Standards of Ethical Conduct of the Teaching-Family Association

The preparation of these Standards was undertaken by Dr. Curtis J. Braukmann, the first chairperson of the Teaching-Family Association Ethics Committee. These standards are based upon the informal principles of conduct that emerged from and guided the development of the early Teaching-Family training sites and the review of ethical behavior and guidelines published by various professional organizations.

To obtain further information concerning these Standards or to suggest modifications, contact the present Chairperson of the Teaching-Family Association Ethics Committee through our Association Office.

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Standards of Ethical Conduct

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STANDARDS OF ETHICAL CONDUCT OF THE TEACHING-FAMILY ASSOCIATION

BACKGROUND

Standards of Ethical Conduct of the Teaching-Family Association have been set forth in this document to aid members in the individual and collective maintenance of high standards of ethical conduct. These Standards are applicable to the activities of all members, and pertain to activities in such areas as I) treatment, 2) training of treatment providers, 3) research, and 4) administration of research and training projects. Adherence to the Standards is a membership requirement. Each prospective member is asked to sign an affirmation of the Standards before joining the Association (this affirmation is part of the application form) which formalizes the member's commitment to advancing the highest standards of professional practice.

In abiding by the Standards, the member views his or her obligations in as wide a context as the situation requires. The decisions required by the Standards must depend upon common sense and sound professional judgement. In situations in which there is a possibility that an activity may be in conflict with the Standards or in which two or more principles appear to dictate incompatible courses of action in a given situation, the individual is responsible for weighing all the information available, considering alternatives, and choosing an appropriate, balanced course of action that is compatible with the welfare of the client and of society at large, and that is consistent with the Standards' spirit and intent. In situations involving minimal risks and demands on clients, members might seek ethical advice from colleagues and other appropriate advisors. In instances in which intended or actual practice is significantly incompatible with the Standards, or in any other way presents a serious ethical dilemma, the Sponsor Member Agency should be contacted. For example, if a member is aware of foreseeable situations or of proposed or actual policies or procedures that are likely to pose unavoidable conflicts among these various Standards, the member(s) involved is responsible for describing such situations, policies, or procedures to his or her Sponsor Member Agency for consideration and review.

When a member violates these Ethical Standards or otherwise engages in any illegal, corrupt, or unethical behavior that would affect a client or the integrity of the Association, other members directly aware of such activities should make reasonable, informal attempts to correct the situation. That failing, the conduct should be brought to the attention of the Ethics Committee of the local Sponsor Member Agency.

The Standards are divided into six parts: Part 1. Basic Standards of Professional Conduct; Part 2. Treatment Standards; Part 3. Research Standards; Part 4. Standards Concerning the Training and Evaluation of Treatment Providers; Part 5. Standards Concerning Informed Consent; and Part 6. Standards Concerning Confidentiality. Within several of these parts are Standards calling for review of procedures and programs by appropriate local standing or ad hoc committees (boards) concerned with participant rights and with ethics. In this regard, each Sponsor Member Agency will submit to the Accreditation and Ethics Committee information concerning which board(s) will review ethics procedures.

These Standards should be evaluated and, as necessary, revised in light of future experience, research data, ethical arguments, and legislative and judicial actions. Such revisions should remain consistent with the Standards' original spirit and intent.

PREAMBLE

Members of the Teaching-Family Association respect the dignity, individuality, and worth of each person and value the preservation and protection of fundamental human rights. They are dedicated to promoting, without discrimination, the well-being and best interests of the consumers of their services, colleagues. and society in general. They are committed to providing professional service characterized by competence, compassion, and integrity.

SECTION I: STANDARDS

PART 1. BASIC STANDARDS OF PROFESSIONAL CONDUCT

101. In professional activities, members respect and protect (and avoid any action that will violate, diminish, or otherwise infringe upon) the legal and civil rights of others.

102. Members accord informed choice, confidentiality, due process, and protection from physical and mental harm to their clients, consumers, colleagues, supervisees, employees, trainees, and research participants.

103. Members refuse to participate in, condone, or be party to practices or policies which result in illegal or otherwise unjustifiable discrimination on the basis of race, color, national origin, sex, religion, age, physical handicap, political affiliation, or socioeconomic status.

104. Members have a clear responsibility to remain informed on relevant legal and ethical issues and criteria, relevant federal, state, local, and agency regulations, and, relevant professional standards of practice. Discussion: There would, of course, be no duty to anticipate unforeseeable developments in regard to such regulations and standards.)

105. Members duly exercise that reasonable degree of requisite skill, knowledge, and care ordinarily possessed and exercised by members under similar circumstances.

106. Members take steps to keep abreast of current practices and values, and seek consultation, continuing training, and performance evaluation whenever professional activity is enhanced thereby.

107. Members take reasonable precautions against situations where personal interests, personal problems, external pressures, or conflicts of interest interfere with free and objective exercise of professional judgement, skills, and responsibilities. (Discussion: In this regard, if members are providing services on a for-profit, members must inform all relevant consumers of the for-profit nature of the services before they participate in the services. Due care must be taken to ensure that profit-making activities or interests in no way detract from the quality of services provided. There should be no undue, excessive, or otherwise inappropriate profit-making as judged by accepted practice and local community standards.)

108 Members attempt to preserve requisite conditions for development and maintenance of sound relationships with consumers of their services. They treat consumers with courtesy, consideration, and respect. They are honest, open, and responsive to consumers. Members attempt to terminate a relationship with a consumer when it is reasonably clear a consumer is not benefiting from it.

109. In collaborative or supervisory relationships, members take the necessary time to provide reasonable and timely feedback and to ensure able, careful, ethical, and otherwise appropriate conduct of professional responsibilities.

110. In educational relationships, members attempt to be full and objective in their instruction, to provide consultation and practical experience when appropriate, and to teach others to take into account ethical issues and differences among individuals when carrying out their professional activities.

111. Members present information to consumers, colleagues, and society in a full, fair, and accurate manner to thus aid others in forming their own judgements, opinions, and choices.

112. Members accurately represent their skills, education, and experience, and correct any misrepresentation of any member's professional qualifications or associations.

113. Members do not misrepresent themselves or the Association through unsupported claims of superiority, nor do they display any membership or association in a manner that falsely implies sponsorship or qualifications. (Discussion: Members only use the words "Teaching-Family" in labeling their programs if those programs are formally associated with the Teaching-Family Association. Thus, if a developing or sponsor agency loses its formal association with the Teaching-Family Association, it should not continue to use the term "Teaching-Family" in labeling its programs. Also, if an agency is associated with some homes that are considered part of that agency for TFA purposes and with some homes that are not so considered, the latter programs should not be called "Teaching-Family" programs. Members not only follow this guideline, but encourage and educate others, including non-members, to do so as well. Non-members, as well as members, are seen as responsible in this regard because it is generally accepted that it is unethical to claim, or to seem to claim, affiliations or endorsements that do not exist.)

114. Members seek to support the viability, rights, and reputation of professional organizations of which they are employees or members and first seek necessary change in such organizations through constructive action within the organizations.

115. In professional presentations of their work, members give appropriate credit (e.g., joint authorship, acknowledgement, footnote statements, or other appropriate means) to those who have substantially contributed to the work. (Discussion: See, for example, the Publication Manual of the American Psychological Association.)

116. Members respect the responsibilities and areas of concern of other members and work cooperatively with them to meet objectives of the Association. (Discussion: Members avoid personnel recruitment practices that may have adverse effects on treatment participants, and members promote timely educational discussions among the parties directly involved concerning ethical recruitment practices and specific recruitment and transition plans during all recruitment endeavors. Agencies interviewing potential staff from another Teaching-Family Association member Agency will encourage the applicant to notify the appropriate supervisor(s) about their intentions. The interviewing agency will contact the applicant(s') Agency Director to confirm the interview. The hiring agency will allow the applicant to comply with their agency's policy and procedure regarding notification and termination prior to reporting to the new position. Agency Accreditation Applications will include data to reflect staff hired from other agencies.)

PART 2. TREATMENT STANDARDS

201. Members provide adequate, proper, humane, individualized treatment that is planned, respectful of personal integrity, sensitive to cultural differences, the least restrictive necessary, in line with prevailing community standards, and designed to foster individual competencies.

202. Members attempt to provide a treatment living environment that is as natural, normalized, and family-style as possible and encourage the building of close family relationships characterized by concern, respect, fun, trust, understanding, honesty, sympathy, and affection.

203. Members work to ensure treatment participants the same rights as any other citizen. In this regard, members ensure participants as much freedom of movement, normality, independence of choice, and personal life responsibility as possible without endangering the health and welfare of the participant or others.

204. Members provide participants with direction, assistance, and support to help them acquire the intellectual and emotional skills necessary to achieve individual aspirations and to cope effectively in our society. In this regard, members provide information, counseling, and day-to-day skill development in social, self-help, independent living, recreational, and vocational/academic skills. Further, members conduct themselves in a manner which provides appropriate models for the participants according to community norms.

205. In accordance with the Association's Standards concerning informed consent, members obtain consent from participants and, where appropriate, parents or guardians for participation in the treatment program. (Discussion: The Association's general consent Standards, as well as those specific to treatment, are contained in Part 5 of these Standards.)

206. Members ensure the participant's right to a wholesome, safe, clean, pleasant, and dignifying treatment environment. In this regard, they provide and do not restrict or make contingent regular and adequate sleep; rest; clean bedding; a comfortable bed; access to outdoors; physical exercise; light; warmth; ventilation; personal supplies; space for personal belongings and activities; physical safety; hygiene and sanitation (including access to daily shower or bath, regular laundry, hygienic materials, toilet use, and hot water); well-balanced, nutritional, and appealing diet; and, normal, accepted dress items.

