

Kin note: A Preliminary Treatment Plan may be unnecessary for children who have already been living with their kin prior to entry into the treatment family care program. Instead, the Comprehensive Treatment Plan described above can be completed in partnership with the kin and others who are familiar with the needs of the child. This Comprehensive Treatment Plan should be completed within 30 days of placement and should take into account information gathered during the initial engagement with the kin family. When developing the Comprehensive Treatment Plan, kin should be educated about their role as change agents, and encouraged to actively participate in treatment planning. Kin should be encouraged to advocate for the child without fear that the child will be removed from their home unless there is a true safety concern.

In the case of kin families who have not yet been fully licensed as Treatment Foster Parents, the Comprehensive Treatment Plan should not be delayed due to any delays in licensing. Additionally, the Comprehensive Treatment Plan should include an assessment of the emotional or other support needed to ensure the caregiver has the right level of supports to maintain the child's placement in their home.

**c. Treatment Plan Revisions:** The Treatment Plan is a dynamic document. Treatment plans should be reviewed monthly by the treatment team and revised as necessary, with documentation in quarterly progress reports of revisions and extensions of the plan. As a child stabilizes in the treatment home and

responds to treatment, treatment needs may be less intense. Treatment Parents may become more confident and competent in implementing treatment strategies, and their need for support and consultation may decrease. On the other hand, as the child becomes comfortable in the safety of the treatment home, problems that were unknown or unobserved prior to placement may surface. For example, some children and youth disclose a history of sexual abuse only after they are in a safe environment. That disclosure may result in a re-experiencing of the trauma of the abuse, and new behaviors may appear that require more intense involvement on the part of the Caseworker. Treatment Plan revisions must address the emergence of new target problems and behaviors as well as improvements in referral behaviors and behaviors identified in the early stages of the placement. Some service contracts link improvements in behavior to decreased contractual rates, a change referred to as "step down," even if the child remains in the same treatment home. The Program has an ethical responsibility to assess and respond to the child's needs by documenting increases or decreases in target behaviors and adjusting the treatment plan and its implementation accordingly.

**5. DOCUMENTATION —** A Treatment Family Care Program shall clearly document delivery of all services described in its Program Statement as well as compliance with all minimum-operating standards described above. Documentation of treatment progress and service provision helps to ensure accountability, communicate progress, enhance commitment among team members, and promote sound, effective treatment and transition approaches. Documentation of the child's service needs and treatment progress shall occur through Quarterly Progress Reports, Discharge Reports, and After-care Reports.

**a. Quarterly Progress Report:** Each child's Comprehensive Treatment Plan shall be reviewed in discussions with treatment team members, summarized via quarterly reports, and revised as necessary. Quarterly reports shall document progress on specific short-term treatment goals, describe significant revi-

sions in goals and strategies, and specify any new treatment goals and strategies initiated during the period covered. The quarterly progress report shall summarize progress and note changes regarding the permanency plan, the intended discharge placement if different from the permanency plan, respite plans, and treatment goals.

**b. Discharge Report:** The discharge report shall document, but not be limited to, the course of treatment, major treatment recommendations and outcomes, and a list of records to be transferred based on the discharge placement as well as appointment information for follow-up treatment. The report shall be available at the time of the child's discharge from the Program.

**c. After-care Report:** When after-care services are provided in part or in total by the Treatment Family Care Program, after-care reports shall be compiled on a schedule that meets the needs of those involved in post-treatment planning and service delivery. The after-care report shall document the nature, frequency, and duration of after-care services provided to the child or youth and his or her family along with recommendations for service termination or further service provision.

**6. TRANSITION PLANNING** — Transitions are particularly challenging for children and youth in placement. Respite Planning, Discharge Planning, and After-care Planning enhance the child's opportunities for success and well-being in new environments and promote a coordinated and thoughtful approach to meeting the child's needs. These plans shall be documented either in the Comprehensive Treatment Plan or in a separate text. In all cases, the treatment team shall sign off on the plans.

**a. Discharge Planning:** Discharge planning begins at the time of placement. Discharge plans are reviewed continually and are formally reviewed at least quarterly. Discharge planning should review the expected duration of treatment and major treatment recommendations that are likely to facilitate a successful discharge placement. The plan shall be regularly

reviewed to determine whether it remains the most viable and beneficial placement for the child or youth.

**b. After-care Planning:** Written recommendations for after-care shall be made for each child prior to his or her planned departure from the Program. Such recommendations shall specify the nature, frequency, duration, and responsible parties for after-care services to be provided to the child, to his or her family, or to other persons involved with the child's permanency plan. Recommendations for after-care also shall be made within seven days of discharge for children and youth whose discharge is not planned. The youth himself or herself shall be provided with the discharge or transition plan, a list of emergency and contact persons, and the Program's contact information. The Program shall coordinate all after-care and permanency planning with other involved service providers, including courts.

## 7. ORGANIZATIONAL PERFORMANCE

**a. Fidelity to the Standards:** Effective organizational performance requires that programs adhere to or exceed FFTA Standards and provide a holistic CQI environment. Programs should strive to develop practice models that produce the best possible outcomes for the children, youth, and families. This result requires, at the minimum, that programs develop methods of measuring organizational performance and outcomes that are directly related to FFTA Standards. A Program must stay aware of current effective Treatment Family Care and related practices, literature, and research, as well as methods of measuring adherence to effective practices and outcomes. Programs that do not conform to the Standards shall make reasonable efforts to improve organizational performance.

**b. Program Evaluation:** Evaluation is essential for programmatic self-knowledge, self-improvement, and accountability. Program Staff and Treatment Parents must receive regularly scheduled, formal feedback on their performance and training in order to maximize strengths and receive support in improving performance. Although the format of the information presented

may vary from Program to Program, at a minimum, Treatment Family Care Program evaluation efforts should address the following:

- **Staff Performance Evaluations:** Programs shall provide Staff with weekly or biweekly feedback regarding performance and with written performance evaluations at least annually. Both ongoing and annual feedback must be properly documented and contain evidence of both strengths and needs. At least some of this evidence should come from Program Data being continually collected around critical indicators of program effectiveness, such as number of disruptions, meeting of treatment goals, and child progress toward permanence. Evidence gathered from observation, documentation reviews, and feedback from Treatment Parents, youth, and community partners shall be included as well. Annual evaluations must summarize ongoing supervision feedback and include descriptive assessments of Staff performance of specific job responsibilities along with goals for improved performance.
- **Treatment Parent Evaluations:** Programs shall provide Treatment Parents with ongoing quarterly (at a minimum) feedback regarding performance. All feedback shall be documented in the Treatment Parent record. In addition, Programs will provide Treatment Parents with at least annual written reviews of performance summarizing ongoing feedback, fulfillment of responsibilities, and goals for improvement. Both ongoing and annual feedback must contain evidence of both strengths and needs. At least some of this evidence should come from Program Data being continually collected around critical indicators of program effectiveness, such as indicators of child safety and number and severity of critical incidents. Evidence gathered from observation, documentation reviews, and feedback from Program Staff, youth, and community partners shall be included as well. Evaluations of Treatment Parents may be included as part of the re-licensure or re-certification of all Treatment Parents in accordance with Program and state/provincial requirements and accreditation body requirements.

**8. QUALITY IMPROVEMENT** — Programs shall have a Quality Improvement system and a written plan describing the system. The Program’s system and plan shall include at a minimum:

**a. Membership and Meetings:** Describe participation in the Quality Improvement system and list participation from programs and/or levels within a program, and other stakeholders who are represented. Specify the frequency of Quality Improvement system meetings as well. Ideally, Quality Improvement teams would include members of every agency program and level within a program, as well as non-agency stakeholders (e.g., funders, Treatment Parents, youth, and community partners). Teams should meet at least quarterly and review up-to-date reports on selected performance measures, stakeholder satisfaction, case record reviews, and incident, accident, and grievance review results, comparing actual versus desired results and making recommendations for improvement in areas where results do not meet expectations. Results of improvement attempts should be monitored at each Quality Improvement team meeting, and further program and policy adjustments should be made as needed.

**b. Information Collection:** Demographic data such as age, race, and gender shall be collected and maintained on current children and youth, their families, Treatment Parents, and Program staff. Agencies should also distinguish between kin and non-kin Treatment Parents and for Kin Treatment Parents, collect data on the Treatment Parents’ relationship to the child.

**c. Performance Measures:** As part of the written Quality Improvement system, Programs shall collect, review, and analyze performance measures concerning service delivery and outcomes to maintain, improve, and document sound Treatment Family Care Program operations. The Program should describe how it measures Program outcomes that focus on formative evaluation to address Program improvement. Measures typically gathered in this area are related to process, which measures how well the service was provided to the desired youth. This evaluation

focuses on program activities and outputs to ensure that the outcomes being sought are occurring. Formative measures may include demographics and aggregated information describing in-program events, including moves within the Program and critical incidents. Summative evaluation addresses whether the program worked and generates information that is used to demonstrate Program results. Measures focus on Program outcomes and impacts that occurred at time of discharge as well as through follow-up tracking of children/youth discharged from the Program. Summative measures may include well-being scores from standardized assessments, the nature of current or past living environments, employment status, involvement in training or education programs, graduation rates, status of treatment goals at time of discharge, and current services being received by the child or youth.

Kin Note: Agencies should look at kin-specific data, including the relationship of the child to kin, for ongoing program improvement related to the delivery of services to children in kin settings.

**d. Process Data:** Process data shall include aggregated information describing in-program events, including moves within the Program, critical incidents, and treatment gains. At a minimum, the following data shall be tracked at intake and, where follow-up is indicated, updated at 3 months, 6 months, and 1 year after admission:

- Safety
  - Maltreatment/Trauma during care (follow up)
  - Child Protective Services reports
  - Critical incidents
  - Screening for trauma
  - Harm (physical injury during placement) (follow up)
  - Physical aggression (self and others) (follow up)
- Permanency
  - Placement stability (i.e., placement changes and reason for change) prior and during placement (follow up)
  - Restrictiveness of placement (prior to placement and discharge) (follow up)

- Reason for discharge
- Permanency achieved (reunification, adoption, guardianship/legal custody)
- Length of stay
- Family contacts during placement
- Attendance of family at service/treatment planning meetings
- Youth connections scales
- Readmissions into program (follow up)
- Well-Being
  - Assessments of current functioning (e.g., CANS, CAFAS)
  - Emotional and behavioral assessments
  - Trauma assessment
  - Treatment goals achieved (percentages)
  - Services received (provided by Program and in the community)
  - Education (type, attendance, grades) (follow up)
  - Employment (follow up)
  - Life skills assessments
  - Criminal activity (follow up)
  - Substance use (follow up)

**e. Outcome Data:** Outcome data shall include a summary of information collected through follow-up tracking of children and youth discharged from the Program. Outcome data shall be tracked at discharge and at 3 months, 6 months, and 1-year post-discharge and include:

- Diagnosis
- The nature of the current living environment
- Listing of other living environments accessed during the year
- Employment status
- Involvement in training or education programs
- Current status with regard to major in-program treatment goals
- Current services being received by the child

**f. Consumer Satisfaction Data:** Programs shall periodically evaluate program services by polling children and youth, families, Treatment Parents, and referring agencies. Such data shall include feedback on consumer

satisfaction with the cultural competence of the service and with support for family involvement.

