

Specialized Services and Support

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TABLE OF CONTENTS

XI. SPECIALIZED SERVICES AND SUPPORT		
A. Behavior Management	1	
1. Children Covered	2	
2. Disagreements and Grievances	2	
B. Behavior Management Intervention	2	
1. Prohibited Interventions	4	
2. Less Restrictive Interventions for Managing Existing and Teaching New Behaviors	5	
a. Modeling	5	
b. Rewards, Privileges and Positive Reinforcers	5	
c. Positive Communication	6	
d. Redirecting	6	
e. Contracting	6	
f. Time-Out	6	
g. Natural Consequences	6	
h. Logical Consequences	6	
i. Ignoring the Behavior	6	
j. Stating the Boundaries	6	
k. Behavioral Charting	7	
l. Family Meetings	7	
m. Punishment	7	
n. Levels Programs As An Intervention	7	
o. More Restrictive Interventions for Managing Existing and Teaching new Behaviors	9	
i. Isolation	9	
ii. Medication, Seclusion and Restraint	10	
(1) Medication	10	
(a) Criteria For Use	11	
(b) Documentation	12	
p. Seclusion or Restraint	13	
i. Criteria For Use	14	
ii. Physical Environment and Care of the Child	15	
iii. Notification of Parent, Legal		

	Guardian/Custodian, DHR.....	16
iv.	Procedural Requirements.....	16
	(1) Authorization/Orders.....	16
v.	Exceptions.....	17
vi.	Release.....	18
vii.	Documentation.....	19
3.	Provider Responsibilities.....	19
4.	DHR Responsibilities for Behavior Management.....	20
5.	Assessing Behavioral Needs.....	20
6.	Designing and Implementing the Behavior Management Plan.....	21
7.	Assessing and Monitoring Behavioral Management Interventions.....	23
8.	Discharge Planning and Training for Managing Behaviors.....	23
C.	Multiple Needs Children.....	24
D.	Alabama Child Welfare Practice.....	25
	1. Children Covered.....	25
	2. Court Orders.....	25
	3. Guidelines and Procedures.....	25
	a. Criteria for Accepting Referrals by Local Facilitation Teams.....	25
	b. Criteria for Establishing Multiple Needs Child Status.....	26
	4. Referral Process.....	26
	5. Imminent Risk of Out-of-Home Placement.....	27
	6. Imminent Risk of a More Restrictive Placement.....	27
	7. Responsibilities of Local/State Teams and Member Agencies Including DHR.....	28
	8. Referrals to State Facilitation Team.....	29
E.	Relationships of State and Local Facilitation Teams to Other Teams.....	31
	1. DHR Procedures.....	30
	a. Custody.....	30
	b. Payment.....	30
	c. Tracking.....	31
F.	Commitment of Children in DHR Custody to SDMH/MR.....	31

XI. SPECIALIZED SERVICES AND SUPPORT

A. Behavior Management

Behavior Management is designed to serve several functions for children, their families, DHR and provider staff when behavior management interventions are deemed necessary for children to manage existing or learn new behaviors. These functions are:

- the identification of general guidelines for behavior management interventions;
- a description of interventions which may be utilized when helping children manage existing or learn new behaviors;
- the identification of prohibited interventions; and
- the provision of guidelines and procedures for managing behaviors through the development of behavior management plans which use interventions that are in accordance with generally accepted professional standards.

Provider responsibilities for behavior management are included in this policy (1) as guidelines to follow when serving DHR children, and (2) as a reference tool for DHR staff. It is essential that all staff are knowledgeable of these responsibilities as they partner with service providers to design, implement, and monitor behavior management interventions and plans for our children.

Interventions used to manage children's behaviors must be authorized by the child and family planning team and documented in the individualized service plan. The most normalized, least restrictive interventions must be used to manage behaviors before the more restrictive interventions are pursued. It is recognized that different service providers will utilize different behavior management interventions based upon the needs of the children they serve.

The Alabama Child Welfare practice shall require that any behavior modification program employed in the treatment or management of a child be individualized and meet generally accepted professional standards, including that:

- the program relies primarily on rewards instead of punishment;
- the program be based on a careful assessment of the antecedents of the behavior that the program is designed to change; and
- the program be consistently implemented throughout the day, including in school, residential and leisure activity settings.

Alabama Child Welfare practice provides children with the following rights: the right of access to counsel and the courts, the right of access to family members, the right to be free of excessive medication, and the right to be free from unnecessary seclusion and restraint. DHR shall promulgate policies acceptable to both parties, describing and protecting these rights.

1. Children Covered

All children in the custody and/or planning responsibility of the Department may require behavior management services, if determined necessary in the ISP process. Providers using behavior management interventions must follow these policies when designing and implementing behavior management plans for children in the custody and/or planning responsibility of DHR.

2. Disagreements and Grievances

Disagreements and grievances about the type of behavior management interventions being used will be addressed in a fair, timely, and impartial manner by DHR and providers. Procedures for conflict resolution shall be established by the appropriate provider or provider agency. The parent(s) and age-appropriate child will be informed of these procedures in a manner understandable to them.

The Department shall make age-appropriate children and their parents aware, in an effective manner, of the availability of advocacy and appropriate support services to assist them in pursuing a grievance in case of a disagreement. Services may include, but are not limited to, the following:

- providing a second opinion regarding the disputed treatment intervention(s),
- assisting the parent(s) and age-appropriate child identify and clarify treatment options and outcomes, and
- advocating on behalf of the parent(s) and child to express concerns and arrive at an acceptable solution.

The parent(s) or age-appropriate child may request the child be discharged from the provider's program if the conflict cannot be resolved. Likewise, the provider can withdraw services or discharge the child from placement. However, the provider or DHR, whichever is appropriate, must give sufficient (i.e., as soon as possible, but not less than 30 days) **written** advance notice of the intent to withdraw services or discharge the child from placement in order to permit the child and family planning team to plan and provide appropriate alternative services or placement. Sufficient written advance notice may be waived only pursuant to the decision of the child and family planning team when the ISP is reviewed prior to the decision to move the child (per *Individualized Service Plans* policy).

B. Behavior Management Interventions

The following information provides general guidelines which apply to all interventions utilized by residential and non-residential providers, including foster family homes, to manage children's behaviors.

Behavior management interventions shall be based upon the needs of each individual child and supportive of the child's permanency goal as stated in the family's individualized service plan.

Decisions regarding the use of specific behavior management interventions must be based upon an assessment that considers, among other things, whether (1) the safety of

the child and others can be adequately met by the proposed intervention(s) and (2) the behavior(s) is being managed with the minimum physical and psychological risk to the child and others.

The parent(s) or other legally responsible person/agency and the age-appropriate child shall be informed of the purpose and benefits as well as the potential risks involved in behavior management interventions that will be used with a child.

Behavior management interventions must be administered in a manner which (1) assists in establishing safety and emotional well-being for the child, (2) offers ways for the child to gain control and have needs met without risk to personal safety or the safety of others and (3) demonstrates respect for the child as a person of worth and value.

The child's behavior must be managed in a way that promotes the child's personal growth and assists in the development of a positive self-concept.

Behavior management interventions which stress the use of praise, supportive feedback and rewards shall be the principle methods used, and these interventions must be managed in a way that encourages and leads to self-regulation by the child.

