

DBHS Practice Protocol

Out of Home Services



**Developed by the
Arizona Department of Health Services
Division of Behavioral Health Services
Effective June 1, 2007
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NOTE:

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

Title

Out of Home Care Services

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

To operationalize best practices in residential treatment centers and behavioral health group homes to ensure that children and adolescents who receive out of home care services, and their families, receive services consistent with the Arizona Vision and 12 Practice Principles.

Target Population(s)

All enrolled behavioral health recipients under the age of 21 receiving out of home behavioral health services in Level I, II or III residential settings.

Definitions

- **Child and Family Team:** a defined group of people that includes, at a minimum, the child and his/her family, a behavioral health representative, and any individuals important in the child's life and who are identified and invited to participate by the child and family. This may include, for example, teachers, extended family members, friends, family support partners, healthcare providers, coaches, community resource providers, representatives from churches, synagogues or mosques, agent from other service systems like Child Protective Services (CPS) or the Division of Developmental Disabilities (DDD), etc. The size, scope and intensity of involvement of the team members are determined by the objectives established for the child, the needs of the family in providing for the child, and by which individuals are needed to develop an effective service plan, and can therefore expand and contract as necessary to be successful on behalf of the child.
- **Family:** The primary care-giving unit, inclusive of the wide diversity of primary care-giving units in our culture. Family therefore is a biological, adoptive or self-created unit of people residing together and consisting of adult(s) and children, with adult(s) performing duties of parenthood for the children. Persons within this unit share bonds, culture, practices and significant relationships. Biological parents, siblings and others with significant attachment to the individual living outside the home are included in the definition of family.
- **Family-focused Therapy:** Involves all members of the family unit and provides psychoeducation about the nature of the mental illness and therapeutic interventions that address the family dynamics and relationships that may be contributing to conflicts within the family.⁵
- **Level I Residential Setting:** Behavioral health facilities that include the following subcategories: hospitals, subacute facilities, and Residential Treatment Centers (RTC).

- **Level II Residential Setting:** These facilities provide a structured treatment setting with 24-hour supervision and counseling or other therapeutic activities for persons who do not require on-site medical services, under the supervision of an on-site or on-call behavioral health professional².
- **Level III Residential Setting:** These facilities provide continuous 24-hour supervision and intermittent treatment in a group residential setting to persons who are determined to be capable of independent functioning but still need some protective oversight to insure they receive needed services³.
- **Natural Supports:** Refers collectively to support commonly identified as:
 - "Informal Support " (support provided by those individuals who know or are related to the individual/family, but do not provide a paid service, such as a grandparent or neighbor who is connected to the individual/family) and
 - "Community Support" (those supports that are part of the individuals/family's community, such as faith community, neighborhood or community organizations).

Background

The Arizona Vision clearly articulates as a core value that services be provided in the most appropriate, least restrictive setting and, whenever possible, in the child's home and local community. At the same time, Arizona Department of Health Services (ADHS) recognizes that there are children/youth whose needs, in spite of intensive community-based service provision, can only be adequately and safely addressed through temporary out of home placement. When community-based services are not effective or safety concerns are critical, out of home care can provide essential behavioral health treatment to stabilize and maintain a child until alternative services can adequately meet the needs of the child in the community. A court order for placement of a child with an out of home provider does not change the need for a determination of medical necessity by the provider and the Child and Family Team (CFT).

