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Introduction:

Treatment Foster Care is an essential part of the State of Maine's children's service delivery system. Treatment Foster Care is provided in a specialized foster care setting, contracted with, and supported by, a licensed child placing agency under contract for such services with the State.

A Treatment Foster 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 foster 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, which are logically described and justified within the framework of a consistent treatment philosophy. As a program, Treatment Foster Care is agency-led and team-oriented. It is not simply the provision of higher payment and more training to foster parents for work with more difficult children and youth. Nor is it solely the addition of therapeutic resources external to the treatment foster 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 receives flexible services over time to meet their changing needs. Treatment typically involves the teaching of adaptive, pro-social skills, and responses which equip young persons and their families with the means to deal effectively with their unique conditions or individual circumstances which 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 them, and a process for assessing the results. Treatment accountability requires that goals and objectives be time-limited and outcomes systematically monitored.

As part of an individualized approach to treatment, children's levels of care and movement between levels are 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.

When it is determined that a child needs less intensive treatment within the framework of the Treatment Foster Care Program, treatment services will be reduced. There should also 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.

During the ongoing treatment planning and revision process, Program Staff, Treatment Parents or public agency caseworkers/legal guardians may suggest a Levels of Care Review based on the changing treatment needs of the child. Change in level of care should always be based on a change in treatment needs rather than an automatic change dictated by time spent in the Program. It is the responsibility of Program staff to provide input into decisions regarding the level of care that is made by another professional or entity and to advocate for the level that best meets the needs of the child.

Treatment Foster Care is family-based. The treatment foster family is viewed as the primary treatment setting, with Treatment Parents trained and supported to implement key elements of treatment in the

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context of family and community life while promoting the goals of permanency planning for children in their care. While 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 is a team function carried out under the clinical direction of qualified Program Staff.

Treatment Foster Care serves children and youth whose special needs cannot be met in their own families or who are unable to live at home due to neglect and/or abuse and for whom a more permanent living arrangement is currently not available.

While many Treatment Foster Care programs focus on services to children and youth with serious emotional and behavioral disturbance, the term "special needs" may apply to any clinical problem or handicap - whether of an emotional, behavioral, medical, delinquent, intellectual or developmental nature. In addition to providing treatment for specific problems or conditions, Treatment Foster Care seeks to promote a permanent family living arrangement for the children and youth served.

Treatment Foster Care Programs also serve the families of children and youth and seek to involve children 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 that respectfully embraces cultural diversity. This includes the recognition that promoting family reunification can be facilitated by Treatment Foster Care that is delivered in the child's and family's community. Treatment Foster 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.

A. PROGRAM STATEMENT

As an accountable human service, a Treatment Foster Care Program shall develop a Program Statement that describes its administrative structure, policies, and procedures. This Program Statement, in addition to content areas required by their licensing and/or other administrative authority, shall describe its mission, organizational structure, services, policies, record-keeping and evaluation procedures. The Program Statement shall include:

1. The Program's treatment philosophy and the specific treatment modality (ies) it employs.
2. The services the Program provides.
3. The process for matching; for developing, implementing, and monitoring the service plan; for assessing the progress of the child; for discharge planning, and safety protocols.
4. The children it is designed to serve with regard to age, gender, geographic service area and types of special needs the Program is prepared to address.
5. A staffing pattern which allows for the intensity of service required in Treatment Foster Care.
6. An assertion of the Program's commitment to being representative of the community which it serves, reflecting the cultural diversity of that community in the composition of its staff and treatment parent population.

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7. A policy committing the Program staff and Treatment Parents to practices that respect and promote positive birth family connections and positive cultural or ethnic identity.

8. A policy that affirms that the primary use of behavior management strategies will be to teach pro-social, adaptive behavior rather than simply reduce or eliminate undesirable behaviors.

9. A policy on the use of medication that commits the Program to the following principles and practice:

   (a) The first line of intervention with children and youth should be non-medical unless clear research evidence indicates otherwise for a particular condition. When a physician prescribes psychotropic medications, they should be used together with other interventions where such interventions may also contribute to remediation of the problem or safely reduce reliance on medication alone.

   (b) All prescribed medication shall be stored in an inaccessible and/or locked location.

   (c) 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 in their care.

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

10. A policy on discipline which includes a description of acceptable methods of control and discipline, a prohibition of corporal punishment, and a discussion of specific types of discipline which are unacceptable. Unacceptable discipline procedures include the loss or threat of loss/restriction of a child's contact with his/her parents, the denial or threat of denial of mail sent to the child, threats of removal from the treatment home, threats of physical harm, denial or threats of denial of basic needs including meals, emotionally demeaning or humiliating actions or consequences, and physically intrusive discipline.

