

	<p>Department of Human Services  <b>CHILDREN, ADULTS &amp; FAMILIES</b></p> <p>RESOURCE MANAGEMENT MANUAL II</p> <p>ISSUED BY: Program Operations  EFFECTIVE DATE: January 2, 1996</p>	<p>NUMBER: II-E.1.2  OAR: 413-210-0400 thru 0480</p> <p>SECTION: E. Licensing  Residential Care</p> <p>SUBSECTION: 1. Child  Caring Agencies</p>
<p>SUBJECT: 2. Treatment Foster Care - Oregon Administrative Rule</p>		

**Interpretation:** Manager,  
Resource Development Unit

**Approval:** Assistant Administrator,  
Program Operations

**REFERENCES:** Pam 9005, Procedures and Guidelines for Treatment Foster Care

**PURPOSE**

**413-210-0400** Treatment Foster Care is a program for children, youth and their families whose out-of-home treatment needs can be met through services delivered by treatment foster parents, and/or professional staff trained, supervised and supported by an agency. These rules set standards for the operation of a Treatment Foster Care Program. All agencies under contract with SOSCF to provide this service, or proposing to provide this service, must adhere to these rules.

**Statutory Authority: HB2004**

**Stats. Implemented: HB2004**

**DEFINITIONS**

**413-210-0410 (1) "After Care":** The plan which outlines the services and resources that will be needed when the child leaves the treatment foster care program.

**(2) "Agency":** A public or private organization which contracts with SOSCF to provide treatment foster care services.

**(3) "Agency Staff":** A person employed by the treatment foster care program who gives support to the treatment foster parent or the child/family, (for example, the treatment specialist or clinical supervisor).

**(4) "Clinical Supervisor":** A person employed by the treatment foster care program who provides support, supervision and consultation to the treatment specialist and/or the TFC foster parent.

**(5) "Crisis-On-Call":** Twenty four hours-a-day, seven days-a-week availability, either by phone or in person, for the provision of emergency and/or back-up services.

**(6) "Matching":** The process of placing the child in a home that can specifically

meet the individual treatment needs of that particular child. These needs include, but are not limited to, a foster parent's ability to speak the language of the child, the home's proximity to the child's family, and same race, ethnicity and culture.

**(7) "Permanent Plan":** A plan designed to provide a safe and permanent family resource with the parents or other people who will assume legal responsibility for the child during the remaining years of the child's dependency.

**(8) "Respite Care":** A temporary arrangement of 12 hours or more, to allow the treatment foster parent(s) time away from the child.

**(9) "Treatment":** The coordinated provision of services designed to produce a planned outcome in a person's behavior, attitude or general condition. Treatment is based on a thorough assessment of factors contributing to the attitude, condition or behavior.

**(10) "Treatment Foster Care":** The model of treatment in which a child receives treatment in the foster home from the foster parent who is under the supervision and support of a professional therapist of an identified program.

**(11) "Treatment Foster Care Program":** A separately identifiable unit of a larger agency or an independent agency itself.

**(12) "Treatment Foster Parents":** In-home treatment providers of a TFC program who implement treatment strategies identified in the treatment plan in addition to carrying out their regular foster care responsibilities.

**(13) "Treatment Plan":** A course of individualized treatment which considers the child's needs and is developed by the treatment foster care program in conjunction with the treatment foster parent(s) and SOSCF.

**(14) "Treatment Specialist":** A person employed by the treatment foster care program who provides training, supervision, support and consultation to the TFC foster parent.

**(15) "Treatment Team":** Those people concerned with the care and treatment of the child. The team may be comprised of, but is not limited to, the treatment foster parent(s) and the treatment specialist.

**Statutory Authority: HB2004**

**Stats. Implemented: HB2004**

## POLICY

**413-210-0420** Children and youth appropriate for treatment foster care have serious emotional and/or behavioral disorders. The level of supervisory treatment and family intervention needs of these children is comparable to those served in residential

treatment facilities. Treatment foster care consists of:

(1) A treatment foster care agency with staff who give support to the treatment foster parent and the child/family; and

(2) Treatment foster families who implement treatment strategies identified in the treatment plan in addition to carrying out their regular foster care responsibilities.

**Statutory Authority: HB2004**

**Stats. Implemented: HB2004**

### TREATMENT FOSTER CARE PROGRAM

**413-210-0430** A treatment foster care program must be a separately identifiable unit of a larger agency or be an independent agency itself.

#### (1) Eligibility.

(a) The program must meet OARs 413-210-400 through 413-210-480 to be eligible to be a treatment foster care program;

(b) Selection of a treatment foster care program will be made by the Department of Human Resources based on current need and ability to fund the program.