Procedures

There are twelve (12) essential concepts related to serving children and youth in out of home settings:

1. **The primary goal of out of home care is to prepare the child and family, as quickly as possible, for the child's return to home and community.** Service programming, therapeutic strategies, and discharge planning must reflect this goal and must be focused on assisting the child/youth to successfully function in the setting to which they will be returning rather than where they are currently receiving services. The child's underlying behavioral health problems must be addressed in order to accomplish this, and therapeutic interventions must target the behaviors and symptoms that have limited the child's success in the community. It is important to recognize, however, that these underlying problems need not be fully resolved before a child can successfully transition

¹ Refer to exceptions noted in the ADHS/DBHS Covered Services Guide Section II.F. Inpatient Services (http://www.azdhs.gov/bhs/bhs_gde.pdf)

² ADHS/DBHS Covered Services Guide Section II.G.1 (http://www.azdhs.gov/bhs/bhs_gde.pdf)

³ ADHS/DBHS Covered Services Guide Section II.G.2 (http://www.azdhs.gov/bhs/bhs_gde.pdf)

back home or to a less restrictive level of care. The most appropriate setting for long term therapeutic work is the environment in which the child will be living and functioning. Transitions to home should not be contingent upon the child and family having surmounted *every* problem or challenge. Instead, a return to home should be based upon the family having sufficient practice to feel comfortable in meeting the challenges at home, and on the availability of community-based formal and informal supports (including in-home supports) that can adequately address their needs.

Service Expectations: Service Plans must include goals and objectives meant to prepare the child and family for the child's return to home, or to an alternative permanent placement, as quickly as possible and must be focused on assisting the child/youth to successfully function in the setting to which they will be returning rather than where they are currently receiving services.

2. **Families must be encouraged and supported to be actively and meaningfully involved in all aspects of care.** Providers must work with the members of the CFT to continually pursue an effective level of engagement with the family, at times perhaps reaching out to extended family members. Likewise, providers should respect that not all families may be able or willing to participate in their child's care. The child's family must be included in the assessment process, the setting and prioritizing of treatment goals, the review of ongoing care and the planning for discharge. The family's involvement must be considered a treatment priority and addressed in the Service Plan. The Continuum of Parental Involvement⁴ includes:

- **Engagement:** when considering available resources, look at what is "ideal" and what is "real;" play to what the parents do well; ask for strategies from the parent and show something is possible by bridging the gap between now and the future.
- **Participation:** have parents participate in the residential milieu by working alongside staff who model the skills and behavior that will support the parents' ability to resume their parenting role.
- **Empowerment:** parents start to make the decisions when staff involve them when setting consequences for the child in the out of home setting.
- **Discharge and aftercare/supportive services:** discharge involves helping the child/parent leave the process/program feeling better about themselves with staff provision of aftercare and supportive services post discharge that help a child through transition from the residential to home setting.

The primary goal of family centered work in an out of home care setting is to assist the child and family in developing the best kind of relationship they can have, whether they live together or not.⁵ Out of home service providers should collaborate with community providers (e.g. outpatient, community service agency) to deliver family-focused therapy and to ensure continuity of care.

⁴ Fairhurst PhD, S.K. in conjunction with The Sycamores, Altadena, CA (1996). Promoting Change in Families Treatment Matching in Residential Treatment Centers. *Journal of Residential Treatment for Children & Youth*, Vol.14(2).

⁵ Appelstein, Charlie. (2007) Presentation on The Power of Strength-Based Family-Centered Youth Care. (www.charliea.com)

Service Expectations: Providers must work with the members of the CFT to continually pursue an effective level of engagement with the family. All aspects of service planning must include family involvement and/or the provider's active and ongoing attempts to engage the family. Family involvement, or attempts to engage, must be clearly documented in the clinical record.

- 3. Children must be treated within the context of their family systems.** Each family should be encouraged to view the child's placement as a transition period meant to help the family as a whole to develop new skills and a renewed sense of confidence, competence and optimism as parents, siblings and others reunite as a family. Out of home programs should not be viewed as "dispositions," "destinations," reflective of "failures" or as a "last resort." Children and youth who do not have an identified family to return to must be assisted in developing ties to their community, including non-family resources and/or caregivers who can meet their relationship needs and provide natural support.

Service Expectations: Children/youth without an identified and involved family must be assisted in developing ties to their community, including non-family resources and/or caregivers who can meet their relationship needs and provide natural support.

