

Section 4 Overview

This section pertains to the policy and procedures necessary when an out-of-home placement of a child is imminent or has occurred.

Chapter 16 Overview

This chapter describes the process of recommending placement of a child in out-of-home care into a therapeutic foster home. As in all decisions regarding the removal of children from their parents' homes, decisions must be made based on what is in the best interest of the child(ren). If it is determined therapeutic foster care is in the best interest of the child, all treatment planning must be tied to Adoption and Safe Families Act (ASFA) goals of reunification, adoption, guardianship, or independent living, meet all ASFA guidelines, and discharge planning must begin at the time of admission.

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16.1 Definition

Therapeutic foster care (TFC) is a living situation consisting of highly intensive individual treatment for one (1) or two (2) children living in a family foster home setting and community environment. TFC is administered as part of a residential treatment agency's array of services for children with significant emotional or behavioral needs, who, with additional resources, can remain in a family setting and achieve positive growth and development. TFC programs provide services to youth with severe behavioral disorders, psychiatric diagnoses, delinquency, and symptoms of complex trauma. TFC exists to serve children and youth whose special needs are severe enough that in the absence of such programs, they would be at risk of placement into restrictive residential settings such as hospitals, psychiatric centers, correctional facilities, or residential treatment programs.

Individualized treatment refers to the coordinated provision of services and use of procedures designed to produce a planned outcome in a person's behavior, attitude, or general condition based on a thorough assessment of possible contributing factors. Because treatment is individualized, each child, youth, and family receives flexible services over time to meet their changing needs. Treatment typically involves teaching adaptive, pro-social skills and responses that equip young people and their families with the means to deal effectively with the unique conditions or individual circumstances that have created the need for treatment. The term "individualized treatment" presumes stated, measurable goals based on a professional assessment, a set of written procedures for achieving those goals, and a process for assessing the results. Treatment accountability requires that goals and objectives be time-limited and outcomes systematically monitored.

The TFC parents are trained and supported to implement key elements of treatment in the context of the family and community life while promoting the goals of permanency planning for youth in their care.

Each therapeutic foster home and child is assigned a TFC worker with the primary responsibility for the development of treatment plans. The TFC worker also provides support and consultation to the TFC foster parents, to families of children in care, to children enrolled in the TFC program, and to other treatment team members. The TFC worker coordinates activities to ensure children and families receive needed services according to their treatment plan. The contractor provides at least weekly consultation to the TFC home and in-person contact every two (2) weeks or more frequently when indicated.

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16.2 Referral Process

Children referred to the program shall be between the ages of 6-21 and demonstrate behavior which indicates the need for an intensive and individualized therapeutic intervention. Children accepted into the TFC program have severe behavioral disorders, psychiatric diagnoses, delinquency, and symptoms of complex trauma. TFC exists to serve children and youth whose special needs are severe enough that in the absence of such programs, they would be at risk of placement into restrictive residential settings such as hospitals, psychiatric centers, correctional facilities, or residential treatment programs. Children referred to this program require a higher level of care than a traditional or elevated needs foster home, but may not require placement in a restrictive setting. This program may also be used for children who have received residential treatment services but are no longer in need of such services.

If the decision is made that therapeutic foster care (TFC) can best meet the child's clinical needs, referrals to the TFC program shall follow these guidelines:

1. The case manager must assess the child's need, via completion of the Residential Treatment Referral (CS-9), for therapeutic foster care.
 - a. If other services are needed, involve the Department of Mental Health (DMH): Division of Comprehensive Psychiatric Services (CPS)/Division of Developmental Disabilities (DD) at this time to maximize interagency expertise and financial participation.
2. The FST shall assess the child's needs and devise the treatment plan:
 - a. Because placement should always be in the least restrictive setting, efforts should be made to place a child with a relative home, kinship home, traditional foster home, or an elevated needs home prior to referral to TFC.
 - b. Collateral documentation of behavior or other factors that indicate a need for therapeutic foster care services should be provided.
 - c. The treatment plan must include strategies to allow for the child to remain "connected" to his/her family, kin, community, etc.
 - d. Connection to the community must be an integral part of the treatment plan for older youth who have a permanency plan of independent living.
 - e. The case manager/worker and the FST must remain an active and viable part of treatment planning.

3. Submit the following materials to the RCST Coordinator when the child has met the above criteria. The family, community members, or others who know the child can help with providing this material:
 - a. Completed CS-9 that includes the CSPI:

Upon completion of the CSPI, staff shall update the Alternative Care (AC) Client Information Screen. The Rehabilitation (REHAB) Service Begin Date will be the date on which the CSPI is completed.
 - b. Social history or psychosocial assessment or court assessment completed within last 60 days
 - c. Current case plan (CS-1)
 - d. Current school report/grade level and any applicable records. For children with special education requirements, current Individualized Education Plan (IEP) and educational diagnostic assessment
 - e. Medical history
 - f. Copy of parent's service agreement
 - g. Immunization record
 - h. Court orders and petitions
 - i. Criminal history
 - j. Psychological/psychiatric evaluation, and
 - k. For any youth age 16 and over, include CS-3 Life Skills Inventory, Daniel Memorial Life Skills Inventory, or CS-1 Attachment.
4. The case manager, supervisor, and RCST Coordinator will share information about the referral, discussion of possible placement resources, the urgency of need for placement, and other relevant information.

The RCST Coordinator will determine the most appropriate residential treatment agency, treatment period and placement date, authorizing all items on the service authorization.

