



Residential Treatment Center Manual



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www.BecomeACASA.org



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This manual is a beginning, a gathering of information to share and to prompt more collaborative work to improve the lives and outcomes of children whose journey in our child protection system has placed them in residential care settings. This manual serves no purpose unless it is used by what we affectionately call, **“Fierce Advocates”!**

We know the children placed in RTC’s have experienced trauma – some acute, some chronic, many have experienced both. We know that these traumatic experiences have occurred during different developmental stages, greatly impacting the child, in ways unseen to us at first. And we all acknowledge that our intervention can also be another source of trauma, grief and loss for these children.

In our child protection system, it is the children with the highest needs – intensive needs – that find themselves in residential care. Often these children have been in care for a long time. Many have had dozens of placements and are greatly impacted by the instability which causes them to lose trust and hope. **It is these children that need our very best - our best understanding, our best response and our “Fiercest Advocacy.”**

So, what does it mean – our “best understanding?” Usually it is a child’s behaviors that require the highly restrictive settings of residential care. What is the root cause or causes of these behaviors? What do we need to know and understand about what has caused or continues to cause behaviors that make it “unsafe” or “difficult” or even “impossible?” for a child to self regulate, follow rules and succeed in a family home and public school?

And what does it mean to provide our “best response?” Would this mean providing ample time and attention in terms of resources that provide for the child in a culturally sensitive, skillfully trained, trauma informed, consistent, and committed manner?

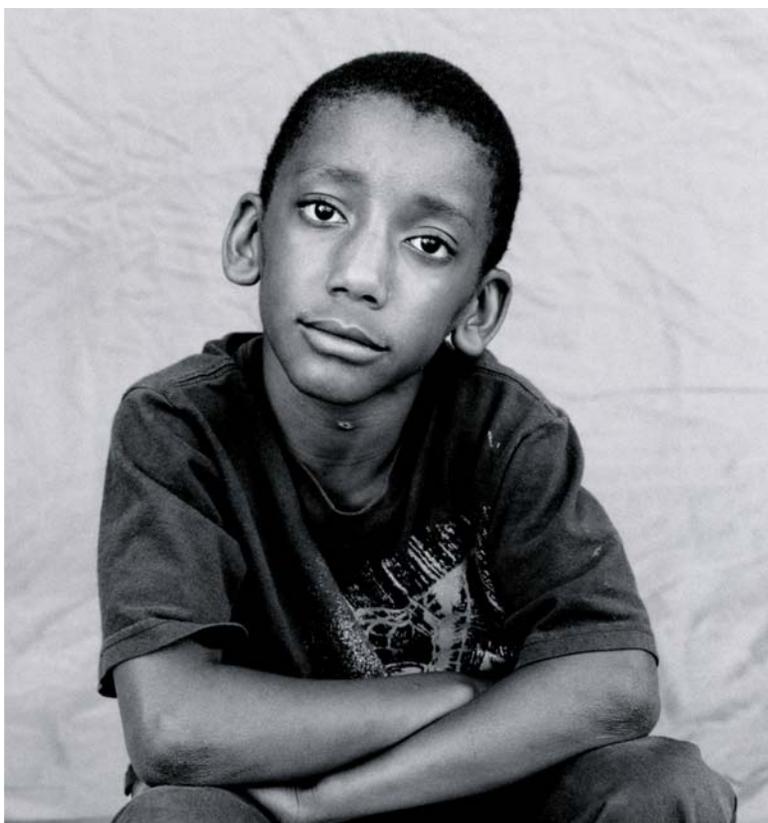
And what would a “fierce advocate” for these children do? Would this advocate let barriers stop them? Would this advocate get to know the child – really know the child? Would this advocate let the child know that someone really does care? Would this advocate help this child have their voice heard? Would this advocate seek to become informed? Would this advocate ask questions, lot of questions, and push the system and demand of the system - accountability and high standards and adherence to policies and laws. And if new laws or policies were needed, would this advocate speak up to demand better? And would this advocate never, never, ever give up, but always believe that for every child there is safety, trust, healing, love and a family – a forever family.

The information in this manual should help inform and send you in the direction of supporting children that are placed in RTC’s. We at Texas CASA humbly ask that you join us in improving the outcome of children. Hopefully, you understand the need for **“Fierce Advocacy”**, the question for you now is...**will you become one?**

Texas Casa Staff

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About Residential Treatment Centers



*“Our lives begin to end
the day we become silent
about things that matter”*

~ Martin Luther King, Jr.

WHAT IS A RESIDENTIAL TREATMENT CENTER?

Basic Information

General Residential Operation (GRO) A residential child-care operation that provides child care for 13 or more children or young adults. The care may include treatment services and/or programmatic services. These operations include formerly titled emergency shelters, operations providing basic child care, operations serving children with mental retardation, and halfway houses.

Residential Treatment Center (RTC) A general residential operation for 13 or more children or young adults that exclusively provides treatment services for children with emotional disorders.

Minimum Standards for Residential Treatment Centers and all child care facilities can be found on the DFPS website under Child Care Licensing – Standards and Regulations. A copy of these Minimum Standards is on page 111.

What policies should the RTC have?

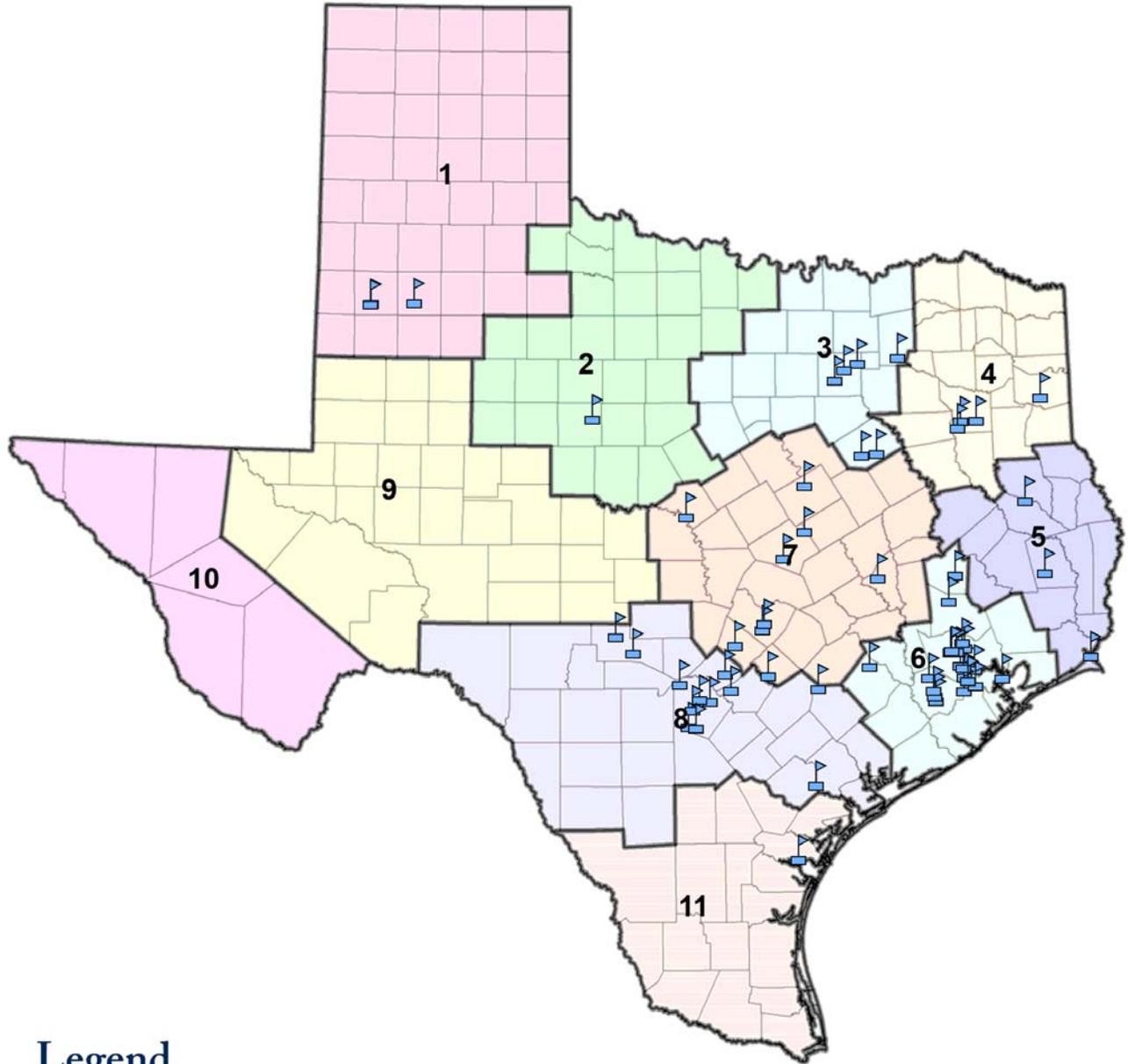
- Visitation rights between the child and family members and the child and friends;
- The child's rights to correspond by mail with family members and friends, including any policies regarding mail restrictions and receipt of electronic mail;
- The child's rights to correspond by telephone with family members and friends;
- The child's rights to receive and give gifts to family, friends, employees, or other children in care, including any restrictions on gifts;
- Personal possessions a child is or is not allowed to have;
- Emergency behavior intervention techniques if the use of emergency behavior intervention is permitted. If its use is not permitted, the RTC must have a policy disallowing its use;
- Discipline policies, including techniques and methods for ensuring the appropriateness of discipline techniques used with a child.
- Any religious program or activity that the RTC offers and whether participation is required.
- The plans for meeting the educational needs of each child, including the RTC's educational program and required participation by children.
- When trips with caregivers away from the operation are allowed and what protocols will be used;
- Program expectations and rules that apply to all children;
- A general daily schedule for routine activities for children in care;

- Child grievance procedures;
- Procedures for routine and emergency diagnosis and treatment of medical and dental problems;
- A plan for providing health-care services to a child with primary medical needs;
- Weapons, firearms, explosive materials, and projectiles
- Written plans and procedures for handling disasters and emergencies, such as fire, severe weather, and transportation emergencies.



Diana Myrindorf

Texas Residential Treatment Centers



Legend

 Residential Treatment Centers

Residential Treatment Centers

Region	County	Resource Name	Address	City	Zip Code	Phone
1	Hockley	Children's Hope Residential Services	1313 W Washington St	Levelland	79336-3921	(806) 897-9735
1	Hockley	Children's Hope Residential Services	500 West Ave	Levelland	79336-3341	(806) 897-9735
1	Lubbock	Children's Hope Residential Services	2402 Canyon Lake Dr	Lubbock	79415-2000	(806) 762-5782
3	Dallas	Autistic Treatment Center, Inc	10503 Metric Dr	Dallas	75243-5514	(214) 221-4405
3	Dallas	Bright Star Youth Academy	2519 Oak Lawn Avenue	Dallas	75219	(214) 780-0969
3	Navarro	Independence Farm	2715 Liberty Dr	Corsicana	75110-9286	(903) 874-2377
3	Navarro	New Encounters Residential Treatment	4121 FM 637	Corsicana	75109-9520	(903) 874-1577
3	Dallas	North Fork Educational Center	3001 Elm Grove Rd	Wylie	75098-6251	(972) 412-2444
3	Dallas	North Fork Educational (IPTP Only)**	3001 Elm Grove Rd	Wylie	75098-6251	(972) 412-2444
3	Hunt	Thompson's Residential Treatment	1995 FM 1564 E	Greenville	75402-8661	(903) 883-5437
4	Smith	Azleway Boy's Ranch	15892 County Road 26	Tyler	75707-2728	(903) 566-6827
4	Harrison	East Texas Open Door RTC	411 & 413 West Burleson	Marshall	75670	(903) 935-2099
4	Smith	Willow Bend Center	2902 Highway 31 E	Tyler	75702-8613	(903) 596-8900
4	Smith	Willow Bend (IPTP Only)	2902 Hwy 31 E	Tyler	75702-8613	(903) 596-8900
4	Smith	Youth And Family Enrichment Center	14023 Hwy 155 S	Tyler	75703-6635	(903) 534-0414
5	Nacogdoches	Nacogdoches Boy's Ranch	7245 Fm 1275	Nacogdoches	75961-3867	(936) 569-0293
5	Tyler	Sinclair Children's Center	207 N Nellius St	Woodville	75979-4809	(409) 283-6800
6	Harris	A Fresh Start Treatment Center	7809 Winship St	Houston	77028-2441	(713) 635-1081
6	Harris	A New Day Foundation	17202 Garden Creek Dr	Spring	77379-3899	(281) 257-1218
6	Fort Bend	Carter's Kids Residential Treatment	1203 Lark Ln	Richmond	77469-7803	(281) 239-6999
6	Harris	Center For Success and Independence	3722 Pinemont Dr	Houston	77018-1220	(713) 426-4545
6	Fort Bend	Depelchin Children's Center	710 S 7th St	Richmond	77469-3445	(281) 342-4906
6	Harris	Depelchin Children's (IPTP Only)	123 Shepherd	Houston	77007	(281) 342-4906
6	Harris	Embracing Destiny Foundation	17803 Woodbark Rd	Spring	77379-6120	(281) 251-4857
6	Austin	Five Oaks Achievement Center	7674 Pechacek Rd	New Ulm	78950-2160	(979) 992-3791
6	Austin	Five Oaks Achievement (IPTP Only)	7674 Pechacek Rd	New Ulm	78950-2160	(979) 992-3791
6	Harris	Good Shepherd Residential Treatment	23538 Coons Rd	Tomball	77375-8202	(281) 374-0777
6	Harris	Guardian Angels I Residential	9530 W Montgomery Rd	Houston	77088-4706	(281) 447-1812
6	Harris	Have Haven Inc.	14054 Ambrose St	Houston	77045-5818	(832) 667-8851
6	Harris	Hearts With Hope Foundation	17718 August Meadows Ln	Spring	77379-8713	(281) 376-0320
6	Harris	Hold My Hand Residential Treatment	7722 Glenvista St	Houston	77061-2118	(713) 645-0042
6	Harris	Houston Serenity Place	6703 Sealey Street	Houston	77091	(713) 691-5453
6	Harris	Houston Serenity Place, Inc.	6509 Morrow St	Houston	77091-2316	(713) 691-5572
6	Harris	Houston Wee Care Shelter Inc.	28915 S Plum Creek Dr	Spring	77386-2318	(281) 363-4020
6	Fort Bend	Krause Children's Residential	25752 Kingsland Blvd	Katy	77494-2086	(281) 392-7505
6	Harris	L'Amor Village RTC	16540 Kuykendahl Rd	Houston	77068-2756	(281) 586-9708
6	Fort Bend	New Hope Youth Center	4111 Brandt Rd	Richmond	77406-8140	(281) 344-8050
6	Harris	Positive Steps Inc.	2701 Rosedale St	Houston	77004-6187	(713) 522-0559
6	Harris	Shamar Hope Haven Residential	2719 Truxillo St	Houston	77004-5455	(713) 942-8822
6	Harris	Sheltering Harbour	17803 W Strack Dr	Spring	77379-8378	(281) 379-4578
6	Harris	Unity Children's Home RTC	2111 River Valley Dr	Spring	77373-6396	(281) 355-0716
7	Falls	Avalon Center Inc.	480 Highway 7	Eddy	76524-2448	(254) 859-5990
7	McLennan	Brookhaven Youth Ranch	5467 Rogers Hill Rd	West	76691-2415	(254) 829-1920
7	Brazos	Everyday Life Inc.	6955 Broach Rd	Bryan	77808-8897	(979) 589-1885
7	Travis	Helping Hand Home For Children	3804 Avenue B	Austin	78751-4906	(512) 459-3353
7	Bell	HMIH Cedar Crest, LLC	3500 S IH 35	Belton	76513-9426	(254) 939-2100
7	Mills	New Horizons Ranch Residential	850 FM 574 W	Goldthwaite	76844	(325) 938-5518
7	Caldwell	Pegasus Schools, Inc.	896 Robin Ranch Rd	Lockhart	78644-4578	(512) 376-2101
7	Hays	The Burke Foundation-Pathfinders	20800 FM 150 W	Driftwood	78619-9202	(512) 858-4258
7	Fayette	Whispering Hills Achievement Center	4110 FM 609	Flatonia	78941-4917	(361) 865-3083
7	Fayette	Whispering Hills (IPTP)	4110 Fm 609	Flatonia	78941-4917	(361) 865-3083
8	Bexar	Autistic Treatment Center	16111 Nacogdoches Rd	San Antonio	78247-1002	(210) 590-2107
8	Victoria	Devereux-Victoria	120 David Wade	Victoria	77905	(361) 575-8271
8	Bexar	Habilitative Homes Inc.	9019 Old Sky Hbr	San Antonio	78242-3225	(210) 623-5419
8	Bexar	Hector Garza Residential Treatment	620 E Afton Oaks Blvd	San Antonio	78232-1236	(210) 568-8600
8	Bexar	Hector Garza Center (IPTP)	620 E Afton Oaks Blvd	San Antonio	78232-1236	(210) 568-8600
8	Kerr	Hill Country Youth Ranch Residential	3522 Junction Highway	Ingram	78025	(830) 367-2131
8	Kerr	Hill Country Youth (IPTP Only)	3522 Junction Hwy	Ingram	78025-5061	(830) 367-2131
8	Bexar	KCI Servants Heart Residential	4040 High Ridge Cir	San Antonio	78229-4143	(210) 212-2500
8	Comal	New Life Children's Treatment Center	650 Scarborough	Canyon Lake	78133-4529	(830) 964-4390
8	Comal	New Life Children's Treatment Center (IPTP)	650 Scarborough	Canyon Lake	78133	(830) 964-4390
8	Kendall	Roy Maas Youth Alternatives	121 Old San Antonio Rd	Boerne	78006-3415	(830) 816-2425
11	San Patricio	Shoreline Inc.	1220 Gregory St	Taft	78390-3044	(361) 528-3356

**IPTP (Providing Intensive Psychiatric Transition Program Services)

General Residential Operations (Providing Basic Child Care)

Region	County	Resource Name	Address	City	Zip Code	Phone
1	Oldham	Cal Farley's Boys Ranch	8 Julian Bivins Blvd	Boys Ranch	79010	(806) 534-2211
1	Randall	Children's Home	3400 Bowie St	Amarillo	79109-4997	(806) 352-5771
1	Lubbock	Childrens Home Of Lubbock	4404 Idalou Rd	Lubbock	79403-9554	(806) 762-0481
1	Randall	High Plains Children's Home	11461 S Western St	Amarillo	79118-4119	(806) 622-2272
1	Lubbock	Texas Boys Ranch	4810 N County Road 2800	Lubbock	79403-7297	(806) 747-3187
2	Taylor	New Horizons Audrey Grace House	598 Medical Dr	Abilene	79601-4557	(325) 437-2535
2	Brown	Sweeten Home For Children Inc.	2301 C R 135	Brownwood	76801	(325) 641-0632
3	Tarrant	ACH Child And Family Services	1424 Summit Ave	Fort Worth	76102-5912	(817) 886-7120
3	Hunt	Boles Children's Home, Inc.	7065 Love	Quinlan	75474-4609	(903) 224-4931
3	Denton	Cumberland Presbyterian Children's Home	909 Greenlee St	Denton	76201-7064	(940) 382-5112
3	Dallas	Jonathan's Place	6065 Duck Creek Dr	Garland	75043-3649	(972) 303-5303
3	Ellis	Methodist Children's Home	300 Brookside Rd	Waxahachie	75167-2208	(469) 548-3400
3	Ellis	Presbyterian Children's Homes & Services	300 Brookside Rd	Waxahachie	75167-2208	(972) 937-1319
3	Erath	Sherwood-Myrtie Foster Home For Children	1779 N Graham St	Stephenville	76401-2201	(254) 866-2143
4	Smith	Azleway Valley View	15892 County Road 26	Tyler	75707-2728	(903) 566-8444
4	Smith	Children's Village And Family	3659 FM 724	Tyler	75704-5645	(903) 592-3421
4	Harrison	East Texas Open Door Inc	414 W Burleson St	Marshall	75670-3213	(903) 935-2099
5	Jefferson	Boys Haven Of America	3655 N Major Dr	Beaumont	77713-9574	(409) 866-2400
5	Jefferson	Girls Haven	3380 Fannin St	Beaumont	77701-3840	(409) 832-6223
6	Harris	Boys & Girls Country Of Houston	18806 Roberts Rd	Hockley	77447-9327	(281) 351-4976
6	Harris	Boys & Girls Harbor	514 Bayridge Rd	Morgans Point	77571-3511	(281) 471-9622
6	Brazoria	Brazoria County Youth Homes	3315 Fm 523 Rd	Oyster Creek	77541-6616	(979) 233-7281
6	Harris	Embracing Destiny Foundation	8014 Forest Breeze Ln	Spring	77379-8726	(281) 251-4857
6	Walker	Gulf Coast Trades Center	143 Forest Service Rd. 233	New Waverly	77358-3945	(936) 344-6677
6	Harris	Hands Of Healing	105 W Pearce St	Baytown	77520-7772	(281) 424-2000
6	Harris	Hearts With Hope Foundation	3407 Spring Creek Dr	Spring	77373-6118	(281) 651-1207
6	Brazoria	The Jim H. Green Kidz Harbor	638 Harbor Dr	Liverpool	77577-8716	(281) 581-2505
7	Travis	Austin Children's Shelter	4800 Manor Rd	Austin	78723-5471	(512) 499-0090
7	Williamson	Casa Esperanza Inc DBA Hope House	1705 County Road 285	Liberty Hill	78642-6093	(512) 515-6889
7	Travis	Central Texas Children's Home	1925 Crane Rd	Buda	78610-9613	(512) 243-1386
7	San Saba	Cherokee Home For Children	Hwy 16 N	Cherokee	76832	(325) 622-4201
7	Travis	Lifeworks Transitional Living	4606 Connelly St	Austin	78751-3415	(512) 458-2704
7	McLennan	Methodist Children's Home	1111 Herring Ave	Waco	76708-3642	(254) 753-0181
7	McLennan	Methodist Children's Home Boys	1439 Methodist Ranch Rd	Waco	76705-4924	(254) 799-2434
7	Bell	Post Country Care	5741 Elm Grove Rd	Belton	76513-7675	(254) 939-7322
7	Williamson	Texas Baptist Children's Home	1101 N Mays St	Round Rock	78664-4203	(512) 255-3682
7	Travis	The Settlement Club Home	1600 Payton Gin Rd	Austin	78758-6506	(512) 836-2150
8	Bexar	BCHM San Antonio Campus	7404 W US Highway 90	San Antonio	78227-4024	(210) 674-3010
8	Dewitt	Bluebonnet Youth Ranch	4652 US Highway 77a S	Yoakum	77995-5365	(361) 293-3546
8	Bexar	Boysville Inc	8555 E Loop 1604 N	Converse	78109-2915	(210) 659-1901
8	Comal	Connections Individual and Family Services	705 Comal Street	New Braunfels	78130	(830) 620-0214
8	Bexar	George Gervin Youth Center	511 Yucca St Apt 2	San Antonio	78220-3122	(210) 532-3948
8	Kerr	Hill Country Youth Ranch	3522 Junction Highway	Ingram	78025	(830) 367-2131
8	Bexar	Mission Road Developmental Center	8706 Mission Road	San Antonio	78214	(210) 924-9265
8	Bexar	Mission Road Developmental Center	8706 Mission Rd	San Antonio	78214-3140	(210) 924-9265
8	Medina	New Beginnings Children's Home	400 County Road 3821	San Antonio	78253-6914	(210) 892-2915
8	Kerr	Pathways 3H Youth Ranch	110 3H Youth Ranch Cir Nw	Mountain Home	78058	(830) 549-2457
8	Kendall	Roy Maas Youth Alternative	121 Old San Antonio Rd	Boerne	78006-3415	(830) 816-2425
8	Bexar	Seton Home	1115 Mission Rd	San Antonio	78210-4505	(210) 533-3504
8	Comal	St Judes Ranch For Children	1400 Ridge Creek Ln	Bulverde	78163-2804	(830) 885-7494
8	Bexar	St Peter - St Joseph Childrens	919 Mission Rd	San Antonio	78210-4501	(210) 533-1203
8	Comal	St. Jude's Ranch For Children	652 Old Bear Creek Rd	New Braunfels	78132-2867	(830) 629-0659
9	Tom Green	Concho Valley Home For Girls	404 Preusser St	San Angelo	76903-3618	(325) 655-3821
10	El Paso	Lee Beulah Moor Children's Home	1100 E Cliff Dr	El Paso	79902-4625	(915) 544-8777
11	Hidalgo	Rio Grande Children's Home	3780 N Bentsen Palm Dr	Mission	78574-8207	(956) 585-4847
11	Bee	South Texas Children's Home	9243 FM 2617	Pettus	78146	(361) 375-2101
11	Cameron	Sunny Glen Childrens Home	2385 W Expressway 83	San Benito	78586-7831	(956) 399-5356

COMMON TERMS & ACRONYMS

Individual Treatment Plan (ITP): Every child in a residential treatment center has an ITP. The ITP includes:

- The child's diagnosis or diagnoses
- Strength's and assets of the child
- Goals, methods and expected outcome
- Evaluation of the child's progress towards treatment goals
- Needed services and the staff responsible for them
- The child's length of stay in the program
- A discharge plan

Treatment Plan Review: A treatment plan review should occur at least every three months. Participants in this staffing may consist of RTC staff, CPS staff, therapists, teachers, surrogate parent, CASA, Attorney ad litem, and parents or kin. Advocates are encouraged to attend these staffings.

Incident Report: RTCs are required to provide written documentation on all critical incidents involving children/youth. If you are made aware of a critical incident, please ask to review the incident report. Below are examples of critical incidents:

- **Abduction** – a child/youth taken from the facility by unauthorized individual or individuals
- **Alleged abuse or Neglect** – RTC staff or contracted professional or any person in with the child/youth is alleged to have physically, sexually or verbally abused the child/youth
- **Arrest of child/youth** – child/youth is arrested
- **Assault by child/youth** – a willful and malicious attack by a child/youth
- **Assault by youth on staff** – child/youth attacked staff and the assault may or may not require medical attention
- **Confinement** – secure detainment of child/youth for the purpose of control or discipline
- **Contraband** – any item possessed by an individual or found within the facility that is illegal by law or prohibited by the facility
- **Emergency Medical treatment** – child/youth has been injured or has suffered an illness that requires emergency medical attention
- **Emergency use of psychotropic medications** – one time dose of a psychotropic medication in the event of a psychiatric emergency when all other measures have been unlikely to prevent the child/youth from imminent harm to self and / or others

- **Major event at RTC** (i.e., riot, fire, flood, etc.)
- **Physical restraint** – involuntary immobilization of an individual without the use of mechanical devices. This includes escorts where the child/youth is not allowed to move freely
- **Medication Error**- medication is not administered according to the prescribing provider and /or according to the RTC policies and procedures
- **Mental Health Crisis** – child/youth has engaged in or experienced self-injurious behavior, suicidal ideation or behavior, homicidal ideation or behavior or acute psychotic episode
- **Property damaged** - property that is lost, stolen, missing or damaged with or without intent
- **Runaway** – a child/youth is away without consent of the RTC, and or legal guardian
- **Search** – contraband is found in the facility or on a child/youth during a pat down
- **Seclusion** – confinement of an individual alone in a locked room or egress prevented

Discharge Plan: How long a child remains in an RTC should be determined by the child's progress in treatment. A discharge plan can include:

- Continuing educational planning
- Continuing physical and behavioral health care planning
- Recreation, activities and for older youth transitional living planning
- Assessment of risk factors and a crisis plan

Some Diagnostic acronyms to know:

- **ADD** – Attention Deficit Disorder
- **ADHD** – Attention Deficit with Hyperactivity Disorder
- **ASD** – Autism Spectrum Disorder
- **BD** – Behavioral Disorder
- **BP** – Bipolar Disorder
- **BPD** – Borderline personality Disorder or bipolar disorder
- **CD** – Conduct Disorder
- ***DSM** – Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association
- **ED** – Emotionally Disturbed or Eating Disorder
- **FAS** – Fetal alcohol syndrome
- **AD** – Anxiety Disorder

- LD – Learning Disorder
- MDD – Major Depressive Disorder
- OCDC – Obsessive Compulsive Disorder
- PTSD – Post Traumatic Stress Disorder
- RAD – Reactive Attachment Disorder
- SAD – Separation Anxiety Disorder
- SMI – Severe Mental Illness

Other acronyms

- ADA –Americans Disability Act
- ARD – Admission, Review, and Dismissal
- BIP – Behavior Intervention Plan
- BMP – Behavioral Management Plan
- CBT – Cognitive Behavioral Therapy
- DD- Development Disorder
- DFPS – Department of Family and Protective Services
- DX – Diagnosis
- FAPE – Free Appropriate Public Education
- IDEA – Individual with Disabilities Education Act
- IEP – Individual Education Plan
- NAMI – National Alliance on Mental illness
- PRN – Prescribed for use as needed
- R/O – Rule out
- SA – Substance Abuse
- SASS –Screening Assessment Support Services
- SEP – Special Education Plan

RESIDENTIAL CHILD CARE CONTRACT INFORMATION

Accessing information about the Residential Child Care Contracts (RCC) Division and the Residential Child Care Contract can be found at the following link:

http://www.dfps.state.tx.us/PCS/Residential_Contracts/default.asp

The Residential Contracts Web site includes important helpful information:

- **Residential Contract, Executive Summary, Forms, and Sample Letters** (a copy of the current fiscal year contract, attachments and a summary of what changed from last year)
http://www.dfps.state.tx.us/PCS/Residential_Contracts/contract_forms.asp
- **RCC Staff Contact Information** (list of current residential contracts staff)
http://www.dfps.state.tx.us/PCS/Residential_Contracts/contract_managers.asp
- **Applicant's Guide to Contracting** (a good overview of Licensing, Contracts, CPS, YFT and STAR Health) http://www.dfps.state.tx.us/documents/PCS/RCC_Contracting_Guide.pdf
- **List of Active Contracts** (updated quarterly)
http://www.dfps.state.tx.us/PCS/Residential_Contracts/active_contracts.asp
- **Helpful Links** (Guides for certain types of services, trainings, resources, and requirements) http://www.dfps.state.tx.us/PCS/Residential_Contracts/contract_resources.asp
- **Email address for contacting the Residential Contracts division**
Residential_Contracts@dfps.state.tx.us

Access to Children.