207. Members ensure that each participant has an individualized, mutually agreed upon, written treatment plan that is based on careful assessment of the participant's strengths and weaknesses and that is developed with input from the participant and the participant's parents or guardians. The plan should be developed early within the program participation, should be reviewed and revised periodically on the basis of progress and renegotiation; should be kept confidential and privileged; and, as soon as possible, should include plans relative to the participant's post-treatment situation. The plan should specify long-term and short-term goals that are realistic, for the participant's benefit, relate to specific behaviors that are individualized, and reflect community norms. The plan should also specify the procedures to be employed to meet each objective and the termination criteria. Short-term goals should be consistent with and facilitative of long-term goals

208. Members seek to develop, secure, and maintain appropriate out-of-program and post-program living environments and, to this end and when possible and advisable, work closely and meet regularly with parents or surrogates to inform them of the participant's progress, counsel and train them on methods of child rearing, and implement the participant's reintegration into the natural home or other appropriate community settings.

209. Members accord participants adequate and appropriate educational opportunities in accordance with each participant's best interest, state laws, and community norms.

210. Members meet regularly and remain in close contact with participant's teachers and/or employers and/or referral agencies to facilitate and keep abreast of each participant's progress in school and employment settings. When problems arise in these settings, members work cooperatively with appropriate personnel to attempt to solve those problems. Members shall remain in contact with the participant's referral agencies.

211. Members represent the participant's best interests and advocate for them in situations involving decision-making processes that directly effect the participant, the removal of the participant from the program, and/or, the temporary exercise of control over the participant by another agency. In such situations, members monitor the procedures, attempt to ensure that the participant and parent or guardian is informed of guaranteed rights (including, where appropriate, right to counsel and/or an advocate), attempt to encourage the least restrictive alternative course of action, and attempt to secure for the participant and his or her representative the opportunity to be fully heard.

212. Members seek for their participants any necessary medical or dental treatment and take steps to ensure that such treatment is immediate and of high quality (Discussion: When a reasonable question arises as to whether or not a given behavior or condition is a result of a physical problem, members should obtain Accreditation from a physician before extended attempts to treat the problem as non-physical.)

213. Members provide reasonable and regular opportunities for participants to engage in the following activities and ensure that such opportunities are free from restraint, interference, coercion, discrimination, reprisal, or undue influence: 1) participation in decisions that affect disciplinary processes, daily life patterns, and participant's lives, including decisions concerning regulations and policies; 2) explanations of their own actions; 3) expressions of dissatisfaction and grievances; and, 4) recommendations for changes.

214. Members seek to provide a supportive setting in which participants can learn to accept responsibility for their own actions and, where appropriate, those of other participants. This includes the opportunity for participants to participate (under conditions in which they have volunteered, are specifically trained and adequately and closely supervised, have demonstrated humane judgement, and in which their judgements and actions are subject to careful ongoing review and approval) in the determination of fair, reasonable, and justified consequences for fellow participants; the reporting of serious rule violations of other participants, and, the supervision of routine activities of other participants.

215. Members ensure that participants have reasonable, regular opportunities for communication with others (e.g., parents, same and opposite sex peers, counsel, public officials, and agency personnel) through visits, telephone, mail, and other means of contact. Furthermore, members ensure that participants have reasonable and regular opportunities for access to mass communication and information (e.g, radio, television, and reading material). (Discussion: For example, members cannot fail to deliver mail or phone calls, nor can they make all television viewing contingent upon behavior. Here, reasonable access to television news and educational programs should be routinely available.)

216. While members are aware of the need to provide adequate supervision, they respect participants' right to privacy and do not, without due cause, seek access to personal information concerning participants or conduct searches of their person, belongings, or room. Members do not read participants' mail and do not, without informed consent, permit public display of the participants' pictures or names either in association with the program or in any manner with some likelihood of adverse effects.

217. Members protect the participants' right to the free exercise of religious, political, cultural or other philosophical beliefs, including attendance at services, and do not impose religious or political attitudes or prayers. (Discussion: If specific religious behaviors are required by the board or funding support of a program, such a situation needs to be clearly specified in the informed consent.)

218. Members ensure that treatment-associated risks (whether physical, psychological, sociological, or other) are outweighed by potential benefits to the participant and that such benefits stand in a reasonable relationship to the demands made upon him or her.

219. Members protect participants from physical or psychological discomfort, harm, or danger. Prohibitions include mental cruelty, emotional cruelty and intentional emotional stress (e. g., humiliating, shaming, frightening), hazardous procedures, and physically intrusive procedures (e.g., corporal punishment, chemotherapy).

220. Members do not employ corporal punishment or other aversive stimulation (whether tactile, auditory, gustatory, olfactory, or visual), but rather employ more humane ways of interacting and fostering goals of education, training, and socialization.

221. Members provide treatment that is the least restrictive necessary and avoid excessive, arbitrary, or otherwise undue restrictions on the activities of participants. Those reasonable and limited restrictions that are employed are described in the informed consent and are used when more positive and less intrusive alternatives are either exhausted or would be clearly ineffective, when the procedures would be in the best interest of the participant, and when the benefits clearly outweigh the harm. (Discussion: The issue of whether or not a treatment environment, such as a group home, represents the least restrictive alternative for a potential participant is an issue that needs to be discussed and weighed by a duly constituted admissions committee.)

222. Members avoid the use of physical restraint except under emergency conditions when there is a clear and imminent threat to the physical safety and well-being of the participant or others or when there is actual extensive property damage. Such restraint is the minimal (least restrictive) necessary, is used only during the acute episode, is not of a mechanical or chemical nature, and is not used for punishment or staff convenience. Any use of restraint will be documented in the participant's file with specification of date, time, and nature of the inappropriate behavior, surrounding conditions, and length of the restraint episode.

223. Members avoid secluding or confining participants. If under extreme conditions, the least restrictive alternative for the immediate protection of the participant or others is the temporary restriction of a participant's activities to a given room, room will not be locked, and frequent observations of the participant will be made. Members will not have rooms specifically for the purpose of confining participants, and no form of confinement is ever used as a form of punishment. (Discussion: Temporary and infrequent exclusion of a participant from an environment or activity might represent a least restrictive option under certain conditions. Such exclusion should be brief, mild, and evaluated as to its effectiveness. Examples include: asking a young child to sit out of an activity for a brief period, asking a participant to temporarily leave a situation in which there appears to be danger of confrontation. In the latter case, a participant might be asked to go to his room and given a specific reentry behavior and an invitation to engage in that behavior within a reasonable time period.

224. Members recognize the diverse needs of residents in their care. Administering medication for the purpose of controlling behaviors or for the convenience of staff is not condoned. When indicated by case assessment that such pharmaceuticals are necessary and in the best interest of the client, members will advocate for minimal dosages that are consistently monitored. (Discussion: Drugs are never used for behavior control, restraint, or punishment. Medications will only be used when authorized by a licensed physician and administered strictly and according to prescription instructions. Medications will be maintained under lock and key and logged to document frequency and dosage of use.)

225. Members protect participants from work that is not related to treatment, non-therapeutic, meaningless, or not related to family-living activities typical to a natural household. Participants are not asked to engage in work for the primary benefit of another, unless they volunteer and are paid minimum wage. (Discussion: Specifically prohibited here is non-voluntary, unpaid personal work for members, such as cleaning the member's room or babysitting his or her children and pets. Also prohibited is repetitive, meaningless work or activity as a form of punishment.)

226. Members ensure that the procedures and programs they employ are reviewed by appropriate standing or ad hoc committees/boards concerned with participant rights and the ethics of treatment.

227. In accordance with the Association's Standards concerning confidentiality, members employ proper and reasonable confidentiality safeguards to protect the confidentiality of information obtained relative to treatment participants. (Discussion: The Association's general Standards on confidentiality, as well as those specific to treatment, are contained in Part 6 of these Standards.)

PART 3. RESEARCH STANDARDS

301. Members attempt to select areas of research that are of immediate relevance to human and social problems and/or that advance the understanding of significant aspects of human experience and behavior. (Discussion: Ideally, members' research should relate directly to the welfare of the individuals involved or of individuals participating in similar or future programs. Members ensure that participants in their research efforts are not overused in research unrelated to their welfare solely because of administrative convenience of availability.

302. As researchers, members use methods that are appropriate to the objectives of the research, select areas in which they have sufficient competence, and ensure they have adequate facilities to conduct the research.

303. Members plan their research to minimize the possibility of misleading findings and remain alert to moderate pressures that may distort findings. They discuss the limitations of their data and reasonable alternative hypotheses, especially when their research may considerably affect policy or practice. In publishing reports of their research, they never suppress disconfirming data. Members take credit only for the research they have actually done.

304. In planning and conducting research, members act in accordance with and thus avoid action that interferes or is incompatible with the spirit of the Standards put forth in the other parts of this document (e.g., Treatment Standards).

305. In planning and conducting research, members act in accordance with other applicable standards, regulations, and laws. (Discussion: By ways of examples, members who belong to the American Psychological Association adhere to that organization's research guidelines and ethical principles, and members conducting research supported by the Department of Health and Human Services adhere to that agency's regulations concerning the protection of human subjects.)

306. Members use research procedures that result in subject treatment that is proper, humane, respectful of personal integrity, and the least restrictive necessary. Research participants are encouraged to express their opinions and dissatisfactions and to suggest changes.