**g. Benchmarking:** In addition to annually collecting and reporting the above data, the Program recognizes the benefits of such data by benchmarking with appropriate peer agencies whenever possible.

**h. Stakeholder Satisfaction:** Describe how Program participant, funder, and other stakeholder input are incorporated in the Quality Improvement process. This can be done through stakeholder surveys or direct participation in a Quality Improvement group.

**i. Case Record Reviews:** Describe the frequency and inclusiveness of the case record review process and how the results of case record reviews are incorporated in the Quality Improvement system.

**j. Incident, Accident, and Grievance Reviews:** Describe the frequency and inclusiveness of the incident, accident, and grievance review process and how the results of incident, accident, and grievance reviews are incorporated in the Quality Improvement system.

**k. Data System and Security:** Describe the data system(s) used to capture and secure client data.

**l. Reporting, Data-based Decision Making, and Results Communication:** Describe the frequency of reporting, the data reported on and utilized in the Quality Improvement system, and ways the data are used to improve programs and services. Additionally, describe how the results of Quality Improvement system meetings are communicated to all Staff and other stakeholders.

**g. INCORPORATING EVIDENCE-BASED PRACTICE —** Programs are encouraged to develop evidence-informed practices through practice supervision and Quality Improvement processes to ensure the outcomes of service delivery meet or exceed identified benchmarks. Evidence-based practice is evolving; while specific programs and integration of evidence-based interventions are somewhat limited at this

time, Programs should use evidence-informed and evidence-based practices, policies, and tools when available, feasible, and appropriate for their service participants. At a minimum, Programs are encouraged to contribute to the evidence base by being field-based collaborators and sources for moving innovative, promising practices to established EBPs.

## PROGRAM STAFF

Professional Treatment Family Care Staff perform several roles and carry a wide variety of responsibilities. Primary among these is their responsibility for treatment planning and for leadership of the treatment team, which typically is comprised of a Caseworker, a Supervisor or clinical consultant, the child or youth and his or her parents, the Treatment Parents, and other professionals closely involved with the child and family, such as therapists, teachers, or special education instructors. Other major responsibilities required of Treatment Family Care Program Staff include case assessment; case management; case reviews; parent support and consultation; clinical and administrative supervision of staff; 24-hour crisis on-call services; Treatment Parent recruitment, orientation, training, and selection; youth intake and placement; record-keeping; and program evaluation. Because of the 24-hour responsibilities inherent in a Treatment Family Care Staff person's duties, an effective Treatment Family Care Program cannot be carried out by a single professional Staff person. The equivalent of two full-time professional Staff is required to constitute a Treatment Foster Care Program. At least one Staff member must be full-time.

A Treatment Family Care Program may be a separately identifiable program of a larger agency, or it may be an independent agency. To function in this manner, the Program shall designate an individual to be responsible for its administration and to assume responsibility for the provision and oversight of all essential tasks and services described in these standards.

Although documented performance of the tasks and functions described here is essential, their distribution among Program Staff will vary according to the size, nature, and discretion of individual agencies. Critical responsibilities and minimum qualifications are described below for the positions of Case Supervisor and Caseworker. The responsibilities ascribed to each must be met, but may be allocated differently according to an individual agency's internal organization and staffing. Requirements for selection, training, and support pertain to all professional Staff.

Kin note: Agencies providing treatment foster care with kin must determine the staff structure that best aligns with their program. Having a specialized kin worker or unit can be helpful in engaging kin families in the most effective manner possible. Staffing considerations may be impacted by the size of the organization, skills and experience of staff, and number of kin families in the treatment family care program.

Regardless of staffing structure, staff working with kin should have the competencies needed to engage kin families. These competencies include understanding of the complex family dynamics and emotions associated with caring for a kin child, the fact that kin have little preparation for their role as Treatment Parents, and ability to engage the kin triad, including the child, birth parent, and kin caregiver. Agencies are strongly encouraged to provide training for staff on family search and engagement. These skills are critical to ensure that all children in the Treatment Foster Care Program can be connected to, or eventually placed within, their own extended family network.

## CASE SUPERVISOR

The role of the Supervisor is to provide support and consultation to the Caseworker in much the same manner as the Caseworker provides support and assistance to Treatment Parents and the Treatment Family. Specifically, the Supervisor must perform the functions and meet the qualifications stated below.

## SUPERVISOR'S RESPONSIBILITIES AND QUALIFICATIONS

**10. CASEWORKER SUPERVISION** — The Supervisor shall provide regular support and guidance to the Caseworker through weekly supervisory meetings. Formal supervisory meetings shall be supplemented as needed by informal contact between Supervisor and Caseworker. Weekly clinical consultation to the Caseworker shall be arranged or provided by the Treatment Foster Care Program if the Supervisor does not possess the experience and qualifications required to offer such specialized guidance. The Supervisor-to-Caseworker ratio shall not exceed 1 to 5.

NOTE: The Supervisor-to-Caseworker ratio should be adjusted downward to account for such variables as the severity of the problems presented by youth served, the experience/qualifications of casework Staff and Supervisor, whether the child is placed with a new Treatment Parent or especially a new Kin Treatment Parent who needs more preparation in the early stages of the placement, and whether the Supervisor is providing direct care on cases.

**11. TREATMENT PLANNING** — The Supervisor takes ultimate clinical responsibility for the development of a Comprehensive Treatment Plan based on a thorough case assessment for each child admitted to the Program and demonstrates accountability by signing each plan. He or she supervises ongoing treatment planning and implementation for each child, evaluating quarterly progress reports and treatment plan updates and indicating approval by signature. In order to oversee effective development and implementation of treatment planning, the Supervisor must have direct contact with Treatment Parents and Treatment Families at least once a month.

**12. TREATMENT TEAM** — The Supervisor oversees and supports the Caseworker as leader of the treatment team and shares ultimate responsibility for team plans and decisions.

**13. CRISIS ON-CALL** — The Supervisor provides coordination and backup to ensure that 24-hour on-call crisis services are available and delivered as needed to Treatment Parents, children and youth, and families. Further, a Supervisor or other Program Leader with appropriate clinical experience and training must always be on call to assist the Caseworker should he or she need direction or support during the course of providing on-call services.

**14. QUALIFICATIONS** — The Supervisor shall have a minimum of a graduate degree in a human services field plus a minimum of two years' experience in the placement of children and treatment of children and families. The Supervisor shall be familiar with current clinical research and practice to ensure that current empirical findings inform the treatment planning process. If the above-stated minimum qualifications of the Supervisor are not met, additional regular clinical consultation shall be provided at least monthly. Clinical consultants shall be licensed or otherwise recognized as qualified by the state or province in the discipline(s) required for the children and youth served by the Program. Such persons may include, for example, MSWs, psychologists, or professional counselors.

## CASEWORKER

The Caseworker is the practical leader of the treatment team. As such, the Caseworker takes primary responsibility for the development of treatment plans; provides support and consultation to Treatment Parents, to families of children and youth in care, and to other treatment team members related to their role as described in the treatment plan; and conducts advocacy, coordination, and linking activities to ensure children, youth, and families receive needed services available from the Program or in the greater community. Specifically, the Caseworker must perform the functions and meet the qualifications stated below.

## CASEWORKER'S RESPONSIBILITIES AND QUALIFICATIONS

**15. TREATMENT TEAM** — Under the supervision of the Case Supervisor, the Caseworker has primary day-to-day responsibility for leadership of the treatment team. The Caseworker organizes and manages all team meetings. If the Caseworker is prevented from participating in a team meeting by exigent circumstances, the Supervisor assumes that responsibility. As team leader, the Caseworker manages team decision making regarding the care and treatment of the child and support of Treatment Parents and the families of children and youth in care.

The Caseworker provides information and training as needed to treatment team members designated in the Comprehensive Treatment Plan. The Caseworker prepares these individuals to work with Treatment Parents and the child's family in a manner that is supportive of the Treatment Parents' role as well as the safety, permanency, and social-emotional well-being of the child. Additionally, the Caseworker must prepare them to participate in the treatment team in a manner consistent with Treatment Family Care practice and values. The Caseworker shall take an active role in identifying treatment goals and coordinating treatment services provided to children, youth, and their families by persons or agencies outside the Program, whether or not these persons or agencies participate regularly as treatment team members.

**16. TREATMENT PLANNING** — The Caseworker takes primary responsibility for conducting a comprehensive assessment and the preparation of each child's written Comprehensive Treatment Plan, treatment plan revisions, and quarterly written updates, based on the child's assessed needs. The Caseworker informs other team members and involves them in this process, including the child, the child's family, the Treatment Parents, and the funding or referral agency.

Although the Caseworker maintains primary responsibility for preparing, updating, and coordinating the plan, the Program takes ultimate clinical responsibility for the plan, its quarterly review, and any revisions. Sign-off on each plan reflects this overall Program responsibility.

Although treatment planning is the responsibility of the Program, decisions regarding level of treatment may be made by the court, the child’s legal representative, or the public agency that contracts for the service. Those decisions impact the placement of the child. Program Staff have the responsibility of assessing the needs of the child and advocating for the level of care that, in their judgment, best meets the child’s needs.

#### **17. SUPPORT/CONSULTATION TO TREATMENT PARENTS —**

The Caseworker provides regular support and technical assistance to Treatment Parents in their implementation of the treatment plan and with regard to other responsibilities they undertake. Fundamental components of such technical assistance will be the design or revision of in-home treatment strategies and trauma informed care, including proactive goal-setting and planning, and the provision of ongoing child- and family-specific skills training and problem-solving in the home during home visits. Other types of support and supervision should include emotional support and relationship building, the sharing of information and general training to enhance professional development, assessment of the youth’s progress, observation and assessment of family interactions and stress, and assessment of safety issues.

The Caseworker maintains at least weekly contact by phone or in person with the Treatment Parent of each youth on his or her caseload. The Caseworker visits the treatment home to meet with at least one Treatment Parent no less than twice monthly.

