

Keeping Families Together

A Guide to the Children's
Mental Health System



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National Alliance on Mental Illness

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NAMI Minnesota champions justice, dignity, and respect for all people affected by mental illnesses. Through education, support, and advocacy we strive to eliminate the pervasive stigma of mental illnesses, effect positive changes in the mental health system, and increase the public and professional understanding of mental illnesses.

KEEPING FAMILIES TOGETHER

A Guide to the Children's Mental Health System

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INTRODUCTION

Parenting a child with a mental illness can be very difficult. The child may be struggling in school, at risk of hurting themselves or others, or involved in the juvenile justice system. The professionals who treat the child may not be able to agree on a diagnosis, and the diagnosis may keep changing especially as the child develops. It may be difficult to find treatment that works. The family may have strained relationships and strained finances. Parents¹ may feel frustration and guilt as they seek help for their child.

This guide, *Keeping Families Together*, provides information about treatment services and supports available to children with a mental illness and their families.

It covers many of the questions parents may have such as:

- ▶ What are my family's legal rights?
- ▶ How do we know what level of care is best for our child?
- ▶ What happens if my child needs more support than what's available in our community? ■

CHILDREN WITH MENTAL ILLNESSES

About 1 in 5 children has a mental illness, and half of all mental illnesses emerge by age 14. Emotional or mental health problems can develop at any age. Many children experience conditions like depression, anxiety, ADHD and eating disorders.

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

It's important to identify and treat mental illnesses in children as soon as possible as it leads to better outcomes. Difficult behavior can be a symptom of a mental illness. It is important to learn what is causing the behavior so that the right treatment can be provided.

Emotional Disturbance and Severe Emotional Disturbance

Terms used to describe children who have a mental illness include *emotional disturbance* (ED) and *severe emotional disturbance* (SED). These

1. Throughout this booklet we use "parent" to refer to guardians and caregivers of children.

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

An emotional disturbance is defined as:

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

- ▶ Is listed under a specific set of diagnosis in the clinical manual of the ICD-10
- ▶ Seriously limits a child's capacity to function in primary aspects of daily living such as personal relations, living arrangement, work, school and recreation

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

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

- ▶ The child has been admitted within the last three years or is at risk of being admitted to inpatient treatment or residential treatment for an emotional disturbance.
- ▶ The child is a Minnesota resident and is receiving inpatient treatment or residential treatment for an emotional disturbance through the interstate compact.
- ▶ The child has one of the following as determined by a mental health professional:
 - psychosis or a clinical depression
 - risk of harming self or others as a result of an emotional disturbance
 - psychopathological symptoms as a result of being a victim of physical or sexual abuse or of psychological trauma within the past year
- ▶ The child, as a result of an emotional disturbance, has significantly impaired home, school or community functioning that has lasted at least one year or that, in the written opinion of a mental health professional, presents substantial risk of lasting at least one year.

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

Diagnostic assessments can be performed by the following:

- ▶ Licensed psychologists (LP)
- ▶ Licensed independent clinical social workers (LICSW)
- ▶ Psychiatrists (M.D.)
- ▶ Clinical nurse specialists (CNS)
- ▶ Psychiatric nurse practitioners (NP)
- ▶ Licensed Marriage and Family Therapists (LMFT)
- ▶ Licensed Professional Clinical Counselors (LPCC)
- ▶ Advanced Practice Registered Nurse (APRN)
- ▶ Mental Health Practitioner—working towards licensure under the supervision of a licensed professional

Providers with these credentials are referred to as mental health professionals and have to meet specific criteria. Before receiving their license from a state licensing board they have to have their degree and practice their skills extensively under the supervision of a licensed professional.

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

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

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

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

Mental Health Services

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

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

These services include:

- ▶ Outpatient treatment
- ▶ In home services
- ▶ School linked services

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

There are many treatments or paths for a child to enter the mental health system. The services that are available will also depend on whether the treatment will be paid for by private insurance, public insurance,² Federal IV-E, or county dollars and where the child lives.

While it is best for children to start with less intensive treatment in their community, it doesn't always work that way. Sometimes a child's symptoms develop suddenly or progress quickly and very intensive treatment needs to be started right away. Some counties or health plans may not want to recommend residential treatment. Many families have found that therapeutic foster care or residential treatment is the best choice at the time. Data collected by Minnesota's treatment centers has also shown that residential treatment can be helpful.

Assessments

Parents of a child with mental illness will encounter a variety of "screens" or "assessments." Screens are typically brief questionnaires that can alert the screener to the need for more information or further assessment. Screenings can be thought of like thermometers; they signal that something might be wrong, but they do not give a diagnosis or treatment plan. Mental health screening tools are frequently used in doctor's offices and schools and do not need to be completed by a licensed professional. Counties and providers use assessments to measure the level of service needed. If a county is considering out-of-home placement, then the county will use a tool called a "level of care determination." This is used to determine the best treatment or placement for the child. It is important for parents to keep track of difficult behaviors and what interventions have been tried. Parents should provide this information when they are completing screens and assessments.

Having a mental illness does not mean a child will qualify for all types of mental health services. These tools are used to measure how well the child is able to function at home, at school and in the community. The scores from these assessments are used to determine whether a child

2. Throughout this booklet we use "public insurance" to refer to Medical Assistance, MinnesotaCare and TEFRA.

qualifies for specific services. They are used to determine what intensity and level of treatment is needed. They are also used to measure a child's progress and show if there is a need for change in services or treatment plan.

For children over the age of six, the Minnesota Department of Human Services requires the use of the Strength and Difficulties Questionnaire (SDQ) combined with the Child and Adolescent Service Intensity Instrument (CASII) to determine the level of care needed. Children below the age of six are assessed using the Early Childhood Service Intensity Instrument (ECSII). The SDQ should be completed by the child, the caregiver and any other interested parties, such as school staff. The CASII looks at the level of care needed by a child. It assesses the severity of symptoms.

It also looks at service needs in several areas:

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

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

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

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

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

Family Driven Systems and Services

The most effective services and systems are family driven. The goal of a family driven system is to make families feel empowered to share their opinions and ideas, be involved in the decision making process and viewed as experts on the family experience.

In family driven systems professionals are empowered to act as partners with families and take action on the needs and ideas voiced by families. Family engagement should occur at each system level, including the provider level, counties, and the state. Not every family is going to want to engage at all or any levels, but they should be encouraged to be involved.

At a clinic level, families should be able to participate on the board of directors or advisory councils. Providers should also offer easy opportunities for feedback from families through short surveys or interviews. At the community level families can get involved with their Local Mental Health Advisory Councils and Mental Health Collaboratives. These platforms offer an opportunity for families to have a voice at the community and service level and influence policy and best practices.

It’s also critical that services are family driven. Children living with a mental illness often have multiple providers involved in their treatment

and recovery. A team may consist of school staff, psychiatrists, therapists, case managers, skills workers, and parents. Parents are important members of the team; they are the experts on their child. The family experiences and perspectives are crucial to the recovery process.

Parents should feel comfortable voicing their concerns, questions, and recommendations.

