



**UNIQUE BEHAVIORAL HEALTH
SERVICES FOR NEEDS OF CHILDREN,
YOUTH AND FAMILIES INVOLVED WITH
DEPARTMENT OF CHILD SAFETY
PRACTICE TOOL**

Effective Date: 10/01/16



**UNIQUE BEHAVIORAL HEALTH SERVICE NEEDS OF CHILDREN,
YOUTH AND FAMILIES INVOLVED WITH DCS PRACTICE TOOL**

I. GOAL (WHAT DO WE WANT TO ACHIEVE THROUGH THE USE OF THIS PRACTICE TOOL?)

1. 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,
2. To outline the clinical considerations for serving children involved with DCS, their families, and other caregivers,
3. To delineate the Rapid Response procedures that must be followed when a child is removed from their home by DCS see ACOM Policy 449.

II. BACKGROUND

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 than 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 exposure 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 the numbers of 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.

Finally, understanding the complex interrelationships of individual, family, and community risk factors in the onset of a behavioral health issue is also shaped by the presence of protective factors – personal qualities, familial rituals and relationships, and social/peer group norms among other variables – that contribute to individual resilience or the capacity to cope with significant stressors.

Across the two most common behavioral health issues in the U.S. today – depression and alcohol abuse/dependence – situational stressors and adverse family conditions including a significant loss, traumatic exposure, and family conflict or violence are significantly associated with later onset of the condition, particularly in children whose close biologic relatives also suffer depression or alcoholism.^b In a survey testing for associations between adverse childhood experiences and health risk behaviors and chronic disease among 9,500 adults at a large California HMO, the study's authors found a strong association between individuals exposed to a variety of negative environmental risk factors as children and the likelihood of smoking, suffering chronic pulmonary disease, use of illicit drugs, and attempting suicide as adults.^c The categories of exposure reviewed included experiencing emotional, physical, or sexual abuse, witnessing domestic violence, parental

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separation, or divorce, living in a household characterized by substance use, or with an adult with mental illness, and incarceration of one or more parents.^d

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 AHCCCS System of Care 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.^e

Refer also to Attachment A, Unique Behavioral Health Service Needs of Children, Youth, and Families Involved with DCS – Desktop Guide.

A. PROCEDURES**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 as outlined in AMPM Policy 430. Partner agencies may include a variety of health, social service, and justice system organizations, including the AHCCCS System of Care, DCS, juvenile justice, DDD, 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. Integrated Service Plans 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, 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 AHCCCS System of Care shall begin to address the child and family's need for behavioral health treatment and service at the earliest moment as specified in A.R.S. §8-512.01, and ACOM Policy 449 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, 8-553, 8-824,

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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 AHCCCS System of Care 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. Behavioral health services must be designed to help the child remain stable in the temporary, out-of-home placement to minimize or eliminate the risk of placement disruption and to avoid the involvement of the police and the criminal justice system. 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 AHCCCS System of Care is expected to 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 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, AHCCCS System of Care 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, a friend providing kinship care, or an adoptive family giving legal guardian -- 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

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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 AHCCCS System of Care Service Plans for family members should be coordinated with those of the child to make them compatible and mutually reinforcing. Without diminishing the needs that may exist for individual interventions, the CFT should participate in an overall plan that makes sense to the family and is consistent with the goals of DCS and the juvenile court.

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 AHCCCS System of Care involvement through provision of treatment and support services to parents that also reduce risks to the children. Service providers working with families who are involved with DCS must remain alert to common emotional responses of children that may indicate a need for further assessment or referral to the AHCCCS System of Care. If a CFT has convened, such considerations should be factored into developing the Service Plan. Common responses can include:

- a. Disturbed parent-child and child-sibling relationships,
- b. Disrupted capacity for trust and attachments,
- c. Anxiety,
- d. Developmental delays or compromised learning,
- e. Dysfunctional coping skills,
- f. Behavioral disturbances,
- g. Post-traumatic stress disorder (PTSD),^f
- h. Mood disturbances, and/or
- i. Physical complaints or symptoms like headaches, abdominal pain, or bedwetting.

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 AHCCCS System of Care 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. When DCS services are also in place, behavioral health professionals and other providers should work in concert with those services.

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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 and delivery, and advised of choices they may exercise in the process.

The behavioral health representative must 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 and promotion of the child’s ability to live and thrive in his/her own family home, with safety and stability.

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^{g,h}. 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 potential removal. Behavioral health representative(s) may be invited to participate in these meetings in order to provide insight into the AHCCCS System of Care 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. See ACOM Policy 449.