(2) **Administration.** The program must designate an individual who is responsible for the provision and oversight of all essential tasks and services described in these rules.

#### (3) Staff.

(a) Clinical supervisor's responsibilities/qualifications include:

(A) Clinical Supervision. The supervisor provides regular support, consultation and guidance to the treatment specialist. The supervisor to treatment specialist ratio must not exceed one to five.

(B) 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/youth admitted to the program. She or he supervises ongoing treatment planning and implementation for each child, evaluating all progress reports and treatment plan updates.

(C) Treatment Team. The supervisor oversees and supports the treatment specialist as leader of the treatment team and shares ultimate responsibility for team plans and decisions.

**(D) Crisis On-Call.** The program provides coordination and back-up to assure that 24-hour on-call crisis intervention services are available and delivered as needed to treatment parents, children, youth and families.

**(E) Qualifications.** The supervisor must have a graduate degree in a human service field plus a minimum of two years' experience in the placement/treatment of children and families. The supervisor must be familiar with clinical research and practice. If the education and experience of the supervisor are not recognized, additional clinical consultation shall be provided. Clinical consultants must be licensed or otherwise recognized as qualified by the state in the human service field.

**(b) Treatment specialist's responsibilities/qualifications include:**

**(A) Treatment Team.** The treatment specialist takes primary day-to-day responsibility for leadership, training, support and consultation to the treatment team. The treatment specialist organizes and manages all team meetings. If the treatment specialist is prevented from participation in a team meeting by a crisis or personal leave reasons, the supervisor takes over that responsibility. As team leader, the treatment specialist manages team decision-making regarding the care and treatment of the child and services to the child's family.

**(B) Treatment Planning.** Under the supervision of the clinical supervisor, the treatment specialist takes primary responsibility for the preparation of each child's written comprehensive treatment plan and of quarterly written updates of the plan. The treatment specialist signs off on treatment plans and updates. The treatment specialist seeks to inform and involve other team members in this process including treatment parents, the child and the child's family.

**(C) Support/Consultation to Treatment Parents.** The treatment specialist will provide regular support and technical assistance to treatment parents in their implementation of the treatment plan and with regard to other responsibilities they undertake. The treatment specialist will provide at least weekly contact in person with the treatment parent of each youth on his/her caseload. The treatment specialist will visit the treatment home to meet with at least one treatment parent no less than once monthly.

**(D) Caseload.** The maximum number of youth that may be assigned to a single individual is ten.

**(E) Contact with Child/Youth.** The treatment specialist or other program staff shall regularly spend time, outside the presence of the

treatment foster family, with children in care to allow them the opportunity to communicate special concerns, to make a direct assessment of their progress, and to monitor for potential problems in the current placement. Such face-to-face contact must occur at least twice monthly.

**(F) Support/Consultation to the Families of Children/Youth.** The treatment specialist will arrange for and encourage regular contact and visitation between children and their parents and other family members and provide for or coordinate treatment or training to the family as specified in the treatment plan. The treatment specialist will seek to involve the child's parents when appropriate, in treatment team meetings, plans and decisions and to keep them informed of the child's progress in the program.

**(G) Community Liaison and Advocacy.** The treatment specialist will determine which community resources are required and how they may be used to meet the objectives of the child's treatment plan. The treatment specialist will advocate for and coordinate the provision of such services and will provide technical assistance to community service providers as needed to maximize the benefit of these services to the child.

**(H) Crisis On-Call.** The treatment specialist or other professional staff, as designated by the agency, will be on-call to treatment parents, children and their families on an around-the-clock, seven-day-a-week basis.

**(I) Qualifications.** The treatment specialist shall have at a minimum a B.A. or B.S. degree in a human service field plus two years direct experience working with children and families, or an A.A. degree with three years experience working with children and families.

#### **(4) Staff Training and Support:**

**(a) Agency Staff Development.** Professional staff shall participate in a minimum of 40 hours of preservice training on treatment foster care prior to assuming responsibilities and participate in ongoing training as scheduled by the agency throughout the year. At a minimum there will be two hours per month of professional consultation provided by a licensed or qualified professional in the human service field.

**(b) Liability Insurance.** Professional staff shall be covered by liability insurance.

**Statutory Authority: HB2004**

**Stats. Implemented: HB2004**

#### **TREATMENT FOSTER PARENTS**

**413-210-0440** Treatment foster parents serve as in-home treatment agents implementing strategies specified in a child's treatment plan including support of the child's family relationships.