There are strategies parents can use to make meetings with providers as effective and productive as possible:

- ▶ Gather information prior to meetings; make sure you understand the goal of the meeting, ask for an agenda, research your child's diagnosis, and ask other parents what has worked for their child and family.
- ▶ Make a list of topics you would like to discuss including questions, concerns, and strengths and send these to team members ahead of time if possible. Focus on the top three topics.
- ▶ Treat your interactions with providers as business; be calm, respectful, and strategic. Try to keep things short and to the point.
- ▶ Sometimes it seems as though providers are speaking another language. Ask for clarification if you don't understand something.
- ▶ Invite additional supports as needed. This could include other caregivers, friends or relatives who know your child well, or a family peer specialist.
- ▶ Create a binder to hold all your most up-to-date information on your child, treatment plans, notes from meetings, etc. ■

TREATMENT OPTIONS

It is best to try to keep children with their families and treat them in their own community. There are a variety of services available in the community including counseling or therapy, day treatment, in-home services, crisis services and respite care. What is available depends on the needs of the child, the county they live in and the child's insurance.

Children's Mental Health Targeted Case Management (CMH-TCM)

This is a service for families who have a child diagnosed with a severe emotional disturbance (SED). The county is required to provide targeted case management to the family if they meet eligibility criteria and request the service. CMH-TCM is provided through Medicaid. To access this service families should call their county and specifically request a children's mental health targeted case manager. Some counties contract

with mental health clinics to provide this service. If the county contracts with a clinic families will be referred by the county.

The role of a targeted case manager is to help connect families to needed supports and services. These may include mental health, education, vocational, or recreation services. Case managers are also knowledgeable about, and know how to access, financial supports, including Medical Assistance and other health insurance, social security income, waivers, and grants.

Sometimes when families are receiving multiple services they will have a few different types of case managers. Each case manager plays a different role and has specific requirements they need to follow. Some examples of other types of case managers include CADI, child welfare, county financial, etc. It can be very confusing to keep track of all the case managers on a child’s team. Families should ask case managers to clarify their role if they are confused, and case managers need to make clear to families the services and supports they do and do not provide.

	CHILDREN’S MENTAL HEALTH—TARGETED CASE MANAGEMENT (CMH-TCM)	CHILD WELFARE—TARGETED CASE MANAGEMENT (CW-TCM)	WAIVER CASE MANAGEMENT	BEHAVIORAL HEALTH HOME (BHH)—PROVIDED AT MENTAL HEALTH CLINICS (NOT A COUNTY SERVICE)
HOW CAN THEY HELP:	<ul style="list-style-type: none"> ► Referral to treatment, housing, education, vocational, financial, & treatment services ► Coordination between providers & supports (family, school, county, etc.) 	<ul style="list-style-type: none"> ► Coordinating referrals to services & supports ► Ongoing contact between caregivers, family members, and providers ► Coordination with providers 30 days prior to discharge back to a community setting 	<ul style="list-style-type: none"> ► Manage and support waiver use ► Identify opportunities for use of waiver and support applications/ process for accessing funds ► Linkage to supports 	<ul style="list-style-type: none"> ► Referral to community and social support services ► Promotion of health and wellness (identifying gaps in care) ► Coordination between providers and supports (family, school, county, etc.)

	CHILDREN'S MENTAL HEALTH—TARGETED CASE MANAGEMENT (CMH-TCM)	CHILD WELFARE—TARGETED CASE MANAGEMENT (CW-TCM)	WAIVER CASE MANAGEMENT	BEHAVIORAL HEALTH HOME (BHH)—PROVIDED AT MENTAL HEALTH CLINICS (NOT A COUNTY SERVICE)
HOW DO CHILDREN QUALIFY:	<ul style="list-style-type: none"> ▶ Current diagnostic assessment (within the past 6 months) ▶ Meet SED criteria ▶ CASII score of 3 or higher ▶ Cannot be receiving BHH ▶ No insurance requirements 	<ul style="list-style-type: none"> ▶ At risk of out-of-home placement or involved with child protection ▶ Recipient of public insurance 	<ul style="list-style-type: none"> ▶ Recipient of Medical Assistance ▶ Certified disabled ▶ CASII score of 5 or higher ▶ Current diagnostic assessment (within the past 12 months) 	<ul style="list-style-type: none"> ▶ Recipient of public insurance ▶ Current diagnostic assessment (within the past 12 months) ▶ Meet emotional disturbance (ED) criteria ▶ Cannot be receiving CMH-TCM
WHAT THEY DON'T DO:	<ul style="list-style-type: none"> ▶ Treatment or therapy ▶ Legal support/advocacy ▶ Diagnostic assessments ▶ Mediation between providers, school, family, etc. 			

Community Services

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

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

Youth Assertive Community Treatment (Youth ACT) is for youth ages 16–20. It is an intensive, nonresidential mental health service provided by a team to support the young person in their community. Team members include a licensed mental health professional, an Advanced-Practice Registered Nurse, a licensed drug and alcohol counselor and others, as needed, to address the specific needs of the youth such as probation, housing specialist, a peer specialist, vocational support, etc. It is paid for by public insurance.

Eligibility for Youth ACT is based on:

- ▶ A diagnosis of serious mental illness or co-occurring mental illness and a substance abuse disorder
- ▶ A CASI score of 4 or higher
- ▶ Functional impairment and a history of difficulty in functioning safely and successfully in the community, school, home, or job
- ▶ Probable need for services from the adult mental health system within the next two years
- ▶ Have a current diagnostic assessment indicating the need for intensive nonresidential rehabilitative mental health services

Children's Mental Health and Family Services Collaboratives may pay for or provide some mental health services in their communities. Funding for collaboratives has decreased in recent years, but some collaboratives continue to provide wraparound services or family navigation supports. Many collaboratives offer support/funding for training, classes, or conferences for families. They also provide an opportunity for families, providers, schools, and community members to discuss concerns and implement change. To find out if your community has an active collaborative go to: <https://mn.gov/dhs/partners-and-providers/policies-procedures/childrens-mental-health/collaboratives/>

Children's Therapeutic Services and Supports (CTSS) are offered by certified CTSS providers. CTSS is commonly known as 'in-home' services. Some schools are certified as CTSS providers and can bill for services, but most CTSS providers are mental health clinics. They must provide individual, family or group psychotherapy, individual and group skills training, family skills training, crisis planning and mental health behavioral aide services. Mental health behavioral aides help children practice the skills they learn in therapy between appointments. Families can choose which of the services they need or they can use all of the services as a package. The services can be provided in the family's home, child's school or other community settings. Parents should be involved in developing the treatment plan. Children on public insurance can receive up to 200 hours of service per year without prior authorization. Families can apply to receive more than 200 hours if needed, but it must be approved by the state. Very few private health plans pay for all of the services included under CTSS.

Collaborative Intensive Bridging Services (CIBS) is an intensive treatment program for children age 6-17. This service combines intense in-home therapy with a brief placement at a residential treatment facility. The goal of CIBS is to keep children in their home and community while receiving the intensive treatment they need to stabilize their symptoms. To receive CIBS, a child must have a CASI score of 5

or higher. Both private and public insurance may cover some or all of CIBS. Minnesota is working to expand CIBS across the state. For more information visit mn.gov/dhs/mnsoc.