307. Members undertake research only if the risks to those involved are minor and stand in a reasonable relationship to the benefits (including the avoidance of a greater harm) likely to accrue to the subject and to the public in general. Members use the safest procedures that are consistent with sound research design and request only that time and inconvenience of subjects is justified by the importance of the research, even if no more than minimal risk is involved.

308 Members do not undertake research that is incompatible with, or significantly interruptive of, expected services in a human service relationship. Further, they do not undertake research that involves physical or mental stress, harm, or danger, deprivation or restriction of rights (e.g., to communication, privacy, nutritional diet, light, warmth, sleep, safety), physically intrusive procedures, participant seclusion, deception, or administration of drugs for control, restraint, or punishment.

309. Members do not undertake research for personal gain that they would otherwise refuse to do because of the harmful purpose it would serve.

310. Compensation to research volunteers should never be such as to constitute undue inducement. When potential research participants have such strong needs that they have little freedom to reject incentives related to these needs, an investigator should never use such incentives without first securing ethical advice.

311. Members ensure that the research they undertake is reviewed by appropriate standing or ad hoc committees (boards) concerned with participant rights and the ethics of research.

312. In accordance with the Association's Standards concerning informed consent, members obtain informed consent from participants and, where appropriate, parents and guardians for participation in the research. (Discussion: The Association's general consent Standards, as well as those specific to research, are contained in Part 5 of these Standards.)

313. In accordance with the Association's Standards concerning confidentiality, members employ proper and reasonable safeguards to preserve the confidentiality of information obtained through the research. (Discussion: The Association's general Standards on confidentiality, as well as those specific to research, are contained in Part 6 of these Standards.)

PART 4. STANDARDS CONCERNING THE TRAINING AND EVALUATION OF TREATMENT PROVIDERS

401. Members involved in the training and evaluation of treatment providers give appropriate and sufficient direction, advice, and feedback to the providers, and adequately and regularly monitor their performance in order to facilitate the professional growth of the providers and help them be responsive to consumer needs.

402. Through integrated programs of academic study and supervised practice, members carefully teach legal, ethical, and treatment concepts and procedures to trainees in order to facilitate their delivery of quality, ethical treatment.

403. Members involved in training and evaluating treatment providers work to ensure that consumers of the treatment services are receiving proper, ethical treatment. In this regard, the members work to ensure that direct participants in the treatment activities are treated in full accord with each of the Association's Treatment Standards (see Part 2 of these Standards). (Discussion: In this regard, for example, members ensure that each treatment participant has an appropriate updated treatment plan.)

404. Members involved in training and evaluating treatment providers act in accordance with formal Association policy for such activities.

405. Members involved in the training and evaluation of treatment providers make appropriate and periodic consumer evaluation information on provider performance available to those individuals and agencies that are responsible for I) administering the treatment program with which the provider is associated, as well as 2) referring potential participants to the program. Members are obligated to ensure that adequate interpretation accompanies the sharing of this information.

406. Members involved in training and evaluating treatment providers ensure that Accreditation of the providers under the auspices of the Association is based on the quality of their performance as formally evaluated by the consumers of the providers' services.

407. In accordance with the Association's Standards concerning informed consent, members obtain informed consent from participants for participation in training and evaluation. (Discussion: The Association's general consent Standards, as well as those specific to training and evaluation, are contained in Part 5 of these Standards)

408. In accordance with the Association's Standards concerning confidentiality, members employ proper and reasonable safeguards to preserve the confidentiality of information obtained relative to those individuals participating in training and evaluation. (Discussion: The Association's general Standards on confidentiality, as well as those specific to training and evaluation, are contained in Part 6 of these Standards.)

409. As trainers, members have the responsibility of not only assisting the trainee in securing remedial assistance, but also screening from the training program those trainees who are unable to provide competent services.

410. When agreeing to provide services that omit one or more of the Teaching-Family Model components, members shall make explicit written agreements with those persons or agencies agreeing to receive such services, stipulating that the services to be received by those persons or agencies are not to be considered Teaching-Family Model services. Further, members assure, through the same explicit written agreements, that those persons or agencies agreeing to receive such services shall not represent themselves to be receiving Teaching-Family Model services or to be Teaching-Family Model programs. (Discussion: In some cases, members must provide a modified training workshop for foster parents or house parents to satisfy the terms of an overall contract for services in a state, yet post-workshop consultation or performance evaluation is not permitted because of cost or distance. The omission of these important components would warrant the explicit written agreement called for in this paragraph to prevent any possible confusion between what the member does with Teaching-Family Model programs and what the member does with other types of care.)

PART 5. STANDARDS CONCERNING INFORMED CONSENT

501. In accordance to the right to give or withhold informed consent to potential direct participants in their professional activities (e.g., clients, trainees, and research participants), members take reasonable steps to ensure that conditions would permit competent, informed, and voluntary consent to be given by the participants and/or their legal representatives.

502. Members make clear that they are inviting mutual agreement of the parties concerned and attempt to provide clear, accurate, and full descriptions of relevant procedures, objectives, risks, and benefits.

503. Members permit no exploitation of special needs or vulnerabilities, nor any overt or indirect element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion.

504. In obtaining informed consent, members do not use exculpatory language through which the participant or representative is made to waive, or appear to waive, any constitutional rights.

505. Members ensure and make clear that consent may be withdrawn at any time without prejudice or unpleasant consequences.

506. To ensure the adequacy of their consent procedures, members may present their procedures to a review board.

507. Members obtain appropriate consent for treatment, training, and research participation from each participant older than seven unless, in the opinion of the appropriate review board, the participant is incapable of consent. If the participant is under the age of 18 or is incapable of understanding the situation and making appropriate judgements, consent is also obtained from the parent(s), legal guardian(s), or other legally-authorized, independent third-party representative(s) of the participant's interests. (Discussion: Any proposed variance from this guideline shall only be undertaken following formal approval of the appropriate review board or when existing state statutes specifically provide different criteria. For example, not every state has set 18 years of age when parental consent is no longer needed.)

508. Members provide participants and their representatives with the necessary information for informed consent through use of written forms that contain comprehensible, non-technical, and objective language aimed at the level of the parry involved. When helpful, these forms are read aloud to the party. In all cases, they are explained, and all questions are answered. Agreement is indicated by signature on the form. The party is told that he or she may take time to think over or consult with others regarding the consent before signing. (Discussion: In order to document and ensure that the party involved understood well what was being consented to members obtaining consent might ask the party to manifest his or her knowledge by, for example, answering written or oral questions concerning the various conditions being consented to. It is often good practice to conduct informed consent sessions in the presence of a witness who would then also sign the form.)

509. In obtaining informed consent, members provide the following:

a) descriptions of objectives and rationales;
b) a fair explanation of procedures (programs) including, when known, their typical frequency and duration;
c) an indication of available, reasonable, appropriate alternative procedures (programs) that would be advantageous;
d) a statement about the rights of the participant and of the parent or guardian;
e) an explanation of how progress is to be evaluated;
f) a description of procedures to be used to preserve confidentiality;
g) a description of what benefits might be expected, reviewing previous results when appropriate;
h) a description of what collateral discomforts or risks of injury (psychological, physical, or social) might be expected, reviewing previous results when appropriate;
i) an explanation of procedures for withdrawing consent and/or terminating the procedures (program);
j) explanations of data collection, including types of data to be collected and from what sources, length of time the data will be retained, who is to have access to the data; plans for use of the data in publications; and, when the data will be destroyed.

510. In addition to including the elements described in the above Standards, members provide the following information in seeking informed consent for treatment: eligibility criteria for the program; description of each treatment element; probable length of stay (provide range); and, a general description of program activities that may include training, consultation, and evaluation.

511. In addition to including the elements described in the above Standards, members provide the following information in seeking informed consent for research: a statement that participation in treatment or training is not contingent upon participation in the research; eligibility criteria for participation in the research; description of all experimental procedures; and, description of probable length of research.

PART 6. STANDARDS CONCERNING CONFIDENTIALITY

601. Members make due provision for the maintenance of the confidentiality of any information that has been obtained in the course of their professional activities. They take due precautions against the accidental or malicious release of confidential information and the use of such information to the detriment of any individual. They maintain reports, records, and other information under conditions of security (e.g., locked files), and make provisions for the ultimate disposition of such materials in a manner that maintains confidentiality.

602. Members ensure that privacy and confidentiality are maintained by all persons they supervise, or who are in the employ or volunteer service of the agency or office in which they work.

603. Information received in confidence by a member shall not be forwarded to another person or agency without the client's express permission.

604. Information received in confidence is revealed only after the most careful deliberation and only after one or more of the following conditions are met: 1) the individual has given consent; 2) there is a clear and imminent danger to the client, to others, or to society; or, 3) there exists proper legal compulsion. Under such conditions only necessary, relevant, and verifiable information is to be released, and then only to appropriate professional workers or public authorities. Reasonable attempts should be made to ensure that these latter individuals maintain the confidentiality of the information. Under conditions of legal compulsion, as in a court or legislative inquiry, ethical considerations may dictate that members raise question of adequate need for disclosure, right to dissent, and the possibility of providing information that is relevant to the legal question at hand but that is as disassociated from individuals to the extent possible.

605. Individuals who are asked by members in the course of their professional activities to provide personal information should be informed in advance about the purposes of information gathering and about limits of confidentiality. They should subsequently be informed of external conditions requiring reporting of information to someone else.

