



# Office of Children and Family Services

Andrew M. Cuomo  
Governor

52 WASHINGTON STREET  
RENSSELAER, NY 12144

Sheila J. Poole  
Commissioner

## Informational Letter

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<b>To:</b>	Commissioners of Social Services Executive Directors of Voluntary Authorized Agencies
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<b>Contact Person(s):</b>	See section IV.
<b>Attachments:</b>	

### Filing References, if applicable

Previous ADMs/INFs	Releases Cancelled	NYS Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.

### I. Purpose

The purpose of this Informational Letter (INF) is to provide guidance to local departments of social services (LDSS) and authorized voluntary agencies (VAs) on therapeutic foster care (TFC), including the guiding principles, outcomes with its use and the key components of a therapeutic foster care model.

### II. Background

TFC is a critical component of the child welfare continuum of care. It has distinct differences from a regular foster care program and can best serve children (the term youth will be used when referring to children age 16 or older) who are experiencing emotional and behavioral issues, but who need less programming structure and supervision than what is provided in a residential treatment program. TFC should be provided to assist a child to be placed in

the least restrictive environment, but only for the length of time to meet the child's needs while efforts are being made to promote the child's permanency plan. The administrative rate provided to VAs that operate a TFC program is higher than the rate provided for regular foster care programs. The higher administrative rate allows the VA to provide higher level supports and services to the children and foster parents in the TFC program. The higher rate also compensates for the additional training and staff development needs required of TFC program staff and TFC parents. The maintenance rate provided to the TFC parents is dependent on the child's level of difficulty (LOD) and is prohibited from being less than 100 percent of the Maximum State Aid Rates (MSARs) established by OCFS.<sup>1</sup>

### III. Program Implications

The purpose of this guide is to inform both VAs that provide TFC and LDSSs that purchase this service about what is expected in promoting positive outcomes for children receiving TFC services.

TFC programs are specialized family boarding home programs that care for children who, due to the child's special needs or significant emotional and behavioral issues, would otherwise need to be served in group foster care. Examples of issues impacting a child who may be appropriate for placement in a TFC include the following:

- Severely developmentally disabled infants and/or children
- Adolescents with a documented history of acting out behavior and/or adjudication as PINS or juvenile delinquents
- Severely emotionally disturbed children
- Children with histories of group care placement or who are at risk of group care placement
- Children with at least one failed foster boarding home placement
- Severely and/or multiply physically handicapped children<sup>2</sup>

Any child cared for in a TFC programs should meet the criteria for special or exceptional foster care services found in 18-NYCRR 427.6(c) and (d).

#### Outcomes of the Use of Therapeutic Foster Care

- Children will achieve measurably improved or stabilized clinical outcomes resulting in fewer placement disruptions.
- Children will be able to be reunified with their family, adopted, discharged to kinship guardianship, or transferred to a less restrictive family setting, if in the child's best interest.
- Children will experience less reentry into foster care.

The decision to place a child in TFC must be made by the LDSS. However, TFC is provided in New York State by VAs that are approved, inspected, supervised and visited by the New York State Office of Children and Family Services (OCFS). VAs wishing to operate a TFC program must seek approval from OCFS to operate such a program by contacting its regional office.

<sup>1</sup> Standards of Payment Manual, Chapter 3.

<sup>2</sup> Standards of Payment Manual, Chapter 7, Section B1.

The VA that provides the TFC program is responsible for the case planning and treatment of the child placed in a TFC home, as well as providing services to the parent/caregiver. VAs in New York City contracting with the New York City Administration for Children's Services (ACS) are also responsible for case management. VAs should be keeping in close communication with the LDSS placing the child and regularly seek guidance from the LDSS while maintaining primary responsibility for the case. Reassessment of a child's need for TFC should be done at a minimum during each service plan review (SPR)<sup>3</sup> at a minimum. SPRs are held within 90 days after removal of the child from their home, at six months after removal and every six months thereafter.

