

## **DBHS Practice Tool**

**The Unique Behavioral Health Service Needs  
of Children, Youth and Families Involved with DCS**



**Developed by the  
Arizona Department of Health Services  
Division of Behavioral Health Services**

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**NOTE:**

*This DBHS Practice Tool has required implementation elements. Providers are required to implement the identified Service Expectations, as clearly identified in this document.*

**Title**

**The Unique Behavioral Health Service Needs of Children, Youth and Families Involved with DCS**

**Goal/What Do We Want to Achieve Through the Use of this Tool?**

- 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
- To outline the clinical considerations for serving children involved with DCS, their families, and other caregivers
- To delineate the Urgent Response procedures that must be followed when a child is removed from their home by DCS

**Target Audience**

- Individuals involved with the provision of behavioral health services to children and families
- DCS Specialists and their supervisors
- DCS Mental Health Specialists
- Division of Developmental Disabilities (DDD) Child Welfare/Support Coordinators<sup>1</sup> and their supervisors

**Target Population**

Families referred by DCS for behavioral health screening, assessment, and services including:

- All children under the age of 21 who are involved with DCS (including those living with their own families, in foster care, kinship care, adoptive families, and independent living situations),
- Parents, relatives, and other adults living within the home, and
- Adults accepting temporary or permanent placement of a child removed by DCS.

**Definitions**

[Urgent Response](#)

[Child and Family Team \(CFT\)](#)

[Team Decision Making \(TDM\)](#)

[Preliminary Protective Hearing \(PPH\)](#)

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<sup>1</sup> In some (but not all) cases involving foster children enrolled in the Division of Developmental Disabilities, CPS transfers child welfare/CPS functions to DDD case managers called DDD child welfare/support coordinators. These staff perform child welfare functions for children with developmental disabilities who have been adjudicated dependent. When DDD assumes ongoing case management responsibilities for children in foster care, it is required to follow Title 8 statutes and CPS policy.

## **Background**

During the past 40 years, a growing body of research has identified some of the risk factors that predispose children and adults to mental disorders.<sup>2</sup> Risk factors are those characteristics, variables, or hazards that, if present, make it more likely that 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 mental disorder – is also shaped by the accumulation and timing of risk factors across the lifespan.

An adverse childhood exposure or a biologic vulnerability may increase the risk for certain mental disorders, such as alcohol abuse, 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 number 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 4 to 11 than in older adolescents.

Finally, understanding the complex interrelationships of individual, family, and community risk factors in the onset of mental disorder 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 mental disorders 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.<sup>3</sup> 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.<sup>4</sup> The categories of exposure reviewed included experiencing emotional, physical, or sexual abuse, witnessing domestic violence, parental separation, or divorce, living in a household characterized by substance abuse, or with an adult with mental illness, and incarceration of one or more parents.<sup>5</sup>

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

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<sup>2</sup> National Academy of Sciences. *Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research*. (1994)

<sup>3</sup> Ibid.

<sup>4</sup> 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.

<sup>5</sup> 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].

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 Arizona's behavioral health system to provide rapid behavioral health assessment, treatment, and services for referred families that may also reduce the risk of future mental disorder among children experiencing abuse or neglect.<sup>6</sup>

## **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 agencies work collaboratively through a unified service planning process that upholds the 12 Arizona Principles [<http://www.azdhs.gov/bhs/children/pdf/JK/principles.pdf>]. Partner agencies may include a variety of health, social service, and justice system organizations, including the behavioral health system, 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. Allied agencies, including 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 by family need in order 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 agencies involved with the child should be developed by the CFT and jointly implemented. The Regional Behavioral Health Authorities (RBHA's) may also place links to their DCS collaborative tool on their respective websites.

Referrals from the child welfare system can be initiated through an urgent 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 behavioral health system must begin to address the child and family's need for behavioral health treatment and service at the earliest moment in order to understand, shape, and align its efforts 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 three and their siblings, A.R.S. §§ [8-113](#), [8-553](#), [8-824](#), [8-829](#), [8-847](#), [8-862](#) expedites the time in care requirement to 6 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, a foster family), 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

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

be designed to help the child remain stable in the temporary, protective placement to minimize or eliminate the risk of placement disruption and to avoid the use 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 behavioral health system is expected to support the DCS caseworker by:

- establishing a CFT to identify and describe the strengths, needs, and important cultural considerations of the child and family,
- 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,
- using the CFT to develop a behavioral health service plan, crisis plan, and to present recommendations and options to the court as appropriate; and
- furnishing information and reports about the provision of behavioral health services to allied agencies including DCS and the juvenile court.

