

**260 – THE UNIQUE BEHAVIORAL HEALTH SERVICES - NEEDS OF CHILDREN,
YOUTH, AND FAMILIES INVOLVED WITH DCS**

EFFECTIVE DATES: 07/01/16, 10/01/21

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I. PURPOSE

This Behavioral Health Practice Tool applies to ACC, ALTCS E/PD, DCS/Comprehensive Health Plan (CHP), DES/DDD (DDD), and RBHA Contractors. This Practice Tool is an optional resource for the Fee-For-Service Programs and is not a requirement for the Fee-For-Service Programs. This Behavioral Health Practice Tool intends to:

- Provide an understanding of the unique behavioral health service needs of children involved with the Department of Child Safety (DCS) and to provide guidance to Child and Family Teams (CFTs) in responding to those needs.
- Outline the clinical considerations for serving children involved with DCS, their families, and other caregivers.
- Delineate the Rapid Response procedures that must be followed when a child is removed from their home by DCS (Refer to ACOM Policy 449 and AMPM Policy 541).

II. GUIDANCE

During the past 40 years, a growing body of research has identified some of the risk factors that predispose children and adults to behavioral health issues.^a Risk factors are those characteristics, variables, or hazards that, if present, make it more likely an individual will develop a disorder as opposed to someone selected at random from the general population. Risk factors can reside in the individual (such as a genetic vulnerability) or within the family, community, or institutions that surround the individual. Some risk factors play a causal role while others merely mark or identify the potential for a disorder. The degree of risk and the likelihood of developing a behavioral health issue is also shaped by the accumulation and timing of risk factors across the lifespan of the individual.

An adverse childhood experience or a biologic vulnerability may increase the risk for certain behavioral health issues, such as substance use, depression, and juvenile conduct disorder; however, other risk factors may also be necessary for the illness to be expressed. Studies of conduct disorder have consistently confirmed that as adverse conditions accumulate, the risk of disorder onset increases proportionately. However, certain risk factors, such as low income, are a more significant predictor in children aged four to 11 than in older adolescents.

Additionally, a study of adverse childhood experiences, known as the ACES Study, originally conducted at Kaiser Permanente during the mid-1990's provided longitudinal data and support for the connection between adverse childhood experiences and negative health outcomes during adulthood. This study of 9,500 adults provided strong evidence that exposure to traumatic events was more likely to lead to poor physical and/or mental health for adults. More specifically, early exposure to one or a combination of emotional, physical, or sexual abuse, domestic violence, parental separation or divorce, incarceration of one or more parents, living in a household characterized by substance use, or familial mental illness, lead to a greater prevalence of chronic health conditions (e.g. chronic heart and/or lung conditions, substance use, smoking, increased risk for suicide, depression, anxiety, other mental health issues).

Finally, understanding the complex interrelationships of individual, familial, and community risk factors in the onset of a behavioral health issue is also shaped by the presence of protective factors. These include but are not limited to— personal qualities, familial rituals and relationships, social/peer group norms, or level of spirituality —and they may contribute to individual resilience or the capacity to cope with significant stressors.

While any child might experience trauma, loss, or anxiety, children in the child welfare system tend to be exposed to an accumulation of adverse childhood experiences and life transitions to which children from other families may never be exposed. The mission of the child welfare system and DCS is to ensure children experience safety, permanency, and wellbeing. This mandate can be supported through strong partnerships between DCS and behavioral health providers to provide prompt behavioral health assessment, treatment, and services for referred families that may also reduce the risk of future behavioral health issues among children experiencing abuse or neglect.

In addition to this Behavioral Health Practice Tool, a training curriculum of the same title was developed jointly by DCS and Behavioral Health. It is currently a required training in the behavioral health system for all staff working with children.