Section 33. of the Residential Contract clarifies the access to children granted by the Texas Family Code for CASA, guardians ad litem and attorneys ad litem. In Fiscal Year 2012, DFPS added the following to the Residential Contract:

33. Access to Children. The Contractor will, at all times, permit access to all Children placed by the Department in the care of the Contractor by... properly identified individuals appointed by a court of competent jurisdiction (Volunteer or Court Appointed Special Advocates (CASA), guardians ad litem, and attorneys ad litem).

- A) All parties will exercise their right of access in a reasonable manner and attempt to plan and coordinate such visits in cooperation with the Contractor and in a manner that minimizes disruption of the care of the Children placed with the Contractor.
- B) In order to assess that an individual is appointed by a court of competent jurisdiction, a Contractor or Caregiver should:
 - i. If such individual is an employee of the CASA, review for a valid court order; and

- ii. If such individual is a CASA volunteer, review for a valid court order and a notification letter of volunteer assignment and acceptance, that clarifies the individual's appointment to the Child; or
 - iii. Review that the individual is named on the Child's Contact List.
- C) If Contractor or Caregiver cannot readily determine the identity or authority of an individual appointed by a court of competent jurisdiction, then the Contractor or Caregiver should obtain approval from the Child's Caseworker or Chain of Command prior to granting the individual access to the Child.

School Requirements.

School-age children in the conservatorship of DFPS should be enrolled in an accredited Texas Public School within three school days of placement, unless an exception has been granted by the Child's Caseworker.

In addition, if a Child has to withdraw from a Public School due to a change in placement that results in the Child being discharged, the discharging Residential Contractor must notify the Public School within three school days of this discharge.

Education Portfolio.

The caseworker creates an Education Portfolio for each school-age child in DFPS conservatorship. The portfolio contains the child's current academic and psychological assessments, as well as immunization records, and copies of report cards. For children with special needs, the portfolio also includes notes from Admission, Review, and Dismissal (ARD) meetings.

Contract Section 15 B) i. identifies all items that must be updated in the Education Portfolio:

- i. School enrollment documentation: Birth certificate, Social Security number, Immunizations, and withdrawal notice from the last school;
- ii. Special education documentation: Admission, Review & Dismissal (ARD) team meeting notes, Individual Education Plan (IEP), Documents related to Section 504 of the Rehabilitation Act of 1973 regarding reasonable accommodations, Full Individual Evaluation and/or other diagnostic assessments;
- iii. Report cards, progress reports, and/or IEP progress reports;
- iv. Transcripts;
- v. Standardized test results;
- vi. Referrals, notices, or correspondences; and
- vii. School pictures.

Preparation for Adult Living (PAL) Activities and Transition Planning.

Residential Contractors are expected to participate in and provide transportation to Transition Planning and PAL activities.

PAL services include benefits and services provided to Children in DFPS-paid Substitute Care who are age 16 and older and likely to remain in foster care until at least 18, who can qualify for services up to their 21st birthday and includes:

- A) Casey Life Skills Assessment to assess strengths and needs in life skills;
- B) Life Skills training in core areas including financial management;
- C) Job readiness and life decisions/responsibility;
- D) Educational/vocational services;
- E) Transitional Living Allowance (TLA) up to \$1000 (distributed in increments up to \$500 per month for children who participate in PAL Life Skills training, to help children with initial start-up costs in adult living);
- F) After Care Room and Board (ACRB) assistance, based on need, up to \$500 per month for rent, utility deposits, food, etc. (not to exceed \$3000 of accumulated payments per Child);
- G) Case management to help Children with self-sufficiency planning and resource coordination;
- H) Teen conferences;
- I) Leadership development activities; and
- J) Additional supportive services, based on need and availability of funds, such as mentoring services and driver's education.

DFPS policy requires the development of a Transition Plan (Form 2500) for a youth who turns 16 while in DFPS care and also requires a transition plan meeting within 90 days of a youth turning 18 in care.

As per contract section 29 G), Residential Contractors have an important role in coordinating with CPS for Children 16 years of age and older regarding:

- i. The use of the CPS Transition Plan, Form 2500, as appropriate, at <http://www.dfps.state.tx.us/Application/Forms/showFile.aspx?Name=2500.doc>
- ii. Maintaining a copy of the Voluntary Extended Foster Care Agreement Form 2540 and Trial Independence: Ability to Return for Extended Foster Care Form 2532 in the record;
- iii. The provision of information available at http://www.dfps.state.tx.us/Child_Protection/Transitional_Living/default.asp related to:
 - a. Aftercare services, benefits and provider contacts;
 - b. Educational Supports, Services and Benefits;
 - c. Extended Care and Return for Extended Foster Care information;
 - d. Preparation for Adult Living (PAL) services;
 - e. Texas Foster Care Handbook for Youth;
 - f. Transitional Medicaid and STAR Health;

- g. Information related to the Child's Special Immigrant Juvenile Status, if applicable; and
- h. Other region-specific services available.
- iv. The provision of information about Transition Service Centers available under the "contacts link" at: <http://www.dfps.state.tx.us/txyouth/default.asp>; and
- v. The Contractor shall support and facilitate computer access required for job search activities, career research, Texas Youth Connection and approved social media.

Driver License.

Senate Bill 218, enacted through the 82nd Regular Legislative session, resulted in the waiver of driver license fees for youth in the temporary or permanent managing conservatorship of the Texas Department of Family and Protective Services (DFPS) and for young adults at least 18 years of age, but younger than age 21 and who reside in a DFPS paid foster care placement.

This bill was part of the recommendations of the SB 983 (of the 81st Legislature) Report titled "Plan to Ensure Youth in Permanent Managing Conservatorship are Provided the Opportunity to Complete Driver Education Courses and to Obtain a Driver License" which can be found at: http://www.dfps.state.tx.us/documents/about/pdf/Legislative/2010-12-21_SenateBill_983_Report.pdf

As a result of this change, the Contract states that the Contractor shall:

- Ensure that the following are made available to Children to facilitate driver license fee waiver-residency affidavit requirements:
 - a. A DFPS Foster Youth Driver License Fee Waiver Letter; (FORM 2042)
 - b. A Texas Department of Public Safety (DPS) Texas Residency Affidavit (Form DL-5), which is completed and signed by the Child and a Representative; and
 - c. For Children under age 18, a Representative to accompany the Child to the DPS driver license office to provide acceptable proof of residency; and
- Inform Children who have applied for a driver license of the need to notify DPS of a new address change within 30 days of a change in placement.

Basic Living and Social Skills.

Contractors are responsible for ensuring that children are taught basic living and social skills which involves ensuring that children gain the skills necessary to care for themselves and to function in the community.

- **Basic Living Skills** include, but are not limited to, grocery shopping, food planning and preparation, maintenance of living environment, laundry, personal hygiene, utilization of transportation systems, personal identification documents, personal finance, and budgeting.
- **Social Skills** are those skills necessary to function in the community. Social Skills include, but are not limited to, the ability to communicate with others, knowledge of community resources, scheduling and attending medical appointments, interviewing for a job, cultural competency, and the ability to interact in various social situations.

Experiential Life Skills Activities.

Contractors are also responsible for maximizing opportunities for learning through the use of Experiential Life Skills Activities and provide access to them through community resources.

- Experiential Life Skills Activities are those which engage youth in learning new skills, attitudes, and ways of thinking through hands-on learning opportunities. Experiential life-skills training is tailored to a Child's skills and abilities and may include training in practical activities that include:
 - grocery shopping,
 - meal preparation/cooking,
 - use of public transportation,
 - money management, and
 - basic household tasks
- The youth's experiential learning while in care and receipt of PAL services should complement one another and are discussed and addressed in each core life skill area within the youth's service and transition plan.

DFPS Guides Related to Services to Older Youth and Experiential Life Skills Activities.

http://www.dfps.state.tx.us/documents/PCS/2010-10_ProviderGuideServingOlderYouth.pdf

- Provider Guide for Serving Older Youth http://www.dfps.state.tx.us/documents/PCS/2010-10_ProviderGuideServingOlderYouth.pdf
- Extended Foster Care - Documentation for Work and Education Activities http://www.dfps.state.tx.us/documents/PCS/2010-09_WorkandEducationActivities.pdf
- 6/23/10 - Tips for Providing Experiential Life Skills Training in Residential Treatment Settings http://www.dfps.state.tx.us/PCS/Residential_Contracts/2010-06-23_Tips_for_Providing_Experiential.asp
- 6/23/10 - Resources to Aid Caregivers in Providing Experiential Life Skills Training to Foster Youth http://www.dfps.state.tx.us/PCS/Residential_Contracts/2010-06-23_Resources_to_Aid_Caregivers.asp

Maintaining Connections.

Preserving connections for children and youth is an important part of the contract and is highlighted by the requirements of Section 20) "Maintaining Connections", Section 21) "Contact with Siblings", Outcome Measure #2 "Children are able to maintain healthy connections with caring Family Members who can provide a positive influence in their lives" and Outcome #3 "Children are able to maintain connections to siblings" and share information about use of Child Protective Services (CPS) Placement Summary Form 2279.

A key component of preserving connections is visitation. Visitation is essential for a child's well-being, fundamental to permanency, and vital to a child maintaining family relationships and cultural connections. Visitation is a right and should never be used as a reward or punishment.

Visitation with siblings is extremely important. Sibling connections are the most long-lasting relationship an individual is likely to experience. When young adults leave long-term foster care, they more often searched for siblings from whom they had been separated than they did parents. While placed with a contractor, the following is required related to Contact with Siblings:

- A) Initiate Personal Contact between a Child and a Child's sibling(s) who is/are in foster care at least one time per month in a Face-to-Face meeting if siblings are separated but within 100 miles of each other;
- B) Initiate Personal Contact between a Child and a Child's sibling(s) who is/are in foster care by initiating twice monthly Telecommunications if separated by more than 100 miles during which the Child and their siblings discussion and actions are not directed by the Contractor.
- C) If licensed as a CPA, arrange and facilitate sibling visits when siblings are at different placements within the same CPA.
- D) Exceptions to A), B), and C) above include the following:
 - i. Prohibited by court order;
 - ii. Contrary to the best interest of the Children as reflected in any of the Plans of Service of the Child or the Child's sibling(s); or
 - iii. As approved in writing by the Regional Program Director or a mental health professional treating the Child or any of the Child's siblings.

Contractors must make and document good faith efforts to ensure that children are able to preserve desired and appropriate Connections to the child's own cultural identity and community, including religious/spiritual, Family Members, school, and appropriate organizations through on-site or off-site means.

Some ideas for practice for preserving connections include the following:

- Get the child's input and share with the case worker: Ask the child or youth how they would like to keep connected to siblings, parents, and important others. The child may have some useful suggestions or plans that the case worker may not otherwise think of. Share this information with the child's case worker so that they can follow up on such connections and if appropriate, approve contact.
- Permit contact via phone, email and texting: When contact is approved by the case worker and under the level of supervision required, electronic communication such as the internet, e-mail, social networking, instant messaging, and wireless data exchange is one of the least expensive and most efficient means of communication. Wherever possible and in line with the contract requirements, it should be facilitated.
- Note Issues of Visitation Documented in the Child's Plan of Service: Look for expectations for sibling visitation and other types of contact in the child's plan of service. This should include the level of supervision that is required and the conditions under which DFPS staff must be contacted.

- Discuss maintaining the child's connections at all staffings: Whether the staffing is a more formal Family Group Decision Making meeting or a staffing conducted by your agency, the issue of the child's connections should be discussed. Review the specifics of how, when, and by whom connections will be maintained are included in written documents from the meetings, such as your service plan.
- Note updated contact information in the Placement Summary Form (2279): Check the contact information provided to caregivers and note if they are accurate and up to date. Caregivers rely on this form for current contact information for the siblings, parents and others with whom the child wants to maintain connection. If they are not current, contact the case worker to update the documentation.
- Maintain participation in extracurricular, social and enrichment activities: If at all feasible, the child or youth should be permitted to continue participation in the activities, hobbies and interests that preceded entry into care. While participation may not always be possible, it should be explored.
- Take and share pictures: Make efforts to take and share photos of the child and others when they are together and share them (within the parameters of Contract Section 43) L. "Regarding Release or Otherwise Use of a Photo or Image of a Child").
- Coordinate and transport child siblings: Support attendance at events and coordinate / transport siblings to activities which are important to them, such as ball games, recitals, and birthdays.
- Encourage children and youth to keep a "lifebook" with names, contact information and pictures of important people in their lives. This can include friends, classmates, foster families, mentors, caseworkers, etc.

Trauma Informed Care.

The need to address trauma is increasingly viewed as an important component of effective service delivery. The impact of trauma is experienced by children, families, caregivers, and the social service providers who serve them.

DFPS provides training opportunities to assist families, caregivers and other social service providers in fostering greater understanding of trauma informed care and child traumatic stress. This training is designed to help with understanding the effects that trauma can have on child development, behaviors, and functioning, as well as recognize, prevent and cope with compassion fatigue. This training can be accessed at the following link: http://www.dfps.state.tx.us/Training/Trauma_Informed_Care/default.asp

Attachment C Section B502.03 requires providers and foster parents to receive training on trauma informed care:

B502.03 Each direct care staff must receive trauma informed care training annually. Each newly hired direct care staff must receive trauma informed care training within 60 days of hire or foster home verification. Certification of completed trauma informed care training must be placed in staff and foster parent records containing the training staff signature, completion date and number of hours. STAR Health Trauma Informed Care training is available at no cost at the following website: <http://www.fostercaretx.com/about-us/centene-corporation/training/>

Note: No minimum hours of trauma informed care training is required. Hours earned for trauma informed care training may be counted towards pre-service training requirements.

STAR Health.

The goal of STAR Health is to provide a medical home for each child and coordinated, uninterrupted health care when a child changes placements. Components include:

- Enrollment for immediate access to Medicaid benefits;
- An initial Texas Health Steps evaluation within 30 days of a Child entering the conservatorship of DFPS;
- Integrated physical and behavioral health care;
- Physical, occupational, speech, and other health-related services;
- Healthcare coordination through a medical home and service management;
- Enhanced access to services through a network of providers and service coordination;
- Dental, vision and pharmacy services;
- A health passport; and
- 7 day, 24 hour Nurse and Behavioral Health Hotlines available to members, caregivers and medical consenters.

Access to Services.

All health care for children in DFPS conservatorship must be provided by a STAR Health provider. Contract Sections 12 A) iv and 12 B) i. require the following with regard to accessing to STAR Health services:

- The Contractor shall access Medicaid through STAR Health for covered Medical, Dental, Vision and Pharmacy services available to Children.
- The Contractor shall ensure that Behavioral Health Services are available and provided to each Child as needed by a STAR Health Network Provider (Network Provider).

To access a STAR Health provider please reference the following phone numbers:

- Vision Services (Opticare): 866-642-8959;
- Behavioral Health Services (Cenpatico): 866-218-8263;
- Dental Services (DentaQuest): 888-308-4766; or
- STAR Health Member Services (Superior): 866-912-6283.

For additional information, see;

- The STAR Health website at <http://www.fostercaretx.com/>; and
- The DFPS Medical Services website at http://www.dfps.state.tx.us/Child_Protection/Medical_Services/guide-star.asp

Upon placement of a child, the caregiver or youth should receive a packet in the mail and receive a phone call from a STAR Health representative to assist with navigating the steps to accessing STAR Health services, including the selection of a primary care provider. A primary care provider is the doctor or clinic that takes care of most of the child's health care needs. Caregivers will be asked to select primary care providers for children in their care. The medical consentor for a child should present the child's STAR Health ID Card, Medicaid Card, or DFPS Medical consent Form 2085-B at the time of the appointment.

Medical Consenter.

Each child in DFPS conservatorship will have a designated medical consentor to make health care decisions for the child. The court names (authorizes) either an individual or DFPS as the medical consentor and puts it in the court order.

- When the court names an individual as medical consentor, that person is ultimately responsible for the medical decisions for that child and answers directly to the court.
- When the court names DFPS to make medical decisions for a child, DFPS must designate medical consentor and a back-up medical consentor for the child. They answer to DFPS, and DFPS answers to the court.

For information about the provision of medical consent for children in DFPS conservatorship, see:

- http://www.dfps.state.tx.us/Child_Protection/Medical_Services/medical-consent.asp; and
- http://www.dfps.state.tx.us/Child_Protection/Medical_Services/guide-consent.asp.

A STAR Health provider or medical consentor may contact STAR Health Member Services if they have questions about a child's eligibility for STAR Health services. After hours, contact the NurseWise Hotline by dialing (866) 912-6283 (press option "7" after hours and weekends) to talk to a nurse 24-hours a day, 7-days a week.

Texas Health Steps.

Children in DFPS conservatorship must get Texas Health Steps <http://www.dshs.state.tx.us/thsteps/about.shtm> medical and dental checkups. The Texas Health Steps program, known under federal law as the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, is Medicaid's preventive healthcare program for children, teens, and young adults age 20 and younger. Texas Health Steps checkups are designed to find and treat medical and dental problems. Only licensed providers who are enrolled in Texas Health Steps may perform Texas Health Steps checkups.

How often the child gets Texas Health Steps medical checkups depends on the child's age. Children and youth age 3 through 20 years need medical checkups every year. Children under 3 years of age need more frequent medical checkups. You can access more information regarding Texas Health Steps at: http://www.dfps.state.tx.us/Child_Protection/Medical_Services/guide-steps.asp

Contract Sections 12 A) ii and iii. require the following regarding Texas Health Steps:

- i. The Contractor will provide access to Texas Health Steps Medical Checkups in the following manner:
 - a. For all Children, an initial Texas Health Steps Medical Checkup within 30 days of entry into DFPS conservatorship;
 - b. For all Children, unless required more frequently by the Child's medical provider, a subsequent Texas Health Steps Medical Checkup must be scheduled one year after the previous checkup and no later than the child's next birthday;
 - c. For Children under 36 months of age, Texas Health Steps Medical Checkups in accordance with the Texas Health Steps Periodicity Schedule: <http://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589962005>
 - d. For all Children, provided by a licensed health care practitioner who is enrolled in Texas Medicaid as a Texas Health Steps provider; and
 - e. For Children with Primary Medical Needs, request written documentation from the Child's Primary Care Physician (PCP) if the Child is unable to attend Texas Health Steps Medical Checkups in accordance with required timeframes.
- ii. The Contractor shall provide access to Texas Health Steps Dental Checkups in the following manner:
 - a. For all Children who are under six months of age upon entry into DFPS conservatorship, within 30 days of becoming six months of age;
 - b. For all Children six months of age or older, within 60 days of entry into DFPS conservatorship;
 - c. For all Children, a subsequent checkup must be obtained six months after the month in which the Child received the previous checkup;
 - d. For all Children six to 35 months of age who have been determined by a Texas Health Steps provider to be at risk for early tooth decay, dental checkups as frequently as required, as determined by the Child's Texas Health Steps provider;
 - e. For all Children, provided by a licensed dentist who is enrolled in Texas Medicaid as a Texas Health Steps provider or a dental hygienist who is working under the supervision of a licensed dentist who is enrolled in Texas Medicaid as a Texas Health Steps provider; and
 - f. For Children with Primary Medical Needs, request written documentation from the Child's Primary Care Physician (PCP) if the Child is unable to attend Texas Health Steps Dental Checkups in accordance with required timeframes.

Health Passport.

The Health Passport is a secure electronic health information website that was created to ensure medical information follows each child in DFPS conservatorship wherever they live. It contains information about doctor and dentist visits, hospital stays, prescriptions and shot records. The Health Passport can be found at www.fostercaretx.com.

At a minimum, the Health Passport contains:

- The child's name, birth date, address and Medicaid ID number;
- The names and addresses of the child's doctors, other healthcare providers and medical consenters;
- A record of each visit to a doctor or other healthcare provider, including routine checkups;
- A record of the child's shots (vaccinations);
- A child's known health problems and allergies; and
- Information on all medications.

Foster parents and staff will have access to children's Health Passport records as follows:

- Foster parents will have access to the Health Passport records of children for whom they are serving as medical consenters; and
- A limited number of staff with your operation will have access to the Health Passport records of children placed with your operation.

Psychotropic Medications.

DFPS expects the safe and effective use of psychotropic medications by children in DFPS conservatorship. The Psychotropic Medication Utilization Parameters for Texas Foster Children (the Parameters), which can be found at the following link: <http://www.dfps.state.tx.us/documents/about/pdf/TxFosterCareParameters-December2010.pdf> serves as a resource for physicians and clinicians, and provides recommendations for the appropriate use of psychotropic medications for foster children.

As a result of the wide use of the Parameters, the prescription patterns of psychotropic medications for Texas foster children have improved significantly since 2004 as can be demonstrated by the annual HHSC outcomes report "Update on the Use Of Psychotropic Medications in Texas Foster Children" which can be found at: http://www.hhsc.state.tx.us/medicaid/OCC/Psychoactive_Medications.html.

Contract Section 12. D) requires the following regarding Psychotropic Medications:

- i. The Psychotropic Medication Utilization Parameters for Foster Children (Parameters) must be used, where applicable, in the treatment and care of Children served under this Contract. The Parameters, now incorporated into this Contract by reference, may be accessed at: <http://www.dfps.state.tx.us/documents/about/pdf/TxFosterCareParameters-December2010.pdf>.
- ii. If a Child is prescribed psychotropic medications and the Contractor has questions/concerns about the medication regimen for the Child, the Contractor shall request assistance from a STAR Health Service Manager by calling 1-866-912-6283. If additional assistance or clarification is needed, contact the Caseworker or the Caseworker's Chain of Command.
- iii. If a Child is prescribed psychotropic medications the Contractor is required to ensure that a physician in the STAR Health Network evaluates the need for continued treatment with the medication at a minimum of every 3 months.

Contractors must ensure that Medical Consenters are properly educated to ensure the safe and effective use of psychotropic medications by children in DFPS conservatorship. DFPS Psychotropic Medication Training, which meets the requirements of Residential Child Care Licensing Minimum Standards and the Contract, can be found at the following link: http://www.dfps.state.tx.us/Training/Psychotropic_Medication/default.asp

Although this memorandum does not include all of the requirements of the Contract as it relates to STAR Health services, it serves as an introduction and reference guide for the STAR Health Program and the role of the Residential Contractor in ensuring that children receive the medical, dental, and behavioral health services that they need.



DFPS RESIDENTIAL CHILD-CARE CONTRACTS

DFPS contracts with about 300 licensed residential child-care providers including Child Placing Agencies (CPAs) and General Residential Operations (GROs) which provide Residential Treatment Services (RTC), the Intensive Psychiatric Treatment Program (IPTP), Emergency Care Services (Emergency Shelter care), Basic and Treatment Services to children in the conservatorship of DFPS. Through these contracts, DFPS establishes the payment expectations, qualifications, services, requirements, and outcomes for 24-hour child-care facilities / General Residential Operations (GROs) and Child Placing Agencies (CPAs).

A Residential Contract Manager is assigned to each DFPS Residential Contract and is your point of contact for contract-related issues with a CPA or GRO.

A listing of residential contract managers can be found at the following link: http://www.dfps.state.tx.us/PCS/Residential_Contracts/contract_managers.asp

Residential Contract staff work closely with CPS program staff (both in the region and state office level), Residential Child Care Licensing, and the Service Level Monitor (Youth for Tomorrow) in order to ensure that the contractor is compliant with all requirements of the Residential Child-Care Contract.

Another option for reaching one of us is to just send an email to us at residential_contracts@dfps.state.tx.us or search for “DFPS Residential Contracts” in Outlook.

Did you know...?

- **In order to obtain documentation from a CPA or GRO**, such as therapy notes, foster parent notes, case manager notes, medical/dental reports, CPS must make a request for the specific documentation from the Contractor and provide a clear timeframe for when it is needed. The Contract offers two options for a Contractor:
 - A **14 Day Request** is made when there is no immediate need for the documentation. **TIP!! It is best to make this request in writing.**
 - An **Emergency Request** is when there is an emergency situation such as a service level review for a placement change or court /attorney requested information that must be submitted prior to 14 business days. In these instances, CPS can make a verbal request for documents to be sent within needed timeframes. **TIP!! Be sure to specify the date/time by which you need the information.**
- **Contractors have obligations related to the providing travel for Children.** Contractors are responsible to provide or arrange all travel necessary to ensure a Child’s access to all medical, dental and vision care for each Child, including behavioral health services, recreational, educational and after-school activities, family visits, court hearings, Preparation for Adult Living (PAL) activities, Youth Leadership Council activities, Permanency Conferences, CPS Transition Plan Meetings, Family Group Conferences, Circles of Support Conferences, and any other services necessary to fulfill the tasks on a Child’s Plan of Service.

- **Contractors are responsible for providing, maintaining, and sending at discharge Child's clothing and personal items.** Contractors are expected to provide needed clothing (not through a CPS voucher) and inventory them at placement, discharge, and on a quarterly basis while a Child is in their care.
- **Contractors are required to give CPS notice prior to discharging a Child.** The amount of notice required is dependent on the type of discharge.
 - **24-hour notice:** If a Child is admitted to a psychiatric hospital or placed in juvenile detention/jail and upon admittance/detention the Contractor may notify CPS that they are not willing to take the Child back into their care. At that point, CPS must remove the Child from the Contractors care within 24 hours.
 - **14-day notice:** If a Contractor provides CPS with documentation from a Psychiatrist, licensed psychologist, physician, LCSW or LPC showing that a Child consistently exhibits behavior that cannot be managed by the Contractor, CPS must remove the Child within 14 days (10 days for emergency shelters).
 - **30-day notice:** If the Contractor provides other documentation to CPS that it is no longer in the Child's best interest to remain in the Contractor's care, CPS must remove the Child within 30 days (10 days for emergency shelters).
- **CPS should provide a Contractor with 30 days notice** if the Department has decided it is in the best interests of the child to change placements unless a situation arises when it is necessary to immediately remove a child. **Tip!! It is always best to give notice to allow for a coordinated transition if it is possible.**

These are only some of the issues that may arise as you work with Contractors to provide for the needs of children in the conservatorship of DFPS. Should you have concerns regarding the above issues, or any other situation, please contact a residential contract manager in the region in which the child is placed.

**The Standard DFPS Residential Child-Care Contract
can be located on the DFPS public website at:**

http://www.dfps.state.tx.us/PCS/Residential_Contracts/contract_forms.asp

TEXAS HEALTH AND HUMAN SERVICES COMMISSION 24-HOUR RESIDENTIAL CHILD CARE FACILITIES RATES

The Texas Health and Human Services Commission (HHSC) developed the following payment rates for the 24-Hour Residential Child Care (Foster Care) program operated by the Department of Family and Protective Services (DFPS). HHSC authorized DFPS to implement these recommended payment rates effective September 1, 2009.

24-Hour Residential Child Care Rates

Service Level	Type of Care	FY 2012-2013
Basic	Child Placing Agency	\$39.52
	Foster Family	\$22.15
	Residential Treatment Facility	\$42.18
Moderate	Child Placing Agency	\$71.91
	Foster Family	\$38.77
	Residential Treatment Facility	\$96.17
Specialized	Child Placing Agency	\$95.79
	Foster Family	\$49.85
	Residential Treatment Facility	\$138.25
Intense	Child Placing Agency	\$175.66
	Intense Foster Family	\$88.62
	Intense Residential Treatment Facility	\$242.85
	Emergency Shelter	\$115.44
	Intensive Psychiatric Transition Program	\$374.33

Minimum Daily Amount to be Reimbursed to a Foster Family *

Service Level	FY 2012-2013
Basic	\$22.15
Moderate	\$38.77
Specialized	\$49.85
Intense	\$88.62

* Effective December 1, 2011, the amounts above are the minimum amounts that a child-placing agency must reimburse its foster families for clients receiving services under a contract with the Texas Department of Family and Protective Services.