606. Information obtained in treatment and training and evaluation activities is discussed only for professional purposes and only with persons clearly concerned with the case. To the extent possible and when reasonable, the anonymity of the individuals concerned is protected in such discussions through withholding of name and personal identifying data. When professional discussions and communications with relevant others concerning participants is standard, accepted practice, the individual participant must be fully informed concerning this practice prior to providing information. Care must be taken to ensure that the third parties involved respect the confidentiality of the information. (Discussion: In regard to providing treatment services, members may need to share information with those assisting in the treatment or providing training or consultation concerning treatment. Participants should be so informed in accordance with this Standard.)

607. Every effort should be made to avoid undue invasion of privacy, and sensitive data is only collected if necessary.

608. Reports of other materials are only presented when the identity of each involved person is so disguised that no identification is possible unless the client or responsible authority has reviewed the materials, is informed of the extent of risk, and has explicitly agreed to presentation or publication.

609. Records concerning participants in treatment are confidential. (Discussion: Files of the agency's individuals in treatment should not go beyond the program. The parent or guardian of an individual receiving treatment has the right to see the files, unless otherwise regulated by state statutes or court order. Open discussion shall occur at the beginning of treatment and there should be agreement between the parties involved as to what information will/will not be available. Records can only be disclosed to other agencies for the purpose of treatment and then only when accompanied by a written Informed Consent Release of Information Form. If records include materials provided by other agencies, access shall only occur with express approval of those other agencies.) All efforts will be made to maintain confidentiality and to comply with applicable licensing standards.

610. Members conducting research should collect only relevant and necessary information, share the data only with authorized personnel and only for authorized purposes, expunge individualized data once the research is completed, and utilize codes rather than names when possible (with the codes kept securely and distinctly separate from the data).

SECTION II: ETHICS COMMITTEE FUNCTIONS

PART 1: COMMITTEE RESPONSIBILITIES

A. The Ethics Committee functions as part of the Accreditation and Ethics Committee, a standing committee of the Teaching-Family Association.

B. The purpose of the Ethics Committee shall be to develop and implement standards, policies, and procedures concerning the ethical conduct of Association members.

C. The Ethics Committee shall report to the Board of Directors of the Teaching-Family Association.

D. The Board of Directors of the Teaching-Family Association shall have the authority to approve and periodically review the policies, action, advice, and counsel of the Ethics Committee.

E. An annual report of the Ethics Committee and any interim reports required by the Board shall be filed with the Secretary of the Teaching-Family Association.

F. The Ethics Committee shall propose revisions in the Standards and in the Committee's policies and procedures as the need for such revisions becomes apparent. The Committee shall conduct a thorough review of standards, policies, and procedures every five years. To be adopted, revisions must be approved by the Board of Directors. The Ethics Committee shall keep minutes of all actions and decisions.

G. The make-up of the Committee and its operation shall conform to the guidelines specified in the Association's `Bylaws.

PART 2: STATEMENT OF PURPOSE AND SCOPE

The Ethics Committee has as a primary concern the ethical conduct of all Teaching-Family Association members. The objective of the Committee with regard to the individual members shall be to provide constructive education about ethical conduct. To facilitate this goal, the Ethics Committee is responsible for the development and necessary updating of the Standards of Ethical Conduct and for the establishment and implementation of policies and procedures.

The Ethics Committee will encourage continuing constructive communication between itself and members as a means of safeguarding the rights and welfare of individuals who are participants in Association activities; however, the Committee is not involved in policing the conduct of the membership or enforcing the Standards as applied to individuals. The Teaching-Family Association and their Ethics Committee does not accept nor process referrals regarding the unethical behavior of individuals as it relates to the Standards of Ethical Conduct, nor will they communicate to any entity or to any individual any information about the unethical conduct of any of its members.

Reports of violations of employees, supervisees, trainees, contractors, or other members shall be dealt with by the individual Sponsor Agencies who are responsible for reviewing situations and deciding on action. The individual Sponsor Agency review process might involve such information collection procedures as personal interviews, on-site visits, consumer evaluations, or whatever appears appropriate, depending on the ethical gravity of the situation involved. Decisions as to courses of action would be made by careful consideration of the ethical concerns involved and in accordance with the Association's Ethical Standards.

PART 3:
COMMITTEE REVIEW PROCEDURES

Any ethical allegations against an agency will be reviewed by the Accreditation and Ethics Committee during the agency Accreditation process and according to the Accreditation and Ethics Committee policies and procedures. This includes allegations of general or repeated failure to substantially comply with the Standards. Because the Association intends that member agencies monitor the ethical conduct of their employees and associates, part of the Accreditation process is a review of the agencies' actions with regards to individuals who might have violated the Standards. The Accreditation review team is charged with determining if the agency adequately adheres to the Standards of Ethical Conduct. The responsibility for enforcing and implementing the Teaching-Family Association Standards of Ethical Conduct rests with the individual member agencies.

Referrals of complaints about isolated unethical conduct of members should be made to the applicable agency and not be made to the Teaching-Family Association. All agencies and their personnel are required to abide by the Teaching-Family Association Standards of Ethical Conduct. Any disciplinary action relating to the violation of the Standards is a matter to be handled by the agencies and not the Teaching-Family Association nor the Ethics Committee.

PART 4:
COMMITTEE RECORDS

The permanent files of the Accreditation and Ethics Committee will be maintained by the Association Office. They will contain: I) copies of all documents presented or required for initial and continuing review; 2) committee meeting minutes including records of discussions of substantive issues and their resolutions, and, 3) transmittals on actions, instructions, and conditions resulting from committee deliberations.

Files that contain allegations of unethical conduct by a member or other individuals shall be confidential. Only members of the Accreditation and Ethics Committee and the Executive Committee of the Association will have access to said files and then only as necessary to permit sound decision-making.

TEACHING-FAMILY ASSOCIATION
STANDARDS OF SERVICE OF THE TEACHING-FAMILY MODEL
(Revised October, 2014 by TFA)

Teaching-Family programs offer community or campus-based programs for children, adolescents, or adults in need of life skills. Treatment, based on the Teaching-Family Model, is carried out by skilled practitioners. These Treatment Providers use precise intervention strategies to create opportunities for the teaching, learning, and generalization of a wide variety of skills in natural settings based on the needs of the client population.

GOALS

Humane

Teaching-Family programs demonstrate compassionate, considerate, respectful, and unconditional positive regard for all clients with no tolerance for abuse or neglect. Integrated systems ensure that clients are treated humanely and agencies adhere to Teaching-Family Associations Standards of Ethical Conduct. Agencies have clear policies, procedures, and systems addressing alleged abuse, neglect and unethical actions by staff and service providers. Staff is trained and has an understanding of client rights and procedures regarding unethical practices.

Effective

The services stated by Teaching-Family Association agencies are delivered. Outcomes are observable and measurable. Clients demonstrate progress towards goals by demonstrating an appropriate reduction in the level of services needed. Clients and staff acquire skills necessary to achieve their goals. The quality and stability of agency staff are appropriately maintained to ensure effectiveness. Consumers indicate satisfaction with services provided.

Individualized

Services provided by Teaching-Family Association agencies are client-centered, strength-based and directly related to the individual needs of the client. Services are culturally sensitive. Client assessment identifies strengths as well as needs and clients are involved in planning of services. Clients indicate a high level of satisfaction with services.

Consumer Satisfaction

Teaching-Family Association agencies provide opportunities for client and consumer input. Clients and consumers express a high degree of satisfaction with services provided. The agencies conduct comprehensive client and consumer polling with a minimum of 50% return from each consumer group achieved. The agencies' quality assurance processes incorporate consumer feedback.

Trauma Informed Care

Teaching-Family Association agencies provide a trauma informed approach. The standard ensures realization of the prevalence of trauma; recognizes how trauma affects all individuals involved with the program (including staff); and responds by putting this knowledge into practice.

INTEGRATED SYSTEMS

Facilitative Administration

A facilitative administration is one that offers staff opportunities to provide input regarding program components. Teaching-Family Association agencies facilitate and promote system integration by providing necessary tools, training, and support; coordinating and assessing the service delivery system; and developing processes and resources to support and maintain the systems. The agencies have training, consultation and evaluation systems that complement each other. Consumer evaluation processes are in place to assess systems, programs, and staff and service providers. The agencies' leadership, including their governing bodies, participate with other organizations and individuals to: improve services for individuals and families, identify and advocate for needed change, identify gaps in service and work for their elimination, and share resources and expertise where appropriate.

Training

Teaching-Family Association agencies provide initial and on-going skill development for all staff; staff are familiar with the Teaching-Family Model. Agencies enable, facilitate, and hold all staff and service providers accountable for implementation of the Teaching Family Model. Agencies provide competency-based training to increase the skill level of all staff and service providers to maintain and improve skill development. Agencies ensure that all staff and service providers attend training prior to being responsible for client services and on a regular basis thereafter. Agencies have clearly defined competency-based training materials and procedures along with qualified trainers on-site. Staff and service providers demonstrate competency in service delivery.

Consultation/Supervisions
Teaching-Family Association programs incorporate a supportive consultation and supervision component which supports and promotes practitioner skill development, ensures integrity of the Teaching Family Model, and monitors services to clients. Practitioners are satisfied with services and support provided by the Consultant/Supervisor who serves as a liaison/advocate for the practitioner. Consultation and supervision focus on providing effective services to clients by following an effective service delivery plan for monitoring services. Consultants/Supervisors are adequately trained and knowledgeable in Teaching-Family Model goals, systems and elements.

Evaluation
Evaluation systems of Teaching-Family Association agencies facilitate continuous quality improvement in service and care by assessing the skill of the practitioner and implementation of the Teaching-Family Model. The agencies assess consumer satisfaction to assess quality. They observe, assess, and review practitioner skills and Model implementation. Practitioners are prepared for all evaluation activities and are evaluated on at least an annual basis.

