

KEEPING FAMILIES TOGETHER

A Guide for Families Who Have Children with Mental Illnesses that Need Intensive Treatment

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INTRODUCTION

Parenting a child with a mental illness can be very difficult. The child may be in trouble in school, be at risk of hurting themselves or others, or be involved in the juvenile justice system. The professionals who treat the child may not be able to agree on a diagnosis, or the diagnosis may keep changing. Everyone may have difficulty finding treatment that works. The family may have strained relationships and strained finances. Parents or caregivers may feel frustration and guilt as they seek help for their child.

Sometimes the child cannot be safe in the home, or the child needs more care than can be provided in the home or community. When this happens, parents or professionals may believe that residential treatment is the best option for the child. It is always a difficult decision for parents. It can happen after all options to keep the child in the home have been tried. It can happen because the symptoms or behaviors are dangerous. It can happen because children need to get very intensive treatment and the treatments the child needs are not available in their community. While it is important to keep children with their families whenever possible, sometimes the symptoms of a child's mental illness are so severe that the parents need to ask for out-of-home placement. This can happen with families of any income level and in any family situation.

This guide, *Keeping Families Together*, explores the issues families face when they decide that their child needs out-of-home treatment.

It covers many of the concerns parents will have such as:

- ▶ How can we continue to make decisions about our child's care?
- ▶ How will we pay for treatment?
- ▶ What does Minnesota Law say about sending my child away from home for treatment? ■

CHILDREN WITH MENTAL ILLNESSES

About 1 in 5 children has a mental illness. Mental illnesses are not caused by poor parenting or family income. Emotional or mental health problems can develop at any age. Many children experience conditions like depression, anxiety, ADHD and eating disorders. A child's mental health can affect them in many ways—how they get along with other family members, grades in school and friendships.

It's important to identify and treat mental illnesses in children as soon as possible so they can get better. Difficult behavior can be a symptom

of a mental illness. It is important to learn what is causing the behavior so that the right treatment can be provided.

Emotional Disturbance and Severe Emotional Disturbance

Terms used to describe children who have a mental illness include *emotional disturbance* (ED) and *severe emotional disturbance* (SED). These terms are not mental health diagnoses. Neither is the special education term *emotional or behavioral disorder* (EBD). These are terms used to describe how severe a child's behaviors are. These terms are also used by county agencies, schools and mental health providers to determine if a child qualifies for services.

An emotional disturbance is defined as:

An organic disorder of the brain or a clinically significant disorder of thought mood, perception, orientation, memory or behavior that:

- ▶ Is listed in the clinical manual of the ICD-10 code range 290.0 to 302.9 or 306.0 to 316.0
- ▶ Seriously limits a child's capacity to function in primary aspects of daily living such as personal relations, living arrangement, work, school and recreation

This means that mental illnesses are illnesses of the brain that affect the way a child thinks, feels and acts. They also affect the way a child is able to live their life from day to day. They may struggle with relationships, in their home, work, school or play.

The ICD-10 is the International Classification of Diseases, 10th Edition. This book is used to classify and code diseases throughout the world. The code ranges mentioned above refer to mental health diagnoses.

To meet the definition of a severe emotional disturbance, one of the following must apply:

- ▶ The child has been admitted within the last three years or is at risk of being admitted to inpatient treatment or residential treatment for an emotional disturbance.
- ▶ The child is a Minnesota resident and is receiving inpatient treatment or residential treatment for an emotional disturbance through the interstate compact.
- ▶ The child has one of the following as determined by a mental health professional:
 - psychosis or a clinical depression
 - risk of harming self or others as a result of an emotional disturbance
 - psychopathological symptoms as a result of being a victim of physical or sexual abuse or of psychic trauma within the past year

- ▶ The child, as a result of an emotional disturbance, has significantly impaired home, school or community functioning that has lasted at least one year or that, in the written opinion of a mental health professional, presents substantial risk of lasting at least one year.

To determine if a child meets the definition of ED or SED, a diagnostic assessment is needed. A good diagnostic assessment will measure how the child functions in all areas of their life. It will also evaluate how the child does at home and school. It should also include a visit to a pediatrician to rule out any other physical problems that may be causing symptoms. A diagnostic assessment is not the same as a special education assessment.

Diagnostic assessments can be performed by the following:

- ▶ Licensed psychologists (LP)
- ▶ Licensed independent social workers (LICSW)
- ▶ Psychiatrists (M.D.)
- ▶ Clinical nurse specialists (CNS)
- ▶ Psychiatric nurse practitioners (NP)
- ▶ Licensed Marriage and Family Therapists (LMFT)
- ▶ Licensed Professional Clinical Counselors (LPCC)

The diagnostic assessment is used to determine the diagnosis and guide the treatment plan. In order to obtain a good diagnostic assessment, parents should keep track of troubling behavior so they can provide good information to professionals.

Parents can feel frustrated when they try to find the right professional help for their child. The mental health system is very complex, and parents may find it hard to navigate. Often it feels like nothing works and nobody understands. It can also be difficult and take a long time to find professionals who understand how to treat some mental illnesses.

Parents should not be afraid to ask questions, such as:

- ▶ How will this treatment work?
- ▶ How much time will it take?
- ▶ What do you expect of me or my child?
- ▶ How long before we see changes?

Mental Health Services

Children with mental illnesses often benefit from a full array of mental health services.

These services include:

- ▶ Outpatient treatment
- ▶ In home and school linked services

- ▶ Crisis services
- ▶ Day treatment
- ▶ Partial hospitalization
- ▶ Inpatient hospitalization
- ▶ Therapeutic foster care
- ▶ Residential treatment

This array of services needs to be available and tailored to meet the unique needs of the child's diagnoses, age, culture and functioning level.

There are many treatments or paths for a child to enter the mental health system. The path a child takes may depend on whether the treatment will be paid for by private insurance, Medical Assistance, special education, MinnesotaCare, Federal IV-E (foster care) or county dollars. The services that are available will also depend on who is paying for the treatment and where the child lives.

While it is best for children to start with less intensive treatment in their community, it doesn't always work that way. Sometimes a child's symptoms develop suddenly or progress quickly and very intensive treatment needs to be started right away. Some professionals may not want to recommend residential treatment. They may believe that it will harm a child's relationships with their family. They may not be aware of information that shows that residential treatment works. Many families have found that therapeutic foster care or residential treatment is the best choice. Data collected by Minnesota's treatment centers has also shown that residential treatment can be helpful.

Assessments

Having a mental illness does not mean a child will qualify for all mental health services. Counties and providers should use assessment tools to see what services are needed. These tools are used to measure how well the child is able to function at home, at school and in the community. The scores from these assessments will be used to determine whether a child qualifies for specific services. They can be used to determine what intensity and level of treatment is needed. They also can be used to measure a child's progress and show if there is a need for more services.

Parents of a child with mental health needs will encounter a variety of "screens" or "assessments." Screens are typically brief questionnaires that can alert the screener to the need for more information or further assessment. Counties use assessments to measure the level of service needed. If a county is considering out-of-home placement, then the county will use a tool called a "level of care determination." This is

used to determine the best treatment or placement for the child. Parents should help decide if a child needs residential treatment. It is important for parents to keep track of difficult behaviors, what interventions have been tried, and report them when they are completing screens and assessments.

If a family wants to receive services or needs access to funding from the county, they will work with a county case manager. The case manager will arrange for a functional assessment to be completed. For children over the age of six, the Minnesota Department of Human Services requires the use of the Strength and Difficulties Questionnaire (SDQ) combined with the Child and Adolescent Service Intensity Instrument (CASII) to determine the level of care needed. Children below the age of six are assessed using the Early Childhood Service Intensity Instrument (ECSII). The SDQ should be completed by the child, the caregiver and any other interested parties, including school staff for example. The CASII looks at the level of care needed by a child. It assesses the severity of symptoms.

It also looks at service needs in several areas:

- ▶ **RISK OF HARM:** Is it likely that the child will harm themselves or someone else without more intensive treatment?
- ▶ **FUNCTIONAL STATUS:** Is the child able to function safely at home, at school and in the community?
- ▶ **CO-MORBIDITY:** Does the child have more than one mental health diagnosis, a chemical dependency, a medical condition or a developmental condition?
- ▶ **RECOVERY ENVIRONMENT—ENVIRONMENTAL STRESS:** Are there stresses at home or in the child's community that make it hard to recover?
- ▶ **RECOVERY ENVIRONMENT—ENVIRONMENTAL SUPPORT:** Are family members or other caregivers able to support the child in their home environment?
- ▶ **RESILIENCY:** Does the child have the tools and skills needed to recover without more intensive treatment?
- ▶ **CHILD/ADOLESCENT INVOLVEMENT IN SERVICES:** How many times has the child needed more intensive treatment such as hospitalization? Is the child cooperating with treatment in the community?
- ▶ **PARENT/PRIMARY CARETAKER INVOLVEMENT IN SERVICES:** Does the parent/caretaker have good relationships with treatment providers and take the child to appointments?

CASII scores range from 1–5 in each area, with 40 possible points. There are 6 levels of care based on the scores.

The chart below shows the scores for each level of care and what each level means.

LEVEL	DESCRIPTION	SCORE
0	Prevention services	7–9
1	Managing recovery	10–13
2	Receiving outpatient treatment	14–16
3	More intensive outpatient treatment	17–19
4	Very intensive integrated services	20–22
5	24-hour psychiatric care (residential treatment)	23–27
6	Secure 24-hour psychiatric care (secure residential treatment)	28+

The CASII will also show:

- ▶ the child’s mental health symptoms
- ▶ use of drugs and alcohol
- ▶ ability to function at work, school and in the community
- ▶ how the child’s symptoms are affecting their relationships
- ▶ whether the symptoms are making it hard for the child to care for their medical or dental health or learn to live independently

The SDQ measures a child’s overall stress, emotional distress, behavioral difficulties, hyperactivity and concentration difficulties, concern in school about activity and attention, the child’s ability to get along with same-age peers, and kind and helpful behavior. A full SDQ score of 0–15 is considered “normal;” 16–19 is considered “borderline” and above 19 is considered “abnormal.” ■

TREATMENT OPTIONS

It is best to try to keep children with their families and treat them in their own community. Parents often try many types of services before thinking about residential treatment. Many services are available in the community. These include counseling or therapy, day treatment, in-home services, crisis services and respite care. What is available depends on the needs of the child, the county you live in and whether your family has applied for county social services. Some families feel forced to seek residential treatment because community supports are not available or are offered too late. Some families are incorrectly told that they have to try all other options before seeking residential treatment.