- 4. Community providers, out of home service providers, and child serving agencies must develop successful and well-defined protocols to ensure appropriate placements, collaborative service planning and successful and meaningful coordination of care.** Community providers and child serving agencies must be well informed about the roles and responsibilities of out of home service providers in Arizona's system of care. Likewise, out of home service providers must ensure their workforce is well educated about system of care approaches and the expected collaboration with child welfare, education, law enforcement, primary care providers and other child-serving system partners. It is imperative that child welfare workers, probation officers and other involved systems' partners who are involved with the child and family be included in team meetings and in care coordination. The development and implementation of internal policies and procedures must guarantee ongoing collaboration and coordination between agencies and providers.

Service Expectations: Out of home service providers must maintain written policies that promote collaboration and coordination with other child-serving system partners and primary care providers. Training records must indicate that staff have received training on these policies and are well educated about system of care approaches.

- 5. Every child must be served through a Child and Family Team (CFT).** ADHS is committed to the provision of behavioral health services to children and youth through the Child and Family Team (CFT) practice, which identifies the strengths and cultural preferences of the family while also identifying and addressing the needs of the family. Child and Family Teams must ensure that any child in an out of home care setting is promptly returned to his/her community and home when clinically appropriate.

Whenever out of home care is required, it is imperative that a Child and Family Team be formed, if one is not already in place. While most children entering out of home placements will have functioning CFTs in place at the time of admission, out of home service providers must work with community providers and referral sources to initiate the development of a CFT when children are admitted without a team in place.

The out of home service provider must recognize the role of the CFT in addressing the needs of the child and family. As an existing CFT expands to incorporate members from the out of home service provider agency, team members should share information about what services, activities, and interventions have worked in the past for the child and family as well as information about those that were not successful. Out of home service providers must participate fully in the CFT meetings and should integrate the CFT into aspects of their programming, including staffings and visits. Service Plans for children in out of home care must exist only as an extension of the CFT's overall Service Plan. Prior authorization and utilization review processes should give substantial weight to the needs and goals as identified by the CFT. The prior authorization and utilization review process must function as a supportive resource, and in the case of a denial, must assist the team to identify alternative services that are congruent with the child and family's needs.

Service Expectations: Every child in out of home placement must have a Child and Family Team, and the Residential Placement Service Plan must be in alignment with the CFT's overall Service Plan. For services requiring prior authorization, the T/RBHA must assist the CFT to identify alternative services that are congruent with the child and family's needs.

- 6. Out of home care should be a community resource, and not a “placement” and continuity of care must be maintained.** Out of home service providers are encouraged to integrate the services they provide with community-based programs to more effectively stabilize and support placements in the community. It is essential that out of home service providers view themselves as resources to the CFT by serving to reinforce and enhance community-based services and supports. Out of home service providers are part of a community-based continuum of care and play a vital role in transitions into or out of more restrictive settings.

Out of home service providers should encourage individualized interventions and support existing therapeutic relationships that were present prior to placement. Out of home service providers are encouraged to consider expansion of their range of services to include crisis stabilization, substance abuse treatment, respite and other opportunities to support and preserve family stability and integrity in the community. In addition, out of home service providers are encouraged to utilize the skills and expertise of their workforce in helping to support the family, school and community during transition back home and after discharge. Aftercare services, when there is continuity in service providers, have been shown to facilitate a successful discharge. Aftercare programs create a bridge of seamless services for a child's recovery when transitioning from out of home care to outpatient care.