ELEMENTS

Teaching
Teaching-Family Association programs emphasize the positive teaching of functional skills and behaviors. Agencies promote a systematic, positive behavioral approach to teaching behavior. Staff and service providers model appropriate skills when teaching clients. Teaching is provided through positive interactions with clients, which typically include praise, specific descriptions of behavior, client-centered rationales, acknowledgment, opportunities for practice, and positive quality components. Staff use appropriate crisis intervention techniques when dealing with aggressive and intensive behavior.

Self-Determination
Teaching-Family programs give clients as much control over their lives as possible. Clients participate in their own goal setting and receive the least restrictive services necessary for them to achieve their goals. Staff and service providers facilitate the learning of decision-making and problem-solving skills. Staff and service providers facilitate and support client decision-making opportunities. Clients are encouraged to support one another's goals.

Relationships
Teaching-Family Association programs promote the development of relationships with clients that are maintained through trust, respect, and positive regard within professional boundaries. Staff and service providers utilize warm, caring interaction styles and are sensitive and responsive to client needs especially in times of crisis, illness, and times of need. Clients are encouraged to appropriately express feelings. Family interaction and participation is encouraged.

Family-Sensitive Approach
Teaching-Family programs recognize the importance of family to the client by promoting and advocating for the client's family. The family or significant individuals are included in the planning and delivery of services.

Diversity
Teaching-Family programs provide services that are culturally sensitive and competent. Staff is trained in areas relating to diversity, ethnicity, and multi-cultural values. The program environment reflects respect for diversity of the population and the community served. Staff recruitment actively seeks to promote diversity relative to client population. The agency promotes cultural sensitivity and competence. Services are offered regardless of race, religion, gender, etc.

Professionalism
Each agency encourages participation in the Teaching-Family Association through educating staff at the time of orientation about the history and goals of the Teaching-Family Model and the benefits of membership in the Teaching-Family Association.

www.teaching-family.org

TEACHING-FAMILY ASSOCIATION
STANDARDS OF SERVICE

INTRODUCTION

The following Standards of Service of the Teaching-Family Association is comprised of five parts:

AA. Definitions
Throughout the Standards, specific terms are used which may require further explanation. This section attempts to define those terms to provide a clearer understanding of their use within the Standards.

BB. Indicators/Sources
Several terms identified as Indicators of Compliance or Sources for Evidence of Compliance can be applied to all standards. These are listed in this section along with definitions regarding their use throughout the Standards.

CC. Goals
Within the Teaching-Family Model there are four goals to which all Certified or Sponsor Agencies to which agencies must adhere. These include programs that are Humane, Effective, Individualized and achieve Consumer Satisfaction.

DD. Integrated Systems
The Teaching-Family Model programs must include training, consultation, evaluation and facilitative administration systems.

EE. Elements
All Teaching-Family Model programs consist of the elements of teaching, self-determination, client advocacy, client relationships, family-sensitive approaches, and diversity.

Each of the previous Standards of Service are further defined by their corresponding Indicators of Compliance. All indicators must be present in a Certified or Sponsor Member Agency of the Teaching-Family Association.

To determine adherence to all Standards of Service and Indicators of Compliance, several sources may be reviewed. These are identified in the boxes following each Standard's Indicators. These Sources for Evidence of Compliance are "possible" areas where information regarding compliance may be found. They are not required. Those completing or reviewing annual review materials may look to these sources to obtain information related to the specific Standard or Indicator.

AA. DEFINITIONS

AA.1 The Teaching-Family Model

The Teaching-Family Model is a unique approach to human services characterized by clearly defined goals, integrated support systems, and a set of essential elements.

AA.2 Client

Any person who receives direct services from the agency. The client may refer to a child, student, family, parent, youth, or other individuals or groups.

AA.3 Consumer

Any person who has a stake in the agency. This may include: a provider of resources, accrediting and licensing bodies, an authority over the agency, a paying customer or client. Some examples of consumers are: youth, parents, families, foster parents, support staff, administration, neighbors, school personnel, therapists, referring workers, court workers and judges, and Board of Directors.

AA.4 Family

A group of individuals consists of a parent(s), relatives or significant others, and child(ren) as defined by the client.

AA.5 Family-Style/Most Natural Environment

Family-Style living includes but is not limited to relaxed environment; physical proximity between practitioners and clients; practitioner is ultimately responsible and has the autonomy with regard to work with the client both inside and outside the environment; practitioner also has decision-making authority and ownership of the work as it relates to the Teaching-Family Model implementation with clients.

The definition of family-style within the confines of the Teaching-Family Model means married couples are encouraged as the practitioner in residential programs. However, staffing patterns and agency staff-to-client ratios may vary depending on the program and its purposes. In any Teaching-Family Model program, ratios and staffing patterns must sufficiently provide the following to each client: 1) a safe environment (i.e., adequate supervision), 2) individual treatment planning, 3) the consistent implementation of individualized treatment, 4) effective teaching, and 5) a family-style/most natural environment --- taking into consideration: 1) the age of the clients; 2) the severity/difficulty of the clients' problems (i.e., medically needy, developmentally delayed, sex offending, etc.); 3) the type of treatment program providing services; and/or 4) the expertise or experience level of the treatment provider. When determining the appropriateness of staff-to-client ratios in any program, all these factors should be taken into consideration. In addition, guidelines established by an agency's state licensing body should be considered. Recommendations can be made if the quality of care is compromised due to staff-to-client ratios or staffing patterns.

AA.6 Service Documentation

Refers to any written documents relating to services provided by the agency. This may include (but is not limited to): treatment plans, progress reports, training, supervision/consultation, and evaluation schedules and reports.

AA.7 Quality Components

Refers to the demeanor of the staff member when interacting with clients. This demeanor includes facial expression; voice tone; and body language that demonstrates respect, sincerity, concern, warmth, etc.

AA.8 Staff and Service Provider

Includes all employees and persons hired, contracted or licensed by the agency to provide Teaching-Family Model services.

AA.9 Practitioner

Includes any person providing services directly to the client.

AA.10 Consultant/Supervisor

Includes individuals providing support and supervisory services to the practitioner.

BB. INDICATORS/SOURCES

Several Indicators and Sources can be applied to all standards. These include:

BB.1 Consumer Satisfaction

The evaluators will review the agency's methods of obtaining consumers' opinions about the services provided and how their input is used to improve services.

BB.2 Observation

On-Site evaluators will observe program operations, service delivery by staff and interactions with client(s) while visiting the agency.

BB.3 Services Documentation

Evaluators will review any documents relating to the services provided by the agency.

BB.4 Outcomes

Evaluators will review evidence of program effectiveness and positive client outcomes that may include data, reports, graphs, observations, demographics of race or ethnicity, restrictiveness of programs and discharge information etc.

BB.5 Client/Staff Interviews

On-Site evaluators will interview clients and staff regarding services provided by the agency.

BB.6 Integrated Systems

The facilitative administrative, training, consultation, and evaluation systems support and complement each other.

CC. TEACHING-FAMILY MODEL GOALS

CC.1 **Humane**

How satisfied is the review team that the Agency demonstrates compassionate, considerate, respectful, and nonjudgmental positive regard for all clients with no tolerance for abuse and neglect *and* adheres to the treatment standards and client rights listed in Part Two of the Teaching-Family Association Standards of Ethical Conduct, specifically meeting the following **indicators of compliance**:

A. The Agency **ensures/supports the clients' rights to a wholesome, clean, safe, pleasant, and dignifying treatment environment** (i.e., a supportive, family-style or creates the most natural, nonjudgmental atmosphere for the treatment setting)? See Standard 206.

B. The Agency **does not tolerate in any way inhumane approaches to treatment** (e.g., humiliating, shaming, or frightening clients, or using corporal or aversive stimulation or excessive or arbitrary restrictions with clients)? See Standards 219-222.

C. The Agency **meets all other client rights** listed in Part Two of the Teaching-Family Association Standards of Ethical Conduct (e.g., rights to privacy, Standard 216; free exercise of religious, political, cultural, or other philosophical beliefs, Standard 217; medical treatment, Standard 212; communication with others, Standard 215; etc.)?

D. The Agency **has clear policies, procedures, and systems** to address alleged or substantiated abuse/neglect, restrictive interventions, and unethical actions by service providers/practitioners, **and staff is trained** and has an understanding of client rights and procedures regarding unethical practices, including abuse and neglect?

E. The Agency **routinely administers a staff practice/client safety questionnaire** to assess client safety **and appropriate procedures are understood and followed** when disclosures occur?

SOURCES FOR EVIDENCE OF COMPLIANCE			
Mission/Vision Statement	Restraint Data	Outcome Data	Consumer Satisfaction
Agency & Program Description	Training Records	Substantiated Abuse/Neglect Reports	Grievance Policies
Client Interviews/Feedback	Onsite Observation	Unethical Practices Documentation	Agency Reports

CC.2 **Effective**

How satisfied is the review team that the Agency delivers services that are effective (i.e., clients demonstrate progress toward goals, and outcomes are observable and measurable), specifically meeting the following **indicators of compliance**:

A**. Clients acquire skills necessary to achieve goals** related to treatment plans, life goals, permanency planning, family re-unification, etc. (e.g., clients are learning social skills, academic skills, problem-solving skills, job skills, parenting skills, independent living skills, etc.)?

B. **Clients demonstrate progress** (i.e., clients advance through the program systems, and the Agency outcome data indicate a trend that clients are moving to or maintaining the least restrictive environments post-treatment)?