TCCH - Residential Contract Managers

RCM's assess, monitor, and manage contracts with 24 hour residential child care facilities, including General Residential Operations and Child Placing Agencies. RCMs serve as liaisons between DFPS regional staff and providers to improve communication, gather input, and resolve conflicts. They also work closely with a DFPS third party reviewer (Youth for Tomorrow), Child Protective Services and the DFPS Child Care Licensing Division to ensure contractors comply with service level requirements, contract expectations, and licensing standards.

Residential Treatment Placement Coordinators

RTPC's seek placement options for children in DFPS conservatorship that require a more structured setting. This includes placement settings such as foster homes serving intense level children, emergency shelters when structured settings cannot be immediately located and Residential Treatment Centers/General Residential Operations providing Treatment Services. Residential Placement Coordinators send information regarding the youth to treatment facilities for review to assure the child meets the facility's admission requirements. Each provider has written admission criteria and must adhere to by virtue of their Residential contract and Residential Child Care Licensing. The RTPC's are experts in the field of placement and knowing which facilities accept youth of differing sexes, IQ's, behaviors, etc.

How CASA can work with RCM and RTPC staff:

CASA is encouraged to first work with case workers and regional staff regarding issues with a case using the protocols that have been established regionally.

CASA is encouraged to report abuse/neglect or a Minimum Standards violation to the DFPS Abuse Hotline at 1-800-252-5400 (or online at: www.txabusehotline.org) and if unsure who should address concerns relating to a DFPS case, may contact the Office of Consumer Affairs (OCA) at 1-800-720-7777 or by email at: oca@dfps.state.tx.us. OCA will collaborate with the various DFPS staff, including RCMs and RTPCs to assist in responding to concerns.

A list of RCMs can be found on the DFPS website at: http://www.dfps.state.tx.us/PCS/Residential_Contracts/contract_managers.asp

RESIDENTIAL CONTRACT MANAGERS AS OF MAY 2013

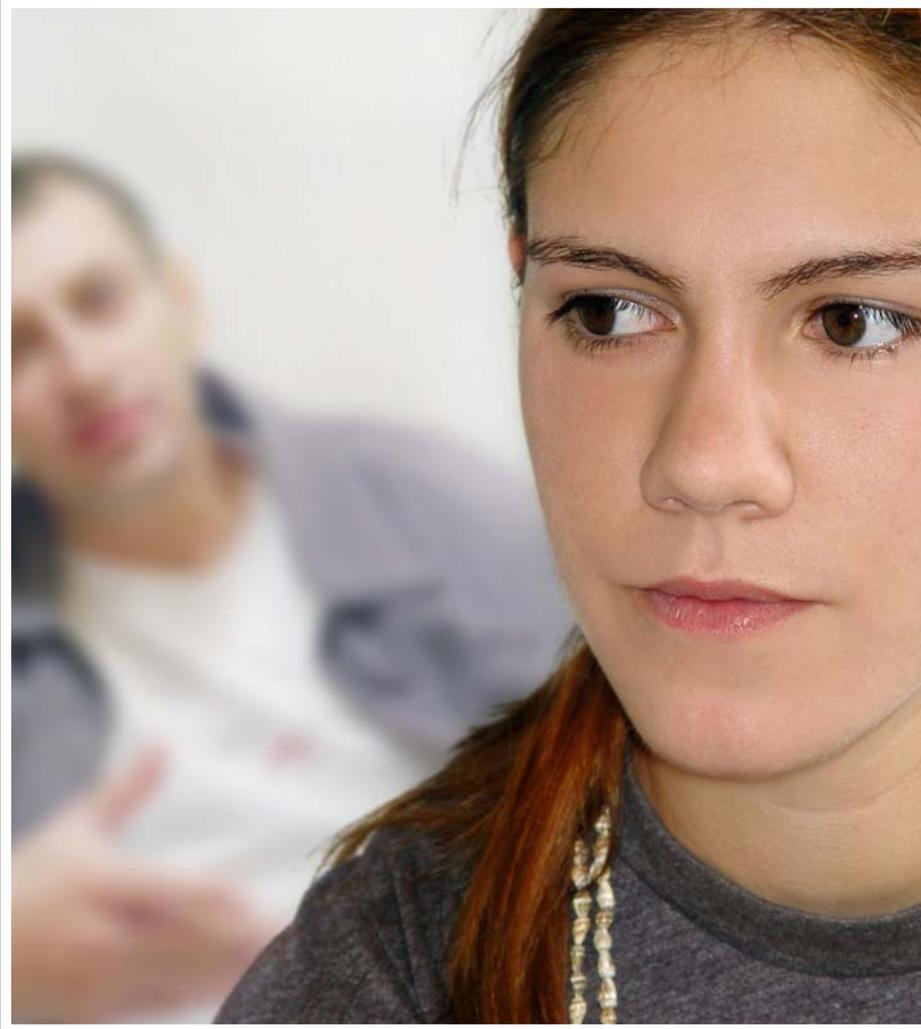
DFPS contract managers for 24 hour residential child care facilities are listed below. Foster families who have questions should contact their foster/adoptive development worker. If your region is not represented below, you may contact a section manager.

Regions	Name	Address	Phone/Fax	Email address	Mail Code
Director State Office	Heather Shiels	701 West 51st St. Austin, TX 78751	Phone: 512-438-5123 Fax: 512-339-5885	Heather.Shiels@dfps.state.tx.us	E-541
Division Manager (Regions 2,3,4,5,6,9,10)	Carol Wilkinson	701 West 51st St. Austin, TX 78751	Phone: 512-438-3149 Fax: 512-339-5885	Carol.Wilkinson@dfps.state.tx.us	E-541
Division Manager (Regions 1,7,8,11)	Kimberly Henry	701 West 51st St. Austin, TX 78751	Phone: 512-438-4164 Fax: 512-339-5885	Kimberly.Henry@dfps.state.tx.us	E-541
Section Manager	Lisa Jernigan-Graham	3521 W. 15th, Cube #298 Amarillo, TX 79102	Phone: 806-354-6298 Fax: 512-339-5885	Lisa.Jernigan-Graham@dfps.state.tx.us	005-1
Section Manager	Gloria Stevenson	1200 E. Copeland Rd., 4Fl., Suite 400 Arlington, Texas 76011	Phone: 817-543-8386 Fax: 512-276-3524	Gloria.Stevenson@dfps.state.tx.us	013-8
Program Specialist	Nancy J. Simpson	701 West 51st St. Austin, TX 78751	Phone: 512-438-2282 Fax: 512-339-5885	Nancy.Simpson@dfps.state.tx.us	E-541
Program Specialist	LaQuita Davis	701 West 51st St. Austin, TX 78751	Phone: 512-438-5048 Fax: 512-339-5885	Laquita.Davis@dfps.state.tx.us	E-541
Program Specialist	Heather Terrell	701 West 51st St. Austin, TX 78751	Phone: 512-438-4433 Fax: 512-339-5885	Heather.Terrell@dfps.state.tx.us	E-541
Child Specific Statewide	Stephanie Yeargan	701 West 51st St. Austin, TX 78751	Phone 512-438-3127 Fax 512-339-5885	Stephanie.Yeargan@dfps.state.tx.us	E-541
Child Specific Statewide	Kelly Shaw	701 West 51st St. Austin, TX 78751	Phone 512-438-4269 Fax 512-339-5885	Kelly.Shaw@dfps.state.tx.us	E-541
1	Kathy Perkins	3521 W. 15th Steet, Cube #311 Amarillo, TX 79102	Phone: 806-354-5311 Fax: 512-339-5885	Kathy.Perkins@dfps.state.tx.us	005-1
2, 9, and 10	Terri Wynn	1200 E. Copeland Rd., 4Fl., Suite 400 Arlington, Texas 76011	Phone: 817-792-5227 Fax: 512-276-3524	Terri.Wynn@dfps.state.tx.us	013-8
3	Christina Hausenfluke	1200 E. Copeland Rd., 4Fl., Suite 400 Arlington, Texas 76011	Phone: 817-792-5228 Fax: 512-276-3524	Christina.Hausenfluke@dfps.state.tx.us	013-8
3	Crista Wilson	1200 E. Copeland Rd., 4Fl., Suite 400 Arlington, Texas 76011	Phone: 817-792-4537 Fax: 512-276-3524	Crista.Wilson@dfps.state.tx.us	013-8
3	Mistie Wolfe	1200 E. Copeland Rd., 4Fl., Suite 400 Arlington, Texas 76011	Phone: 817-792-5220 Fax: 512-276-3524	Mistie.Wolfe@dfps.state.tx.us	013-8
3	Michelle Englert	1200 E. Copeland Rd., 4Fl., Suite 400 Arlington, Texas 76011	Phone: 817-792-4419 Fax: 817-276-3924	Michelle.Englert@dfps.state.tx.us	013-8

Texas CASA Residential Treatment Center (RTC) Manual

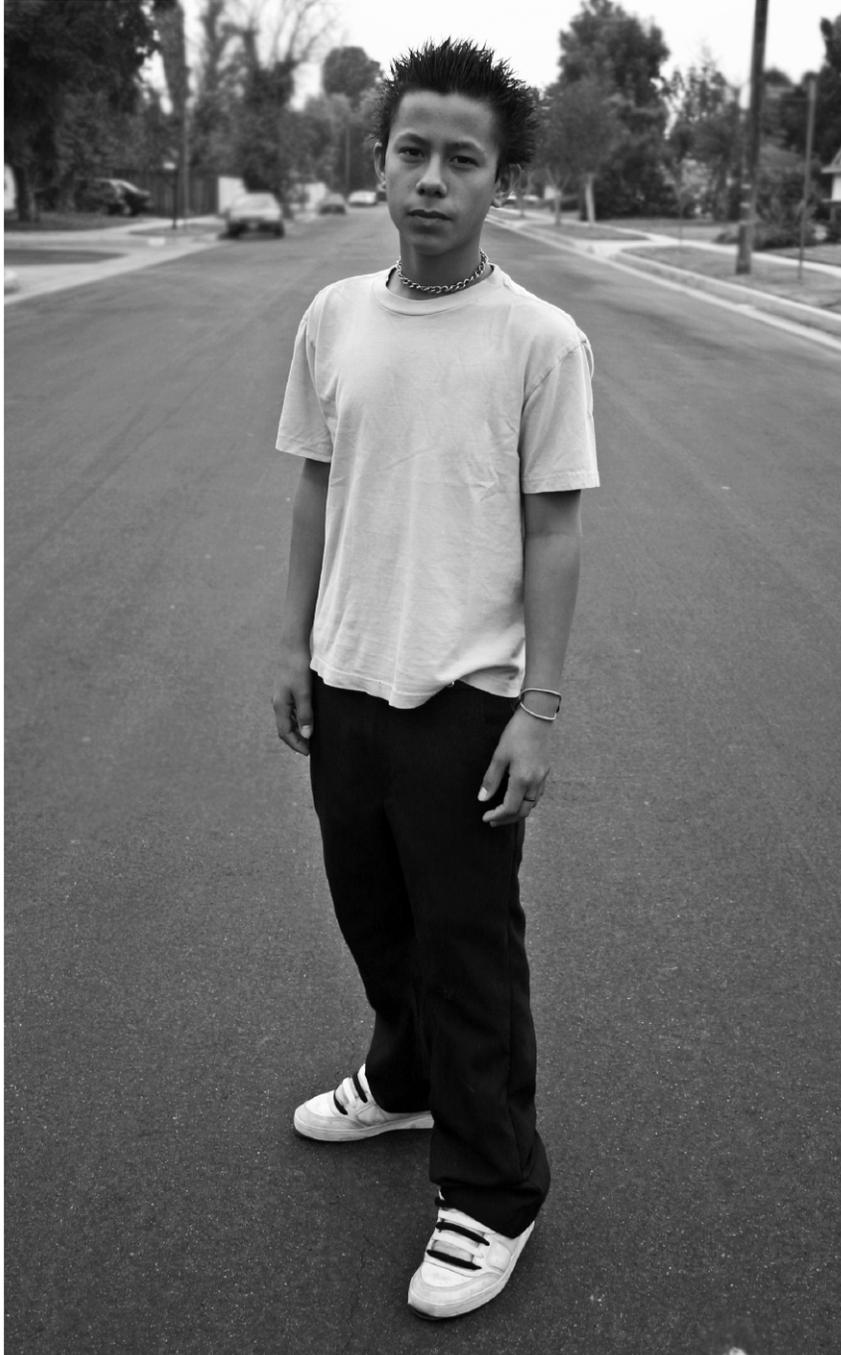
Regions	Name	Address	Phone/Fax	Email address	Mail Code
6	Meika Sherrer	5425 Polk St Suite 180A WS 1012 Houston, TX 7023	Phone: 713-767-2620 Fax: 512-276-3018	Meika.Sherrer@dfps.state.tx.us	177-9
6	Chelsea Sweeney	5425 Polk St. Suite 180A WS 1009 Houston, TX 77023	Phone: 713-767-2667 Fax: 512-276-3018	Chelsea.Sweeney@dfps.state.tx.us	177-9
6	Anita Johnson	5425 Polk St. Suite 180A WS 1013 Houston, TX 77023	Phone: 713-767-2625 Fax: 512-276-3018	Anita.Johnson@dfps.state.tx.us	177-9
6	Sandra Box	5425 Polk St. Suite 180A WS 1004 Houston, TX 77023	Phone: 713-767-2653 Fax: 512-276-3018	Sandra.Box@dfps.state.tx.us	177-9
7	Veronica Alvarez	14000 Summit Dr. Suite 100 Austin, TX 78728	Phone: 512-834-3490 Fax: 512-339-5930 or 5904	Veronica.Ramirez@dfps.state.tx.us	016-5
7	Annette Arciniaga	14000 Summit Dr. Suite 100 Austin, TX 78728	512-834-3249 Fax 512-339-5930	Annette.Arciniaga@dfps.state.tx.us	016-5
7	Jacalyn Morley-Webb	14000 Summit Dr. Suite 100 Austin, TX 78728	Phone: 512-834-3485 Fax: 512-339-5930 or 5904	Jacalyn.Morley-Webb@dfps.state.tx.us	016-5
7	Patricia Yelverton	14000 Summit Dr. Suite 100 Austin, TX 78728	Phone: 512-834-3827 Fax: 512-339-5930 or 5904	Patricia.Yelverton@dfps.state.tx.us	016-5
8	Beatrice (Bea) Ramirez-Martinez	3635 SE Military Dr. 2D33, cube #3 San Antonio, TX 78223	Phone: 210-337-3273 Fax: 512-934-9638	Beatrice.Ramirez-Martinez@dfps.state.tx.us	278-5
8	Melanie Trevino	3635 SE Military Dr., 2D33, cube#12 San Antonio, TX 78223	Phone: 210-304-3963 Fax: 512-934-9638	Melanie.Trevino@dfps.state.tx.us	278-5

Identifying and Meeting the Needs in RTC's



*“Children are likely to live up
to what you believe of them”*

~ Lady Bird Johnson



PHYSICAL AND BEHAVIORAL HEALTH NEEDS CHECKLIST FOR ADVOCATES

Some “questions” to consider

- Have you reviewed the child’s Health Passport?
- Who is the medical consentor?
- If the youth is 16 or older, has the court decided if the youth may consent to all, some or none of his or her medical care?

Physical Health

- Any dental assessments/reports/needs?
- Any vision assessments/reports/needs?
- Last physical exam and any recommendations/needs?
- Any special nutritional needs?
- Does the child get adequate sleep? Does the child have any problem sleeping?
- What physical activities does the child engage in? Has a desire to engage?
- Does the child participate in any group sports?

Behavioral Health

- What is the child’s current diagnosis and reason for being in the residential treatment program?
- Has an individual treatment plan that details the child’s goals, progress and how crisis problems will be handled been developed and reviewed?
- Has there been a trauma screen? A trauma assessment? If yes, what recommendations, treatments, interventions resulted?
- What behavioral health assessments have been completed?
- Is the child taking any psychotropic medications?
- What else was tried prior to medication for behavioral symptoms?
- Has there been a recent change in medications?
- Are you familiar with the Psychotropic Medication Utilization Review (PMUR) parameters and processes?
- Ask about physical restraints and seclusion policies. Ask to see the seclusion room.
- What does the child say/think about their current placement? Behavioral health interventions? Treatment plan?

HEALTH PASSPORT FACTS AND FAQ

Health Passport Is Not A Medical Record

Health Passport is populated with data from Medicaid claims filed with STAR Health and at least two years of medical, dental and prescription claims for children in the foster care system who have been on CHIP or Children's Medicaid prior to coming into DFPS substitute care. Texas Medicaid providers, including Medical and Dental Providers, may file claims up to 95 days from the date of service.

Pharmacy claims should appear in the Health Passport as close to "real time" as electronic processing allows. Pharmacy data in the Health Passport reflects prescriptions which have been filled, not necessarily all prescriptions currently taken by a child. Some examples of how these may differ are:

- The provider may replace a previous medication with a prescription for a different dose or different medication
- When changing medications a provider may titrate the child off one prescription while gradually introducing the new prescription
- Some prescriptions are meant to be taken for a short period of time or on an as needed basis and the child may no longer be taking a medication
- A psychotropic medication utilization review is not considered for a medication regimen which appears to be outside the Psychotropic Medication Utilization Review Parameters unless the child has been taking the medications for 60 days or longer

If you need further information about the child's health care or the prescriptions a child is currently taking contact the CPS Caseworker, the child's Medical Consenter, Caregiver, or the DFPS Residential Child Care Contractor.

Information Needed To Look Up A Child's Health Passport Record

Child's name, Child's IMACT Person ID (PID), Social Security number, or Medicaid ID number.

You can also find the Health Passport On-Line Training Tools and Frequently Asked Questions at: <http://www.fostercaretx.com/health-passport/>

Health Passport FAQ

What is the Health Passport?

The Health Passport is a patient-centered, internet-based health record. It makes a foster child's information available to authorized providers and medical stakeholders, such as medical consenters and caseworkers. The data in the Health Passport is not a person's complete medical record, but it does contain information on patient demographics, doctor visits for which claims have been paid or denied, allergies, lab test results, immunizations, and filled medications. There are also electronic Texas Health Steps, Dental, and Behavioral Health forms available through the Health Passport.

How does the Health Passport differ from the Electronic Medical Record (EMR) or Electronic Health Record (EHR)?

There are several major differences between the Health Passport and the EMR or EHR. The first is that the EMR is a patient's COMPLETE medical record. The Health Passport doesn't contain all the information that the EMR does.

Second, the EMR only contains comprehensive information from one healthcare provider or health care system. The Health Passport contains select information from many providers and facilities. The EMR must be maintained and updated by the providers who use it, but the Health Passport is maintained and updated by the STAR Health program. Most of the information in Health Passport can be viewed by a provider but cannot be changed. There are only a few areas that are interactive- Vital Signs, Allergies, and the Texas Health Steps, Dental, and Behavioral Health forms – where providers can add information into the Health Passport.

Whose information is included in the Health Passport?

Each foster child's demographic information, and paid and denied medical, behavioral, pharmacy, dental, and vision claims. Other information includes lab results, as well as each foster child's immunization history.

How often is the information in the Health Passport updated?

Demographics and contact information – Daily

Medical & Behavioral Health claims – Daily

Pharmacy claims – Daily

Dental & Vision claims – Bi-weekly

Quest Labs data – Weekly

Immunizations (ImmTrac, State Registry) – Monthly

Will pending claims show up on the Health Passport?

No. The claim will not show up on the Health Passport until after it has been processed by the payer.

What is the source of patient demographic information?

The foster child's demographic information will be updated daily by the Texas Department of Family Protective Services (DFPS).

If there are no allergies recorded for a patient, does it mean that they do not have any allergies?

No. The Health Passport allergy section is an interactive section that depends on provider input for updating. If "No allergy information has been documented for this person" is displaying in the Allergies section, the patient may have allergies, but no provider has documented them in the Health Passport yet. If "No Known Allergies" is displaying in the Allergies section, it means that a provider has documented that the patient has no allergies to their knowledge. We strongly encourage providers to take just a minute to add in any allergies they are aware of.

Is the Fill Date in the Medications Claims section the date the prescription was written or the date the medication was dispensed?

The medication fill date is the date that the medication was dispensed.

How can the system help patients who have potential drug interactions?

The Medications section of the Health Passport will be helpful in preventing possible drug interactions. If providers are able to see what medications the patient is already taking, he or she can avoid prescribing drugs that could cause an interaction. This could be especially helpful in Emergency Departments where providers frequently don't have all the information they need before giving treatment to the patient.

The Health Passport also contains an Allergies section. The patient's providers enter the allergies and having this information is helpful to providers as they prescribe medications. When the patient has an allergy to a medication, an allergy icon will appear next to that prescription. The allergy icon is a red A with a box around it.

How do I search claims and medications past the 12 month default?

You can view claims past 12 months by clicking "18 months" on the drop-down menu. You can also enter a "From (MM/DD/YYYY)" to view claims past 18 months.

How quickly does all of this information download in the Health Passport when a child enters DFPS Conservatorship. For example: How long does it take a child's information to show up on the Health Passport when we take custody?

Claims will update in the normal time frame outlined below.

Demographics and contact information – Daily

Medical & Behavioral Health claims – Daily

Pharmacy claims – Daily

Dental & Vision claims – Bi-weekly

Labs data – Weekly

Immunizations (ImmTrac, State Registry) – Monthly

The Medicaid historical data will show after Superior receives the State Eligibility File to activate the child/youth's Medicaid through STAR Health.

Is there is a way for DFPS staff to have the allergy information added to the Health Passport if the provider will not do it?

We always ask that the Providers enter the allergies. If the Provider refuses, DFPS staff can contact their Well-Being Specialist who can call the Superior STAR Health Liaison. The Liaison will then have a Superior Provider Relations Representative outreach to the Provider.

What should DFPS do if they see medication interaction warnings?

If you see that there is an interaction warning, you can contact the prescriber and alert them of the warning, call the CPS Nurse Consultant or your Well Being Specialist for help.

What does someone do if the Health Passport indicates information that is inaccurate? For example, one time the Health Passport showed a child was taken to the Emergency Room for suicidal ideations, but research showed stitches were removed.

If the Health Passport has an entry that you find wrong, call the Health Passport Support Desk at 1-866-714-7996 or TX_PassportAdmin@centene.com.

What do I do if a child has been in DFPS Conservatorship for several months but does not show up on the Health Passport?

If the child is not appearing on the Health Passport within two weeks after a child is in care, call the Health Passport Helpdesk at 1-866-714-7996, or TX_PassportAdmin@centene.com.

You can also find the Health Passport On-Line Training Tools and Frequently Asked Questions at: <http://www.fostercaretx.com/health-passport/>

Who has access to Health Passport?

STAR Health Providers, Medical Consenters, and DFPS/RTC/CPA Staff. *AND local CASA program offices by special agreement and training with DFPS.*



TEXAS STAR Health
Health Passport Monthly Behavioral Health Update

866-439-2042
Fax: 866-274-5952

Member Information:

Name:
Medicaid ID#:
Date of Birth:
DFPS level of care:
 Basic Moderate Specialized Intensive

Provider Information:

Provider:
 Group/Agency Name:
Professional Degree: MD PhD Other:
Phone Number:
Fax Number:

Current Placement:

Shelter Foster Home Kinship placement RTC
If this member is in an RTC? Admission Date:
Change in Placement since last update? Yes No

Child Permanency Plan (if known):

Reunification with family Remain in CPS Custody
 Kinship placement Adoption

Please indicate the type of service provided by YOU:

Individual Therapy Family Therapy Group Therapy
 In-home Therapy Medication Management
 Other:

Frequency of visits/month:
Date last seen:

Please indicate YOUR Diagnoses for this Member:

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V:

Any Changes to diagnoses since last update?
 Yes No

Source of Changes:

New symptoms Psychological testing
 Hospitalization

Please document treatment goals and progress in the domains below

Mood regulation/Self control/Response to trauma:

Goals:1)
2)
3)

What are the member's strengths and what supports are in place?

Response to treatment: Minimal Improving Moderate Significant
What is still needed to help this youth to be successful?

Community stability/Social skills/Progress towards permanency plan:

Goals:1)
2)
3)

What are the member's strengths and what supports are in place?

Response to treatment: Minimal Improving Moderate Significant
Family Contact: Yes No
Impact of family visits on treatment:

Academic functioning:

Goals:1)
2)
3)

What are the member's strengths and what supports are in place?

Response to treatment: Minimal Improving Moderate Significant
What is still needed to help this youth to be successful?

STAR HEALTH- A GUIDE TO MEDICAL SERVICES AT CPS

What is STAR Health?

STAR HealthExternal Link is a statewide, comprehensive healthcare system that was designed to better coordinate and improve access to health care for:

- Children in DFPS conservatorship (under age 18).
- Youth in CPS extended foster care (ages 18 to 22).
- Youth who were previously under DFPS conservatorship and have returned to foster care (ages 18 to 22) through voluntary foster care agreements.
- Youth ages 18-21 who were previously in foster care and are living independently and receive Medicaid for Transitioning Youth (MTFCY).
- Former foster care youth (ages 21 to 23) enrolled in an institution of higher education located in Texas enrolled in the Former Foster Care in Higher Education (FFCHE) program.

STAR Health began on April 1st, 2008. The Texas Health and Human Services Commissioner picked Superior HealthPlan Network (Superior) to run the STAR Health program.

STAR Health provides a full-range of Medicaid covered medical and behavioral health services for children in DFPS conservatorship and young adults in DFPS paid placements.

STAR Health Goals

The main goal of STAR Health is to quickly give children in state care the coordinated medical and behavioral health care services they need. These services are available to these children no matter where they are in the state and even when they move.

STAR Health at a Glance

- A Medical Home for each child, meaning a doctor [or other Primary Care Provider (PCP) or PCP Team] to oversee care
- Speedy enrollment for immediate health care benefits
- Coordination of physical and behavioral healthcare
- Preventive care through Texas Health Steps
- Access to healthcare through a network of providers (doctors, nurses, hospitals, clinics, psychiatrists, therapists, etc.)
- Health Passport to makemore health history and health information available to medical consenters, doctors, and other healthcare providers
- Nursing and Behavioral Health help-lines for caregivers and caseworkers - 24 hours a day, 7 days a week,
- Medical advisory committees to monitor healthcare provider performance
- Recruitment of providers with a history of treating children who have been abused or neglected

STAR Health Services

- Physical and behavioral healthcare
- Dental services
- Vision services
- Service coordination
- Clinical service management and disease management
- Health Passport
- Help-lines for consumers and healthcare providers
- Physical, occupational, speech, and other health-related services

Accessing STAR Health Services and Information

For a child enrolled in the STAR Health program, DFPS staff, caregivers and medical consenters can get information and help with finding a provider, scheduling an appointment, or getting services by:

- Calling STAR Health Member Services at 1-866-912-6283.
- Using the STAR Health website at www.fostercaretx.com*External Link*.

The medical conserter for a child in the program should present the child's STAR Health ID Card, Medicaid Card, or DFPS Medical consent Form 2085-B at the time of the appointment. The Star Health provider or medical conserter may contact STAR Health Member Services if they have questions about the child's eligibility for STAR Health services.

Let a DFPS well-being specialists know if you have any issues or concerns about STAR Health.

STAR Health FAQs

Please click on the question below to read the answer.

Quick Guide to STAR Health for Caregivers

- [*English Word Document*](#)
- [*Spanish Word Document*](#)

Additional STAR Health Information and Training

See the STAR Health website at www.fostercaretx.com*External Link*

Key STAR Health phone numbers

Organization	Phone Number
Superior HealthPlan Network	1-866-912-6283
Cenpatico (Behavioral Health)	1-866-218-8263
Delta Dental (Dental Services)	1-866-287-3419
TVHP (Vision Services)	1-866-642-8959
NurseWise	1-866-912-6283
Medical Transportation Program	1-877-633-8747
Vendor Drug Program (Prescriptions)	1-800-252-8263

Regional Well-being Specialists

Well-being specialists are DFPS liaisons to Superior HealthPlan, the company that operates the STAR Health provider network. Contact your regional well-being specialist for help with STAR Health.

<u>Region</u>	<u>Name</u>
Amarillo and El Paso Regions (Regions 1 and 10)	Kathy Roberts kathy.roberts@dfps.state.tx.us
Midland and Abilene Regions (Regions 2 and 9)	John Clymer john.clymer@dfps.state.tx.us
Arlington Region (Region 3)	Pam Baker pamela.baker@dfps.state.tx.us
Tyler and Beaumont Region (Regions 4 and 5)	Sheryl McCloney sheryl.mccloney@dfps.state.tx.us
Houston Region (Region 6)	Debbie Kumar-Misir Deborah.Kumar-Misir@dfps.state.tx.us
Austin Region (Region 7)	Magen Henderson magen.henderson@dfps.state.tx.us
San Antonio and Edinburg Regions (Regions 8 and 11)	Jackie Lerche jacqueline.lerche@dfps.state.tx.us

MEDICAL CONSENT

Texas law requires that each child in DFPS conservatorship has a medical consentor to make health care decisions for the child. The court names (authorizes) either an individual or DFPS as the medical consentor and puts it in the court order.