**(1) Qualifications and Selection:**

**(a)** Treatment foster parent(s) must be certified as a SOSCF foster home as defined in OARs 413-200-100 through 413-200-190 (Certification Standards for Foster, Adoptive and Family Group Homes) or be approved as a foster home by the Treatment Foster Care Program; and

**(b)** Treatment foster parent(s) must be employees of, or have a contract with, a Treatment Foster Care Program;

**(c)** Prospective applicants, foster parent(s) and members of the household 18 years of age and older shall consent to a criminal record check by the agency. SOSCF may require a criminal record check for any employee, volunteer, or other adult having regular contact with children placed in the foster home. SOSCF may require a criminal history on members of the household under 18 years if there is reason to believe that member may pose a risk to children placed in the home. SOSCF may require that the applicant(s)/foster parent(s)/member(s) of the household provide fingerprints and processing fees for the purpose of a criminal record check.

**(d)** Language. At least one treatment parent must demonstrate effective communication in a language of the child in the treatment family's care, and in a language of the program/treatment team with which they work.

**(e)** Age. Treatment parents must be at least 21 years of age.

**(f)** Health. The physical health of treatment parents must be equal to the stress inherent in the care of a special needs child/youth as evidenced by a physician's statement to that effect.

**(g)** Transportation. Treatment parents must have access to reliable transportation. If using a car, they must have a valid driver's license and document ownership of liability insurance as required by law.

**(h)** Physical Discipline. Treatment parents must agree not to use physical discipline with children placed in their care and to adhere to the agency's policies regarding the use of discipline generally.

**(2) Responsibilities.**

**(a)** List of Responsibilities. Prospective treatment parents must be provided

with a written list of duties clearly detailing their responsibilities both as treatment parents and as foster parents prior to their approval by the program.

**(b) Treatment Responsibilities.**

**(A) Treatment Planning.** The treatment parent shall assist the treatment specialist and other team members in the development of treatment plans for the child or youth in their care.

**(B) Treatment Implementation.** The treatment parent shall assume primary responsibility for implementing the in-home treatment strategies specified in the youth's initial and comprehensive treatment plans and revisions thereof.

**(C) Treatment Team Meetings.** The treatment parent shall work cooperatively with other team members under the leadership of the treatment specialist and attend team meetings, training sessions and other gatherings required by the program or by the child's treatment plan.

**(D) Record Keeping.** The treatment parent shall systematically record information and document activities as required by the agency and the standards under which it operates.

**(E) Contact with Child's Family.** The treatment parent shall assist the child in maintaining contact with his/her family and work actively to support and enhance these relationships, unless contraindicated in the youth's treatment plan.

**(F) Permanency Planning Assistance.** The treatment parent shall assist with efforts specified by the treatment team to meet the child's permanency planning goal(s).

**(G) Community Relations.** The treatment parent shall develop and maintain positive working relationships with service providers in the community such as schools, departments of recreation, social service agencies, and mental health programs and professionals.

**(H) Advocacy.** The treatment parent, in concert with the agency treatment specialist and other 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 assure full access to and provision of public services to which the child is legally entitled.

**(I) Notice of Request for Child Move.** Unless a move is required to

protect the health or safety of the child or other treatment family members, the treatment parent shall provide at least 14 day's notice to program staff if requesting a child's removal from the home so as to allow a planful and minimally disruptive transition. SOSCF shall be notified of such change.

(c) **Foster Parent Responsibilities.** Treatment foster parents must fulfill the responsibilities of foster parents as defined in OARs 413-200-100 through 413-200-190.

### **(3) Treatment Foster Parent Training.**

(a) Training of treatment parents shall be a systematic, planned and documented process which includes competency-based skill training and is not limited to the provision of information through didactic instruction.

(b) **Preservice Training.** Prior to the placement of children in their homes, all treatment parents must satisfactorily complete 20 preservice hours of primarily skill-based training consistent with the agency's treatment methodology and the service needs of the children.

(c) **Inservice Training.** A written, agency approved, professional development plan shall be on record in each agency which describes the content and objectives of inservice training for all agency treatment parents. All treatment parents must satisfactorily complete a minimum of 40 hours of inservice training annually based on the training needs identified in the agency's professional development plan and the specific services treatment parents are required to provide. Inservice training should emphasize skill development, as well as knowledge acquisition, and may include a variety of formats and procedures including in-home training provided by agency casework staff.

(d) **Evaluation of Training.** All treatment parents must be provided an opportunity to evaluate mandated training.

### **(4) Treatment Parent Support.**

(a) **Information Disclosure.** All information the TFC program receives concerning a child to be placed with a treatment family shall be shared with and explained to the prospective family prior to placement. 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 goes the responsibility to maintain agency standards of confidentiality.