C. **Consumer and client feedback contained in program/practitioner evaluation reports reflects satisfaction** with the effectiveness of treatment?

D. **Stability and quality of staff and practitioners are appropriately maintained** and contribute to the effectiveness of treatment?

SOURCES FOR EVIDENCE OF COMPLIANCE

Review of Case Files	Functional Assessments	Documentation of Services
On-Site Observation	Staff Interviews	Quality Assurance Measures
Staff turnover rates	Outcome Data	Practitioner Evaluations
Treatment Plans/Notes		

CC.3 **Individualized**

How satisfied is the review team that the Agency provides services that are client-centered, strength-based, and directly related to the individual needs of the client, i.e., specifically meeting the following **indicators of compliance**:

A. Clients have **individualized,** mutually agreed upon, written **treatment plans based on** careful assessment of **each client's strengths and weaknesses**?

B. The Agency **includes clients (and their families) in the treatment planning process** – in the early stages and also periodically throughout treatment (i.e., clients and families help determine treatment goals, clients know their goals and indicate satisfaction with their opportunity for input regarding treatment planning, etc.)?

C. **Treatment plans are reviewed and revised periodically** on the basis of progress and renegotiation and include plans relative to the client's post- treatment situation?

D. The Agency **adapts the program to fit the client** (i.e., the agency does not expect the client to fit the program; treatment strategies/approaches/systems are modified as needed to fit the client's developmental, cultural, and other needs; treatment teams are flexible and creative in treatment approaches)?

E. Interviews of and observations of clients indicate **clients view their treatment as individualized**?

SOURCES FOR EVIDENCE OF COMPLIANCE

Client Interviews	Documentation of Services	On-Site Observation
Consumer Evaluations/Feedback	Practitioner Evaluations/Client Feedback	
Staff Interviews	Treatment Plans/Notes	

CC.4 **Consumer Satisfaction**

How satisfied is the review team that the Agency provides opportunity for client and consumer input and that clients and other consumers express a high degree of satisfaction with services provided, specifically meeting the following **indicators of compliance**:

A. **Clients** have the opportunity to give input and to express their level of satisfaction with their treatment and treatment providers (i.e., all clients are routinely interviewed and encouraged to provide specific feedback to support their ratings and opinions) and **the results of that process indicate satisfaction**?

B. **Consumers** via the practitioner evaluations have the opportunity to give input and to express their level of **satisfaction with the treatment providers**, **and the results of that process indicate satisfaction**?

C. **External consumers** have the opportunity to give input and to express their level of **satisfaction with the agency at large,** and **the results** of that process achieve **at least a fifty percent response rate** and **indicate satisfaction**?

D. **Practitioners** have the opportunity to give input and to express their level of **satisfaction with the agency at large**, and **the results** of that process achieve **at least a fifty percent response rate** and **indicate satisfaction**?

E. When client, consumer, or practitioner feedback indicates less than satisfactory results, the agency **responds to feedback by developing a plan to strengthen consumer satisfaction** and effectiveness in that area?

SOURCES FOR EVIDENCE OF COMPLIANCE		
Client Interviews	Evaluation/Quality Assurance Documentation	
Practitioner Evaluations	Agency Consumer Satisfaction Report	Staff Interviews
Practitioner Satisfaction Report	Consumer Questionnaires	

CC.5 **Trauma Informed Care**

How satisfied is the review team that the Agency Teaching-Family programs train staff about the prevalence and impact of trauma, screen for trauma history, and provide services that are informed about, and sensitive to, the potential trauma-related issues present in survivors and their families., specifically meeting the following **indicators of compliance**:

A. The agency and program environments assure the safety of and respect for clients with a known history of trauma and their families. (*Note: Compliance with this indicator is another demonstration of Humane services).*

B. Staff is trained about the impact of trauma and the prevalence of traumatic experiences in the lives of persons and populations they serve. *(Note: Training around trauma as demonstrated through training outlines denotes compliance with this indicator).*

C. Program participants are screened for histories and symptoms of trauma.

D. Program participants' histories of trauma and their related symptoms of trauma inform the planning and delivery of services in order to strengthen their resilience and protective factors. *(Note: compliance with this indicator is demonstration of individualization in treatment).*

E. As appropriate, based on agency resources, service types, and legal and/or other reasonable restrictions/limitations, the agency attempts to educate families about trauma, its impact, and treatment; and address known parent caregiver trauma and its impact on the client and the family system. *(Note: Not Applicable could be a response to this indicator if the agency does not have access to families of clients in care).*

F. The program works collaboratively with clients with a history of trauma and their families, and other service agencies in a way that empowers them and meets their need to be informed, connected, and hopeful regarding recovery and which provide for continuity in care/treatment. *(Note: this indicator demonstrates individualization, consumer satisfaction, self-determination, strong relationships and a family-sensitive approach.)*

G. The agency has an established environment of care for staff that increases staff resilience and that addresses, minimizes, and, dependent on cultural and/or community and/or agency resources, treats secondary traumatic stress (e.g., debriefing after crises, employee assistance programs, training on self care, open-door policy with administrators, wellness and recreation programs, access to agency chaplain). *(Note: this indicator also suggests that administration is facilitative and consultation/supervision is supportive).*

SOURCES FOR EVIDENCE OF COMPLIANCE

Client Interviews	Consumer Satisfaction Surveys	On Site Observation
Training Outlines	Services Documentation	Outcomes
Staff Interviews	Program Descriptions	Site Director's Report
Trauma Screening Tool	Treatment Plans	

DD. TEACHING-FAMILY MODEL INTEGRATED SYSTEMS

DD.1 **Facilitative Administration**

How satisfied is the review team that the Agency's administration facilitates effective Teaching-Family Model program implementation (i.e., system integration, client-centered treatment, strength-based approaches, etc.) and provides necessary training, tools, support, and resources — specifically meeting the following **indicators of compliance**:

A facilitative administration is one that offers staff opportunities to provide input regarding program components. The administration facilitates and promotes system integration by providing necessary tools, training, and support; coordinating and assessing the service delivery system; and developing processes and resources to support and maintain the systems.

- Facilitative administrative decisions are based on the needs of clients and practitioners.
- A qualified staff administrator could be an individual who has been trained in the Teaching-Family Model.
- Agency administration is a proponent of the Teaching-Family Model.
- Facilitative administration abides by, regulates and monitors adherence to the standards of ethical conduct.
- Facilitative administration should comply with the legal regulations outlined by the local rules.
- There is a grievance process for staff.
- Facilitative administration promotes the professional participation of practitioners in the Teaching-Family Association.
- Facilitative administration supports safe, clean, environments.
- Facilitative administration should have a staff selection process that promotes implementation of the Teaching-Family Model.
- Facilitative administration supports longevity of direct care staff.
- Facilitative administration promotes diversity in the work place.

A. The Board and administration **provides sufficient resources** (i.e., safe, functional treatment environments, adequate program staff and practitioner positions, adequate tools, training, and equipment, etc.) **to effectively support and maintain the implementation of the Teaching-Family Model and its integrated systems**?

B. The administration has **staff selection/hiring procedures that support the implementation of the Teaching-Family Model (**i.e., the agency recruits and hires qualified, diverse individuals who uphold the standards of the Teaching- Family Model)?

C. The Board and administration **promotes longevity/stability of program staff** (i.e., provides adequate pay and benefits, opportunities for professional growth, recognition and appreciation, and an effective staff grievance process)?

D. The administration **promotes the goals, elements, and principles of the Teaching-Family Model** through education as well as participation in the Teaching-Family Association (e.g., encourages TFA membership, encourages participation in TFA committees, encourages and supports conference attendance, engages in data collection, contributes articles to TFA Newsletter, etc.)?

E. Administrative **decisions are based on the needs of clients and practitioners,** taking into account administrative decisions must comply with the legal regulations outlined by the local rules (i.e., the agency solicits practitioners' input; client-centered rationales can support agency decisions, etc.)?

F**. Feedback from** Teaching-Family **staff** and **practitioners indicates satisfaction** with Facilitative Administration?

SOURCES FOR EVIDENCE OF COMPLIANCE		
Staff/Practitioner Interviews	Affiliations/Memberships	Practitioner Satisfaction Report
Program Budget	Agency Consumer Feedback Reports	On-site Observation
Site Director's Report	Mission Statement	Policies/Procedures
Supervision Procedures	Training, Consultation, and Evaluation Data	

DD.2 **Training**

The agency provides pre-service and on-going skill development for all staff; staff are familiar with the Teaching-Family Model. The agency enables, facilitates, and holds all staff and service providers accountable for implementation of the Teaching-Family Model. The agency provides competency based training to increase the skill level of all staff and service providers to maintain and improve skill development.

- Pre-service training: training prior to being responsible for client services. Training is provided by a qualified trainer.
    - A qualified trainer is an individual who has been trained as a trainer; experienced in TFM implementation; has hands-on experience with clients; or combinations of any of the above.
    - Conducts trainer and training evaluations (i.e., trainers and content)

- Pre-service training should include the following:
    - Understanding the teaching procedures
        - Effective Praise;
        - Teaching-Interaction;
        - Situations, Options, Disadvantages, Advantages, Solutions;
        - Skill-based practice/behavioral rehearsal
        - Intensive teaching;
        - Planned/preventative teaching
    - Self-determination/self-government;
    - Relationship development (quality components)
    - Family-style living/creating the most natural, nonjudgmental atmosphere;
    - Individualized treatment planning;
    - Learning theory
    - Motivation systems
    - Client rights
    - Professionalism
    - Diversity and includes race, gender, ethnicity, age, socioeconomic status, sexual orientation, religion, disability in accordance with population serviced
    - Orientation of the Teaching-Family Model and Standards of Ethical Conduct
    - The impact of trauma on the individual, family, and community and the prevalence of traumatic experiences in the lives of the persons and populations serviced.