Clinical Care Consultation is communication between a treating mental health professional and other health care providers, who are working with the same child. These professionals use the consultation to discuss the following:

- ▶ Issues about the child's symptoms
- ▶ Strategies for effective engagement, care and intervention needs
- ▶ Treatment expectations across service settings
- ▶ Clinical service components provided to the child and family

For example, if a pediatrician is prescribing medication for a mental illness when a child psychiatrist is not available, the pediatrician can consult with mental health professionals and psychiatrists.

This service allows both providers to bill for their time for collaboration and communication.

Community Alternatives for Disabled Individuals (CADI) waivers

can be used to pay for services and supports in a family's home and community. Listed below are some examples of what CADI waivers can be used for:

- ▶ Safety equipment for home (keypads for doors, alarms, etc.)
- ▶ Holistic therapy services (equine therapy, music therapy, art therapy, etc.)
- ▶ Therapeutic respite, including camps

These waivers are limited and only available to those who meet SED criteria and are on Medical Assistance. They must also be at risk for entering an intensive residential placement including hospitalization, the equivalent of a CASII score of 5 or higher. To access this support, a MnCHOICES assessment will need to be completed, along with an up to date diagnostic assessment. A MnCHOICES assessment is a three hour (can be longer) in-person assessment, usually in the child's home, and there is no cost to the family. The completed assessment will provide recommendations for services and determines which publicly funded programs a child might qualify for. MnCHOICES assessments can be requested by calling the child's home county and should be completed within 20 days of the assessment request.

Community mental health centers provide many mental health services, and include Certified Community Behavioral Health Clinics (CCBHCs). These services include diagnostic assessments, psychotherapy, and substance use supports. They should also have staff that can help manage psychiatric medications. If the center has been certified as a CTSS

provider, they can also provide those services. They usually accept all types of insurance (public and private) and for people who are underinsured, or uninsured can bill on a sliding scale. Sliding scale fees are based on income.

The following agencies are currently certified as CCBHCs and can provide services on a sliding fee scale for those who are underinsured or uninsured:

- ▶ Amherst H. Wilder Foundation
- ▶ Human Development Center
- ▶ Northern Pines Mental Health Center
- ▶ Northwestern Mental Health Center
- ▶ People Incorporated
- ▶ Ramsey County Mental Health Center (adult only)
- ▶ Western Mental Health Center
- ▶ Zumbro Valley Health Center

Counseling and therapy can be one-on-one, with the entire family or in a group session. Private clinics and independent mental health professionals in private practice also provide specific therapies or treatments. Certain types of therapy have been shown to work best for particular mental health conditions. These types of therapy are called “Evidence-Based Practices.” When choosing a therapist, parents should ask if the therapy provided will be evidence-based or evidence-informed. Private insurance and public insurance typically pay for these services.

Day treatment services are a package of CTSS services and are very structured. A child spends several hours per week in day treatment. Services include individual or group psychotherapy and skills services. Other intensive services such as help managing medication may also be included. Day treatment is used to stabilize the child’s mental health when regular therapy is not enough. Staff also help the child develop and practice independent living skills and work on social skills to improve relationships. Day treatment services must be offered year-round. Services must be provided by a certified provider a minimum of 2 hours, one day per week, and a maximum of 3 hours per day, up to five days per week. Some programs are full days, and all full day programs work with the local school district to provide minimal education for part of the day. Private insurance and public insurance usually pay for these programs. Sometimes they are also paid for by counties or a school’s special education program. Some schools call their level 4 setting for children with emotional or behavioral disorders day treatment. These school programs do not meet the same clinical standards nor provide the same level of care.

If education is being provided as part of day treatment during the school year, the home district should provide transportation each day. Parents should communicate with their child's school district to coordinate transportation. Many public and private health plans also may provide or fund transportation assistance. If the child is on Medical Assistance, transportation will be provided through Non-Emergency Medical Transportation (NEMT), or if their parents drive them to and/or from treatment, they are eligible for gas mileage reimbursement (though only while the child is in the car). Transportation must be scheduled at least 3 days before appointments. More information can be found at www.mtm-inc.net/minneapolis.

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

Hospital In-reach Service Coordination funds providers who work in hospitals to connect children and youth to outside services after their discharge from an emergency department. This service can last for up to 60 days after discharge, and is intended to reduce the need for additional ED visits. Providers are able to refer children to services that address their mental health needs and coordinate with community based providers.

In-home services are currently provided through CTSS or by the Personal Care Assistant (PCA) program. The Community First Services and Supports (CFSS) program will eventually replace PCAs, which are funded under Medical Assistance. PCAs are used to provide in-home support to people with significant disabilities. CFSS is in the process of being approved by the Federal Government to be billed under Medical Assistance. Individuals must be screened to qualify for this service. Changes to state law have made PCAs services much more difficult to qualify for when the child has a mental illness rather than a physical disability. However, if PCA support is needed, you should still apply by contacting your county Human Services department.

Psychiatry/medication management can be a beneficial part of treatment for a child with a mental illness. Medication can be used to help control the symptoms of mental illness. It is often most effective when combined with therapy.

Medication can be prescribed by the following:

- ▶ Psychiatrists (MD)
- ▶ Physicians (Pediatricians, Family Practice)
- ▶ Advanced Practice Registered Nurse (APRN)
- ▶ Physician Assistant (PA) (under the supervision of an MD)

Many pediatricians and family practice doctors will prescribe medications for mental illness. This can be a good option for families as there is a significant shortage of psychiatrists, especially for children, so the wait can be very long. Medication is generally covered by private and public insurance.

Respite care: This type of support gives families a break from caring for the child. Respite care reduces the stress of caring for a child with a mental illness. It helps to prevent out-of-home placement. It can be provided by bringing a caregiver into the home or placing the child in another setting (such as a person's home, YMCA activities, camps, etc.). A respite provider may be another parent, foster care provider or professional who takes care of the child for a brief time. Many counties receive state grant funds but can also use their own funds. Parents can ask the child's case manager or call the county about respite care. Some families may be incorrectly told they need a case manager to receive respite funds. There is nothing in law that requires case management for respite.

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

TEFRA is for families who are above the poverty level and want to use more intensive services covered under Medical Assistance. The child must have developmental disabilities or a serious emotional disturbance to qualify. If the child qualifies, all mental health services covered by Medical Assistance will be available to the child. This includes waiver programs, health care, mental health care, Personal Care Assistance, day treatment, residential treatment and CTSS. Parents will pay a fee according to their income.

During the TEFRA application process, families should be given paperwork to determine if their private insurance is cost effective. If the private insurance plan is determined to be cost effective, parents will be

reimbursed for a portion of their private insurance costs for that child. Parents' fees may increase if they drop their private insurance. When billing for services, private insurance will be listed as primary, and will be billed first. Anything not covered by private insurance will then be billed to TEFRA. A parental fee estimator can be found at pfestimator.dhs.mn.gov.