A. PROCEDURES

The Contractor shall ensure the following eight steps are utilized/applied by behavioral health providers when with working with Children/Youth involved with DCS

1. Working in Partnership

Efforts to meet the unique service needs of children and families referred by DCS are best supported when all involved Contractors and DCS work collaboratively through a unified service planning process that upholds the Arizona Vision-and 12 Principles for Children Service Delivery. Partner agencies may include a variety of health, social service, and justice system organizations, including behavioral health providers, DCS, juvenile justice, DDD, education, and allied service providers

(including pediatricians and day care providers). The CFT provides the platform for unified assessment, service planning, and delivery based on the individual needs of the children and other family members. Other child-serving agencies, such as the DCS caseworker and Juvenile Justice probation officer (if the child is a dual ward/dually adjudicated) should be invited as members of the team where indicated to align efforts of the CFT with the child welfare case plan or other agency Service Plans. The CFT must strive to fully understand the unique needs of each child and family. Continuity of team membership and its clinical representative(s) is particularly important during the child's transitions and subsequent placement. Whenever possible, an integrated Service Plan among child-serving agencies involved with the child should be developed by the CFT and jointly implemented.

Referrals from the child welfare system can be initiated through an urgent, rapid, or crisis behavioral health response after a child's removal from his/her home (Refer to ACOM Policy 449 and AMPM Policy 541), or by referral from DCS (e.g., as part of an in-home intervention plan or when behavioral health needs of removed children and/or family members warrant re-assessment and potential intervention). In all cases, the behavioral health provider shall begin to address the child and family's need for behavioral health treatment and service at the earliest moment. A.R.S. § 8-512.01, also known as Jacob's Law", and ACOM Policy 449 were established in 2016 in order to understand, shape, and align with the child welfare case plan. For example, if the child is removed from his/her family of origin with a case plan focused on reunification, behavioral health services are expected to support that plan by providing services directed toward the behavioral health treatment needs of the child. For children under the age of three and their siblings, A.R.S. §§ 8-113, 8-824, 8-829, 8-847, 8-862 reduces the time in care requirement to six months; this highlights the need for timely behavioral health services as part of the reunification plan through DCS. Services should also be provided to the parent(s), when necessary, to help them address their own behavioral health treatment needs. This may require separate enrollment of the parent(s) in the behavioral health system when eligible. If the child is placed with temporary caregivers (e.g. an uncle, out-of-home placement or adoptive parent(s) and families), behavioral health services should support the child's stability with those caregivers by addressing the child's treatment needs; identifying any risk factors for placement disruption and providing support to minimize the risk; and anticipating crises that might develop and indicating specific strategies and services to be employed if a crisis occurs. In particular, behavioral health services must anticipate and plan for transitions in the child's life that may create additional stressors, such as transitions to new schools or transitions to a permanent family living situation.

The Contractor shall ensure that providers support the DCS caseworker by:

- a. Establishing a CFT to identify and describe the strengths, needs, and important cultural considerations of the child and family,
- b. Using the CFT to assess clinical risks, symptoms, and behaviors indicating a need for extended assessment or more intensive treatment services for both children and adults,
- c. Using the CFT to develop a Service Plan, crisis plan, and to present recommendations and options to the court as appropriate, and
- d. Furnishing information and reports about the provision of behavioral health services to child serving agencies, including DCS and the juvenile court.

2. Addressing Needs in the Context of Each Child's Family

The involvement of DCS indicates the presence of significant safety and risk concerns within the family unit. The family circumstances that lead to involvement by DCS can be expected to create needs for behavioral health treatment for most children and may also reflect behavioral health treatment needs of other family members. It is important that the CFT understand these concerns and their clinical implications and explore opportunities where behavioral health services can help to mitigate them. This can be accomplished through assessment and referral of adult family members for substance use and/or behavioral health services and by identifying those strengths and resources within the family and community that can fortify the child's abilities to cope with problems and adapt to change. Together, DCS, the behavioral health provider and other involved agencies should identify resources to support the needs of both family and child.

Families – whether the child's family of origin, an out-of-home placement or adoptive parent(s) and families, a relative, or a friend providing kinship care -- can be supported through the individual Service Plan of the child with services and/or interventions such as respite, family support, peer support, living skills training, or family counseling to address the child's treatment needs. The CFT may recommend behavioral health services that can help to stabilize the child's family situation and address behavioral health and substance use needs of family members without removing the child from the home. Parents and others in the home, including siblings, may also need specific individualized treatment, and it may be necessary to refer those family members for enrollment in the behavioral health system. Service Plans for family members should be coordinated with those of the child to make them compatible and mutually reinforcing.