(b) **Respite.** Treatment parents shall have access to both planned and crisis

respite care for their treatment foster children by providers who have been selected and trained by the program in providing respite care. Respite providers must be informed of the youth's treatment plan and supervised in their implementation of the in-home strategies it specifies.

(c) Counseling. Treatment parents and their children shall have assistance in finding counseling when requested, for personal issues/problems caused or exacerbated by their work as treatment parents. Such issues may include, for example, marital stress, or abuse of their own child(ren) by a child placed in their care by the TFC program.

(d) Support Network. The TFC program shall facilitate the creation of formal or informal support networks for its treatment parents as, for example, through the coordination of parent support groups or treatment parent "buddy" systems.

(e) Financial Support. Agency financial support to treatment parents must cover the cost of care as well as payment for the difficulty of care associated with their treatment responsibilities and the special needs of the children they serve.

(f) Damages and Liability. The program must have a written plan concerning compensation for damages done to a treatment family's property by children placed in their care. This plan must be given and explained to prospective treatment parents as part of their preservice orientation. The agency must provide or assist treatment parents in obtaining liability coverage. Treatment parents are required to document that they carry home/apartment, automobile (if they have a motor vehicle), property and liability insurance themselves in addition to any liability and damage coverage provided by or through their TFC program.

**(5) Treatment Home Capacity.** The number of treatment foster care children placed in one treatment home shall not exceed two unless there is a need to place a sibling group. The total number of children living in a treatment foster home, including the foster parents' own children, will not exceed five. **Exceptions to the total number of children including the foster parents' own children will be granted to foster homes who provided treatment foster care prior to July 1, 1992.** Treatment parents have the right to refuse placement of any child they feel is inappropriate for the home or endangers the safety of children currently in the home. On a case-by-case basis, a treatment foster care child may be eligible to remain in the treatment foster care home as an on-going foster care placement upon completion of the treatment foster care program if there is special justification and it is in the best interests of the child. At no time will there be more than one on-going foster care placement in a treatment foster care home with two treatment foster care children.

**Statutory Authority: HB2004**

**Stats. Implemented: HB2004**

## CHILDREN, YOUTH AND THEIR FAMILIES

**413-210-0450 Placement and Support. (1) Matching.** Placement of a child will be made only after careful consideration of how well the prospective treatment family will meet the child's needs and preferences and will represent a reasonable "match" for the child.

**(2) Placement Decisions.** Children, youth and their families shall be consulted as to their preference for a child's placement with specific treatment families.

**(3) Assessment.** To achieve sound placement decisions and planning for relevant treatment services to children/youth, program staff must receive and review the following case material prior to a child's admission: current case plan(s), legal documents and relevant police records, etc., social history information, previous and current (within a year of referral date) psychological assessments if available, school information, medical information, previous placement history and outcomes, potential problems and information on the child's/youth's skills, interests, talents and other assets.

**(4) Records.** For children/youth admitted to treatment foster care, an individual case record will be kept which includes the above information as well as the following:

- (a)** Personal identifying information;
- (b)** A pre-admission psychological evaluation (if available);
- (c)** A child social and family history;
- (d)** Educational history including school reports and available standardized test results;
- (e)** Medical information including sight, hearing and dental exam reports, current medications and allergies, child's physical description, immunization records, medical history and Medicaid/SSI number, if applicable;
- (f)** Authorizations for routine and emergency medical care, dental care and other medical procedures;
- (g)** Other required authorizations such as authorization for out-of-state travel, participation in special activities, publicity releases, etc.;
- (h)** Correspondence with/from agencies involved with the child, including a statement of the placing agency's service goals for the child and family;
- (i)** The initial treatment plan;
- (j)** The comprehensive treatment plan;

(k) Progress reports;

(l) Case notes including contacts with the child's family/extended family;

(m) Incident logs or records on serious behavior problems, police and relevant juvenile court records and reports when possible, illnesses or injuries.

**(5) Child's Access to Agency Staff.** Treatment foster children/youth shall have access to designated program staff at all times to discuss concerns including any problems they are experiencing with their treatment family. Provider staff will provide regular one-to-one contact with each child on at least a twice monthly basis.

**(6) Child-Family Contact/Relationships.** Unless specifically proscribed by court or custodial agency decision, treatment foster children/youth shall have access to regular contact with their families as described in the treatment plan. The TFC 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 placing agency. Specific activities to be undertaken in this regard shall be described in the child's treatment plan.