#### Guiding Principles of TFC programs:

- A. As noted in the OCFS Child Welfare Practice Model,<sup>4</sup> the Principles of Partnership should be embedded in TFC whereby all children/youth and their families and TFC parents are treated as partners in the planning and delivery of services.
- B. All children and families have strengths and needs. Planning must be done with the child and their family to build upon their strengths and to help meet their needs.
- C. All services provided for children in TFC placements should be family oriented and community based for children and youth with emotional issues that lead to significant behaviors that need to be addressed in a therapeutic setting. Services should also be provided to the child's family while the child is receiving treatment in an out-of-home placement to expedite permanency.
- D. TFC provides for the use of an individual behavior management plan that should take into consideration the cultural differences and special needs of the child and his or her family.

#### **Agency Staffing**

VAs are to maintain a high staff-to-child ratio and ensure that children have access to a treatment team of highly skilled and experienced professional staff. As noted in the *Standards of Payment for Foster Care of Children Manual*, staff include:

- Social Worker/Caseworker
  - Capacity/caseload - One (1) full time equivalent (FTE) social worker/caseworker for every eight (8) children
- Social Worker/Caseworker Supervisor
  - Capacity/Caseload - One (1) FTE supervisor for every four (4) social workers/caseworkers
- Educational Consultant

<sup>3</sup> 18NYCRR 430.12(2).

<sup>4</sup> The *Child Welfare Practice Model* can be found at <https://ocfs.ny.gov/main/prevention/CW%20Practice%20Model.pdf>.

- Capacity/Caseload – One (1) FTE educational consultant for every 40 children
- Child Care Worker
  - Capacity/Caseload – One (1) FTE child care worker for every six (6) children
- Child Care Worker Supervisor
  - Capacity/Caseload – One (1) FTE child care worker supervisor for every eight (8) child care workers

### **Agency Case Planning**

The VA must provide case planning services to the child and the family so that they are connected to appropriate services that are coordinated to meet the child's treatment needs. Case planning includes: connecting or referring the child to all required services and supports as noted in the child's individualized service plan; case-specific advocacy (interceding on behalf of the child to gain access to needed services and supports); and monitoring the child's services plan to determine that services and supports are received.

The VA is also responsible for providing 24-hour, on-call availability and support to families.

### **Qualifications and Selection of the Therapeutic Foster Care (TFC) Parent**

TFC parent selection process begins at the time of initial recruitment and extends through orientation and training. Keeping in mind that kinship caregivers are critically important resources in child welfare, efforts to qualify kinship homes as therapeutic are equally important. When appropriate and in the child's best interests, kin placements are preferred because they maintain the child's family connections. A large body of research demonstrates that children in kinship placements experience less trauma, fewer behavioral and mental health problems, less placement disruption, and have greater school stability and general well-being than children placed with caregivers with whom the children have no prior relationship.

TFC parents are selected partly based of their acceptance of the program's treatment philosophy, and also their ability to practice or carry out this philosophy on a daily basis. They need to be willing and able to accept the intense level of involvement and supervision provided by the program staff and understand the impact of that involvement on their family life. TFC parents need to be willing to carry out all the tasks specified in their TFC program's roles and responsibilities, including working directly and in a supportive fashion with the families of children placed in their care.

In selecting TFC parents, several important qualities should be sought. These may include, but are not limited to

- commitment,
- a positive attitude,
- willingness to implement treatment plans and follow the program's treatment philosophy,
- a sense of humor,
- enjoyment of children,
- flexibility,
- tolerance, and

- the ability to adjust expectations of achievement and progress to a child's individual needs and capabilities.

TFC parents need to approach working with a child as a family commitment that comes with a sense of unconditional care and inform their own children about the nature of the program. TFC families shall be financially stable and shall demonstrate emotional stability individually and as a family unit. TFC parents should have access to reliable backup and a network of support, in addition to professional support provided by the approving agency.

#### Approval/Certification Process

All TFC parents are subject to the same minimum standards as traditional foster parents as outlined in 18 NYCRR §443.3. The additional requirements, as noted in this guide, should be considered by the VA.