The role of managing a child's behavior may be delegated to another child only when participating in an organized program of self-government which conforms to these behavior management standards and which is properly supervised by group home or residential staff.

Medication is to be used only when needed to assist children in gaining control of their behavior and if medically indicated by a qualified physician as a method of therapeutic treatment and only as prescribed by the physician on the prescription.

Seclusion and restraint are to be used only when alternative interventions have been unsuccessful or would not be practicable and (a) when needed to protect children from seriously harming themselves or others, including other children, staff, and family members, or (b) needed to prevent substantial property damage.

The DHR worker, caregiver or others, as identified by the child and family planning team, will provide supportive services necessary to implement behavior management interventions in the least restrictive environment for the child.

Services may include, but are not limited to, the following:

- coaching to assist the child and family in identifying needs,
- conflict resolution and mediation services relating to interventions,
- assistance with identifying training needed for effective implementation of the behavior management interventions, and
- access to crisis intervention services.

Disagreements and grievances about the type of behavior management interventions being used will be addressed in a fair, timely, and impartial manner by both DHR and provider staff.

1. Prohibited Interventions:

Behavior management interventions that infringe upon the rights of the child and family and that do not consider the child's individualized treatment needs are prohibited. Medication, seclusion, and restraint shall not be used as retaliation or punishment, for the convenience of providers and their staff or as a substitute for more appropriate and less restrictive interventions or because of inadequate staffing. The most normalized, least restrictive measures for controlling children's behavior must first be implemented before pursuing more restrictive measures.

Prohibited interventions include, but are not limited to, the following:

- Interventions that deny the child the right to humane care and protection from danger including abusive and neglectful actions of others and actions that prolong physical discomfort. Physical/corporal punishment, verbal abuse, threats or derogatory remarks about the child or the child's family must not be used.
(Examples: Slapping, striking, or hitting the child; cursing the child; forcing the child to stand or kneel rigidly in one spot for a prolonged period of time; or placing the child in a small, cold room for a calming effect.)
- Interventions that conflict with Department of Human Resources policies regarding telephone/mail access and visiting.
(Examples: Withholding or denying a child telephone contacts or visits with family when behavioral expectations have not been met.)
- Interventions that withhold the basic necessities from a child (i.e., food, water, exercise, acceptable social interaction and age-appropriate activities).
(Example: Withholding meals or sleep from the child as punishment for eating "junk food" before bedtime.)
- Interventions that allow a child's peers to carry out discipline and/or fail to provide the child with proper adult supervision and guidance.
(Example: Placing the child in isolation for 4 hours without any observation; physical outbursts of anger by an authority figure when a child fails to obey, e.g., shouting, pounding on the table, "getting in the child's face.")
- Interventions that deny the child opportunities for dignity, personal privacy and to live in a normalized environment.
(Example: Punishment for bed-wetting or lack of toilet training; withholding personal possessions which help preserve the child's identity, e.g. pictures, letters; searches of a child's personal possessions or room that are unrelated to the safety and well-being of the child or others.)
- Interventions that are of a vindictive nature and/or used for retaliation.

(Example: Washing the child's mouth out with soap; biting the child as a "pay-back" for biting someone else; arbitrarily sending the child to bed early; making the child run laps at 5:00 a.m. as punishment for running away from the facility.) and

- Interventions that are clearly not age-appropriate or are inappropriate for the child's abilities.
(Example: Requiring a six year old to write 50 sentences which are each 10 words long; requiring the child with A.D.H.D. to memorize or repeat a long poem when day-to-day school performance reflects the child is unable to master that task.)

The use of medication, seclusion or restraint when:

- the intervention **has not been authorized** by the child and family planning team in the individualized service plan;
- more appropriate or less restrictive interventions have not been tried; and
- the intervention is used in a manner that is not in accordance with this policy.

(Example: Placing a four year old in a locked bedroom as routine punishment for angry outbursts; medicating the child who has been kicking and screaming for one hour as a method of relief for the caregiver.)

2. Less Restrictive Interventions For Managing Existing and Teaching New Behaviors

The following behavior management techniques are examples of less restrictive interventions which may be useful when helping children manage existing behaviors and/or learn new behaviors. This list is not intended to be all-inclusive.

- a. Modeling - Learning by observing and imitating a competent model, thus transferring the new learned behavior to a real life situation.

(Example: A four-year-old foster child is sitting in the living room floor and is given a puzzle to put together. Instead of putting the puzzle together, the child screams and pulls her hair. This pattern of behavior continues each time the child is given a puzzle to put together. The foster mother begins responding to the behavior by sitting on the floor and quietly putting together the puzzle. The process is repeated until the child learns the new behavior.

- b. Rewards, Privileges and Positive Reinforcers - Providing short-term incentives and specific, positive feedback that helps the child focus on the desired behavior.

(Example: A child is allowed extra TV time after finishing homework in a timely manner.)

c. Positive Communication - Using language in positive terms to describe clear expectations to the child.

(Example: "Bruce, I want you to pick up your clothes" instead of "Don't leave your clothes on the floor.")

d. Redirecting - Substituting an acceptable behavior for an unacceptable one.

(Example: The child care worker tells Jimmy that he may not kick his friend, but may kick the soccer ball as hard as he likes.)

e. Contracting - Negotiating with the child through a written mutual agreement that provides incentives to help the child focus on desired behavior and outlines consequences for non-compliance with expectations.

(Example: Foster mom contracts with Susan that she can rent an extra movie for viewing if she completes her chores.)

f. Time-Out - A method of discipline which is explained to a child in advance of implementation and consists of a brief interruption of the child's activity. It includes "time-out" from reinforcement, rewards and attention followed as soon as possible by the child's return to the ongoing activity and the reinforcement of positive behavior.

(Example: A two-year-old child bites her foster mother. A chair has been designated as a time-out chair, and the child must sit there for 2 minutes.)

g. Natural Consequences - Allowing the child to experience the results of a behavior.

(Example: Ten year old Joey is responsible for putting his completed homework assignment in his book bag before he goes to bed. If Joey forgets to do this, leaves the assignment at home, then the homework does not make it to school and Joey suffers the natural consequence of receiving a lower grade for late work.

h. Logical Consequences - Clearly describing and imposing the consequences to the inappropriate behavior.

(Example: "Mike, if you stay out late, you will lose the opportunity to go out next weekend.")

i. Ignoring the Behavior - Withholding attention to behavior so that it is not reinforced.

(Example: When a six-year-old begins to whine, the foster dad does not respond.)

j. Stating the Boundaries - Stating rules and expectations up-front and reaching agreement about the boundaries.

(Example: Foster mom tells her six-year-old daughter what is expected from her before the guest arrives for dinner.)

k. Behavioral Charting - Using visual tools for tracking the frequency, duration and precipitating factors of a behavior in order to:

- provide baseline data for designing the behavior management plan and measuring progress towards desired outcomes,
- promote awareness and self-control, and
- assist with determining when to use positive reinforcements which is decided by the accumulation of points/tokens earned by the child for specific activities or behaviors.