During non-crisis and non-adjustment periods, contact with the Treatment Family may take place using computer/video technology. This type of contact must not comprise the majority of contact and shall only be used to supplement face-to-face contact rather than replace it. Only in cases where face-to-face contact would otherwise be impossible should computer/video technology be used in lieu of in-person contact. This option should be considered more frequently in rural communities.

NOTE: It is expected that the frequency of home visits will increase substantially beyond the minimum during the initial 6 weeks of a child’s placement, during and immediately after re-placements within the Program, during discharge planning, during emergency or crisis situations in which youth are considered at greater risk, and as otherwise required by the child’s individual needs and clinical status or the needs of the Treatment Family.

Kin note: Frequent caseworker visits in the immediate days following the placement and/or referral helps ensure families have the necessary resources to meet the child’s needs, to establish a relationship with the kin family, and to develop a plan to ensure they have the support needed to meet the treatment needs of the child.

**18. CASELOAD —** Caseload size may be affected by a number of considerations, including state statute. Special service needs, such as the placement of siblings together, may require the flexibility allowed by a larger maximum caseload. Unusual staffing configurations or service designs, such as a small Supervisor-to-Caseworker ratio or the use of paraprofessional aides, may enhance and broaden the delivery of support services and allow for caseloads beyond the preferred maximum. Caseloads that include children and youth in long-term care who have achieved a measure of stability with a Treatment Family but continue to require specialized treatment may be viewed somewhat differently than caseloads comprising only children and youth newly admitted to the Program. Given such considerations, a degree of flexibility is allowed in this Standard.

- a. The preferred maximum number of children and youth that may be assigned to a single individual is eight (8).
- b. The caseload size should be adjusted downward if:
  - The Caseworker’s responsibilities exceed those described under “Caseworker’s Responsibilities” in this section.

- The difficulty of the client population served requires more intensive support, contact, and training of Treatment Parents.
- The Caseworker’s assignment of Treatment Families covers a large geographic area requiring many hours of travel time.
- The child’s family requires intensive services.
- The Caseworker is working on a regular basis with the child’s biological family, extended family network, adoptive family, or other identified intermittent or permanent placement in addition to the Treatment Family and child.

c. Some circumstances (see above) may allow for a larger maximum caseload size, but in no instance may it exceed twelve (12).

**19. CONTACT WITH CHILD** — The Caseworker or specifically designated Program Staff shall spend time individually with each child in care at least twice monthly. During this time alone with the child, the Caseworker shall create the opportunity for the child to communicate special concerns. The Caseworker shall make a direct assessment of the child’s progress as well as monitor the health, safety, and well-being of the child and work on age-appropriate life skills. Specifics related to such individual contact will be based on the child’s individual needs and detailed in the Comprehensive Treatment Plan.

NOTE: Although infants also must be seen directly by Program Staff according to the above schedule, the “time alone” condition applies on a developmentally and age-appropriate basis.

**20. SUPPORT/CONSULTATION TO FAMILIES** — During a child’s tenure in Treatment Family Care, the Caseworker supports and enhances the child’s relationships with family members. The Caseworker arranges for and encourages regular contact between children and youth and their family as specified in the treatment plan. The Caseworker actively and persist-

ently works to involve the child’s family in treatment team meetings, plans, and decisions and to keep them informed of the child’s progress. Rationales for minimizing family contact must be documented in the treatment plan (e.g., safety issues, legal issues).

Kin note: For kin treatment placements, the Caseworker should help caregivers, the child, and parents manage the complex family dynamics associated with these types of placements, including changing roles within the kin family and maintaining safe boundaries between children and parents.

**21. COORDINATION/COLLABORATION/ADVOCACY WITH THE EDUCATIONAL SYSTEM** — Education is a critical component of a child’s success in treatment, and a positive school experience contributes to placement stability. The Caseworker provides guidance and support to the Treatment Parents in their primary task of interacting with the school regarding the child’s day-to-day successes, challenges, needs, and issues in the school setting. In addition, the Caseworker monitors the child’s educational progress and placement. The Caseworker, as well as the Treatment Parents, shall develop relationships with the child’s teacher, the school counselor, and school administrators. The Caseworker advocates for appropriate placement for the child and referral to special services within the educational system as needed and collaborates with the school and the Treatment Parents to achieve consistency of treatment planning and implementation between the school and the Treatment Home.

**22. COMMUNITY LIAISON AND ADVOCACY** — After a thorough assessment of the child’s needs, the Caseworker will determine which additional community resources may be required and how they may be used to meet the objectives of the child’s treatment plan. The Caseworker advocates for and coordinates the provision of such services and provides technical assistance to community service providers as needed to maximize the benefits of these services to the child.

**23. CRISIS ON-CALL** — The Caseworker, together with other professional Staff as designated by the agency,

shall be on call to Treatment Parents, children, and youth around the clock, 7 days a week. When the child is with his or her family, the Caseworker or other designated Staff are on call for the child and family.

NOTE: Although the Caseworker should always be accessible to other treatment team members as needed, primary on-call responsibilities should be distributed among Staff to allow each Caseworker regular respite from primary and exclusive on-call responsibilities.

**24. QUALIFICATIONS** — The Caseworker shall have a minimum of a Master’s degree in a human services field. In states where it is allowed, the Caseworker may have a BA, BS, or BSW in a human services field with two years’ experience working with children, youth, and families or a BA or BS degree in a non-human services field and three years’ experience working with children, youth, and families as a substitute for the graduate degree. In Canada an acceptable equivalent to the Bachelor’s-level educational requirements would be a diploma awarded through specialized programs offered by some Canadian colleges in child and youth care or applied behavior analysis combined with 3 years’ experience working with children, youth, and families.

## **STAFF SELECTION, TRAINING, AND SUPPORT**

A Treatment Family Care Program is strengthened by attention to Staff selection, by professional development and support relevant to individual job responsibilities, and by the implementation of the Treatment Family Care model.

The standards below refer to training for Program Staff who regularly come into direct contact with children, youth, and Treatment Parents in the course of their job duties as well as for their supervisors, administrators, and managers.

**25. EQUAL OPPORTUNITY** — The Program shall promote equal opportunity with respect to recruitment, selection, training, supervision, and ongoing support of all Program Staff without regard to culture, race, national origin, ancestry, ethnic background, religion,

age, political affiliation, gender, gender identity, sexual orientation, marital status, physical handicap, HIV status, or other medical condition within the context of state/provincial/federal regulations.

**26. CULTURAL COMPETENCY** — Professional Staff must be willing to become culturally competent and be able to demonstrate a level of self- understanding of personal bias and how that bias may impact their interactions with the children, youth, and families served. All Program Staff must be able to accept and understand the importance of cultural issues in family and community life. Staff recruitment plans and efforts should target candidates for positions who share or know about the cultural background of children and youth in care.

**27. AGENCY STAFF TRAINING** — Treatment Family Care Staff providing direct service shall participate in competency-based training prior to assuming casework responsibilities and in ongoing training as scheduled by the agency throughout the year.

Within the first 3 months, education and training opportunities shall include but should not be limited to competencies in the following areas:

- a. The history, development, and current status of Treatment Foster Care and Treatment Family Care
- b. The agency’s treatment philosophy and the specific treatment methodologies the agency employs
- c. Crisis prevention and intervention, including passive physical/manual restraint (if used in the Program), preferably from a standardized behavior management course that includes behavior management practices and verbal de-escalation
- d. Grief, loss, and attachment, issues for children and youth
- e. Trauma related training, the assessment and identification of childhood trauma, and trauma-informed interventions, treatment and practices

f. Significance and value of birth and extended families to children and youth in care, including research on how children living with kin fare better than children with non-kin, including improved placement stability, higher levels of permanency, and decreased behavioral problems

g. Permanency planning

h. Agency policies and procedures, including documentation and evaluation requirements

i. Skills and knowledge needed to work effectively with the educational system, including information regarding rights of children and youth in the educational system and special education programs, and advocacy skills

j. Reasonable and prudent parent standards

k. First Aid, CPR, and Universal Precautions for infectious disease

i. Identifying and reporting child abuse and neglect

m. Supervision and teaching skills

n. Program policies and procedures related to protection of privacy of child and family information

o. Cultural competence: The training curriculum shall be designed to increase knowledge and understanding of the history, traditions, language and communication styles, values, family and social systems, and social customs of the populations served, including those associated with diverse nationalities, ethnicities, religions, and sexual orientations, and to reflect understanding of the diversity between and within cultures

p. Culturally responsive services: The curriculum shall instruct how to incorporate knowledge and understanding of culturally diverse groups into culturally sensitive and culturally effective service delivery, including clinical intervention, treatment planning,

advocacy activities, and strategies to address language barriers

q. Information on the disproportionate representation of children of color in the systems, the roles that individual biases and systems can play in perpetuating disproportionality and disparities, and strategies to advance race equity and inclusion

r. Substance use and abuse and prevention and intervention, including signs, symptoms, and common risk factors for substance use and abuse

s. All state/provincial and accrediting body education or training requirements

At a minimum, ongoing education or training of agency staff shall include:

a. Working with children and youth who may have emotional, behavioral, and/or physical problems or developmental delays and who may have been abused and/or neglected.

b. New information on trauma-informed services.

c. Treatment and care specific to the needs of a particular population being served by the agency (e.g., medically fragile, sexually aggressive, youth who have been victims of sexual exploitation or sex trafficking, immigrant youth, teen parents, developmental disabilities, LGBT).

d. Weekly case consultation to receive ongoing clinical development from the Case Supervisor.

Upon beginning employment, Program Staff must participate in the first available sequence of the agency's preservice training for Treatment Parents.



Kin note: For agencies providing treatment foster care with kin, staff should receive training on the positive outcomes for children living with kin, the differences between engaging kin and non-kin families, the complex family dynamics associated with kin placements, and strategies/skills for addressing the unique needs of kin families.

**28. LIABILITY INSURANCE —** Professional Staff shall be covered by liability insurance. Licensed Staff should carry liability coverage above and beyond that provided by the agency. Agencies must verify that contractors carry liability insurance.

**29. LEGAL ADVOCACY AND REPRESENTATION—**The Program shall have a written policy explaining the assistance that will be provided to Program Staff in obtaining legal advocacy for matters directly related to the proper performance of their professional duties.

## SECTION 2

# TREATMENT PARENTS

## INTRODUCTION

The role of the Treatment Parent is central to Treatment Family Care. Treatment Parents are viewed as colleagues and as part of the professional team. Treatment Parents serve both as caregivers for children and youth with treatment needs (the fostering role) and as active agents of planned change (the treatment role).