#### Training for Therapeutic Foster Care Parents

TFC parents must attend and complete an OCFS-approved pre-service training, in addition to the requirements found in 18 NYCRR 427.6(e). They must also participate in Reasonable and Prudent Parenting Standard (RPPS) (Normative Experiences<sup>5</sup>). Additional trainings are strongly encouraged to assist TFC parents in providing care for children with difficult behaviors prior to having children in their home. Trainings should be consistent with the program's treatment philosophy and methods and equip the TFC parents to carry out their responsibilities as agents of the treatment process. Additional suggested trainings include

- cardiopulmonary resuscitation (CPR);
- working with lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth;
- preparing youth for adulthood;
- parenting skills training (PST);
- motivating youth in care;
- constructive confrontation; and
- transition planning.

#### Support for Therapeutic Foster Care Parents

TFC programs must provide intensive support, technical assistance and supervision to all TFC parents. TFC parents should be provided support and assistance that includes the following:

**Information disclosure** - VAs should provide basic information to TFC parents about each child who is to be placed in the home. Where a child is placed on emergency basis, such information shall be provided within 30 days of placement. Information shall include, but need not be limited to the following topics:

- (i) The estimated length of time a child may need to be in placement and the assumptions and knowledge on which the estimate is based

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<sup>5</sup> 18 NYCRR 441.25 and 17-OCFS-ADM-01.

- (ii) The health of the child, including the procedure to be followed in obtaining consent for emergency medical treatment in accordance with 18 NYCRR 507.5, and the child's medical history in accordance with the provisions 18 NYCRR357.3.
- (iii) Handicaps or behavior problems
- (iv) School and educational experiences
- (v) The relationship of the child and the natural parents
- (vi) Requirements and plans for visitation of and by the natural family, including probable location of such visits
- (vii) Placement and discharge goals<sup>6</sup>

The information shared with the TFC parent should be documented in the child's case record. The information to be shared should include the child's strengths, potential problems and needs, and initial intervention strategies for addressing these areas.

This information must remain confidential in keeping with agency standards. TFC parents should be trained in the requirements of the Health Insurance Portability and Accountability Act.

**Counseling** - TFC parents and their own children should have access to counseling and therapeutic services arranged by the TFC program for personal issues or needs that are caused or complicated by their work as TFC parents (e.g., marital stress or abuse of other children in the household by a TFC child placed in the home).

**Support Network** - The program should facilitate the creation of formal or informal support networks for its TFC parents (a foster parent support group, for example). TFC parents should also be encouraged to join a local foster parent association, if one exists.

**Financial Network** - Financial support for children placed with TFC parents should be reimbursement payments that are commensurate with the level of difficulty in addressing the child's needs.

**Damages and Liability** - The program should have a written plan concerning the availability of compensation for damages in accordance with 18 NYCRR 427.3(c)(2)(x) and 15- OCFS-ADM-21.

**Legal Advocacy** - The VA may assist TFC parents in obtaining legal advocacy for matters associated with the proper performance of their role as TFC parents.

**Reporting of Abuse and Maltreatment** - TFC parents are not mandated reporters, however, when a TFC parent has reasonable cause to suspect abuse or maltreatment of the child placed in their home, the TFC parent is expected to make a report to the New York Statewide Central Register of Child Abuse and Maltreatment at 1-800-342-3720. A TFC parent does not need the consent of the VA caseworker to make a report.

### **Capacity**

Therapeutic foster boarding homes must meet the criteria for certification and approval described in 18 NYCRR 443.3. Additionally, when determining the number of children to be placed in the home, each child's assessed Level of Care must be considered (18 NYCRR 427.6).

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<sup>6</sup> 18 NYCRR 443.2(e)(3).

Realistic expectations of a TFC parent's capacity to provide appropriate care to the child(ren) with therapeutic needs must be also be considered. All information acquired about a TFC parent and the other individuals residing in a TFC parent's home should be considered when determining whether a TFC parent is able to provide care for a child with therapeutic needs as well as a TFC parent's ability and willingness to partner with the VA caseworker to support the child's permanency plan.