(Example: Missy makes her bed before school and finishes her homework by 7:30 p.m.; she earns 10 stars and is rewarded by being allowed to rent an extra video of her choice.)

l. Family Meetings - A unit or house meeting whereby the parents/house parents and children discuss an issue important to the group and decide upon a course of action.

Example: Several children in the group home cottage violated the 11 o'clock curfew. The house parents and children held a family meeting and made a joint decision that the children who violated the curfew would lose one off-campus privilege during the following week.)

m. Punishment

A child must have a clear understanding of behavioral expectations and the consequences for non-compliance before any type of punishment is used. Punishment should be limited, imposed as soon as possible following the inappropriate behavior, always linked with constructive feedback and re-education, and used only when it is the most effective method of teaching new behaviors, not just reducing or eliminating undesirable behaviors. The effectiveness of punishment must be assessed frequently and will not be used any longer or more frequently than is needed to change or modify the behavior or protect the child.

The use of physical/corporal punishment is prohibited. Some situations, however, may warrant the use of non-physical punishment (e.g., taking away privileges) especially if the child needs to make the connection between actions, responsibilities, and the rights of others. An example is the family rule is that telephone conversations with friends are limited to no more than 30 minutes at a time. The child continues to ignore the rule and telephone privileges with friends are limited for a specific period of time as long as the limitation is consistent with Telephone and Mail Contacts policy.

n. Levels Programs As An Intervention:

Levels programs are another strategy for managing children's behaviors. This intervention is based on a motivational approach and is used to:

- clarify expectations,
- provide clear steps toward defined goals,

- provide clear recognition of incremental gains,
- reduce arbitrary decisions,
- provide immediate feedback about behavior (which helps the child learn,
- socially appropriate behavior), and
- set fair and consistent limits and boundaries for the child who does not possess this ability internally.

Levels programs rely on a point system or token economy to determine the privilege level on which a child is placed. Desirable behavior is acknowledged through rewards (earning points or tokens) and behavior which needs to be reduced or eliminated is acknowledged through consequences (loss of points or tokens). The structure of a levels program should be balanced between overall program goals which are necessary for the smooth, efficient functioning of the residential community and the child-based goals which address the strengths, needs and abilities of the child as reflected in the individualized service plan.

In addition, a levels program should be structured in a manner that individualizes the various levels based upon the child's unique strengths and needs and allows the child to achieve a degree of success. Requirements of a levels program should not be so restrictive that "minor infractions" are dealt with more severely than they are in less restrictive placements and which, ultimately, may inhibit a child from attainment of a higher level (e.g., a child who occasionally fails to make his bed is punished by being retained on Level I which denies store privileges; whereas, the child in a foster family home is verbally reprimanded for failing to make his bed and allowed to go to the mall).

Levels programs must permit the child to "move through" the levels system in an effective manner. The child and family planning team must monitor the child's progress through levels and require changes in the child's behavior management plan, including the levels placement, if needed. Discharges from levels programs should be based upon changes in behavior and attainment of individual goals as outlined in the individualized service plan instead of completion of or failure to complete broad program requirements.

The decision to use a levels program as a treatment intervention must be based upon the child and family's strengths and needs, and determined to be the most effective way of managing the child's behavior. If the child and family planning team determines that a levels program is not appropriate for a child, the child shall not be placed in a treatment setting which employs a levels program as the intervention. When the child and family planning team determines that a levels program may be appropriate, the team shall determine if the proposed placement can meet the child's needs.

A levels program must provide the child with access to individualized services and resources, and be supportive of the behavioral objectives and desired outcomes for the child as determined in the individualized service plan. Levels programs may not have arbitrary requirements that every child begins at the same level, but must be based on the child's individual needs. Progression to higher levels cannot be based on arbitrary requirements that do not consider the individual strengths and needs of the child.

Staff who use levels programs as a treatment intervention shall receive education and training to effectively implement this intervention. The training shall be conducted by a qualified source and documented in the provider's file. Training needs shall be continually assessed with training provided to support the level of skill needed by the staff.

o. More Restrictive Interventions for Managing Existing and Teaching New Behaviors

i. Isolation - Isolation is a less restrictive intervention than medication, seclusion or restraint and is designed to be used with less extreme or dangerous behaviors than those requiring seclusion or restraint. Isolation shall be:

- used only when therapeutically indicated and as part of a behavior management;
- plan to modify or eliminate targeted behaviors;
- used in conjunction with supportive and interactive treatment methods as the principle interventions;
- conducted in a manner that fosters the child's capacity for self-regulation; and
- time-limited as specified in the behavior management plan with the child being released as indicated by the plan.

When a child is isolated, provisions shall be made for humane and safe conditions including room space appropriate to the developmental level of the child, adequate ventilation and lighting, and a room temperature consistent with the rest of the home or facility. Meals, routine medication and water must be provided. Observation of a child in isolation shall occur **at least every 30 minutes** or more often as necessary. The behavior management plan will describe how frequently the child must be observed and will authorize any restrictions imposed while the child is in isolation, e.g., no TV or radio.

The use of isolation must be authorized in advance by the child and family planning team in accordance with the ISP and behavior management plan. Appropriate members of the child and family

planning team (e.g., mental health professional, DHR worker, residential provider) shall explain and assist the age-appropriate child and family to understand the need for this intervention. The individuals designated to implement and monitor isolation will review the intervention frequently (e.g., weekly, bimonthly, monthly depending upon the frequency of usage) to determine if it is having the desired effect on the child. If the desired outcome is not being achieved, isolation must be modified or discontinued.

Providers who utilize isolation as an intervention will work in partnership with the child and family planning team to monitor use of the intervention to determine if it is having a positive effect on the child and whether more normalized, less restrictive interventions could be used. **The use of isolation 3 times or more in a 24 hour period or for more than 2 hours in a 24 hour period will be reviewed by the provider's treatment team for the intervention's appropriateness and the need for alternative interventions.** Documentation of this review must be recorded in the provider's file. The child and family planning team will be provided regular updates about interventions utilized as part of the assessment and monitoring process.

ii. Medication, Seclusion and Restraint

Medication, seclusion, and restraint are the more restrictive interventions for managing children's behaviors and **shall be used only** when approved by the child and family planning team to do so and when more normalized, less restrictive interventions have been unsuccessful or would not be practicable. The following information applies specifically to these interventions and is a supplement to the general guidelines previously provided for the less restrictive interventions.

(1) Medication

Medication may only be administered to children when (a) the informed consent of the parent, legal custodian/guardian, or the foster parent legally authorized to provide consent and (b) the informed consent of the child (age 14 or older) has been obtained. The child and adult(s) whose consent is sought will be provided sufficient information to permit them to make an informed decision. The reasons for using the medication, its expected benefits, and the potential side effects should be explained in terms understandable to them along with any significant alterations in dosage. The child's and parent's preferences and requests for alternative interventions should be considered. Consent may be withdrawn at any time; however, a child's refusal to consent may be overridden by a court of appropriate jurisdiction. Prescriptions for medication

must be made by a licensed physician who is trained in the use of medication with children and adolescents. When medication is used as a treatment intervention, it must be administered only as prescribed by the physician writing the prescription. Medication is to be carefully and closely monitored by the child's physician and the child and family planning team for both desired effects and potential side effects. Monitoring should include information received from the child, parent(s), and caregivers.