3. When the Child Remains with His/Her Own Family

Children involved with DCS often live in family homes where DCS is actively monitoring identified concerns relating to safety, security, or basic needs. In these situations, adults and siblings living in the home may be the primary focus of the behavioral health providers involvement through provision of treatment and support services to parents that also reduces risks to the children. Service providers working

with families who are involved with DCS must remain alert to common emotional responses of children as a result of exposure to trauma (e.g. anxiety, disrupted capacity for trust and attachments, mood disturbance, etc.) that may indicate a need for further assessment or referral. If a CFT has convened, such considerations should be factored into developing the Service Plan. Refer to AMPM Policy 210.

Some of these responses might be associated with – or indicate potential need for -- involvement in primary health care, juvenile justice, special education, and/or developmental disabilities systems. The provider must furnish behavioral health services to address critical behavioral health needs, ideally as part of a collaborative intervention with DCS, the juvenile court, and other child-serving systems. Behavioral health treatment can be most effective when provided prior to a child's removal.

A child remaining at home with a family involved with DCS may need to develop or strengthen supportive relationships with family and others – both peers and adults. To meet these unique needs, behavioral health services with most families will need to be intensive, comprehensive, and delivered quickly in order to maximize engagement with the family and to strengthen their existing support systems.

Parents should be helped to learn/know how to manage their child's unique needs, and to anticipate and respond to those needs as they change. A key challenge for many parents and family members in this situation is the need to advance their own recovery from behavioral health conditions or substance use disorder while remaining responsive and attentive to the needs of their child. Behavioral health services provided to such families must be designed to impart skills and confidence to the parents – both in their role as caregivers and their role as a person entering recovery. Siblings and other family members should be incorporated in service planning, delivery, and advised of choices they may exercise in the process.

The behavioral health representative (case manager, therapist, etc.) shall ensure the provision of covered behavioral health services identified and recommended by the CFT that address the child's treatment needs, including coordination with services for parents.

4. When the Child Is Removed to Out-Of-Home Placement

The presence of serious safety concerns may require DCS to remove children from their family home to an out-of-home placement (shelters, receiving homes, relative ["kinship"] placements, family foster homes, or group homes). A child who may already have been seriously neglected or abused (physically, sexually, and/or emotionally) within the family home will very likely be affected not only by the neglect or abuse that precipitated removal, but also by the removal itself. The child may experience trauma, disorientation, and uncertainty related to such a drastic change in his/her life circumstances^{b,c}. A Team Decision Meeting (TDM) can be scheduled by DCS when there is consideration of removal of a child or when removal

has occurred. The meeting is typically held within a very short time frame to address the removal or potential removal. Behavioral health representative(s) may be invited to participate in these meetings in order to provide insight into the behavioral health system and the services that may be provided to the child, family or relatives.

AHCCCS considers the removal of a child from his/her family home to the protective custody of DCS to be an urgent behavioral health situation. In these situations, the Contractor shall ensure timely provision of all behavioral health services including crisis services, 72-hour rapid response, urgent need response, and ongoing behavioral services, including screening and evaluation as specified in ACOM Policy 449 and AMPM Policy 541.