Fostering and kinship caregiving responsibilities encompass all basic parenting duties typically required of foster parents and kinship caregivers. Treatment responsibilities, which are outlined below, reflect Treatment Parents' roles as active agents of planned change and integral members of the treatment team. Their primary functions are to provide safety, help to build children's social and emotional well-being, and assist in moving the child to permanency. Treatment Family Care Programs recognize the Treatment Family as the primary locus of intervention with children and youth in their care and seek to integrate rather than substitute treatment services provided outside the home. Treatment Parents are not expected to function independently. They are asked to perform tasks central to the treatment process in a manner consistent with the child's treatment plan and the decisions of the treatment team.

## TREATMENT HOME RESPONSIBILITIES

**30. DESCRIPTION OF RESPONSIBILITIES** — Prospective Treatment Parents shall be provided with and shall review with Program Staff a written list of duties clearly detailing their responsibilities both as Treatment Parents and as foster parents prior to their approval by the Program.

**31. ASSESSMENT** — Treatment Parents shall participate in the assessment process and provide all necessary information relevant to the development of the child's treatment plan.

**32. TREATMENT PLANNING** — Treatment Parents shall participate with the Caseworker and other team members in the development of treatment plans for the child in their care. Treatment Parents contribute vital input based upon their observations of the child in the natural environment of the treatment home, in contact with family members, and in participation in community life.

**33. TREATMENT IMPLEMENTATION** — Treatment Parents shall assume primary responsibility for implementing effective in-home treatment strategies specified in the child's preliminary and Comprehensive Treatment Plans and revisions thereof. Treatment Parents shall be responsible for assisting the child in understanding treatment goals, objectives, and interventions and for helping the child to achieve success. Should interventions not be effective, it is the Treatment Parents' responsibility to collaborate with Program Staff and the treatment team to revise interventions accordingly. Treatment Parents shall receive assistance and support from Program Staff with implementation strategies as needed.

**34. TREATMENT TEAM MEETINGS** — Treatment Parents shall work cooperatively with other team members under the leadership of the Caseworker. Treatment Parents shall have the responsibility to be active and full participants in team meetings, trainings, and other gatherings; to provide input; and to engage with others on the treatment team as required by the Program or by the child's treatment plan. Treatment Parents shall have the responsibility to come to a child's treatment team meeting prepared to present relevant information that contributes to the child's treatment evaluation, assessment, and progress and to fully engage with team members, including the child's family. In extreme situations, should Treatment Parents not be able to attend a meeting, training, or other gathering, Program Staff should work with the Treatment Parents to arrange their participation via video or audio conference.

**35. RECORD KEEPING** — Treatment Parents shall keep systematic, accurate, and descriptive records at all times. Information to be kept as part of the regular records may include the child's behavior and progress in targeted areas, family contacts (such as phone contacts, letters exchanged, e-mails exchanged, face-to-face visitations), appointments (such as medical appointments or counseling appointments), community activities (such as community service activities), and face-to-face contacts with Program Staff. Information should be recorded weekly or daily with frequency determined by the child's treatment plan. Treatment Parents also must systematically record information, log medication administration, and document activities as required by the Program and the standards, regulations, and contractual obligations under which it operates. Such documentation allows for the tracking and evaluation of services provided by the Treatment Family, in the community, in the child's family, and by the Program as a whole.

Treatment Parents shall keep all records private and confidential and share information only with members of the child's treatment team. All HIPAA regulations shall be followed along with organization policy related to record keeping and the privacy thereof.

**36. CONTACT WITH CHILD'S FAMILY** — Treatment Parents shall assist the child or youth in maintaining contact with his or her family, including siblings, and work actively to support and enhance these relationships, unless contraindicated by the child's treatment plan. As part of the concurrent planning process, Program Staff will work with Treatment Parents and the child's family to avoid conflict of interest and confusion for the child or family. Treatment Parents are responsible for positive and meaningful engagement with a child's family, creating a positive relationship between the Treatment Family and the child's family. Treatment Parents will actively support a child's contact with his or her family, including arranging and supervising visitation, providing transportation, and assisting the child in having contact with the family through letters, phone conversations, and e-mail. Additionally, Treatment Parents will have regular contact with a child's family to reinforce the positive relationship, to report on the

child's progress and goals, and to attempt to include the family in events such as birthday celebrations, doctor appointments, and school activities. Unless the child's treatment team has made prior authorization, or the court has ordered such, taking away any form of communication or contact between the child and the child's family should never be used as a consequence for a child's negative behavior.

Kin note: Kin Treatment Parents may need additional support for maintaining safe and appropriate boundaries with the child's family members given their preexisting relationship with the child and parent, and the complexities of changing roles within the kin family.

**37. TECHNOLOGY AND SOCIAL MEDIA** — Each Treatment Family will develop technology rules that are appropriate for their household and consistent with the child's treatment plan. These rules should be developed in collaboration with Program Staff and the treatment team.

Technology devices such as computers, televisions, digital music players, and phones with texting capabilities shall be monitored by Treatment Parents and used in communal spaces in the house. Age-appropriate blocks or filtering systems shall be activated. The Program shall require that children and youth under age 14 have the consent of the Program and the Treatment Parents to access any online resource or technology, including e-mail accounts, social media sites, and other social networking services that request individually identifiable information.

Children and youth of all ages must provide their username and password to the Treatment Parents for any technology that requires such for access. Treatment Parents shall monitor use of the Internet and social media sites. Treatment Parents shall discuss with youth the potential dangers of posting or sharing personal identifying information, such as names, phone numbers, addresses, school name, passwords, and pictures. Treatment Parents shall reinforce with children and youth the importance of privacy and the right to confidentiality and explain that sharing personal information

or identifying information about other foster youth or Treatment Family members is not appropriate.

Each child shall be informed that if he or she ever feels unsafe, bullied, or at risk while using any method of social media, he or she should discuss those concerns with the Treatment Parent(s) or Program Staff.

### **38. PERMANENCY PLANNING ASSISTANCE —**

Treatment Parents shall assist in meeting the child's permanency goal(s). Permanency planning begins at intake and should be consistently worked on and monitored by Treatment Parents and the treatment team to ensure children and youth do not remain in care longer than absolutely necessary and reach permanency in a timely fashion. Such efforts shall include the support and intervention necessary to successfully transition the child to a permanent family, which may include emotional support, information sharing, and demonstration of effective child behavior management and other therapeutic interventions with the child's permanent family. Treatment Parents will maintain positive, supportive relationships with the child's biological family (unless parental rights are terminated for safety reasons or direction from the legal representative/court states otherwise) and will work collaboratively with the child's family to establish timely and successful permanency from the time of intake through discharge.

Treatment Parents shall assist in preparing the youth and shall provide a supportive relationship while he or she is developing self-sufficiency and transitioning to adulthood. Treatment Parents shall assist the child or youth in their care, regardless of permanency plan, to use the results of complete independent living assessments as a tool to help the child or youth to gain skills for his or her transition to independence. This assistance may include helping the youth find housing and employment, enroll in a school or vocational program, link to community supports, and the like. Treatment Parents are encouraged to remain as a continued support to children and youth who enter into Independent Living situations.

When children and youth are available for adoption or become available for adoption while in the Program,

Treatment Parents may be candidates for becoming adoptive parents and may choose to work toward that goal. If Treatment Parents want to adopt children and youth in their care, Program Staff will need to clarify the roles of the Treatment Parents in respect to family involved in the lives of the children and youth. In some situations, the family may support adoption of the child by the Treatment Parents, and a potential goal would be open adoption.

Kin note: Children in kin homes may remain in the permanent care of a relative if reunification is not an option. For children living with kin, adoption or guardianship/legal custody with their current caregiver may be the most appropriate option to prevent an additional move. Due to the unplanned nature of kin placements, permanency options may have not been fully explained or understood by families at the time of placement. Agencies should work with their public partners to ensure that kin receive continuous education about permanency options, the pros and cons of these options, and assurances that they will be given time to consider what works best for their family. This education should include written materials that clearly explain the options. While adoption provides a more legally secure form of permanency, it does not work for all families and some kin families may be more interested in guardianship. Agencies should understand their state-specific options.

**39. COMMUNITY RELATIONS —** Treatment Parents shall develop and maintain positive working relationships with service providers in the community, such as departments of recreation, social services agencies, mental health programs and professionals, and other community resources the child or youth might access. Treatment Parents must always keep in mind that they represent the Program, and they must always represent the children and youth in their care in a positive, professional manner whether in person or when engaging in social media/networking situations or any other form of interaction involving community or public exposure.

It is the Treatment Parents' responsibility to spread awareness of and gain community stakeholder support for Treatment Family Care whenever possible.

**40. SCHOOL RELATIONS** — Treatment Parents shall assume primary responsibility for ongoing relationships with the teachers and administrators in the child’s school. Treatment Parents will monitor school attendance, homework, and academic achievement, actively participate in educational planning for the child, and work with the school to address behavioral or academic problems that may arise in the school setting. Treatment Parents should support and encourage the child’s involvement in age-appropriate extracurricular activities.

Treatment Parents will be aware of and educated about programs and information that could impact children and youth in their care. With the assistance of Program Staff as needed, Treatment Parents will advocate to ensure children and youth in their care receive all needed educational services.

Upon becoming aware that children or youth in their care are facing harassment or discrimination in school, Treatment Parents should take immediate action. Response may include informing Program Staff and school administrators of the harassment and ensuring that steps are taken to respond to harassing and discriminatory behavior.

**41. ADVOCACY** — Treatment Parents, in concert with Program Staff, shall advocate on behalf of the child to achieve the goals identified in the child’s treatment plan; to obtain educational, vocational, medical, and other services needed to implement the plan; and to ensure full access to and provision of public services to which the child is legally entitled. Treatment Parents must be aware of and educated about the services and supports to which children and youth in their care are entitled and actively collaborate with Program Staff in obtaining needed resources.

**42. NOTICE OF REQUEST FOR CHILD MOVE** — It is imperative that children and youth experience stability. Therefore, every effort shall be made to avoid moves to new foster families or kinship caregivers. If a move becomes unavoidable, Treatment Parents shall provide at least 30 days’ notice to Program Staff to allow for a planned and minimally disruptive transition. Less than

30 days’ notice may occur if a move is precipitated by a serious family crisis or is required to protect the health or safety of the child or other Treatment Family members. Whenever possible, alternatives to moving the child shall be explored to prevent placement disruption. Should a 30-day notice be given for a child, it is the responsibility of the Treatment Parents to participate in a direct meeting with Program Staff to discuss interventions that could preserve the placement. If none is found, the meeting participants will discuss proper planning for appropriate transition and for treatment team notification and planning. The child or youth shall be notified as soon as it is clear a transition is imminent.

