

DBHS Practice Protocol

Children's 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

Children's Out of Home Services

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

To operationalize the use of best practice guidelines in residential treatment centers, behavioral health group homes and Home Care Training to Home Care Client (HCTC) provider settings to ensure that children and adolescents receive treatment interventions that are consistent with the Arizona Vision and 12 Practice Principles.

Target Audience

This Protocol is specifically targeted to Tribal/Regional Behavioral Health Authorities (T/RBHAs) and their subcontracted Level I, II and III residential and HCTC service providers.

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 and HCTC settings in collaboration with their families.

Attachments

[*Attachment 1: HCTC Specific Guidelines*](#)

Definitions

[Child and Family Team](#)

[Family](#)

[Family-focused Therapy](#)

[Level I Residential Setting¹:](#)

[Level II Residential Setting²:](#)

[Level III Residential Setting³](#)

¹ Refer to the ADHS/DBHS Covered Behavioral Health Services Guide Section II.F. Inpatient Services for billing code exceptions at http://www.azdhs.gov/bhs/bhs_gde.pdf

² See ADHS/DBHS Covered Behavioral Health Services Guide Section II.G.1 at http://www.azdhs.gov/bhs/bhs_gde.pdf

³ See ADHS/DBHS Covered Behavioral Health Services Guide Section II.G.2 at http://www.azdhs.gov/bhs/bhs_gde.pdf

Natural Support

Home Care Training to Home Care Client (HCTC)

Background

The Arizona Vision and 12 Practice Principles clearly articulate as a core value that services be provided in the most appropriate, integrated setting responsive to the child's needs. At the same time, the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) recognizes that there are children/youth whose needs, in spite of intensive community-based service provision, can only be adequately and safely addressed through the use of targeted, short-term out of home treatment intervention. When community-based services are not effective in maintaining the child in his/her home setting, or safety concerns become critical, the use of out of home treatment services can provide essential behavioral health interventions to stabilize the situation. Risks and benefits are explored in any discussion about utilizing out of home treatment services as an intervention

Procedures

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

1. **Prior authorization and utilization review processes evaluate the needs and goals identified by the Child and Family Team (CFT).** When initiating a request for out of home services, the behavioral health provider with the CFT is responsible for following the prior authorization process to ensure that a determination of medical necessity is made prior to initiating residential treatment services. Refer to [ADHS/DBHS Provider Manual Section 3.14 Securing Services and Prior Authorization](#) for additional information. The prior authorization and utilization review process must function as a supportive resource to the CFT. As a routine part of this process when prior authorization results in a denial of out of home treatment, recommendations of alternative services that are congruent with the child's/family's needs are to be provided to the CFT for consideration.

<p>Service Expectations: for services requiring prior authorization, if the prior authorization is denied the T/RBHA must assist the CFT with recommendations of alternative services that are congruent with the child's/family's needs.</p>
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2. **The primary goal of out of home treatment intervention is to prepare the child and family, as quickly as possible, for the child's safe return to his/her home and community settings.** Service programming, therapeutic strategies, and discharge planning must reflect this goal and be focused on assisting the child/youth to successfully function in the community setting to which s/he will be returning. Therapeutic treatment interventions must target the behaviors and symptoms that have limited the child's ability to live successfully in previous community settings. Behaviors and symptoms need not be fully resolved before a child can successfully transition back home or to a less restrictive community setting. Transitions to home should not be contingent upon the child and family having surmounted every challenge. Instead, a return to home should be based upon the family being provided the resources necessary for maintaining the child in

his/her home setting. These may include, but are not limited to, working in partnership with the family while the child is receiving out of home treatment services and providing access to community-based formal and informal supports, including in-home services upon the child's return to home. The most appropriate setting for long term therapeutic work is the family/home-like environment and surrounding community in which the child lives.

Service Expectations: Service Plans must include goals and objectives that prepare the child and family for the child's return to home or to a less restrictive community setting, as quickly as possible.

- 3. Every child receiving treatment services in an out of home setting must be served through a CFT.** ADHS/DBHS is committed to the provision of behavioral health services to children and youth through CFT practice, which identifies the strengths and cultural preferences of the child/family while also identifying and addressing their needs. Whenever out of home treatment services are required, it is imperative that a CFT be formed, if one is not already in place. While most children entering out of home treatment settings will have a functioning CFT at the time of admission, for those children without a team in place residential service providers must work with the community behavioral health provider and referral source to initiate the development of a CFT.