The behavioral health service provider shall consider an extended assessment period (e.g., 30 to 45 days) to more accurately identify any emerging/developing behavioral health treatment needs that are not immediately apparent following the child's removal. When children are placed in DCS custody, the child and family shall be referred for ongoing behavioral health services for a period of at least six months (refer to ACOM Policy 449) unless services are refused by the guardian or the child is no longer in Department of Child Safety custody. Children in out-of-home placement who do not initially demonstrate behavioral health symptoms may still require active therapeutic intervention, including family-focused services and continued close observation to address any potential effects of their removal and to support placement stability. The behavioral health service provider identifies areas which may require further assessment during the period of time the child is enrolled. The CFT is also expected to support familial relationships, such as visitations with their siblings and other members of their birth families as arranged by DCS. Every effort should be made by participants of the CFT to develop a single unified Service Plan. The Service Plan should address the needs and mandates of all the parties involved. If the child has received behavioral health services for at least six months and is adjusting well and no longer exhibiting signs and symptoms of behavioral health concerns, the child may be disenrolled from behavioral health services. The child can still be referred for future services, including re-assessment, should a need arise. The behavioral health service provider must work collaboratively with DCS caseworkers to establish a process for a subsequent referral to the AHCCCS System of Care should those clinical symptoms manifest and a need for services arise in the future.

Out-of-home placement or adoptive parent(s) and other protective caregivers must be recognized as significant, knowledgeable members of the CFT. They should experience well-integrated coordination among, and clear communication from, all involved systems, beginning immediately upon placement of the child. Out-of-home placement or adoptive parent(s) and other protective caregivers will need guidance and support to raise children experiencing the trauma of neglect/abuse and subsequent removal from their family homes. The caregivers may need guidance to better understand each child's adjustment, how to respond to the coping mechanisms the child may demonstrate in his/her new situation, and how to seek outside assistance and/or recommendations to support any treatment.

When children are removed to out-of-home placement their parents may also benefit from behavioral health services, either as included in the treatment plan for the child or through separate enrollment in the adult behavioral health system. Parents may need assistance in order to:

- a. Learn how to better analyze and solve problems in relation to the safety needs of the child and other family members, and
- b. Be engaged (or possibly re-engaged) to participate in assessment, service planning, and delivery processes for their children and themselves.

The behavioral health provider is expected to assist DCS Specialists, judges, attorneys, court-appointed special advocates (CASAs), and others to understand how behavioral health services, as well as their own respective relationships with the child, impact the child's overall treatment progress and functional outcomes.

In addition, some children may need specially informed treatment to address their victimization by sexual abuse, including specific interventions for such children who act out in a sexually aggressive manner.

Any child who has experienced a removal by DCS is at risk for negative emotional consequences and future behavioral health disorders. When DCS initiates a removal of the child, specific requirements for behavioral health contractors are specified ACOM Policy 417.

5. When the Child Returns to His/Her Family of Origin from Placement Outside their Home

Children who have been living apart from their families of origin have had time to adapt to new expectations, interactions, roles, and experiences. Coping skills and behavioral response patterns have likely been adapted to the dynamics of the protective caregivers, and these may be distinct from those of their own families. At the same time, their families of origin will likely have adapted to new daily realities that have not included the child.

Consequently, visitation and contact must be promoted with family members and other anchoring relationships (e.g., friends, extended family, and teachers) to the greatest extent possible. The CFT must work collaboratively with DCS caseworkers to identify opportunities for therapeutic support during episodes of visitation and other family contact and to promote practicing the new skills and behaviors that successful reunification requires. All involved parties will need to understand how to optimize the transition process according to the child's age, developmental level, and specific circumstances, including how to support productive transition strategies.

In spite of the planning and work undertaken to prepare for the child's return home, reunification will likely be stressful and difficult. Issues relating to neglect, abuse, abandonment, fear, and mistrust may resurface. Negative feelings, memories, and

traumatic stress symptoms can be triggered by re-exposure to the home environment. Familiar but dysfunctional family coping patterns may return and threaten to replace recently learned adaptive patterns. The CFT must focus on preparing both the child and the family for reunification by ensuring that appropriate Service Plans (including crisis plans) are in place as needed.

Children and family members may require additional assessment and individualized behavioral health services during the period of reunification based on new or recurrent behavioral health needs. Behavioral health providers and child welfare professionals on the CFT must work collaboratively to promote:

- a. A strong recovery environment for the family,
- b. The child and family of origin being embraced, re-accepted, and not blamed (e.g., for the initial removal) by his or her reunified families,
- c. Family engagement and permanency,
- d. Evidence that the family will put the child's needs first, and
- e. Confidence that the child's stay with the family will last.