### **Treatment**

**Treatment Planning** - TFC uses a multidiscipline approach to treatment planning. Treatment planning starts with the child and his or her family. The child and family identify what they want from services and how providers may assist them. Planning includes assessment of strengths of the family and child and their needs, the reason for placement, and any safety factors. Assessment of the child's functioning may include the Child and Adolescent Needs and Strengths (CANS) assessment, clinical risk screens, Columbia Suicide Severity Rating Scale (C-SSRS), ACES score, fire setting assessment, trauma assessment, developmental assets profile, GAIN-SS, assessment of the child's connections, life skills assessment (Casey Life Skills Assessment). Additional assessments from service providers included in treatment planning may include psychiatric assessment, psychological assessment, educational assessment, and health assessments. The treatment plan is developed based on the assessments, the desired goals (outcomes) of the family and child, and input from case manager and treatment providers. Family connections and parenting time plans are identified, as well as a permanency plan. Safety plans are developed based on behaviors and risk assessments. Copies of treatment plans are provided to the child, family, TFC parents, case manager, case planner, caseworkers and additional VA and community service providers to be aware of the goals and plan to achieve them. There are ongoing reviews of treatment plans. Revisions to the plan are made based on child and family input, assessment of needs, and progress on identified goals. Discharge planning is part of planning for treatment, addressed through the work with the child and family and reviewed along with the treatment plan.

For youth ages 18-21, treatment must include transition planning, which is done with youth to assist them in understanding and working on planning for their future. The transition plan (see *Transition Plan*, OCFS-4922) is completed with youth who are planning to discharge from foster care from ages 18 to 21 regardless of their permanency plan goal. The transition plan is unique to each youth and is developed to represent the youth's plan for their future. The development of the plan should begin at least 180 days prior to the youth's 18<sup>th</sup> birthday, with the completion of the transition plan 90 days prior to the scheduled discharge. Beginning when the youth is 18 ½ years of age and every six months thereafter for youth who remain in foster care, the *Transition Plan* (OCFS-4922) is reviewed, and if changes are necessary a *Transition Plan Amendment for Youth Ages 18-21* (OCFS-3917) must be completed. The VA agency worker documents in the treatment plan how the youth is working on their transition plan and what goals they are developing. The transition plan must include specific options on housing, health insurance, education, local opportunities for mentors, continuing support services, and workforce supports and employment services (18 NYCRR 430.12 (j)).

Per NYCRR 430.12(k), upon attaining the age of 14 years and each year thereafter until discharged from foster care, each child in foster care must receive a copy of any consumer report on such child, as prescribed by OCFS at no cost to the child. The VA agency

responsible (as determined by the social services district that has legal custody of the foster child) for the child's case management, case planning or casework must provide or arrange for the provision of assistance to the foster child that includes, where feasible, assistance from any court-appointed advocate in interpreting and resolving any inaccuracies in the report(s). A *consumer report* means information by a consumer reporting agency bearing on the consumer's credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living which is used or expected to be used or collected in whole or in part for the purpose of serving as a factor in establishing the consumer's eligibility for

- (i) credit or insurance to be used primarily for personal, family, or household purposes;
- (ii) employment purposes; or
- (iii) any other purpose authorized by federal law.<sup>7</sup>

Additionally, per 18 NYCRR 430.12(l) "a child in foster care who is leaving foster care by reason of attaining 18 years of age or older and who has been in foster care for six months or more may not be discharged from care without being provided with the following, if the child is eligible to receive such document:

- (1) an official or certified copy of the child's United States birth certificate;
- (2) social security card issued by the Social Security Administration;
- (3) health insurance information;
- (4) copy of the child's medical records in accordance with 18 NYCRR 357.3; and
- (5) a driver's license or identification card issued by the State in accordance with the requirements of Federal law."

When a youth who has been in foster care for at least six (6) months is being discharged from foster care, by reason of the youth reaching 18 years of age or older, the youth must be provided with a completed OCFS-5184, *Foster Care Placement Verification Form*.<sup>8</sup>

**Treatment Implementation** - The VA caseworker directs the implementation of the treatment plan including ensuring the goals are worked on through direct involvement, referral/linkage, or monitoring. VA caseworkers make referrals to service providers to meet a child's needs that identified through the detailed assessments and development of the service plan. Referrals may include a community mental health or medical providers, daycare, after school program, summer programs, camps, tutoring, mentoring, school district Committee on Special Education (CSE), or a specialized treatment modality (e.g., therapeutic riding, behavior specialist). VA caseworkers have ongoing collateral contact with service providers to monitor progress and efficacy. The VA caseworker links with medical provider, mental health therapist, psychiatric provider, and school personnel in addition to other community based services that may be involved to monitor implementation of the treatment plan, address barriers, assess progress, and identify changes as needed.