Children transitioning both from an out of home facility and into services in the adult behavioral health system simultaneously may require additional supports to further ease this transition.⁶

- 7. A strengths-based, culturally competent approach must be used in all aspects of care.** Assessments conducted while in out of home care settings should survey and document individual/family strengths and community resources. Assessments should consider findings from previous outpatient assessments completed by behavioral health or other child-serving systems. When possible, assessments should include input from the Child and Family Team. Residential setting service plans must be strengths-based and encourage further development and enhancement of both internal and external strengths. Cultural experiences and preferences, including spiritual and gender-related issues, should be considered in the formulation of a treatment approach, especially for children who are from cultures where out of home placement is viewed as shameful or stigmatizing. Out of home service providers should welcome involvement of cultural guides (e.g. other team members, tribal organizations) to help tailor accommodations to such cultural norms. Discharge and transition plans must reflect identified strengths and cultural priorities and include natural supports as well as professional services.

Service Expectations: Residential setting assessments and service plans must reflect the values, priorities and cultural preferences of the child and family. Discharge and transition plans must reflect identified community services and supports that are aligned with the child's strengths, needs and cultural preferences.

- 8. Treatment and support is highly individualized to the needs of each child and family.** Programming and treatment interventions within out of home settings must be highly individualized, addressing each child's specific needs. Interventions should be based on functional assessments, and their success evaluated in terms of functional outcomes. When multiple out of home options are available, the child should be matched to the best setting, based on the individualized treatment needs of the child and the recommendations of the CFT. T/RBHAs are encouraged to creatively contract for out of home beds. For example, some children may need stabilization by being in out of home care for one or two days each week, and at home during the remaining days. Transition back to the community must be well-coordinated and individualized. Transitional discharge approaches utilizing a gradual discharge model, where the number of home visits and time at home increase over time, are often successful. Creative arrangements that maximize the integration of home and residential services should be explored.

Service Expectations: Programming and treatment interventions must be individualized based on the specific needs of the child.

- 9. Effective interventions are delivered by competent, well-prepared and diligently supervised individuals.** Out of home service providers must be competent and well-trained as documented by education, experience, training and certification. Given the

⁶ See the Transitioning to Adult Services: Practice Protocol at <http://www.azdhs.gov/bhs/tas.pdf>

complexity of issues that surface during out of home care, providers at all levels require sound clinical supervision. Clinical supervision must be provided as required by licensure; however, additional supervision must be provided as indicated to ensure treatment plans are being implemented appropriately and effectively. The goals of supervision should be to promote professional growth and development of staff, monitor their performance and competence, and empower them to self-supervise and carry out goals.⁷ The service expectations and guidelines in this protocol should assist supervisors. Without the provision of quality clinical supervision, emotional or personal influences may go unrecognized, and could compromise the services being provided. Therapists, case managers, support staff and care providers at all levels must receive regularly scheduled, dependable and focused clinical supervision.

Service Expectations: Out of home service providers must be trained and supervised to ensure treatment plans are being implemented effectively. All staff directly involved with client care must receive dependable and regularly scheduled supervision, as well as event-driven supervision when necessary, to ensure the provision of sound clinical treatment.

10. **Out of home service providers demonstrate a commitment to care provision.** Out of home service providers must recognize and appreciate the diverse range of characteristics among the children and families in Arizona (e.g. language differences, cultural needs, sensory impairments, cognitive limitations, other developmental and health-related conditions), and should strive to accommodate such diversity, rather than restricting admission or service options. Service providers must demonstrate a commitment to serve these individuals after admission, regardless of any challenges that arise. Program policies and procedures, organizational values and staff development all need to be aligned to minimize coercive and/or law enforcement intervention. When service plans must address alternatives to law enforcement involvement and avoidance of the use of seclusion or restraint. Service plans should, however, encourage the involvement of law enforcement and the criminal justice system as another means of deterring juvenile delinquency when necessary and when the situation dictates this involvement.⁸

Multiple placements should be avoided. In recognition of the behavioral health system's principled commitment to avoiding delinquency, the inappropriate use of law enforcement and criminal justice systems must be avoided, and policies must be developed to inform all decisions when it is necessary to engage these system partners. If an out of home placement is interrupted by hospitalization or arrest, the provider should allow the child's return if the same level of care is being recommended.