Counties must provide targeted case management services to children who have a severe emotional disturbance if families ask for or agree to the services. The role of a case manager is to help families obtain needed services. These include mental health, social, educational, vocational and recreational services. Case managers should also coordinate these services. Case managers should be aware of available community services. They should also understand how to qualify for medical assistance programs and make sure there are no gaps in treatment. Sometimes parents are assessed a fee for Medical Assistance based on their incomes.

Community Services

There are many different types of services available to provide treatment and support to a child and his or her family. Services are paid for in many ways. These include private insurance, Medical Assistance, MinnesotaCare, county funds and educational funds.

Here is a listing of services that may be available in your community:

Youth Assertive Community Treatment (Youth ACT) is for youth ages 16–20. It is an intensive, nonresidential mental health service provided by a team to support the young person in their community. Team members include a licensed mental health professional, an Advanced-Practice Registered Nurse, a licensed drug and alcohol counselor if needed, and a peer specialist. It is paid for by Medical Assistance.

Eligibility for Youth ACT is based on:

- ▶ A diagnosis of serious mental illness or co-occurring mental illness and a substance abuse addiction
- ▶ A level of care determination for “intensive integrated intervention without 24-hour medical monitoring” and a need for extensive collaboration among multiple partners

Children’s Mental Health Collaboratives may pay for or provide some mental health services in some communities. Funding for these services has gone down in recent years, but these collaboratives do receive some funding to pay for services for children who are uninsured. Some collaboratives do continue to provide wrap-around services. Wrap-around uses a team of people connected to the child to provide care. This care is driven by the needs of the family and based on the strengths and culture of the child. It includes both formal treatment services and informal community supports.

Children’s Therapeutic Services and Supports (CTSS) are offered by a community provider or county. The state certifies CTSS providers. They must provide individual, family or group psychotherapy. If this is not medically necessary, the provider must document why it is not needed. If it is not possible to provide therapy because there is not a licensed provider available in the child’s community, this must be documented as well. CTSS also provides individual and group skills training, family skills training, crisis assistance and mental health behavioral aide services. Mental health behavioral aides help children practice the skills they learn in therapy between appointments. Families can choose which of the services they need or they can use all of the services as a package. The services can be provided in the family’s home, child’s school or other community settings. Parents should be involved in developing the treatment plan. Children on Medical Assistance can receive up to 200 hours of service per year without prior authorization. Families can apply to receive more than 200 hours if needed, but it must be approved by the state. Medical Assistance and some private health plans pay for these services.

Community Alternatives for Disabled Individuals (CADI) waivers are a limited special program. CADI waivers can be used to pay for intensive services in the home or other community-based setting for children who have a serious emotional disturbance. They must also be at risk for entering or be leaving an intensive residential placement such as a private or state hospital. CADI waivers are only available to those who are on Medical Assistance.

Community mental health centers provide many mental health services on a sliding fee scale. These services include diagnostic assessments and psychotherapy. They should also have staff that can help manage psychiatric medications. If the center has been certified as a CTSS provider, they can also provide those services. Private clinics and independent mental health professionals in private practice also provide specific therapies or treatments. They usually accept all types of insurance (public and private) and can bill people on a sliding scale.

Counseling and therapy can be one-on-one, with the entire family or in a group session. Certain types of therapy have been shown to work best for particular mental health conditions. These types of therapy are called “Evidence-Based Practices.” When choosing a therapist, caregivers should ask if the therapy provided will be evidence-based or evidence-informed. Private insurance and state health care programs typically pay for these services.

Crisis assistance includes helping a family develop a crisis plan. Crisis plans help families know what to do if their child is in crisis. They can

also help families learn how to avoid a crisis before it happens. They can help find crisis placement when a child needs a place to stay. They provide resources in the community for after the crisis. They also provide emotional support to the family during the crisis. Many counties and health plans offer 24-hour crisis response teams or crisis hot lines, and some provide 24-hour mobile crisis teams. Mobile crisis teams can send a mental health practitioner to the family wherever they are located to provide in-person support. Crisis teams can also provide short term services to develop and implement a crisis stabilization plan.

Day treatment services are a package of CTSS services and are very structured. A child spends several hours in day treatment. Services must be provided by a certified provider 2-3 hours per day at least 3-5 days per week. Services should include individual or group psychotherapy and skills services. Other intensive services such as help managing medication may also be included. Day treatment is used to stabilize the child's mental health status when regular therapy is not enough. Staff also helps the child develop and practice independent living skills and work on social skills to improve relationships. Day treatment services must be offered year-round. Many programs work with the local school district to provide minimal education for part of the day. Private insurance and state health care programs usually pay for these programs. Sometimes they are also paid for by counties or a school's special education program. Some schools call their programs for children with emotional or behavioral disorders day treatment. These school programs do not meet the same clinical standards nor provide the same level of care.

If education is being provided as part of day treatment during the school year, the home district should provide transportation each day. You should communicate with your school district to coordinate transportation. Many public and private health plans also may provide or fund transportation assistance.

Family community support services must be offered by counties under the Children's Mental Health Act. These services are designed to keep a child with their family. They may include outreach to the family, therapeutic foster care, medication management, assistance with independent living, leisure and recreation, parenting skills and home-based family therapy. Families may also receive help finding financial assistance, respite care and special needs day care providers.

In-home services are currently provided through CTSS or by the Personal Care Assistant (PCA) program. The Community First Services and Supports (CFSS) program will eventually replace PCAs, which are funded under Medical Assistance. PCAs are used to provide in-home

support to people with significant disabilities. CFSS is in the process of being approved by the Federal Government to be billed under Medical Assistance. Individuals must be screened to qualify for this service. Changes to state law have made PCAs much more difficult to qualify for when the child has a mental illness rather than a physical disability. However, if PCA support is needed, you should still apply by contacting your county Human Services department.

Respite care: This type of support gives families a break from caring for the child. It can be provided by bringing a caregiver into the home or placing the child in another setting. A trained respite provider may be another parent or professional who takes care of the child for a brief time. Respite care reduces the stress of caring for a child with a mental illness. It may help to prevent out-of-home placement. If a child receives case management (called Rule 79), then he or she will be eligible to receive respite care through funds from the state. These funds can pay for traditional and nontraditional (such as summer camps, etc.) respite care. Many counties receive these funds, but not all. Ask your child's case manager about respite care if you think you may need it.

School-linked mental health services are delivered by mental health providers in public schools. Therapy is provided to students who need mental health services. The school linked therapist meets regularly with school personnel so they can work together to meet the needs of students. Students do not need to qualify for special education services to receive services. The services are paid for by private insurance, Medical Assistance, MinnesotaCare and in some cases, with state grant funds for children who are uninsured or underinsured.

TEFRA gives families who are above the poverty level a way to qualify their child for Medical Assistance. The child must have developmental disabilities or a serious emotional disturbance to qualify. If the child qualifies, all mental health services covered by Medical Assistance will be available to the child. The child must qualify for the services to receive them. This includes waiver programs, health care, mental health care, Personal Care Assistance, day treatment, residential treatment and CTSS. Parents will pay a fee according to their income. Parents' fees may increase if they drop their current insurance.

Inpatient and Residential Services

Inpatient and residential services are available when the child's need for treatment or safety requires it. The most intensive services are provided in these settings.

Inpatient hospitalization offers 24-hour care seven days a week. Hospital programs provide the most structure for children and adolescents in crisis. The goal is to quickly stabilize the child and return him or her to their home or a less restrictive treatment setting. The hospital treatment team should work with the family to provide a smooth transition from the hospital to the next setting. The average length of stay for a hospitalization is four to seven days. Emergency services for psychiatric evaluation are available through some hospital emergency rooms 24 hours a day. Not all hospitals have inpatient care for children or adolescents. It sometimes can be difficult to find an open bed. All hospitals have access to a statewide bed tracking system to find an open bed. Hospital care is typically covered by private insurance, Medical Assistance or MinnesotaCare or the hospital's charity care program.

Partial hospitalization provides the same support a child would receive in an inpatient hospitalization program, but the child is able to come home each evening. Some education is usually provided as part of the program during the school year. Often the school will provide transportation to and from the program each day. Medication management, group therapy, skills building, family therapy and family group therapy are often a part of these programs.

Intensive treatment in foster care provides a higher level of support than can be offered at home or in traditional foster homes. This is a family-based approach which involves a team of professionals who work with the child and caregivers. Services include psychotherapy, clinical care consultation and psychoeducation. Psychoeducation helps parents learn about the mental illnesses the child is diagnosed with along with symptoms and treatments. Intensive treatment in foster care is for children through age 20 who live with a mental illness. Each child must be assessed for a history of trauma. This is because trauma has a big impact on symptoms. The child and foster family must have access to clinical phone support 24/7. The services can be provided in the home, school or in the community. This care is accessed through the county social service agencies and is paid for using public funds.

Treatment foster care requires foster parents to obtain a special foster care license and limits the number of children in the home to two. Foster parents receive extra training to deal with more challenging behaviors and mental health diagnoses. There are very few licensed treatment foster care homes in Minnesota.

Therapeutic foster care is provided by private agencies, but still paid for by counties. Foster parents who provide therapeutic foster care receive additional training and support provided by their private agency.

Residential programs are year-round programs designed to meet the intensive needs of children. Group facilities that serve only a few children with less intensive needs are commonly referred to as group homes. Larger facilities are called residential treatment centers. Each licensed facility can be specially certified for the particular services provided. Certifications include secure programs, chemical dependency treatment programs, transition programs, shelter, mental health treatment programs and corrections. Education is provided either on site or in local public schools. Some programs are licensed by the Department of Human Services. Others are licensed by the Department of Corrections. The rule that governs how they operate is called the “Umbrella Rule,” which provides core standards of care for all residential facilities. Residential services are designed to provide stabilization. They address mental health issues and symptoms, improve the child’s ability to function and help the family develop skills to care for the child when they return home. When county funds are used to pay for residential services, parents must pay a fee based on their income.