**Service Expectations: Behavioral health service plans must be developed by the CFT to address the behavioral health treatment needs of the child, and should strive to be consistent with service goals established by other agencies serving the child and/or family. The team should seek the active participation of other involved agencies in the planning process.**

## **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 abuse 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, behavioral health, and other involved agencies should identify resources to support the needs of both family and child.

Families – whether the child's family of origin, a foster family, 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 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 mental health and substance abuse 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. 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.

**Service Expectations: The behavioral health service provider facilitates the CFT development of a behavioral health service plan that is consistent with the goals of DCS and the juvenile court and incorporates the family's preferences, strengths and culture in alignment with their vision for the future. The Service Plan identifies formal services and natural supports that address the identified needs.**

### **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 behavioral health system 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 behavioral health system. If a CFT has convened, such considerations should be factored into developing the service plan. Common responses can include:

- disturbed parent-child and child-sibling relationships,
- disrupted capacity for trust and attachments,
- anxiety,
- developmental delays or compromised learning,
- dysfunctional coping skills,
- behavioral disturbances,
- post traumatic stress disorder (PTSD),<sup>7</sup>
- mood disturbances, and/or
- 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. Behavioral health treatment can be most effective when provided prior to a child's removal to protective foster care. The behavioral health system 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.

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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<sup>7</sup> 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.

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 Clinical Liaison 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.

**Service Expectations: The behavioral health service provider must furnish behavioral health services to address critical behavioral health needs of children, youth, and/or adult family members. The CFT must identify any unmet behavioral health service needs. The Regional Behavioral Health Authority (RBHA) must ensure that needed behavioral health services are promptly provided and barriers to service are rapidly removed.**

#### **4. When the Child Is Removed to Protective Foster Care**

The presence of serious safety concerns may require DCS to remove children from their family home to a protective 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<sup>8,9</sup>. A Team Decision Meeting (TDM) can be scheduled when DCS is considering removal of a child or has removed a child from their home. The meeting is typically held within a very short time frame to address the potential removal. Behavioral health staff 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.

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<sup>8</sup> 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.

<sup>9</sup> 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).

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) 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 RBHA must respond within 24 hours of a referral from DCS surrounding a child's removal from his/her home unless an alternative timeframe has been agreed upon as detailed below under the Urgent Response process.

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. Children in foster care 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. 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. A child who is adjusting well and is not exhibiting signs and symptoms of behavioral health concerns over the course of the assessment may be disenrolled after an appropriate period of time, but 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 behavioral health system should clinical symptoms manifest in the future.

Each RBHA and DCS district in Arizona has established joint local tools to implement the urgent response requirement. The Urgent Behavioral Health Response for Children Entering Foster Care is intended to:

1. **Identify immediate behavioral health needs and presenting problems** of children removed from their homes, to stabilize crises, enroll the child in the behavioral health system and offer the immediate services and supports each given child may need;
2. **Provide direct (therapeutic) support to each child** removed from their home as appropriate, intending to reduce stress or anxiety the child may be experiencing;
3. **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;
4. **Identify a point of contact within the behavioral health system;**
5. **Initiate the development of a Child and Family Team;** and
6. **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 is the latter

Foster parents 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. Foster parents 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 protective foster care, 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:

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

The behavioral health system 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:

- disrupted parent-child and child-sibling relationships,
- disrupted capacity for trust and attachments,
- anxiety,
- developmental delays or compromised learning,
- dysfunctional coping skills,
- behavioral disturbances,
- running away,<sup>10</sup>
- post traumatic stress disorder,
- mood disturbances,
- substance abuse,<sup>11</sup> and/or
- 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. Under the Urgent Response process, the procedure outlined below must be followed.

Upon notification from DCS that a child has been, or will imminently be physically removed from his/her home and taken into the custody of DCS, RBHAs or their

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<sup>10</sup> 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.]