The VA caseworker engages with the family, child, and TFC parent to carry out the developed treatment plan toward achieving goals. The VA caseworker may provide treatment interventions to the family and child and provide education to TFC parents regarding child specific needs. The VA caseworker engages the child, and TFC parent to address the child's treatment goals. TFC parents receive training to meet the needs of children in their care. VA caseworkers work with the child, family and TFC parents to address behavioral, emotional and social challenges. Treatment plan goals to be

<sup>7</sup> 18 NYCRR 430.12(k) and 15-OCFS-ADM-13.

<sup>8</sup> 18-OCFS-ADM-16.

addressed may include social skills, anger management, coping skills, hygiene, independent living skills for those aged 14 and over, school-related needs, understanding mental health diagnosis, management of symptoms resulting from mental health diagnosis, work on personal boundaries and support of interventions, and skills learned through individual therapy. Parenting skills and behavior management techniques are taught. The VA caseworker may work with the child and school staff to support the child and provide information on treatment interventions useful to the child to increase the likelihood of school success. Interventions also include addressing crisis situations with a child, family and TFC family, offering support, direct intervention, and linkage with resources such as mental health provider. TFC parents have access to 24-hour on call crisis support. This can include support from the child's treatment team.

**Treatment Team Meetings** - All SPRs must comply with the standards set forth in 18 NYCRR 428.9 and 18 NYCRR 430.12. Persons invited to all treatment planning meetings and individualized service plan meetings should include: the child, the biological family of the child in care, the VA caseworker, and any other VA staff that may work with the child/family, the TFC parent(s), the LDSS caseworker, the child's mental health therapist, a school representative, the court-appointed special advocate (CASA) or attorney for the child (AFC), and Indian tribal representatives (if working with Indian children and families). The child and family may request that other interested parties be invited to the treatment plan meetings. At the option of the child, up to two members of the child's case planning team who are chosen by the child and who are neither the child's TFC parent(s) nor the child's case manager, case planner, or caseworker. The VA with case management responsibility may reject an individual selected by the child to be a member of the child's case planning team if the VA has good cause to believe that the individual would not act in the child's best interests. One individual selected by the child to be a member of the child's case planning team may be designated to be the child's advisor and, as necessary, advocate with respect to the application of the reasonable and prudent parent standard for the child.

Treatment plan meetings provide an opportunity for the child and family to share progress on goals, express needs, and discuss barriers to achieving the goals. Permanency plans and parenting time plans are reviewed and updated at these meetings. All are encouraged to participate in the discussion at treatment plan meetings.

**Documentation** - The Family Assessment and Service Plan (FASP) is the documentation of the treatment plan. The VA caseworker also develops individualized treatment plans addressing child-specific needs in concert with the FASP. Progress on goals is documented in the progress notes, in the FASP, and in the individualized treatment plan. Documentation used to develop the treatment plan include assessments done by the VA and gathered from community service providers. Documents may include health assessments, medical reports, clinical risk screens, educational assessments, Individualized Education Plans (IEPs), school progress reports, psychiatric evaluations, psychological evaluations, biopsychosocial assessments, court orders, life skills assessments (as applicable), assessment of the child's connections, safety assessments, child specific assessments (substance use, fire setting, trauma), and assessment of functioning such as CANS. VA caseworkers communicate regularly with service providers with whom they have linked the child to, and request updates on the child's progress in order to make adjustments to services as needed. These efforts are documented in progress notes. Documentation of the services that have been provided to the child is obtained by VA caseworkers (such as progress report, psychological assessment, and

therapy). The treatment plan includes the needs of the child and how the need will be addressed by staff or other service provider. Documentation of staff work on the needs (goals and objectives) is documented in progress notes and reflected in the treatment plan.