Types of residential programs include the following:

- ▶ **Mental health certified residential facilities** offer individual, group and family psychotherapy in a highly structured environment. Therapeutic and educational services are provided for children and adolescents who have serious emotional or behavioral difficulties. Residential treatment is for children who have not been successful or have needs that cannot be met in their homes or communities. Mental health residential treatment programs provide services based on individual treatment plans. These plans are based on the clinical needs of the child. They should support the child in gaining the skills they need to return to the community. They should also support the family in gaining the skills they need to care for the child. They are provided by qualified staff under the clinical supervision of a mental health professional. Minnesota law requires commercial health plans to cover mental health residential treatment and this service is also included in Medical Assistance (MA) benefits. Families can only access MA coverage through county placement.
- **Shelters** provide a temporary safe placement for children who cannot stay at home. The county social service agency has become involved with the child and the child’s family when a child is placed in a shelter. Children are screened and, if needed, further assessment is arranged. If needed, children may be referred to other levels of care or services.

- ▶ **Transition programs** serve children between the ages of 16 to 21. These programs are designed to help young people prepare for adulthood and independence. Services include housing, independent living skills training and supportive services. Services may be located in group housing, in a young person's own apartment or in a cooperative setting.
- ▶ **Evaluation/Diagnostic** programs provide an inpatient assessment. This can take from 15 to 45 days. The child is evaluated through formal diagnostic testing, observation and functional assessment. Such programs often exist within residential treatment facilities.
- ▶ **Restrictive procedures certification** means that the facility is certified to use procedures to limit the movement of the child in the case of an emergency. These include physical escort, physical holding and seclusion. Certification requires that these procedures only be used when necessary to prevent harm to the child or others. Staff must be trained in the proper use of these procedures. Use is monitored and reviewed. Procedures such as mechanical restraints and disciplinary room time are only allowed in a correctional program.
- ▶ **Secure programs** are programs in a building or part of a building that is secured by locks. These programs are intended to prevent the child from leaving the program without authorization.
- ▶ **Contract Beds in certain hospital settings** will be available in the future for children who are in crisis. The Department of Human Services will work with stakeholders to develop this service. NAMI Minnesota hopes to have a service designed that will include room and board in the cost of the service. This will avoid the need to use the foster care system to pay for care.
- ▶ **Psychiatric Residential Treatment Facilities (PRTF)** were established in the 2015 legislative session. They will provide up to 150 new residential beds for children over the next three years. These beds are for children who need more intensive treatment than traditional residential treatment can provide, but do not need to be hospitalized. Children who need a more intensive level of care because of a medical or mental health condition will qualify. Because room and board are covered as part of the cost, voluntary foster care will not be required. Youth up to age 21 (or 22 if they turn 22 while in treatment) will be eligible for this service. It will be effective July 1, 2017.
- ▶ **Child and Adolescent Behavioral Health Services (CABHS)** is a residential treatment facility operated by the state of Minnesota. It is located in Wilmar, Minnesota. Children who are not eligible to receive treatment in a private facility but require residential treatment can be treated at CABHS.

Reasons a child may not be able to qualify for another treatment center include:

- Other medical conditions
- Difficult behaviors such as extreme self-harm or aggression
- Symptoms that have not responded to treatment in other settings
- Developmental or intellectual disabilities

A complete list of residential programs is available on the Minnesota Department of Human Services website. This information can be found by going to www.dhs.state.mn.us, clicking on “General Public” and opening the “Licensing” section. Information includes the certification of the facility, the address and contact information. You can also visit the Minnesota Council of Child Caring Agencies website at www.mccca.org for more information on residential programs. ■

THE DECISION TO PLACE YOUR CHILD IN RESIDENTIAL TREATMENT

There are times when parents have done everything possible to help their child or to keep their child safe. Yet, they still find themselves in the difficult position of considering residential treatment. It’s not their fault; it’s nobody’s fault. Some children need a high level of care. They need a high level of structure and a set routine to manage their mental illness.

Making this decision is difficult. Parents should weigh all the options. As with any treatment, there are risks. Some parents and professionals worry about their children getting hurt in out-of-home placements. It is hard for children to be away from their families. If the treatment facility is far from home, it may be hard for parents to visit. On the other hand, children can be helped by a structured environment and intensive treatment. They may find relief and support from other youth struggling with similar problems.

Remember that this decision won’t be made alone. Assessments will be made by the mental health professionals and in some situations by the county. Your child will need to meet a level of care need as determined by the CASII or ECSII along with the SDQ (see pages 4–5). In the end, parents have to decide what they feel is best for their child and their family.

Choosing a Program

When parents have decided that their child needs residential treatment, the next step is to decide which facility is best for the child. Parents will face many questions: How do you find out where these facilities are? Whom do you ask? How do you determine which facility can best meet your child's needs? What questions should you ask? How do you advocate for your child? Who can help you decide where to place your child?

The best way to find out about facilities is to speak with someone who is familiar with the children's mental health system in Minnesota. Parents can ask the staff of psychiatric units, professionals who work with their child, school social workers, community agencies and other parents. Residential services can be recommended by a mental health professional, the county case manager or the staff of the county mental health services unit for children. The parents' health insurance plan may also have a list of treatment facilities that it covers. Counties will have a list of facilities that they contract with and will want you to use. Parents can also view the online searchable directory of the Minnesota Council of Child Caring Agencies at www.mccca.org or go to the Minnesota Department of Human Services website at www.dhs.state.mn.us.

Once parents know the names of facilities, they should talk with the admissions staff and visit some of them if possible. This will provide an opportunity to ask questions and meet staff. Parents should trust their instincts. You know your child best. You may want to consider bringing a family member or friend along when you visit the facility. This is a difficult time for your family and having support may help make the process easier.

Parents should know, however, that they may have little control over which facility their child enters. If immediate placement is needed, the child may simply end up in the nearest facility with an open bed. Sometimes families need to wait until there is an open bed in the facility they prefer. It may be helpful to know that all residential programs in Minnesota have to meet common licensing standards. They can then choose to seek additional certifications based on the clients they serve.

Questions to Ask

Parents can be very vulnerable when they are selecting a program for their child who is in crisis. They need a lot of information about treatment programs.

Below is a list of questions you may want to ask to help you decide which facility is the right place for your child:

General Information

- ▶ How long has the facility been working with children?
- ▶ What types of behaviors, symptoms or illnesses do you specialize in?
- ▶ What are the ages of other children in the program?
- ▶ What is the cost of treatment?
- ▶ Who pays for the treatment?
- ▶ Will my child go out into the community to participate in activities such as visiting the library or seeing a movie?
- ▶ What if my child gets sick? How are emergencies handled? Will I be called?
- ▶ What about my child's safety?
- ▶ What if I have a complaint? What are your procedures for handling complaints?
- ▶ Has the facility had any recent licensing violations?
- ▶ What treatment or support do you offer to the family?
- ▶ Will my child receive passes to go out into the community? Who is involved in that decision?

Staffing

- ▶ How many staff work with how many children? Is this different at night versus during the day?
- ▶ What type of training does the staff have?
- ▶ Who will be working with my child, and what is their experience and background?

Treatment

- ▶ Does the facility have defined successful outcomes? Have they collected data to prove they are successful?
- ▶ What is the average length of stay?
- ▶ How often will the treatment plan be reviewed by me, my child and the staff?
- ▶ What types of therapies are included in the treatment plan?
- ▶ What about medications? Will you change my child's medications and how will I be informed?
- ▶ What will my child do when they are in treatment?
- ▶ Do you use time-outs, seclusion or restraints? Can I see your policy?
- ▶ What if I have questions after my child is in treatment? Whom do I contact?
- ▶ How do you plan for discharge? How much notice do you provide? How do you include the family in discharge planning?

- ▶ Is there a program to help my child transition back home?
- ▶ How will you keep my child's current psychiatrist informed and involved?
- ▶ What are your discipline policies?

Family Involvement

- ▶ How will I be involved in my child's treatment and care?
- ▶ How will I be kept up-to-date on my child's progress?
- ▶ What items can my child bring from home? What is not allowed?
- ▶ How long should I expect my child to be in treatment?
- ▶ What are the policies about visits from friends? Will I have a say in who is allowed to visit my child?
- ▶ What are the policies about family visits, phone calls, e-mail and mail?
- ▶ What does the facility do to support family involvement and home visits?
- ▶ Will my child be allowed to have home visits?
- ▶ Can we use Skype or another internet application to contact our child?

Education

- ▶ What about my child's education? Will they go to the local school or receive education at the facility? How much time per day will be devoted to education?
- ▶ My child receives special education or accommodations at school. What happens to my child's IEP/504 plan from our current school district? Who will be responsible for carrying it out?
- ▶ How will my child's home school be involved in the discharge planning? When will they receive the discharge plan? Will it include recommendations for educational accommodations?

A good treatment facility will want parents to ask questions. They will have a written set of policies and procedures that parents can take home and look at later. They will answer questions and follow up on any other information requested. Each facility is also required to have admission standards that will help parents decide if it is an appropriate placement for their child. The facility will also help parents obtain authorization for treatment from their insurance provider or the county.

Out-of-State Treatment

Parents should be very careful if someone recommends an out-of-state facility for their child. These facilities are governed by different rules and laws than Minnesota facilities. In certain circumstances, however,

this can make sense. If your family lives near a state border and the nearest residential treatment facility is in the next state, treatment may still be covered by your county. The placement must be made by the county. The treatment center must be the nearest treatment center that will treat the child's level of care needed. It must be located in Wisconsin, North Dakota, South Dakota or Iowa. Also, the facility must be inspected by the Licensing Division of the Department of Human Services. They must certify that it substantially meets the standards applicable to children's residential mental health treatment programs (under Minnesota Rules, chapter 2960) by the Minnesota Department of Corrections. If your medical insurance will cover the cost of treatment, you should coordinate with your insurance company. ■

PAYING FOR RESIDENTIAL TREATMENT

Health Insurance

Residential treatment services are very expensive. Few families can afford to pay out-of-pocket for them. Health insurance plans may or may not pay for residential treatment depending upon whether the plan is a Minnesota-based plan or a self-insured plan. It is important to learn as much as possible about your private health insurance coverage. Contact your human resources department to find out if you have a self-insured plan.