The behavioral health service provider is expected to consider an extended assessment period (e.g., over 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 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

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which may require further assessment during the period of time the child is enrolled. While identifying and arranging the behavioral health services needed for a child, 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. When there is multi-agency involvement, every effort is made by the CFT to collectively develop a single, unified Service Plan that addresses the needs and mandates of all the parties involved. If after receiving behavioral health services for at least six months a child is adjusting well and no longer exhibiting signs and symptoms of behavioral health concerns receiving such services that child may be dis-enrolled from those 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.

AHCCCS and DCS established mechanisms to implement the rapid response requirements. Rapid Response for children entering out-of-home placement is intended to:

- a. Identify immediate behavioral health needs and presenting problems of children removed from their homes, to stabilize crises, enroll the child in the AHCCCS System of Care and offer the immediate services and supports each given child may need,
- b. Provide direct (therapeutic) support to each child removed from their home as appropriate, intending to reduce stress or anxiety the child may be experiencing.
- c. Provide direct support to each child's new caregiver as appropriate, including guidance about how to respond to the child's immediate behavioral health needs,
- d. Identify a point of contact within the AHCCCS System of Care,
- e. If a CFT is not already in place, initiate the development of a CFT, and
- f. Provide the DCS Specialist with findings and recommendations, related to the behavioral health needs of each child, within five to seven days of the referral or prior to the Preliminary Protective Hearing, whichever occurs first.

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 will 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 AHCCCS System of Care. 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

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- b. Be engaged (or possibly re-engaged) to participate in assessment, service planning, and delivery processes for their children and themselves.

The AHCCCS System of Care 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.

Children who have been removed by DCS from their family homes because of neglect or abuse might experience the following emotional responses:

- a. Disrupted parent-child and child-sibling relationships,
- b. Disrupted capacity for trust and attachments,
- c. Anxiety,
- d. Developmental delays or compromised learning,
- e. Dysfunctional coping skills,
- f. Behavioral disturbances,
- g. Running away,ⁱ
- h. Post-traumatic stress disorder,
- i. Mood disturbances,
- j. Substance abuse,^j and/or
- k. Physical complaints or symptoms like headaches, abdominal pain, or bedwetting.

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 identified ACOM Policy 417.

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

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

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according to the child's age, developmental level, and specific circumstances, including how to support productive transition strategies.

Each CFT member/partner agency should contribute knowledge, skills, appropriate services, and resources to the reunification plan. In spite of the planning and work undertaken to prepare for the child's return home, reunification will likely be stressful and difficult.^k 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 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. Such losses are rarely recognized in the context of adoption, and few supports have been made available to children experiencing them. 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 organize to meet the many needs of the child in their new home. Adoptive parents, child welfare, and behavioral health professionals must work together to help the child understand what adoption/guardianship means, and to name and manage confusing feelings. The team may identify the need for such feelings to be addressed in the context of individual, family, or group therapy or identify behavioral health services that prepare the child for success in the new family situation. Minimally, the family should receive information on how to access additional assistance if concerns arise.

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 out-of-home placement, 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.¹ 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 the Psychiatric Guidelines for Children Birth to Five Practice Tool 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, as individual interventions with such young children are rarely indicated),

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- b. Recognize signs, symptoms, and indicators of other needs (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 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,^m 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.ⁿ 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 former in out-of-home placement frequently experience poor outcomes,^o 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,

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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. The AHCCCS Transition to Adulthood Practice Tool provides specific guidance and required service expectations to support the CFT in thorough planning and preparatory activities.

While this 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 as specified in AMPM Policy 510.

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 Practice Tool is updated or revised, Contractors 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 Practice Tool is to be incorporated into other supervision processes which the Contractor and their subcontracted network have in place for direct care clinical staff.

C. ANTICIPATED OUTCOMES

1. Anticipated outcomes include:
 - a. Improved engagement and collaboration in service planning between children, families, community providers and Department of Child Safety.
 - b. Improved functional outcomes for children involved with Division of Child Safety
 - c. Improved identification and incorporation of strengths and cultural preferences into the planning processes
 - d. Increased statewide practice in accordance with the Arizona Vision and -12 Principles for Children Service Delivery

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- e. Coordinated planning between behavioral health and Department of Child Safety to ensure seamless transitions for children involved with DCS

Bibliography

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

^b Ibid.

^c Anda, RF, Croft JB, Felitti VJ, et al. "Adverse Childhood Experiences and Smoking During Adolescence and Adulthood." *Journal of the American Medical Association*. 1999. 282:1652-1658.

^d Felitti, Vincent J., MD, "The Relationship of Adverse Childhood Experiences to Adult Health: Turning Gold into Lead," in: *Praxis der Kinderpsychologie und Kinderpsychiatrie* (2003), 52: 547-559 [English translation].