*Kin Note:* If a child is at risk of disrupting out of their current Treatment Family placement, agencies should make every effort to find and engage placement options within the child’s extended family network. Programs can work with their public partners to identify kin resources throughout the child’s involvement in the Treatment Program in the event that a disruption occurs or the child is ready to transition to permanency and cannot return home.

Because placement stability is paramount in providing successful treatment for children and youth, agencies shall work with Treatment Families whose placements disrupt (except in unavoidable cases such as illness) to address any and all barriers to future successful placements. Agencies must not place children and youth in the homes of Treatment Families who are unwilling or unable to work toward placement stability.

## TREATMENT PARENT QUALIFICATIONS AND SELECTION

Treatment Parent selection begins with the initial recruitment contact and extends through orientation and training. Treatment Parents are selected in part because of their acceptance of the Program’s treatment philosophy and their ability to practice or carry out this philosophy. They must be willing and able to accept the intense level of involvement and supervision provided by the Program in their Treatment Parenting functions

and the impact of that involvement on their family life. Treatment Parents must be willing to carry out all tasks specified in their Program’s job description, including working directly and in a supportive fashion with the families of children and youth placed in their care.

Several qualities are vital when considering prospective Treatment Parents. These qualities include commitment, positive attitude, willingness to implement treatment plans and follow the Program’s treatment philosophy, a sense of humor, enjoyment of children and youth, flexibility, tolerance, and the ability to adjust expectations concerning achievement and progress to children’s individual needs and capabilities. Treatment Families must express openness to children and youth regardless of culture, language, socioeconomic status, race, ethnic background, religion, gender, political affiliation, gender identity, sexual orientation, and ability. Treatment Parents need to approach the commitment to work with a child as a family commitment, informing their own household members of the nature of the Program and the children and youth it serves and involving them closely in the decision to function as a Treatment Family. Treatment Families should be financially stable and demonstrate emotional stability individually and as a family unit. Treatment Parents should have access to reliable backup care and a strong network of social support.

The process of recruiting and selecting Treatment Parents, including respite providers, is key to the success of the Program and should include the following provisions and criteria.

**43. RECRUITMENT** — The Program shall develop and implement a Treatment Parent recruitment plan designed to meet the resource needs of its service population. Recruitment activities must be ongoing in order to have a pool of Treatment Parents from which the Program can select appropriate placement matches for children and youth. Approaches to recruitment vary and can include word of mouth recruitment by treatment families and staff, faith-based community engagement, social media, print and electronic advertisements, feature articles and speaking engagements.

Successful recruitment programs follow no set formulas, but the following guidelines apply:

- a. Recruitment efforts shall be carefully planned and implemented; Programs shall regularly evaluate the effectiveness of recruitment efforts and adjust strategies accordingly; Recruitment plans shall involve key stakeholders, including foster care alumni, current foster parents, foster care workers, community leaders, and other organizations in the community.
- b. Agencies should actively consider kin as possible Treatment Parents, and if kin resources are not immediately available, actively search for, engage, and prepare kin to be future placement options and be involved in the child’s treatment plan.
- c. The Program shall implement targeted recruitment efforts for a particular child if that child has very specialized needs—for example, a child who has a hearing impairment and needs placement with a Treatment Parent who is proficient in sign language.
- d. Programs shall develop and execute plans to recruit Treatment Parents from diverse cultures, languages, socioeconomic statuses, races, ethnic backgrounds, religions, genders, political affiliations, gender identities, sexual orientations, and abilities.
- e. For children and youth who are free for adoption or who are likely to become free for adoption, recruitment should target Treatment Families who would be interested in adopting children and youth placed in their homes.
- f. Although Treatment Parents with one Program may approach another Program to inquire about changing Programs, it is unethical for Programs to direct recruitment efforts to Treatment Parents already affiliated with another Program. When a Treatment Parent seeks to transfer from one agency to another, the receiving agency shall contact the agency holding the current license to discuss the Treatment Parent’s performance and experience with that agency.

g. Staff shall refrain from making negative comments about other agencies' programs.

h. Program Staff should not be Treatment Parents for the Program in which they are employed. In a large agency, it is possible that Staff members who work in other departments could be considered prospective Treatment Parents with the caveat that the Program must guard against potential conflicts of interest arising from dual relationships. If such a situation arises, the senior TFC Program Staff member shall give approval.

**44. LICENSING AND CERTIFICATION** — All Treatment Parents must meet all state/provincial social services, mental health, or other applicable standards for licensed foster parents or licensed kinship caregivers appropriate to the service provided. An initial assessment or "Treatment Home Study" of each Treatment Family must be conducted that covers all elements required by state/provincial licensing regulations and accrediting body requirements. The assessment will include the family's ability to meet the special needs of the children and youth served by the Program. All home studies, home study updates, and home inspections shall comply with state/provincial and accrediting body standards.

*Kin Note:* In some cases, children will already be living with kin and the agency or its public partner is responsible for fully licensing the family as quickly as possible. When working with kin families, agencies must develop processes to assist families to meet the licensing standards, while also weighing the sense of urgency for making the placement as soon as possible to improve placement stability. Programs can work with their public partners to ensure that considerations are made when kin families face barriers to meeting licensing standards that do not impact safety for the child as permitted under federal law.

**45. CHECKS AND REFERENCES** — A background check must be completed for each Treatment Parent and any other adult living in the home. Criminal record checks, sex offender registries, child abuse registries, and FBI fingerprint checks are sources of information for background checks. The sources for background checks will depend on access available in a particular geographic

area. The Program shall collect a minimum of three non-relative references (e.g., employer, neighbor, family physician, or clergy) for each Treatment Family. If a prospective Treatment Parent has served previously as a licensed foster parent for one or more other agencies, every attempt shall be made to access references and information from those agencies as well. The Program shall document such attempts and the resulting information.

*Kin note:* In the case of emergency kin placement, criminal background and child abuse registry checks should be conducted prior to placement in the home. These checks may be conducted by the public agency that has recommended placement with kin or the Treatment Program, depending upon the practice in the jurisdiction.

**46. EQUAL OPPORTUNITY** — The Program shall promote equal opportunity with respect to recruitment, selection, training, supervision, and ongoing support of Treatment Parents without regard to culture, language, socioeconomic status, race, ethnic background, religion, gender, political affiliation, gender identity, sexual orientation, and ability within the context of state/provincial and federal regulations.

**47. CULTURAL COMPETENCY** — Treatment Parents must be willing to become culturally competent, be welcoming and affirming of diverse populations, be willing to recognize their own biases and able to accept and understand the importance of cultural issues in family and community life and in treatment planning.

**48. LANGUAGE** — At least one Treatment Parent shall demonstrate effective communication in the language of the child in the Treatment Family's care and in the language of the Program with which the Treatment Parents engages.

**49. AGE** — Treatment Parents shall be at least 21 years of age.

**50. HEALTH** — As evidenced by a doctor's statement, Treatment Parents should be physically healthy to the degree that they can manage the stress inherent in providing Treatment Family Care.

**51. EMPLOYMENT** — Employment outside the home shall not interfere with the ability of Treatment Parents to carry out the responsibilities listed in the Standards. At least one Treatment Parent must be available to respond to issues or emergencies that arise at school or in a child-care program. Although Treatment Parents' employment may require them to be out of the home during non-school hours, hours of employment or travel required by an employer cannot be so extensive or time-consuming that there is inadequate time to develop relationships with children and youth in care and establish a nurturing family environment. If Treatment Parents are not in the home during non-school hours or during school holidays, the Program must approve alternative child-care arrangements.

**52. TRANSPORTATION** — Treatment Parents shall have access to reliable transportation. If using a car, they shall have valid driver's licenses and documented ownership of liability insurance as required by their state/province.

**53. PHYSICAL PUNISHMENT** — Treatment Parents shall agree to adhere to the Program's policy regarding discipline. Specifically, Treatment Parents must sign a statement agreeing not to use physical punishment and agreeing not to consent to others' use of physical punishment with children and youth placed in their care.

## TREATMENT PARENT TRAINING

Training of Treatment Parents shall be a systematic, planned, and documented process that includes competency-based skill training. Training shall not be limited to the provision of information through didactic instruction, but include creative and engaging methods, such as Treatment Parent self-study or shadowing. Programs are encouraged to allow open discussion after each training session to ensure thorough comprehension of the material. Training shall be consistent with the Program's treatment philosophy and methods and shall equip Treatment Parents to carry out their responsibilities as agents of the treatment process. Treatment Parents shall be involved in determining their training needs.

At a minimum, all Treatment Parents, including both partners of a couple and regular respite providers engaged by the Program, must meet the training requirements outlined below. Additionally, every Program shall ensure that its training requirements comply with state/local regulations and accrediting body guidelines. This list is not meant to be exhaustive but to highlight training topics that, when added to location- and program-specific material, will comprise a comprehensive and valuable curriculum. The requirement for both parents to participate in trainings may pose a hardship for Treatment Parents. Providers are encouraged to assist with child care and supervision as well as transportation to facilitate participation.

**54. PRESERVICE TRAINING** — Prior to the placement of children and youth in their homes, Treatment Parents shall satisfactorily complete primarily skill-based training consistent with the Program's treatment methodology and the service needs of the children and youth. Treatment Parents will also receive an orientation to foster care services. The number of hours of training required should be commensurate with state/provincial and accrediting body requirements and be sufficient to ensure all material is covered adequately. Time spent completing the Program's orientation or home study/assessment process and First Aid and CPR training may not be considered part of this training requirement. However, First Aid and CPR training shall be provided by a certified trainer prior to child placement. It is crucial that Treatment Parents and Program Staff receive training on issues related to birth families and are educated on the importance of permanency and healthy birth-family connections.

Preservice training shall cover policies, procedures, and practices for ensuring privacy of child and family information. Treatment Parents shall demonstrate knowledge and understanding of the provisions for protection of privacy.