Contact your insurance company to see what treatment providers and facilities are covered under the plan. Check your benefit amount and find out if there are any limits to coverage. Health insurance plans that are self-insured may not offer any coverage of mental health services. Regular Minnesota health plans must provide the same coverage for residential treatment as they do for any other health care service. It is best to check with your insurance company before assuming that it will pay for all or some of the cost of out-of-home treatment. The residential facility staff can help you with this.

It is important for parents to find out whether they have a regular Minnesota health plan or a self-insured plan. They are different and are governed by different laws. Generally, large employers or employers that cover more than one state have a self-insured plan. They sometimes contract with a Minnesota company to manage the benefits. This makes it even more difficult to know what type of plan you have. Read through the policy book, especially the section on mental health care or behavioral health care. This will help you understand how to obtain treatment, what services are covered and any financial or treatment limitations. The mental health parity law was passed in 2008. This law

says that there must be parity between coverage for mental health and substance abuse services and medical/surgical benefits in insurance plans that offer coverage for both benefits. Please note that this new law does not require that health plans provide mental health and substance abuse services.

In Minnesota, health plans must pay for medically necessary services if they provide coverage for mental health and substance abuse.

A medically necessary service is a recommended health service that is consistent with the child's mental health diagnosis and condition and:

- ▶ Is recognized as the prevailing standard of care or current practice; and
- ▶ Is provided in response to a life-threatening condition or pain; to treat an injury, illness or infection, or
- ▶ Is intended to treat a condition that could result in physical or mental disability, or
- ▶ Is intended to achieve a level of physical or mental functioning.

You should contact your county mental health services unit if:

- ▶ You cannot afford to pay for treatment services
- ▶ Your health insurance plan does not cover the cost of treatment
- ▶ You have exhausted your benefits

Minnesota Health Care Programs

Some children may qualify for one of Minnesota's publicly-funded health care programs or for county payment for treatment. The Minnesota health care programs are Medical Assistance and MinnesotaCare. The MNsure website has all the eligibility information at www.mnsure.org/individual-family/cost/ma-mncare.jsp. You will find a link to learn more about the Minnesota health care programs. There is also a calculator to determine if you may qualify for one of these programs. If you do not qualify financially, you may still qualify for TEFRA. You will apply for these programs at the MNsure site. Navigators are available to help with the process at many community organizations, including NAMI Minnesota. Qualifying for one of these plans can make it easier to pay for residential treatment.

It's important to know whether you have fee-for-service Medical Assistance or a Prepaid Medical Assistance Program (PMAP) because decisions regarding residential treatment are treated differently. PMAPs are managed by health plans under contract with the state of Minnesota.

County Social Services

Medicaid programs pay for the treatment but they do not pay for room and board costs. County agencies access Title IV-E to pay for the cost of room and board for some children and can use county dollars to pay the cost for those who don't qualify for Title IV-E.

Title IV-E is the federal foster care program. Minnesota Statutes Chapter 260D was enacted in 2008 to make it easier for parents get help paying for residential treatment through Title IV-E. This law clarifies the legal issues when a child with a developmental disability or a mental illness needs to receive treatment outside of the home and for whom there are no child protection issues. Chapter 260D makes it clear that parents and guardians **do not** have to give up legal custody of their child to access or receive mental health services and treatment. This law looks at medical necessity, meaning the child's need for treatment. Placements under 260D are considered "voluntary" placements.

Foster care is the term used to describe a variety of out-of-home placements, including residential treatment. Throughout this booklet, when the term *foster care* is used, it refers to all of the options such as a family foster home, therapeutic foster care, group homes, shelters and residential treatment. It does not include hospitals, inpatient chemical dependency treatment facilities or secure correctional facilities. The word *parent* includes parents and guardians. The law also uses the term *voluntary foster care agreement* (VFCA). The voluntary foster agreement is the method parents can use to get help from the county to pay the cost of residential treatment.

When a county agency has responsibility for placement, care and supervision under a VFCA, the county must provide the same protection requirements of the Title IV-E federal program. This includes court reviews and permanency for children. Permanency means stability and a permanent home. If your child is covered under Medical Assistance, the county will need to be involved in the decision making regarding residential treatment because they may be paying for part of the cost. Usually, the county will use a combination of funding sources, including federal and county funds, to pay the room and board costs or the full cost of care.

It is highly likely that the county will be involved in the decision about the need for residential treatment and the procedures that follow once that decision is made. It is very important for parents to know that they do not have to give up or relinquish custody of their child and make their child a ward of the state in order for the county to pay for treatment. The steps that are required to place a child in residential

treatment are complicated. Please read the next sections of this booklet carefully to fully understand your rights and responsibilities as a parent.

Another item parents need to know is that if public or government funds are used to pay for the care, you will be required to pay a fee or co-payment that is based on your income, and it can be quite high. Be sure to ask what the fee will be. Every county uses a different schedule. You can appeal the fee if you believe it is too high and does not take into account other family medical expenses. ■

LEGAL ISSUES

When the county is going to pay for any part of a child's residential care, parents will need to go through a voluntary foster care process and sign an agreement with the county. When a county agency is involved in decision making regarding a child not living with a parent, the county must have legal authority for the placement, care and supervision of the child. That legal authority is granted through a voluntary foster care agreement and court order. Legal authority for placement, care and supervision is different than legal custody and all other parental rights. Legal custody of the child remains with the parents unless they *willfully fail or are unable* to make decisions in child's best interests.

The county will also look at whether the treatment outside of the home is "medically necessary care." Generally this means health care services that are appropriate and required to treat the child's diagnosis and condition. Medically necessary care must help restore or maintain the child's health or keep the child's condition from getting worse.

Voluntary Foster Care Agreements

Voluntary foster care agreements are required as the "legal authority" for a county to place a child with an emotional disorder or developmental disability. Under the law, *foster care* is a broad term that includes all types of residential treatment, including foster care, group homes, emergency shelters and residential facilities. It does not include hospitals, in-patient chemical dependency treatment facilities or correctional facilities.

Issues related to the placement of children with developmental disabilities or emotional disturbances are addressed in a law called *Child in Voluntary Foster Care for Treatment* (Minnesota Statutes 260D).

This law:

- ▶ Establishes voluntary foster care agreements as a way to provide out-of-home treatment for a child with a developmental disability or a mental illness

- ▶ Establishes court reviews for a child in a voluntary placement
- ▶ Establishes the ongoing responsibility of the parents as legal custodian to visit the child, plan for and make treatment decisions, and obtain the necessary medical, dental and other care for the child
- ▶ Applies the new law when the child's parent and the agency agree that the child's treatment needs require foster care due to a level of care determination

The purpose of the law is to:

- ▶ Allow counties to help pay for residential treatment for children whose families cannot afford it
- ▶ Make the child's safety, health and best interests the most important consideration in all proceedings
- ▶ Ensure that children with developmental disabilities or emotional disturbances are provided services necessary to treat the symptoms of the child's disability
- ▶ Preserve and strengthen family ties, approving placement away from the parent's home only when the child's need for care and treatment require it and the child cannot be maintained in the parent's home
- ▶ Ensure that the legal custody of the child and associated decision-making authority remains with the parent
- ▶ Support the rights and obligations of parents to plan for their child

This law is to be used if a child with an emotional disturbance or developmental disability needs foster care (residential treatment) and there is no need for child protection involvement. The county reports to the court after 165 days of placement. There is no initial court hearing required unless the parent or child requests it. Court hearings are required, however, when the child has been in voluntary foster care placement for 13 months, or 15 of the past 22 months.

If county funds or fee-for-service Medical Assistance are being used to pay for treatment, before a child is placed for treatment, the county must determine if the child meets the definition of a child with an emotional disturbance or developmental disability. Then the agency and parent must agree that the child's treatment needs require foster care based on an assessment using an approved and validated tool (see pages 4–5, CASII or ECSII combined with the SDQ). Counties have what is called a screening meeting to determine if the child qualifies for and needs residential treatment. Parents are encouraged to attend this meeting to be sure that their voice is heard. Not all counties allow parents to attend these meetings. If the county decides that the child does not need residential treatment, then parents can appeal that decision. The county must provide written instructions on how to appeal.

For a child on a Prepaid Medical Assistance Plan (PMAP) rather than regular fee-for-service Medical Assistance, residential treatment is a covered service. In these situations, both the health plan (PMAP plan) and the county will need to determine medical necessity of residential treatment. Parents should ask the health plan for an expedited review of medical necessity. This way the decision will be made in 72 hours instead of 10 business days. The health plan will assign someone to work with you. They will contact the county so that a screening meeting can be scheduled and held. The county screening team and the health plan must both approve the placement. If either the health plan or county decide that a child doesn't need residential treatment, parents can appeal the decision.

Once everyone agrees that residential treatment is appropriate for a child, parents and the county will sign a voluntary foster care agreement (VFCA). The agreement, which is on a form required by the Minnesota Commissioner of Human Services, will include a list of the rights and responsibilities of the parents. It states that parents keep legal custody of their child and that parents agree to place their child for the purpose of care and treatment. It states that the county has agreed to provide or authorize supervision of the child while in treatment. A copy of the form is included in the back of this booklet.

The county needs the “legal authority” to place a child. This is different than a parent's legal authority to make decisions for their child. Parents will continue to have legal custody of their child unless they willfully fail or are unable to make decisions in their child's best interest and there is clear and convincing evidence that their child is in need of child protection services. **A parent disagreeing with the county's choice for treatment is not a reason for taking legal custody from the parent. When a child goes into foster care for other reasons, the county is required to look for a relative who is willing to take the child. When foster care is used to provide mental health treatment for a child, this search is not required.**

The agreement also includes a promise that parents will:

- ▶ participate in the development of the out-of-home placement plan
- ▶ carry out their responsibilities in the out-of-home placement plan
- ▶ participate in the development of the treatment plan
- ▶ visit and keep in touch with the child
- ▶ cooperate with the county to figure out the payment of fees
- ▶ provide health insurance information to the county
- ▶ arrange for or participate in the child's routine medical care
- ▶ authorize the appropriate agencies to have access to the child's educational and medical records

Both parents and the agency must sign the agreement.