**Contact with the Child's Family** - In accordance with 18 NYCRR 441.21, contact with the child and family is made by the VA caseworker at least once a month; however, it is suggested twice monthly (one time in the foster home with the child) to work with the child, family and TFC family on the child's identified goals. As applicable, the VA caseworker provides supervision of parenting time. The VA caseworker focuses on the development and implementation of treatment plan goals, permanency planning, and child visits with the family. The VA caseworker engages the family in identifying child and family strengths as well as needs and reason for foster care placement. During contacts with the family and the treatment plan meeting, the VA caseworker gathers family input and view for the treatment plan. The established treatment plan includes the family and child goals, parenting time plan, and permanency plan. The VA caseworker may work directly with the family on goals, make referral to community providers, and support the family in taking steps toward achieving goals. Areas of focus may include parenting skills training, mental health professional referral, housing needs, and/or referral to support groups. The agency worker may also be involved with supervising parenting time with the child (if parenting time is supervised). VAs work with families to plan for the parenting time, encourage parents to meet the needs of the child, and to follow any court-established or LDSS-established expectations of the parenting time, and document the parenting time.

**Permanency Planning** - As always, permanency planning is done with urgency. VA caseworkers engage families around permanency early in the treatment planning process. VA staff discuss with the family Adoption and Safe Families Act (ASFA) timeframes and explore family connections. The need for permanency resources is discussed with the family and they are asked to identify potential resources for the child and continue to have conversations about resources throughout the duration of the case. Additional exploration of family or other individual resources may be made to increase options for potential child connections and permanency. Concurrent permanency plans are documented in the FASP. VA caseworkers prepare the child for permanency: reunification, adoption, kinship or other resource. VA caseworkers engage the child and family around reunification, changes that have happened, the needs of the child and family, and the supports that will need to be in place for successful reunification. Where reunification is not possible, the VA caseworker (with the LDSS staff) explores the alternative permanency plans.

Additionally, the VA caseworkers engages the child, while partnering with the child's mental health providers and additional service providers, about the change, the loss of family connection, the plan for permanency, adoption preparation and process, and exploration of adoption and other resources. This may include identification of an adoptive family, photolisting a child, and activities to find adoption resources (e.g., Heart Gallery, adoption exchange). VA caseworkers engage permanency resources to prepare them for connection with a child. VA caseworkers provide information about the child, identify strengths and needs, provide child specific education, assess the resource's relationship with the child and the resource's capacity for involvement and commitment to the child. VA caseworkers educate individuals on resources provided by the VA and community to support them and the child.

Discharge to an adult residential care may be the only permanency goal for children for whom the necessity of placement is based in whole or part on a "child service need" arising out of a factor other than the child's behavior [18 NYCRR 430.11(f)(1)(i)]. Planning and

communication with the LDSS and the Office of Mental Health or the Office for People with Development Disabilities may need to start for a child as young as 14 years of age.

**Partnership with Service Providers** - The VA caseworker partners with the child's and family's service providers. To address the needs of the child, the VA caseworker supports and educates the TFC parent on the specific needs of the child, and works with the TFC parent to address the child's goals. The VA caseworker may provide information or recommend external sources for training needs. The VA caseworker maintains regular communication with school and internal and external service providers. These include participating in CSE meetings or student-focused school meetings for a child, attending mental health, psychiatric and medical provider appointments, attending service planning meetings for specialized services or therapies, and other specific services identified for a child and family. To meet the goals of the child and family, VA caseworkers communicate with these providers on progress, needs and barriers. These service providers are also invited to participate in treatment team meetings that occur regularly. The VA caseworker monitors the services provided, communicates with the child, family, and provider to ensure that the service is having the desired outcome; the VA caseworker endeavors to overcome barriers and gathers regular updates to include in treatment planning. Input from the service providers is gathered to document goal progress and goal modifications. Service providers are invited to regular treatment team meetings.