- When the court names an individual as medical consentor, that person is ultimately responsible for the medical decisions for that child and answers directly to the court.
- When the court names DFPS to make medical decisions for a child, DFPS must designate medical consentor and a back-up medical consentor for the child. They answer to DFPS, and DFPS answers to the court.

DFPS may choose medical consentors and back-up medical consentors who are:

- Professional employees of emergency shelters.
- Foster parents.
- Relatives.
- CPS caseworkers.

DFPS may not pick medical consentors (or back-ups) who are employees of staffed facilities, such as residential treatment centers or intermediate care facilities for mental retardation. CPS caseworkers are usually designated in these cases unless a relative or other person is available.

DFPS designates medical consentors and back up medical consentors by issuing Form 2085-B. These medical consentors and back-ups must provide copies of Forms 2085-B to each child's doctors or other health care providers. Form 2085-B contains contact information for CPS supervisors and the court in case the health care provider has issues with the decision(s) of a medical consentor.

DFPS may decide to change a child's medical consentor or back up medical consentor for a variety of reasons by issuing another Form 2085-B and notifying the court.

Training on Informed Consent

All medical consentors and back-up medical consentors must take training whether they are chosen by the court or DFPS. Mandatory training is available on the DFPS Intranet for DFPS staff and on the DFPS Public Website for all other medical consentors and back-ups.

To see the training, go to:

- http://www.dfps.state.tx.us/Child_Protection/Medical_Services/medical-consent-training.asp
- En Español: http://www.dfps.state.tx.us/Espanol/Servicios_de_Proteccion_al_Menor/Medical_Consent_Training.asp

Participation in Each Medical Appointment

Medical consentors must participate in a child's medical appointments according to CPS policy but healthcare providers may require greater participation. CPS' minimum participation guidelines are below:

- **Preventive Care.** The medical consenter or back up medical consenter may provide written consent for a residential provider or another person to take a child to a healthcare appointment, unless the health care provider requires the consenter to come in person or call by phone.
 - Each child in DFPS conservatorship must get the preventive care required by Texas HealthSteps:
 - Well child examinations.
 - Sensory screening (e.g., vision, hearing).
 - Developmental/behavioral assessment.
 - Immunizations.
 - Laboratory testing for screening purposes (e.g., blood work, urinalysis, TB testing, STD screening, pelvic exam).
 - Anticipatory guidance.
 - Dental check-ups.
- **Ongoing Behavioral Health Therapy and Allied Health Services.** The medical consenter or back up must approve the behavioral or allied health care plan and monitor the progress of the child. The medical consenter is not required to attend every appointment but should participate when the therapist request it. These therapies or services include dietary services, occupational, physical, speech or other therapy.
- **Other Medical Care.** The medical consenter or back up medical consenter must attend the appointment or participate by phone with the healthcare provider, as specified by the healthcare provider, for all other medical care. This medical care includes medical appointments for:
 - Physical health treatment, (e.g., acute care).
 - Dental treatment (e.g., fillings, crowns).
 - Progress reviews every three months for children prescribed psychotropic medications. This is required by DFPS policy, Service Level Indicators, Licensing Minimum Standards for Child-Placing Agencies, and Residential Child Care Contract Standards.

When the child's medical consenter is a live-in caregiver, participation in medical appointments should not be a problem. However, this can be difficult when the child's medical consenter is an employee of an emergency shelter or CPS. DPFS recognizes that health care providers also have busy schedules and appreciate any attempt by healthcare providers to accommodate CPS employees who are required to participate in children's appointments.

Consent by 16 and 17 Year Old Youth

Sixteen and 17 year olds in DFPS care can ask the court whether they can consent to their medical care. This can happen at any hearing after the youth turns 16 years old. The court decides if a youth may consent to all, some, or none of his or her medical care.

When the court allows a youth to consent to medical care, DFPS staff, the youth or the youth's caregivers will have a copy of the court order. The youth's caseworker and caregivers are required to help the youth get information about any medical condition(s), tests, treatment, and medications, and to support them in making informed decisions.

However, the court can overrule a youth's decision to refuse medical care even after authorizing the youth to make medical decisions. To do that the court must find by clear and convincing evidence that the medical care is in the best interest of the youth and one of the following:

- The youth lacks the capacity to make the decision.
- Not getting the care will result in observable and material impairment of growth, development, or functioning of the youth.
- The youth is at risk of causing substantial bodily harm to himself/herself or others.

In these situations, DFPS may file a motion asking the court to order a specific medical treatment or allow DFPS to consent to medical care for the youth. The motion must include the youth's reasons for refusing medical care and a statement signed by the physician explaining why medical care is necessary.

Emergency Medical Care

In an emergency, state law allows a child in DFPS conservatorship to receive medical care without a medical consentor's permission. The Texas Family Code §266.009(a) defines an emergency as a situation in which:

It is immediately necessary to provide medical care to the foster child to prevent the imminent probability of death or substantial bodily harm to the child or others, including circumstances in which: the child is overtly or continually threatening or attempting to commit suicide or cause serious bodily harm to the child or others; or the child is exhibiting the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the child's health in serious jeopardy, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part.

In an emergency, the child's caregiver or caseworker is required to take the child to an emergency room or healthcare provider. If no medical consentor is available, the doctor decides if the child's condition is an emergency under the law. If the doctor provides medical care without consent, he or she must notify the medical consentor no later than the second business day after providing medical care.

Judicial Review of Medical Care

The court must review a summary of each child's medical care at each hearing held under Chapter 263, which includes the status, permanency, and placement hearings. DFPS includes this information in its reports to the court.

Notification to Parents of Significant Medical Conditions

DFPS must notify parents if their child has a significant medical condition. Examples of a serious medical condition include injuries or illnesses that are life threatening or have potentially serious long-term health consequences, including hospitalization for surgery or care other than minor emergency care.

Texas Family Code 266.007

Summary of Child's Medical Care and Report for Hearings

The court must authorize one of the following persons to consent to medical care:

- (1) *an individual designated by name in the order including:
 - a.) *the child's foster parent; or*
 - b.) *the child's parent if the parent's rights have not been terminated and the court determines it is in the best interest of the child to make medical decisions;**
- (2) *the department or an agent of the department;*
- (3) *the child if age 16 or older and mature enough to make the decision*

Note: When placed in a RTC setting, depending upon the region of placement, the CVS caseworker or the I See You Caseworker is a recommended designee/medical consentor.

In the CPS court Report, the Caseworker is to summarize the child's medical care since the last hearing. Medical care includes: physical, dental, behavioral and allied health care (e.g., physical therapy, occupational therapy, speech therapy, dietetic services, etc.).

- (1) The nature of any emergency medical care provided to the child and the circumstances necessitating emergency medical care, including any injury or acute illness suffered by the child:
- (2) All medical and behavioral health treatment that the child is receiving and the child's progress with the treatment:
- (3) Any medication prescribed for the child and the condition, diagnosis, and symptoms for which the medication was prescribed and the child's progress with the medication:
- (4) The degree to which the child or foster care provider has complied or failed to comply with any plan of medical treatment for the child:
- (5) Any adverse reaction to or side effects of any medical treatment provided to the child:
- (6) Any specific medical condition of the child that has been diagnosed or for which tests are being conducted to make a diagnosis:
- (7) Any activity that the child should avoid or should engage in that might affect the effectiveness of the treatment, including physical activities, other medications, and diet:
- (8) Any views the child has expressed regarding his or her medical care:
- (9) Any other medical information.

Psychotropic Medication Utilization Review (PMUR) Process for STAR Health Members FAQ and Stakeholder Manual

The STAR Health Medication Monitoring Program

Q: What indicators does Cenpatico/SHPN use to screen foster children in a PMUR?

A: Children who have received treatment with a psychotropic medication(s) for 60 days or more that fall into the following categories:

- All children under the age of 4 years
- Any child whose medication regimen appears to have class polypharmacy as defined by:
 - 2 or more stimulant medications
 - 2 or more antidepressants
 - 2 or more atypical antipsychotic medications
 - 3 or more mood stabilizers
- Any child with 5 or more psychotropic medications (polypharmacy)

Q: Where can I find the DFPS Psychotropic Medication Utilization Parameters?

A: You can find them at the following link:

<http://www.dfps.state.tx.us/documents/about/pdf/TxFostercareParameters-December2010.pdf>

Q: What are ways PMURs can be triggered?

A: Health Screening - SHPN/Cenpatico Service Managers do comprehensive health screens on foster children and identify medication regimens which appear to be outside the DFPS Psychotropic Medication Utilization Parameters

Automated Pharmacy Claims Screening - Cenpatico has collaborated with HHSC to develop an automated screening program using pharmacy claims information from Health First. This screening is run monthly to identify foster children who have medication regimens which may fall outside the DFPS Psychotropic Medication Utilization Parameters

External Request - CPS Nurse Consultants, other CPS staff, CASAs, children's caregivers, attorneys, residential child care providers and other interested parties can request a medication review

Court Request - Judges having jurisdiction over CPS cases can request a PMUR to answer questions about a foster child's medication regimen

Requests for PMURs

Q: How do I request a PMUR for a foster child?

A: Requests for PMUR can be directed to a Cenpatico Service Manager based on the foster child's placement region.

DFPS Regions	Cenpatico Contact
1, 2, 3, 4, 7, 9, 10	Michael Scrivner M.A., LPC Behavioral Health Service Manager Cenpatico 866.218.8263 x42229 mscrivner@cenpatico.com
5, 6, 8, 11	Bob Dryden, M.Ed., LPC Behavioral Health Service Manager Cenpatico 866.218.8263 x42659 rdryden@cenpatico.com

Q: Will all requests result in a formal PMUR report?

A: No. There are many instances where Cenpatico may be able to answer questions about medication usage and the DFPS Psychotropic Medication Utilization Parameters without the need for a formal PMUR. In addition, the Cenpatico Service Manager will direct the requestor to the prescriber under certain circumstances. These include:

1. If the CPS staff, medical consentor, caregiver or other individual has questions about why a specific medication was prescribed by the physician.
2. If the medication regimen and dosages of medications prescribed are clearly within the DFPS Psychotropic Medication Utilization Parameters.
3. If the CPS staff, medical consentor, caregiver or other individual has questions about medication side effects, wants to stop a particular medication, or does not think the medication is needed.
4. If there are questions about giving consent for new medications or changes in medication doses recommended by the child's treating physician.
5. Requests made because the medication does not appear in the DFPS Psychotropic Medication Utilization Parameters for Foster Children (2007).
6. Concerns about giving consent for new medications or changes in medication doses while foster children are in treatment at a psychiatric hospital.

Q: Why won't all the requests result in a formal PMUR report?

A: Cenpatico encourages CPS staff, medical consentors and caregivers to contact the treating physician directly with questions about why a specific medication or dosage was prescribed. Only the treating physician can answer why the specific medication was prescribed based on the foster child's problems

and symptoms. More importantly, the PMUR process can take 2-3 weeks to complete, and waiting for the formal PMUR report can delay needed treatment, or change in medications. The treating physician should be made aware of any concerns about side effects immediately to take any necessary action.

Q: What other resources do CPS staff members have when they have questions about medications?

A: The CPS Nurse Consultants can also assist with medication questions, and consent issues. The CPS Nurse Consultants can make referrals to Cenpatico to initiate a PMUR investigation, if needed.

Q: If I'm a CPS caseworker, and I'm going to court can I get a PMUR report for court?

A: Cenpatico will attempt to complete PMURs requested by caseworkers for status, permanency and placement hearings. If the medication review is “court ordered,” the Cenpatico Service Manager will ask for a copy of the court documents to ensure the court’s concerns are addressed in the report, and will submit to the court a copy of the final PMUR report. Upon request, the Cenpatico Service Manager has 3 business days to gather needed information to submit the PMUR request for review. The Cenpatico Medical Director will review the information and forward to the consultant child psychiatrist. If there is not enough information, the process could be delayed. The consultant has 10 business days to attempt peer-peer contact with the treating physician, and complete the PMUR report. Please note that Cenpatico will make every attempt to expedite a PMUR request for court, but we cannot guarantee completion of requests received less than 3 business days from the court date.

If one of the following special circumstances is documented in the court order, the requestor will be advised of the appropriate course of action:

1. If the court order is requesting a “second opinion” psychiatric evaluation, then the Service Manager will document the request and transfer the caller to Cenpatico Care Coordination for a referral to an in-network psychiatrist.
2. If the court order is requesting a “second opinion” psychiatric evaluation or medication review outside of the STAR Health network, the Service Manager will advise the caller that evaluations outside the STAR Health network are not a covered benefit even with a court order. Psychiatric re-evaluations under these circumstances are the responsibility of DFPS.

Obtaining the PMUR Results

Q: If I've requested a formal PMUR report, how will I get a copy of the report?

A: The Cenpatico Service Managers will fax a copy of the completed PMUR report to the requestor. In addition, the PMUR report will be posted to Health Passport within approximately 7 business days of completion. PMUR reports can be found in Health Passport under the Forms tab of the child’s record. To locate the report, first click the “Forms” tab on the navigation panel of the left side of the screen, then “behavioral health” the documents screen finishes loading. In some cases, the PMUR report will be labeled “Other,” but in the near future the document will be titled “PMUR Report” to assist Health Passport users in identifying the reports.

Q: If I speak to a Cenpatico Service Manager and my request does not result in a formal PMUR report, can I get documentation that the medication regimen was reviewed?

A: Please notify the Cenpatico Service Manager that you need documentation that the child's medication regimen was reviewed, and provide your contact information including a fax number. The Cenpatico Service Manager will fax you a letter advising that the child's medication regimen was reviewed but did not meet criteria for a formal PMUR review within 3 business days.

PMUR Determinations

The PMUR report will contain a formal determination about the foster child's medication regimen. The possible determinations are as follows:

- Medication regimen within Parameters
- Medication regimen outside Parameters. Medication regimen reviewed and found to be within the standard of care
- Medication regimen outside Parameters, and there is opportunity to reduce polypharmacy
- Medication regimen is outside Parameters, and there is risk for or evidence of significant side effects.

Q: How can the PMUR determination be "within Parameters" when the medication prescribed does not appear in the DFPS Parameters?

A: The DFPS Parameters clearly indicate that not all medications or doses which can be prescribed to treat childhood mental health disorders are included. Since the Parameters were published in 2007, new medications have been developed, and many medications have been recently approved for other uses, and younger age groups. The Parameters have been revised, but even the updated December 2010 Parameters will not contain all the medications or doses which can be prescribed to treat childhood mental health disorders.

Q: I have read the PMUR report, and I don't understand what "outside Parameters but within the standard of care" means?

A: There are times when the child's diagnoses or combination of diagnoses may require the use of multiple medications or doses of medications which fall outside the dosing guidelines described in the current Parameters. This determination is made based on a review of the current accepted treatments, and the individual child's medical record, symptom severity, peer-peer contact, the prescriber's reasons for choosing the medications, and weighing the benefits versus risks.

Q: If the determination made is "outside Parameters, and there is opportunity to reduce polypharmacy" should the extra medication be stopped?

A: If this determination is made as a result of the PMUR process, Cenpatico encourages CPS staff, medical consenters, caregivers or other interested parties NOT to stop any medications unless directed by a

physician. Quickly changing or stopping medication can have serious consequences, and side effects more severe than just continuing the medications. It may take days to weeks to safely stop or change medications, and Cenpatico will work with the treating physician and will review cases with this determination on an ongoing basis to see if the medications have been reduced.

Q: What happens when the determination is “outside Parameters, and there is risk for or evidence of serious side effects”?

A: In these cases, the DFPS Medical Director is notified, so that specific actions can be planned. Again, Cenpatico emphasizes that any medication (s) should NOT be stopped unless directed by a physician. Cenpatico Service Management can assist in finding a new treating physician if necessary.

Quality of Care Concerns

Q: How does Cenpatico handle quality of care concerns identified through the PMUR process?

A: Physicians who appear to consistently prescribe “outside Parameters, and there is an opportunity to reduce polypharmacy” or “outside Parameters and there is risk for or evidence of significant side effects” are referred to the Quality of Care review process. Additional records will be requested, and the cases reviewed in detail. If over-prescribing or dangerous prescribing is identified as a pervasive pattern, the cases and physician will be referred to the Credentialing Committee for further investigation, and action. Please note the results of Quality Improvement and Credentialing Committee investigations and actions are confidential and may not be released to or discussed with the public.

Q: What response will I receive when I submit a QOC?

A: You will receive an acknowledgement in writing within 5 business days and a thorough investigation of the concern will be conducted; however, results of the Quality Improvement and Credentialing Committee investigations and actions are confidential. The results may not be released to or discussed with the public, or the person filing the concern. All QOC issues are tracked and trended. Any practitioner showing a pattern or trend may be placed on corrective action and/or face disciplinary action up to and including termination if warranted.

Excerpts from an article adapted from Psychotropic Medication and Children in Foster Care: Tips for Advocates and Judges, a new practice and policy brief developed by the ABA's Improving Understanding of Maternal and Child Health Project, a project of the ABA Center on Children and the Law. JoAnne Solchany, PhD, ARNP, is a Board Certified Psychiatric Nurse Practitioner and Therapist with infants, children, and families in Seattle. Her focus is on children and families in the child welfare system, child-parent relationships, and infant mental health.

The American Academy of Child & Adolescent Psychiatry makes the following recommendations for Questions Judges and Attorneys Should Ask about the use of psychotropic medication with children and teens in care. Judges and attorneys should consider the following questions when considering the best interests of or advocating for a child or teen in care. Children and teens have little, if any, power over their lives when they enter care. They generally lack the knowledge to understand what they need medically, regardless of the type of treatment needed. Asking the following questions will help identify their needs and determine which recommended treatments are in their best interests.

What is this medication needed for?

What kind of symptoms is this child experiencing? Are these symptoms interfering with the child's ability to function? Are these problems an issue in multiple environments?

Were you able to obtain an accurate medical, behavioral, and psychological history from parents and past providers?

Children in foster care do not always have a consistent caregiver who can be a reliable historian for what a child has experienced or what kinds of symptoms they are dealing with. Parents who are in conflict with their child may exaggerate symptoms or blame the child when they are really at the root of the presenting issues. Other parents may not have been around their children enough to provide accurate information. Parents and other caregivers can also become so frustrated by a child's behaviors that they exaggerate the child's symptoms to gain added support and sympathy. It is important to explore the source of the information about the child.

What else has been tried?

Has counseling been provided? Has it been consistent? Has the child had a psychiatric evaluation? Has the child had a medical examination?

What other modes of treatment or intervention will also be provided?

Medications should never be the sole mode of treatment for mental health disorders. Counseling should be provided to help children learn to manage or minimize their symptoms. Children often need to learn new skills, such as anger management or problem solving, to help them interact with others more successfully. Some children need to talk about their trauma or their grief to make sense of and resolve it; medication will not do this for them. Additional types of treatment may include Play Therapy, Social Skills Group, Parent-Child Interactive Therapy (PCIT), Dialectic Behavioral Therapy (DBT), Cognitive Behavioral Therapy (CBT), Child-Parent Psychotherapy, Parent Coaching, and Anger Management Groups.

Who will monitor the ongoing use of this medication? How often will this child be seen?

Successful medication management includes regular follow-ups. Especially when first started, medications often need to be adjusted for proper dosage or better timing. The development of side effects needs to be monitored. In children, medications often need to be slowly introduced over several weeks; the incremental adjustments will need to be monitored. Medication changes and ending a medication often require tapering as well. About 20% of people have some type of difficulty with the first psychotropic medication they are prescribed and will need to work with their mental health provider to find a better treatment option. It is important to consider who will take the child to appointments on a regular basis so a consistent adult is also well informed of the medications being used.

What are the possible side effects of this medication and how will they be handled?

Some medications carry transient side effects, such as stomach upset or initial drowsiness. These often disappear over the first few days on the medication or they can be minimized by taking the medication at night rather than in the morning. Other side effects, such as vomiting, confusion, or inability to sleep, may mean this medication will not work with this child or that the child needs additional medication to balance the effects. Some side effects are seen weeks or even months after a medication is introduced. Some antipsychotics lead to rapid weight gain while some stimulants used to treat attention disorders lead to significant weight loss—these issues can impact overall health and can add to self esteem and other mental well-being problems.

What evidence supports the use of this medication with children?

What do we know about how this medication works in children? Are there safety warnings that go along with this medication? What evidence do we have that it will not harm the child? Is this medication well tolerated in children?

Will this child be able to comply with the prescribed medication?

Is there someone available who can assure the child has regular access to the medication and that it is being given as directed? Is this medication easy to use? For example, is it a once-a-day dose versus a four-times-a-day dose? Is the type of medication right for this child? For example, is there a liquid form available for a child who cannot swallow pills? Will additional lab tests be needed to start or sustain use of this medication? For example, will the child need a baseline EKG to assess for cardiac functioning or will the child require regular blood tests to assess medication levels. Can the patient afford the drug? If a patient cannot afford a medication, he or she will not be able to take it. Is it covered under Medicaid? Medicaid often has rules for what kinds of medications it will cover; alternative medications can often be prescribed, but sometimes a very specific drug may be needed for certain symptoms.

Does the child agree with taking this medication?

Despite the age of consent, how does this child feel about being on this medication? Has it been discussed with the child? Has the child been told what to expect? Is someone talking regularly with the child about how it feels while on this medication?

Who has given permission to begin this child on medication?

Who should be giving permission? The parent? The foster parent? The prescriber? The child's advocate? The child? The social worker? Do the people involved in this child's life know of this medication and understand the risks and benefits? Have they been taught how to properly administer and monitor this medication?

What other medications is this child on? Can this medication be safely combined with the current medication?

Is the child already on medications for other things such as asthma or acid reflux? Can this new medication be safely used with the current medications? Who has assessed this? Does the prescriber of the psychotropic medication know what the child is already on? What over-the-counter medications, vitamins, or naturopathic medications is the child taking?

How will this medication help improve this child's functioning?

What challenges is the child struggling with that should change with this medication? Will this make life easier for this child?

What are the risks versus benefits of using this medication? What are the risks versus benefits of not using the medication?

It is critical to understand the risks of any medication and of any other intervention or therapy. Equally important is understanding the benefits of using the medication or other therapies. The benefits need to outweigh the risks. Both the patient and the caregivers need to fully understand the risks and benefits as well.

Is a second opinion warranted in this case?

Cases involving children on multiple medications, young children under six, and the use of atypical medications should always be reviewed by other practitioners. Children who have been difficult to treat or who have tried various medications previously may require a second opinion.

Conclusion

Psychotropic medication use in children and adolescents has increased over the past decade. Many medications used today are safer, have fewer side effects, and are more effective than medications used 15 years ago. However, little research has studied the long-term effects of these medications or their effects on children and adolescents. Despite this lack of knowledge, psychotropic medications are used to treat and manage behavioral, emotional, and psychological symptoms experienced by children and teens.

Children in foster care or in other state care appear especially vulnerable to medication use. Concerns continue to be raised over adequate monitoring, second opinions, use of multiple medications at once, consent for the use of medications with children in care, and providing other necessary treatments such as counseling. Evidence shows individuals experience greater improvement when medication is combined with counseling than without.

The risks and benefits of treating a child with and without medication need to be examined with each medication considered. Children should be on the least-potent medication and the lowest possible dose, and for the shortest amount of time. Their developmental progress across all domains should be considered and protected. Psychotropic medications should be supportive and helpful and never place a child at risk of harm.

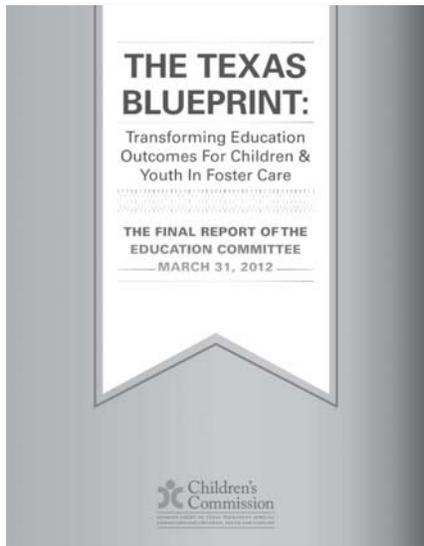


EDUCATIONAL NEEDS CHECKLIST FOR ADVOCATES

Some “questions” to consider

- Does the child have a complete and maintained Education Portfolio?
- Have you received the guiding principles in The Texas Blueprint: Transforming Outcomes for Children and Youth in Foster Care?
- Was the child automatically enrolled in the RTC associated Charter School when a mainstream public school opportunity was available?
- If your child has an ARD or IEP how are you notified?
- Is the child eligible for special education services? Is an appropriate ARD committee reviewing the school assignment for the least restrictive environment?
- Who is the surrogate parent?
- Are disciplinary standards outlined in CPS handbook, section 15400, being met?
- How do the school staff and RTC staff communicate, and how often? Are there regular meetings to share information?
- If youth is older, ask if he or she is prepared to pursue his or her goals, such as college or technical school?

Advocating for a Child's Educational Success



Taken from The Texas Blueprint: Transforming Education Outcomes for Children and Youth in Foster Care - The Final report of the Education Committee, March 31, 2012 - Children's Commission

Guiding Principles:

Guiding Principle # 1: Children and youth in care are entitled to remain in the same school when feasible

Guiding Principle # 2: Children and youth in care experience seamless transitions between schools

Guiding Principle # 3: Young children in care receive services and interventions to be ready to learn

Guiding Principle # 4: Children and youth in care have the opportunity and support to fully participate in all developmentally appropriate activities and all aspects of the education experience

Guiding Principle # 5: Children and youth in care have supports to prevent school dropout, truancy, and disciplinary actions, and to reengage in the education experience

Guiding Principle # 6: Children and youth in care are involved, empowered and prepared to self-advocate in all aspects of their education

Guiding Principle # 7: Children and youth in care have consistent adult support to advocate for and make education decisions

Guiding Principle # 8: Children and youth in care have support to enter and complete post-secondary education

Recommendations:

School Experience, Supports and Advocacy Subcommittee Recommendations and Strategies

Related to Guiding Principles #4, 5, 6, and 7

- 1.1 Amend the Family code to authorize the education decision maker access to education records and notice of and attendance at specified school meetings, including parent/teacher conferences, ARDs, and disciplinary hearings, to the same extent as parents and amend the Education Code to require provision of notice of school meetings to the education decision maker, caretaker and DFPS caseworker, if the school is made aware of the identities of these persons.
- 1.2 Clarify in DFPS policy the list of different types of education decisions that may be made about a child in care and who should make that decision.
- 2.1 As a best practice, conduct a conference for foster children upon/after enrollment in a new school, to be attended by all relevant school personnel as determined by the school district, the foster parent, youth, caseworker (in person or by conference call), the education decision maker, CASA, and the attorney and/or guardian ad litem.
- 2.3 Require the DFPS caseworker to go over the contents of the Education Portfolio with parents and youth, as age appropriate, on a quarterly basis.
- 6.1 Coordinate with the Texas Charter School Association (TCSA) to encourage all charter school board members that admit children and youth in foster care to receive training about their educational and other needs. Discuss with TCSA whether charter school administrators and faculty may also be encouraged to receive this type of training.
- 6.2 **Clarify the DFPS Residential Child Care contract to say that a child placed in a Residential Treatment Center (RTC) may not automatically be enrolled in a RTC-associated charter school. If a child is eligible for special education services, an appropriate ARD committee should determine that the charter school would be the least restrictive environment for the child and DFPS and the surrogate parent should approve the child's attendance at the charter school. If the child is not eligible for special education services, DFPS should, in conjunction with the child's education decision maker, approve the child's attendance at the charter school and apprise the court as soon as practicable but by no later than the next scheduled court hearing pursuant to Chapter 262 of the Texas Family Code.**
- 7.2 Clarify for school districts and charter schools that the foster parent or caregiver is the person to notify of use of restraints.

15360 The Child's Education Portfolio

CPS March 2009

The child's Education Portfolio contains important school documents and is designed to follow all school-aged children to each placement. The portfolio gives caregivers, CPS staff, and the child access to the child's current educational records and documentation.

The purpose of the Education Portfolio is to facilitate the child's transfer to any school and ensure that the child receives proper educational placement and services.

The caregiver and the youth update and maintain the portfolio.

At least quarterly, CPS caseworkers make copies of new documentation from the portfolio and place the copies in the child's case file.

See 15330 Education-Related Documents Required for the Case File.