Below is a table with example parental fees:

PARENTS IN HOUSEHOLD	DEPENDENTS	HOUSEHOLD AGI (ADJUSTED GROSS INCOME)	PARENTAL FEE ESTIMATE (PER MONTH)
1	2	\$70,000	\$145
2	2	\$70,000	\$0
1	2	\$100,000	\$350
2	2	\$100,000	\$270
2	2	\$150,000	\$650
2	3	\$150,000	\$580
2	3	\$200,000	\$870

Telemedicine is the delivery of mental health services through real-time video. Psychiatry and therapy are common services provided through telemedicine and can be a good option for families where scheduling or transportation is a barrier, who live in rural areas, or who have a lack of providers available in their area. This service is covered under public insurance and most private insurance.

Crisis Support

Every county in Minnesota has a mental health crisis line, and should be 24/7. Some counties have a mobile crisis team and are able to meet the person in the community (i.e. school, home, mental health clinic, etc) when there is no immediate danger. Some way crisis teams can help:

- ▶ Cope with immediate stressors
- ▶ Develop a crisis plan
- ▶ Make referrals to a hospital or other services.

Crisis teams can also provide stabilization services for as long as necessary. A child does not need to have a mental health diagnosis to receive crisis services, and a team will respond regardless of insurance status. If the person has insurance, the team will bill insurance if it is available, but individuals will not be charged.

Ideally crisis teams will respond within 30 minutes. Unfortunately, this is not always the case, and it can take hours for a mobile team to respond. Families should have a back-up plan if the crisis team can't respond immediately, or the situation escalates. It is important to note that most counties do not have crisis response teams specifically for children. Families report mixed experiences in the effectiveness of crisis support. For more detailed information on crisis support please see NAMI Minnesota's booklet, *Mental Health Crisis Planning for Children*.

School Supports and Services

When a child struggles with mental illness, it is not uncommon for them to need additional support in school. There are several types of formal education supports schools can put in place.

Functional Behavior Assessments (FBA) can be done by the school to determine when and why a child engages in a specific problem behavior. This assessment can be requested as part of an IEP evaluation, but can also be done without an IEP for a student in general education. An FBA can help determine what is causing the concerning behavior, what makes it worse, and what makes it better. The FBA can be used to create a behavior intervention plan (BIP).

Behavior Intervention Plans (BIP) are created after an FBA has been completed. They provide a plan to change or prevent a specific behavior. Behavior intervention plans need to be reviewed annually which can be done at the annual IEP meeting.

Multi-tiered System of Supports (MTSS) is a framework used by schools to support student academics. This is not part of special education. An assessment is completed to determine the needs of the student and the best way to support those needs. **Response to Intervention (Rti)** is a type of MTSS and includes three different levels of support. Another example of MTSS is **Positive Behavioral Intervention and Supports (PBIS)**. PBIS has been implemented in one-third of Minnesota's schools. It is a school wide model for preventing problem behavior and providing positive supports. Support plans for specific students are created when children show a need for more support. These tools might work for some children, but families should know that if their child's needs are not being met they can request a formal special education evaluation.

504 plans are formal plans to provide accommodations to general education instruction. It is a federal law, Section 504 of the Rehabilitation Act, and prohibits discrimination based on disability. This is not part of the special education law and is very different from an IEP. Some examples of accommodations include:

- ▶ Longer time to take tests
- ▶ Preferred seating
- ▶ Option to take breaks
- ▶ Decreased homework

To start the process, parents can request a 504 plan for their child. It is best to do this in writing and submit it to the child's teacher, principal, and school/district 504 coordinator. The school will review the child's academic records and they will likely ask for a written letter of diagnosis from a pediatrician, psychiatrist or therapist with information about the diagnosis. Once a formal plan is in place schools generally review the plan annually, but there are no legal timeline requirements, so it is important for parents to request meetings or updates as needed.

An IEP provides access to special education services and modifications to the general education curriculum. IEPs are part of the Individuals with Disabilities Education Act (IDEA), a federal law with significant legal requirements that schools have to follow. Some examples of modifications provided through IEPs include:

- ▶ Para support
- ▶ Occupational/speech/physical therapy
- ▶ Assistive technology (ex. Speech to text software)
- ▶ Special education classroom
- ▶ Modified curriculum and academic expectations

Once the IEP is implemented there will be an annual IEP meeting to review progress and make changes. Parents can request an IEP meeting throughout the year if they feel their child is not making progress or needs changes to their plan.

IEP Development Timeline

Initiation: Parent/guardian or school provide a written request for a special education evaluation. The parent/guardian must agree to the evaluation plan and sign off on the Prior Written Notice before the evaluation can be started. If the school denies the request for evaluation, they must notify the family and provide information on their rights.

Within 30 school days of receiving the signed evaluation plan, the school will complete the evaluations, write a report, and hold a meeting to discuss the results. If the school determines the child is not eligible for services, they will notify the family and the family may choose to pursue an Independent Educational Evaluation.

Within 30 calendar days of the evaluation review meeting the school will schedule a meeting to complete an Individualized Education

Program (IEP). Parents are an equal part of the team in this process. Once the IEP is signed by parents, the school must implement the IEP services and changes as soon as possible.

Families should know that schools are allowed to use restrictive procedures in extreme circumstances.

Restrictive procedures are when a child is physically held or secluded and can only be done during an emergency. Minnesota law defines an emergency “where immediate intervention is needed to protect a child or other individual from physical injury.” Seclusion and restraints cannot be used as a punishment. Schools must have a plan for using restrictive procedures and the plan must be available to the public. When restrictive procedures are used at a school, the staff must complete a form to notify the district and state. Parents must be notified within two days of when the restrictive procedure was used.

Inpatient and Residential Services

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

Inpatient hospitalization offers 24-hour care. Hospital programs provide the most structure for children and adolescents in crisis. The goal is to quickly stabilize the child and return him or her to their home or a less restrictive treatment setting. The hospital treatment team should work with the family to provide a smooth transition from the hospital to the next setting. The average length of stay for a hospitalization is four to seven days. Emergency services for psychiatric evaluation are available through hospital emergency rooms 24 hours a day. Only a few hospitals have inpatient care for children or adolescents.

The following hospitals have inpatient psychiatric units for children, and it is recommended families use these emergency rooms when possible:

- ▶ Abbott—Minneapolis
- ▶ Essentia—Duluth
- ▶ University of Minnesota Medical Center (Fairview Riverside)—Minneapolis
- ▶ Prairie Care—Brooklyn Park (inpatient only, no ER)
- ▶ Centra Care-St. Cloud Hospital—St. Cloud
- ▶ Saint Mary’s Hospital—Rochester
- ▶ United—Saint Paul

It sometimes can be difficult to find an open bed. All hospitals have access to a statewide bed tracking system to find an open bed. It is also possible the child may be transferred to a hospital in a neighboring state (most likely Prairie St. John's in ND or Avera in SD) if there are no beds available in Minnesota. Hospital care is typically covered by private and public insurance or the hospital's charity care program.