6. When the Child Achieves Permanency through Adoption or Guardianship

Children who leave out-of-home placement for other permanent situations (such as adoption or guardianship) may experience significant feelings of loss at the same time their permanency is viewed as a success by DCS, the juvenile court, their new families, and even by themselves. Many adopted children experience feelings of isolation and being different. They may feel irreversibly abandoned by their families of origin, engendering anger, feelings of guilt, and even self-blame. The adopted child may experience the loss of not only both natural parents, but also of extended family, cultural and genealogical heritage, a sense of connectedness, former social status, and personal identity. The CFT must draw upon the expertise and resources of participating agencies to identify supports for children in this stage of transition.

The same children may strive for, and be integrating, new feelings of gratitude, inclusion, and acceptance. Children entering new ties through adoption or guardianship are likely to strive to gain a new sense of identity and belonging – a feeling of “fitting in” – in their new home and community. Given their prior losses, they are likely to need reassurance that “I am wanted, no matter what I do or how I act”. Many will choose to test limits repeatedly to try the strength of their new ties as they adjust. Children in adoptive or guardianship situations need to know that their past will be considered by others and included in their futures.

These emotional responses may occur on top of existing issues such as: abuse and neglect, the trauma of separation, the adaptation challenge posed to the child by his/her removal from family to out-of-home placement, and the additional transitions the child most likely endured within out-of-home placement. All children eligible for the Adoption Subsidy program remain categorically eligible for Title XIX behavioral health services for the duration of their childhoods.

The CFT must recognize that the child's new family may also need adequate preparation and support to successfully welcome and incorporate a new family member. Every member of the child's new family will be affected by the changing relationships within the family system. They may need to be prepared for complex emotional and behavioral issues often presented by children, and to anticipate that the older the child, and the longer he/she has been in out-of-home placement, the more challenges and limit-testing will be likely. Supportive services provided by the child welfare system, behavioral health services, and other individualized services must be readily available, consistently provided, and sufficiently tailored to meet the unique needs of the child and the adoptive family. Adoptive parents will feel the need to be fully recognized as the child's parent and reassured that they will know what to do when faced with the child's adjustment issues over time.

"Safe" people from the child's family of origin or past support system, who are important to the child, should remain involved in the child's life as much as possible. This dimension may also require assistance by the behavioral health provider to ensure that the child and his/her new family can have positive connections to the child's past. The CFT should continue involving those safe people in the ongoing planning and treatment process.

7. Special Considerations for Infants, Toddlers, and Preschool-Aged Children

The CFT can contribute to the well-being of infants, toddlers, and young children by helping other involved partners to view the child holistically. Clinicians are expected to facilitate the special assessment approach prescribed by AHCCCS in AMPM Policy 210 which supports this holistic perspective. The behavioral health expertise they bring to the CFT must:

- a. Help family members to appreciate the impact of their interactions on young children (most therapeutic work at this age is likely to focus on those dyadic interactions and relationships, and interventions at the relationship level),
- b. Recognize signs, symptoms, and indicators of needs that may arise out of either medical conditions or exposure to adverse events or trauma (e.g., speech delays, sensory challenges, secondary effects of maternal substance abuse) that may impact children's social and emotional development (and, for children below age three, initiate referrals for early intervention services [Arizona Early Intervention Program (AzEIP)] when indicated by developmental screenings), and
- c. Work closely with family members, pediatricians, and other early intervention partners (Arizona Early Intervention Program/AzEIP) to recognize and address such needs.

Parents, out-of-home placement or adoptive parent(s), and other protective caregivers must be given guidance and support to understand the strong sensory base to an infant's experience of interactions with people and the world in general. Pediatricians, parent aides, behavioral health clinicians, or early interventionists must educate caregivers to recognize indicators of the young child's adjustment through observable behavior (e.g., an infant's eating, sleeping, and other bodily functions). They must be

helped to understand that, as children make gains with receptive and expressive language and with cognitive development,^d they will have increasing capacity to identify and describe how they are reacting to or coping with new situations, how it feels, and perhaps what might help them to feel better.