(a) Criteria For Use

A qualified physician must complete a thorough assessment of the child before prescribing medication. The assessment is performed to determine the appropriateness of prescribing the medication and to establish baseline data for monitoring its effects. The physician shall conduct a physical examination of the child, review the child's medical history and other relevant evaluations (e.g., medical, psychiatric, psychological) and obtain input from the child's parent(s)/caregiver(s), the DHR worker, and other relevant service providers and school personnel. The child's and parent's preferences and requests for alternative interventions should be considered by the physician as informed consent is required prior to administering medication (Refer to E. 2. (A) for additional information regarding informed consent).

The physician shall be a member of the child and family planning team (input at times may be obtained via written report, telephone calls, etc.). If the physician is a consultant to a service provider, the provider and the child's DHR worker shall ensure the physician is aware of the caregiver's capabilities, appropriate alternative treatment interventions, and the changing needs of the child and family.

In a crisis where the child will seriously harm self, harm others, or cause substantial property damage, medication may be administered without informed consent upon an order by the treating physician and in accordance with generally accepted medical

standards. There must be documented evidence in the child's record that in the physician's professional judgment, the harm or substantial property damage will occur without the benefit of the medication and that less restrictive interventions are not therapeutically indicated. The child's physical and psychological condition must be frequently monitored by the physician or an appropriate staff member or other provider following administration of the medication.

If it appears that medication will be used to address crises in a periodic, on-going pattern with the child, a court order or informed consent must be obtained from the child (age 14 or older) and the parent(s), legal custodian, guardian or foster parent legally authorized to provide consent. The child's refusal to consent may be overridden by a court of appropriate jurisdiction.

The dispensing of Prescribed as Needed (PRN) medication can only be allowed if in compliance with a physician's approved protocol and the order is documented in the child's medical file of the provider's record and the child's DHR case record. **PRN medications administered to address a child's behavior two or more times a week for three consecutive weeks will result in a comprehensive review of the child's individualized service and behavior management plans and the incidents, factors, and rationales for such PRN medication use.**

(b) Documentation

The provider's record for the child must maintain adequate documentation of the following:

- The physician's initial assessment and order for medication, and any subsequent assessments and orders;
- Evidence of proper administration and regular monitoring for side effects appropriate to the specific medication;

- Evidence of timely reassessments and evaluations of the medication, its effects and side effects;
- Evidence that decisions resulting from the reassessments and evaluations have been implemented;
- Evidence that adequate and effective education has been provided to the child, parents, and any service providers who are responsible for administering or monitoring the medication, its effects and potential side effects;
- Evidence of informed consent or a court order issued to override the child's refusal to consent; and
- Orders and related documentation issued during a crisis situation.

p. Seclusion or Restraint

- Seclusion and restraint are two of the most restrictive interventions addressed in this policy and shall be used only by those providers who meet the following criteria and who have been approved by DHR to utilize the interventions. Seclusion or restraint may be used **only** as part of a behavior management plan approved by the child and family planning team and when more normalized less restrictive interventions have been unsuccessful or would not be practicable.
- The use of these interventions must be consistent with the child and family's goals identified in the individualized service plan.
- Seclusion or restraint may be used only when needed (a) to protect a child from seriously harming self or others (including other children, family members, and provider staff) or (b) to prevent substantial property damage. and
- Mechanical restraint may be used only when needed to protect the child from engaging in behavior that has a likelihood of resulting in serious self-injury

(e.g., head banging, sticking objects in ears or nose, pulling at IV tubes).

i. Criteria For Use

Residential treatment providers may use seclusion or restraint only if:

- The provider has an on-site or on-staff QCCP at the time of the seclusion or restraint;
- The staff member(s) who will implement seclusion or restraint has received training from a qualified source to safely use the intervention(s);
- The provider's behavior management policy provides for adequate documentation of the use of seclusion or restraint;
- The provider has internal reporting and review procedures that include reporting all use of seclusion or restraint to the program's director and documenting all use of seclusion or restraint in a central file. A periodic review of seclusion or restraint practices will be done by a committee convened by the provider that includes outside persons; and
- The rooms or spaces used to seclude or restrain the child meet generally accepted professional standards.

The use of seclusion or restraint as a behavior management intervention must be assessed and authorized by the child and family planning team. It shall be consistent with the child and family's goals. In addition, the team shall consider the extent and circumstances surrounding any previous use of seclusion or restraint, any historical information on the child that might alert the provider to the potential for an extreme reaction to seclusion or restraint, and the extent and circumstances which could necessitate future use of these interventions. The authorization shall indicate the type of intervention and any special procedures, in addition to those in policy, required of the provider.

The DHR worker or other appropriate team member, (e.g., mental health professional), shall assist the parent(s) and age appropriate child to understand the need for the intervention. If seclusion or restraint is authorized, there must be evidence in the provider's record for the child and the child's case record that the intervention is the most

effective and least restrictive for managing behavior. The use of seclusion or restraint must be discontinued as soon as the child is no longer a danger and in accordance with the release criteria outlined in the QCCP's authorization / order.

The provider using seclusion or restraint and the child and family planning team shall monitor use of the intervention to determine if it is having a positive effect on the child and whether more normalized, less restrictive interventions could be used. **The use of seclusion or restraint 3 times or more in a 24 hour period or for more than 2 hours in a 24 hour period will be reviewed by the provider's treatment team and the program director for the intervention's appropriateness and the need for alternative interventions.** Documentation of this review must be recorded in the provider's file. The child and family planning team will be provided regular updates about interventions utilized as part of the assessment and monitoring process.

ii. Physical Environment and Care of the Child

The room or space used for seclusion or restraint is to be constructed to protect the health, safety and well being of children placed there. The floor space will be appropriate to the developmental level of the child, the purpose of the seclusion or restraint and the maximum time a child might spend in the room. The design, construction and operation of any room or space used for seclusion or restraint are to conform to all applicable provisions of the Life Safety Code prescribed by the National Fire Prevention Association. In addition, the following shall apply when a child is being restrained or secluded:

- Periodic observation of the child shall occur **at least every 15 minutes**, or more often as necessary, as well as verbal interaction with the child when appropriate. The person making the observation will be made aware of and take account of any special medical and psychological concerns regarding the child. Staff shall be immediately available to intervene if necessary. The child's physical and psychological condition shall be documented every 15 minutes or more frequently if indicated or ordered. Vital signs must be taken as clinically indicated;
- The child shall not be deprived of food, fluids, toilet and bathing opportunities, and appropriate exercise;

- The child shall be protected from other children and environmental hazards;
- The child shall be protected from potential risks of self-injury, i.e., possession of dangerous objects such as shoe laces, belts, buttons, matches, tobacco products, etc.; and
- Care must be taken so that mechanical restraint does not restrict the flow of blood to the limbs, and protective devices (e.g., leather restraint, helmets, handcuffs and shackles) are kept clean at all times.

iii. Notification of Parent, Legal Guardian/Custodian, DHR

A child's parent, legal guardian/custodian, and the DHR worker shall routinely receive information about any use of seclusion or restraint with the child. This information sharing can occur at child and family planning team meetings, treatment team meetings or upon individual request by the parent(s), legal guardian / custodian or DHR.