Required Documents for the Education Portfolio

All Children	Children Receiving Special Education or Section 504 Services*
<ul style="list-style-type: none"> ■ Report cards (current school year) ■ Transcripts ■ Birth certificate (copy) ■ Immunization records ■ Placement authorization forms ■ List of medications taken during the school day (the caseworker gives a copy to the school nurse) ■ Standardized testing scores ■ School Withdrawal documentation (if applicable) ■ Social Security card (a copy, when available) ■ Correspondence to and from the school 	<ul style="list-style-type: none"> ■ Notices of Admissions, Review, and Dismissal (ARD) meeting for the current school year ■ Results of the child's Full and Individual Evaluation (FIE) or current assessments and evaluations of tests offered by the school district ■ Results of the child's Individualized Education Plan (IEP), updated annually (ARD meeting paperwork) ■ Current Individual Family Service Plan (IFSP) ■ Documentation of services provided under Section 504 ■ Individual Transition Plan or Summary of Performance (9th-12th grade)
<p><i>* Section 504 of the Rehabilitation Act of 1973 protects the rights of individuals with disabilities in schools that receive federal funds. The Rehabilitation Act requires reasonable and appropriate accommodations for persons with disabilities.</i></p>	

Taken from CPS Handbook: Creating – Delivering – Maintaining the Education Portfolio Discipline in Public Schools; Discipline of Children with Disabilities

15371 Creating the Education Portfolio

CPS January 2012

The Education Portfolio serves several purposes in ensuring that each child and youth receives the most appropriate educational services and documents his or her school records. The Education Portfolio is a compilation of a child's school records and the Education Portfolio remains with the child or youth and his or her foster home placement. It serves as a valuable resource for tracking appropriate educational and ancillary services, assessments, report cards, and transcripts. The caseworker also maintains a case file with the education information.

The caseworker plays a crucial role in minimizing a child's disruption of school services and maintaining the child's Education Portfolio.

The Investigative or Removal Caseworker

The investigative caseworker or the removal caseworker is responsible for securing the child's immediate school records and creating the child's initial Education Portfolio. The investigative or removal caseworker secures the documents within five days of the child's removal from his or her home. Copies of all of the following documents must be submitted to the child's school within 30 days of enrollment:

- The child's birth certificate, if available
- The child's Immunization Record
- The child's records from the school the child most recently attended if the child has been previously enrolled in a school in Texas or out-of-state.

In addition, the following documents are needed for the student's Education Portfolio:

- Current school courses, grade records, latest report card, absences
- School transcripts up to the time of removal
- Documentation, including educational and psychological assessments and Admission, Review, and Dismissal (ARD) committee decisions that supports the child's special education services
- Documentation that supports the child's accommodations under Section 504 of the Rehabilitation Act

If school is in session, the investigative or removal caseworker contacts the school registrar for most of the child's school-related information. If school is not in session because of a scheduled break, such as summer vacation or spring vacation, the investigative or removal caseworker must send a letter to the school registrar requesting the child's school-related information within five days of DFPS obtaining conservatorship. A copy of the letter to the school registrar is placed in the student's Education Portfolio.

The investigative or removal caseworker documents creation of the Education Portfolio in the IMPACT data management system. He or she completes and updates the student information on the Person Detail page and on the Education Detail page.

The investigative or removal caseworker is responsible for delivering the Education Portfolio to the child's placement within five days of initial placement.

The Conservatorship (CVS) Caseworker

The conservatorship caseworker assumes responsibility for maintaining a child's Education Portfolio. The conservatorship caseworker ensures the following documents are included in the Education Portfolio:

- All documents necessary for school enrollment, including birth certificate, and immunization records*
- The investigative or removal caseworker is responsible for securing the initial documents for a child's school enrollment. The conservatorship caseworker is responsible for obtaining any documents not immediately available to the investigative caseworker after the investigative caseworker closes his or her investigation case.
- Social Security card
- Ongoing report cards
- Ongoing attendance records
- All Admission, Review, and Dismissal (ARD) committee meeting decisions and accompanying documentation which includes:
 - the child's Individualized Education Plan (IEP);
 - Behavior Improvement Plan (BIP), as well as Functional Behavior Assessments; and
 - progress notes
- Documentation of accommodations under Section 504 of the Rehabilitation Act
- The child's psychological and educational assessments
- School transcripts or grade records of all previous schools the child attended
- Any additional documents, such as school correspondence, school pictures, honors

The conservatorship caseworker is responsible for creating an Education Portfolio for a child already in DFPS conservatorship when he or she reaches age 4 years 10 months. Children in DFPS conservatorship are eligible for kindergarten enrollment in a public school setting if they are 5 years old by September 1.

Original documents are kept in the child's case file. Copies are kept in the child's Education Portfolio.

15372 Delivering the Education Portfolio to the Child's Caregiver CPS January 2012

Under the following circumstances, the caseworker delivers the child's Education Portfolio as noted:

- For all school-age children in DFPS conservatorship, the caseworker at the time of the child's removal delivers the education portfolio to the child's caregivers within five working days after DFPS is granted or retains conservatorship at the 14-day hearing.
- For a child who becomes school age while in DFPS conservatorship, the conservatorship caseworker delivers the education portfolio to the child's caregivers within five working days of the child being registered to start academic instruction.
- For a school-age child in DFPS conservatorship who is changing placements, the conservatorship caseworker delivers the Education Portfolio as soon as the placement occurs.
- For a school-age child in DFPS conservatorship who is subject to an emergency change in placement for health and safety reasons, the conservatorship caseworker delivers the child's Education Portfolio to the new placement within three working days.

15373 Maintaining the Education Portfolio

15373.1 The Role of CPS in Maintaining the Education Portfolio CPS March 2009

The caseworker's responsibilities in regard to the Education Portfolio are as follows:

- Review and discuss the contents of the Education Portfolio during the monthly visits with the child and caregiver. Be prepared to update the contents of the portfolio and add new content provided by the child, caregiver, caseworker, and school personnel. Note and document pertinent information, changes, and additions in the IMPACT case management system and in the case file.
- Obtain withdrawal documentation from the previous school, if a child is transferring schools, and file the documentation in the Education Portfolio.
- Retain possession of the Education Portfolio, if the child is in a placement that cannot maintain the Education Portfolio (for example, if the child is in a medical or psychiatric hospital, is a runaway, or lives in an emergency shelter)
- Document the delivery of the Education Portfolio to the new caregiver on the Placement page in IMPACT within seven working days of the delivery. Also document in IMPACT any changes in the child's placement.

15373.2 The Role of the Caregiver in Maintaining the Education Portfolio CPS March 2009

The caregiver's responsibilities in regard to the Education Portfolio are as follows:

- Make the Education Portfolio readily available to DFPS caseworkers on all visits with the child.
- Maintain and update the Education Portfolio for each child in care. Necessary documents include but are not limited to report cards; transcripts; all special education documents, including the meeting notes of the Admissions, Review, and Dismissal (ARD) team; the Individual Education Plan (IEP); and paperwork related to the child's withdrawal or discharge from school.
- Review and discuss the progress reports and report cards with each child.
- Provide the child's Education Portfolio to the DFPS caseworker at the time a child is discharged from the caregiver's home. Ensure that it contains the current education-related documents and records, including paperwork on the child's most recent withdrawal from school.

15400 Discipline of Children in DFPS Conservatorship in the Public Schools

CPS March 2009

In Texas, school districts are authorized to set policy on corporal punishment in schools.

DFPS policy prohibits caregivers from using corporal punishment. Caseworkers instruct foster parents not to consent to corporal punishment of a foster child on any school form.

If a child in DFPS conservatorship is being physically disciplined or a child with behavior problems is in a school district that permits corporal punishment and the disciplinary issues appear to be escalating, the caseworker:

- consults with the regional education specialist for guidance;
- meets with relevant school personnel;
- explains the circumstances that make corporal punishment inappropriate for abused and neglected children, in general, and in the individual case;
- proposes alternate sanctions or strategies for dealing with a child's behavior; and
- offers consultation and provides documentation, if a child's therapist or other mental health professional can describe the risk corporal punishment brings to the child or can recommend alternate discipline methods.

If the problem regarding physical discipline of a child continues, contact the regional education specialist, the school district's school administration staff (principal or superintendent), the regional attorney, and the attorney and guardian ad litem.

15410 Discipline of Children With Disabilities CPS March 2009

If a discipline issue involves a child who may be eligible for special education services, but whose status has not been confirmed, the child may be protected by discipline rules applicable to special education students (See 15420 Discipline Strategies and Restrictions for Children With Disabilities).

If the possibility of referring the child for special education services has been raised, or if the child's behavior or performance indicates that special education services may be appropriate, the caseworker contacts the regional education specialist to assess the options.

15420 Discipline Strategies and Restrictions for Children With Disabilities

CPS March 2009

State law requires that all students be treated with dignity and respect.

Texas Education Code [§37.0021\(a\)](#) *External Link*

Federal and state laws sharply restrict the use of confinement, restraints, seclusion, and time-outs for children with disabilities. If a child's behavior is problematic in a school setting, the caseworker refers to the child's Individual Education Plan (IEP) for examples of the positive interventions and strategies to be used.

34 CFR [§300.527](#) *External Link*

Restraints, specifically, may be used on a child only in an emergency by staff trained to use restraints.

Any use of restraints requires documentation in a child's Individual Education Plan (IEP), Behavior Improvement Plan (BIP), or both. Written notice must be given to the child's caregiver. If the caregiver is notified of an incident involving restraints used on a child, the child's caseworker must be contacted immediately.

Texas Administrative Code, Title 19, Education, [§89.1053\(c\)](#) *External Link*

Advocating for the Child

If there are concerns regarding the use of restraints, seclusion, or time-outs while the child is in an educational setting, the caseworker:

- summarizes the facts;
- consults with the DFPS supervisor; and
- consults with the regional education specialist, regional attorney, or attorney ad litem.



PERMANENCY AND ENGAGEMENT NEEDS CHECKLIST FOR ADVOCATES

Some “questions” to consider

- Does your child or youth have an individualized permanency plan? Are there identified goals and services in the RTC setting focused on this plan?
- Does your child or youth participate in permanency goal setting and have an understanding and voice in their future?
- What opportunities have they had to participate in court reviews?
- Would the court allow the youth to submit a report to the court?
- Does the Attorney ad litem keep in contact? Are there any legal barriers to permanency?
- Who do they feel connected to? Who do they love? Miss? Who would they want to visit them?
- If the child or youth has been in care for a significant time, have efforts to case mine and re-assess or engage family or relatives occurred? Will the therapeutic team at the RTC be involved if these efforts occur?



To: Texas Judges Who Hear CPS Cases

From: The Honorable Robin Sage, (ret.)
Jurist in Residence, Office of Court Administration

Date: January 23, 2013

RE: Permanency Summit Follow-up

I hope you found the Permanency Summit we attended in October to be as helpful and inspiring as I did. I'm encouraged by the overwhelmingly positive feedback received from participants. Almost without exception, we heard that participants left the conference not only inspired to make changes in their jurisdictions, but felt better-equipped with strategies and tools to do so. Some courts are bringing more children into court and others have rearranged their dockets to improve efficiency and continuity. For example, one district judge changed his docket and assigned to an associate judge all hearings for children in permanent managing conservatorship to promote closer case oversight and to allow those children to see one judge.

The Children's Commission is dedicated to supporting courts in their efforts to improve their hearing practices, and is especially committed to helping judges bring more children to court. A few jurisdictions suggested that a video featuring youth in foster care that explains what court is like and what to expect would be helpful to youth who might feel intimidated or reluctant to attend court hearings. The Children's Commission is working with Texas Applesseed and the Texas Center for the Judiciary to develop this video.

While having children in court is ideal, it may not always be possible so we also encourage you to use video conferencing. The Children's Commission has a growing video conferencing project that has connected several courts with Residential Treatment Centers, allowing youth to participate in hearings via video conference. Another tool that can help ensure you're hearing from the youth on your docket is to use a Youth Court Report. An example is attached that you can modify for your court. Also attached is an open letter by two Houston Judges to foster youth that explains their right to have their voice heard. Houston Judges Mike Schneider and Angela Ellis have posted the letter in their courtroom and hand it out to caseworkers, ad litem, and youth at each hearing.

Texas Applesseed and Casey Family Programs are also committed to continuing the work we began at the Permanency Summit. Someone from Texas Applesseed may be in touch with your court so see how we can support you. As we all improve our practices surrounding court hearings, we hope you will share success stories and suggestions for overcoming obstacles. Thank you to everyone who left the Permanency Summit committed to doing more to ensure children have a voice in their future, which not only helps everyone involved make better decisions but also is just the right thing to do.

Robin Sage
Jurist in Residence
Texas Office of Court Administration

CHILDREN AND YOUTH IN RTC'S VIDEO CONFERENCING WITH THE COURTS

To meet the needs of the child, many children are placed in group homes or residential treatment centers that are located far from their home and the court. These distant placements have created hurdles to comply with the Family Code Chapter 263.302 and 263.501(f) that mandate the child participate in their permanency and placement review hearings.

Examples of these hurdles include:

- Loss of treatment or service time for the child.
- Disruption of the child's daily routine.
- Travel expenses.
- Staff expenses to transport the child to and from the court.
- Staff expenses from the loss of staff time to provide services to other children.

In an effort to overcome these hurdles the Texas Office of Court Administration (OCA) and the Texas Department of Family and Protective Services (DFPS); Child Protective Services (CPS) are engaged in a collaborative video conferencing project for child abuse and neglect cases.

The project is using Internet based video conferencing to enable children involved in child abuse and neglect cases to participate in their permanency and placement review hearing.

This technology is hosted and maintained at OCA. Additional remote video endpoints can be established if:

- The end point has access to a computer with a configuration to support the client software. NOTE: A minimum system requirements guide is available.
- The end point must have an Internet connection to support a high-quality session. Download speed – 1.0 Mbps minimum. Upload speed – 0.40 Mbps minimum.
- The end point will need a web camera (built-in or USB plug compatible).

As of May 1, 2013 there were 47 RTC facilities with video conferencing capability that have participated in hearings remotely. These facilities can connect with any of the 10 courts currently participating in the project.

The following is offered as a collection of quotes and paraphrased feedback provided by RTC facility staff and Judges regarding the use of video conferencing.

- The older children enjoyed the video conference experience and appreciated the opportunity to speak with the judge. However, sometimes the older children prefer to go to court to participate rather than using video conferencing. They want to get off campus for the day. – RTC staff.

- “The children are very receptive and pleased to participate in their hearing through a video conference link.” - RTC staff
- The younger children are shy and often times the case manager or therapist has to provide a more complete or accurate response to the Judge. – RTC staff
- Video conferencing allows additional RTC staff participation (program directors, clinical directors, case managers, and therapists) during the child’s hearing. This larger exchange of information is beneficial to everyone. – RTC staff
- Using a video conference link enables the child to stay in a stable environment. This avoids the risk of the child’s behavior issues arising while attending a court hearing. – RTC staff.
- “I felt I was able to make a connection with the child, show him that he has value/is special, and has reason to hope for a better future.” - Judge
- “The children seemed very open and forthright.” - Judge
- The video conferencing enabled the child to be more relaxed and comfortable. The child provided valuable information that I had not considered to ask about. – Judge
- It is beneficial to have input and feedback from the case managers or therapists at the RTC facilities that have been working with the child. – Judge
- There are a number benefits to having a child participate in their hearing through a video conference link. However; one-on-one conversations between the child and the Judge is always better, particularly for the younger children.

The next phase of the project will have an expanded scope to include at least two of the following areas of participation.

- Additional courts.
- General residential service facilities.
- Foster group homes.
- Remote visitation between the child and parents, siblings, CPS case workers, CASA volunteers and attorneys.

Residential Treatment Centers with Video Conferencing Capability Provided by the Texas Office of Court Administration (OCA)

DFPS Service Provider	Placement Address	Video Conferencing Enabled
Austin Children's Shelter	4800 Manor Road Austin, Texas 78723	Yes
Azleway Valley View RTC	15892 CR 26 - Tyler, TX 75707	Yes
A New Day Foundation RTC	17202 Garden Creek Drive, Spring, TX 77879	Yes
Bayes Achievement RTC	7517 Highway 75 South, Huntsville, TX 77340	Yes
Big Springs Ranch for Children	10664 Hwy 83 North, Leakey, TX 78873	Yes
Boys Haven of America, Inc.	3655 N. Major Drive, Beaumont, TX 77713	Yes
Brookhaven Youth Ranch	5467 Rogers Hill Road, West, TX 76691	Yes
Carter's Kids RTC	1202 Lark Lane, Richmond, TX 77469	Yes
Children's Hope RTC	500 West Ave., Levelland, TX 79336	Yes
Children's Hope RTC	2402 Canyon Lake Drive, Lubbock, TX 79415	Yes
DePelchin Children's Center	710 S. 7th Street, Richmond, TX 77469	Yes
DePelchin Children's Center	4950 Memorial Drive, Houston, TX 77007	Yes
Devereux RTC	120 David Wade, Victoria, TX 77905	Yes
East Texas Open Door	410 West Grand, Marshall, TX 75670	Yes
Everyday Life Inc.	6955 Broach Road, Bryan TX 77808	Yes
Five Oaks Achievement Center	7674 Pechacek Road, New Ulm, TX 78950	Yes
Good Shepherd RTC	23538 Coons Rd. - Tomball, TX 77377	Yes
Guardian Angels RTC	9530 W. Montgomery Road, Houston, TX 77088	Yes
Habilitative Homes Inc.	9018 Island View Drive, San Antonio, TX 78242	Yes
Have Haven, Inc. RTC	14054 Ambrose Street, Houston TX 77045-5818	Yes
Hearts with Hope Foundation RTC	27706 Tiverton Court, Spring, TX 77386	Yes
Hector Garza Treatment Center	620 East Afton Oaks Blvd., San Antonio, TX 78232	Yes
Helping Hand Home for Children	3804 Avenue B, Austin, TX 78751	Yes
Hill Country Youth Ranch	3522 Junction Hwy, Ingram, TX 78025	Yes
Houston Serenity Place RTC	6509 Morrow Street, Houston, TX 77091	Yes

Texas CASA Residential Treatment Center (RTC) Manual

DFPS Service Provider	Placement Address	Video Conferencing Enabled
Hughen Center RTC	2849 9th Avenue, Port Arthur, TX 77642	Yes
KCI Servants Heart RTC	4040 High Ridge Circle San Antonio TX 78229	Yes
Krause Children's Center RTC	25752 Kingsland Blvd., Katy, TX 77494	Yes
L'amor Village RTC	16540 Kuykendahl Road, Houston TX 77068	Yes
Meadowland RTC	121 Old San Antonio Rd, Boerne, TX 78006	Yes
Minola's Place of Texas RTC	17940 Country Walk Drive, Spring, TX 77379	Yes
Mission Road Ministries RCT	8706 Mission Road, San Antonio, TX 78214	Yes
New Hope Youth Center	4111 Brandt Road, Richmond, TX 77469	Yes
New Horizons Ranch RTC	850 FM 574 West, Goldthwaite, TX 76844	Yes
New Life Children's Center RTC	650 Scarborough, Canyon Lake, TX 78133	Yes
North Fork Educational Center	3001 Elm Grove Road, Wylie, TX 75098	Yes
Pegasus Schools RTC	896 Robin Ranch Road, Lockhart, TX 78644	Yes
Settlement Home for Children	1600 Payton Gin Road Austin, Texas 78758	Yes
Sheltering Harbour RTC	SOUTH CAMPUS - 17803 West Strack Drive, Spring, TX 77379	Yes
Shoreline Inc., Treatment Center	1220 Gregory Street, Taft, TX 78390	Yes
St. Jude's Ranch for Children	1400 Ridge Creek Lane, Bulverde, TX 78163-4354	Yes
Texas Hill Country School	5309 Texas Lone Star Trail, Maxwell, TX 78656	Yes
Thompson's RTC	1995 FM 1564 E., Greenville, TX 75402	Yes
Unity Children's Home RTC	2111 River Valley Dr., Spring, TX 77373	Yes
We Care Treatment Center	28915 South Plum Creek Drive, Spring, TX 77386	Yes
Whispering Hills Achievement Center	4110 FM 609 - Flatonia, Texas 78941	Yes
Willow Bend Center RTC	2902 Hwy 31 East, Tyler, TX 75702	Yes

For information on video conferencing with these RTC facilities, please contact:
 Tim Kennedy, CIP Technology Project Manager
 Texas Office of Court Administration
 (512) 463-6057 or tim.kennedy@txcourts.gov

MY NEEDS:

MY WISHES:

MY TRANSITION PLAN:

THE COURT NEEDS TO KNOW:

MY RECOMMENDATIONS:

1. _____

2. _____

3. _____

4. _____

Youth report written by: _____ Date: _____
Youth Signature

Youth report submitted to the court by: _____
Signature and Title

Date submitted: _____

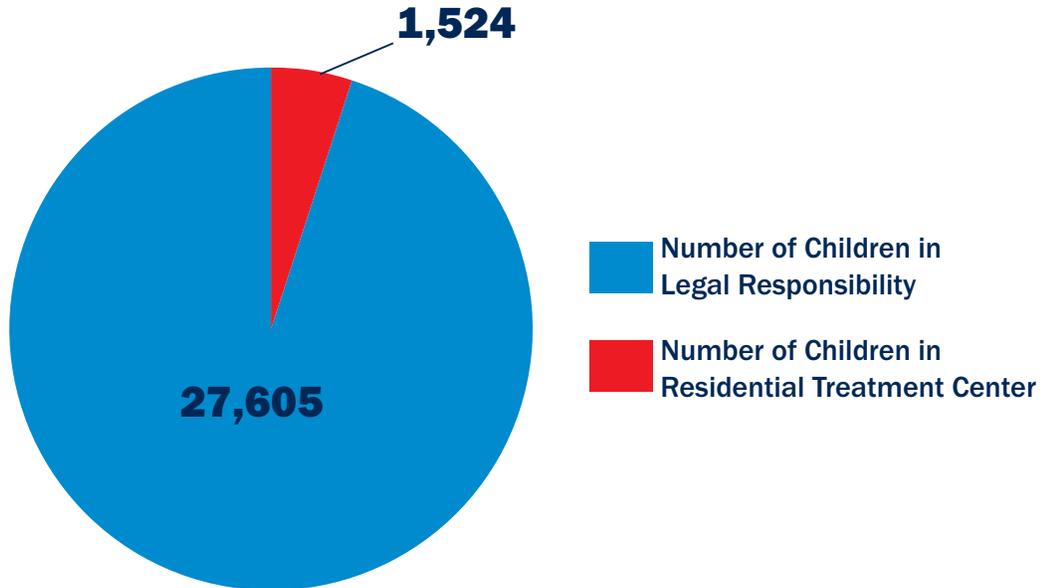


OLDER YOUTH NEEDS CHECKLIST FOR ADVOCATES

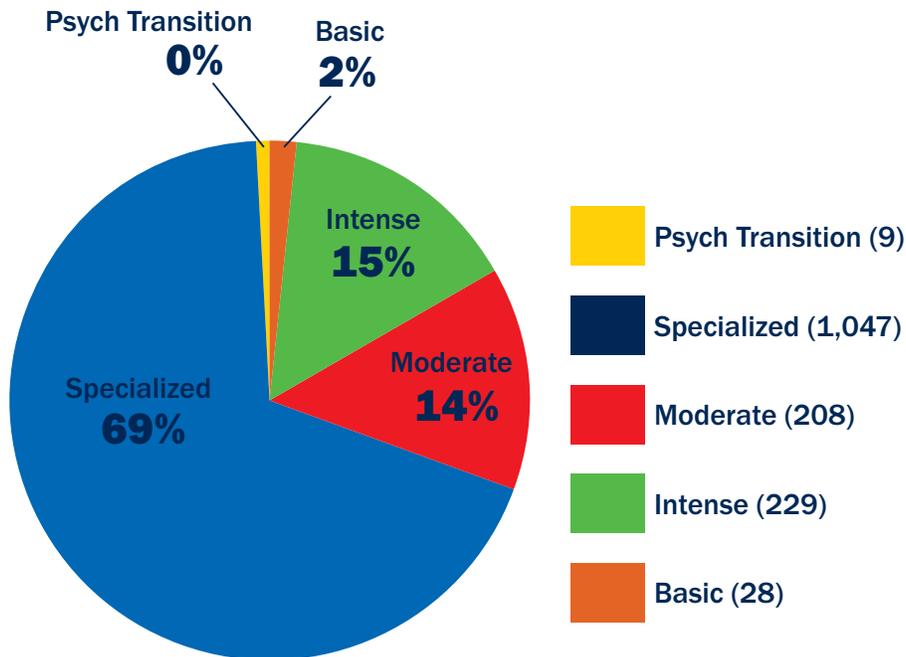
Some “questions” to consider

- Does your youth know how to participate and advocate for themselves regarding their healthcare and medications? Do they have someone they can talk with about their concerns for the future in this area?
- Do they have a copy of their Education Portfolio – Social Security card, birth certificate, immunization records?
- Has your youth had an opportunity to get their drivers license? Open a bank account?
- What experiential life skills has your youth been able to participate in?
- Have you talked with your youth about life skills and preparation for adult living?
- Does the RTC assist in assuring youth receive information about Transitional Living Services?
- How can you help RTC staff in preparing youth?

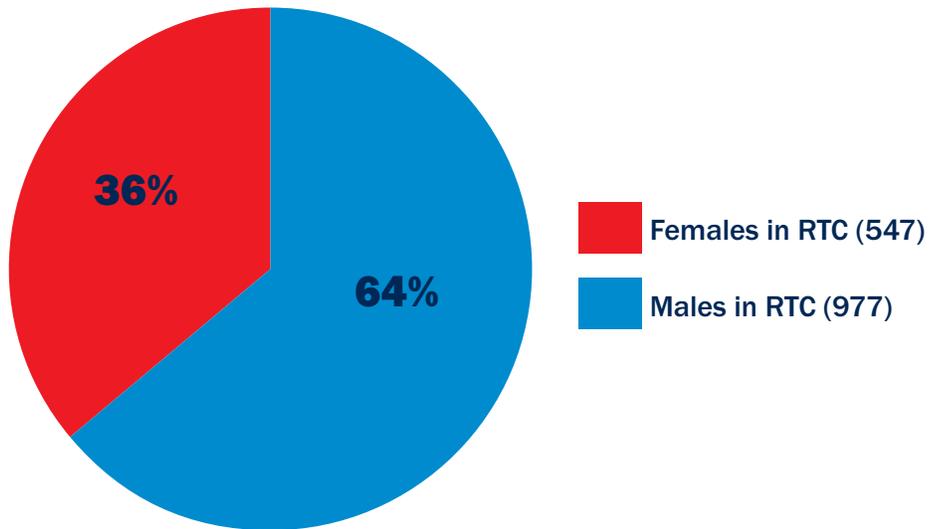
Number of Children in State Legal Responsibility (March 31, 2013)



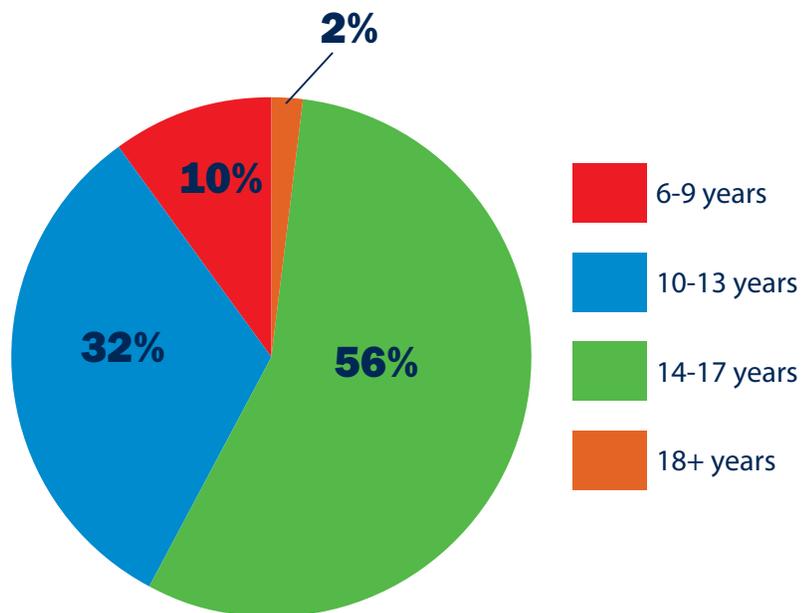
Children in Residential Treatment Centers Statewide by Service Level (March 31, 2013)



Gender of Children in Residential Treatment Centers (March 31, 2013)



Age of Children in Residential Treatment Centers (March 31, 2013)



RESOURCES TO AID CAREGIVERS IN PROVIDING EXPERIENTIAL LIFE SKILLS TRAINING TO FOSTER YOUTH

The resources listed below are just some suggestions to get you started on your journey of providing experiential life skills activities to youth in your care. This list is a product of the House Bill 1912 (81st Legislative Session) workgroup and were developed to help caregivers fulfill the requirement of providing or assisting foster youth age 14 or older in obtaining experiential life-skills training to improve their transition to independent living.

This list is not comprehensive, and caregivers are not required by DFPS to use any of these resources. The materials referenced below contain information created and maintained by other government, public and private organizations and are provided for the user's convenience.

If you have ideas for other materials to include on this list, please contact DFPS at gaye.vopat@dfps.state.tx.us.