Bringing a child to the hospital for a mental health assessment or crisis does not guarantee the child will be admitted. Admission criteria vary and depend on medical necessity as determined by a doctor. If the child is not admitted, family members will be instructed to bring the child home. There are a few things parents should do if their child is being sent home:

- ▶ Verify the county mobile crisis number
- ▶ Notify team members (school, therapist, psychiatrist, etc.) about the emergency visit and schedule appointments with appropriate providers
- ▶ Reference NAMI Minnesota's *Mental Health Crisis Planning for Children* booklet to prepare for any future mental health crisis
- ▶ Return to the hospital if the child becomes unsafe again

Parents should know that if they refuse to bring their child home from the hospital, for any reason, the hospital will file a report with child protective services. Police may come and the child could be dropped off at a homeless shelter for youth.

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

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

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

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

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

Types of residential programs include the following:

- ▶ **Mental health certified residential facilities** offer individual, group and family psychotherapy in a highly structured environment. Therapeutic and educational services are provided for children and adolescents who have serious emotional or behavioral difficulties. Residential treatment is for children who have not been successful in treatment or have needs that cannot be met in their homes or communities. Mental health residential treatment programs provide services based on individual treatment plans. These plans are based on the clinical needs of the child. They should support the child in gaining the skills they need to return to the community. They should also support the family in gaining the skills they need to care for the child. They are provided by qualified staff under the clinical supervision of a mental health professional. Minnesota law requires public and private health plans to cover mental health residential treatment.
- **Shelters** provide a temporary safe placement for children who cannot stay at home. The county social service agency has become involved with the child and the child’s family when a child

is placed in a shelter. Children are screened and, if needed, further assessment is arranged. If needed, children may be referred to other levels of care or services.

- ▶ **Transition programs** serve youth between the ages of 16 to 21. These programs are designed to help young people prepare for adulthood and independence. Services include housing, independent living skills training and supportive services. Services may be located in group housing, in a young person's own apartment or in a cooperative setting.
- ▶ **Evaluation/Diagnostic** programs provide an inpatient assessment. This can take from 15 to 45 days. The child is evaluated through formal diagnostic testing, observation and functional assessment. These programs often exist within residential treatment facilities.
- ▶ **Restrictive procedures certification** means that the facility is certified to use procedures to restrain a child in the case of an emergency (danger to themselves or others). These include physical escort, physical holding and seclusion. Certification requires that these procedures only be used when necessary to prevent harm to the child or others. Staff must be trained in the proper use of these procedures. Use is monitored and reviewed. Procedures such as mechanical restraints and disciplinary room time are only allowed in a correctional program.
- ▶ **Secure programs** are programs in a building or part of a building that is secured by locks. These programs are intended to prevent the child from leaving the program without authorization.
- ▶ **Contract Beds in certain hospital settings** are available for children who are in crisis. These beds are designated for children who need longer stays due to the complexities of their diagnosis.
- ▶ **Psychiatric Residential Treatment Facilities (PRTF)** were authorized in the 2015 legislative session. These beds are for children who need more intensive treatment, because of a medical or mental health condition, than traditional residential treatment can provide, but do not need to be hospitalized. Because room and board are covered as part of the cost, voluntary foster care agreements are not required. Youth up to age 21 (or 22 if they turn 22 while in treatment) are eligible for this service. As of May 2019 there is one PRTF in Minnesota run by Northwood Children's Services, and another under development in East Bethel which will be run by Cambia Hills.
- ▶ **Child and Adolescent Behavioral Health Services (CABHS)** is a residential treatment facility operated by the state of Minnesota. It is located in Wilmar, Minnesota.

Children served at CABHS may have:

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

A complete list of residential programs is available on the Minnesota Department of Human Services website. This information can be found by going to www.dhs.state.mn.us, clicking on "General Public" and opening the "Licensing" section. Information includes the certification of the facility, the address and contact information. ■

THE DECISION TO PLACE YOUR CHILD IN RESIDENTIAL TREATMENT

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

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

This decision will not be made alone. Assessments will be made by mental health professionals. Children will need to meet a level of care need as determined by the CASII or ECSII along with the SDQ (see pages 4–6).

Some families feel forced to seek residential treatment because community supports are not available or are offered too late. Some families

are incorrectly told they have to try all other options before seeking residential treatment. Minnesota statute states:

When a level of care determination is conducted, the responsible entity may not determine that referral or admission to a treatment foster care setting or residential treatment facility is not appropriate solely because services were not first provided to the child in a less restrictive setting and the child failed to make progress toward or meet treatment goals in the less restrictive setting.

This means counties and insurance providers cannot require a child to try, and fail, multiple treatment options before being admitted to residential treatment if residential treatment has been determined to be medically necessary.

Choosing a Program

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

The best way to find out about facilities is to speak with someone who is familiar with the children's mental health system in Minnesota. Parents can ask the staff of psychiatric units, professionals who work with their child, school social workers, community agencies and other parents. Residential services can be recommended by a mental health professional, the county case manager or the staff of the county mental health services unit for children. The parents' health insurance plan may also have a list of treatment facilities that it covers. Counties will have a list of facilities that they contract with and will want you to use.

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

Parents should know, however, that they may have little control over which facility their child enters. If immediate placement is needed, the child may simply end up in the nearest facility with an open bed. Sometimes families need to wait until there is an open bed in the facility they

prefer. It may be helpful to know that all residential programs in Minnesota have to meet common licensing standards. They can then choose to seek additional certifications based on the people they serve.

Questions to Ask

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

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

General Information

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

Staffing

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

Treatment

- ▶ Does the facility have defined successful outcomes? Have they collected data to prove they are successful?
- ▶ What is the average length of stay?
- ▶ How often will the treatment plan be reviewed by me, my child and the staff?
- ▶ What types of therapies are included in the treatment plan?

- ▶ What about medications? Will you change my child's medications and how will I be informed?
- ▶ What will my child do when they are in treatment?
- ▶ Do you use time-outs, seclusion or restraints? Can I see your policy?
- ▶ What if I have questions after my child is in treatment? Whom do I contact?
- ▶ How do you plan for discharge? How much notice do you provide? How do you include the family in discharge planning?
- ▶ Is there a process to help my child transition back home?
- ▶ How will you keep my child's current psychiatrist and/or therapist(s) informed and involved?
- ▶ What are your discipline policies?

Family Involvement

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

Education

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

A good treatment facility will want parents to ask questions. They will have a written set of policies and procedures that parents can take home and look at later. They will answer questions and follow up on any other information requested. Each facility is also required to have admission standards that will help parents decide if it is an appropri-

ate placement for their child. The facility will also help parents obtain authorization for treatment from their insurance provider or the county.