The residential service provider works with the CFT in addressing the needs of the child and family. An existing CFT expands to incorporate members from the residential service provider treatment team. The CFT shares information with new team members about what services, activities, and treatment interventions have worked in the past for the child and family, as well as information about those that were not successful. In situations where Child Protective Services (CPS) is the guardian, family members should be included in the CFT process as determined by CPS.

While the child is in the out of home setting the residential treatment team is expected to participate fully in CFT meetings and integrate CFT practice into aspects of their programming. Scheduling meetings is based on the availability and convenience of family members and are not scheduled solely at the discretion of the residential treatment team. Service Plans for children receiving out of home treatment intervention must be aligned with the CFT's Service Plan. When the out of home treatment goals have been met, or significant progress has been made and treatment can continue in the child's home and community, the focus of the CFT turns to planning for the child's return to his/her community.

Service Expectations:

- Every child receiving treatment services in an out of home setting must be served through a CFT.**
- The Residential Service Provider and CFT Service Plans must be in alignment.**

4. **The family must be encouraged and supported to be an active partner involved in all aspects of the child's out of home treatment.** Residential service providers must work with other members of the CFT to continually pursue an effective level of engagement with the family, which may include reaching out to extended family members. The child's family must be included in the assessment process, the setting and prioritizing of treatment goals, the review of ongoing care, and transition planning prior to the child's discharge. The family's involvement must be considered a treatment priority and addressed in the Service Plan.

The primary goal of family driven work is to partner with the child and family in developing the best kind of relationship they can have. This may include mending or strengthening the relationship between the child and family. Home visits can provide families with opportunities for practicing what is learned while the child is receiving out of home treatment services. It is imperative that residential service providers collaborate with community providers to ensure the child does not experience any disruption in care while transitioning into and out of residential treatment services.

Service Expectations: Family involvement and partnership, including the provider's attempts to engage the family, must be clearly documented in the clinical record.

5. **Every child receiving out of home treatment services must be treated within the context of their family system.** Each family should be encouraged to view the child's out of home treatment services as a therapeutic intervention designed to support the entire family as an inter-related unit. By developing an understanding of the dynamics of their child's behavior the family can acquire new skills and improve ways for relating to their child which can result in a renewed sense of confidence, competence and optimism as parents. When a child receives out of home treatment it is helpful to inform the child and family that they are utilizing a type of intervention along a continuum of services that addresses their needs and is not reflective of personal failure or used as a last resort. Children and youth who do not have an identified family to return home to must be assisted in developing ties to their community, including non-family resources and/or caregivers who can meet their needs.
6. **Behavioral health community and residential service providers must develop well-defined protocols to ensure development of appropriate treatment interventions, collaborative service planning, and successful coordination of care.** Behavioral health community providers and child serving agencies must be well informed about the roles and responsibilities of the residential service providers in Arizona's overall system of care. Likewise, residential service providers must ensure their workforce is well educated about system of care practice approaches and service planning expectations when collaborating with child welfare, education, law enforcement, primary care providers and other child-serving system partners who are involved with the child and family. The development and implementation of internal policies and procedures must guarantee ongoing collaboration and coordination between these behavioral health service providers and other child-serving agencies.

7. **Out of home services are utilized as a treatment intervention, not a “placement” and continuity of care must be maintained.** Residential service providers are required to integrate the services they provide with community-based programs to effectively stabilize the child’s and family’s situation. It is essential that they view themselves as resources to the CFT by serving to reinforce and enhance community-based services, supports, and treatment interventions as part of a seamless, community-based continuum of care.

Residential service providers are encouraged to individualize treatment interventions and support existing therapeutic relationships that were present prior to the child’s receiving residential treatment services. These providers are required to consider expanding their range of services to include crisis stabilization, substance abuse treatment, respite and other opportunities that would support and preserve family stability and integrity in the community. Additionally, residential service providers are required to utilize the skills and expertise of their workforce in helping to support the family and school during the child’s transition back to his/her home community. Continuity of service providers has been shown to facilitate successful transitions between settings. Residential service providers who make aftercare programs available create a bridge of seamless service delivery for a child’s return home or to other community settings.

Children simultaneously transitioning from out of home treatment services into the adult behavioral health service system may require additional supports and detailed transition planning. This is especially critical when the child has no family support in the community. Refer to the *ADHS/DBHS Practice Protocol: Transition to Adulthood*⁴ for additional information.