Life Skills Training Resources

- Texas Youth Connection web site: <http://www.dfps.state.tx.us/txyouth/default.asp>
- DFPS Transitional Living Services Information http://www.dfps.state.tx.us/Child_Protection/Transitional_Living/default.asp
- Ready, Set, Fly! A Parent's Guide to Teaching Life Skills by Casey Family Programs - Available in print and also online at <http://www.caseylifeskills.org/pages/res/rs%5CRSF.pdf>
- Casey Family Programs list of free web resources: http://www.caseylifeskills.org/pages/res/res_ACLSAGuidebook.htm#5
- Casey Family Programs comprehensive list of resources, including those available for purchase: http://www.caseylifeskills.org/pages/res/res_ACLSAGuidebook.htm
- "50 Things You Can Do to Help Someone Get Ready for Independent Living" <http://www.hss.alaska.gov/ocs/IndependentLiving/Docs/RS%2050%20Things.pdf>
- "Life Skills Inventory: Independent Living Skills Assessment Tool" http://www.dshs.wa.gov/pdf/ms/forms/10_267.pdf
- Independent Living Books and DVDs by Social Learning <http://www.sociallearning.com/catalog/topics/lifeskills/independent-living.html;jsessionid=a8boZGg48se5>
- "Truth About Drugs" DVD <http://store.discoveryeducation.com/product/show/51960>
- "Truth About Drinking" DVD <http://store.discoveryeducation.com/product/show/53563>
- "Truth About Sex" DVD <http://store.discoveryeducation.com/product/show/48582>

- FosterClub <http://www.fosterclub.com/>
- Retailers of Life Skills Training Resources
- National Resource Center of Youth Services <http://www.nrcys.ou.edu/catalog/>
- National Independent Living Association
- Daniel Memorial <http://www.danielkids.org/sites/web/store/product.cfm>
- Youth Communication <http://www.youthcomm.org/>
- Social Learning <http://www.sociallearning.com/>
- Discovery Education <http://www.discoveryeducation.com/>

Training for Caregivers

- “Teaching Moments: How Foster Parents Can Teach Independent Living Skills To Teens” DVD
<http://www.sociallearning.com/catalog/items/DVD7316.html;jsessionid=adIWbottIDV9>
- Foster Care and Adoptive Community Training: <http://www.fosterparentstest.com/store/index.htm>
 - “Teaching Essential Life Skills to Children of All Ages”
 - “Teaching Independence & Keeping Fragile Kids Safe”
 - “Preparing for Post High School Education”
 - “Enhancing Independence Through Recognizing and Improving Job Skills”
 - “Money Skills”
 - “Sexually Transmitted Diseases: What You Need To Know”
 - “Health Issues”

**TEXAS DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES
TRANSITIONAL LIVING SERVICES-Revised NOVEMBER, 2012
BRIEF OVERVIEW OF SERVICES**

Transitional Living Services provides a systemic and integrated approach in transition planning, the provision of transitional services, and access to and information about benefits that affect both older youth in foster care and those who have aged out. Transitional Living Services are multipurpose and available to youth ages 14 up to age 23.

Experiential Life Skills Training for Youth Age 14 and older

Foster parents and other providers are required to include training in independent living skills through practical activities such as meal preparation, use of public transportation, money management, and basic household tasks for youth age 14 and older. The youth's experiential learning while in care and receipt of PAL services should complement one another and are discussed and addressed in each core life skill area within the youth's service and transition plan.

TRANSITION PLANNING/PERMANENCY PLANNING FOR OLDER YOUTH

TRANSITION PLAN: The transition plan identifies services for each youth to accomplish goals to assist them in transitioning from foster care. The plan is used statewide and is **incorporated into the youth's plan of service** to ensure consistency of services. Procedures for identifying caring adults for youth and involving them in transition planning help to ensure personal and community connections are incorporated into the transition planning process.

CIRCLE OF SUPPORT (COS): A Circle of Support is a youth driven process based on Family Group Decision Making (FGDM). COS's are offered to youth beginning at 16 years of age (although they can be offered as early as 14). This is a coordinated and facilitated meeting with participants that a youth identifies as "caring adults" who make up their support system. COS participants can include a youth's birth family members, substitute care providers, teachers, church members, a mentor and so on. Participants come together to develop and review the youth's transition plan, identifying strengths, hopes and dreams, goals and needs in the areas of education, employment, health/mental health needs, housing, and PAL life skills training components. Each caring adult participant identifies a personal way they can help support the youth's transition plan and to help attain short- and long-term goals toward self-sufficiency. All participants sign the transition plan to seal their agreements. http://www.dfps.state.tx.us/handbooks/CPS/Files/CPS_pg_6270.asp#CPS_6274_1

INDEPENDENCE PROGRAMS

PREPARATION FOR ADULT LIVING (PAL) SERVICES/BENEFITS: The DFPS Preparation for Adult Living (PAL) program assists older youth in foster care prepare for their departure and transition from DFPS care and support. Supportive services and benefits are provided by PAL Staff or PAL Contract Providers to eligible young adults up to age 21 to become self-sufficient and productive. PAL is funded by the *federal Chafee Foster Care Independence Program*, State general revenue funds and/or community match (20%). PAL services include:

- Life skills assessment (Casey Life Skills Assessment) to assess strength and needs in life skills attainment www.caseylifeskills.org (assessments are conducted before Life skills training):
- Life skills training (age 16 to 18) in the following core areas:
 - Health and Safety;
 - Housing and Transportation;
 - Job Readiness;
 - Financial Management;
 - Life Decisions/Responsibility;
 - Personal/Social Relationships
- Educational/vocational services
- Supportive services (based on need and funding availability) may include:
 - graduation items,
 - counseling,
 - tutoring,
 - driver's education fees, or
 - mentoring.
- A transitional living allowance of up to \$1,000 - distributed in increments of up to \$500 per month, for young adults up to age 21 who participated in PAL training, to help with initial start-up costs in adult living.
- Aftercare room and board assistance (ages 18-21) is based on need of up to \$500 per month for rent, utilities, utility deposits, food, etc. (not to exceed \$3,000 of accumulated payments per young adult).
- Case management to help young adults with self-sufficiency planning and resource coordination.

http://www.dfps.state.tx.us/handbooks/CPS/Files/CPS_pg_x10200.asp#CPS_10200

***Contact Regional Preparation for Adult Living Staff for more information about all Transitional Living Services at:

http://www.dfps.state.tx.us/Child_Protection/Preparation_For_Adult_Living/PAL_coordinators.asp

**TEXAS DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES
TRANSITIONAL LIVING SERVICES-Revised NOVEMBER, 2012
BRIEF OVERVIEW OF SERVICES**

Extended Foster Care Program: With the implementation of the federal **Fostering Connections Act** (*Title IV-E of the Social Security Act*) on **10-1-2010**, a young adult who ages out of foster care at age 18 will continue to be eligible for Extended Foster Care provided there is an available placement, the young adult signs a voluntary extended foster care agreement and meets at least one of the following conditions:

18 or up to 22 year olds, and:

- regularly attending high school or enrolled in a program leading toward a high school diploma or school equivalence certificate (GED); or is

18 to 21 years old and;

- regularly attending an institution of higher education or a post-secondary vocational or technical program (minimum six hours per semester); or
- actively participating in a program or activity that promotes, or removes barriers to, employment;
- employed for at least 80 hours per month; or
- incapable of doing any of the above due to a documented medical condition.

[HTTP://WWW.DFPS.STATE.TX.US/HANDBOOKS/CPS/FILES/CPS_pg_x10400.ASP#CPS_10400](http://www.dfps.state.tx.us/handbooks/CPS/FILES/CPS_pg_x10400.ASP#CPS_10400)

SUPERVISED INDEPENDENT LIVING (SIL) PROGRAM (ANTICIPATED START DATE-JANUARY 2013): The federal Fostering Connections legislation in 2008 established a supervised independent living (SIL) program which will be a component of the Extended Foster Care program. The SIL program will allow young adults to live independently under a minimally supervised living arrangement provided by a DFPS contracted provider. A young adult in SIL is not supervised 24-hours a day and is allowed increased responsibilities, such as managing their own finances, buying groceries/personal items, and working with a landlord. Living arrangements may include apartments, non-college and college dorm settings, shared housing and host home settings. Young adults are assisted in transitioning to independent living, achieving identified education and employment goals, accessing community resources, engaging in needed life skills trainings, and establishing important relationships. http://www.dfps.state.tx.us/handbooks/CPS/FILES/CPS_pg_x10440.asp#CPS_10480

Return for Extended Foster Care: Young adults who aged out of DFPS conservatorship may return to participate in the Extended Foster Care Program until the age of 21 if the required stipulations are met:

- Is offered an available placement;
- Understand that court jurisdiction will be extended, if the court permits;
- Sign or re-sign a Voluntary Extended Foster Care agreement; and
- Agree to one of the Extended Foster Care activities within 30 days of being placed in Extended Foster Care.

PAL staff pre-screen young adults who want to return for Extended Foster Care and refer to the regional re-entry staff.

Regional Re-entry Staff Contact List- <http://intranet/CPS/Regional/re-entry.asp>

OTHER RELATED INFORMATION:

Trial Independence Period (TI): (Effective 9/19/11): A young adult in DFPS conservatorship who turns 18 as well as a young adult enrolled in the Extended Foster Care Program may leave foster care for a "trial independence" period of 6 months (or up to 12 months with a court order). During the TI period, the young adult may be living independently and receiving other transitional living benefits such as **PAL, ETV, and Transitional Medicaid**. A Young adult that elects to return for Extended Foster Care during the TI period may do so without losing Title IV-E eligibility.

Extended Court Jurisdiction: Young adults that leave foster care at age 18 for a TI period will have court jurisdiction extended for 6 months. Additionally court jurisdiction may be extended for a 12 month TI period if ordered by the court. If a young adult is in Extended Foster Care, court jurisdiction will continue during this period but will not exceed the month of their 21st birthday. More information is available at:

http://www.dfps.state.tx.us/handbooks/CPS/FILES/CPS_pg_5363.asp#CPS_5363

POST-SECONDARY EDUCATION

EDUCATION AND TRAINING VOUCHER (ETV) PROGRAM: ETV is a *federally-funded (Chafee)* and state-administered program. Based on the cost of attendance (as established by higher education), youth in foster care or other eligible young adults ages 16 up to the age of 23 may be eligible to receive up to \$5,000 in financial assistance per year to help them reach their postsecondary educational goals if they meet the following criteria:

- Meet college enrollment and be enrolled at least 6 semester hours in an *accredited or pre-accredited*
 - public or non-profit program that provides a bachelor's degree or not less than a 2 year program that provides credit towards a degree or certification; or

**TEXAS DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES
TRANSITIONAL LIVING SERVICES-Revised NOVEMBER, 2012
BRIEF OVERVIEW OF SERVICES**

- a public or non-profit program that provides not less than a one-year program of training to prepare students for gainful employment; or
- a public or non-profit program, or a private institution that has been in existence for two years and offers training programs to prepare students for gainful employment in a recognized occupation (training may be less than one year).
- Students participating in the ETV Program on their 21st birthday may remain eligible until the month of their 23rd birthday as long as they are enrolled in ETV and making satisfactory academic progress toward completing their postsecondary education or training program as determined by the institution.

Students interested in continuing education courses or distance learning courses must contact ETV staff for prior approval to ensure accreditation and that courses lead to a degree or recognized certificate program.

Individuals eligible for ETV include:

- Youth in foster care who are at least 16 and likely to remain in care until 18; or
- Youth who aged out of foster care but have not yet turned 21; or
- Youth who were adopted from DFPS foster care after turning age 16 and are not yet 21; or
- Youth who enter Permanency Care Assistance after age 16; or
- Youth who are in the custody of the Texas Juvenile Justice Department (formerly TJJC) and are in a Title IV-E placement when turning age 18.

http://www.dfps.state.tx.us/handbooks/CPS/Files/CPS_pg_x10300.asp#CPS_10320

Note: Young adults in the Extended Foster Care Program, enrolled in higher education and eligible for ETV may have certain expenses paid by the ETV program (ex., books, computers, child care, and transportation). ETV will not cover residential housing, personal items and food since this is provided for in the Extended Foster Care program.

Apply for the ETV Program at: <http://www.discoverbcfs.net/NetCommunity/Page.aspx?&pid=988>

COLLEGE TUITION AND FEE WAIVER-Texas Law (Sec. 54.366 and 54.367-Texas Education Code (2009): The college tuition and fee waiver provides exemptions from payment of tuition and fees at Texas' **state supported institutions** of higher education to individuals formerly in Texas state foster care) and adopted youth. To be exempt from the payment of tuition and fees youth or young adults must have been in DFPS conservatorship. Exemptions occur:

- the day before the student's 18th birthday;
- the day of the student's 14th birthday, if the youth was eligible for adoption (parental rights being terminated) on or after that day;
- the day the student graduated from high school or received the equivalent of a high school diploma;
- if a youth was adopted and the adoption occurred on or after September 1, 2009;
- if permanent managing conservatorship of the youth was granted to a non-parent on or after September 1, 2009; or
- when a student is enrolled in a dual credit course or other course in which the student may earn joint high school and college credit. *Note: Youth enrolled in a dual credit course may access ETV funds to cover certain educational expenses related to college attendance.*

Youth or young adults may also be eligible to enroll in AA-level courses or vocational / certificate courses at their local state supported community colleges. Young adults must be enrolled as an undergraduate **no later than his or hers 25th birthday**.

Adopted youth subject to an adoption assistance agreement that provides monthly payments and Medicaid benefits are also eligible for the college tuition and fee waiver. For these students there is no age limit to enroll in college in order to take advantage of the tuition and fee waiver. http://www.dfps.state.tx.us/handbooks/CPS/Files/CPS_pg_x10300.asp#CPS_10311

TEMPORARY HOUSING ASSISTANCE BETWEEN ACADEMIC TERMS (EFFECTIVE 9/1/2011): Texas' institutes of higher education are required to assist full-time students formerly in DFPS conservatorship or who have been legally emancipated in locating temporary housing between academic terms (Christmas and summer holiday breaks). Students must request the housing assistance and are encouraged to inquire at financial aid offices, student affairs offices, admissions offices, or housing/residence life/residential living offices.

**TEXAS DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES
TRANSITIONAL LIVING SERVICES-Revised NOVEMBER, 2012
BRIEF OVERVIEW OF SERVICES**

BACTERIAL MENINGITIS VACCINE FOR STUDENTS ENTERING POST-SECONDARY EDUCATION (EFFECTIVE 1/2/2012): Students under age 30 entering a Texas institution of higher education must be vaccinated for bacterial meningitis. For DFPS foster youth, payments for doctor's visits and vaccination costs are covered by Texas Medicaid (STAR Health or Traditional); Medicaid for Transitioning Foster Care Youth (MTFCY); or the Former Foster Care Youth in Higher Education (FFCHE) program. Young adults are encouraged to check college admissions policies for more information about vaccination requirements.

HEALTHCARE COVERAGE

MEDICAID FOR TRANSITIONING FOSTER CARE YOUTH (MTFCY) / STAR HEALTH: Provides continuous medical coverage to young adults age 18 to 21 that have aged out of foster care and meet the following eligibility criteria:

- Be between 18 and 21 years of age;
- Aged out of Texas foster care / DFPS custody at age 18;
- Have no other healthcare coverage (private insurance or other category of Medicaid);
- Meet the Texas Department of Human Services (DHS) income and assets guidelines.

Young adults may call the Medicaid Help Desk for replacement MTFCY cards at 1-855-827-3748. To reenroll in MTFCY, the young adult must complete Form 1011 which may be requested by calling 2-1-1 or the form is available at the HHSC website: <http://www.hhsc.state.tx.us/help/healthcare/children.shtml>

STAR Health/Health Passport: For information about STAR Health, to re-enroll in MTFCY and if a young adult wants access to his or hers Health Passport visit www.fostercartx.com. Young adults may contact the regional Well-being specialists as a STAR Health resource contact. More information about STAR Health is available at: http://www.dfps.state.tx.us/Child_Protection/Medical_Services/guide-star.asp

2-1-1 TEXAS: To report any changes to an address or other contact information, young adults must contact **2-1-1** and report calling about Medicaid for Transitioning Foster Care Youth (MTFCY). Young adults may also go to <https://www.yourtexasbenefits.com> to set up an account, update contact information, report changes in his or her case, receive an identification card, or find out about other benefit information. Additionally, **2-1-1** may be contacted for non-medical issues such as applying for food stamps and medical assistance for other members of the family. More information about **2-1-1** may be accessed at <https://www.211texas.org/211/>

FORMER FOSTER CARE IN HIGHER EDUCATION (FFCHE) PROGRAM: SINCE October 1, 2009, the Health and Human Services Commission has offered a state funded, healthcare benefits program to certain former foster care youth. The following criteria applies:

- Be age 21 year or 22;
- Be enrolled in a college or technical school;
- Have been in DFPS foster care at age 18;
- Have no other healthcare coverage; and
- Meet the DHS income and assets guidelines.

To request a FFCHE application, young adults may contact **2-1-1** and request Form H1868 and Form H1870 to be mailed to them or visit the HHSC website and download the forms at: <http://www.hhsc.state.tx.us/help/healthcare/children.shtml>

[HTTP://WWW.DFPS.STATE.TX.US/HANDBOOKS/CPS/FILES/CPS_pg_x10000.asp#CPS_10150](http://www.dfps.state.tx.us/handbooks/CPS/FILES/CPS_pg_x10000.asp#CPS_10150)

OTHER YOUTH/YOUNG ADULT SERVICES

Driver License Fee Waiver (Effective May 2012): Senate Bill 218 (82nd Regular Legislative session), waived driver license fees for youth in DFPS temporary or permanent managing conservatorship and for young adults at least 18 years of age, but younger than age 21, who reside in a DFPS paid foster care placement.

http://www.dfps.state.tx.us/handbooks/CPS/FILES/CPS_pg_x10600.asp#CPS_10642

TEXAS YOUTH HOTLINE is a resource for young adults who are under 21 years of age, including those who have aged out of the foster care system. Youth may contact the statewide hotline at **1-800-210-2278** for telephone counseling, information, and referrals. The hotline can help young adults locate services available in their communities.

TEXAS DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES
TRANSITIONAL LIVING SERVICES-Revised NOVEMBER, 2012
BRIEF OVERVIEW OF SERVICES

TEXAS YOUTH CONNECTION is a website designed with input from youth and young adults and is a resource for youth in the Texas Foster Care system, alumni of foster care seeking general tips and information. This website offers information and resources in education, finances, records, diversity, health, contacts, job links, food, housing, books, stories, Transition Center information, hotlines and other hot stuff. This website is also the location of the National Youth in Transition Database (NYTD) Youth Survey. Check this resource out at: www.texasyouthconnection.org

Texas Youth Connection-FACEBOOK PAGE was launched to provide another source for youth and young adults to find resources, benefits, and other relevant topics such as NYTD updates, accessing current educational and career resources, learning about current trends and fun topics of interest. This page allows DFPS to stay connected with youth and young adults using a popular social media website. The page is located at www.facebook.com/TexasYouthConnection.

Regional and Statewide Youth Leadership Councils (YLC) are comprised of two elected or appointed youth or young adults (ages 16 to 21) per region. These councils address identified issues and formulate recommendations for improving services to children and youth in foster care. YLC's review state policies and programs and provide feedback. Regional YLC activity details are located at www.texasyouthconnection.com under "Events". Benefits of youth participation include:

- Opportunities for Community Services and Outreach projects to support foster youth;
- Advocacy training to ensure the voices of foster youth are heard and incorporated into policy and practice;
- Leadership building skills;
- Planning and facilitating events;
- Learn how to strategically share their story; and
- Developing supportive friendships/caring adults.

ACTIVITIES AND EVENTS FOR YOUTH:

- **PAL PEAKS Camp**-Two, four-day experiential learning camps held annually for children and youth aimed at increasing self-esteem, improving communications, problem-solving, and having fun. The Texas Network of Youth Services (TNOYS) offers the PEAKS Camp through a partnership with DFPS. <http://www.tnoys.org/>
- **PAL Statewide Teen Conference**-Annual three day conference held on a college campus offering workshops for youth that lead to self-sufficiency and independence.
- **PAL College Conference**-Texas A&M Commerce host an annual two day (weekend) conference for youth to learn about and prepare for higher education opportunities.
- **Aging-Out Seminars**: These seminars are provided to youth ages 15½ to 18 in two (2) separate tracks before they leave care. Seminars include topic areas identified by youth to reinforce their knowledge and skills about DFPS programs, benefits, resources and other Life Skills topics. These seminars build on information from PAL Life Skills Training classes.
- **Statewide Youth Leadership Councils (Youth Advisory Boards)-Regional Activities**-Some regions may host regional Teen Conferences (based on fund availability) and other activities to help youth/young adults prepare to transition to adulthood and to provide leadership opportunities.

OTHER RELATED INFORMATION:

Transition Centers provide a central clearinghouse of one-stop services to serve the diverse needs of current and former foster youth, homeless youth, or other at-risk youth. Services may include employment assistance, educational support, access and referrals to community partners and resources and various transitional living services such as PAL classes, food and housing assistance, and substance abuse / mental health counseling. Transition Centers also provide co-location opportunities for local partners such as local Workforce Solutions offices, and community colleges and universities to jointly serve the diverse needs of the youth in one location. There are currently 16 Transition Centers which are independently funded, operated and supported by partnerships between DFPS, their Providers, community partners and the Texas Workforce Commission. A list of these Centers with contact information is available under the "Resources" tab at: www.texasyouthconnection.org

Texas Workforce Commission/Local Workforce Boards Partnership: DFPS regional offices and 28 local Workforce Development Boards have jointly developed and entered into Memoranda of Understandings (MOU) addressing the unique challenges facing current and former foster youth transitioning to independent living, including improving employment outcomes for these youth. The purpose of the MOU relates to:

- Furthering the objectives of the DFPS Preparation for Adult Living (PAL) program;
- Ensuring services are prioritized and targeted to meet the needs of current and former foster youth; and
- Making referrals, where feasible, for short term housing for foster youth who need housing.

TEXAS DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES
TRANSITIONAL LIVING SERVICES-Revised NOVEMBER, 2012
BRIEF OVERVIEW OF SERVICES

DFPS staff, caregivers, and PAL contractors refer youth ages 16 and older to local Workforce Solutions offices for job search and readiness assistance, career exploration, and job placement services. Each Board has designated a point of contact for staff and youth to access for assistance and services. Additionally all youth and young adults are encouraged to register in the state job search system- www.WorkInTexas.com

National Youth in Transition Data Base (NYTD): NYTD is a data collection system created to track independent living services and to learn how successful states are in preparing youth to move from state care into adulthood. Texas will survey youth in foster care when they turn age 17 and will conduct follow-up surveys of some of these same youth at age 19 and again at age 21. From October 1, 2012 through September 30, 2013, a follow up survey will be conducted on some of the 19 year olds who were surveyed when they were age 17.

Youth Specialists (alumni of foster care) have been hired as full time DFPS employees in each region of Texas. Youth Specialists and their supervisors play a key role in the development and support of Youth Leadership Councils, ensure that the voices of foster youth are heard, and engage foster youth in advocating activities. Youth specialists also serve to help strengthen and support CPS casework by informing DFPS of initiatives and activities affecting policy and practice. A list of regional Youth Specialists is available at: http://www.dfps.state.tx.us/txyouth/contacts/youth_specialists.asp

Employment Preference to Former Foster Youth- Texas Government Code 672.002 (2009) requires state agencies to give an employment preference to former foster youth who were in the permanent managing conservatorship of DFPS on the day preceding the young adult's 18th birthday over other applicants for the same position who do not have a greater qualification. An individual is entitled to an employment preference only if the young adult is 25 years of age or younger (day before turning 26). PAL staff provide the employment preference letter to eligible young adults when they turn 18 or upon request.

Provision of Personal Documents to Youth/Young Adults (Ages 16 and 18):

Age 16-Youth in DFPS conservatorship on or before they turn age 16 must be provided with a:

- Certified copy of the youth's birth certificate;
- Social Security card or replacement Social Security card, as appropriate; and
- Personal identification certificate/card issued by the Texas Department of Public Safety (DPS).

Age 18-Young Adults discharged from foster care or are legally emancipated will receive:

- A certified copy of his or her birth certificate;
- A Social Security card or a replacement Social Security card;
- A personal state identification certificate/card issued by DPS;
- Immunization records;
- Information contained in the youth's health passport;
- Proof of enrollment in Medicaid, if appropriate; and
- Medical Power of Attorney Information-Forms 2559 [A](#) and [B](#)
- *Almost 18 Letter* and Youth Transition Portfolio

http://www.dfps.state.tx.us/handbooks/CPS/Files/CPS_pg_x10000.jsp#CPS_10130

ⁱ DFPS does not control or guarantee the accuracy, relevance, timeliness or completeness of this outside information. Further, the inclusion of references to particular materials and/or of links to particular organizations or sites is not intended to reflect their importance, nor is it intended to endorse any views expressed, or products or services offered on these outside sites, or the organizations sponsoring the sites.

Advocacy



*“If we don’t stand up for children,
then we don’t stand for much”*

~ Marion Wright Edelman



ADVOCACY

Advocacy Tip Sheet

Before you visit

- What are your child's needs? Why was this RTC facility chosen for your child's particular needs?
- Did your child have an admission interview?
- Ask for written information about the RTC rules and procedures regarding visits, phone calls, meals, behavior management, crisis intervention, physical restraints, seclusion, safety, participation in religious services, activities after school or evenings, medical and therapeutic services.
- Does the RTC have an on-site campus school or do children in the RTC go to public school? If there is an on-site campus school, can children, if it is in their educational best interests, attend a public school?
- Review the RTC website for information
- What does the RTC know about CASA and CASA's roles and responsibilities?

About the Facility

- Ask how many children are currently in the facility? What is the total number of children that can legally reside in the facility?
- What are the training and credentials of the staff?
- What is the turnover of staff?
- Is there a RTC person(s) to contact for treatment, educational, financial, or administrative questions?
- If your child has allergies or other serious medical issues, what precautions or accommodations will be made?
- How are medical emergencies handled?
- Does the facility provide trauma informed care?

About Treatment

- What is the model of treatment?
- What is the typical length of treatment at this facility?
- How does the RTC administer and assess the effectiveness of psychiatric medications? How and when will you be informed about changes in your child's medication?
- What therapy services are provided?
- How will you be able to talk to your child's treatment team? And receive reports about treatment?
- What does a child's daily schedule look like?
- What life skills are taught and how? For example, if the youth is older, will he or she learn to do his or her laundry, budget money, participate in PAL classes, etc?

Contact with child

- Will you be allowed to make unannounced visits?
- How can you contact by phone? Email? In person?
- How will school and RTC staff communicate with you?
- How are parents, siblings involved? Are visits allowed with family members, siblings?
- How does the RTC support a child's participation in court reviews and permanency planning?

- Can you volunteer to help your child or assist in other ways?

During your visit

- Ask for a written copy of the RTC policies and procedures. See if this information is consistent with what you observe or hear.
- Try to visit when children and youth are at the RTC and engaged in their typical routines. Observe interactions between the staff and children.
- Ask for a tour of the building or unit where your child would most likely reside.
- Talk to a staff member who regularly works in that residence.

Behavioral and crisis management

- RTC's are required to develop an individual treatment plan that details the child's goals, progress and how crisis and problems will be handled.
- Ask to review your child's individual treatment plan.
- Ask how your child's plan will be individualized and what behavior reinforcements and age-appropriate consequences might be used.
- Ask about physical restraint and seclusion policies. Ask to see the seclusion room, if used.
- Ask if you will be informed if physical restraint or seclusion is used with your child.
- How are disagreements or problems (grievances) between youth and staff handled? What is the grievance procedure if youths have a complaint?

Education

- Where will your child attend school?
- Is the school able to provide the educational services that are prescribed by your child's IEP?
- If your child has an ARD or IEP how you are notified? Who will serve as the surrogate parent for ARD meetings?
- How do the school staff and RTC staff communicate, and how often? Are there regular meetings to share information?
- If youth is older, ask that he or she be prepared to pursue his or her goals, such as college or technical school?

Cultural Sensitivity

- How does the RTC understand and address cultural, race & ethnicity, sexual orientation and religious differences?
- Does the RTC staff have experience working with children similar to your child?
- Does the staff receive training in cultural sensitivity and diversity?
- Will your child be a minority in the RTC? If so, how will the RTC address that?

After your visit?

- Document your visit.
- Review any reports or written materials you collected.
- Ask yourself, if you feel your child is making progress?
- Document any concerns. Address concerns.
- Talk with others on the child's case and share pertinent information.

It is important to stay engaged with the RTC staff about your child or youth. Do not hesitate to ask questions. Ask questions frequently. Keep in consistent contact with your child or youth.