Out-of-State Treatment

Parents should be very careful if someone recommends an out-of-state facility for their child. These facilities are governed by different rules and laws than Minnesota facilities. In certain circumstances, however, this can make sense. If a family lives near a state border and the nearest residential treatment facility is in the next state, treatment may still be covered by their county. The placement must be made by the county, and the facility must be inspected by the Licensing Division of the Department of Human Services. They must certify that it substantially meets the standards applicable to children's residential mental health treatment programs (under Minnesota Rules, chapter 2960) by the Minnesota Department of Corrections. The treatment center must be the nearest treatment center that will treat the child's level of care needed. It must be located in Wisconsin, North Dakota, South Dakota or Iowa. If medical insurance will cover the cost of treatment, families should coordinate with their insurance company. ■

PAYING FOR RESIDENTIAL TREATMENT

Health Insurance

Residential treatment services are very expensive. Few families can afford to pay out-of-pocket for them. Private health insurance plans may or may not pay for residential treatment, but public insurance is required to pay for residential treatment. It is important for families to learn as much as possible about their health insurance coverage.

Families can contact their insurance company or human resources department to see which treatment providers and facilities are covered under their plan, check their benefits and find out if there are any limits to coverage (such as number of days covered, out of pocket cost, etc.). Some health insurance plans that are self-insured may not cover any mental health services. Regular Minnesota health plans must provide coverage for residential treatment. It is best to check with the insurance company before assuming that it will pay for all or some of the cost of residential treatment. The residential facility staff can help families with this.

It is important for parents to find out whether they have a regular Minnesota health plan or a self-insured plan. They are different and are governed by different laws. Generally, large employers or employers

that cover more than one state have a self-insured plan. They sometimes contract with a Minnesota company to manage the benefits. This makes it even more difficult for families to know what type of plan they have. Parents should read through the policy book, especially the section on mental health care or behavioral health care. This will help to understand how to obtain treatment, what services are covered and any financial or treatment limitations.

If a regular Minnesota health plan provides coverage for mental health and substance abuse they must pay for medically necessary services.

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

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

You should contact your county mental health services unit if:

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

Mental Health Parity

The mental health parity law was passed in 2008. This law says that there must be parity between coverage for mental health and substance abuse services and medical/surgical benefits in insurance plans that offer coverage for both benefits. Please note that this law does not require that health plans provide mental health and substance abuse services.

Generally, health plans should not impose:

- ▶ Costs for mental health and substance use disorder care that are not comparable to physical health care costs
- ▶ Limits on the number of visits for outpatient mental health and substance use disorder care, if there are no limits for physical health care
- ▶ More restrictive prior authorization requirements for mental health and substance use disorder than the requirements for physical health services

Health plans must provide information about the services and coverage they offer for mental health and substance use treatment as well as

how medical necessity is determined. If payment or authorization for services is denied, plans must provide a written explanation for denial and how to appeal. Families can call the Consumer Services Center at (651) 539-1600 to file a mental health parity violation.

Formal written complaints of parity violation can be mailed to:

Minnesota Department of Commerce
Attention: Consumer Services Center
85 7th Place East, Suite 280
Saint Paul, MN 55101

Online complaints can be filed at <https://mn.gov/commerce/consumers/file-a-complaint/>

Minnesota Health Care Programs

Some children may qualify for one of Minnesota's publicly-funded health care programs or for county payment for treatment. The Minnesota health care programs are Medical Assistance and MinnesotaCare. The MNsure website has all the eligibility information at www.mnsure.org/individual-family/cost/ma-mncare.jsp. There is also a calculator to determine if a person may qualify for one of these programs. If a family does not qualify due to their income being too high, the child may still qualify for TEFRA (for more information on TEFRA see page 14). Parents can apply on the MNsure site. Navigators are available to help with the process at many community organizations. Qualifying for one of these plans can make it easier to pay for mental health treatment.

It is important for families to know whether they have fee-for-service Medical Assistance or a Prepaid Medical Assistance Program (PMAP) because decisions regarding residential treatment are treated differently for these two programs.

Prepaid Medical Assistance Program (PMAP) is a health care program that pays for medical services for families and children who qualify for Medical Assistance. Health plans (ex. UCare, Medica, Health Partners, etc) have contracts with the Minnesota Department of Human Services to provide PMAPs. These plans must cover all medically necessary services that are covered by Medical Assistance. It is important for families to know if their child is using a PMAP because PMAPs can use their own formularies. They do not have to use the state's formularies. Parents can call their child's insurance provider for more information.

County Social Services

When Medicaid was used to pay for treatment in residential facilities it only paid for treatment, and county funds (Title IV-E) were used to pay

for room and board. This changed in May 2018 when the majority of children's residential treatment facilities were classified as Institutes for Mental Diseases (IMDs) because the facilities have more than 16 beds. This means **federal** Medicaid dollars cannot be used to pay for treatment. Funding was made available through June 2019 by the Minnesota legislature, and NAMI Minnesota is participating in a joint effort to find a long term solution to this funding and service gap. Psychiatric Residential Treatment Facilities (PRTFs) are not IMDs and are not impacted by this change.

Another item parents need to know is that if public or government funds are used to pay for the care, they will be required to complete a determination of ability to pay, and may need to pay a fee based on their income. Be sure to ask what the fee will be. Every county uses a different schedule. Parents can appeal the fee if they believe it is too high and does not take into account other family medical expenses. ■

LEGAL ISSUES

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

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

Voluntary Foster Care Agreements

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

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

This law:

- ▶ Makes it clear that parents and guardians do not have to give up legal custody of their child to access or receive mental health services and treatment
- ▶ Establishes voluntary foster care agreements as a way to provide out-of-home treatment for a child with a developmental disability or a mental illness
- ▶ Establishes court reviews for a child in a voluntary placement
- ▶ Establishes the ongoing responsibility of the parents as legal custodian to visit the child, plan for and make treatment decisions, and obtain the necessary medical, dental and other care for the child
- ▶ Applies the new law when the child's parent and the agency agree that the child's treatment needs require foster care due to a level of care determination

The purpose of the law is to:

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

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

If county funds or fee-for-service Medical Assistance are being used to pay for treatment the county must determine if the child meets the criteria of a child with mental illness or developmental disability. This determination must be made before the child is placed for treatment.

Then the agency and parent must agree that the child's treatment needs require foster care based on an assessment using an approved and validated tool (see pages 4–6, CASII or ECSII combined with the SDQ). Counties have what is called a screening meeting to determine if the child qualifies for and needs residential treatment. Counties are supposed to allow parents to attend these meetings, and parents are encouraged to attend this meeting to be sure that their voice is heard. If the county decides that the child does not need residential treatment, then parents can appeal that decision. The county must provide written instructions on how to appeal.

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

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

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

The agreement also includes a promise that parents will:

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

Both parents and the agency must sign the agreement.

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

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

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

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

that a parent or treatment provider wishes to include. This report is due by the 165th day that the child has been in placement.

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

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

If no hearing is requested, the judge will review the report and make a decision about continuing with the placement within ten days. The decision includes whether the placement is in the child's best interest, whether the parent and agency are appropriately planning for the child and whether children age 12 or over have an appointed attorney or a guardian ad litem. A guardian ad litem is a person appointed by the court to investigate facts and make sure the best interests of the child are represented.