In addition, the parent or legal guardian/custodian and the DHR worker shall be notified, within the next 24 hours, if the child is placed in seclusion or restraint 3 times or more in a 24 hour period or for more than 2 hours in a 24 hour period. The DHR worker will convene the child and family planning team to reassess the child's needs and resulting changes needed to the individualized service and behavior management plans.

iv. Procedural Requirements

Providers must follow the procedures below when authorizing and implementing seclusion or restraint.

(1) Authorization/Orders

- Prior to authorization and implementation, children shall receive a physical evaluation to identify any medical restrictions or prohibitions associated with the use of restraint or seclusion.
- Each use of seclusion or restraint must be authorized by a written order from a QCCP who is physically present and has assessed the child's physical and psychological condition.

v. Exceptions

(1) A QCCP's authorization/order is not required for the brief use of seclusion (i.e., fifteen minutes or less) or the brief use of restraint (i.e., five minutes or less) for the purpose of interrupting aggressive or assaultive behaviors or disruption to the therapeutic environment.

(2) In a crisis situation, seclusion or restraint may be authorized and implemented for up to 2 hours by a staff member who has experience and training in the proper use of the procedure. The staff member must be physically present and evaluate, to the extent feasible, the child's physical and psychological condition. The staff member must consult with the QCCP as soon as possible to obtain verbal authorization to use the intervention. The QCCP must provide a written authorization/order including any related documentation within 24 hours after implementation of the verbal authorization. The intervention may be used no longer than two (2) hours unless the QCCP is physically present to personally assess the child and write a new authorization/order to continue use of the intervention.

(3) In extraordinary circumstances, the SDHR Family Services Division may allow a provider without an on-site or on-staff QCCP to use seclusion or restraint in a specific child's case; (e.g., intervention is therapeutically indicated for a child and the facility has ready access to and can consult with a psychiatrist who has a knowledge of the child's history).

The provider is to contact the child's worker immediately to discuss their assessment regarding the need for intervention. The worker and supervisor will contact the county's child welfare consultant to discuss the circumstances in order to obtain the allowance. This allowance is to be carefully monitored and documented in the child's DHR and provider case records.

NOTE: When situations of this nature occur after hours or on weekends, the provider is to contact the county's on-call child welfare worker who will discuss the need with the supervisor. Contact with the child welfare consultant is to occur on the next working day, and followed up by the appropriate documentation.

(4) Authorizations/orders for seclusion or restraint are valid for no more than 8 hours. All

written authorizations/orders (including crisis situations) shall include a clinical assessment of the child, a description of precipitating events and alternative interventions attempted, and the criteria for the child's release.

(5) Children must be released from seclusion or restraint when the criteria for release have been met or at the end of the time frame set out in the authorization/order, whichever occurs first. If additional time in seclusion or restraint appears to be needed, a QCCP must examine the child and write a new authorization/order. **Prescribed as Needed (PRN) orders are not to be used to authorize seclusion or restraint.**

vi. Restraint may be authorized when a child is transported from one location to another only because of threat of harm to self or others and only if there has been a documented dangerous incident within the past 14 days that clearly indicates restraint is necessary to prevent injury to the child or others; e.g., the child has assaulted staff or other residents being transported.

vi. Release

A child must be released from seclusion or restraint when the child is no longer a danger and in accordance with the release criteria outlined in the authorization/order. A child who falls asleep in seclusion or restraint shall be released immediately. The person supervising the child must be aware of the steps necessary for the child to be released from restraint or to leave seclusion and the intervals when these steps should be attempted or repeated.

If the child needs to remain in seclusion or restraint for a longer period than initially specified, a new authorization/order must be obtained. It must describe the basis for the belief that the child needs extended time in seclusion or restraint. The use of extended periods is to be reviewed at the child and family planning team meetings.

vii Documentation

The use of seclusion or restraint must be documented in both the provider's and DHR's case records for the child. In addition, the provider's record for the child must maintain -adequate documentation of the following:

- a clinical assessment of the child including a description of precipitating events, any medical restrictions or prohibitions associated with the intervention, and alternative interventions attempted;
- the QCCP's written order identifying the intervention authorized, time frames for periodic observation, and criteria for termination;
- the date, time, and duration the intervention was used, and presence or absence of contraindications;
- the periodic observation of the child's physical and psychological condition;
- the provision of meals, toilet opportunities, fluids on a regular basis, bathing and exercise, as needed;
- an assessment of the child's physical and emotional condition upon release;
- a medical evaluation of any injury suspected to be related to the use of seclusion or restraint;
- orders and related documentation issued during a crisis situation;
- evidence of timely reassessment of the intervention's use and its effects on the child; and
- evidence that decisions indicated by the reassessments and evaluations have been made.

Note: Included in the Appendix is a reference sheet on Critical Actions and Timeframes for isolation, medication, seclusion/restraints.

3. Provider Responsibilities

Child care institutions, group homes, shelters, other facilities, and licensed child placing agencies responsible for approving foster homes that serve children in the custody and/or planning responsibility of the Department are to develop written behavior management policy which includes procedures for emergencies and crisis situations. These facilities may adopt DHR policy or develop their own as long as it is consistent with Department policy and provides children the same rights as children in DHR approved foster homes. Facilities which elect to develop their own behavior management policy must have the policy reviewed and approved by the State Department of Human Resources, Office of Agency Licensing.

A provider's behavior management policy must be explained to all DHR-placed children and their parents so the family has a clear understanding of the policy. A copy of the facility's behavior management policy will be given to the parent(s) and/or legal custodian upon their request. These facilities may choose to apply Department policy to only those children placed by DHR.

Providers who use isolation, seclusion, and/or restraint are to receive specialized or certified training in safely implementing these interventions as well as training in alternative, less restrictive interventions for managing behavior. Providers responsible for administering and monitoring medications must also receive training and instruction in the dispensing, storage, and disposal of medication, and how to administer medication and monitor the effects and potential side effects. Evidence of the proper storage, dispensing and disposal practices must be documented.

Facilities shall also maintain documentation of all training received or provided. Training must meet generally accepted professional standards and be provided by a qualified source. In addition, facilities will survey their staff on an annual basis regarding training needs, and document in their resource or personnel files all plans or programs utilized to meet those needs. The Department will assist providers with locating training as needed.

4. DHR Responsibilities for Behavior Management

Plans designed to address behavioral needs must be systematic, based upon a careful assessment of the child's behavior, and utilize behavior management interventions which are in accordance with generally acceptable professional standards. Interventions will be:

- based primarily on rewards, redirecting and re-education rather than punishment;
- consistently implemented in all areas of a child's life (e.g., school, church or leisure activities);
- implemented in a therapeutically appropriate manner according to the individual treatment plan developed by the provider; and
- timely evaluated for effectiveness.

Children are to be referred to providers qualified and trained to authorize and implement behavior management interventions. **DHR staff shall be aware of a provider/facility's behavior management policy and may request a copy, when needed, to assure it is consistent with Departmental policy and provides children the same rights as children in DHR approved foster homes.** If the need for intervention becomes apparent after placement, and the provider is not appropriately trained to authorize and implement the needed intervention, DHR shall assist the provider to secure the needed training.