8. **A strengths-based, culturally competent approach must be used in all aspects of out of home treatment service delivery.** Residential service providers must recognize and appreciate the diverse range of characteristics among children and families in Arizona such as language differences, cultural needs, sensory impairments, cognitive limitations, and other developmental and health-related conditions. Providers should accommodate such diversity rather than limit service delivery through restrictive admission criteria or inflexible treatment programs.

Assessments conducted while a child is receiving treatment in an out of home setting should identify and document individual/family strengths, as well as available community resources. Findings from previous outpatient assessments completed by behavioral health or other child-serving systems are taken into consideration and include input from the CFT. Residential service plans identify the child’s needs and strengths and are responsive to the presenting concerns that led to the child’s receipt of out of home treatment services.

Treatment interventions contain a strengths-based approach and encourage the further development and enhancement of both the child’s and family’s internal and external strengths that will support the child’s transition back to his/her home or community.

⁴ <http://www.azdhs.gov/bhs/tas.pdf>

Cultural experiences and preferences, including spiritual and gender-related considerations, should be addressed when formulating a treatment approach. Use of out of home treatment intervention may be viewed by some persons or cultures as shameful or stigmatizing and providers need to address these potential concerns. Residential service providers may involve the use of cultural guides (e.g., members of spiritual, community or tribal organizations) to help tailor accommodations to various spiritual and cultural norms. Discharge and transition plans must reflect identified strengths, cultural priorities, and include natural supports in conjunction with professional services.

9. **Out of home treatment and support interventions are highly individualized to the needs of each child and family.** Programming and treatment interventions within out of home settings must be highly individualized in addressing each child's and family's specific needs. Treatment interventions are based on functional assessments and their success is evaluated in terms of functional outcomes specific to the child. When multiple out of home treatment options are available, the child is matched to the program and setting most conducive to his/her presenting concerns and individualized treatment needs as identified through the CFT process. Transition back to the community must be well-coordinated between the residential and community behavioral health providers. Transitional discharge approaches that incorporate active family involvement and graduated periods of time spent at home while the child is receiving out of home treatment services are often successful. Creative arrangements that maximize this integration of home and residential services should be incorporated into treatment delivery whenever possible.
10. **Effective treatment interventions in out of home settings are delivered by competent and supervised individuals.** Residential service providers must be competent and well-trained as documented by education, experience, training, and certification/licensure. Given the complexity of needs and presenting concerns that surface during the delivery of out of home treatment services, providers at all levels require sound clinical supervision to ensure that treatment interventions and service plans are effectively assisting the child and family in meeting treatment goals and outcomes. Clinical supervision must be provided as required by licensure. Goals of supervision are to promote the professional growth and development of staff (skills/knowledge grounded in best practices), to monitor staff performance and competence and their adherence to agency, licensing and accrediting requirements, and oversight of legal, ethical, and cultural concerns. Without the provision of quality clinical supervision, emotional or personal influences may go unrecognized and could compromise the effectiveness of the services being provided. Therapists, case managers, support staff, and care providers at all levels must receive regularly scheduled and focused clinical supervision.

Service Expectations: Residential service provider staff must be trained and supervised to ensure treatment interventions and service plans are being implemented effectively. All staff directly involved with the child's care must receive regularly scheduled clinical supervision, as well as event-driven supervision when necessary, to ensure the provision of sound clinical treatment.

11. **Out of home settings provide services and supports that are flexible in responding to changes in the child’s needs.** Residential service providers must work collaboratively with the CFT to identify and address the changing needs of the child and family while the child is receiving treatment services in an out of home setting. As new situations arise, the service plan goals, treatment interventions, supports and services, and/or discharge plan may need to be modified.

Service providers must demonstrate a continuing commitment to serve individuals after admission into treatment, regardless of any challenges that arise. Program policies and procedures, organizational values and staff development need to be aligned to minimize coercive and/or law enforcement intervention. Service plans shall address alternatives to law enforcement involvement when appropriate and the use of de-escalation techniques other than seclusion or restraint.

Service Expectations: Residential service providers must work collaboratively with the CFT to identify and address the changing needs of the child and family. Treatment interventions and services are modified as needed.

12. **Out of home settings must provide, to the extent possible, as natural and home-like an environment as possible.** Residential service settings should support the ability of the child to sustain existing positive relationships with family, friends, teachers and neighbors. When possible, continued participation should be arranged for activities (e.g., school, recreation, church) that the child was involved in prior to receiving out of home treatment services. Parents and guardians have the statutory right to participate in decision-making about their child’s care, including but not limited to phone calls and family visits. 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.