Parents and the county will then develop an out-of-home placement plan (OHPP). This must be done before the child goes into foster care, or at least within 30 days of the child going into foster care. This plan has information in it about the placement, how that placement will meet the child's treatment needs, the reasons for placement, the services offered and requested to prevent placement and how parents will visit their child (including how the county will help parents do that if a parent needs help). It also authorizes sharing of health and education records and sets out the specific services the child should have to meet their mental health care needs and what the treatment outcomes will be. Parents will want to read this agreement carefully, especially the section on what services were offered to prevent placement. Make sure that the plan reflects why the services that were offered were not appropriate, adequate or effective.

Children age 12 or over have the right to be involved in the out-of-home placement plan. They also have the right to disagree with the facility or services provided under the plan and have that information included in the county's report to the court.

Once a child is placed in the facility, parents will work with the staff to develop an individual treatment plan. Parents have the right and responsibility to be involved in developing the treatment plan.

If the child is placed away from home for more than 165 days, the county agency will conduct an administrative review of the out-of-home placement. A report is sent to the court which includes information such as the reasons the child needs foster care, basic contact information, the name of the facility or foster home, a copy of the out-of-home placement plan, a written summary of the administrative review, a copy of the individual treatment plan or service plan for the child, a report of any disagreement by a child age 12 or over and any other information that a parent or treatment provider wishes to include. This report is due by the 165th day the child has been in placement.

Parents, the child and the foster care provider should receive a notice from the county agency of:

- ▶ The requirements of the report and the date it was received
- ▶ The right to submit information that a parent/caregiver would find helpful to understand and plan for the child's treatment
- ▶ That there will be no hearing unless the parent or the agency requests it

If no hearing is requested, the judge will review the report and make a decision about continuing with the placement within ten days. The decision includes if the placement is in the child's best interest, whether

the parent and agency are appropriately planning for the child and whether children age 12 or over have an appointed attorney or a guardian ad litem. A guardian ad litem is a person appointed by the court to investigate facts and make sure the best interests of the child are represented.

When a child has been in foster care for 13 months, or 15 out of the last 22 months, the child's situation will be reviewed. Parents should be aware that they may now have to go to court if their child needs to remain in the foster care setting to receive treatment.

The county agency must review the voluntary foster care agreement and:

- ▶ Terminate the voluntary foster care agreement and return the child home
- ▶ Determine that there are compelling reasons to continue the voluntary foster care agreement and seek court approval **or**
- ▶ File a petition to terminate parental rights

When the county determines that the child should remain in the placement rather than terminate parental rights or return the child home, it must write down the compelling reasons why this is in the child's best interests.

While there is nothing listed in the law, compelling reasons could include:

- ▶ There are no grounds to terminate parental rights
- ▶ The child must be in placement to access appropriate treatment
- ▶ The child's individual treatment needs cannot be met in the home
- ▶ The parent continues to be involved in planning for child and maintains contact with child

When the agency seeks court approval to continue the child in the foster care placement because there are compelling reasons, they file a petition called "The Petition for Permanency Review Regarding a Child in Voluntary Foster Care for Treatment." It is drafted by the county attorney.

The petition includes:

- ▶ The date of the voluntary placement agreement
- ▶ Whether it is due to a developmental disability or emotional disturbance
- ▶ The plan for the ongoing care of the child and the parent's participation in the plan
- ▶ A description of the parent's visitation and contact with the child
- ▶ The date of the court finding that voluntary placement was in the child's best interests

- ▶ The agency’s reasonable efforts to finalize the permanent plan for the child including returning the child to the family
- ▶ The basis of the petition, which is Minnesota Statute 260D
- ▶ An updated copy of the out-of-home placement plan

The court will then set a date for the permanency review hearing. This must be no later than 14 months after the child has been in placement or within 30 days of the date the petition was filed. Parents will receive a notice in the mail about the hearing. Be sure to read all the documents, including the petition, the out-of-home placement plan and the treatment plan to make sure they are accurate.

Court hearings can be scary. Knowing what to expect can help. At the hearing, the judge will ask the parents if they have read the “The Petition for Permanency Review Regarding a Child in Voluntary Foster Care for Treatment.” The judge will also ask if the parents are satisfied with the county agency’s efforts to finalize the permanent plan for the child. This includes whether there are services available and accessible to the parent that might be able to allow the child to be safely with the family. The judge will ask if the parents agree with the county’s determination that there are compelling reasons why the child should continue in the voluntary foster care arrangement. Essentially, the judge wants to make sure that the parents think their child needs to remain in treatment and not that the county is not offering the services needed for the child to return home.

The judge will also ask the child’s guardian ad litem and any other party if they also agree with continuing the child in foster care. A child age 12 or older can object to remaining in foster care and be heard at this hearing.

The judge will make a decision to either approve continuing the voluntary foster care agreement or to not approve it. If the judge does not approve it, then the child will be returned to the care of the parent(s). If the parent(s) will not accept the child, the county agency can file a petition to terminate parental rights. If the judge does approve the placement, then the child will continue in foster care. His or her placement will be reviewed every 12 months.

Every 12 months, the court will determine whether the agency made reasonable efforts to finalize the permanency plan for the child.

This means the county agency has worked to:

1. Ensure that the agreement for voluntary foster care is the most appropriate legal arrangement to meet the child’s safety, health and best interests

2. Engage and support the parent(s) in continued involvement in planning and decision making for the needs of the child
3. Strengthen the child's ties to the parent(s), relatives and community
4. Implement the out-of-home placement plan and ensure that the plan requires the provision of appropriate services to address the physical health, mental health and educational needs of the child
5. Ensure appropriate planning for the child's safe, permanent and independent living arrangement after the child's 18th birthday

These reviews are all required by federal and state law. The purpose is to ensure that children don't languish in foster care or residential treatment. That is why parents will see the emphasis on the child's ties to the family. It is very important that parents carefully and fully document their efforts to communicate, contact and visit with their child.

Legal Timeline

Even though this is a voluntary process, because of the type of funding used and federal law, the court maintains oversight. Here is what happens:

BY DAY 1: A child enters voluntary placement due to a developmental disability or emotional disturbance. A voluntary placement agreement is signed on the day of placement.

BY DAY 30: An out-of-home placement plan will be developed by the county with the parents and their child.

PRIOR TO DAY 165: The County must conduct an administrative review of the out-of-home placement plan. People reviewing the plan must

It is important to know that any information parents share with the county can be used later if the county believes that it needs to conduct a child protection assessment. There are words used in the mental health system that mean something different in the child protection system. For example, families are often told by mental health professionals to say that they can't "keep their child safe" in order to obtain treatment. But this phrase can be misinterpreted in the child protection system to mean that your child is in need of protection. **Families need to use terms such as "treatment" or "danger to self or others" instead of "safety."** In any agreement that parents sign, be sure that the stated purpose of the child going into out-of-home placement is for *treatment* for their behaviors, which are symptoms of their illness.

include one person who is not directly responsible for case management. The review is open to the parent and child as appropriate.

BY DAY 165: The county must file a report with the juvenile court. The report includes the out-of-home placement plan, the individual treatment plan and the individual service plan. It should also include any information the parent, county agency or facility wants the court to consider. A child aged 12 or over must be given the right to disagree with the plan. All parties must be informed of their right to be heard by the court. No hearing is required unless requested.

BY DAY 175: The judge will decide if voluntary placement is in the child's best interest. The judge will also determine whether the parents and the county are appropriately planning for the child. This decision will be based on the report and information provided by the parent, the child and the facility. The judge will look at whether the parent and the agency are planning for the child's return home. If the child is over age 12 and disagrees with the placement, the judge could appoint a guardian ad litem. A guardian ad litem is an advocate for children who gathers information and makes recommendations to the court regarding the best interests of a child.

BY MONTH 13 (or if the child has been in placement 15 out of the last 22 months): A county attorney must petition the court for a permanency review.

Federal and state laws require that the agency ask the court to do one of three things at this point:

1. End the placement agreement and return the child home
2. Terminate parental rights
3. Continue the child in placement. This can only happen if there are compelling reasons to do so.

BY MONTH 14: At the review hearing, parents will be asked if they have read the petition.

They must agree that:

- ▶ The petition is accurate
- ▶ Foster care is in the child's best interest
- ▶ They are satisfied with agency efforts to provide services that could bring their child home

The judge will also ask the child's guardian ad litem if they agree that residential treatment is still in the best interest of the child.

If the judge agrees that there are compelling reasons to keep the child in treatment, he or she will grant the petition to continue the child in placement. If the judge does not approve the voluntary agreement, he

or she will dismiss the petition. In that case, the child must then be returned to care of the parents. If the parents cannot or will not accept the child, the agency must file a termination of parental rights petition.

AFTER MONTH 14: When the judge agrees that the child should continue in voluntary foster care for treatment, the court will also approve the continued voluntary foster care arrangement. The court must review the child's placement every 12 months while the child is in foster care. The court's approval of the continued voluntary placement means the county agency has continued legal authority to place the child.

BY MONTHS 26 +: The court must review the placement every 12 months. In the annual review, the court must again look at whether the placement is appropriate. The county must engage and support the parents in the planning and decision making. They must make sure the child's ties to the parents, other relatives and the community are strengthened. They must make sure the family is following the out-of-home placement plan. ■

RESIDENTIAL TREATMENT PROGRAMS

Admission

Children are often referred to a treatment facility by a county or mental health provider. When a referral has been made, an intake screening will be completed. This may happen over the phone or as an interview with the child and family at the treatment facility. The intake screening process will determine if the facility is the appropriate place for the child. It will also explain the admission process, secure placement for the child and gather information from parents, referring parties and agencies.

Admissions is the process of gathering information.