**Advocacy on Behalf of the Child** - VA caseworkers advocate for the child and family in seeking needed agency and community services. Advocacy may include school services such as CSE services, 1:1 aides, tutoring, extracurricular activities, and transportation. VA caseworkers advocate for psychiatric services including evaluations, medication evaluation, and answering the child's medication questions; medical services and evaluations to address concerns; and level of programming to meet the child's needs. The VA caseworkers work to maintain positive connections with family, friends and community; they advocate for sibling contact, parenting time in the home and increases in parenting time in pursuit of timely reunification; and they work for child activities and socialization to promote normalcy. VA caseworkers advocate with the courts and LDSSs to meet the needs of the child and his or her family for services, resources and timely permanency.

### **Services for Children**

TFC is designed to support children by providing treatment and support to help them to 1) decrease any challenging behavior they exhibit, 2) improve developmentally appropriate and adaptive gains, and 3) live in a less restrictive family-based setting either while still in care or upon discharge, without the intensive amount of services provided in TFC. The VA shall provide child welfare services that ensure each child's safety and supports their optimal health, development and well-being. The VA shall be strongly focused on addressing and promoting the best interests of each child.

The VA must provide clinical services to children, and develop individualized clinical treatment plans to support each child and increase their ability to respond in ways that are both developmentally appropriate and adaptive. The VA must conduct a comprehensive assessment upon intake, which should include an assessment of past trauma.

The VA should access health, mental health, and substance abuse services that meet the full range of care (specialty, subspecialty, ancillary, and hospital services) needed by each child in a comprehensive, accessible, high quality, child-focused and friendly way.

**Mental Health/Clinical Services** - TFC allows for VAs to explore programs to assist with psychiatric needs including psychosis. Each child's length of stay in the program should be based on an individualized assessment and a determination of how and where their needs can be best supported. VAs must use diligence to place children in homes with the needed supports, including when children are being returned home. Some families may need ongoing services after TFC, and VAs and LDSSs should attempt to place those services in their homes as aftercare supports, or refer them to other service systems when appropriate and available.

- Engagement of the child and their family is the first step in offering family-driven care and is crucial for the treatment process. A variety of approaches to family engagement should be used throughout the assessment and treatment process to maintain involvement and promote successful outcomes for families.
- All children should have a designated clinician to ensure that an assessment is completed in a timely manner. The assessment process should begin with the child and their family or discharge resource and TFC parents. An integrated assessment report should be developed and should include the psychiatric, psychological, medical, and educational assessments, prior evaluations, current therapy reports, initial observations and medication history. This comprehensive document should inform treatment throughout the child's placement, reflect their progress, and guide VAs as they make decisions concerning discharge planning and aftercare services. Every child in TFC must be evaluated using a psychological assessment tool. If the psychological assessment indicates weekly individual therapy, then that process must be followed. Family therapy is a biweekly requirement unless the psychological assessment indicates that it should be done weekly. Both types of therapy must fit within the child and family's permanency plan and the frequency of the intervention must be listed in the permanency planning goal. The agency must design, with input from the treatment team, a structured individualized treatment program for each child, which the TFC parents will implement. The provider must also involve the birth parents/discharge resource in treatment planning. All staff must be thoroughly knowledgeable about the individualized behavior treatment, and management and safety plans.

**Substance Abuse Education and Prevention Services** - If the child is using alcohol or drugs, the VA must provide strong support and guidance to help the child to break any dependence, help the child understand the underlying reasons for their substance use, and teach them about the consequences of continued substance abuse. If the child is using illegal substances and taking prescribed medications, the child will require immediate substance abuse treatment. Providers may refer the child to a community partner for treatment for alcohol or substance use, and/or offer to refer the child to substance abuse/drug counseling classes as needed.

TFC parents, birth parents/caregivers and discharge resources are encouraged to be trained on how to recognize the signs of alcohol and substance abuse and how to work with children who may be abusing or addicted to a drug or alcohol.

**Education Services** - An assessment of the child's education strengths, and needs should be done upon entry into a TFC program, if not done prior to their placement. Arrangements for the child's enrollment, educational placement, and school transportation must be done as quickly as possible. When in the best interest of the

child, the VA should coordinate with the appropriate school officials to arrange for the child to remain enrolled at the child's current school. The TFC program should advocate on behalf of the child and work with the school, TFC parents, and birth parents to identify the child's educational program needs.<sup>9</sup>

The child's caseworker should attend scheduled conferences, CSE meetings, and activities related to the child's educational programming. The child's parents and TFC parents should be encouraged to participate. All school reports should be reviewed to assess the child's progress on meeting their educational goals.