8. Preparing the Adolescent for Independent Living

Behavioral health service needs of children reaching the age of majority while in protective state custody can be multi-dimensional. Some individuals may continue to have behavioral health needs that can be addressed through enrollment in services for adult General Mental Health, Substance Abuse, and/or Serious Mental Illness.^e Studies demonstrate that problems that tend to surface in adolescence (e.g., alcohol and drug use, truancy) will be more common among adolescents in the child welfare system. In addition, in order to become stable and productive adults, they may require transitional financial assistance (including but not limited to DCS independent living subsidy) and budget management skills. Added challenges of moving to adulthood include assistance in locating and securing housing, connecting to a first job, and/or beginning pursuit of higher education. Employment, higher education, and housing issues will pose significant challenges for many young people.

Some young adults continue their involvement with DCS on a voluntary basis during this period. DCS independent living and young adult programs offer opportunities to gradually develop skills necessary for stable, productive adult living. Many young adults, understanding they are now fully responsible for making their own decisions, opt to forego such opportunities and cut ties with the system that may have, in their view, been “controlling my life” before now. Because youth formerly in out-of-home placement frequently experience poor outcomes,^f behavioral health counseling may assist them in realizing their decision-making power without “proving it” by cutting ties with this important lifeline.

Many young people who have been in the DCS system have expressed the recurring theme of stigma, of an overwhelming desire to be free of it, and to be seen in the world as competent, self-sufficient, and independent. Many young adults will still have – or will strive to re-establish -- close connections with others from their past, such as siblings, family, friends, educators, and faith communities. The behavioral health provider, in collaboration with DCS personnel, must:

- a. Respond quickly to meet any identified behavioral health needs,
- b. Solicit input from the young adult to determine their needs,
- c. Involve the young adult’s own support system,
- d. Plan adequately to address their needs,
- e. Stay involved in their lives, and
- f. Help them transition to adulthood by teaching them the skills they need to thrive and to meet their ongoing needs, including behavioral health issues that may continue into adulthood, or which may emerge over time.

The CFT must anticipate the need to help a young person prepare for the transition to adulthood beginning at age 16. AMPM Policy 280 provides specific guidance and required service expectations to support the CFT in thorough planning and preparatory activities.

While this Behavioral Health Practice Tool describes many likely emotional responses of children and adolescents, it is not exhaustive. Children and youth may manifest a wide variety of psychological, social and even medical problems in combination. The Contractors and their providers are expected to recognize and appropriately address the unique behavioral health needs of children involved with DCS, their families, and caregivers through the CFT process.

B. TRAINING AND SUPERVISION EXPECTATIONS

Contractors shall establish their own process for ensuring all clinical and support services staff working with children and adolescents understands the required service expectations and implements the practice elements as outlined in this document.

Whenever this Behavioral Health Practice Tool is updated or revised, the Contractor must ensure their subcontracted network is notified and required staff is retrained as necessary on the changes. In alignment with A.A.C. R9-20-205, Clinical Supervision requirements, the supervision for implementation of this Behavioral Health Practice Tool and it is to be incorporated into other supervision processes which the Contractor and their subcontracted network have in place for direct care clinical staff.

^a National Academy of Sciences. Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research. (1994)

^b Landsverk, Garland & Leslie (2002), Mental health services for children reported to Child Protective Services, In John E. B. Myers., L. Berliner, J. Briere, C. T. Hendrix, C. Jenny, and Theresa Reid (Eds.), APSAC Handbook on Child Maltreatment (pp. 487-507). Thousand Oaks, CA: Sage Publications.

^c Landsverk, J, National Study of Child and Adolescent Well-Being, 2003 (Washington, DC: U.S. DHHS Administration for Children and Families):

^d Lederman, C., Osofsky, J & Youcha, V, (2005) Meeting the unique needs of infants and toddlers in juvenile and family court, Zero to Three, “

^e Chapin Hall Center for Children (2004), *Northwest Foster Care Alumni Study (2005)* of 479 young adults in Oregon and Washington,