How satisfied is the review team that the Agency provides comprehensive Teaching-Family Model pre-service training and on-going skill development for all staff for the purpose of providing quality treatment, specifically meeting the following **indicators of compliance**:

A. The Agency ensures that **staff and practitioners are trained prior to being responsible for client services**, (i.e., documentation of pre-service training and attendance records)?

B. **Qualified trainers provide training** (i.e., trainers have had experience in TFM implementation and/or have had other hands-on experience with clients and have benefited from some type of "how to train" training), and the **agency has a procedure to allow trainees to evaluate content, delivery, and quality of pre-service training**?

C. **Pre-service training is comprehensive** and includes all recommended sections that apply to the population served and program setting (i.e., the various teaching procedures, self-determination/self-government, relationship-development, family-style living, individualized treatment planning, learning theory, motivation systems, client rights, professionalism, diversity, and orientation of the Teaching-Family Model and Standards of Ethical Conduct)?

D. **Pre-Service Training is competency-based** and includes behavior rehearsals and procedures to assess skill acquisition?

E. **In-service training occurs regularly** and covers topics relevant to the staff and their professional development?

F. **Feedback from the practitioners' consumer surveys indicates satisfaction** with training?

SOURCES FOR EVIDENCE OF COMPLIANCE		
Training Schedules	Staff Training Logs/Competency-based assessments	Resumes of Trainers
Training Materials for Trainers and Staff	Staff Interviews/Observation	Training Attendance Records
Practitioner Satisfaction Report	Training/Trainer Evaluations	

DD.3 **Supportive Consultation/Supervision**

A supportive consultation and supervision component supports and promotes practitioner skill development, ensures integrity of the Teaching-Family Model, and monitors services to clients.

- Consultation service delivery plan should be designed based on experience of practitioner, and the needs of clients
- Consultation needs to be frequent enough to meet the needs of the client, the practitioner and the program
- Consultation service delivery should be conducted through onsite observations, and telephone consultation and be available 24/7.

- The content of the consultation service delivery is reflective of the practitioner skill development and support as well as individualized treatment of clients. The consultation service delivery includes review and feedback where applicable. The consultation service delivery should include the following:
    - Treatment Planning,
    - Motivation reviews where applicable.
    - Understanding the teaching procedures
        - Effective praise;
        - Teaching-interaction;
        - Situations, Options, Disadvantages, Advantages Solutions;
        - Skill-based practice/behavioral rehearsal
        - Intensive teaching;
        - Planned/preventative teaching
    - Self-determination/self-government;
    - Relationship development (quality components)
    - Family-style living;
    - Individualized treatment planning;
    - Learning theory
    - Motivation systems
    - Client rights
    - Diversity and it should include race, gender, ethnicity, age, socioeconomic status, sexual orientation, religion, disability in accordance with population serviced
    - Professionalism
- Consultations should be conducted by qualified consultants
    - Consultants can be qualified through mentoring, consultation training, experience as a practitioner; and experienced in Teaching-Family Model
    - Consultants must have attended pre-service training

How satisfied is the review team that the Agency's consultation and supervision component supports and promotes practitioner skill development, monitors services to clients, and ensures the integrity of the Teaching-Family Model, specifically meeting the following **indicators of compliance**:

A. Consultation **service delivery plans are designed to effectively meet the needs of the client, the practitioner, and the program** (i.e., frequency and methods are based on experience, skill level, population served, special needs, etc.)?

B. Consultation service delivery includes **on-site observations that focus on feedback of trained program components, on-call telephone consultation** (i.e., constant availability), **treatment planning**, and **motivation system reviews** (where applicable)?

C. The **consultants/supervisors meet the service delivery plan and maintain documentation** of their consultation services?

D. **Consultants/Supervisors are adequately trained and knowledgeable in Teaching-Family goals, systems, and elements**. (Consultants must have attended pre-service training. Additional training can occur through mentoring, formal consultation training, or by way of experience as a practitioner and/or other involvement in the Teaching-Family Model)?

E. **Consultation focuses on providing effective TFM services to clients** (i.e., consultants provide strength-based feedback reflective of the practitioners' skill development in all elements of the Teaching-Family Model)?

F. **Feedback from the practitioners' consumer surveys indicates satisfaction** with the consultation services they receive?

SOURCES FOR EVIDENCE OF COMPLIANCE		
Staff Interviews	Service Delivery Plans	Practitioner Satisfaction Report
Outcome Measures	Service Delivery Documentation	Agency Consumer Satisfaction Report
Staff Resumes/Training Logs	Job Descriptions	

DD.4 **Evaluation**

The evaluation systems facilitate continuous quality improvement in service and care by assessing the skill of the practitioner and implementation of the Teaching-Family Model. This delivery system includes evaluation of all practitioners and of the agency.

A. Practitioner Evaluation

Frequency of evaluations

- The practitioner should participate in at least one "eyes-on", client and consumer evaluation annually.
- There should be a process in place to prepare practitioners for their annual evaluation. Initial evaluations are encouraged as a preparation for annuals.

Eyes-on Evaluation

- There are three parts to an evaluation: observations; community questions; client questionnaire.
    - The "eyes-on" evaluations consist of observing the implementation of the skills trained in the Teaching-Family Model.

Criteria

- All evaluations are conducted on a scale of 1-4, 1-5 or 1-7. Satisfaction is 3 on a 4 point scale; 4 on a 5 point scale or 6 on a 7 point scale.
- Annual evaluations and subsequent annual evaluations should be conducted by two qualified evaluators (*there may be an exception in the case where two evaluators may seem intrusive in the environment. In these cases reliability must be demonstrated through other means).
    - Evaluators can be qualified by mentoring, evaluation training, experience as a practitioner, experience in Teaching-Family Model evaluations, and must have attended pre-service training.
    - The primary evaluator should not be a program consultant to the program or practitioner being evaluated.
    - The agency will assure that practitioners will reach criteria in a timely manner through retakes for below criteria scoring.

Client Consumers

- There are two portions to a client consumer evaluation of the practitioner: a quality of care questionnaire and staff practice evaluation. The quality of care questionnaire needs to include questions pertaining to fairness; pleasantness; helpfulness/effectiveness; client input; concern and any additional comments they want to make. Criteria will be consistent with eyes-on observation scales. The staff practices evaluation should include, at a minimum, a question or set of questions to determine the safety of the client. (Adjustments to the tool will be made for unique client populations.)

Community Consumer

- The agency should conduct a community consumer evaluation for practitioners annually. Community consumers could include as examples, parents/guardians, courts, schools, social workers, mental health, neighbors, administrators, etc.
- Concepts covered by the community questionnaire should include cooperation, effectiveness of treatment, communication, quality of the environment, advocacy for the client and additional comments depending upon the community consumers' role with the client and the practitioner. We will use a rating scale consistent with all consumers. Insufficient information to respond will be included on any scale used although it is not included in averages.

B. Agency Wide Consumer

- The practitioner consumer evaluates the agency providing the four integrated services: training; evaluation; consultation and facilitative administration which will be conducted annually. The practitioner should evaluate the integrated systems independently.
- The agency will conduct a community consumer evaluation in conjunction with their onsite review cycle among those individuals impacting or impacted by the agency services.
- Rating Scales is consistent with practitioner level evaluations.
- Agencies have published guidelines for their evaluation review committees or process.
- Agencies strive for the highest return rate possible on all evaluations -- both agency and practitioner -- with a minimum of 50% on each category of the consumer portions polled.
- Agency consumer would include satisfaction questions related to the following areas
  - cooperation
  - effectiveness of treatment
  - communication
  - quality of the environment
  - advocacy for the client
  - additional comments

How satisfied is the review team that the Agency's practitioner evaluation systems facilitate continuous quality improvement in service and care by assessing the quality of treatment provided by the practitioner and the agency, specifically meeting the following **indicators of compliance**:

A. Efforts are made to maintain an interval of evaluations **occurring for each 12 months of service delivery** to the practitioner, taking into consideration extenuating circumstances; in these cases, an evaluation should occur at the first opportunity. **The 12-months of service delivery need not be consecutive**. Circumstances necessitating postponement of the evaluation beyond the 12-month window is documented.

B. Evaluations are **comprehensive** and **include** an **"eyes on,"** a **client consumer**, and general **consumer evaluation** (i.e., the eyes-on covers the skills and elements taught in pre-service training; the **client** portion assesses the practitioners' concern, fairness, opportunities for client input, pleasantness, and helpfulness/effectiveness; and the **consumer** portion assesses cooperation, communication, effectiveness of treatment, quality of the environment, advocacy for the client, plus the opportunity to provide additional comments)?

C. **Consumer polling procedures promote optimum participation** (i.e., consumer groups are identified and include all groups and individuals who have a vested interest in the agency, program, or clients served (e.g., parents/guardians, courts, schools, social workers, mental health professionals, neighbors, Board members, etc.; *and* polling procedures/efforts achieve optimal response rates, meeting at least the minimum fifty percent requirement)?

D. **Policies and procedures are in place to enhance fairness and effectiveness** in the evaluation/accreditation process (i.e., pre-evaluation training; *initial/six month evaluations; timely, well-written strength-based reports, post-annual/re-take evaluation options; use of a TFA approved rating scale, i.e., 1-4 — with 3 being criterion, 1-5 — with 4 being criterion, or 1-7 — with 6 being criterion; & e.g., a method with policy, evaluation review committee, etc.)?