The treatment center will need the following:

- ▶ Your child's name and nickname(s)
- ▶ Your address and contact information
- ▶ Your child's race or cultural heritage
- ▶ Any languages the child speaks and writes
- ▶ A description of presenting problems. This includes medical problems, circumstances leading to admission, mental health concerns, safety concerns including assaultive behavior and victimization concerns
- ▶ Medical records
- ▶ School records (including evaluations and special education services, if appropriate)

- ▶ Juvenile justice system records
- ▶ Reports from outpatient treatment facilities
- ▶ Reports from agencies involved with the child's current treatment or care
- ▶ Insurance information
- ▶ A description of your child's assets and strengths
- ▶ Spiritual or religious affiliation
- ▶ The placing agency's case plan goals for your child

The admissions process may also include a thorough assessment of your child's functioning levels to help develop an initial treatment plan. Parents should be prepared to sign releases of information for the school, doctors and anyone else involved in the child's treatment.

A treatment plan is a written document. Input is needed from parents, the child, County agencies and the facility. It describes the child's needs and the goals of treatment. It is also used to document the child's progress in treatment. It identifies a time limit to address the concerns of the family and child. Parents should be involved in planning, developing and monitoring of their child's treatment plan. The plan is a working document. It should be updated and changed during the course of treatment as the child's needs change. The treatment plan should include a thorough diagnostic assessment to help identify the child's functioning levels. It should set specific goals and interventions. These are developed to address mental health symptoms and improve the child's level of functioning.

Soon after admission, the facility should conduct several different screenings. Required screenings include a health screen. This should include any history of abuse, vulnerability to abuse, potential for self-injury, current medications, and most recent physician's and clinic's name, address and telephone number. Other screenings include a mental health screen, educational screen, substance abuse screen, cultural screen and sexually abusive behavior and vulnerability screen. The facility must also find out if there any needs related to the child's gender, such as a history of abuse that might require staffing adjustments.

Parents have the right to be involved in the development of the plan for their child during their stay at the facility. The program staff should include the family in determining the treatment goals and the outcomes expected for the child. It should include what kind of skills they will work on so the child can return home. Regular meetings to review the child's progress will be scheduled, and parents and county workers will be invited to participate.

Services Provided

A certified mental health residential facility must offer a specific set of services, including:

- ▶ **INDIVIDUAL, GROUP AND FAMILY PSYCHOTHERAPY.** This should be designed to achieve the outcomes of the child's individual treatment plan and, when possible, help the child rejoin family and community.
- ▶ **CRISIS ASSISTANCE SERVICES.** These should help the child and family members recognize factors that lead to a psychiatric crisis, anticipate behaviors and symptoms and know the resources to use when a crisis is about to occur or occurs.
- ▶ **MEDICATION EDUCATION** to help the child and family members understand the role of medication in the child's treatment. They should learn how the medication may affect the child's physical and mental health, and the physical, emotional and behavioral changes that may result from the child's use, misuse or refusal to use prescribed medications.
- ▶ **INSTRUCTION IN INDEPENDENT LIVING** skills to strengthen a child's ability to function in a less restrictive environment than a residential treatment center. The services must support the child in carrying out the tasks of daily living, encourage the development of self-esteem and promote self-sufficiency.
- ▶ **RECREATION, LEISURE AND PLAY ACTIVITIES.** These help the child develop recreational skills. They also help the child and their family learn how to plan and participate in recreation and leisure activities.
- ▶ **SOCIAL AND INTERPERSONAL SKILLS DEVELOPMENT** to help the child develop and maintain friendships. This helps them to communicate and interact appropriately with peers and adults.
- ▶ **VOCATIONAL SKILLS DEVELOPMENT** to prepare the child for the world of work. Children learn such skills as use of time, acting responsibly and working within the goals of an organization.
- ▶ **PARENTING SKILLS.** Parents learn therapeutic parenting techniques to help manage behaviors or learning issues caused by the child's mental illness.
- ▶ **FAMILY SUPPORT SERVICES.** These services help family members learn how to resolve conflicts, get support from extended family and friends, set new family goals and improve family coping skills.

Rights of Residents

Every facility is required to guarantee basic rights of its residents.

A resident has the right to:

- ▶ Reasonable observance of cultural and ethnic practice and religion
- ▶ A reasonable degree of privacy
- ▶ Participate in development of the resident's treatment and case plan
- ▶ Positive and proactive adult guidance, support and supervision
- ▶ Be free from abuse, neglect, inhumane treatment and sexual exploitation
- ▶ Adequate medical care
- ▶ Nutritious and sufficient meals, and sufficient clothing and housing
- ▶ Live in clean, safe surroundings
- ▶ Receive a public education
- ▶ Reasonable communication and visitation with adults outside the facility, which may include a parent, extended family members, siblings, a legal guardian, caseworker, attorney, therapist, physician, religious advisor and case manager in accordance with the resident's case plan
- ▶ Daily bathing or showering and reasonable use of materials, including culturally specific appropriate skin care and hair care products, or any special assistance necessary to maintain an acceptable level of personal hygiene
- ▶ Access to protection and advocacy services, including the appropriate state-appointed ombudsperson
- ▶ Retain and use a reasonable amount of personal property
- ▶ Courteous and respectful treatment
- ▶ Be free from bias and harassment regarding race, gender, age, disability, spirituality and sexual orientation
- ▶ Be informed of and how to use a grievance procedure
- ▶ Be free from restraint or seclusion used for a purpose other than to protect the resident from imminent danger to themselves or others, except for the use of disciplinary room time, which is only allowed in correctional facilities

Facilities are required to have “no eject policies.” This means that a child cannot be discharged before the treatment goals have been reached unless certain things have happened. If a facility wants to discharge a child, there must be a review by all those interested – including the parent. The child can be temporarily placed in another facility during this review period if necessary. The review must take place within five days of the decision to discharge the child. It will determine whether additional strategies could be used to resolve the issue. If there

are other strategies that could be tried, they must keep the child in the facility and try those strategies. Before the child is discharged, the treatment team must develop a discharge plan. They must notify you, the school and the county case manager at least 10 days before discharge. The plan should include arrangements for follow-up care in the community. If you have concerns about the residential facility, complaints can be made to the Department of Human Services Licensing Division, the Department of Health Office of Health Facility Complaints, Department of Corrections or the Ombudsman for Developmental Disabilities and Mental Health.

Staying Involved

Saying goodbye and leaving your child at a treatment facility can be emotional and overwhelming. It isn't easy for your child either. Staying involved in your child's care requires communication and effort. Families should be involved in all phases of the treatment program. This includes intake screening, admissions, treatment plans, progress reports, home visits and discharge plans. Parents should understand the policies of the treatment facility.

A child's mental illness affects the whole family. Family therapy is important. It can help families discover their strengths. Everyone can learn new ways to support the child as they recover. Siblings can have conflicted feelings about their brother or sister. Family therapy can help mend those relationships. It provides opportunities for all family members to support each other. The residential facility will work with you to schedule family therapy at times that are convenient for your family. If weekly sessions are too difficult due to distance, the facility can arrange for monthly or bi-weekly sessions and some will have the capacity to use technology to provide more frequent contact and therapy.

Regular contact between parents and their child keeps the family connected and strengthens it. It is also important to maintain close contact with the staff.

Parents should:

- ▶ Schedule regular meetings and phone conferences with the child's treatment team. Include the therapist and other staff members who regularly have contact with the child.
- ▶ Visit regularly with your child. If distance prevents you from visiting in person, you can establish a regular schedule of phone calls. You can also request weekly or biweekly phone calls or written reports from the therapist and teacher. The county can help arrange

visits with your child if you do not have transportation. Many treatment centers can also use Skype or other conferencing tools.

- ▶ Provide preaddressed envelopes or postcards for the child to write letters to family and friends. Be sure to ask about technology options: Can your child have access to a computer at the facility to help them have regular contact?
- ▶ Establish communication with the treatment team. Provide them with dates you want reports sent and what information you want included. Let them know the best way to communicate with you (e-mail, mail, phone, fax, etc.)
- ▶ Schedule frequent home visits when appropriate.
- ▶ Your child can have personal items from home. Sometimes, expensive items can be lost or stolen. This can create conflict with other residents. Ask the facility staff what your child should bring, and what is appropriate before giving gifts.

Home visits provide an opportunity for the parent and child to practice new skills. They will help the child get used to being part of the family again. This will make them better prepared to live in a less restrictive setting as soon as possible. Parents should let staff know what happened on the visit. Did you see improvements in how your child gets along with other family members? Were there any behavioral concerns? What may have triggered the behaviors?

Remember that the court reviews what type of involvement parents have had with their child while they are in treatment. It is a good idea to record each time you call, write or visit in a journal or spreadsheet program. Parents want to make sure that they can show the court that they care about their child and have tried to maintain contact. Some families keep a file with copies of the agreement, reports, all the plans, a phone log, etc., in one place. ■

PLANNING FOR YOUR CHILD TO COME HOME

Discharge Planning

When your child's treatment is nearing completion, parents should be involved in the discharge planning process. This process should include the family, extended family, school and community supports. It should include meetings with parents, the child, the treatment team, case managers, agencies and the school district. The family should be involved in choosing the appropriate services and supports at home, at school and in the community.

Ideally, the family, county and treatment facility will all agree that the child is ready to return home. However, the placement can be terminated by any of the parties. Sometimes, parents will want to terminate the voluntary foster care agreement. This could be because the child is ready to come home or because the parent would like the child to go to a different residential facility. To do so, parents must request it in writing to the county.

If the county wants to end the agreement, it must contact the parents about transition planning. They should send parents a notice in writing about their desire to terminate the agreement. Transition planning is planning for the child's return home. It includes deciding when the child will return home, increasing home visits and a plan for what services will be provided when the child returns home.

Once a parent receives a notice of termination, the parents, facility and county must come up with an agreed-upon time for ending the agreement. This must not be less than 72 hours or more than 30 days, unless everyone agrees otherwise. Parents may disagree with the county's proposed termination of the placement. They can request a hearing before an appeals referee with the Minnesota Department of Human Services. The notice from the county should include the right to a hearing and how to appeal the decision. The placement, if funded by Medical Assistance, must continue until the department makes a decision on the appeal. No matter who seeks to terminate the agreement, the county must provide transition planning. The notice to terminate the agreement doesn't mean the agreement ends right away. The agreement stays in place until the child is returned home or parents are not successful in an appeal.