**(7) Rights of Children and Youth in Treatment Foster Care.** Children in treatment foster care have the same basic rights as all foster children including the right to privacy, to humane treatment, to adequate shelter, clothing, nutrition, essential personal care items and allowances, and access to religious worship services of their choice. The program shall explain to each child what his/her rights are in a manner consistent with the child's level of understanding, and make this information available to the child in writing.

**Statutory Authority: HB2004**

**Stats. Implemented: HB2004**

## TREATMENT

**413-210-0460 (1) Initial Treatment Plan.** An initial written treatment plan shall be completed by the time of the youth's admission to the program. The plan shall describe specific tasks to be carried out by the treatment team during the first 45 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. The initial plan should assess short-term goals for the first 45 days of placement, identify potential problems likely to be encountered with the child and specify how the treatment team is to respond to them.

**(2) Comprehensive Treatment Plan.** A written comprehensive treatment plan shall be completed for each youth admitted within 45 days of admission addressing the long-term goals of treatment including criteria for discharge, projected length of stay in the program, projected post-TFC setting and aftercare services. It shall address the child's permanency plan, regarding the goals of placement. The plan shall identify and build on the child's strengths and assets as well as respond to presenting problems. The

comprehensive treatment plan shall include proactive short term treatment goals which are measurable and time-limited along with specific strategies for promoting and regularly evaluating progress.

**(3) Quarterly Progress Reports/Updates.** Each child's/youth's treatment plan shall be specific, reviewed via quarterly reports and revised as necessary. Quarterly reports shall document progress on specific short term treatment goals, describe significant revisions 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 long-term placement and treatment goals. The interagency team members will be invited to participate in the process to review and approve the quarterly report.

**(4) Aftercare Plan.** All planned discharges from treatment foster care will be reviewed and discussed by the treatment team, including the child/youth and family. An approved aftercare plan shall be ready for implementation prior to the child's planned departure from the program. The plan shall specify the nature, frequency and duration of aftercare services and designate responsibility for service delivery. The TFC program shall provide these aftercare services directly or provide consultation to the person/agency assuming responsibility for working with the youth following discharge from the program. An aftercare plan also shall be developed in a timely fashion for children whose discharge is not planned, with follow-up services provided or assisted as described here.

**Statutory Authority: HB2004**

**Stats. Implemented: HB2004**

## PROGRAM STATEMENT

**413-210-0470** All treatment foster care programs shall have a written program statement which describes its mission, organizational structure, services, policies, record-keeping and evaluation procedures. The program statement shall describe:

**(1)** The agency's treatment philosophy and the specific treatment modality(ies) it employs.

**(2)** The services the program provides.

**(3)** 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. Clients served must exhibit an identifiable special need.

**(4)** A staffing pattern which allows for the intensity of service required in treatment foster care and designates the individual responsible for program administration.

**(5)** How the services to be provided will reflect the cultural diversity of the community and be responsive to the needs of the community.

(6) A policy assuring that the program staff and treatment parents adhere to practices that respect and promote positive family relationships and positive cultural or ethnic identity.

(7) A policy on discipline and physical restraint which includes a description of acceptable methods.

(8) A policy on the use of physical restraint prohibiting the use of mechanical restraint or seclusion (e.g., in a locked room) and stating that passive physical restraint is justified only 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, physical restraint will be used only by persons who have been trained in its use and will not be employed as a punishment.

(9) The plan for crisis intervention procedures.

(10) The protocol for investigating, responding to and reporting allegations of misconduct and/or abuse by treatment parents, program agency staff, or their children.

(11) The policy advising children and parents of their rights and the grievance procedures available to them.

**Statutory Authority: HB2004**

**Stats. Implemented: HB2004**

## PROGRAM EVALUATION

**413-210-0480 (1) Documentation of Service Delivery.** A treatment foster care program must clearly document delivery of all services described in its program statement as well as compliance with all minimum operating standards described above.

**(2) Individual Treatment.** Treatment foster care programs must 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 care.

**(3) Performance Evaluations.** Programs will provide to treatment parents and professional staff written performance evaluations at least annually which include descriptive assessments of their performance of specific job responsibilities and goals for improved performance.

**(4) Program Evaluation.** TFC programs shall have a program evaluation plan which describes information to be collected, summarized and analyzed at least annually. The plan will identify who will have access to the evaluation and how it will be used. The evaluation shall include demographics on current children, youth and their families, treatment families and professional staff; aggregated information describing in-program

events such as placement disruptions; and a summary of information collected through follow-up tracking of children/youth discharged from the program. The plan also will provide for periodic evaluations of program services by treatment parents, children/youth and their families.

**Statutory Authority: HB2004**

**Stats. Implemented: HB2004**