<sup>11</sup> 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.

subcontractors shall respond within a timeframe indicated by clinical need, but no later than 24 hours from initial contact by DCS, unless the RBHA or subcontracted provider and DCS have mutually arranged an alternative timeframe for coordinating a response based on the best interests of the child. This requirement applies regardless of the child's Title XIX/XXI eligibility status at the time of referral.

More specifically, once the notification is received from DCS, the RBHA or subcontracted provider will;

- Contact the DCS Specialist to gather relevant information such as the outcome of the DCS Safety Assessment, the reason for the removal, how-when-where the removal occurred, any known special needs of the child, any known supports for the child, where siblings are, any known needs of the new caregiver, etc.
- Contact the caregiver to schedule the face-to-face, in-placement response to occur within 24 hours of referral, unless there is a mutually agreed upon and arranged alternative timeframe (as mentioned above), in order to achieve the six goals of the Urgent Response Process.
- Complete an initial assessment focused on immediate presenting concerns, to include a determination of the immediate behavioral health needs of the child and family. At this time, trauma issues such as grief and loss should be addressed. If the child is not currently enrolled with the RBHA, the intake process should be initiated at this time as well.
- Provide the DCS worker with a copy of the initial assessment and behavioral health recommendations within five to seven days of the referral or prior to the Preliminary Protective Hearing, whichever is the latter.

In the event that a child enrolled in one RBHA is removed from his/her home and placed in another RBHA catchment area, the Urgent Response Process should follow the guidelines outlined in [ADHS/DBHS Policy and Procedures Manual Policy 901, Inter-RBHA Coordination of Care](#). This policy calls for the RBHA of origin or subcontracted provider to make arrangements and pay for the services provided by the receiving RBHA.

Since one of the main goals of this process is to help identify the immediate behavioral health needs of children and address the trauma of the removal itself, the timeliness of the referral from DCS is crucial. The RBHA receiving the referral is responsible for providing the urgent response if the notification is received within 5 calendar days of the physical removal of the child from his/her home. If a referral is made after the 5<sup>th</sup> day of removal, the RBHA has the discretion to follow the Urgent Response Process or schedule the child for a regular intake appointment, depending on the specific circumstances surrounding the referral.

**Service Expectations: The behavioral health assessment process must detect both initial and delayed effects of trauma. Unless otherwise agreed upon, an urgent behavioral health response must be provided within 24 hours to every child removed and referred by DCS. An extended assessment period of 30-45 days is recommended best practice in order to detect possible delayed reactions to the traumatic experience. During this early assessment period the behavioral health service provider must extend clinically indicated services to the children who have been removed from their homes to address their immediate and**

ongoing behavioral health needs in addition to foster families and other protective caregivers; must support the child through CFT practice; and must serve as educational resources for staff from other child-serving agencies. The RBHA has the discretion to implement the Urgent Response Process or other Intake timelines as outlined in [ADHS/DBHS Policy and Procedures Manual Policy 102, Appointment Standards and Timeliness of Service](#), for referrals submitted after the 5<sup>th</sup> day of a child's removal by DCS.

## **5. When the Child Returns to His/Her Family of Origin from Foster Care**

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.

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.<sup>12</sup> 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 strong recovery environment for the family,
- The child being embraced, re-accepted, and not blamed (e.g., for the initial removal) by his or her reunified families,
- The child being wanted, permanently,
- Evidence that the family will put the child's needs first, and
- Confidence that the child's stay with the family will last.

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<sup>12</sup> 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."

**Service Expectations: The behavioral health service provider must coordinate with staff from other child-serving agencies involved in the child's reunification process and provide clinically indicated behavioral health services. Integrated service planning and provision will include transition strategies and be implemented through CFT practice.**

## **6. When the Child Achieves Permanency through Adoption or Guardianship**

Children who leave foster care for other permanent situations (adoption, 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 foster care, and the additional transitions the child most likely endured within foster care. (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 problems occur.

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 leaving foster care, and to anticipate that the older the child, and the

longer he/she has been in foster care, the more challenges and limit-testing will be likely.<sup>13</sup> 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.