Before a child comes home, parents should consider:

- ▶ Several weeks before a child is to be discharged, request meetings with staff. Discuss and plan for what supports will be needed when the child comes home. This can include, for example, intensive case management, CTSS services, personal care assistance (PCA), in-home services, respite care and special education services. Decide who will arrange and set up aftercare services—parents, the school, the mental health case manager or facility staff.
- ▶ Plan for your child's school program and make sure that it will be in place.
- ▶ Visit the school and talk to your child's teachers.
- ▶ Make sure the school classroom offers an appropriate program for your child.
- ▶ Request an individualized education plan (IEP) conference if your child requires a special education program or a 504 plan if your child needs accommodations in the classroom.

- ▶ Set up a support system for yourself, your child and other members of the family. Contact NAMI Minnesota about teen and parent support groups.
- ▶ Encourage an open conversation between your child and the rest of the family about the difficulties of getting used to each other again. Talking things out can help ease some of the tensions.
- ▶ Contact agencies and services such as social workers, mentoring programs and in-home behavior therapists that can provide services and supports.
- ▶ Create a detailed safety plan with your child's entire treatment team. The plan should include the things that tend to make your child's behaviors worse, tips for avoiding those triggers and what to do when your child becomes upset and needs help to calm down. Share the safety plan with your child's personal care attendants, case manager, school, therapist, doctors, the local police department and the county's Crisis Response Unit, if necessary. Having a good safety plan is a proactive way to anticipate and address a crisis before it happens.
- ▶ Find out what kind of aftercare is available from the treatment program, especially if you live near-by.
- ▶ Arrange for respite. If it is available through your county, request the service. If it is not, look for ways to get informal respite if it is needed. Respite from friends, family, or other sources can give everyone a break, including your child.

Bringing your child home can raise many questions for you, including: Will I be able to obtain the in-home services necessary to support my child? Will I be able to prevent my child from hurting themselves or others? Will my child be mad at me? What will "normal" be? These are all typical questions that many parents ask themselves. Talk to the treatment facility and other parents to find answers to these and other questions and find out what support may be available from the program.

Putting Services into Place

When your child has been living in a facility and visiting on weekends, the transition to living at home full-time can be difficult for both your child and your family. Your child has been accustomed to living in a very structured group environment. Your family has adjusted to living without that child in the house. You may want to consider bringing additional support into your home as your child and family make this adjustment. Ongoing family therapy can be very helpful during this transition time.

Several types of support, many of which were mentioned earlier, may be available to help your family. Work with your county case manager and health insurance company to obtain the services your child will need to do well at home. These can include the services shown on pages 7–10.

PARENT EDUCATION: Learn about your child’s illness. Learn what can cause your child to become upset. Develop a plan to support your child so they can remain calm. Educate your child’s treatment team so they can lend support as well. Parenting a child with mental illness is not a do-it-yourself project. Enlist the help of everyone involved in your child’s life to ensure that your child is supported at home, at school and in the community. Attend a class provided by NAMI Minnesota (National Alliance on Mental Illness) or the Minnesota Association for Children’s Mental Health (MACMH). By doing so, you give your child every chance to be successful at home. This will minimize the risk that they will need to return to residential treatment.

SUPPORT GROUPS: These groups offer parents a way to connect to other families that have children with mental illnesses. Caring for your child as they return home from residential treatment is exhausting and very time-consuming. Support groups give you a way to help take care of yourself. At a support group, you can meet other parents with similar experiences. You will benefit from the support they give you. You also have a chance to support others who may be experiencing a situation you have already been through. By networking in these ways with other families, you create more support for yourself and your child and increase your family’s chance of staying together. ■

IF YOU DISAGREE

If you disagree with a decision to deny residential treatment, you have the right to appeal to the agency that made the decision. For example, if the health plan denies treatment, you can appeal that decision to the health plan. You can also contact the Minnesota Department of Health, Minnesota Department of Commerce and the Minnesota Attorney General’s Office if you have a complaint about your health insurance. Contact the U.S. Department of Labor for self-insured plans. If the county denies treatment, you can file an appeal to the state. If the treatment plan created by the treatment facility is not what you think is best for your child, you can meet with facility staff. If the county or health plan decides to terminate residential treatment before your child has completed treatment, you can appeal to the health plan or county. If the treatment is funded by a health plan or in part by Medical Assistance and you appeal before the discharge date, you have the right to

have treatment continue pending the outcome of the appeal. Everyone should give you written instructions on how to appeal decisions they make. ■

OTHER RELEVANT LAWS

The **Minnesota Comprehensive Children's Mental Health Act of 1989** established a mental health system of care that is comprehensive, unified and accountable. It was designed to effectively and efficiently meet the mental health needs of children. This act also mandated that each county develop a system of affordable and locally available children's mental health services.

In 1993, the Minnesota Legislature authorized **Children's Mental Health Collaboratives**. These Collaboratives create a system of care that coordinates children's mental health services with counties, schools, community-based organizations, local mental health providers and the juvenile justice system. It established an integrated system of services for families and children. The collaboratives recognize that children with mental illnesses require services from several different providers and systems. The counties work in collaboration with local community providers and agencies to create locally appropriate and culturally competent service systems.

It is important that parents are at the center of a team that may include special education, juvenile justice and child welfare services along with other natural supports. These collaboratives identify needs and service gaps in the system of care and then plan and coordinate services. The collaborative partners then put together staff, money and other resources to provide local services and resources in the community. Parents should always be a part of this team. They help guide providers and agencies to work together. They help coordinate services and supports. The goal of the collaboratives is to create a better system of care for children with mental illnesses.

Mental health collaboratives should ensure that children with mental illnesses and their families receive *wrap-around* services and family supports. *Wrap-around* means that services and supports surround the family. This allows creative solutions to meet the needs of the child using multiple systems. It ensures that all systems involved in the child's care work together. This avoids duplication of services. It focuses the services around the family and child's needs. Few counties in Minnesota formally support wrap-around services. Most families receive informal wrap-around supports through a team of providers and local agencies.

The **2007 Mental Health Initiative** improved health care for children and adults with mental illness. The initiative was based on the recommendations of the Minnesota Mental Health Action Group and Governor. It included \$34 million in new investments to continue improving the accessibility, quality and accountability of publicly funded mental health services. It includes new improvements based on recommendations from individuals living with mental illnesses, advocates, family members, counties and providers. More information about the initiative can be found at the Minnesota Department of Human Services website, Children's Mental Health Division website: www.dhs.state.mn.us/cmh.

Parents want to be involved in the care and treatment of their minor children. However, some minor children can and receive mental health services without parental consent. The **Minnesota Consent of Minors for Health Care Statute** allows minor children to consent to medical, mental or other health services.

It also allows any person 16 years or older the right to:

- ▶ request informal admission to a treatment facility for observation or treatment of mental illness or chemical dependency
- ▶ diagnostic evaluation
- ▶ emergency or short-term acute care

It also means that a child can refuse to accept or sign themselves out of treatment. Some counties apply the commitment law to teenagers ages 16 and 17. If you need more information on the civil commitment process, contact NAMI Minnesota or see our booklet, *Understanding the Civil Commitment Process*. Other counties may allow parents to consent to treatment, use the juvenile courts or even use CHIPS petitions for 16 and 17 year olds who are refusing treatment.

Parents generally have access to their minor children's medical records. But, if the minor legally consents to services listed under the **Consent of Minors for Health Care Statute** that is not the case. In that case, parents or guardians do not have access to the records without the minor's authorization. If a health professional believes that it is in the best interest of the minor, they may inform the minor's parents of the treatment. A minor who consents to health services is financially responsible for the cost of the services.

The **Adoption and Safe Families Act of 1997** amended **Title IV-E of the Social Security Act** promote the safety, permanency and well-being of children in foster care. The goal is to speed the permanent placement of children and increase the accountability of the child welfare system.

This federal law requires each state to pass its own laws that require:

- ▶ Periodic review and individualized case planning for each child
- ▶ A permanency hearing by month 14 when children are in voluntary foster care (In Minnesota, there is a requirement that a Permanency Review petition be filed by month 13)
- ▶ A termination of parental rights petition be filed when a child is in placement 15 of the past 22 months, **unless** the court finds compelling reasons to continue the placement, including having no grounds to terminate the parental rights

In Minnesota, generally, the court will approve the agency's "compelling reasons" because when a child is in voluntary foster care to access treatment:

- ▶ The child is in voluntary foster care to access treatment
- ▶ The child's treatment needs cannot be met at home
- ▶ The parents continue to be involved in planning for the child and maintain contact with the child

The act allows children to remain in placement due to a developmental disability or an emotional disturbance on a voluntary basis past 14 months when there are compelling reasons. ■

COMMON TERMS

Here are definitions of some common terms, including the definitions used in the voluntary foster care for treatment law, 260D.

ADJUDICATION: the process of rendering of a decision on a matter before a court.

CASE PLAN: any plan for the delivery of services to a child and parent that is developed according to the requirements of sections 245.4871, subdivision 19 or 21; 245.492, subdivision 16; 256B.092; 260C.212, subdivision 1; 626.556, subdivision 10; and Minnesota Rules, parts 9525.0004 to 9525.0016.

CHEMICAL DEPENDENCY TREATMENT SERVICES: therapeutic and treatment services provided stop a pattern of harmful chemical use.

CHILD IN VOLUNTARY FOSTER CARE FOR TREATMENT: means a child who is emotionally disturbed or developmentally disabled or has a related condition. The child is in foster care under a voluntary foster care agreement between the child's parent and the agency. This is due to agreement between the agency and the parent that the child's level of care requires placement in foster care either:

1. Due to a determination by the agency's screening team based on its review of the diagnostic and functional assessment under section 245.4885; or
2. Due to a determination by the agency's screening team under section 256B.092 and Minnesota Rules, parts 9525.0004 to 9525.0016.

A child is not in voluntary foster care for treatment if it has been determined that the child requires child protective services.

CHIPS PETITION: CHIPS stands for "Child in Need of Protective Services." If a CHIPS petition has been filed, it means that someone involved in the child's life feels they need protection. The courts are involved to investigate whether the child is safe.

CHILDREN'S THERAPEUTIC SERVICES AND SUPPORTS (CTSS): a set of services (therapy and skill development) designed to address problems in functioning due to a mental illness.