Training content should include generic topics relevant to successful parenting and family life, such as relationship building, permanency, cultural competence, child development, and behavior management with a focus on the specialized needs of children and youth in the

Program as well as other topics necessary to prepare Treatment Families. Content may include the following:

a. Topics surrounding child behavior and clinical intervention, including:

- Skills and philosophies supporting effective behavior management
- The needs and common behaviors of children and youth with a history of child abuse and neglect, including sexual abuse
- Principles of trauma-informed care and trauma-informed interventions
- The role of grief, loss, and trauma in the lives of children and youth who have histories of abuse and neglect, including familiarity with the grief cycle and how to respond appropriately, as well as the need for children to live in a permanent, safe, and stable home
- Substance use and abuse, prevention, and intervention, including signs, symptoms, and common risk factors for substance use and abuse
- Information about the clinical model or approach used by the program
- Crisis intervention and de-escalation
- Strength-based parenting approaches that increase and enhance children's well-being

b. Topics surrounding advocacy, including:

- Systems that impact the life of the child, such as the child welfare system, legal system, mental health system, and medical community, and the Treatment Parents' role in relation to each system
- Resources within the education system and the Treatment Parents' role in collaborating with the system and advocating for the child within that system

- Approaches and responsibilities on behalf of themselves and children to achieve treatment goals

- Customer service skills, including communication and coalition building

- Permanency issues related to birth families and the importance of healthy birth-family connections

- Cultural competency training to prepare families to accept and nurture children and youth whose culture, language, socioeconomic status, race, ethnic background, religion, gender, political affiliation, gender identity, sexual orientation, and/or ability differs from those of the Treatment Family

c. Program policies and procedures, including:

- Confidentiality and record keeping, including HIPAA guidelines

- Applicable state/provincial and federal laws and rules

- Information about reasonable and prudent parenting standards

d. Caring for specialized populations served by the Program—for example, teen parents, sexually aggressive children and youth, children and youth with developmental disabilities, youth who are victims of sexual exploitation or sex trafficking, youth in the juvenile justice system, LGBT youth, and children and youth with complex medical problems

Kin note: Placement of children with kin should not be delayed if kin have not yet received or completed training. Training for kin should be flexible and include provisions for in-home and child specific training. Agencies should consider a separate curriculum for kin families that addresses some of the family dynamics associated with caring for kin children and the fact that they have stepped in with little preparation for their caregiving role.

**55. IN-SERVICE TRAINING** — In-service training will be described in a written development plan, which shall be on record for each Treatment Parent. Each Treatment Parent must satisfactorily complete a prescribed number of in-service trainings annually, excluding training in First Aid and CPR, that comply with state/provincial and accrediting requirements and allow for adequate coverage of relevant topics.

a. Training shall emphasize skill development, knowledge acquisition, and preparation related to meeting the needs of children and youth currently placed in the home as well as needs exhibited by the general child welfare population. In addition, training should include program policies and procedures, ethics, and cultural competency.

b. The training may include a variety of formats and procedures such as treatment-specific, in-home training provided by Program Staff, group presentations, or Program-approved external training.

c. Although there is no substitute for the benefits of in-person training, it is acceptable for a portion of training to take place via the Internet or other distance-learning methods. Those trainings, approved in advance by the Program, should have a pre- and post-test component as well as documentation verifying successful completion and comprehension of coursework. The majority of trainings shall take place in person so that Treatment Parents' strengths and needs can be assessed and positive relationships can be developed between Program Staff and Treatment Parents and between Treatment Parents.

d. The professional development plan shall be produced in partnership with Treatment Parents based on the needs of Treatment Parents, the needs of the child placed, and Program and state/provincial requirements.

e. The Treatment Parents' progress toward meeting objectives described in the professional development plan shall be included as a part of the Program's annual assessment of the Treatment Parents' performance.

Kin note: Kin Treatment Parents should have access to continued development and education that addresses the knowledge and skill building needed to meet the treatment needs of the child placed in their home.

**56. EVALUATION OF TRAINING** — All Treatment Parents must be given an opportunity to provide feedback about training.

#### **TREATMENT PARENT SUPPORT**

Treatment Family Care Programs are obligated to provide intensive support, technical assistance, and supervision to all Treatment Parents. Such support and assistance will include the specific case management and supervision services described in Section I of these Standards. Additional types of support and support services shall include:

**57. INFORMATION DISCLOSURE** — All information the Treatment Family Care Program receives concerning a child to be placed with a Treatment Family shall be shared with and explained to the prospective Treatment Family prior to placement, or in the case of a child already placed in a kin home, at the time the family becomes involved in the program. Agency staff will discuss with the prospective Treatment Parents the child's strengths and assets, potential problems and needs, and initial intervention strategies for addressing these areas. As full treatment team members, Treatment Parents have access to full disclosure of information concerning the child. With this access comes the responsibility to maintain agency standards of confidentiality regarding such information.

**58. RESPITE** — Treatment Parents shall have access to both planned and crisis respite. Respite may provide time for Treatment Parents to tend to aspects of life that are not appropriate for child involvement or to expand the child's network of social interaction and family support. Agencies should consider providing regularly scheduled respite time and Treatment Parents should be encouraged to take respite time. To provide for an effective respite experience, a written respite plan shall be developed and reviewed at least quarterly. The respite plan shall list the settings and the individuals

eligible to provide respite and shall include the qualifications of the respite provider(s) and the Program resources available to the respite provider(s). The Program must ensure that respite providers are adequately compensated.

Because crisis respite by its nature can interrupt treatment gains and create uncertainty for the child or youth, Treatment Parents should be encouraged to use planned respite along with behavioral interventions to avoid the need for crisis respite.

When crisis respite is necessary, it is important to repair and restore the relationship once the crisis is over. Program Staff, Treatment Parents, and respite providers must invest time and resources to ensure that treatment plan implementation and a warm transition to and from respite are accomplished.

Respite shall be provided by individuals who have been approved by the treatment team. Respite homes shall meet all standards and guidelines required of other foster homes within the Program and shall not house more than two children with therapeutic needs at any time. Respite providers shall be made aware of the child's needs in order to equip them to provide adequate care and shall be informed of the youth's treatment plan and supervised in their implementation of the in-home strategies as deemed necessary by the treatment team. When possible, the youth's existing supports, such as biological family, friends, or teachers, should be approved and trained as respite providers. Treatment parents may prefer to have respite by another family member or adult who has a relationship with them and the child. In these circumstances, the agency should have a process that allows Treatment Parents to designate individuals they would like to provide respite and a procedure to assess the proposed respite provider for their capacity to provide safe respite care.

The treatment team shall work to ensure that respite is not only valuable to Treatment Parents but also clinically beneficial to foster children and youth. Respite must never be used or threatened as punishment, and crisis respite is to be used only in order to maximize safety or

avoid danger. Respite must not interfere with the child's day to day activities, whenever possible and the participation in the rituals and traditions of family life, such as holiday celebrations or vacations. The respite experience of the youth is to be positive and supportive of the course of treatment.

Kin note: Kin Treatment Parents also need respite, but may not want to leave the child with someone they don't know. The agency should have a process that allows Kin Treatment Parents to designate other members of the extended family network as respite providers, and a procedure to assess the proposed respite provider for their capacity to provide safe respite care in a manner that is consistent with the treatment plan.

**59. AGENCY RESPONSIVENESS** — It is vital that Program Staff be available and responsive to Treatment Parents at all times. When the primary Staff person with whom the Treatment Family has contact is unavailable, the person who is responsible for responding should be familiar with the needs and goals of the Treatment Family and child. This can be accomplished through record reviews and debriefings from the Caseworker.

Additionally, Programs should collaborate with Treatment Parents to ensure that providing for children's needs is not burdensome, especially in instances where a Treatment Parent is expected to maintain employment. This support could include assistance with scheduling and transportation for the child. This aid should not be interpreted as usurping the treatment parents' involvement in the child's important day-to-day activities but instead as a support to ensure that the child's and the Treatment Family's needs are met and to reduce stress and family crisis.

**60. COUNSELING** — Treatment Parents and their children or youth shall have access to crisis counseling arranged by the Program for issues and problems caused by a specific incident related to a child's receiving treatment within the Treatment Family. The Program shall have in writing a plan concerning access to crisis counseling, whether in a separate policy or in the statement of Treatment Parents' rights.

**61. SUPPORT NETWORK** — The Treatment Family Care Program shall facilitate the creation of formal and informal support networks for its Treatment Parents—for example, by creating parent support groups or Treatment Parent “buddy” systems. Such endeavors should be coordinated and guided by Program Staff, ensuring that Treatment Parents understand the limits and requirements of confidentiality as well as helping Treatment Parents to maintain a positive and productive focus on the needs of children and youth.

Kin note: Agencies may want to develop kin support groups or refer Kin Treatment Parents to community-based support groups specifically designed for kin families. These support groups provide an important source of emotional support for kin, help reduce the social isolation they may experience when caring for a child, and enable kin caregivers to receive information and education that is uniquely relevant to their circumstances. Kin support groups should be facilitated by people who understand the unique needs of kin families.

**62. FINANCIAL SUPPORT** — Agency financial support to Treatment Parents must cover the cost of care as well as reimbursement for the difficulty of care associated with their treatment responsibilities and the special needs of the children and youth they serve. As reimbursement rates are often determined by states/provinces, Programs have a duty to advocate for adequate reimbursement rates.

NOTE: The additional financial support given to Treatment Parents over that provided to parents in traditional foster family care system at large is directly related to the special skills, functions, responsibilities, and increased time required of them in fulfilling their role as Treatment Parents.

Kin note: Treatment agencies should advocate for the same level of financial support for kin Treatment Parents as non kin Treatment Parents in the program. Given that kin parents do not receive full financial support until they are fully licensed in some states, treatment agencies should work with their public partners to ensure that families are licensed in a timely

manner and have a mechanism to provide treatment services to the child while awaiting full licensure.

**63. RESOURCES AND INFORMATION** — The Program must provide Treatment Parents with information on resources in the community and state/province as well as nationally to help them care for children and youth successfully. Such information can include an up-to-date list of resources specific to the needs of a particular population being served, such as those with specific medical needs, teen parents, youth who identify as LGBT, immigrants, youth who are victims of sexual exploitation or sex trafficking and others with special advocacy needs, as well as resources generally geared toward foster parenting and, when applicable, adoption or guardianship/legal custody preparation.

**64. DAMAGES AND LIABILITY** — The Program must have a written statement regarding compensation for damages to a Treatment Family’s property by children and youth placed in their care by the Program. The Program also must have a written statement regarding professional liability coverage, including the legal and financial responsibilities of the Program and those of the Treatment Parent, should a claim arise. This statement also should include the types and amounts of coverage required and must be given and explained to prospective Treatment Parents as part of their preservice orientation. Treatment Parents are required to document that they carry homeowner’s or renter’s insurance, general liability insurance, and insurance for any motorized vehicles owned by immediate family members. This documentation and coverage are in addition to any liability and damage coverage provided by or through the Program or the state/province. Although a Program may opt to provide some or all of the required coverage for each Treatment Family, those that do not must be diligent in ensuring that the family’s coverage is current and sufficient to meet state/provincial and accrediting body requirements.