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

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

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

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

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

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

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

The petition includes:

- ▶ The date of the voluntary placement agreement
- ▶ Whether it is due to a developmental disability or emotional disturbance
- ▶ The plan for the ongoing care of the child and the parent’s participation in the plan
- ▶ A description of the parent’s visitation and contact with the child
- ▶ The date of the court finding that voluntary placement was in the child’s best interests
- ▶ The agency’s reasonable efforts to finalize the permanent plan for the child including returning the child to the family
- ▶ The basis of the petition, which is Minnesota Statute 260D
- ▶ An updated copy of the out-of-home placement plan

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

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

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

The judge will make a decision to either approve continuing the voluntary foster care agreement or to not approve it. If the judge does not approve it, then the child will be returned to the care of the parent(s). If

the parent(s) will not accept the child coming home, the county agency can file a petition to terminate parental rights. If the judge does approve the placement, then the child will continue in foster care. His or her placement will be reviewed every 12 months.

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

This means the county agency has worked to:

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

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

Legal Timeline

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

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

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

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

PRIOR TO DAY 165: The county conducts an administrative review of the out-of-home placement plan. People reviewing the plan must include one person who is not directly responsible for case management. The review is open to the parent and child as appropriate.

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

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

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

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

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

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

They must agree that:

- The petition is accurate
- Foster care is in the child's best interest

- They are satisfied with agency efforts to provide services that could bring their child home

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

If the judge agrees that there are compelling reasons to keep the child in treatment, they will grant the petition to continue the child in placement. If the judge does not approve the voluntary agreement, they will dismiss the petition. In that case, the child must then be returned to care of the parents. If the parents cannot or will not accept the child, the agency must file a termination of parental rights petition.

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

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

RESIDENTIAL TREATMENT PROGRAMS

Admission

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

Admissions is the process of gathering information.

The treatment center will need the following:

- The child's name and nickname(s)
- The parent's address and contact information
- The child's race or cultural heritage
- Any languages the child speaks and writes

- ▶ A description of presenting problems. This includes medical problems, circumstances leading to admission, mental health concerns, safety concerns including assaultive behavior and victimization concerns
- ▶ Medical records
- ▶ School records (including evaluations and special education services, if appropriate)
- ▶ Juvenile justice system records
- ▶ Reports from outpatient treatment facilities
- ▶ Reports from agencies involved with the child's current treatment or care
- ▶ Insurance information
- ▶ A description of your child's assets and strengths
- ▶ Spiritual or religious affiliation
- ▶ The placing agency's case plan goals for your child

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

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

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

Parents have the right to be involved in the development of the plan for their child during their stay at the facility. The program staff should

include the family in determining the treatment goals and the outcomes expected for the child. It should include what kind of skills they will work on so the child can return home. Regular meetings to review the child's progress will be scheduled, and parents and county workers will be invited to participate.

Services Provided

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

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

Rights of Residents

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

A resident has the right to:

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

Facilities are required to have “no eject policies.” This means that a child cannot be discharged before the treatment goals have been reached unless certain things have happened (ex. a child's aggression puts them or others at risk of harm and the facility does not have the supports needed to keep everyone safe). If a facility wants to discharge a child, there must be a review by all those interested—including the parent. The child can be temporarily placed in another facility during this review period if necessary. The review must take place within five days of the decision to discharge the child. It will determine whether

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

Staying Involved

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

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

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

Parents should:

- ▶ Schedule regular meetings and phone conferences with the child's treatment team, including the therapist and other staff members who regularly have contact with the child. Facilities should not enforce an "adjustment period" where parents are encouraged to limit their contact.
- ▶ Visit regularly with your child. If distance prevents you from visiting in person, you can establish a regular schedule of phone calls.

You can also request weekly or biweekly phone calls or written reports from the therapist and teacher. The county can help arrange visits with your child if you do not have transportation. Many treatment centers can also use Skype or other conferencing tools. Some facilities also offer family lodging options for families to use when visiting.

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

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

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

PLANNING FOR YOUR CHILD TO COME HOME

Discharge Planning

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

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

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

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

Before a child comes home, parents should consider:

- Several weeks before a child is to be discharged, request meetings with staff. Discuss and plan for what supports will be needed when the child comes home. This can include, for example, intensive

case management, CTSS services, personal care assistance (PCA), in-home services, respite care and special education services. Decide who will arrange and set up aftercare services—parents, the school, the mental health case manager or facility staff.

- ▶ Plan for your child's school program and make sure that it will be in place.
- ▶ Visit the school and talk to your child's teachers.
- ▶ Make sure the school classroom offers an appropriate program for your child.
- ▶ Request an individualized education plan (IEP) conference if your child requires a special education program or a 504 plan if your child needs accommodations in the classroom.
- ▶ Set up a support system for yourself, your child and other members of the family. Contact NAMI Minnesota about teen and parent support groups.
- ▶ Encourage an open conversation between your child and the rest of the family about the difficulties of getting used to each other again. Talking things out can help ease some of the tensions.
- ▶ Contact agencies and services such as social workers, mentoring programs and in-home behavior therapists that can provide services and supports. Families should ask residential providers if they can provide recommendations or referrals.
- ▶ Create a detailed safety plan with your child's entire treatment team. The plan should include the things that tend to make your child's behaviors worse, tips for avoiding those triggers and what to do when your child becomes upset and needs help to calm down. Share the safety plan with your child's personal care attendants, case manager, school, therapist, doctors, the local police department and the county's Crisis Response Unit, if necessary. Having a good safety plan is a proactive way to anticipate and address a crisis before it happens.
- ▶ Find out what kind of aftercare is available (including video and phone) from the treatment program, especially if you live near-by.
- ▶ Arrange for respite. If it is available through your county, request the service. If it is not, look for ways to get informal respite if it is needed. Respite from friends, family, or other sources can give everyone a break, including your child.

Bringing a child home can raise many questions for parents, including: Will I be able to obtain the in-home services necessary to support my child? Will I be able to prevent my child from hurting themselves or others? Will my child be mad at me? What will "normal" be? These are all typical questions that many parents ask themselves. Parents can talk

to the treatment facility and other parents to find answers to these and other questions and find out what support may be available from the program.

Putting Services into Place

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

Several types of support, many of which were mentioned earlier, may be available to help the family. Families should work with their county case manager and health insurance company to obtain the services their child will need to do well at home. These can include the services shown on pages 8–18.

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

SUPPORT GROUPS: These groups offer parents a way to connect to other families that have children with mental illnesses. Caring for a child as they return home from residential treatment is exhausting and very time-consuming. Support groups give parents a way to help take care of themselves. At a support group, parents can meet other parents with similar experiences. By networking with other families, parents create more support for themselves and their child and increase their family's chance of staying together. ■

IF PARENTS DISAGREE

If parents disagree with a decision to deny any type of treatment, they have the right to appeal to the agency that made the decision. For example, if the health plan denies treatment, parents can appeal that decision to the health plan. Parents can also contact the Minnesota Department of Health, Minnesota Department of Commerce and the Minnesota Attorney General's Office if they have a complaint about their health insurance. Contact the U.S. Department of Labor for self-insured plans. If the county denies treatment, parents can file an appeal to the state. If the treatment plan created by the treatment center is not what a parent thinks is best for their child, they can meet with treatment staff. If the county or health plan decides to terminate treatment before a child has completed treatment, parents can appeal to the health plan or county. If the treatment is funded by a health plan or in part by Medical Assistance and a parent appeals before the discharge date, they have the right to have treatment continue pending the outcome of the appeal. Everyone should give parents written instructions on how to appeal decisions they make. ■

OTHER RELEVANT LAWS

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

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

It is important that parents are at the center of a team that may include special education, juvenile justice and child welfare services along with other natural supports. These collaboratives identify needs and service gaps in the system of care and then plan and coordinate services. The collaborative partners then put together staff, money and other

resources to provide local services and resources in the community. Parents should always be a part of this team. They help guide providers and agencies to work together. They help coordinate services and supports. The goal of the collaboratives is to create a better system of care for children with mental illnesses.