**Service Expectations: Behavioral health service plans developed by the CFT must consider the behavioral health needs of the child and family by specifically addressing the transitional area of permanency when adoption or guardianship processes are involved.**

## 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. Clinical Liaisons are expected to facilitate the special assessment approach prescribed by ADHS/DBHS in the [Instruction Guide for the Assessment Birth to 5, Service Plan and Annual Update](#), which supports this holistic perspective. The behavioral health expertise they bring to the CFT must:

- 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),
- 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 3, initiate referrals for early intervention services [Arizona Early Intervention Program (AzEIP)] when indicated by developmental screenings), and
- work closely with family members, pediatricians, and other early intervention partners to recognize and address such needs.

Parents, foster parents, 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

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<sup>13</sup> 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 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."

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,<sup>14</sup> 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.

**Service Expectations: When serving infants, toddlers and pre-school age children the behavioral health provider must utilize the ADHS/DBHS Assessment and Service Planning process specific to children age birth to five. Assessment, treatment and service planning processes will include the child's primary caregiver and other involved family members.**

## **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.<sup>15</sup> 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 former foster care youth frequently experience

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<sup>14</sup> 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."

<sup>15</sup> 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."

poor outcomes,<sup>16</sup> 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 foster care 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:

- respond quickly to meet any identified behavioral health needs,
- solicit input from the young adult to determine their needs
- involve the young adult’s own support system,
- plan adequately to address their needs,
- stay involved in their lives, and
- 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 [ADHS Practice Tool, Transition to Adulthood](#) provides specific guidance and required service expectations to support the CFT in thorough planning and preparatory activities.

**Service Expectations: Behavioral health service plans developed by the CFT/Adult clinical team must include services, and resources that promote the continuation of supportive relationships and successful transitions to adulthood, consistent with the ADHS/DBHS policy and the [Practice Tool, Transition to Adulthood](#).**

**Summary:** While this 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 RBHAs and their service 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. In addition, in order to ensure coordination of care with the child’s primary care physician, the RBHAs and their service providers must follow the guidelines described in [ADHS/DBHS Policy and Procedure 902, Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers](#).

**Service Expectations: The RBHAs and behavioral health service providers must develop and furnish sufficient behavioral health services consistent with this tool that will meet the needs of the child with special attention to the timeliness, frequency, intensity, duration, and level of expertise of services provided. RBHAs**

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<sup>16</sup> *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 ¼ 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.

**and their service providers must follow the guidelines described in [ADHS/DBHS Policy and Procedure 902, Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers.](#)**

### **Training and Supervision Expectations**

This Practice Tool applies to T/RBHAs and their subcontracted network and provider agencies for all behavioral health service providers who have direct contact with or provide services to children, adolescents and their families. Each RBHA shall establish their own process for ensuring all agency 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. To support the training surrounding this Tool, the behavioral health staff noted above will be required to attend “Unique Needs of Children Involved with DCS” training offered by each RBHA on a regular basis (see [Policy and Procedures Manual Policy 403, Training Requirements, subsection 9.1.6-E, Training Expectations for ADHS/DBHS Clinical and Recovery Practice tools](#)).

Each RBHA is required to provide documentation, upon request from ADHS, demonstrating that all required network and provider agency staff has been trained on the service expectations and guidance contained in this Tool. Whenever this Practice Tool is updated or revised, RBHAs must ensure their subcontracted network and provider agencies are 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 Tool is to be incorporated into other supervision processes which the RBHA and their subcontracted network and provider agencies have in place for direct care clinical staff.

### **Anticipated Outcomes and How they will be Measured**

- Improved engagement and collaboration in service planning between children, families, community providers and Department of Child Safety.
- Improved functional outcomes for children involved with Division of Child Safety
- Improved identification and incorporation of strengths and cultural preferences into the planning processes
- Increased statewide practice in accordance with the 12 Arizona Principles;
- Coordinated planning between behavioral health and Department of Child Safety to ensure seamless transitions for children involved with DCS

### **How will Fidelity be Monitored?**

- Consumer/family satisfaction surveys
- RBHA reviews of CFT practice
- Random audits completed by ADHS/DBHS
  - Administrative Reviews (chart reviews)
  - Monitoring and Oversight Department audits (chart reviews)
    - Morbidity/Mortality reviews

The Unique Behavioral Health Service Needs of Children, Youth and Families  
Involved with DCS  
Desktop Guide