Service Expectations: Out of home service providers must demonstrate a commitment to serve individuals after admission, regardless of any challenges that arise. When necessary, service plans must address alternatives to law enforcement involvement and avoidance of

⁷ Haynes, R., Corey, G., & Moulton, P. (2003). Clinical supervision in the helping professions. A practical guide. Brooks/Cole-Thomson Learning: Pacific Grove, CA.

⁸ ADHS/DBHS recognizes that providers and CFT members may be hesitant to contact law enforcement when a situation demanding law enforcement involvement is necessary. When the risk associated with not contacting law enforcement is great, service plans should not prevent taking this action when necessary.

the use of seclusion or restraint. Policies must be developed to inform all decisions when it is necessary to engage the criminal justice system.

- 11. Out of home settings must provide services and supports that change to continually meet the child's needs.** Out of home service providers must work collaboratively with the CFT to identify and address the changing needs of the child and family throughout the child's placement out of home. As new situations arise, the service plan goals, or discharge plan, for example, may need to be modified. Treatment interventions, supports and services should be adjusted as needed.

Service Expectations: Out of home service providers must work collaboratively with the CFT to identify the changing needs of the child and family. Treatment interventions and services must be adjusted as needed.

- 12. Out of home settings must provide, to the extent possible, as natural and home-like an environment as possible.** Out of home service settings should support the ability for the child to sustain existing positive relationships with family, friends, teachers and neighbors. When possible, continued participation in pre-placement activities (e.g. school, recreation, church) should be facilitated. Parents and other legally appointed representatives (such as guardians, etc.) have the statutory right to participate in decision-making about their child's care, including but not limited to phone calls and family visits, and therefore these should not be restricted unless there is clear clinical justification and strategic goals outlined in the Service Plan.⁹ Therapeutic activities should be mindfully planned to allow children to practice skills and behaviors that will help them in family, school and other community settings. Children should be able to appropriately personalize their environment to reflect their tastes, culture, preferences and interests.

Service Expectations: Protocols, policies and practices must ensure the child's right to normalizing experiences when clinically appropriate. Any restrictions must be clinically justified in the Service Plan and must be removed as soon as clinically appropriate.

Training and Supervision Expectations

This Practice Protocol applies to T/RBHAs and their subcontracted Level I, Level II, and Level III out of home service provider agencies. Formal training on this Practice Protocol is not provided by ADHS/DBHS.

Each T/RBHA shall establish their own process for ensuring all out of home service provider agency clinical staff working with children and adolescents understands the expectations

⁹ Robinson, A.J., Kruzich, J.M., Friesen, B.J., Jivanjee, P., Pullmann, M.D. (2005). Preserving family bonds: Examining parent perspectives in the light of practice standards for out-of-home treatment. *American Journal of Orthopsychiatry*, 75(4), 632-643 as reported by *Data Trends*: #127 December 2005. Out-of-Home Treatment and Family Bonds: Parent Perspectives and Practice Standards. Portland State University Research & Training Center for Family Support and Children's Mental Health in collaboration with the University of South Florida.

outlined in this Protocol. At a minimum, all out of home service provider agency clinical staff working with children and adolescents is required to read this Protocol.

Each T/RBHA must provide documentation demonstrating that all out of home service provider agency clinical staff working with children and adolescents have been trained on this Protocol upon request by ADHS/DBHS.

Whenever this Practice Protocol is updated or revised, T/RBHAs must ensure their subcontracted Level I, Level II, and Level III residential provider agencies are notified and that provider agency clinical staff are retrained as necessary.

Supervision regarding implementation of this Protocol should be incorporated into other supervision processes the T/RBHA and their subcontracted Level I, Level II, and Level III residential provider agencies have in place for direct care clinical staff.