5. Assessing Behavioral Needs

An integral part of designing behavior management plans is a comprehensive assessment of the child's behavior. This behavioral assessment is an essential part of the individualized service planning process and is derived from information

gathered from the child and family planning team. Input is to be sought from the parent(s), age appropriate child, caregivers (for children in out-of-home care), and all other appropriate team members. DHR staff shall partner with the appropriate team members to explain and assist the age appropriate child and the child's family to understand the need for behavior management interventions.

Assessments are to include information gathered from the social, medical, educational, psychological, and legal life domains (areas of family functioning) and will address the following:

- child and family's strengths and needs,
- child's current and past behaviors,
- events, conditions or circumstances that trigger or affect the behavior,
- purpose the behavior serves and how it is displayed,
- frequency and duration of the behavior,
- previous interventions used to manage the behavior and their effectiveness,
- child's degree of readiness to learn self-control, and
- targeted areas for behavioral improvement and increased self-control.

Behavioral expectations (outcomes) for the child will vary according to age, maturity, and the child's ability to manage the targeted behavior(s). Expectations are determined by the child and family planning team and must be clearly communicated to the child and all others involved in managing the behavior. Opportunities should be provided for the child to successfully assume a gradual increase in responsibility and decision-making. The child must not be expected to assume tasks which are not age and developmentally appropriate.

When a child's behavior indicates the need for medication, a medical assessment is required. The DHR worker is responsible for providing the physician with the child's history, information about the caregiver's capabilities and the changing needs of the child and family, and to assure the physician has explored alternative treatment interventions. (Refer to section on medication for more detailed information.)

6. Designing and Implementing the Behavior Management Plan

Behavior management plans are to be individualized for each child, developed, and authorized in advance by the child and family planning team. Interventions used shall be consistent with the individualized service plan goals. The more restrictive interventions (e.g., medication, seclusion, restraint) must also be authorized in advance unless there is a crisis situation (refer to sections on medication, seclusion and restraint in this policy).

Information gathered during the assessment phase of the individualized service planning process is utilized by the child and family planning team to design the

child's behavior management plan. **The behavior management plan and any adjunct treatment plans (as applicable) must be documented in the ISP and will include:**

- the child and family's strengths and needs as they relate to the desired behavioral outcomes;
- a clear description of the targeted behavior(s) to be managed (i.e. specific situation(s) where the behavior occurs, how it is displayed by the child, its frequency and duration);
- the desired outcomes for the targeted behaviors;
- the interventions to be used for teaching positive, alternative replacement behavior and how they will be implemented;
- the methods and frequency for evaluating the effectiveness of the interventions; and
- if applicable, the crisis plan outlining acceptable responses for managing dangerous behaviors.

Good planning also involves assessing and being prepared for a crisis that involves a child presenting a danger to self or others. When case information reveals a child has a history of or the potential to display dangerous behavior, service provider and placement referrals are to be made to appropriately qualified and trained providers and placement resources. **The individualized service plan for these children must include a crisis plan outlining acceptable responses for managing the dangerous behavior.**

Foster family home providers may use a behavior management intervention (e.g., prolonged grounding, exceeding defined time-out limits) which has not been previously authorized and documented in the individualized service plan when a crisis situation arises. The intervention will not be used any longer than necessary to protect the child or others from harm or to help the child gain control. The foster parent must document use of the intervention and notify the DHR worker immediately (i.e., no more than one (1) working day later) of the crisis and subsequent use of the intervention. A meeting of the child and family planning team shall be called to review the intervention's use and determine if the current placement continues to be the most appropriate and least restrictive environment for meeting the child's needs.

Residential providers may also use an intervention not previously authorized and documented in the individual service plan when a crisis arises. The residential provider must have a procedure in place which requires notification of a qualified child care professional (QCCP) who is available to assess the crisis and make decisions regarding the need for and use of the intervention. The same procedures used by foster family home providers regarding documentation, notification of the DHR worker, and review at the next ISP meeting is to be followed.

7. Assessing and Monitoring Behavior Management Interventions

DHR shall work in partnership with providers as interventions are assessed for effectiveness in managing targeted behaviors. Assessment and monitoring shall occur according to the methods and frequency identified in the behavior management and individualized service plans. An intervention will be discontinued when it is no longer needed to manage a behavior or when the intervention is not effective and a more appropriate one has been identified. Changes shall be reviewed by the child and family planning team and documented in the individualized service plan.

Providers are required to notify the DHR worker when specific situations occur during the use of behavior management interventions. (Refer to Section II. E. for more detailed information.) The DHR worker is responsible for documenting the information in the child's case record and for convening the child and family planning team when appropriate. Specifically, all medications prescribed and dispensed, including PRN medications and the use of seclusion and restraint must be documented. In addition, **the child and family planning team must be convened when isolation, seclusion or restraint is used 3 or more times in a 24 hour period or when used for more than 2 hours in a 24 hour period.** The team will reassess the child's needs and make appropriate changes to the individualized service and behavior management plans.

8. Discharge Planning and Training for Managing Behaviors

Changes in a child's placement or provider responsible for implementing behavior management interventions require advance planning to assure consistency in the application of interventions used to manage behaviors. Information supplied to the subsequent caregiver/provider should include the child's behavior management plan including behavioral expectations and desired outcomes, prior interventions that have been both successful and unsuccessful, and current interventions used to manage the behavior(s). The information should be provided by the current caregiver/provider, an appropriate team member or the DHR worker, and should be explained to the subsequent caregiver/provider in a manner that is understandable and supportive of the child and family.

Training regarding behavior management intervention(s) used by the current caregiver/provider shall be provided to the parent(s), family member(s), or foster care provider to whom the child is expected to be discharged. The subsequent caregiver/provider should be encouraged and supported to participate in training so the intervention(s) can be continued after the change occurs. Training on implementing the specific interventions shall be provided by a qualified source (e.g., individual, organization or agency) that has training and experience in the implementation of the behavior management interventions. The Department will assist the caregiver with locating any needed training.

C. Multiple Needs Children

The following information provides guidance to DHR staff who participate in the planning and delivery of services for multiple needs children and their families. It identifies the children and families who may be served, the procedures for accepting and acting on referrals to the local teams and the responsibilities of the member agencies of the local teams.

Multiple needs policies are based on Alabama Child Welfare practice and related policies and the following sections of the Code of Alabama, 1975.

§12-15-1 (19)

"Multiple Needs Child. A child coming to the attention of the court or one of the entities listed herein who is at imminent risk of out-of-home placement or a placement in a more restrictive environment, as a result of the conditions of emotional disturbance, behavior disorder, mental retardation, mental illness, dependency, chemical dependency, educational deficit, lack of supervision, delinquency, or physical illness or disability, or any combination thereof, and whose needs require the services of two or more of the following entities: Department of Youth Services, public school system (services for exceptional needs), Department of Human Resources, Department of Public Health, juvenile court probation services or Department of Mental Health and Mental Retardation."

§12-15-65 (b)

"After the filing of a petition when the petition alleges or evidence reveals to the court that a child may be a multiple needs child, and that previous plans developed by an agency, or agencies, have not met the needs of the child, the court, on its own motion or motion of a party or party's parent or guardian or upon motion of the Department of Youth Services, a school system, the Department of Human Resources, the Department of Public Health, the Department of Mental Health and Mental Retardation, or juvenile court probation services, may refer the child to the county children's services facilitation team for evaluation and review. This evaluation may occur prior to any hearing, or the court may suspend proceedings during the hearing or prior to disposition to review the findings and recommendations of the county children's services facilitation team."