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

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

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

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

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

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

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

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

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

In Minnesota, generally, the court will approve the agency's "compelling reasons" because:

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

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

COMMON TERMS

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

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

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

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

CHILD IN VOLUNTARY FOSTER CARE FOR TREATMENT: means a child who has an emotional disturbance or developmental disability or has a related condition. The child is in foster care under a voluntary foster care agreement between the child's parent and the agency. This is due

to agreement between the agency and the parent that the child's level of care requires placement in foster care either:

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

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

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

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

COMPELLING REASONS: If a child is in foster care for more than 13 consecutive months or 15 months over a 22 month period, the law requires that a permanency plan be created unless there are compelling reasons for the child to remain in care. If a child continues to meet medical necessity for residential treatment, and the family is still involved in the child's life, this can be considered a compelling reason. This is why it is important for family's to keep records showing they are in regular contact with their child.

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

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

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

DEVELOPMENTAL DISABILITY: severe, chronic disability that can be cognitive, physical or both. It must appear before age 22 and be likely to be

life-long. Some are largely physical, such as cerebral palsy. Others are both physical and intellectual such as Down syndrome or fetal alcohol spectrum disorder.

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

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

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

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

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

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

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

MINOR: an individual under 18 years of age.

PARENT: means the birth or adoptive parent of a minor. Parent also means the child's legal guardian or any individual who has legal authority to make decisions and plans for the child. For an American Indian

child, parent includes any American Indian person who has adopted a child by tribal law or custom.

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

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

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

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

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

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

ACRONYMS USED IN CHILDREN'S MENTAL HEALTH

ADHD	Attention deficit / hyperactivity disorder
ASFA	Adoption and Safe Families Act
CA	County attorney
CAFAS	Child and Adolescent Functioning Assessment Score
CASSP	Child and Adolescent Services System Program
CHIPS	Children in need of protection or services
CMHA	Minnesota Comprehensive Children's Mental Health Act
CR	Custody relinquishment
CTSS	Children's therapeutic services and support
DD/ED	Developmental delay / emotional disturbance
DHS	Department of Human Services
DSM-IV	Diagnostic and Statistic Manual of Mental Disorders
EBD	Emotional behavior disturbance
EBP	Evidence-based practices
GAF	Global Assessment of Functioning
IDEA	Individuals with Disabilities Education Act
IEP	Individualized education plan
IIIP	Individualized interagency intervention plan
ITP	Individual treatment plan
MA	Medical Assistance
MRJPP	Minnesota Rules of Juvenile Protection Procedure
OHPP	Out-of-home placement plan
PD	Public defender
PMAP	Prepaid Medical Assistance Plan
SED	Severe emotional disturbance
SSI	Social Security Income
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982
TPR	Termination of parental rights
VFCA	Voluntary foster care agreement
VPA	Voluntary placement agreement
504 plan	Section 504 of the Americans with Disabilities Act ■

FEDERAL AND STATE RESOURCES

Federal Resources

www.nami.org

National Alliance on Mental Illness

www.samsha.org

Substance Abuse Mental Health Services Administration

www.nimh.org

National Institute of Mental Health

www.ed.gov

U.S. Department of Education

www.ssa.gov

Social Security Administration

www.ffcmh.org

National Federation of Families for Children's Mental Health

www.bazelon.org

Bazelon Center for Mental Health Law

www.ojjdp.gov

Office of Juvenile Justice and Delinquency Prevention

www.chadd.org

Children and Adults with Attention-Deficit/Hyperactivity-Disorder

www.nctsn.org

National Child Traumatic Stress Network Center

State Resources

www.namimn.org

NAMI Minnesota (National Alliance on Mental Illness)

www.dhs.state.mn.us/cmh

Minnesota Children's Mental Health Division

www.macmh.org

Minnesota Association for Children's Mental Health

www.pacer.org

Parent Advocacy Coalition for Educational Rights

www.doc.state.mn.us

Minnesota Department of Corrections

www.education.state.mn.us

Minnesota Department of Education

www.health.state.mn.us/mcshn

Minnesota Children with Special Health Needs

www.arcmn.org

Arc of Minnesota

www.ausm.org

Minnesota Autism Society

www.mccca.org

Minnesota Council of Child Caring Agencies

www.mndlc.org
Minnesota Disability Law Center

www.ombudmhmr.state.mn.us
Minnesota Ombudsman for Developmental Disabilities
and Mental Health

www.mnadopt.org
Minnesota Adoption Support and Preservation ■

VOLUNTARY FOSTER CARE AGREEMENT FORM

Purpose

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

THIS IS AN AGREEMENT BETWEEN, _____,

AGENCY NAME

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

_____ and _____,

PARENT 1

PARENT 2

parent(s) of _____, residing at

CHILD'S NAME

_____, _____,

CHILD'S ADDRESS

CHILD'S CITY, STATE, AND ZIP CODE

County of _____ State of Minnesota.

The Agency agrees to

1. Provide or authorize supervision of your child who is placed in a licensed foster care home or in an authorized licensed child care agency.
2. Assume financial responsibility for board, room, clothing, medical care, dental care, and other expenses involved in the care of your child. When appropriate, we will bill your health insurance, Medical Assistance or you for these services. We will assist you in applying for Medical Assistance.
3. Provide current child support information with an authorization for the release of information.
4. Develop a written Out-of-Home Placement Plan with your family within 30 days as required by Minnesota Statutes, section 260C.212, subd.1.

5. When the parent is unable to do so, arrange and provide necessary routine medical and dental care, which may include tests and immunizations.
6. Obtain parent's written permission for major medical care except in an emergency situation when neither parent can be reached.
7. Provide casework and other services according to the required service plan while our child is living out of the home.
8. Return the child to the parent or guardian as soon as possible and no later than 24 hours after receipt of a written and dated request from the parent or guardian unless the request specifies a later date, or, because of child protection concerns, this agency secures legal authority to continue placement outside the home of the parent or guardian.

As a parent, I agree to

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

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

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

SIGNATURE OF MOTHER/LEGAL CUSTODIAN

SIGNATURE OF FATHER/LEGAL CUSTODIAN

SIGNATURE OF AGENCY REPRESENTATIVE

TITLE OF AGENCY REPRESENTATIVE

DATE OF AGREEMENT

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