Anticipated Outcomes and How they will be Measured

Anticipated outcomes include:

- Out of home care that is an extension of the community-based treatment continuum;
- Shorter lengths of stay in out of home care settings;
- Increased involvement of the child's family in all aspects of out of home treatment;
- Better integration of the Arizona Practice Model into out of home care service delivery;
- Improved collaboration in service planning between community providers, out of home service providers, child serving agencies and families;
- Decreased overall number of out of home placements for the child.

Outcomes will be measured through the use of one or more of the following:

- ADHS/DBHS Quality Management Reports
 - Average length of stay
 - Admission rates
 - Re-admission rates
- Random audits completed by ADHS/DBHS
 - Independent Case Review (chart reviews)
 - Administrative Reviews (chart reviews)
 - Monitoring and Oversight Department audits (chart reviews)
- Consumer/Family Surveys

How will Fidelity be Monitored?

Fidelity to this Protocol will be monitored through:

- Chart reviews of the clinical record
- Interviews with family members
- Training records

Out of Home Care Services Desktop Guide

Service Expectations:

- **Service Plans must include goals and objectives meant to prepare the child and family for the child's return to home, or to an alternative permanent placement, as quickly as possible and must be focused on assisting the child/youth to successfully function in the setting to which they will be returning rather than where they are currently receiving services.**
 - **Providers must work with the members of the CFT to continually pursue an effective level of engagement with the family. All aspects of service planning must include family involvement and/or the provider's active and ongoing attempts to engage the family. Family involvement, or attempts to engage, must be clearly documented in the clinical record.**
 - **Children/youth without an identified and involved family must be assisted in developing ties to their community, including non-family resources and/or caregivers who can meet their relationship needs and provide natural support.**
 - **Out of home service providers must maintain written policies that promote collaboration and coordination with other child-serving system partners and primary care providers. Training records must indicate that staff have received training on these policies and are well educated about system of care approaches.**
 - **Every child in out of home placement must have a Child and Family Team, and the Residential Placement Service Plan must be in alignment with the CFT's overall Service Plan. For services requiring prior authorization, the T/RBHA must assist the CFT to identify alternative services that are congruent with the child and family's needs.**
 - **Residential setting assessments and service plans must reflect the values, priorities and cultural preferences of the child and family. Discharge and transition plans must reflect identified community services and supports that are aligned with the child's strengths, needs and cultural preferences.**
 - **Programming and treatment interventions must be individualized based on the specific needs of the child.**
 - **Out of home service providers must be trained and supervised to ensure treatment plans are being implemented effectively. All staff directly involved with client care must receive dependable and regularly scheduled supervision, as well as event-driven supervision when necessary, to ensure the provision of sound clinical treatment.**
 - **Out of home service providers must demonstrate a commitment to serve individuals after admission, regardless of any challenges that arise. When necessary, service plans must address alternatives to law enforcement involvement and avoidance of the use of seclusion or restraint. Policies must be developed to inform all decisions when it is necessary to engage the criminal justice system.**
 - **Out of home service providers must work collaboratively with the CFT to identify the changing needs of the child and family. Treatment interventions and services must be adjusted as needed.**
 - **Protocols, policies and practices must ensure the child's right to normalizing experiences when clinically appropriate. Any restrictions must be clinically justified in the Service Plan and must be removed as soon as clinically appropriate.**
- ❖ Key elements to remember about this best practice:
- Family involvement includes a wide diversity of primary caregivers from biological and adoptive to self-created units of people residing together.
 - The stages of parental involvement include engagement, participation, empowerment, discharge and aftercare/supportive services.
 - The primary goal of family-centered work is to assist the child and family in developing the best kind of relationship they can have whether they live together or not.
 - Cultural guides can be utilized to tailor accommodations according to the identified child/family's cultural norms.
- ❖ Benefits of using this best practice:
- Better integration of the Arizona Practice Model into residential care service delivery
 - Decreased overall number of placements for the child.
 - Increased involvement of the child's family in all aspects of out of home treatment