§12-15-71 (h) (1)

"Regardless of the nature of the petition or allegation, when evidence is presented to the court that a child is at imminent risk of an out-of-home placement or a placement in a more restrictive environment as a result of the conditions of emotional disturbance, behavior disorder, mental retardation, mental illness, dependency, chemical dependency, education deficits, lack of supervision, delinquency, physical illness or disability, or any combination thereof, and if such conditions require the services of two or more agencies pursuant to Section 12-15-1(19), the juvenile court shall refer the child to the county children's services facilitation team for assessment and recommendations unless a current facilitation team plan is available to the court. Within 21 days of receipt of the referral, the county children's services facilitation team shall present to the court a preliminary plan of services addressing the needs of the child and the respective responsibilities of agencies composing this team. Upon receipt of these preliminary recommendations, the juvenile court may adjudge the child as a 'multiple needs child' and

in accordance with the county children's services facilitation team plan, unless the court finds it not in the best interest of the child, order the use of any disposition alternative or service available for dependent or delinquent children or children-in-need-of-supervision, children who are emotionally disturbed, mentally retarded, or mentally ill, or children who need specialized educational services, or children who need health services, or any combination thereof. The county children's services facilitation team shall be responsible for developing a final service plan which shall be filed with the court. The member agencies shall be responsible for the implementation of any ordered service plan. The court may, on its own motion, or on motion of a party, a party's parent or guardian, or a member of the county or state children's services facilitation team, set additional hearings."

§12-15-172

"An organizational meeting of the county team shall be called by the county director of the county Department of Human Resources within three months after May 27, 1993. Other meetings may be held as needed. The county team shall meet within seven days of a case being referred by a court or from notice of a member that there is a need for the team to develop a service plan."

D. Alabama Child Welfare Practice

1. Children Covered

The children covered are those who meet the criteria of a multiple needs child as described in multiple needs policy and Alabama Code Section § 12-15-1 (19).

A child need not be adjudicated multiple needs to be covered by this policy. Nothing in Code of Alabama, 1975 §12-15-1(19) requires that the child be placed in the custody of a state agency or department as an adjudicated multiple needs child in order to receive services.

2. Court Orders

Court orders must be followed until they are modified or lifted. Examples may include when courts:

- Adjudicate children as multiple needs prior to the development of plans by the local facilitation team or
- Order out-of-home placements or courses of treatment that have been formulated outside the local facilitation team.

If the local facilitation team finds, upon receipt of a referral and assessment of the child's needs, that a child should not be classified as a multiple needs child or that the child's needs can appropriately be met in a manner or placement less restrictive than is ordered, the local facilitation team shall seek to have the court order lifted or modified. Similarly, if DHR concludes that a court order violates agency policy, DHR must seek to have the order lifted or modified.

3. Guidelines and Procedures

a. Criteria for Accepting Referrals by Local Facilitation Teams

The court or a member agency may initiate a referral of a child to a local facilitation team. The state and local facilitation teams are not intended to replace the normal collaboration that occurs between and among agencies on behalf of children and families. The facilitation team serves, as a resource to the court in developing plans to serve children and families whose needs cannot be met by a single agency. Additionally, the teams have a preventive role in providing a forum to which member agencies may refer children and families whose needs require the services of multiple agencies but which may not require court intervention.

b. Criteria for Establishing Multiple Needs Child Status

To be considered a multiple needs child, the child must require the services of two or more of the member agencies to meet the child's needs and address the imminent risk of placement **and** meet one of the two following criteria:

- The child must be at imminent risk of placement in out-of-home care; or
- The child must be at imminent risk of placement in a setting more restrictive than the child's current out-of-home placement; and
- The imminent risk of placement must be the result of the conditions of emotional disturbance, behavior disorder, mental retardation, mental illness, dependency, chemical dependency, educational deficit, lack of supervision, delinquency, or physical illness or disability, or any combination of these conditions.

4. Referral Process

When a county DHR office makes a referral to the local facilitation team, it is the department's responsibility to obtain and provide the information needed by the local team to consider the referral. DHR should provide the following information to the team.

- A case summary, including a social and family history;
- Information specific to the child's and family's strengths and needs, including a history of efforts to meet those needs;
- With written permission of the parent, A recent psychological assessment of the child, if appropriate;
- Applicable medical and school records;
- Recent progress reports for children in out-of-home placement;
- Applicable information describing the needs of the child's parents or other caretaker(s) that place the child at risk of placement or at risk of a more restrictive placement;
- Documentation of prior collaboration efforts; and

- Documentation of barriers the referring agency has in meeting the child and family's needs.

When referrals are received without the necessary information, the local team member designated to receive referrals may request the additional information needed before the team convenes to consider the request. The information may be requested from the referring agency or the agency with primary responsibility for custody or planning for the child.

5. Imminent Risk of Out-of-Home Placement

Imminent risk of placement is a set of conditions in a child's environment which, if not altered by the provision of services, is likely to result in placement of the child in out-of-home care within 90 days by a member agency. The environmental conditions that may contribute to imminent risk are abuse, neglect, emotional disturbance, mental retardation, delinquent behavior, assaultive/aggressive behavior, substance abuse, physical illness, or other conditions. Imminent risk conditions may occur during a crisis for the child and/or family or the conditions may be ongoing.

In assessing the imminent risk of placement for a child referred to the local facilitation team, the team shall consider all less restrictive alternatives to placement of the child in out-of-home care, including whether the referral source has considered or provided home and community-based services prior to referral in order to appropriately address the risk of placement. If the referral is received with a request or recommendation for a specific placement, the local facilitation team shall assess the appropriateness of the suggested placement. Depending upon the individual needs of the child and the ability of the child's caregiver to control the risk of harm to the child, the team's service plan shall recommend one of the following: 1) the least restrictive, most appropriate alternative to out-of-home placement or 2) the least restrictive most appropriate out-of-home placement.

6. Imminent Risk of a More Restrictive Placement

The child's own home shall be considered the least restrictive placement. Following are other placements listed in ascending order in terms of restrictiveness: independent living; a foster home; a therapeutic foster home; a group foster home; a group home; a child care institution; an institution.

Local facilitation teams may receive referrals of children who are already in an out-of-home placement that is at risk of disrupting. In those situations, imminent risk of disruption refers to a set of conditions in a child's current out-of-home placement environment which is likely to result in a decision to place the child in a more restrictive out-of-home placement within 90 days. Imminent risk of disruption may be caused by extremes of abuse, neglect, emotional disturbance, mental retardation, delinquent behavior, assaultive/aggressive behavior, substance abuse, physical illness, or other conditions.

Placement in a more restrictive facility may involve a living arrangement in a location with different caregivers from the current placement. It may also include

the risk of children remaining in a more restrictive out-of-home placement than their individual needs require if the lack of services prevents discharge from the current placement to an appropriate less restrictive placement.