BUILDING RAPPORT WITH YOUR CHILD OR YOUTH WHILE IN AN RTC

Visiting Children and Youth at the RTC

Children and youth often feel rejected or forgotten while in a residential treatment center. Visit, email, send cards, and write to your child or youth as often as possible. These children need for you to stay actively involved in his or her lives, education and treatment.

Every residential treatment center has its own visiting policies. Ask for a written copy of the visiting policy. Be wary of RTC's that have arbitrary visitation rules, such as not allowing any visits, or cancelling visits without a clear reason.

Visits allow you to spend time together and provide support and motivation. Visits help you develop relationships and trust.

Telephone calls

You should ask about the phone use guidelines. Ask if there is a policy about phone calls being monitored and if calls are monitored, by whom and when would this be necessary. Ask if you would be notified in advance if the call was being monitored?

The importance of consistent phone calls between you and the child cannot be underestimated. Messages of hope and caring can be conveyed through consistent phone calls. Try to schedule these calls during a time that is good for your child with as few distractions as possible.

Family and sibling visits

Ask about the RTC's family visitation policy, including restrictions and frequency. Visits with family members including siblings can nurture family bonds and smooth your child's or youth's transition back to a less restrictive environment or home. Be aware that sometimes visits with family members can also be stressful, and may require preparation and safeguards.

Find out if visits will be supervised or if visits can happen off-site. Off- site family visitation can provide valuable information to the treatment team about the child's or youth's ability to function and cope outside of a restrictive environment.

Engagement Tips

The Florida GAL Program Scorecard initiative - "A Voice Heard" shares critical concerns that young people feel are important. From their voices, the Florida GAL report identifies four issues of paramount concern:

Person Interest: Caring, concern and emotional support

Advocacy: Judicial, educational and situational

Communication: Talking, listening and understanding

Trust: Responsiveness, honesty and reliability

Children and youth in residential treatment facilities are identified as having many needs, intensive needs, specialized needs, and many issues to address by those involved in their care and advocacy. It is, however, also important to remember they most likely share the same wishes identified by youth in this report. CASA and all advocates and care givers and providers are encouraged to seek ways to engage and seek to provide to youth in RTC settings these supports.

For a report on this scorecard and effectiveness and outcome measures go to:
<http://www.guardianadlitem.org/Documents/Scorecards>





Commissioner
John J. Specia, Jr.

TEXAS DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES

Rights of Children and Youth in Foster Care

As a child or youth in foster care:

1. **I have the right to** good care and treatment that meets my needs in the least restrictive setting available. This means I have the right to live in a safe, healthy, and comfortable place. And I am protected from harm, treated with respect, and have some privacy for personal needs.
2. **I have the right to** know:
 - Why am I in foster care?
 - What will happen to me?
 - What is happening to my family (including brothers and sisters) and how CPS is planning for my future?
3. **I have the right to** speak and be spoken to in my own language when possible. This includes Braille if I am blind or sign language if I am deaf. If my foster parents do not know my language, CPS will give me a plan to meet my needs to communicate.
4. **I have the right to** be free from abuse, neglect, exploitation, and harassment from any person in the household or facility where I live.
5. **I have the right to** fair treatment, whatever my gender, gender identity, race, ethnicity, religion, national origin, disability, medical problems, or sexual orientation.
6. **I have the right to** be free of any harsh, cruel, unusual, unnecessary, demeaning, or humiliating punishment. This includes not being shaken, hit, spanked, or threatened, forced to do unproductive work, be denied food, sleep, access to a bathroom, mail, or family visits. No one will make fun of me or my family or threaten me with losing my placement or shelter.
7. **I have the right to** be disciplined in a manner that is appropriate to how mature I am, my developmental level, and my medical condition. I must be told why I was disciplined. Discipline does not include the use of restraint, seclusion, corporal punishment, or threat of corporal punishment.
8. **I have the right to** attend my choice of community, school, and religious services and activities (including extracurricular activities) to the extent that is right for me, as planned for and discussed by my caregiver and caseworker, and based on my caregiver's ability.
9. **I have the right to** go to school and get an education that fits my age and individual needs.
10. **I have the right to** be trained in personal care, hygiene, and grooming.
11. **I have the right to** comfortable clothing similar to clothing worn by other children in my community.
12. **I have the right to** clothing that does a good job of protecting me against natural elements such as rain, snow, wind, cold, sun, and insects.

13. **I have the right to** have personal possessions and gifts at my home and to get additional things within reasonable limits, as planned for and discussed by my caregiver and caseworker, and based on caregiver's ability
14. **I have the right to** personal space in my bedroom to store my clothes and belongings.
15. **I have the right to** healthy foods in healthy portions proper for my age and activity level.
16. **I have the right to** good quality medical, dental, and vision care, and developmental and mental health services that adequately meet my needs.
17. **I have the right to** not take unnecessary or too much medication.
18. **I have the right to** be informed of emergency behavioral intervention policies in writing. I have the right to know how they will control me if I cannot control my behavior. To know how they will keep me and those around me safe.
19. **I have the right to** live with my siblings who are also in foster care. If I am not living with my siblings, I have the right to know why. If there are no safety reasons why I cannot live with my siblings, it is my caseworker's job to try to work hard to find a home where I can live with my siblings.
20. **I have the right to** visit and have regular contact with my family, including my brothers and sisters (unless a court order or case plan doesn't allow it) and to have my worker explain any restrictions to me and write them in my record.
21. **I have the right to** contact my caseworker, attorneys, ad litem, probation officer, court appointed special advocate (CASA), and Disability Rights of Texas at any time. I can communicate with my caseworker, CASA, Disability Rights of Texas, or my attorney ad litem without limits in private.
22. **I have the right to** see my caseworker at least monthly and in private if necessary.
23. **I have the right to** actively participate in creating my plan for services and permanent living arrangements, and in meetings where my medical services are reviewed, as appropriate. I have a right to a copy or summary of my plan and to review it. I have the right to ask someone to act on my behalf or to support me in my participation.
24. **I have the right to** go to my court hearing and speak to the judge.
25. **I have the right to** speak to the judge at a court hearing that affects where I am living including status hearings, permanency hearings, or placement review hearings.
26. **I have the right to** expect that my records and personal information will be kept private and will be discussed only when it is about my care.
27. **I have the right to** have contact with persons outside the foster care system. These visitors can be, but are not limited to, teachers, church members, mentors, and friends.
28. **I have the right to** have privacy to keep a personal journal, to send and receive unopened mail, and to make and receive private phone calls unless an appropriate professional or a court says that restrictions are necessary for my best interests.
29. **I have the right to** be informed of search policies. I have the right to be told if certain items are forbidden (or I am not allowed to have them) and why. If my belongings are removed, it must be documented.

- 30. **I have the right to** have possession of my personal earnings and to get paid for any work done, except for routine chores or work assigned as fair and reasonable discipline.
- 31. **I have the right to** give my permission in writing before taking part in any publicity or fund raising activity for the place where I live , including the use of my photograph.
- 32. **I have the right to** refuse to make public statements showing my gratitude to a foster home or agency.
- 33. **I have the right to** receive, refuse, or request treatment for physical, emotional, mental health, or chemical dependency needs separately from adults (other than young adults) who are receiving services.
- 34. **I have the right to** call the Texas Abuse/Neglect Hotline at 1-800-252-5400 to report abuse, neglect, exploitation, or violation of personal rights without fear of punishment, interference, coercion, or retaliation.
- 35. **I have the right to** complain to the DFPS Consumer Affairs Office at 1-800-720-7777 and/or Disability Rights of Texas at 1-800-252-9108 if I feel any of my rights have been violated or ignored. I cannot be punished or threatened with punishment for making complaints, and I have the right to make an anonymous complaint if I choose.
- 36. **I have the right to** be told in writing of the name, address, phone number and purpose of the Texas Protection and Advocacy System for disability assistance.
- 37. **I have the right to** not get pressured to get an abortion, give up my child for adoption, or to parent my child, if applicable.
- 38. **I have the right to** hire independent mental health professionals, medical professionals, and attorneys at my own expense.
- 39. **I have the right to** understand and have a copy of the rights of children and youth in foster care.

Child / Youth Signature

_____ Date _____

Caregiver Signature

_____ Date _____

DFPS Caseworker

_____ Date _____

Rights of Youth 16 and Older in Foster Care

When I am age 16 year of age or older in foster care:

1. **I also have the right to** attend Preparation for Adult Living (PAL) classes and activities as appropriate to my case plan.
2. **I also have the right to** a comprehensive transition plan that includes planning for my career and help to enroll in an educational or vocational job training program.
3. **I also have the right to** be told about educational opportunities when I leave care.
4. **I also have the right to** get help in obtaining an independent residence when aging out.
5. **I also have the right to** one or more Circle of Support Conferences or Transition Planning Meetings.
6. **I also have the right to** take part in youth leadership development opportunities.
7. **I also have the right to** consent to all or some of my medical care as authorized by the court and based on my maturity level. For example, if the court authorizes, I may give consent to:
 - Diagnose and treat an infectious, contagious, or communicable disease.
 - Examine and treat drug addiction.
 - Counseling related to preventing suicide, drug addiction, or sexual, physical, or emotional abuse.
 - Hospital, medical, or surgical treatment (other than abortion) related to pregnancy if I am unmarried.

If I consent to any medical care on my own, without the court or DFPS involved , then I am legally responsible for paying for my own medical care.

8. **I also have the right to** request a hearing from a court to determine if I have the capacity to consent to medical care (Sec 266.010).
9. **I also have the right to** help with getting my driver's license, social security number, birth certificate, and state ID card.
10. **I also have the right to** seek proper employment, keep my own money, and have my own bank account in my own name, depending on my case plan and age or level of maturity.
11. **I also have the right to** get necessary personal information within 30 days of leaving care, including my birth certificate, immunization records, and information contained in my education portfolio and health passport.

Youth Signature _____ Date _____

Caregiver Signature _____ Date _____

DFPS Caseworker _____ Date _____

INDIVIDUAL SERVICE PLAN REVIEW

Sample Plan

Advocates should use a child's Individual Treatment Plan to advocate for their needs.

Child's Name: _____ DOB: _____ Age: _____
Placement Date: _____

Date of Placement

Case Manager:

Child Care Services Only: Transitional Services:

Treatment Needs: PMN ED MR PDD

Managing Conservator: TDFPS Juvenile Probation

Worker/Officer Name: _____ County: _____

PERMANENCY PLAN

Estimated length of stay, expected outcomes and discharge plan: Six month to a year in foster care

What is the court directed permanency plan? Return to family Adoption
 Independent Living APS

FAMILY CONTACT

The treatment team will support and collaborate with managing conservator on the family contact plan, including sharing information and feedback. We will be sensitive to the child's feelings about family contact and will provide assistance to child.

Review family contact since last ISP:

Does the child want contact with family? Yes No

If yes, with whom?

Is the child permitted by court to have contact with family? Yes No

If there is contact, what is the family contact plan and how will we help with this plan?

STRENGTHS

Describe the child's unique strengths, abilities, talents, personality, and goals:

TREATMENT NEEDS AND PLAN

Behavioral/Social Background

Review child’s target behaviors, interactions with peers and adults, participation in school and recreation activities, physical limitations, and other challenges which have prevented the child’s success over the last reporting period. The following section is designed to provide a snapshot of the child’s current functioning.

Behavior and Personality:

Developmental and/or Medical Status:

Review Core Issues and Interventions for reporting period:

Goals:

The child’s success on each target behavior this reporting period is measured using the following scale:

- 3 Objective/need achieved and maintained
- 2 Substantial improvement in identified objective/need
- 1 Some improvement in identified objective/need
- 0 No decline or improvement in identified objective/need
- 1 Some worsening in identified objective/need
- 2 Substantial worsening in identified objective/need

*Note: After child achieves “3” on one reporting period, the target behavior will be accomplished.

Target Behaviors:

Target Behavior 1:

Review of Target Behavior During Past Reporting Period:



Target Behavior 2:

Review of Target Behavior During Past Reporting Period:



Target behaviors accomplished including dates achieved:

If there is no progress in meeting the child’s needs, document the justification for maintaining placement.

New Target Behaviors:

- 1.
- 2.

Ways Child Will Achieve Success

Ways Adults Will Help Child Achieve Success

- 1.
- 2.

- 1.
- 2.

BASIC NEEDS

We will provide all children with nutritionally balanced diets, minimum of one nutritional snack per day, adequate seasonal wardrobes, safe environment, adequate supervision and appropriate individual living space. We will be respectful of and sensitive to the child’s cultural and spiritual needs.

Are there any changes or additional needs? Yes No

If yes, explain:

What are the child’s cultural needs and how will these be met?

Is the child involved with a church? Yes No

If so, describe the activities and frequency:

SUPERVISION PLAN/CONCERNS

Children will wear seatbelts when transported, and staff will ensure safety rules are followed. All overnight visits will be approved in writing prior to the visits.

Review of supervision plan since last ISP:

<u>Safety and Supervision Concerns</u>	<u>How Staff Will Carry Out Supervision Plan and Reduce Need for Personal Restraint</u>
1.	1.

DISCIPLINE PLAN

THERE IS TO BE NO FORM OF PHYSICAL DISCIPLINE USED ON CHILDREN IN CARE.

Behavior management techniques used this reporting period:

Which techniques are successful with this child, and will be continued when rules are broken?

Have emergency behavior interventions been used this reporting period? Yes No

If yes, describe the type, frequency and effectiveness of the intervention:

Describe strategies which will reduce the need for emergency behavior interventions:

MEDICAL AND DENTAL

Allergies:

Height:

Weight:

<u>Medical Diagnoses for Chronic Health Problems</u>	<u>Family Care Plan</u>
1.	1.
2.	2.
3.	3.
4.	4.

Has there been a change in the Professional Services Plan? Yes No

If yes, revise and attach new plan

Comment on any special medical issues or concerns from this past reporting period:

<u>Medical and Dental Services Needed</u>	<u>Date Scheduled</u>
1.	1.
2.	2.
3.	3.
4.	4.

RECREATION

Review of child's recreational, leisure and social activities, success, and needs:

<u>Planned Recreation Activities</u>	<u>Child's Responsibilities</u>	<u>Adult's Responsibilities</u>
1.	1.	1.
2.	2.	2.

EDUCATION

Name of School:

Contact Person:

Current Grade Level:

Phone Number:

Limits in child's English speaking proficiency:

Tutoring plan:

Is child in special education? Yes No

If yes, what are the IEP goals and special services provided by the school?

Classes and grades for this reporting period:

Date and content of school contact:

School behavior and disciplinary action:

Review strategies since last ISP:

If child is not on target to complete high school, describe interventions and resources being utilized to help child remain in school:

Discuss child's post high school graduation plans and how we are working toward that goal:

Ways Child Will Achieve Success	Ways Staff Will Help Child Achieve Success
1.	1.
2.	2.

LIFE SKILLS AND PREPARATION FOR INDEPENDENT LIVING

Is child age 13 or older? Yes No

If so, include appropriate assessment and strategies:

If the child has a Transitional Plan completed by the Circle of Support Team, include specific goals from that plan:

Review strategies since last ISP:

Ways Child Will Achieve Success	Ways Adults Will Help Child Achieve Success
1.	1.

EMOTIONAL AND DEVELOPMENTAL

Does child have a current psychological or developmental assessment? Yes No

Diagnosis from psychological evaluation completed by _____ on _____

- Axis I.
- II.
- III.
- IV.
- V.

Does child have a current working psychiatric evaluation? Yes No

Diagnosis from psychiatric evaluation completed by _____ on _____

Axis I.

II.

III.

IV.

V.

Does child have physical or medical disabilities? Yes No

If yes, do we have a current assessment and recommendation for physical, occupational or speech therapy: Yes No Explain if necessary:

Is child receiving treatment services for mental retardation? Yes No

If yes, describe the plan for how the child will receive one hour daily of visual, auditory and tactile stimulation:

Therapy Plan:

Emotional Assessment Scale: Please insert the appropriate numerical response beginning with 1—indicating does not apply to child at all up to 5—indicating very much applies to child.

I. Environment, health, or personal conditions		Score
1.	Death or terminal illness of relative or friend	
2.	Separation, broken relationship, stress on family	
3.	Frequent complaints of physical symptoms such as stomachaches, headaches, or fatigue	
4.	Use of alcohol or drug abuse	
5.	Depression (may be masked by hyperactivity or acting out behavior)	
6.	Suicide or attempt of an acquaintance, friend or family member	
7.	Victim of abuse or neglect	
II.	Emotional and behavior changes associated with suicide	(Leave 0 here) 0
1.	Withdrawn, tired, apathetic, anxious, irritable	
2.	Declining performance in school, work or other activities	
3.	Declining interest in friends or activities previously enjoyed	
4.	Neglect of personal and physical appearance	
5.	Change in sleeping patterns	
6.	Change in appetite or eating habits	
7.	Lack of energy	
8.	Tearful sadness	

9. Guilt	
10. Impulsivity	
11. Inability to carry out normal tasks of daily life	
12. Sudden cheerfulness or unexpected happiness	
III. Suicidal Behavior	(Leave 0 here) 0
1. Preoccupation with themes of death (artwork/drawings, poetry, essays)	
2. Explicit statements of suicidal ideation or feelings	
3. Development of suicidal plan, acquiring the means, "rehearsal" behavior, setting a time for the attempt	
4. Self-inflicted injuries, such as cuts, burns or head banging	
5. Reckless behavior (increased thrill seeking and risky behaviors)	
6. Giving away favorite possessions	
7. Inappropriately saying goodbye	
8. Previous suicide attempt or ideation	
9. Making arrangements; setting one's affairs in order; making a will	
10. Ending significant relationships	
11. Hospitalized for depression or suicide attempts/ideation	

Total Score:

30-59 Low Risk 60-89 Low Moderate Risk 90-119 High Moderate Risk 120-150 High Risk

Plan for addressing risk factors:

Recommendations from evaluations and clinical staffings:

CHILD CARE PLAN

Is the child care plan current and accurate? Yes No

If no, revise and attach new plan

ISP DEVELOPMENT AND DISTRIBUTION

ISP meeting held on _____
Date

Copies of ISP Sent To:

- | | | | |
|--|--|---|--------------|
| <input type="checkbox"/> Managing Conservator | <input type="checkbox"/> Mailed | <input type="checkbox"/> Delivered | Date: |
| <input type="checkbox"/> Foster Family | <input type="checkbox"/> Mailed | <input type="checkbox"/> Delivered | Date: |
| <input type="checkbox"/> Therapist | <input type="checkbox"/> Mailed | <input type="checkbox"/> Delivered | Date: |
| <input type="checkbox"/> Other | <input type="checkbox"/> Mailed | <input type="checkbox"/> Delivered | Date: |

(include name and address)

- | | | | |
|---------------------------------------|--|---|--------------|
| <input type="checkbox"/> Other | <input type="checkbox"/> Mailed | <input type="checkbox"/> Delivered | Date: |
|---------------------------------------|--|---|--------------|

(include name and address)

This treatment plan has been developed with the child's participation, and a copy is available for his/her review upon request. If the child wants a copy, a plan will be developed to keep the ISP in a secure place where it will remain confidential.

Persons Participating in the Plan and Date of the Participation

Child's Name

Foster Child

(Reason for Absence):

Date

Case Manager

(Reason for Absence):

Date

Managing Conservator Representative

(Reason for Absence):

Date

CASA

(Reason for Absence):

Date

AAL

(Reason for Absence):

Date

Therapist

(Reason for Absence):

Date

Psychologist

(Reason for Absence):

Date

Psychiatrist

(Reason for Absence):

Date

Child Placement Management Staff

Date

Registered Nurse (PMN)

Date

Approved by:

Clinical Director/Treatment Director

Date

A JUDGE SPEAKS

Please read from excerpts taken from the National CASA Judge's Page article by Judge Susan B. Carbon, Supervisory Judge, Concord Family Division, NH Past President, National Council of Juvenile and Family Court Judges

What do I expect from the CASA/GAL volunteer in fulfilling his/her role?

- 1. I want a CASA volunteer who really knows the child/teen. This means developing a level of trust and respect, something which isn't done easily, nor quickly.*
- 2. I want the volunteer to know what the child wants and what may be in the child's best interests; to clearly understand if there is a difference, and if so to articulate it.*
- 3. I want the volunteer to understand the parents, their limitations, their potential, and how they are progressing towards reunification (assuming the child has been removed). This helps put the child's wishes and needs in context.*
- 4. I want the volunteer to have spoken with the child protection agency, school and service providers to be able to make independent assessments of progress all around. This enables them to identify gaps, and commend progress.*
- 5. I want the volunteer to be well prepared for the hearing, meaning his/her report is filed on time, and he/she has reviewed all other reports and is prepared to comment in court.*
- 6. I want the volunteer to be confident enough to compliment those who are doing well (parents, child protection agency, service providers, child), and offer constructive criticism for those who are not.*
- 7. I want the volunteer to understand what needs to happen at each hearing so that reports and remarks are tailored to the decisions that must be made.*
- 8. I want the volunteer to empower the child/teen to speak for her/himself; even though the CASA volunteer is the voice of the child, the child's voice should be heard directly if the child so wishes.*
- 9. I want the volunteer to be there for the child from start to finish, so that the child will know he/she is not expendable, and that reliance and consistency mean something.*
- 10. I want the volunteer to hold everyone, including the judge, accountable so that every hearing has a purpose and is time well spent.*
- 11. Finally, I really like it when the volunteer brings a new photo to each hearing. It reminds me that the child's life is ticking by so quickly.*

As I write and reflect, this seems to be a huge load, and yet time and again, our very well trained CASA volunteers come through. We have an amazing group here, all of whom are respectful, courteous, knowledgeable, compassionate and well-grounded. Our kids benefit from their competence and preparation. We rarely have a hearing that was not helpful in moving issues forward. To the contrary, they are purposeful and productive due in part to the CASA volunteers. They support the kids in ways some parents never have, and they never give up on the kids. They guide them, support them, and stand by them, allowing the kids to flex their wings, but they are there to make sure they won't be hurt in the process; most have suffered enough hurt already.

One of my CASA volunteers told me that the child he was assigned to told him he thought the CASA volunteer was the judge. Given all that I expect, and receive, from my CASA volunteers, I took this remark as a compliment! So did he.

For children and Youth in a RTC Setting “minimum” may not be enough. These children identified as needing intensive interventions and restrictive environments need powerful advocacy and our very best efforts and services on their case.

MINIMUM EXPECTATIONS OF SERVICE TO A CASE

Texas CASA Standards

Standard 5: Volunteer Management

1. CASA Will:

- a. In a timely manner after appointment, obtain first hand a clear understanding of the needs and situation of the child by reviewing all relevant documents and records and interviewing the child, parents, social workers, teachers and other persons to determine the facts and circumstances of the child’s situation.
- b. Maintain confidentiality of all issues and records of the case, returning all case files to the CASA program after the case is closed.
- c. Notify all parties to the case of CASA’s appointment.
- d. Communicate with the DFPS caseworker after appointment and at least one time per month for the duration of the case.
- e. Meet the child(ren) in a timely manner after appointment and meet in person with the child(ren) at least one time per month.
 - i. If the child(ren) are placed one to three driving hours away, then CASA will meet in person with the child(ren) at least once every three months.
 - ii. If the child(ren) are placed more than three driving hours away, then CASA will meet in person with the child(ren) at least once every six months.
- f. Have other types of age appropriate contact with the child(ren) including telephone calls, emails, and/or letters as applicable for the child’s age and interests.
- g. Meet in person with the child’s primary placement provider in a timely manner after placement occurs, and communicate with the placement provider at least once a month thereafter for the duration of the assignment of the child’s case.
- h. Advocate for the child(ren)’s best interest in the community by interfacing with mental health, medical, legal, educational and other community systems to assure that the child(ren)’s needs in these areas are met.
 - i. Determine if a permanent plan, an educational passport, and a medical passport has been created for the child(ren).
- j. Participate in all scheduled case related meetings.

- k. Seek cooperative solutions by acting as a facilitator among parties maintaining communication with the child(ren)'s parents, family members, attorney ad litem, teachers, and other service providers as applicable.
- l. Appear at all hearings to advocate for the child(ren)'s best interest and permanency. Provide testimony when necessary, making recommendations for specific appropriate services for the child and when appropriate, the child's family. Provide written court reports for all permanency and review hearings.
- m. On each case, assigned CASA staff and CASA volunteers will communicate at least once a month so as to update records and contact logs and participate together in scheduled case conferences.
- n. Inform the court promptly of important developments in the case through appropriate means as determined by court rules and statute.
- o. Monitor implementation of service plans and court orders assuring that court-ordered services are implemented in a timely manner and that review hearings are held in accordance with the law.

Placing Children and Youth in a RTC Setting

Current Practices

Considerations for Best Practices and Advocacy

Most RTC placements are not the result of proactive triage or diagnostic assessment recommendations. Usually placement in a residential treatment center for DFPS children and youth generally indicates that least restrictive placement has failed. That failed placement usually originates in family based settings such as reunification, kinship, foster care or adoption. Placement in a residential treatment may also mean a child/youth is moving as a result of disruptions that led to temporary stays in respite care, shelters, detention or psychiatric hospitalization. Placement may also be the result of traumatic events such as a serious episode of maladaptive behavior in the family, school or community setting. This can begin with a suicidal gesture or ideation, aggression, property destruction, delinquent or illegal activity, runaway or sexual acting out.

A consideration for best practice would be that before a referral to an RTC setting, other alternatives to maintain stability in the current setting are carefully and thoughtfully considered. In general all placement decisions should not be reactionary but should be carefully made with the long term goals of safety, well being and permanency that nurture safe, healthy, connected relationships that last a lifetime. Failing placements should be thoroughly discussed and debriefed to determine how to meet a child's needs before the next placement is chosen. Consideration of RTC placement is indicative of problems that have reached a threshold that might preclude living in a family and community based setting. It is assumed that a child/youth will be in a more safe, structured and therapeutic environment in an RTC. However, if careful consideration, assessment and planning is not done in the selection of a placement, RTC or other, this may not always be the case.

Placement in an RTC should be part of a continuum of care. Decisions made in crisis have great potential to lead to more crisis. Permanency planning, concurrent planning and case management should address presenting problems but remain focused on long term outcomes. **It is important to identify the goals and expectations that would lead to a successful discharge and outcome from an RTC before placement.** If our expectation is that a youth will learn to succeed in public school and earn enough credits to graduate on schedule we need to make sure the RTC has the resources and programing to deliver that outcome. A critical component to well being may be keeping connections to siblings and family stable and viable. Can that be maintained if an RTC is 200 miles away? How will successful transition back to a less restrictive environment - family or community based care be accomplished?

Children with high needs need "fierce advocates". Everyone has a role in being that fierce advocate. We can not get there if we don't know where we are going and we can't give what we don't have.

Transitioning Children and Youth Out of a RTC Setting *Considerations for Best Practices and Advocacy*

Discharge planning is an important component to a successful residential treatment outcome.

It should begin as quickly as possible after admission.

Permanency planning and concurrent planning is crucial. We need to keep focused on the goal of a safe forever family for every child or youth in care. These children and youth need to be building supportive, healthy, stable and enduring relationships that will last a lifetime. Short term and long term goals should be in synch.

We should not ask or expect children and youth to work on goals without giving them a sense of hope, purpose, belonging and worth. They should be empowered to gain the knowledge, confidence, skills and self regard to be successful in a family, a local school and community setting. Youth need to leave a RTC setting with a healthy world view.

Successful transition is predicated on proactive preparation. Youth deserve to know where they are going and who they are going to. They need to know they will be safe, they have a voice, they have power and they have choices. They need to have an understanding of the permanency plan, the concurrent plans toward a goal for them of a forever home and life-long connections and successful adult living.

Successful transitions give youth time to nurture and develop healthy relationships through repeated interactions with caregivers who will support and believe in them. Transition planning, wrap around services and appropriate training and support will more likely ensure caregivers ability to support and nurture children and youth to resilience.

MINIMUM STANDARDS

Minimum Standards for Residential Treatment Centers and all child care facilities can be found on the DFPS website under Child Care Licensing – Standards and Regulations. It is important for advocates to understand both the licensing standards and the contract requirements of child care facilities. Go to the DFPS website, select Child Care Licensing, select Standards and Regulations and scroll down to Minimum Standards for Residential Operations and Child Placing Agencies.

Basic Information:

General Residential Operation (GRO) A residential child-care operation that provides child care for 13 or more children or young adults. The care may include treatment services and/or programmatic services. These operations include formerly titled emergency shelters, operations providing basic child care, operations serving children with mental retardation, and halfway houses.

Residential Treatment Center (RTC) A general residential operation for 13 or more children or young adults that exclusively provides treatment services for children with emotional disorders.

Minimum Standards are weighted based on risk to children – high, medium-high, medium, medium-low, and low. While weights reflect a common understanding of the risk to children presented if a rule is violated, the assigned weights do not change based on the scope or severity of an actual deficiency. Scope and severity are assessed by the Licensing Representative, documented, and considered in conjunction with the standard weights when making Licensing decisions.