11. A policy on the use of restraint prohibiting the use of chemical or mechanical restraint or seclusion (e.g., in a locked room) and stating that passive physical restraint is justified only in an emergency situation with the risk of immanent harm or danger to the individual or others and to protect the child or others from injury or to prevent serious damage to property. The policy shall further state that if necessary and justified, passive physical restraint will be used only by persons who have been trained in its use and will not be employed as discipline and shall be outlined in the child's treatment plan. Program policies and procedures shall define the type of passive restraint permitted and the training required. The policy shall further specify the forms, timelines and procedures for documenting and reporting each incident of physical restraint.

12. A policy describing the Program's response to the disruption of a child's placement, including:

    - Back up emergency care.
    - Documentation of efforts to maintain the placement prior to disruption.

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- Efforts made to re-place the child, in collaboration with the Office of Child & Family Services, with a treatment family within the agency; or if not possible, efforts made to secure a new placement.
- Efforts of agency staff and foster parent to support and transition the child to the new placement.

13. A written protocol for responding to and reporting allegations of misconduct toward children, consistent with the reporting laws for child abuse/neglect as well as potential licensing violations. 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.

14. A written protocol for investigating and responding to potential harm or danger to the treatment family or the community.

15. A policy on confidentiality consistent with HIPPA & Title 22 MRSA, Section 4008. This policy should include procedures for the handling of sensitive information about child/youth or about members of their biological family or about any other person.

16. A policy requiring written informed consent for participation of children, youth, family members, Treatment Parents or Program staff in research and evaluation.

17. A policy requiring compliance with Maine's Transfer of Foster Home's Policy. Further, the policy must also address the transfer of families who do not currently have children in placement.

18. A policy describing the Program's selection criteria (standards) for foster parents to be accepted or continued in the program.

B. PROGRAM EVALUATION

Evaluation is essential for programmatic self-knowledge, self-improvement and accountability. Information concerning service delivery and impact must be collected, reviewed and analyzed to maintain, improve and document sound Treatment Foster Care Program operations. Such information will be needed for subsequent review and revision of these Standards. At a minimum, Treatment Foster Care Program evaluation efforts should address the following:

1. **Documentation of Service Delivery**: A treatment Foster Care Program shall clearly document delivery of all services described in its Program Statement as well as compliance with the Program Statement described above.

2. **Individual Treatment**: Treatment Foster Care Programs shall document the implementation of all treatment plans and track progress on all long and short-term treatment goals throughout each child's/youth's tenure in the program.

3. **Staff Performance Evaluations**: Programs shall provide Program staff with ongoing feedback regarding performance. Programs shall provide Program staff written performance evaluations at least annually which summarize ongoing supervision feedback and include descriptive assessments of their

performance of specific job responsibilities and goals for improved performance.

4. **Treatment Parent Evaluations**: Programs will provide Treatment Parents with ongoing feedback regarding performance. 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, including assessments of skills and challenges, management of crisis and difficult situations. Evaluations of Treatment parents may be included as part of the re-licensure of all foster parents in accordance with Program and state requirements.

5. **Program Evaluation**: Programs shall have a program evaluation plan which describes information to be collected, summarized and analyzed at least annually. The plan will detail process, outcome and consumer satisfaction data. Programs will collaborate with the Department regarding outcome data. The plan will describe informed consent procedures, Program procedures for reviewing the ethics related to evaluation and research efforts, and who will have access to the evaluation information and its use.

a. Process data shall include:
   (1) Demographics on current children, youth and their families and Program staff.
   (2) Aggregated information describing in-program events including moves within the program, critical incidents and treatment gains.
   (3) Statistics regarding the number of disrupted placements and their reasons as well as the number of successful placements.

b. Consumer satisfaction data shall provide for periodic evaluations of program services by children, youth, families, Treatment Parents and referring agencies. Such data shall include feedback on consumer satisfaction and support for family involvement.

C. PROGRAM STAFF

Professional Treatment Foster Care staff performs several roles and carry a wide variety of responsibilities. Responsibilities of a Treatment Foster Care Program includes: Case Management; Rehabilitative Services; Family Visitation Services; Clinical Services; Parent Support; and Clinical and Administrative Supervision of staff.

FUNCTION	DESCRIPTION	MINIMUM STAFFING QUALIFICATION
Case Management	Coordination of services, Advocacy, Transition planning, Development of treatment plans, Support/consultation to foster parents, families of children in care.	Bachelor's Degree from an accredited four (4) year institution of higher learning with a specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, child development, special education, counseling, rehabilitation, sociology, nursing or closely

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		related field.

The role of the Case Manager is the practical leader of the treatment team. As such, the Case Manager takes primary responsibility for the development of treatment plans; provides support and consultation to treatment foster parents, to families of children in care and to other treatment team members related to their role as described in the treatment plan; and advocates for, coordinates and links children/families with needed services available within the Treatment Foster Care Agency or in the greater community. Specifically, the Case Manager must perform the functions and meet the qualification stated below.