## TREATMENT HOME CAPACITY

**65. PLACEMENT SCOPE** — Determination of the number of children and youth to place within a treatment home must consider the needs and abilities of the child, the Treatment Family, and the Program. When considering the child, the Program must take into account the behaviors and needs of the children and youth served and the intensity of the services required as well as what benefits may be realized from the child's living in the same home as another youth. The potential impact of each child's age, behaviors, and needs on the other must be taken into consideration. Treatment Parents must be assessed for their skills, experience, and support networks and for the ability of the family to meet the individual needs of each person in the home. Treatment Parents' ability can change over time and be influenced by such factors as whether one or both parents work outside the home; the schedules each caregiver keeps; demands placed on caregivers by others living in the home; and the physical makeup of the home (such as the number of bedrooms and their proximity to each other).

Given these considerations, the number of children and youth placed in one treatment home shall generally be one and shall not exceed two without special justification. Such justification may include the need to place a sibling group, the extraordinary abilities of a particular family in relation to the special needs of children and youth, or the potential therapeutic impact provided by the interaction of the children and youth involved.

The special justification for placement of more than two children and youth in a treatment home shall be supported by evidence of the Treatment Family's extraordinary ability in the Treatment Home Study or update. Further, the justification that the child will benefit from such an arrangement must be supported by evidence in the child's Preliminary Treatment Plans and in further detail in Comprehensive Treatment Plans. This documentation must describe how treatment plans will be carried out effectively despite the additional demands on the Treatment Family created by multiple place-

ments. Treatment Parents have the right to refuse placement of any child who they feel is inappropriate for the home or if the placement jeopardizes the safety of children and youth currently in the home.

Rarely can more than two treatment foster children and youth be served effectively in a single treatment home, especially if placed close together in time or in a treatment home that also provides foster care to other children and youth. Programs should consider such variables carefully in decisions regarding multiple placements in a family and respond conservatively in such decisions.

Given the complex nature of determining the advisability of placing more than one child in a treatment home, Programs should not place multiple children and youth in a home when the placement is an emergency and does not allow time for a thorough review of the child's records and in-depth consideration by agency staff. Exceptions to placing multiple children in the home may be made for placement in kin homes when the child is a part of a sibling group, or there are other children living in the home.

Family contact and connections are important for all children and youth in a treatment family care program, and research supports the value of placing sibling groups together. Placement of siblings is not identical to placing the same number of non-related peers in a home. Although it is still vital that the Treatment Family's skills and resources be evaluated and safety concerns be addressed when considering the placement of more than one foster child in treatment home, the placement of siblings must be given special consideration.

## SECTION 3

# CHILDREN, YOUTH AND THEIR FAMILIES

## INTRODUCTION

Treatment Family Care exists to serve children and youth whose special needs are severe enough that, in the absence of such programs, they would be at risk of placement into restrictive residential settings such as hospitals, psychiatric centers, correctional facilities, or residential treatment programs. Treatment Family Care also aims to serve the families of young persons, supporting child-family relationships and, consistent with individual permanency goals, promoting family reunification or alternatives in which children and youth are connected to relationships intended to last a lifetime. In some cases, permanency may be achieved by Treatment Parents' adoption or guardianship/legal custody of children and youth placed in their homes.

The types of special needs exhibited by children and youth in Treatment Family Care may result from a variety of causes, conditions, and diagnostic categories. Children and youth in Treatment Family Care have all experienced the trauma of separation from their birth family and, in most instances, other forms of trauma. In addition, Treatment Family Care Programs typically serve youth with emotional/behavioral disturbances, psychiatric diagnoses, delinquency, developmental disorders, intellectual disabilities, or medical disorders. When making admission and placement decisions, the safety of the children and youth served, the Treatment Families serving them, and the communities within which services are delivered must be considered and addressed in individual treatment plans.

The primary focus of Standards for Treatment Family Care for children and families served in Treatment Family Care is on their rights as service recipients. These rights begin prior to the child's formal placement into a Treatment Family, continue through his or her direct involvement in treatment and other services while in the Program, and extend into the period following Treatment Family Care placement.

Children and youth in Treatment Family Care and their families have a right to services designed to promote healthy interdependence in family relationships and community life. Services to children and youth should not only target the remediation of specific referral problems but also address their needs in all the major developmental areas associated with successful family and community living. Children and youth and their families have the right to participate in decisions about which and how services will be provided to them. They have a right, finally, not to be viewed or treated in isolation from each other. The components of effective Treatment Family Care in relation to children and youth and their families specifically include the following:

### PLACEMENT AND SUPPORT SERVICES

Children and youth and their families have the right to receive all support services described under Sections I and II. They also have the right to be adequately prepared for the child's placement into a Treatment Family, to be involved in the placement decision, to be "matched" with the Treatment Family that best meets the child's needs, and to receive support in maintaining and enhancing their relationships with each other.

**66. PRE-PLACEMENT ACTIVITIES** — Pre-placement activities serve as an introductory process. Guided by the child's needs, these activities allow the child and the Treatment Family to become familiar with each other. A variety of activities may occur to fulfill this function, including day visits, shared activities, and overnight visits when logistically possible. Children and youth referred to Treatment Family Care shall have at least one overnight visit with the Treatment Family with whom they are placed prior to their admission to the Program, except in emergency or kin placements where the child is already in the home. Unless restricted by regulation, the families of

children and youth to be placed shall be given the opportunity to meet with their prospective Treatment Parents prior to placement.

**67. PLACEMENT DECISIONS** — Children, youth, and their families shall be consulted about their preference for placement with specific treatment families. Because the goal of every placement should be advancement toward permanency, permanency planning shall be part of every placement decision. Factors to consider include proximity to the biological family's home/community; ability of the Treatment Family and biological family to interact regularly and in a positive manner; geographical and interpersonal considerations that would impact the Treatment Family's ability to maintain a supportive relationship with a child who achieves independence or after permanency has been achieved; and the Treatment Family's willingness to consider adoption or guardianship/legal custody or be supportive of the child's adoption or guardianship/legal custody into another family.

NOTE: Children and youth generally should have the right not to be placed into a Treatment Family Care Program or with a specific Treatment Family if that is their preference. If the child's and/or the family's preferred option(s) is not possible or is not considered to be in the child's best interest, other preferences they express should be considered major factors in placement decisions. In all cases, youth must be placed in an environment where they will feel safe and supported regardless of culture, language, socioeconomic status, race, ethnicity, religion, gender, political affiliation, gender identity, sexual orientation, or ability.

**68. MATCHING** — Placement will be made only after careful consideration of the child's needs and preferences and the ability and willingness of the Treatment Family to meet the child's needs and to accommodate his or her preferences. A reasonable "fit" for the child is crucial to a successful placement. Important matching variables include but are not limited to the following:

a. Safety issues: The Program must determine whether the child can be safely maintained in a home setting.

b. Treatment Family composition.

c. Willingness and ability of the Treatment Family and the child's family to interact positively and regularly.

d. Willingness and ability to work with significant individuals in the child's life (e.g., extended family, siblings, former caregivers, friends of the family).

e. Treatment Family's ability to speak a language used by the child and the child's family.

f. Children and youth need opportunities to develop an understanding of, as well as positive connection and identification with, their ethnic, racial, cultural, and religious backgrounds as well as their sexual orientation and gender identification. If these opportunities can be fulfilled through placement in a family with a similar background in these areas, there is potential benefit for the child. When children and youth are placed with families who do not share similarities in these areas, the Treatment Family shall receive training in the relevant areas prior to and throughout the duration of the placement. There must be a written plan to connect these children and youth with other children and youth and adults in the community who are similar.

g. Proximity to the child's family and community whenever possible and appropriate.

h. Proximity to the child's current location, especially to maintain school enrollment.

i. Local access to resources required to meet the child's needs.

j. Treatment Parents' specific skills, abilities, and attitudes needed to work effectively with the child to be placed in their care.

k. Willingness to consider adoption if the child is available for adoption or likely to become available for adoption, or willingness to support the child's adoption into another family.

l. In the case of kin families, willingness to adopt if the child cannot return home or to enter into a guardianship/legal custody arrangement if reunification and adoption are not viable options.

m. Treatment Family's willingness and ability to facilitate the child's contact with siblings.

Kin note: When considering kin as Treatment Parents, the agency should have a developmentally appropriate conversation with the young person about their interest and comfort with the kin as a placement option. If the child is already placed in the kin home, he or she should be engaged in conversations about satisfaction with that placement. Programs should also provide kin with the requirements for becoming a Treatment Parent and assess their willingness and capacity to meet these requirements.

**69. SPECIAL POPULATIONS** — Along with a growing recognition of the value of Treatment Family Care has come an expansion of the needs of children and youth considered appropriate for this treatment. Examples of these populations are children and youth with complex medical needs, children and youth with sexually aggressive behaviors, children and youth with developmental disabilities or dual diagnoses, immigrant children and youth, victims of sex trafficking and sexual exploitation, and young parents. Programs must decide which populations they are equipped and qualified to serve and incorporate those decisions into the referral process. Before accepting special populations, Programs must ensure they have at minimum:

- Extensive knowledge of the population served to ensure effective assessments, matching, interventions, and supports
- Available Treatment Parents who have the training and experience needed to manage unique needs
- Clinical and medical professionals on the treatment team who have the expertise to work with the population

- Curricula for staff and foster parent trainings to address the population's unique service, education, and safety needs
- A portion of required training hours dedicated to the needs of the unique population
- Access to medical and community-based services and equipment to support the unique needs of these populations
- Availability of special resources for use by Treatment Parents
- Appropriate risk management protocols in place, including crisis stabilization

**70. CHILD'S ACCESS TO AGENCY STAFF** — Children and youth shall have the right to access Program Staff on both a regular and an emergency basis and may request to meet alone with any Staff member. Children and youth shall be provided with an age-appropriate handbook that includes regular and emergency telephone numbers of the agency and emergency numbers external to the agency. Children and youth will be provided with the agency address and phone numbers at which they may contact their treatment team members.

**71. CHILD'S ACCESS TO PUBLIC AGENCY OMBUDSMAN** — Children and youth shall have the right to access the public agency's ombudsman or other person designated to serve as an advocate for the child in ensuring his or her rights are met and grievances are heard and addressed.