**While TFA highly promotes the use of these measures marked with an asterisk, they are not mandated by TFA; therefore, the score for this indicator should not be negatively affected if they are not present.*

E. **Annual evaluations are conducted by *two qualified evaluators** who have completed pre-service training and other evaluation training (e.g., mentoring, formal sessions, experience as a practitioner, etc.)? **In certain program settings, two evaluators may be intrusive, and one may be used. Also, consultants may not serve as the primary evaluator to their own practitioners.*

F. **Feedback from practitioners indicates satisfaction** with the evaluation services they receive?

SOURCES FOR EVIDENCE OF COMPLIANCE		
Evaluation Tracking Systems	Evaluation Follow-Up Procedures	Practitioner Satisfaction Report
Evaluation Schedules	Evaluation Review Committee Minutes	Consumer Surveys/Materials
Evaluation Reports	Staff Resumes/Training Logs	

EE. TEACHING-FAMILY MODEL ELEMENTS

EE.1 **Teaching**

How satisfied is the review team that the Teaching-Family Model programs emphasize a strength-based approach to the teaching of functional skills and behaviors, specifically meeting the following **indicators of compliance**:

A. The Agency promotes a **systematic positive behavioral approach** to teaching (treatment plans focus on specific target skills that change as needed to reflect progress; focus of teaching is on clients' strengths and appropriate efforts; clients are able to advance through levels as they progress, gaining more privileges and/or freedoms as they earn them, etc.)?

B. Staff and practitioners seize opportunities to teach and rely on **Teaching- Family Model teaching procedures** (i.e., planned and preventive teaching, effective praise and corrective teaching interactions, logical and natural consequences, and/or other innovative teaching strategies appropriate for the population served)?

C. **Teaching interactions are supportive** and typically include TFM components (i.e., initial praise or empathy, specific descriptions of behavior, client-centered rationales, acknowledgement, opportunities for practice and feedback, and positive quality components)? Note: Special programs and/or populations may require adaptations and variances to the TFM interaction?

D. **Practitioners use planned, safe, de-escalation techniques** in response to aggressive and/or severe behavior?

E. Staff and practitioners **model the skills they are teaching** clients (e.g., social skills, problem-solving skills, communication skills, quality components, etc.)?

SOURCES FOR EVIDENCE OF COMPLIANCE		
Training Outlines/Schedules Treatment Plans	Evaluation Reports	Motivation System Reviews Consultation
Client Interviews	Observation	Feedback
Consumer/Client Surveys	Outcome Measures	Restraint Data

EE.2 **Self-Determination**

How satisfied is the review team that the Agency's Teaching-Family Model programs give clients as much control over their lives as possible, specifically meeting the following **indicators of compliance**:

A. Clients participate in own **goal setting** (i.e., clients identify goals that are important to them, those goals are an integral part of the treatment plan, practitioners support those goals and where applicable encourage clients to support one another's goals)?

B Clients are encouraged to **achieve personal goals** (e.g., client can advance through systems that increase their independence, clients are provided appropriate opportunities to explore and pursue interests, clients are encouraged to participate in extra-curricular activities, are given opportunities in less structured environments to apply skills, etc.)?

C. Staff and practitioners **facilitate and support client decision-making opportunities** (i.e., clients are encouraged to bring up issues/ideas; meetings/conferences provide opportunity for clients to make decisions, express opinions, offer feedback, etc.)?

D. Clients are taught **skills pertaining to self-determination** (e.g., self-advocacy skills, decision-making skills, problem-solving skills, leadership skills, etc)?

E. Clients are given **choices and options** (i.e., practitioners rely on methods and communication styles that promote an awareness and reality that choices and options are available to clients in almost every situation)?

SOURCES FOR EVIDENCE OF COMPLIANCE		
Training Outlines	Observation of family conference	Family conference logs
Documentation of Services	On-Site Observation	Practitioner evaluations
Youth Interviews	Treatment Plans/Notes	Goal Sheets/Point cards

EE.3 **Relationships**

How satisfied is the review team that the Teaching-Family programs promote the development of relationships that are maintained through trust, respect, and positive regard within professional boundaries, specifically meeting the following **indicators of compliance**:

A. Practitioners **interact positively** with clients using client-preferred behaviors (e.g., pleasant facial expressions, calm voice, appropriate proximity, etc.) and avoid non-preferred behaviors (e.g., yelling, cursing, judgmental words, sarcasm, etc.)?

B. Staff, practitioner, and program are aware of and **sensitive to clients' culture, environment, and preferences**?

C. Practitioners **encourage clients to appropriately express feelings**?

D. Staff and practitioners are **sensitive and responsive to clients,** especially in times of crisis, illness, and times of need as well as times of celebration?

E. All program staff and practitioners **build positive** relationships in all ways and at all levels (i.e., do staff treat one another as well as clients with respect and positive regard, do consumers report positive relationships, etc.)?

SOURCES FOR EVIDENCE OF COMPLIANCE		
Client Interviews	Practitioner Evaluations	Staff Practice/Client Safety Data
Documentation of Services	On-Site Observation	Consultation Notes
Pre-service training	Agency Consumer Satisfaction Report	

EE.4 **Family-Sensitive Approach**

How satisfied is the review team that the Teaching-Family Programs recognizes the importance of family to the client and encourages and supports family involvement whenever possible, specifically meeting the following **indicators of compliance**:

A. The programs **promote and advocate for the client and the client's family,** including the extended family?

B. Practitioners **involve the family** when appropriate (or significant individuals) **in the delivery of services** (e.g., parent support groups, parent training, opportunities to observe or participate in program activities, etc.)?

C. Practitioners **facilitate family interaction** or other relationship-building and family connectedness activities unless contra indicated (e.g., communication via phone calls, letters, e-mail, etc; creating a family scrapbook; learning/exploring family history, etc.)?

D. Programs create a **family-friendly environment** that is conducive to a family- sensitive approach (e.g., efforts are made to help families feel comfortable and welcome in the program, practitioners make themselves available to families, etc.)?

E. Staff and practitioners receive adequate, **effective preparation in family- sensitive treatment approaches**?

SOURCES FOR EVIDENCE OF COMPLIANCE		
Client Interviews	Practitioner Evaluations	On-site Observation
Documentation of Services	Director's Report	Treatment Plans/Notes
Pre-service training	Agency Consumer Satisfaction Report	

EE.5 **Diversity**

How satisfied is the review team that the Teaching-Family Programs provide services that are sensitive to differences arising from race, color, national origin, sex, gender, religion, age, physical disability, political affiliation, or socio-economic status, or any other protected status as defined by law, specifically meeting the following **indicators of compliance**:

A. **Diversity training occurs and is relevant** to the population served (i.e., staff and practitioners are aware of the diversity issues present in their treatment environments, in their clients, within their agencies and themselves)?

B. The **program environment reflects respect for diversity of the population and community served** (e.g., staff recruitment actively seeks to promote staff diversity relative to client population; agency is an equal opportunity employer; house/room/office décor reflects the population served; magazines, books, music, toys/games, menus, etc. reflect diversity; practitioners are aware of and respect each client's personal self-care needs: hair care products, skin care treatment, special diets, etc.)?

C. **Practitioners provide/support activities that promote and reflect the diversity of their clients** (e.g., the acknowledgement/celebration of holidays, participation in cultural events, opportunities to attend a place of worship of their choice, etc.)? Refer to Standard 217 of Standards of Ethical Conduct

D. The **agency offers services to clients regardless of race, color, religion, sex, sexual orientation, physical or mental challenges, national origin, etc.**?

SOURCES FOR EVIDENCE OF COMPLIANCE		
Training Outline	Consumer Satisfaction	On-site Observation
Documentation of Services	Equal Opportunity Policies/Procedures	Treatment Plans/Notes
Staff Interviews	Agency Consumer Satisfaction Report	Written Policy to support "D"
Cultural representation within the agency		

EE.6 **Professionalism**

How satisfied is the review team that the Agency remains committed to providing professional service characterized by competence, compassion, and integrity, always promoting the professional development and certification of practitioners, specifically meeting the following **indicators of compliance**:

A. The **Agency promotes practitioners' professionalism** through training, consultation, and evaluation and prioritizes and supports practitioner certification?

B. **Practitioners have opportunities to have leadership roles within the agency** (e.g., be special speakers, trainers, presenters, committee members, representatives and advocates to local, regional, state, and/or national organizations, etc.)?

C. **Practitioners participate as members of the treatment team and serve as an advocate for the clients' need(s)**?

D. **Professional development** increases the independence and autonomy of practitioners?

E. The administration, program staff, and practitioners **abide by and practice the Basic Standards of Professional Conduct** (Part I of Standards of Ethical Conduct)?

SOURCES FOR EVIDENCE OF COMPLIANCE		
Staff Interviews	Practitioner Satisfaction Report	On-Site Observation
Standards of Ethical Conduct accessible to staff and clients		

RATINGS OF COMPLIANCE

An Agency applying for Accreditation through the Teaching-Family Association will be rated using the following Scale:

4 **The agency demonstrates full compliance**.
The agency has procedures for and allocates resources to provide full support for this indicator.

3 **The agency demonstrates adequate compliance**.
The agency could more consistently implement or support this indicator.

2 **The agency demonstrates minimal compliance**.
The agency gives low program and resource priority to this indicator.

1 **The agency demonstrates no compliance.**
The agency fails to support this indicator.