Below are excerpts from minimum standards:

Required child-care policies

Policies that describe:

Medium (1) Visitation rights between the child and family members and the child and friends;

Medium (2) The child's rights to correspond by mail with family members and friends, including any policies regarding mail restrictions and receipt of electronic mail;

Medium-Low (3) The child's rights to correspond by telephone with family members and friends;

Medium-Low (4) The child's rights to receive and give gifts to family, friends, employees, or other children in care, including any restrictions on gifts;

Medium-Low (5) Personal possessions a child is or is not allowed to have;

Medium-High (6) Emergency behavior intervention techniques if the use of emergency behavior intervention is permitted in your operation. If its use is not permitted, you must have a policy disallowing its use;

Discipline Policies Discipline policies, including techniques and methods for ensuring the appropriateness of discipline techniques used with a child. These policies and procedures must:

Medium (A) Guide employees in methods used for discipline of a child;

Medium (B) Include measures for positive responses to appropriate behavior;

Medium (C) Make clear that discipline of any type is inappropriate and not permitted for infants; and

Medium (D) Emphasize the importance of nurturing behavior, stimulation, and promptly meeting the child's needs;

Minimum Standards for General Residential Operations

Medium-High (3) The qualifications for caregivers who assume the responsibility for emergency behavior intervention implementation, including required experience and training, and an evaluation component for determining when a specific caregiver meets the requirements of a caregiver qualified in emergency behavior intervention. You must have an on-going program to evaluate caregivers qualified in emergency behavior intervention and the use of emergency behavior interventions;

Medium-High (4) Your requirements for and restrictions on the use of permitted emergency behavior interventions;

Medium-High (A) Post the emergency behavior interventions that you allow in a place where the children and clients can view them, or at admission, provide the children and clients with a personal copy of the operation's emergency behavior intervention policies;

Medium-High (B) During the orientation required in §748.1209 of this title (relating to What orientation must I provide a child?), explain and document the following to a child in a manner that the child can understand:

Medium-High (i) Who can use emergency behavior intervention;

Medium-High (ii) The actions a caregiver must first attempt to defuse the situation and avoid the use of emergency behavior intervention;

Medium-High (iii) The situations in which emergency behavior intervention may be used;

Medium-High (iv) The types of emergency behavior intervention you authorize;

Medium-High (v) When the use of emergency behavior intervention must cease;

Medium-High (vi) What action the child must exhibit to be released from emergency behavior intervention;

Medium-High (vii) The way to report an inappropriate emergency behavior intervention;

Medium (viii) The way to provide voluntary comments on any emergency behavior intervention; and

Medium (ix) The process for making comments on any emergency behavior intervention, such as comments regarding the incident that led to the emergency behavior intervention, the manner in which a caregiver intervened, and the manner in which the child was the subject or to which he was a witness. You may create a standardized form that is easily accessible or give children the permission to submit comments on regular paper; and

Medium-High (C) During the orientation required in §748.1209 of this title obtain each child's input on preferred de-escalation techniques that caregivers can use to assist the child in the de-escalation process;

Medium-High (6) Requirements that caregivers must attempt less restrictive and less intrusive emergency behavior interventions as preventive measures and de-escalating interventions to avoid the need for the use of emergency behavior intervention;

What is a serious incident?

A serious incident is a non-routine occurrence that has or may have dangerous or significant consequences on the care, supervision, and/or treatment of a child.

Reporting Serious Incidents and Other Occurrences

(a) You must report and document the following types of serious incidents involving a child in your care. (see website for complete information in this area)

(1) A child dies while in your care.

(A)(ii) Report as soon as possible, but no later than 24 hours after the incident or occurrence.

(2) A critical injury or illness that warrants treatment by a medical professional or hospitalization, including dislocated, fractured, or broken bones; concussions; lacerations requiring stitches; second and third degree burns; and damage to internal organs.

(A)(ii) Report as soon as possible, but no later than 24 hours after the incident or occurrence.

(3) Allegations of abuse, neglect, or exploitation of a child; or any incident where there are indications that a child in care may have been abused, neglected, or exploited.

(A)(ii) As soon as you become aware of it.

Helpful Information

Regarding subsection (a)(2), not every trip to a hospital or emergency clinic must be reported as a serious incident. Only those incidents involving a "critical injury or illness" must be reported and documented as a serious incident. The rule contains some examples of reportable serious incidents. Visits to the emergency room or emergency clinic (that did not result in hospitalization) for a common illness such as the flu, for a chronic illness such as an asthma attack, or for a routine medical exam would not warrant reporting as a serious incident.

Also, it is the nature of the injury or illness that determines whether it is reportable as a serious incident, not the venue in which it is treated. Taking a child to the emergency clinic or doctor's office for stitches is still reportable as a serious incident, even though the treatment did not occur at an emergency room or hospital.

Regarding children receiving treatment services for primary medical needs, planned admissions to the hospital are not reportable as serious incidents. If the child sustains a critical injury or contracts a critical illness, a serious incident report is required. However, ongoing treatment for the child's chronic illnesses or conditions is not reportable as a serious incident.

In addition, admission to a psychiatric hospital only warrants a serious incident report if the admission is precipitated by a reportable incident, such as a suicide attempt.

How do I make a report of a serious incident or occurrence to Licensing?

Medium (a) All serious incident reports must be made to the Child Abuse Hotline; and

Medium (b) Occurrences that are required to be reported to Licensing in writing must be forwarded to your Licensing representative (See §748.307(2))

How must I document a serious incident?

Medium A serious incident must be documented in a written report that includes the following information:

Medium (1) The name of the operation, physical address, and telephone number;

Medium (2) The time and date of the incident;

Medium (3) The name, age, gender, and date of admission of the child or children involved;

Medium (4) The names of all adults involved and their role in relation to the child(ren);

Medium (5) The names or other means of identifying witnesses to the incident, if any;

Medium (6) The nature of the incident;

Medium (7) The circumstances surrounding the incident;

Medium (8) Interventions made during and after the incident, such as medical interventions, contacts made, and other follow-up actions;

Medium (9) The treating licensed health-care professional's name, findings, and treatment, if any; and

Medium (10) The resolution of the incident.

Children's Rights

Medium-Low (a) A child's rights are cumulative of any other rights granted by law or other Licensing rules.

(b) You must adhere to the child's rights, including:

Medium-High (1) The right to appropriate care and treatment in the least restrictive setting available that can meet the child's needs;

Medium-High (2) The right to be free from discrimination on the basis of gender (if your operation accepts both genders), race, religion, national origin, or sexual orientation;

Medium-High (3) The right to have physical, emotional, developmental, educational, social, and religious needs met;

High (4) The right to be free of abuse, neglect, and exploitation as defined in Texas Family Code, §261.401;

High (5) The right to be free from any harsh, cruel, unusual, unnecessary, demeaning, or humiliating punishment, which includes:

High (A) Shaking the child;

High (B) Subjecting the child to corporal punishment;

Medium-High (C) Threatening the child with corporal punishment;

Medium (D) Any unproductive work that serves no purpose except to demean the child, such as moving rocks from one pile to another or digging a hole and then filling it in;

High (E) Denying the child food, sleep, toileting facilities, mail, or family visits as punishment;

Medium-High (F) Subjecting the child to remarks that belittle or ridicule the child or the child's family; and

Medium (G) Threatening the child with the loss of placement or shelter as punishment;

Medium-High (6) The right to discipline that is appropriate to the child's age and developmental level;

Medium (7) The right to have restrictions or disciplinary consequences explained when the measures are imposed;

High (8) The right to a humane environment, including any treatment environment that provides reasonable protection from harm and appropriate privacy for personal needs;

Medium-Low (9) The right to receive educational services appropriate to the child's age and developmental level;

Medium (10) The right to training in personal care, hygiene, and grooming;

Medium-Low (11) The right to reasonable opportunities to participate in community functions, including recreational and social activities such as Little League teams, Girl Scouts and Boy Scouts, and extracurricular school activities outside of the operation, if appropriate;

Medium (12) The right to have adequate personal clothing, which must be suitable to the child's age and size and comparable to the clothing of other children in the community;

Medium-Low (13) The right to have personal possessions at the child's placement and to acquire additional possessions within reasonable limits;

Medium-High (14) The right to be provided with adequate protective clothing against natural elements such as rain, snow, wind, cold, sun, and insects;

Medium (15) The right to maintain regular contact with family members unless the child's best interest, appropriate professionals, or court necessitates restrictions;

Medium (16) The right to send and receive uncensored mail, to have telephone conversations, and to have visitors, unless the child's best interest, appropriate professionals, or court order necessitates restrictions;

Medium-Low (19) The right to have personal earnings, allowances, possessions, and gifts as the child's personal property;

Medium (20) The right to be able to communicate in a language or any other means that is understandable to the child at admission or within a reasonable time after an emergency admission of a child, if applicable, such as having a plan for an interpreter, having at least one person at the operation at all times who can communicate with the child in the child's own language, or other means to communicate with the child in the child's own language;

Medium-Low (21) The right to confidential care and treatment;

Medium-Low (22) The right to consent in writing before performing any publicity or fund raising activity for the operation, including the use of his photograph;

Medium-Low (23) The right not to be required to make public statements acknowledging his gratitude to the operation;

Medium-High (24) The right not to receive unnecessary or excessive medication;

Medium (25) The right to have a comprehensive service plan that addresses the child's needs, including transitional and discharge planning;

Medium (26) The right to participate in the development and review of the child's service plan within the limits of the child's comprehension and ability to manage the information;

Medium (27) The right to receive emotional, mental health, or chemical dependency treatment separate from adults (other than young adults) who are receiving services;

High (28) The right to receive appropriate treatment for physical problems that affect the child's treatment or safety; and

High (29) The right to report abuse, neglect, exploitation, or violation of personal rights without fear of punishment, interference, coercion, or retaliation.

What right does a child have regarding contact with his parent(s)?

Medium (a) You must allow contact between a child and his parent(s) whose parental rights have not been terminated according to:

Medium-Low (1) Your policies; and

Medium (2) The provisions of a court order or any visitation agreements.

(b) You must document in the child's record:

Medium-Low (1) Any plans for contact between the child and a parent; and

Medium (2) Any decision to limit contact with a parent.

(c) Before the service planning team, treatment director, or professional level service provider can temporarily restrict ongoing contacts or communication between the child and a parent, you must:

Medium-Low (1) Explain the reasons for the restrictions to the child and the child's parent; and

Medium-Low (2) Document the reasons in the child's record.

Medium (d) Restrictions imposed by you that continue for more than 30 days must be re-evaluated monthly by a professional level service provider, who also must:

Medium-Low (1) Explain the reasons for the continued restrictions to the child and the child's parents; and

Medium-Low (2) Document the reasons in the child's record.

Medium-Low (e) If you limit communications or visits with a parent for practical reasons, such as geographical distance

Helpful Information

Although Child Protective Services (CPS) distributes a Bill of Rights to children in CPS conservatorship, you are still required to inform children and parents of the child rights listed in minimum standards. The CPS Bill of Rights does not include all child rights listed in minimum standards and is not intended to meet minimum standards requirements. You are still required to inform children and parents of all child rights listed in the minimum standards.

How must I inform a child and the child's parents of their rights?

Medium (a) Within seven days after you admit a child into your operation, you must review the child's rights with the child and a child's parent, unless the parent's consent is not required. You must

What right to privacy does a child have in his contact with others?

(a) Except as determined by the child's service planning team, treatment director, professional level service provider, or parent, you may not:

Medium (1) Open or read the child's incoming or outgoing mail, including electronic mail, unless necessary to assist the child with reading or writing; or

Medium (2) Listen to or screen the child's telephone calls unless the child needs assistance with using the telephone.

(b) You must document in the child's record:

Medium-Low (1) Any reason for restrictions on the child's mail or telephone calls that you impose; and

Medium-Low (2) A list of the mail or telephone calls that you restrict.

Medium-Low (c) You must inform the child and his parent about restrictions you place on the child.

Medium (d) Restrictions imposed by you that continue for more than 30 days must be re-evaluated monthly by a professional level service provider, who also must:

Medium-Low (1) Explain the reasons for the continued restrictions to the child; and

Medium-Low (2) Document the reasons in the child's record.

Helpful Information

Low (9) The educational program;

Prior to completing a child's initial service plan, the following information must be added to the admission assessment:

Low (1) The child's social history. The history must include information about past and existing relationships with the child's birth parents, siblings, extended family members, and other significant adults and children, and the quality of those relationships with the child;

Low (2) A description of the child's home environment and family functioning;

Low (3) The child's birth and neonatal history;

Medium-Low (4) The child's developmental history;

Medium-Low (5) The child's mental health and substance abuse history;

Low (6) The child's school history, including the names of previous schools attended and the dates the schools were attended, grades earned, and special achievements;

Medium-Low (7) The child's history of any other placements outside the child's home, including the admission and discharge dates and reasons for placement;

Medium-Low (8) The child's criminal history, if applicable;

Medium-Low (9) The child's skills and special interests;

Low (10) Documentation indicating efforts made to obtain any of the information in paragraphs (1)-(9) of this subsection, if any information is not obtainable;

Medium-Low (11) The services you plan to provide to the child, including long-range goals of placement;

Medium-Low (12) Recommendations for any further assessments and testing;

Medium (13) A recommended behavior management plan;

Medium-Low (14) A determination of whether you can meet the needs of the child, based on an evaluation of the child's special strengths and needs; and

Medium-Low (15) A rationale for the appropriateness of the admission.

Medium-Low (d) You must attempt to obtain a signed authorization, so you can subsequently request in writing materials from the child's current or most recent placement, such as the admission assessment, professional assessments, and the discharge summary. You must consider information from these materials when you complete your admission assessment if they are made available to you.

What responsibilities do I have for the education of a child in care?

Low (a) You must arrange an appropriate education for each child, including:

Medium-Low (1) Ensuring the child in care attends an educational facility or program that is approved or accredited by the Texas Education Agency, the Southern Association of Colleges and Schools, the Texas Private School Accreditation Commission or by the out-of-state school district funding the child;

Medium-Low (2) Ensuring a school-age child has the training and education in the least restrictive setting necessary to meet the child's needs and abilities;

Medium-Low (3) Ensuring a child in care attends an educational facility or program that implements a special education student's individual education plan (IEP); and

Medium-Low (4) Advocating that a school-age child receives the educational and related services to which he is entitled under provisions of federal and state law and regulations.

Medium-Low (b) For children receiving treatment services you must designate a liaison between the agency and the child's school.

What are the requirements for a preliminary service plan?

Medium-Low (a) You must complete a preliminary service plan that addresses the immediate needs of a child, such as enrolling the child in school or obtaining needed medical care or clothing, within 72 hours of the child's admission.

(b) In addition, for a child receiving treatment services the preliminary service plan must include:

Medium-Low (1) A description of the child's immediate treatment and care needs;

Medium-Low (2) A description of the child's immediate educational, medical, and dental needs, including possible side effects of medications or treatment prescribed to the child;

Medium-Low (3) A description of how you will meet the child's needs, including any necessary increased supervision or follow-up actions of possible side effects of medication or treatment provided to the child;

Medium (4) The identification of any issues or concerns the child may have that could escalate a child's behavior. Identification of a child's issues or concerns must serve to avoid the use of unnecessary emergency behavior interventions with the child. Child concerns may include issues with food, eye contact, physical touch, personal property, or certain topics; and

Medium-Low (5) A designation of who will be responsible for meeting each of the child's needs.

Medium-Low (c) The plan must be compatible with the information included in the child's admission assessment.

Low (d) You must document the plan in the child's record.

Medium (e) You must inform each professional level service provider and caregiver working with a child about the child's preliminary service plan.

Best Practice Suggestion

It is a good idea to include in service plans specific information about the situations that trigger significant emotional responses for the child (e.g., enclosed spaces, darkness, bedtime), successful intervention strategies to effectively de-escalate those responses, anger and anxiety management options to assist the child in calming, techniques for self-management, and specific goals that address the targeted behaviors that most often lead to emergency behavior interventions for the child

Resources



*“Those who have the privilege to
know have the duty to act”*

~ Albert Einstein

KEY DEFINITIONS

Acute Trauma: “A single traumatic event that is limited in time. An earthquake, dog bite, or motor vehicle accident are all examples are acute traumas” (Child Welfare Committee (CWC)/National Center for Child Traumatic Stress Network (NCTSN) 2008, p. 6).

Chronic Trauma: “Chronic trauma may refer to multiple and varied (traumatic) events such as a child who is exposed to domestic violence at home, is involved in a car accident, and then becomes a victim of community violence, or longstanding trauma such as physical abuse or war.” (CWC/NCTSN, 2008, p. 6).

Complex Trauma: “Complex trauma is a term used by some experts to describe both exposure to chronic trauma—usually caused by adults entrusted with the child’s care, such as parents or caregivers—and the immediate and long-term impact of such exposure on the child.” (CWC/NCTSN, 2008, p. 7).

Hypervigilance: “Abnormally increased arousal, responsiveness to stimuli, and scanning of the environment for threats” (Dorland’s Medical Dictionary for Health Consumers, 2007). Hypervigilance is a symptom that adults and youth can develop after exposure to dangerous and life-threatening events (Ford et al., 2000). The American Psychiatric Association’s Diagnostic Criteria Manual (DSM-IV-TR) identifies it as a symptom related to Post Traumatic Stress Disorder.

Resiliency: “A pattern of positive adaptation in the context of past or present adversity” (Wright & Masten, 2005, p. 18).

Traumatic Reminders: “A traumatic reminder is any person, situation, sensation, feeling, or thing that reminds a child of a traumatic event. When faced with these reminders, a child may re-experience the intense and disturbing feelings tied to the original trauma.” (CWC/NCTSN, 2008, p. 12).

Ten Things to Know About Trauma and Delinquency

By Kristine Buffington, MSW, Carly B. Dierkhising, MA, and Shawn C. Marsh, Ph.D.

The majority of youth who develop a pattern of delinquent behaviors and experience subsequent juvenile court involvement have faced both serious adversities and traumatic experiences. Research continues to show that most youth who are detained in juvenile detention centers have been exposed to both community and family violence, and many have been threatened with, or been the direct target of, such violence. Studies also demonstrate that youth who have multiple exposures to violence or victimization are at higher risk for mental health problems, behavioral problems, substance abuse, and delinquent behaviors.

Juvenile justice courts are tasked with protecting society, safeguarding the youth and families who come to its attention, and holding delinquent youth accountable while supporting their rehabilitation. In order to meet these sometimes contradictory goals, juvenile court judges must understand the myriad underlying factors that affect the lives of juveniles and their families. One of the most pervasive of these factors is exposure to trauma. To be most effective in achieving its mission, the juvenile court must both understand the role of traumatic exposure in the lives of children and engage resources and interventions that address child traumatic stress. Accordingly, we present ten critical points about trauma that judges should be familiar with in order to best assist traumatized youth who enter the juvenile justice system.

1. A traumatic experience is an event that threatens someone’s life, safety, or well-being.

Traumatic events can include being the victim of or witnessing: emotional, physical, and sexual abuse; neglect; physical assaults; family, school, or community violence; war; racism; bullying; acts of terrorism; fires; serious accidents; serious injuries; intrusive or painful medical procedures; loss of loved ones; abandonment; and separation. A key condition that makes these events traumatic is that they can overwhelm a person’s capacity to cope and elicit intense feelings such as fear, terror, helplessness, hopelessness, and despair.

2. Child traumatic stress can lead to Post Traumatic Stress Disorder (PTSD).

Several conditions or criteria must be met for an individual to receive the diagnosis of PTSD. These criteria include having been exposed to a threatening event, experiencing an overwhelming emotional reaction, and developing symptoms causing severe distress and interference with daily life. Further, individuals also must experience a sufficient number of the following three symptoms for more than one month: **avoidance** (i.e., avoiding reminders of the trauma); **hyperarousal** (i.e., being emotionally or behaviorally agitated); and **re-experiencing** (e.g., nightmares or intrusive memories). Not all youth who are impacted severely by traumatic stress develop PTSD.

3. Trauma impacts a child’s development and health throughout his or her life.

The experience of either **acute trauma** or **chronic trauma** has the potential to impact children in all areas of social, cognitive, and emotional development throughout their lives. Youth who experience traumatic events may have mental and physical health problems, problems developing and maintaining healthy relationships, difficulties learning, behavioral problems, and substance abuse problems. Research also suggests that the impact of trauma can persist into adulthood and can increase risk of serious diseases, health problems, and early mortality.

4. Complex trauma is associated with risk of delinquency.

The effect of trauma is cumulative: the greater the number of traumatic events that a child experiences, the greater the risks to a child’s development and his or her emotional and physical health. Youth who have experienced **complex trauma** have experienced a series of traumatic events that include interpersonal abuse and violence, often perpetrated by those who are meant to protect them. This level of traumatic exposure has extremely high potential to derail a child’s development by contributing to a deep distrust of and disregard for adults and rules set by adults—which places youth at a much greater risk for delinquency and other inappropriate behaviors.

5. Traumatic exposure, delinquency, and school failure are related.

Academic failure, poor school attendance, and dropping out of school are factors that increase the risk of delinquency. Success in school requires confidence, the ability to focus and

concentrate, the discipline to complete assignments, the ability to regulate emotions and behaviors, and the skills to understand and negotiate social relationships. When young people live in unpredictable and dangerous environments they often, in order to survive, operate in a state of **hypervigilance**. Attitudes and behaviors associated with hypervigilance (e.g., constantly assessing for threats) fundamentally conflict with the skills and focus needed to succeed in school academically, socially, and behaviorally.

6. Trauma assessments can reduce misdiagnosis, promote positive outcomes, and maximize resources.

Often youth who are exposed to chronic or complex trauma receive a diagnosis of Attention Deficit Disorder, Oppositional Defiant Disorder, Conduct Disorder, or other mental health disorders. These diagnoses are predominantly based on observable behaviors and symptoms. When there is a lack of thorough assessment, youth are provided treatment based on these behavioral diagnoses, without addressing the traumatic experiences that are contributing to the symptoms. In order to avoid this disconnect, trauma screenings and standardized assessments should be implemented at intake and at other points of contact.

7. There are mental health treatments that are effective in helping youth who are experiencing child traumatic stress.

A number of evidence-based practices (EBPs) are available for treating youth who are impacted by trauma. EBPs are practices that have been evaluated through rigorous scientific studies and have been found to be effective. It is imperative that referrals for treatment be made to service providers that use trauma-focused EBPs, so that youth may receive both the best care and the most positive outcomes. The Centers for Disease Control indicates that the most highly effective treatments for traumatic stress are cognitive behavioral treatment models. (Please visit www.nctsn.org for more information on evidence-based treatments.)

8. There is a compelling need for effective family involvement.

Youth who do not have consistent family support are at higher risk of violence and prolonged system involvement. If juvenile courts are to enhance their success in rehabilitating youth who commit delinquent acts, they should maximize opportunities to engage and partner with these young people's caregivers. This means working to develop meaningful involvement of biological parents, extended family members, kinship caregivers, adoptive families, foster parents, and others—and educating them about traumatic stress and effective treatments.

9. Youth are resilient.

Resiliency is the capacity for human beings to thrive in the face of adversity—such as traumatic experiences. Most practitioners approach enhancing resiliency by seeking both to reduce risk factors and increase protective factors in the lives of the children and families with whom they work. Some of the ways youth resiliency can be enhanced include: proactive efforts to protect them from further trauma, expanding their support systems, providing them with positive adult role models, and finding ways to successfully engage their talents to enhance development of self-efficacy. (Please visit www.search-institute.org for more information on developmental assets.)

10. Next steps: The juvenile justice system needs to be trauma-informed at all levels.

Trauma-informed systems of care understand the impact of traumatic stress both on youth and families, and provide resources

that prevent, address, and ameliorate the impact of trauma. It is essential that juvenile courts work to provide environments that are safe and provide services that do not increase the level of trauma that youth and families experience. A trauma-informed juvenile justice system makes system-level changes to improve a youth's feelings of safety, reduce exposure to **traumatic reminders**, and help equip youth with supports and tools to cope with traumatic stress reactions (e.g., by providing safety, trauma-informed assessments, and referral to evidence-based treatments).

Juvenile courts can benefit from understanding trauma, its impact on youth, and its relationship to delinquency. Research has repeatedly shown that the majority of youth in the juvenile justice system have experienced traumatic events; the juvenile court is disadvantaged if this fact is overlooked. By becoming trauma-informed, juvenile justice personnel aid the juvenile court in its mission of protecting and rehabilitating traumatized youth while holding them responsible for their actions. Rehabilitation resources also can be maximized by utilizing effective assessment and treatment strategies that reduce or ameliorate the impact of childhood trauma. Ultimately, such efforts will help promote improved outcomes for youth, families, and communities most in need of our help.

For more information about trauma, delinquency, or other related issues, please contact the National Child Traumatic Stress Network (NCTSN) at info@nctsn.org or the NCJFCJ at jflinfo@ncjfcj.org.

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STAR Health Behavioral Health Trainings

The following trainings are made available to Foster Care stakeholders across the State of Texas. These trainings are free of charge and are provided live and in person by a regional STAR Health trainer. Please contact your regional STAR Health trainer to schedule trainings. CEUs are provided to professionals free of charge as well. Training certificates are issued upon completion of the training.

Trauma Informed Care:

- For Foster Families/Caregivers - 9 hours *
 - Part I Trauma Training for Caregivers - 3 hours
 - Part II Introduction to Trauma Informed Parenting - 3 hours
 - Part III Advanced Trauma Informed Parenting - 3 hours
- Trauma Training for Caregivers/PRIDE – 4 hours
- For CASA Organizations/Judges/Legal - 3 hours
- For Educators & School Counselors- 3 hours
- For Behavioral Health Providers - 2 hours – an overview of Trauma Informed Care

**Caregiver trauma trainings are offered to CPAs (families and staff), Kinship families, RTC staff, and Emergency Shelter staff.*

Topic Trainings:

- Mental Health 101 - 1 to 1.5 hours
- Attachment in Foster Children - 1 to 1.5 hours
- Preventing Sexual Misconduct - 1 to 1.5 hours
- Stress Management - 1 to 1.5 hours
- Suicide Prevention - 1 to 1.5 hours
- Substance Use, Abuse, and Addiction – 1.5 hours
- Childhood Development - 1 hour to 1.5 hours
- Fetal Alcohol Syndrome and Related Disorders - 1.5 hours
- Co-Occurring Disorders - 1.5 hours
- African American Hair Care - 2 to 3 hours
- Post Traumatic Stress Disorder - 1 to 1.5 hours
- Providing Services to Lesbian, Gay, Bisexual, and Transgender Youth in Care - 3 hours
- Psychotropic Medication Utilization Review - 1.5 hours
- Attention Deficit Disorder - 1.5 hours
- Childhood Traumatic Grief - 1.5 hours
- Promoting Placement Stability- 2 hours
- Coping with Trauma Reminders - 1 to 1.5 hours
- Self Care: Preventing Compassion Fatigue and Secondary Traumatic Stress - 1.5 to 2 hours
- Therapy 101 – 1 hour
- Providing Culturally Affirming Care – 2 to 3 hours

Orientation Trainings:

- STAR Health Member Orientation - 1 to 1.5 hours
- Transitioning Youth Orientation - 2 to 3 hours
- STAR Health Provider Orientation - 3 hours

Resource Websites

- Texas CASA** www.texascasaresources.org
- Toolkit – “Youth Permanency Planning Toolkit”
- Texas Children’s Commission** www.texaschildrenscommssion.gov
- Report – The Texas Blueprint – Transforming Education Outcomes for Children & Youth in Foster Care
- National Child Traumatic Stress Network** www.NCTSNet.org
- Article – “Effective Treatments for Youth Trauma”
- National Crime Justice Reference Service** www.ncjrs.gov
- Article – “Crime During the Transition to Adulthood – How Youth Fare as They Leave Out-of-Home Care”
- National Resource Center for Youth Development** www.nrcyd.ou.edu
- Article - “Making Healthy Choices – A Guide to Psychotropic Medications for Youth in Foster Care”
- National Resource Center for Youth Services** www.nrcyd.ou.edu
- Cenpatico – STAR Health** www.cenpatico.com
- Behavioral Health Trainings – Foster Care stakeholders
- American Association of Children’s Residential Centers** www.aacrc-dc.org
- Trauma-Informed Care in Residential Treatment
- Child Welfare League of America** www.cwla.org
- Behavioral Management and Children in Residential Care
- American Bar Association** www.americanbar.org
- Practice & Policy Brief – Psychotropic Medication and Children in Foster Care: Tips for Advocates and Judges
- Mental Health Screening and Assessment Tools for Children**
www.humanservices.ucdavis.edu/academy/pdf/FINAL2MentalHealthLitReview.pdf
- Child Welfare Information Gateway** www.childwelfare.gov
- Casey Family Programs** www.casey.org
- National Alliance on Mental Illness** www.nami.org
- National Council of Juvenile and Family Court Judges** www.ncjfcj.org

RESOURCES USED IN CONTENT

Texas Department of Family and Protective Services

Star Health

Cenpatico

Superior Health Plan

Children's Commission

Texas Office of Court Administration (OCA)

A World For Children

Florida Guardian Ad Litem

National CASA



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