Additionally, the RCST Coordinators will verify a child's REHAB-RT eligibility prior to entering any service authorization for TFC. If the RCST Coordinator determines that an otherwise REHAB eligible youth has not had eligibility established in the FACES system, they will immediately contact the child's case manager and/or supervisor. Service

- authorizations for residential treatment services are not to be entered without verification that the FACES system indicates the child's eligibility.
5. Receive notification from the RCST Coordinator regarding appropriateness of referral for placement, and receive copies of the RCST Coordinator's written request for admission/placements to appropriate providers.
 6. Carry out any of the following actions as appropriate to the RCST Coordinator's decision or recommendations:
 - a. Advise court and develop alternative treatment and/or case plan if the referral is determined inappropriate or if other options for placement have been suggested.
 - b. Coordinate all planning if county of current placement is different from county of jurisdiction.
 - c. Receive notification from the RCST Coordinator when a resource becomes available if child has not yet been accepted in an appropriate placement.
 - d. Notify the RCST Coordinator in writing if placement is no longer needed.

Written notification should be made in all instances of placement or withdrawal of placement request.
 7. Receive notification from provider of date for pre-placement interview visit.
 8. Proceed with placement preparation including the following:
 - a. Prepare the child and parents for change in placement. Provide information about the facility, location, special programs, visitation arrangements, etc.
 - b. Assess clothing needs and seek approval for expenditure if clothing is needed.
 - c. Arrange dental and medical examination within 30 days prior to actual placement, if provider requires more recent medical report.
 9. Assure the child's arrival at the facility on the date arranged for entry.
 10. Update the AC Client Information screen to denote a new placement and CSPI scores. When updating the AC Client Information screen accordingly, the REHAB Service Begin Date shall be the date the CSPI was completed. This is the eligibility determination date. Staff are not to backdate the REHAB Service Begin Date to reflect the date of placement unless the CSPI was completed on that date:
 - a. Complete a payment request if any special expenses are needed, have been approved, and are not included in the residential treatment contract.

- b. Update the AC Client Information screen to remove maintenance for any child entering a residential treatment agency.
11. Provide any needed placement support services consistent with the CS-1 including services to the parents:
 - a. Receive progress reports from the provider. The initial evaluation and plan of care should be in compliance with the FST plan, or if different, the reasons for any change must be documented.
 - b. Determine what needs to occur to facilitate the child's return to family or to another permanent placement in the community, coordinating and planning with the parent(s) and using recommendations of provider and the RCST Coordinator.
 - c. Submit a copy of the CS-1, including Family Support Team (FST) recommendations, to the RCST Coordinator at intervals required for each form.

Representatives of the treatment provider **must** be invited to attend the FST meeting. The treatment facility staffing can be combined with FST when appropriate as treatment goals, modality, and progress of child and family should be relevant discussion for members of both groups. Often the team members are the same for both meetings.
 - d. Submit reports to the court at required intervals incorporating progress reports, and the CS-1 including the FST and the treatment plan as determined by the FST. This should be the same treatment plan as that determined by the residential treatment agency.
 - e. Submit a copy of report to assigned Court Appointed Special Advocate (CASA) volunteer, if applicable.
 - f. Maintain responsibility for case record and case action including FSTs.
 - g. Notify local law enforcement agency or Missouri Highway Patrol immediately if child is reported as a runaway.
 - h. Notify the RCST Coordinator in writing, immediately, of any child removed from an authorized placement. Include the date of discharge and identification of the present placement resource.
12. Inform the RCST Coordinator, in writing, of any additional service needs the child may require. Include information describing the child's actual needs requiring a service outside of those provided by the residential treatment agency. Indicate the reasons as stated by the residential treatment agency that they are unable to provide these

- services. The RCST Coordinator will determine if these services are excluded from the contract with the facility.
13. Integrate the content of progress reports into services to the parents, FSTs, case plan development, reports to court, etc. The family may be included in therapeutic services provided to the child.
 14. Receive written notification from the RCST Coordinator at least 60 days prior to expiration date of treatment authorization.
 15. Receive notification from the provider at least 30 days prior to planned discharge of the child. If the FST has determined that the child and family are to be reunited, this plan shall be put into place. The TFC contractor, through therapeutic intervention with the youth and family, as well as working with the assigned case manager, shall identify necessary systems to support the family and youth during reunification. The case manager and other members of the FST will assure these supports are available to the family and youth as the goal of reunification is put into place. If the FST determines that return to the family or to another family setting is not appropriate, the case manager will:
 - a. Submit recommendations to the RCST Coordinator regarding child's continued need for treatment as soon as possible.
 16. The case-manager shall continue to determine what needs to occur to facilitate the child's return to family or to another permanent placement in the community, coordinating and planning with the parent(s) and using recommendations of provider and the RCST Coordinator. The case manager shall continue to utilize this needs list to develop the treatment plan to be implemented by the case manager and the TFC contractor. If it appears the child will be unable to return to family of origin, the FST, with the involvement of the child and family shall develop alternate plans for the child using concurrent planning and meeting the Court and ASFA time lines. The child and his family shall be encouraged to locate relative placements or other permanent placements that will allow the child to remain involved with his/her family of origin, even if it is not realistic for the youth to be reunited with his/her family.
 17. Provide aftercare services when the child returns to own family. If the child is unable to return to his/her family of origin, provide other replacement services, as appropriate to the child's needs and permanency plan.
 18. Record all activities every 30 days, incorporating progress reports, FST meetings, and case plan changes as appropriate.

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