Training and Supervision Expectations

This Practice Protocol applies to T/RBHAs and their subcontracted Level I, Level II, Level III, and HCTC 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 that all residential service provider clinical staff working with children and adolescents understand the expectations outlined in this Protocol. At a minimum, all residential service provider clinical staff working with children and adolescents are required to read and implement the required elements of this Protocol.

Whenever this Practice Protocol is updated or revised, T/RBHAs must ensure their subcontracted Level I, Level II, Level III residential providers, and HCTC 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, Level III residential providers, and HCTC agencies have in place for direct care clinical staff.

All agencies providing out of home treatment services to children must ensure and document that all required training, per [*ADHS/DBHS Provider Manual Section 9.1 Training Requirements*](#) and according to the Office of Behavioral Health Licensure (OBHL) guidelines, has been completed prior to service delivery.

Service Expectations: All behavioral health staff who provide out of home treatment services must complete required training per *ADHS/DBHS Provider Manual Section 9.1* and OBHL guidelines.

Anticipated Outcomes and How they will be Measured

Anticipated outcomes include:

- Out of home treatment services are utilized as part of a continuum of community-based behavioral health services.
- Children will experience shorter lengths of stay in out of home treatment settings.
- Increased involvement of the child's family in all aspects of the child's out of home treatment.
- Better integration of the Arizona Vision, 12 Practice Principles, and CFT process into residential service programs.
- Improved collaboration in service planning between community providers, residential service providers, child serving agencies and families.
- Decreased use of out of home treatment services statewide.

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

- ADHS/DBHS Utilization/Quality Management Reports
 - Average length of stay
 - Admission rates
 - Re-admission rates
- T/RBHA reviews of all residential service providers using the ADHS/DBHS Out of Home Protocol Monitoring Tools (Levels I, II, III, and HCTC)
- Chart Audits completed by the T/RBHA
- Chart Audits completed by the DBHS Quality Management Office of Monitoring & Oversight

How will Fidelity be monitored?

Fidelity to this Protocol will be monitored through:

- T/RBHA reviews of all residential service providers using the ADHS/DBHS Out of Home Protocol Monitoring Tools (Levels I, II, III, and HCTC)
- Chart Audits completed by the T/RBHA
- Practice reviews using the System Of Care Practice Reviews and Standard Needs Review tools

Children's Out of Home Services Desktop Guide

❖ Service Expectations:

- For services requiring prior authorization, if the prior authorization is denied the T/RBHA must assist the CFT with recommendations of alternative services that are congruent with the child's/family's needs.
- Service Plans must include goals and objectives that prepare the child and family for the child's return to home or to a less restrictive community setting, as quickly as possible.
- Every child receiving treatment services in an out of home setting must be served through a Child and Family Team, and the Residential Service Provider and CFT Service Plans must be in alignment.
- Family involvement and partnership, including the provider's attempts to engage the family, must be clearly documented in the clinical record.
- Residential service provider staff must be trained and supervised to ensure treatment interventions and service plans are being implemented effectively. All staff directly involved with the child's care must receive regularly scheduled clinical supervision, as well as event-driven supervision when necessary, to ensure the provision of sound clinical treatment.
- Residential service providers must work collaboratively with the CFT to identify and address the changing needs of the child and family. Treatment interventions and services are modified as needed.
- All behavioral health staff who provide out of home treatment services must complete required training per [*ADHS/DBHS Provider Manual Section 9.1, Training Requirements*](#) and OBHL guidelines.

❖ Key elements to remember about this best practice:

- Family involvement includes a wide diversity of primary caregivers from biological and adoptive families, to self-created units of people residing together who should be involved in all processes and decision making for their children.
- The stages of parental involvement include engagement, participation, empowerment, discharge and aftercare/supportive services.
- The primary goal of family-centered work is to strengthen the child/family relationship, whether they live together or not.
- Cultural guides can be utilized to tailor accommodations according to the child's/family's cultural norms. Sensitivity to the family's culture and language must be a primary concern.

❖ Benefits of using this best practice:

- Better integration of the Arizona Vision, 12 Practice Principles, and CFT process into residential service programs.
- Decreased use of out of home treatment services statewide and shorter lengths of stay in out of home treatment settings.
- Increased involvement of the child's family in all aspects of the child's out of home treatment.