**Service Expectations:**

- Behavioral health service plans must be developed by the Child and Family Team (CFT) to address the behavioral health treatment needs of the child, and should strive to be consistent with service goals established by other agencies serving the child and/or family. The team should seek the active participation of other involved agencies in the planning process.
- The behavioral health service provider facilitates the CFT development of a behavioral health service plan that is consistent with the goals of DCS and the juvenile court and incorporates the family's preferences, strengths and culture in alignment with their vision for the future. The Service Plan identifies formal services and natural supports that address the identified needs.
- The behavioral health service provider must furnish behavioral health services to address critical behavioral health needs of children, youth, and/or adult family members. The CFT must identify any unmet behavioral health service needs. The Regional Behavioral Health Authority (RBHA) must ensure that needed behavioral health services are promptly provided and barriers to service are rapidly removed.
- The behavioral health assessment process must detect both initial and delayed effects of trauma. Unless otherwise agreed upon, an urgent behavioral health assessment must be provided within 24 hours to every child removed and referred by DCS. An extended assessment period of 30-45 days is recommended best practice in order to detect possible delayed reactions to the traumatic experience. During this early assessment period the behavioral health service provider must extend clinically indicated services to foster families and other protective caregivers; must support the child through CFT practice; and must serve as educational resources for staff from other child-serving agencies. The RBHA has the discretion to implement the Urgent Response Process or other Intake timelines as outlined in ADHS/DBHS PM3.2 Appointment Standards and Timeliness of Service Policy for referrals submitted after the 5<sup>th</sup> day of a child's removal by DCS.
- The behavioral health service provider must coordinate with staff from other child-serving agencies involved in the child's reunification process and provide clinically indicated behavioral health services. Integrated service planning and provision will include transition strategies and be implemented through CFT practice.
- Behavioral health service plans developed by the CFT must consider the behavioral health needs of the child and family by specifically addressing the transitional area of permanency when adoption or guardianship processes are involved.
- Behavioral health service plans developed by the CFT/Adult clinical team must include services, and resources that promote the continuation of supportive relationships and successful transitions to adulthood, consistent with the ADHS/DBHS PM 3.17, Transition of Persons policy and the Practice Tool, Transitioning to Adulthood.

- **The RBHAs and behavioral health service providers must develop and furnish sufficient behavioral health services consistent with this tool that will meet the needs of the child with special attention to the timeliness, frequency, intensity, duration, and level of expertise of services provided. RBHAs and their service providers must follow the guidelines described in ADHS/DBHS Policy and Procedures Manual Section 902 “Coordination of Care with AHCCCS Health Plans, Primary Care Providers, and Medicare Providers”**
  
- ❖ **Key elements to remember about this best practice:**
  - Actively identify and remain vigilant about potential emergence of behavioral health needs of children and family members, as significant risk factors are known to be associated with involvement with the child welfare system.
  - Support enrollment of family members who have behavioral health needs.
  - Integrate/coordinate behavioral health service planning and service provision for all enrolled family members.
  - Ensure appropriate alignment of Behavioral Health (BH) service plan with DCS case plan and any other pertinent plans of other involved systems.
  - Offer specific options and alternatives when out-of-home placement is being considered. The goal is to avoid congregate care settings whenever possible.
  - Plan and provide necessary BH services with respect for timeframes governing DCS case planning.
  - Consider any individual needs for an extended assessment period to detect emerging BH needs following the removal of children into protective foster care
  - Involve any protective caregivers (e.g., foster families, relatives) in service planning and provision, and address their needs related to the BH needs of children in their care.
  - Help DCS know how to quickly re-refer children for BH services when clinical symptoms may manifest in the future.
  - Support appropriate family contact for children in foster care.
  - Provide BH services necessary to support reunification.
  - Help to prepare children and caregivers for permanency (e.g., adoption, guardianship).
  - Ensure specialized BH service is provided when needed for infants and toddlers.
  - Help to prepare youth for transitions and be aware of the multi-dimensional needs of youth preparing for adulthood.
  
- ❖ **Benefits of using this best practice:**
  - Timely BH service can mitigate harmful effects of trauma and other adverse experiences in children and family members.
  - Service coordination/integration increases likelihood of positive outcomes for children and families and uses limited resources most efficiently.
  - Optimal BH service provision can minimize harmful instability in lives of children and families.
  - Effective BH service can prevent deeper penetration of children/families into “the system.”