THERAPEUTIC FOSTER CARE STANDARDS

PURPOSE

The purpose of these standards is to provide direction and guidance to the Children and Family Services (CFS) programs regarding the structure and application of therapeutic foster care services for children with SED. These standards are intended to achieve statewide consistency in the development and application of CMH core services and shall be implemented in the context of all applicable laws, rules and policies.

INTRODUCTION

Historically, children who have needed out-of-home services because of their emotional and behavioral problems have often been placed in a variety of treatment facilities. When this was necessary, the children were frequently moved out of their community, away from their home, school, and social system. This separation necessitated removing them from the support that they were receiving in their community, which can be traumatic for them. When they returned, regardless of how effectively they had been treated in the out-of-community placement, they were left to deal with the problems remaining in their home. Because of those problems, the success of treatment placements outside of the youth's community has been limited.

Therapeutic Foster Care (TFC) is an innovation that successfully answers these problems. Children are placed in natural home settings with trained families. They are in their own community so they are often able to attend their home school, and they can maintain relationships with their social network. They are in the same community as their family of origin or their permanent family. Their close proximity to their school, social network and family makes it possible for services to be delivered in the child's own environment and to deal with the actual problems associated with each of these entities and can provide the necessary education and support of the family's home while in TFC.

It is the intent of the Department to develop a highly effective Therapeutic Foster Care program. Foster families with the greatest potential will be selected and given special training. They will be given advanced training in the general skills required to care for severely emotionally disturbed children as well as specific training geared to meet the needs of the child who has been placed in their home. One Children's Mental Health Clinician will work closely with the Therapeutic Foster Parents while another attends to and oversees the treatment for the child. Psychosocial Rehabilitation providers will participate in the treatment of each therapeutic foster child, working closely with the child, the foster parents and the rest of the treatment team; they will utilize a treatment protocol specially designed to work in Therapeutic Foster Families. The entire service array of Children's Mental Health services, including but not limited to psychiatric services, short-term inpatient hospitalization, psychotherapy, Day Treatment and respite care will be coordinated and wrapped around the child, his or her family, and the TFC family according to the need. All of this will occur while keeping the child in his own

community and near his own home. And when the child is placed in his permanent family, the support and benefits of the Therapeutic Foster Care system will continue to be close at hand and accessible, thus assuring the greatest likelihood of success.

TFC is a service that is developed to meet the needs of both the involuntarily and voluntarily placed child. The philosophies of these systems can differ greatly in terms of the role that the child's family plays in the course of the placement. Involuntary placements are often made to protect a child from the maltreatment of their caretaker(s). Voluntary placements are often made by parents whose child is experiencing a behavioral, emotional, or mental disturbance and the child's family is unable to meet those needs in their home. Parents need to be involved in the planning and treatment of their child and involved in the delivery of the TFC. This requires a paradigm shift for some mental health professional, social workers and foster parents who will need to learn how to involve the child's family as a partner because the child will be returning to their family.

CORE VALUES

- The system of care should be child-centered and family focused, with the needs of the child and family dictating the types and mix of services provided.

- The families and surrogate families of children with emotional disturbances should be full participants in all aspects of the planning and delivery of services.

- Children with emotional disturbance should receive services that are integrated, with linkages between child-serving agencies and programs and mechanisms for planning, developing and coordinating services.

- Children with emotional disturbance should receive services within the least restrictive, most normative environment that is clinically appropriate.

- Children with emotional disturbances should receive individualized services in accordance with the unique needs and potentials of each child, and guided by an individualized service plan.

- The system of care should be culturally competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve.

- The needs of children and families can more effectively be met through flexible funding strategies than through categorical funding restricted to the most expensive resources.

STANDARDS

1. **The usage and development of therapeutic foster care shall be the responsibility of both child welfare and children's mental health.**

2. **Families that place their children in TFC shall be included in all aspects of planning and treatment as a full partner.**

3. **Each region shall develop a method of the coordination of the therapeutic foster care system.**

4. **All children considered for placement in TFC shall receive a comprehensive assessment by a CMH clinician.**

5. **All children placed in TFC shall meet the CMH eligibility criteria of SED and be assigned a CMH clinician; any variance from the standard shall be documented.**

6. **DHW shall contract for TFC service. The contract shall detail rates, expectations, and services to be provided.**

7. **A continuum of support shall be available to each TFC family 24-hours a day/7 days a week.**

8. **All TFC placements shall be approved by the Regional Placement Authority and shall include the participation of the child's family; any variance from this standard shall be documented.**

9. **The CMH clinician that is assigned to provide clinical case management shall be responsible for working with the family, the child (when appropriate), the TFC family and other relevant parties to develop a service plan that identifies the course of treatment, and clear delineation of roles and responsibilities. The plan shall be signed by all parties that participated in its development.**

10. **All placements, whether voluntary or involuntary, CMH or CW, shall adhere to ASFA regulations and DHW rules associated with the alternate care of a child.**

11. **Aftercare and transition planning shall begin at initial placement and strategies for transition shall begin no later than 90-days prior to the anticipated date of exit from TFC.**

12. **The following requirements shall be met before a family shall be considered for a TFC placement.**

    a. **Foster care licensure**
    b. **Completion of required foster care training for licensure**

c. 30 hours of TFC training including, but not limited to:

i. Crisis management
ii. Observation and documentation
iii. Implementation of positive behavior modification techniques
iv. Parenting techniques
v. Treatment plan implementation
vi. Medication management
vii. CPR, First Aid and HIV/AIDS awareness
viii. Involving the child's family in delivery of treatment

13. Each region shall develop and implement strategies for TFC recruitment, retention, and training.

14. Any variance to these standards shall be documented and approved by division administration, unless otherwise noted.

15. Each region shall establish therapeutic foster care service delivery goals and shall annually submit a plan and timeline to achieve those goals to division administration for approval.