**72. CHILD-FAMILY CONTACT/RELATIONSHIPS** — Children and youth in Treatment Family Care shall have access to regular contact with their families as described in their treatment plan. Unless specifically prohibited by court or custodial agency decision, the Treatment Family Care Program shall work actively to support and enhance child-family relationships and work directly with families toward reunification where that is the goal of the treatment plan. Specific activities to be undertaken in this regard shall be described in the child's treatment plan.

Even when the child's plan does not include reunification, the Program shall actively work to support and enhance the child's relationships with his or her parents, siblings, extended family members, and significant others in the child's community. If Treatment Parents want to adopt a child or youth in their care and parental rights are intact but the child is likely to become available for adoption, issues of concurrent planning must be addressed. The potential conflict of interest this situation could create may complicate the Treatment Parents' relationship with the child's family and must be taken into account in regard to interactions between the Treatment Parents and the biological family.

**73. CHILDREN AND YOUTH REENTERING FOSTER CARE —** If a child is reentering the foster care system and is not placed with kin, the child's former Treatment Parents shall be given first consideration for placement of the child.

## TREATMENT

Foster children and youth have the right to receive direct treatment and related services that are planned to ameliorate the specific problems associated with their placement in Treatment Family Care and that address their social, emotional, cognitive, and physical needs in major developmental areas. Treatment assumes written plans with clearly specified procedures and services designed to achieve measurable goals within a set period of time and with regular assessment of progress as outlined in Standard 4, Treatment Planning. Whenever possible, treatment methods should be based on research findings that support their use and efficacy.

**74. TREATMENT MODEL —** Programs shall follow an articulated treatment model that is comprised of components that are either evidence-based or evidence-informed. Treatment Parents and Staff shall receive pre-service training as well as annual training in the skills and knowledge necessary to effectively implement the treatment approach.

**75. TRAUMA-INFORMED CARE —** It is recommended

that any model used is one that acknowledges and responds to the role of trauma in each child's life. Assessment instruments must measure trauma and its impact. There is value in applying the principles of trauma-informed care to biological family members as well to make sense of the strengths, deficits, and needs of all those involved in treating the child and pursuing permanency. Programs shall ensure that Staff and Treatment Families understand the impact of trauma on the developing brain and have tools to respond to children and youth who have experienced trauma.

**76. PLACEMENT STABILITY —** Placement stability is paramount in producing successful treatment outcomes for children and youth. Treatment must be geared toward providing stability for children and youth, ensuring they encounter as few moves as possible. The Program must work diligently to prevent movement, striving to predict and remedy situations that could result in a placement disruption. When a change in placement cannot be avoided, the Program shall provide intensive support to the child during the removal and subsequent placement process and priority should be given to placement with a child's kin network. If deemed necessary by the treatment team, the Program shall arrange for additional therapeutic or other needed services for the child or youth.

Kin note: research shows that children living with kin experience greater stability than children in non-kin placements. Placement stability is a key reason why Programs should make every effort to engage kin as Treatment Parents.

**77. PERMANENCY PLANNING —** Every child in placement needs security, stability, and continuity of living environment and relationships. Competent treatment includes plans for permanent, lasting relationships. Permanency planning includes assessment and treatment of the child and family that focus on opportunities for the child to have ongoing active and meaningful connections to family, kin, and community. The permanency plan shall be reviewed in conjunction with reviews of the treatment plan. Planning for permanence shall include the following:

a. **Goal of Placement:** A goal for achieving permanency and continuity of relationships shall be included in the Comprehensive Treatment Plan and shall be reviewed at the time of quarterly progress reports. Acceptable permanency placement goals include permanent placement with family (nuclear or extended), adoption, guardianship/legal custody, and independent living with permanent supportive resources in place. Permanency planning must take into account a long-term, stable, and permanent placement for the child. Long-term foster care is not an acceptable permanency plan.

Kin note: If the child is not already with kin, programs have a responsibility to continuously search for and engage a child's extended family network throughout their time in the program. Kin can be an important source of support and provide a sense of family belonging for the child, regardless of the permanency goal. These individuals may also be appropriate options for adoption or guardianship/legal custody if the child cannot return home.

As with all treatment planning, permanency planning must be done in concert with meeting clinical goals and meeting the treatment goals established for the child. Although a swift move to permanence is encouraged, Programs are responsible for ensuring that the pacing of meeting that goal is clinically supportive of the child.

Regardless of the permanency plan goal, Programs must take steps to provide children and youth with networks of caring, supportive, and appropriate adults with whom they can choose to maintain involvement. These adults may include current and former Treatment Parents, kin, educators, peers, mentors and members of their community.

b. **Implementation Plan:** The permanency plan, in the context of the Comprehensive Treatment Plan, shall describe specific tasks to be carried out in order to achieve the permanency goal. The plan shall include strategies to promote permanency plans. These strategies and tasks may include:

- Addressing behaviors that place the child at risk for placement disruptions.

- Directing activities to prepare the child's family or kin network for reunification where reunification is the goal.
- Conducting a search for kin, or other appropriate involved adults if no appropriate biological relatives have been identified, for permanent placement. When placement with identified kin is not possible, efforts should be made to engage kin in the lives of the youth.
- Recruiting and training families for adoption or guardianship/legal custody, if appropriate
- Identifying other less restrictive living environments such as supervised independent living and preparing youth for transition to these settings when permanency planning in a family setting has not yet been achieved.
- Providing for healthy, functional relationships with family, including parents, siblings and extended family, regardless of the permanency goal

c. **Treatment Family Role in Permanency:** The Treatment Family is vital to the permanency process. Treatment Parents must:

- Maintain positive and informative interactions with the designated permanent placement
- Maintain positive and informative interaction with supports in the child's life who will continue a positive and active role as part of his or her permanency
- Assist in preparing the child for permanence through keeping him or her informed of plans and progress toward permanence; helping the child to build positive connections with people who will serve as long-term supports; and assisting the child in building developmentally appropriate skills needed for the transition to adulthood.

d. **Permanency-Related Services for the Treatment Family:** The Program shall offer concrete and emotional

support to the Treatment Family during and after the permanent placement process. The Program shall ensure that the Treatment Family understands the permanency plan from the time of placement and is given frequent updates on progress toward permanency. The Program shall give Treatment Parents clear guidelines and expectations regarding relationships with the birth family or other identified permanency placements. The Program shall provide support as the Treatment Family carries out functions necessary to attain permanency, such as coordinating and attending visits and maintaining positive communication.

The Program shall offer emotional support and guidance through the process of separating from the foster child and provide information and support in predicting—and later experiencing—feelings of grief and loss related to the child’s departure. The Program shall provide the Treatment Family with clear guidelines and expectations for contact after the child attains permanency. In cases of successful adoption or guardianship/legal custody, the Program shall advise the Treatment Family on appropriate boundaries for contact with the child and the adoptive or guardian family. The Program shall provide information on the potential for failed adoption or guardianship/legal custody and on predicted reactions of both the Treatment Family and the child and offer strategies for responding to such reactions.

**e. Permanency-Related Services for the Child:** The Program shall offer practical and emotional support to the child during the permanent placement process. The Program shall work in collaboration with the Treatment Family to keep the child apprised of timelines and developments in the process. In cases of successful adoption or guardianship/legal custody, the Program shall collaborate with the biological family and the Treatment Family to outline appropriate boundaries around contact between the Treatment Family, the child, and the adoptive or guardian family. In addition, the Program shall offer the adoptive or guardian family and child information and support in predicting—and later experiencing—feelings of grief and loss related to the child’s separation from the Treatment Family. In the

event of a failed adoption or guardianship, the Program shall offer supportive counseling for the child and work in collaboration with the Treatment Family on implementing strategies for helping the child deal with the resultant reactions.

The agency shall assess and ensure the readiness of the permanent placement. If another provider (such as an adoption agency) is leading the way, the Program must maintain frequent communication to ensure a collaborative relationship and movement toward permanency as well as to share information. If the agency is the only entity working with the permanent placement, such as when reunification with family is the goal, the Program is responsible for using the treatment planning process to work with the treatment team (which should include the identified permanent resource) to establish goals and overcome barriers in order to assess readiness and facilitate permanency.

The agency shall work with state/provincial agencies, courts, outside clinicians, and schools to overcome barriers to permanency.

**f. Concurrent Planning:** The treatment team shall agree on a concurrent plan for permanency, outlining the steps to be taken should the primary permanency plan become impossible to achieve. Concurrent planning must meet all the requirements of permanency planning.

**78. WORKING WITH FAMILIES** — The youth’s family members must be included in assessment and treatment. When family members are part of the permanency plan—such as for reunification, adoption, or guardianship/legal custody—they also need to be part of the treatment team and engaged in treatment planning. Even when the child’s permanency plan does not include return to family, the biological family must be included in treatment to the extent that it is clinically suitable and legally possible to do so. Family may be used as respite providers, emotional supports, mentors, and role models and should be considered resources to serve as long-term supports and positive influences in the child’s life even after exiting care. The Program must provide kin with support and information to help them

effectively guide and care for the child within the framework of appropriate boundaries. The family should be linked to the Treatment Family and given regular updates on progress and pertinent information regarding the youth's treatment, education, medical status, and other factors affecting his or her safety and well-being.

**79. SOCIAL-EMOTIONAL WELL-BEING** — All treatment planning and implementation must address the social and emotional well-being of the child as an element equal to safety and permanency. The four domains of well-being identified by the Administration on Children, Youth, and Families are:

- a. Cognitive functioning
- b. Physical health and development
- c. Behavioral/emotional functioning
- d. Social functioning

Healthy functioning within each domain will vary based on the youth's age and developmental status. Contextual factors such as environmental supports, family economic stability, and personal characteristics of the child must be taken into account as well.

Programs must continuously assess the well-being of children and youth, measure changes over time, and adjust treatment planning accordingly. It is recommended that a variety of assessment tools be available to the Program so that all four domains can be assessed.

Finally, programs must use evidence-based or evidence-informed treatment approaches—or components of those approaches—that are proven to increase and enhance children's well-being. Treatment Parents must be trained and supported in parenting approaches that do the same.

## IN CLOSING

These *Program Standards for Treatment Family Care* create a guide for developing quality services and assist in defining the essential elements of Treatment Family Care. The FFTA encourages the use of these Standards as a mechanism for agency evolution and program development and for enhancing quality improvement processes. As our collective experience, empirical knowledge base, and structures for service delivery evolve, so too will these Standards.

The Family Focused Treatment Association will reevaluate these Standards every few years. Feedback from member agencies, funders, consumers, and experts is encouraged and can be directed to the FFTA office, Board members, Chapters, or Committees. Such feedback, together with self-assessment data from member agencies and empirical studies, will be utilized in subsequent revisions.