Excerpts Regarding Respite Care from:

ADHS/DBHS Clinical Guidance Documents
Practice Improvement Protocols

&

TITLE XIX
CHILDREN'S BEHAVIORAL HEALTH
ANNUAL ACTION PLAN *
November 1, 2004
to
October 31, 2005

By
Arizona Department of Health Services
And
Arizona Health Care Cost Containment System

Practice Improvement Protocol 2

ATTENTION DEFICIT HYPERACTIVITY DISORDER

Developed by the
Arizona Department of Health Services
Division of Behavioral Health Services
Effective October 18, 1995
Last Revised April 3, 2003

IV. Recommended Practice and Coordination

A. Behavioral Health Services

1. A thorough and comprehensive assessment of all domains of a child's life must be made before a diagnosis is given. The core of the assessment should be the parental interview, as the diagnosis rests primarily on observations of those closest to the child and resulting clinical judgment. The child's behavior in home, school, and community settings is evaluated with respect to the features of ADHD, and comorbid conditions common to this diagnosis are reviewed. Family functioning and its potential effect on symptoms is reviewed. Information from the school, regarding the child's behavior and the appropriateness of the learning environment, is obtained. The use of the Conners Scale or other behavioral rating scales is particularly helpful in measuring baseline functioning and subsequent improvement.

Therapeutic strategies generally should utilize a broad-based range of interventions that may include:

- Psycho-Educational approaches
- Parent training in behavioral management skills
- Classroom interventions
- Cognitive behavioral therapy
- Social skills training
- Individual psychotherapy of the child
- Family therapy
- Living skills training
- Health promotion with a focus on medication education and compliance and health-promoting activities
- Peer and family support
- **Respite**
- Other methods of intervention and treatment to address the specific identified needs of the child and family.

Practice Improvement Protocol 12

Therapeutic Foster Care Services for Children

Developed by the
Arizona Department of Health Services
Division of Behavioral Health Services
Effective November 1, 2004
Last Revised October 25, 2004

Stability considerations: Prior to placement, a crisis plan should be developed by the Child and Family Team to anticipate what should occur if the clinical situation worsens, which next steps will be followed, who will be called, where the child will be taken if necessary, and by whom, etc. Respite care should be secured to support the foster family itself and provide necessary rest and relief. Family support and peer support for both the foster family and the child should be made available as needed. If an acute admission, an AWOL, an arrest or other occurrences temporarily disrupt a placement, the Child and Family Team and behavioral health provider should review and implement any and all options to ensure that the child can return to that placement when clinically appropriate. The single fact of a young person reaching his/her 18th birthday should never, by itself, require an otherwise necessary, beneficial TFC placement to end.

Practice Improvement Protocol 14

OUT OF HOME CARE SERVICES

Developed by the
Arizona Department of Health Services
Division of Behavioral Health Services
Effective March 9, 2005

13. Continuity of care must be maintained. Both community and out of home providers should adjust staffing models and patterns, contracting mechanisms and job descriptions to encourage individualized interventions and enduring therapeutic relationships that are not disrupted by changes in residence. Out of home settings should expand their ranges of services to include crisis stabilization, respite and other opportunities to support and preserve family stability and integrity. In addition, out of home service providers are encouraged to make the skills and expertise of their workforces available to help support the family, school and community to provide special attention to successfully transition the child home, and even to help address the needs of the child and family after discharge.

Practice Improvement Protocol 15

The Unique Behavioral Health Service Needs of Children Involved with CPS

Developed by the
Arizona Department of Health Services
Division of Behavioral Health Services
Effective May 15, 2005

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

The family circumstances that lead to involvement by CPS can be expected to create needs for behavioral health treatment and/or support for most children, and may reflect such needs of the family as a whole, or family members. In order to appropriately address their behavioral health needs, interventions should extend beyond the identified needs of the child alone, and should consider the needs of the family as they relate to the safety, permanency, behavioral health and wellbeing needs of the child. Together, CPS, behavioral health and other involved agencies should identify resources to support the needs of both family and child.

The involvement of CPS often indicates the presence of significant safety and risk concerns and needs. It is important that the Child and Family Team understand these concerns and explore opportunities where behavioral health services can help to mitigate them. At the same time, the Child and Family Team should work with CPS to comprehensively assess the strengths and resources of each child, the child's family and community. These strengths and resources can fortify the child's abilities at any age to cope with problems and adapt to changes -- a concept called *resilience.* CPS, behavioral health and other involved agencies should coordinate their services with other public and private services and supports through individually tailored approaches that identify, apply, support and strengthen such assets, and that address any safety and risk issues.

Families – whether the child's family of origin, a foster family, a relative or friend providing kinship care, or an adoptive family or care-giving legal guardian -- may be supported through the individual service plan of the child with supports and/or interventions such as respite, family support, peer support, living skills training (e.g. positive behavior support) or family counseling. The behavioral health system may often need to provide service approaches traditionally offered by the child welfare system, such as (intensive) family preservation services, in order to help stabilize the family situation and address the reasons for CPS involvement with the family.

It is the responsibility of the Behavioral Health System to provide needed interventions to family members, including siblings, who may also need specific individualized treatment, including individual counseling or other focused interventions. When this occurs service plans must be coordinated to make them compatible and mutually reinforcing. Without diminishing the needs that may exist for individual interventions, the Child and Family Team should participate in an overall plan that makes sense to the family, meets the requirements of CPS and the juvenile court, and is therefore more likely to be effectively implemented.

Service expectations: Behavioral Health Service Plans must include both generic resources and services as well as covered behavioral health services, and must include services needed by families and other caregivers.

Title XIX Children's Behavioral Health Fifth Annual Action Plan

Arizona Department of Health Services and AHCCCS

Principle: Stability (minimize multiple placements, identify children at risk of placement disruption, anticipate crisis and address in service plan, plan for transition)

Provision of respite service has nearly doubled between 2003 and 2005, in terms of both spending and percentage of children/families receiving this stabilizing service;

Respite Care:

Settlement Agreement Paragraph 17(b) add respite to the list of covered services as described in paragraph 40. #40 requires AHCCCS to add respite care to its list of Title XIX covered behavioral health services within 30 days of the entry of the Settlement agreement.

The Settlement obligation to add respite care to the list of Title XIX covered behavioral health services was addressed by ADHS in July 2000, when in-home respite services were added to the list of AHCCCS covered services for members enrolled in the ADHS Title XIX behavioral health system. Coverage of respite services was further augmented by adding coverage of out-of-home respite and expanding the type of providers allowed to provide respite services (October 2001)[11]. Since then coverage of respite, availability and utilization of respite services for class members has steadily increased over time as reflected in the table below. (Keep in mind that provision of other behavioral health services can sometimes also have the incidental effect of providing rest and relief for caregivers – the precise purpose for which respite services are primarily used.)

Total Respite Expenditures/Incidence of Respite Encounters for Children

Time Period	Expenditure for respite	% of enrolled children showing encounters for respite
July 1-2001-June 30, 2002	$ 368,961	1.8%
July1-2002 -June 30, 2003	$1,996,095	4.2%
July1-2003 -June 30, 2004	$2,274,569	4.6%
July1-2004 -June 30, 2005	$3,255,637	7.7%

[11] These actions are discussed in more detail in prior years' Annual Action Plans (2001-2004).

For access to complete reports please visit:

http://www.azdhs.gov/bhs/guidance/guidance.htm

http://www.azdhs.gov/bhs/children/action_plan.pdf

http://www.azdhs.gov/diro/reports/pdf/title19_actionplan.pdf