**Health and Medical Care** - A comprehensive assessment of the child's physical and dental health should be done upon entry into the TFC program if this is the child's initial placement, if not done prior to their placement. Parental participation in these assessments is strongly encouraged. Where possible, the child should continue seeing their current family physician and dentist to assist in care continuity.

The assessment should occur within 30 days of the child's initial placement in foster care, in accordance with 18 NYCRR 441.22(c). When records are available that show that the child received such an examination within 90 days prior to the admission into foster care, a subsequent examination is not required. The agency must obtain the medical/dental records and determine the child's current health status. Each child must have a complete, periodic individualized medical examination as required in 18 NYCRR 441.22(f)(1).

Prior to the child's discharge from foster care, the child must receive a comprehensive examination, unless the child has undergone such an examination within one year prior to the date of discharge.<sup>10</sup>

Medications prescribed by a physician must be purchased initially by the agency and provided to the TFC parent for distribution. The instructions for taking the medication must be explained to the child, if they are old enough to comprehend, and to the TFC parent. The TFC parent should be reminded to place all medication in a safe and secure location. Subsequent purchasing of medications should be decided between the TFC parent and the VA.

### **Services to Parents**

The VA, in collaboration with the LDSS that has legal custody of the foster child, is responsible for maintaining regular contact with the parents/caregiver of the child. Meeting with the parents will help facilitate open communication and the sharing of information about the child's progress and what services are needed by the parent to aid in successful reunification.<sup>11</sup> Supportive services should be offered, such as permanency planning services, parenting skills education, and specialized training.

VAs should include the scheduling of parenting time for the parents and their child, as well as visitation for other family members as deemed safe and appropriate and consistent with applicable visitation court orders. Parents should be fully trained in providing support to the child upon discharge. Behavior management and treatment

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<sup>9</sup> 18 NYCRR 430.11(c)(1)(i).

<sup>10</sup> 18 NYCRR 441.22(n).

<sup>11</sup> 18 NYCRR 441.2(b) and (c).

training should be provided to the parents as well as to the TFC parent. Structured family therapy may be helpful in conjunction with the behavior management and treatment strategies to create a structured treatment environment when the child returns home. Parents may have other service needs as well; referrals for those services may require assistance from the LDSS.

#### **IV. Contacts**

Any questions concerning this release should be directed to the appropriate regional office in the OCFS Division of Child Welfare and Community Services:

Buffalo Regional Office - Amanda Darling (716) 847-3145

[Amanda.Darling@ocfs.ny.gov](mailto:Amanda.Darling@ocfs.ny.gov)

Rochester Regional Office - Karen Lewter (585) 238-8201

[Karen.Lewter@ocfs.ny.gov](mailto:Karen.Lewter@ocfs.ny.gov)

Syracuse Regional Office - Sara Simon (315) 423-1200

[Sara.Simon@ocfs.ny.gov](mailto:Sara.Simon@ocfs.ny.gov)

Albany Regional Office - John Lockwood (518) 486-7078

[John.Lockwood@ocfs.ny.gov](mailto:John.Lockwood@ocfs.ny.gov)

Spring Valley Regional Office – Thalia Wright (845) 708-2498

[Thalia.Wright@ocfs.ny.gov](mailto:Thalia.Wright@ocfs.ny.gov)

New York City Regional Office - Ronni Fuchs (212) 383-4873

[Ronni.Fuchs@ocfs.ny.gov](mailto:Ronni.Fuchs@ocfs.ny.gov)

Native American Services - Heather LaForme (716) 847-3123

[Heather.LaForme@ocfs.ny.gov](mailto:Heather.LaForme@ocfs.ny.gov)

*/s/ Lisa Ghartey Ogundimu*

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**Issued by:**

Name: Lisa Ghartey Ogundimu

Title: Deputy Commissioner

Division/Office: Child Welfare and Community Services