Primary responsibility for development of Treatment Plans:

•Provides information and training, as needed, to Treatment Team members. The Case Manager prepares these individuals to work with treatment parents in a manner, which is supportive of the treatment parents' role and prepares them to participate in the Treatment Team in a manner consistent with treatment foster care practices and values.

•Takes an active role in identifying the goals and coordinates the services provided to children, youth, and their families, by persons or agencies outside of the Treatment Foster Care Program, whether or not these persons or agencies participate regularly as Treatment Team members.

•Takes primary responsibility for the preparation of each child's written Individualized Service Plan and of quarterly updates. The Case Manager informs and involves other team members in this process, including the child, the child's family, the treatment parents, the legal guardian, and the funding or referral agency. While the Case Manager maintains primary responsibility for preparing, updating and coordinating the plan, it should be noted that the Program, through qualified supervision of the Case Manager, takes ultimate clinical responsibility for the plan, its quarterly review and revisions, and its success in meeting the treatment needs of the child. Sign-off on each plan reflects this overall responsibility.

Provides support & Consultation:

•Will provide regular support and technical assistance to the treatment parents in their implementation of the Individualized Service Plan and with regard to other responsibilities they undertake. This may include the design or revision of the in-home treatment strategies, proactive goal-setting and planning,

on-going child- specific skills training and problem-solving in the home, assessment of foster parent skills and challenges regarding child management, and development of safety protocols for crisis situations. 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/assessment of family interactions and stress, and assessment of safety issues.

•Will provide at least weekly contact by phone or in person with the treatment parent(s) of each youth on his/her caseload. The Case manager will visit the treatment home to meet with at least one of the treatment parents no less than twice monthly, with at least one visit to include the foster child in order to observe and document the parent-child interaction and that the needs of the child are being met. It is expected that the frequency of home visits will increase substantially beyond the minimum during the initial six weeks of a child's placement, during and immediately after re-placements within the Program,

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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/clinical status or the needs of the treatment family.

•Will spend time individually with each child in care at least once monthly. During this time alone with the child, the Case manager shall create the opportunity for the child to communicate special concerns, and shall make a direct assessment of the child's progress, as well as monitor the health, safety, and well-being of the child. Specifics related to such individual contact will be based on the child's individual needs and detailed in the Comprehensive Treatment Plan. While infants also must be seen directly by the Case Manager according to the above frequency, the time alone condition applies on a developmentally and age-appropriate basis.

•Will support and enhance the child's relationships with birth family members in conjunction with child's DHHS caseworker. The Case Manager will arrange for and encourage regular contact between children and their birth parents and other family members as specified in the treatment plan. The Case Manager will actively and persistently work to involve the child's birth parents 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, etc.)

<u>Advocacy & Service Coordination:</u>

•Will determine which community resources are required and how they may be used to meet the objectives of the child's treatment plan, based on a thorough assessment of the child's needs. The Case Manager will advocate for and coordinate the provision of such services and will provide technical assistance to community service providers as needed to maximize the benefits of these services to the child.

•Provides guidance and support to the treatment parents in their primary role of interacting with the school regarding the child's day-to-day successes, problems, needs and issues in the school setting. In addition, the Case Manager monitors the educational progress and placement of the child. The Case Manager, as well as the treatment parents, shall develop a relationship with the child's teacher, the school counselor, and school administrators. The Case Manager advocates for appropriate placement for the child and refers 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.

<u>Caseload:</u>

The preferred caseload size for each Case Manager will vary between eight (8) and twelve (12) clients. Caseload size may be affected by a number of considerations, including but not limited to:

•Placement of siblings together
•Small Supervisor to Case Manager ratio
•The use of paraprofessional aides
•Children who have achieved a measure of stability in a treatment family
•Caseload consisting of many newly admitted clients
•The difficulty of the client population served requires more intensive support, contact, and training of foster parents
•Assignment of treatment families covers a large geographic area requiring many hours of travel time
•The clients family requires intensive services

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Rehabilitative Services	Rehabilitative services are designed to improve member's instrumental functioning in daily living, emotional and physical capability in areas of daily living, community integration and interpersonal functioning.	Other Qualified Mental Health Provider
Family Visitation Services	Family Visitation Services are designed to promote positive interactions and familial connections.	Other Qualified Mental Health Provider or Other qualified licensed treatment foster care provider
Clinical Supervision	Reviews and approves treatment approaches/interventions as documented in the ISP, provides clinical supervision to OQMHP and Professional Staff, Provides clinical consultation to treatment teams. Weekly supervisory meetings with case managers are recommended.	Clinical Supervisory staff must be conditionally, temporarily, or fully licensed and approved to practice as documented by written evidence from the appropriate governing body.
Crisis Services	Together with other professional staff, as designated by the agency, shall be on-call to treatment parents, children, and youth on an around-the-clock, 7-day-a-week basis.	Caseworkers, Supervisors, or designated on call staff.