In assessing the imminent risk of placement in a more restrictive facility, the local facilitation team shall assess the availability of existing services and develop services they need to sustain a child in a less restrictive environment. If the referral is received with a request or recommendation for a specific placement, the local facilitation team shall assess the appropriateness of the suggested placement. The team shall recommend, in their treatment plan for the child, the least restrictive alternative to out-of-home placement or the least restrictive out-of-home placement, depending upon the individual needs of the child and the ability of the child's caregiver to control the risk of harm to the child.

7. Responsibilities of Local/State Teams and Member Agencies Including DHR

According to state law and Multi-Needs Team procedures, responsibilities of the local/state teams include the following.

Member agencies are required to develop a plan for serving multiple needs children which includes at a minimum:

- arranging for representation on state and local facilitation teams;
- developing service plans for children referred;
- providing services within the scope of the member agencies' responsibilities; and
- sharing costs for services provided to referred children and families, in accordance with this policy.

When a child is referred by a member agency or court to a local or state team, DHR shall:

- assist the child, if an age appropriate child, and his/her family to participate in the team meeting by providing advocacy and other support services to the child and family, and
- assure that the team planning process complies with the strengths/needs individualized services planning model and DHR's *Individualized Service Plan* and *DHR Partnership with Children, Their Families and Providers* policies.

A local facilitation team should meet within seven (7) days of receiving a referral. If the team cannot convene within seven (7) days of receiving a referral from the court, the team may ask the court for an extension of the seven-day period.

A local facilitation team should develop a preliminary service plan for children referred and their families within 21 days of receiving the referral. The plan should include information identifying the individualized strengths and needs of the child and his or her family, the services needed by the child and family and the respective responsibilities of the member agencies and others for providing

services to the child and family. For referrals made by the court, the team shall submit the preliminary plan to the court within the 21-day period, unless a continuance is granted. For referrals made by a member agency, the preliminary plan should be submitted to the referring agency within the 21-day period.

A local facilitation team is responsible for developing a final service plan for children referred when the preliminary plan is not complete (such as when the team determines a more comprehensive plan is needed). For children referred to the team by the court, the final plan must be submitted to the court. For referrals made by a member agency, the final plan must be submitted to the referring agency.

Local and state facilitation teams shall determine the least restrictive plans to address the individualized needs of children referred to the team. Home and community-based services that can manage the risk of harm to a child must be considered prior to considering more restrictive plans and placements.

A local facilitation team may determine a plan for sharing the costs of the service plan developed by the team among the member agencies. Member agencies are not bound to contribute financially to the service plan if they are not providing services as part of the plan. However, member agencies may be bound financially by a service plan that requires the services of the agency, even if the agency did not participate in team meetings where the plan was developed.

Member agencies are not required to share costs for services to children and families whose needs would not otherwise necessitate involvement of the member agency, except for the referral to the local facilitation team, e.g., children with mental retardation whose behavior requires services unrelated to abuse or neglect.

Member agencies should provide appropriate services to meet the individualized needs of multiple needs children. DHR shall provide services pursuant to an ISP.

Member agencies are encouraged to use existing funding and services flexibly and creatively in meeting the individualized needs of children referred and their families, even if it means delivering services not normally provided by the agency or in a manner not normally used by the agency. No provisions in policy or statute shall prevent a member agency from voluntarily contributing to the development of appropriate services in order to meet the needs of children referred and their families.

8. Referrals to State Facilitation Team

When services of a member agency are needed but not available locally, the local facilitation team shall contact the member agency's representative on the Case Review Committee of the State Facilitation Team to obtain needed services. If that step does not provide access to the needed services, the local team shall formally refer the issue to the Case Review Committee of the State Facilitation Team with a request for assistance in accessing needed services in the least restrictive most appropriate manner.

When there is an unresolved disagreement among member agencies of the local facilitation team which is pending beyond eight weeks, the case should be referred by the chairperson of the local team to the chairperson of the state children's facilitation team. In the event the local team requests assistance of the state team because of an inability to agree on a service plan, the service plan developed by the state team is binding on the local team, as well as the departments represented.

E. Relationships of State and Local Facilitation Teams to Other Teams

The state and local facilitation teams for multiple needs children exist as separate entities from other child and family serving teams, such as multi-disciplinary teams for child abuse and neglect, child and family planning teams and juvenile justice coordinating councils. These various teams have separate statutory or administrative authorities and jurisdictions. Although some agency representatives may serve on multiple teams, the functions and responsibilities of the state and local facilitation teams shall remain distinct from the functions and responsibilities of other teams.

Where there is overlap in responsibility for assessing or planning for children referred to a local facilitation team, the local facilitation team should meet jointly with members of the other teams in accordance with the policies and regulations governing the involved teams, including regulations, statutes and policies governing the exchange of identifying information about children and families served by the teams or agencies involved.

1. DHR Procedures

a. Custody

As mentioned above, it is not necessary for DHR to hold custody of a child in order to share in funding for placement. The child may be in the custody of any of the mandated agencies or remain in the parents' custody, if they are in agreement with the placement. If a child is not in DHR custody but requires the services of this department, the case must be opened for on going child welfare services and an ISP developed pursuant to ISP policy.

If no agency holds custody of the child, it is necessary that one of the agencies be identified as the lead agency to serve as the contact point for the provider for case management purposes and to maintain contact with the child. It is important that the child's progress be monitored regularly and that plans be made to step him down to a less restrictive setting as soon as appropriate. The local team will need to meet periodically for updates on the child's progress and to determine if the placement should continue.

b. Payment

DHR is to follow existing policies for ISP's, Title XX, and flex funds to authorize payment for services. DHR's portion of all shared funding services will be paid through flex funds. Bills for approved services should be sent by the provider directly to the Coordinator of the Office of the Multi-Needs Child for processing.

If a child receives an SSI payment and is placed in a secure residential treatment facility immediately notify Social Security of placement.

c. Tracking

All children for whom DHR is sharing in funding for placement should be registered on the FACTS. If the child is not in DHR custody, the child should be registered on FACTS with the custody status of "Custody of Another Agency". It is important that we track these children and that we are aware of how many children are in any given facility.

F. Commitment of Children in DHR Custody to SDMH/MR

Placement of a child in the Adolescent Unit at Bryce Hospital requires a court commitment of the child to the Department of Mental Health/Mental Retardation. This is appropriate only for those children diagnosed with a major mental illness or mental retardation and whose behavior poses a real and present threat of substantial harm to himself/herself or to others. They must require long term treatment and require treatment in an in-patient setting. Before approaching the court, the worker must coordinate with the OCWC consultant following the procedures for hospitalization of a child in DHR custody. After receiving concurrence from the consultant, a petition for commitment along with supporting documentation from a psychiatrist or other mental health professional must be filed in the juvenile court. Such petition shall be verified and filed in the county in which such minor or child is located. The intake officer of the court will notify the Department of Mental Health/Mental Retardation of the petition and schedule a hearing. The child will be placed on a waiting list for the Adolescent Unit at Bryce Hospital if a bed is not immediately available.

When the Department of Mental Health/Mental Retardation feels a child has gained maximum benefit from institutional treatment or is no longer in need of the services or the child has gained maximum benefit from the program, the child may be released. The Department of Mental Health and Mental Retardation shall notify the committing court in writing at least 10 days in advance of the release of a child. The County Department will need to determine if services will need to be provided for the child.