^e See *J.K. v. Eden et al.*, No. CIV 91-261 TUC JMR (6/26/01), Paragraph 21.

^f Saltzman, W.R., Pynoos, R.S., Layne, C.M. et al. (2001), *Trauma- and grief-focused intervention for adolescents exposed to community violence: Results of a school-based screening and group treatment tool*. *Group Dynamics: Theory, Research and Practice*, 5(4):291-303: When failing adolescent students with severe PTSD symptoms were recognized and treated for trauma, their symptoms were markedly reduced, they required no further discipline, and their grade point averages went up significantly.

^g Landsverk, Garland & Leslie (2002), *Mental health services for children reported to Child Protective Services*, APSAC Handbook on Child Maltreatment (Sage Publications), 487-507. In Great Smoky Mountain Study, 80% of children in contact with child welfare (n = 234) met criteria for DSM-IV diagnosis, functional impairment or both; as well as 78% of children (n = 132) who had ever been in foster care.

^h Landsverk, J, *National Study of Child and Adolescent Well-Being*, 2003 (Washington, DC: U.S. DHHS Administration for Children and Families): In San Diego Children's Hospital study, 40-50% of children in out-of-home care ages 4-17 demonstrate significant behavioral problems; and 42% (n = 426) of children in out-of-home care ages 6-17 met criteria for DSM-IV disorders with moderate impairment (POC).

ⁱ Deborah Bass, "Study of Runaway Youths Finds One-Third Were In Foster Care," *St. Louis Post-Dispatch*, (January 19, 1992). [results of a survey of 170 runaway shelters.]

^j Clark, H.W., McClanahan, T.M. & Sees, L.K. (Spring 1997), *Cultural aspects of adolescent addiction and treatment*. *Valparaiso University Law Review*, Vol.31(2). Adolescents with alcohol dependence are six to 12 times more likely to have a childhood history of physical abuse, and 18 to 21 times more likely to have a history of sexual abuse than those without substance abuse problems.

^k National Child Welfare Resource Center for Family-Centered Practice, 2003. "The problems of these children are not likely to disappear once they are adopted or reunified with their families. Therefore children and parents need post-adoptive or post-reunification services to help them deal with lifelong effects of abuse, neglect and separation."

^l A recent survey of 375 Maine families who had adopted children from foster care an average of six years earlier [John Levesque and Michael Lahti, *Maine Adoption Guides Project*, "Maine Post-Adoption Legalization Survey: Child and Family Needs and Services," DHHS IV-E Demonstration Project, January 2002] reported the following problems persisting in at least half of those children: Sudden

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changes in mood or feelings (82%); argues too much (75%); difficulty concentrating (75%); impulsive, acts without thinking (75%); disobedient at home (74%), stubborn, sullen (71%); cheats or tells lies (70%); high-strung, tense or nervous (61%); has trouble getting along with other children (60%); very strong temper, loses it easily (60%); restless, overly active (59%); does not seem to feel sorry after misbehaving (57%); fearful or anxious (55%); disobedient at school (53%); not liked by other children (52%); has obsessions (52%); and easily confused (51%). These problems were identified within stable adoptive families of relatively long standing. Yet even after an average of six years since finalization of the adoptions, 38% of parents rated the child's current adjustment as "somewhat difficult," and 12% as "very difficult."

^m Lederman, C., Osofsky, J & Youcha, V, *Meeting the unique needs of infants and toddlers in juvenile and family court*, (2005), Zero to Three, "Almost 80% of young children (below age 5) in foster care have been prenatally exposed to maternal drugs. Developmental delay among these children is four to five times greater than for children in the general population. More than half suffer from serious physical health problems." See also, Landsverk, op. cit., "50-65% of children in out-of-home placements ages 0-6.4 years screen positive for developmental problems."

ⁿ Chapin Hall Center for Children (2004), "Midwest sample of youth transitioning out of foster care to adulthood found: 12.9% with major depression, 25.1% PTSD, 21.1% substance use disorders. *Northwest Foster Care Alumni Study* (2005) of 479 young adults in Oregon and Washington, "PTSD incidence among former foster children is twice as high as for U.S. war veterans. Foster care alumni experienced over seven times the rate of drug dependence and nearly two times the rate of alcohol dependence experienced in the general population."

^o *Northwest Foster Care Alumni Study*, op.cit., "Between age 20 and 33, 1/3 of the study group lived below the poverty level, 1/3 lacked health insurance, and 1/4 had experienced periods of homelessness." A survey of 113 former foster care youth (Wisconsin, 1998) found that, 12-18 months after leaving foster care, 39% were unemployed, 32% were on public assistance, and 27% of men and 10% of women had been incarcerated at least once.