COMPELLING REASONS: If a child is in foster care for more than 13 months, the law requires that a permanency plan be created unless there are compelling reasons for the child to remain in care. If a child is in foster care to pay for necessary treatment, and the family is still involved in the child's life, this can be considered a compelling reason. This is why it is important for family's to keep records showing they are in regular contact with their child.

CORRECTIONAL PROGRAM SERVICES: services related to the juvenile or criminal justice system. Correctional program services are provided to residents who are at least 10 years old but younger than 21 years old.

DAY TREATMENT: a year-round program that provides therapeutic services. These include individual and group therapy and skill development. They are provided to children when a mental illness interferes with their participation in their community but does not require hospitalization. Many day treatment programs offer an educational component. It is sometimes used to help a child transition back into their community after a hospitalization or time in residential treatment.

DETENTION SETTING: a residential program offering temporary care to children involved with the juvenile justice system who are at least 10 years old but younger than 21 years old.

DEVELOPMENTAL DISABILITY: severe, chronic disability that can be cognitive, physical or both. It must appear before age 22 and be likely to be life-long. Some are largely physical, such as cerebral palsy. Others are both physical and intellectual such as Down syndrome or fetal alcohol syndrome.

DISPOSITION: the court's order directing any of the parties (parent, child or county agency) to act regarding the placement, care or services to be provided to the child.

FOSTER CARE: means 24-hour substitute care for children placed away from their parents. An agency has placement and care responsibility. Foster care includes placement in foster family homes, foster homes of relatives, group homes, emergency shelters, residential facilities, child care institutions and preadoptive homes. Foster care does not include placement in any of the following facilities: hospitals, inpatient chemical dependency treatment facilities, facilities that are primarily for delinquent children, any corrections facility, forestry camps or jails.

GUARDIAN AD LITEM: an individual appointed by the court to advise the court regarding the best interests of the child during court proceedings.

JUDICIAL: what is allowed and enforced by a court in a fair and impartial manner. Also refers to the functions of judges and the court.

JURISDICTION: the right and power over an individual or subject to interpret and apply the law.

LEGAL AUTHORITY TO PLACE THE CHILD: means the agency has legal responsibility for the care and control of the child while the child is in foster care. The agency may acquire legal authority to place a child through a voluntary placement agreement between the agency and the child's parent. Legal authority to place the child does not mean the agency has authority to make major life decisions regarding the child. A parent with legal custody of the child continues to have legal authority to make major life decisions regarding the child, including major medical decisions.

LEGAL CUSTODY: the right to make decisions about a child such as decisions about medication, medical care, placement, services, use of isolation or restraint, education, discharge planning and more.

MINOR: an individual under 18 years of age.

PARENT: means the birth or adoptive parent of a minor. Parent also means the child's legal guardian or any individual who has legal authority to make decisions and plans for the child. For an Indian child, parent includes any Indian person who has adopted a child by tribal law or custom.

PETITION: A civil pleading filed to initiate a matter in juvenile court, setting forth the alleged grounds for the court to take jurisdiction of the case and asking the court to do so.

RESIDENTIAL PROGRAM: 24-hour-a-day care, supervision, food, lodging, rehabilitation, training, education, habilitation or treatment for a child outside of the child's home.

SECURE PROGRAM: a residential program offered in a building or part of a building secured by locks or other physical plant characteristics intended to prevent residents from leaving the program without authorization.

TEFRA: funding that allows some children with disabilities who live with their families to be eligible for Medical Assistance without counting the parent's income. However, parents pay a fee according to their income.

TITLE IV-E FUNDING: a provision of the federal Social Security Act that provides protections and support for eligible children receiving foster care and adoption services. This law includes provisions for the partial reimbursement to counties for the cost of care.

VOLUNTARY FOSTER CARE AGREEMENT (VFCA): required for children about to be placed in residential treatment, an agreement between the county and parents giving the county agency legal authority to place a child in residential treatment. This agreement does not require the transfer of legal custody. ■

ACRONYMS USED IN CHILDREN'S MENTAL HEALTH

ADHD	Attention deficit / hyperactivity disorder
ASFA	Adoption and Safe Families Act
CA	County attorney
CAFAS	Child and Adolescent Functioning Assessment Score
CASSP	Child and Adolescent Services System Program
CHIPS	Children in need of protection or services
CMHA	Minnesota Comprehensive Children's Mental Health Act
CR	Custody relinquishment
CTSS	Children's therapeutic services and support
DD/ED	Developmental delay / emotional disturbance
DHS	Department of Human Services
DSM-IV	Diagnostic and Statistic Manual of Mental Disorders
EBD	Emotional behavior disturbance
EBP	Evidence-based practices
GAF	Global Assessment of Functioning
IDEA	Individuals with Disabilities Education Act
IEP	Individualized education plan
IIIP	Individualized interagency intervention plan

ITP	Individual treatment plan
MA	Medical Assistance
MRJPP	Minnesota Rules of Juvenile Protection Procedure
OHPP	Out-of-home placement plan
PD	Public defender
PMAP	Prepaid Medical Assistance Plan
SED	Severe emotional disturbance
SSI	Social Security Income
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982
TPR	Termination of parental rights
VFCA	Voluntary foster care agreement
VPA	Voluntary placement agreement
504 plan	Section 504 of the Americans with Disabilities Act ■

FEDERAL AND STATE RESOURCES

Federal Resources

www.nami.org

National Alliance on Mental Illness

www.samsha.org

Substance Abuse Mental Health Services Administration

www.nimh.org

National Institute of Mental Health

www.ed.gov

U.S. Department of Education

www.ssa.gov

Social Security Administration

www.ffcmh.org

National Federation of Families for Children's Mental Health

www.bazelon.org

Bazelon Center for Mental Health Law

www.ojjdp.ncjrs.org

Office of Juvenile Justice and Delinquency Prevention

www.bpkids.org

Child and Adolescent Bipolar Foundation

www.chadd.org

Children and Adults with Attention-Deficit/Hyperactivity-Disorder

www.nctsn.org

National Child Traumatic Stress Network Center

State Resources

www.namihelps.org

NAMI Minnesota (National Alliance on Mental Illness)

www.namihelpsyouth.org

NAMI Minnesota (National Alliance on Mental Illness)—Youth website

www.dhs.state.mn.us/cmh

Minnesota Children's Mental Health Division

www.macmh.org

Minnesota Association for Children's Mental Health

www.pacer.org

Parent Advocacy Coalition for Educational Rights

www.doc.state.mn.us

Minnesota Department of Corrections

www.education.state.mn.us

Minnesota Department of Education

www.health.state.mn.us/mcshn

Minnesota Children with Special Health Needs

www.arcmn.org

Arc of Minnesota

www.ausm.org

Minnesota Autism Society

www.mccca.org

Minnesota Council of Child Caring Agencies

www.mndlc.org

Minnesota Disability Law Center

www.ombudmhmrs.state.mn.us

Minnesota Ombudsman for Developmental Disabilities
and Mental Health

www.mnadopt.org

Minnesota Adoption Support and Preservation ■

VOLUNTARY FOSTER CARE AGREEMENT FORM

Purpose

This form formalizes the agreement between the agency and the child's parent(s) when a child is placed in out-of-home care. It gives the agency the authority to provide the child with appropriate medical and dental care.

THIS IS AN AGREEMENT BETWEEN, _____,

AGENCY NAME

an agency duly authorized by the State of Minnesota to place children in out-of-home care, (hereinafter called the "agency") and

_____ and _____,

PARENT 1

PARENT 2

parent(s) of _____, residing at

CHILD'S NAME

_____, _____,

CHILD'S ADDRESS

CHILD'S CITY, STATE, AND ZIP CODE

County of _____ State of Minnesota.

The Agency agrees to

1. Provide or authorize supervision of your child who is placed in a licensed foster care home or in an authorized licensed child care agency.
2. Assume financial responsibility for board, room, clothing, medical care, dental care, and other expenses involved in the care of your child. When appropriate, we will bill your health insurance, Medical Assistance or you for these services. We will assist you in applying for Medical Assistance.
3. Provide current child support information with an authorization for the release of information.
4. Develop a written Out-of-Home Placement Plan with your family within 30 days as required by Minnesota Statutes, section 260C.212, subd.1.
5. When the parent is unable to do so, arrange and provide necessary routine medical and dental care, which may include tests and immunizations.
6. Obtain parent's written permission for major medical care except in an emergency situation when neither parent can be reached.
7. Provide casework and other services according to the required service plan while our child is living out of the home.
8. Return the child to the parent or guardian as soon as possible and no later than 24 hours after receipt of a written and dated request from the parent or guardian unless the request specifies a later date, or, because of child protection concerns, this agency secures legal authority to continue placement outside the home of the parent or guardian.

As a parent, I agree to

1. Follow through with my responsibilities written in the service plan.
2. Visit and to keep in touch with my child as stated in my child's service plan.
3. Keep the agency informed of where I live and how to contact me at all times.
4. Inform the agency if I want to remove my child from out-of-home care before the specified date in the agreement. My request will be in the form of a written and dated statement.
5. Provide the agency with my income information and cooperate with a fee assessment.
6. Reimburse the agency for expenses it incurs in caring for my child in accordance with the plan agreed upon with the agency and as allowed by the Minnesota social services foster care rule.
7. Agree to assign to the agency monthly child support payments for the care of my child(ren) while they are in out-of-home care.
8. Authorize the agency to:
 - a. Obtain medical and school information about my child.
 - b. Provide my child with necessary routine medical and dental care including all tests, and immunizations when I am not able to do so.
 - c. Provide major medical care or surgery in an emergency situation when one or both parents cannot be reached.
9. Provide health insurance information to the agency and turn over to the agency any payments made to me by my insurance company when the agency paid the bill.
10. Apply for Medical Assistance if required by the agency.

NOTE: *If you are on MFIP at the time your child is placed in foster care, it will affect your MFIP grant.*

I agree to the provisions contained in this voluntary placement agreement.

SIGNATURE OF MOTHER/LEGAL CUSTODIAN

SIGNATURE OF FATHER/LEGAL CUSTODIAN

SIGNATURE OF AGENCY REPRESENTATIVE

TITLE OF AGENCY REPRESENTATIVE

DATE OF AGREEMENT

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