# 580 CHILD AND FAMILY TEAM

EFFECTIVE DATE: (TBD)

REFERENCES: 42 C.F.R. § 438.102; A.R.S § 8-512.01; Division Medical Policy 580; Arizona Supreme Court Administrative Order No. 2011-16

## PURPOSE

This policy applies to the Division of Developmental Disabilities' (Division) Administrative Services Subcontractors (AdSS) and outlines the duties and responsibilities delegated to the AdSS, as set forth in this policy, and the implementation of CFT practice for eligible children and their families.

## DEFINITIONS

1. "Child and Family Team" means a group of individuals that includes, at a minimum, the child and their family, a behavioral health representative, and any individuals important in the child's life that are identified and invited to participate by the child and family. The size, scope, and intensity of involvement of the team members are determined by the objectives established for the child, the needs of the family in providing for the child, and by who is needed to develop an effective Service Plan, and can expand and contract as necessary to be successful on behalf of the child.

2. "Crisis" means an acute, unanticipated, or potentially dangerous

behavioral health condition, episode, or behavior.

3. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

4. "Planning Team" means a defined group of individuals comprised of the Member, the Responsible Person if other than the Member, and with the Responsible Person's consent, any individuals important in the member's life, including extended family members, friends, service providers, community resource providers, representatives from religious/spiritual organizations, and agents from other service systems.

5. "Safety Plan" means a written method for potential Crisis support or intervention that identifies needs and preferences that are most helpful in the event of a Crisis; establishes goals to prevent or ameliorate the effects of a Crisis; and specifically address techniques for establishing safety, identification of realistic interventions, physical limitations or unique needs of the Member, trauma informed, and developed in alignment with the Member's Service Plan.

6. "Serious Emotional Disturbance" means a designation for individuals from birth up to age 18 who currently or at any time during the past year have had a diagnosable mental or emotional disorder of

sufficient duration to meet diagnostic criteria specified within the current version of the Diagnostic and Statistical Manual of Mental Disorders that resulted in functional impairment which substantially interferes with or limits the individual's role or functioning in family, school, or community activities.

7. "System of Care" means a comprehensive spectrum of effective services and supports for children, youth, and young adults with or at risk for mental health or other challenges and their families that is organized into a coordinated network of care, builds meaningful partnerships with families and youth, and is culturally and linguistically responsive in order to help them to thrive at home, in school, in the community, and throughout life.
8. "Service Plan" means any plan which outlines Member services and goals. This may include Service Plans, treatment plans, person-centered service plans, individual family service plans, individual education plans, or any other document that outlines services or treatment goals from any entity involved with the Member's care and treatment that is used to improve the coordination of care across multiple systems.

**POLICY**

## A. 12 PRINCIPLES FOR CHILDREN'S BEHAVIORAL HEALTH SERVICE DELIVERY

The AdSS shall require that the following 12 Principles for Children's Behavioral Health Service Delivery, as described in the supplemental section below, are universally applied when working with all eligible children and their families through the use of the CFT practice:

a. Collaboration with the child and family,
b. Functional outcomes,
c. Collaboration with others,
d. Accessible services,
e. Best practices,
f. Most appropriate setting,
g. Timeliness,
h. Services tailored to the child and family,
i. Stability,
j. Respect for the child and family's unique cultural heritage,
k. Independence, and
l. Connection to natural supports.

## B. INDICATORS CONTRIBUTING TO A CHILD AND FAMILY'S COMPLEXITY OF NEEDS

1. The AdSS shall require the development, integration, and

individualization of service delivery to be based on indicators contributing to the child and family's complexity of needs. The level of complexity is determined individually with each child and family taking the following variables into consideration:

a. Involvement of other child-serving agencies.

b. The child and family's overall health status.

c. The presence of a Serious Emotional Disturbance.

d. The presence of environmental stressors or risk factors.

e. The application of Child and Adolescent Level of Care Utilization System (CALOCUS) for children aged six through 18, and must be completed with the child and guardian present.

2. The AdSS shall require that the frequency of CFT meetings, location of meetings, intensity of activity between CFT meetings, and level of involvement by formal and informal supports necessary to adequately support the child and family are based on the following:

a. The preferences of the child and family.

b. The size of the CFT, including the number of agencies involved and the coordination efforts required.

c. The ability of the CFT to communicate effectively between meetings and complete follow-up items.

d. The number of distinct services and supports necessary to meet the needs of the child and family.

e. The CFT's ability to develop a person-centered plan, track progress, and make modifications when needed.

f. The severity of mental health and or physical health symptoms.

g. The effectiveness of services.

h. Stressors currently affecting the child and family.

i. Availability and effective use of needed services, natural supports, and community resources.

j. Adjustments in level of service intensity as level of complexity varies.

## C. NINE ESSENTIAL ACTIVITIES OF CFT PRACTICE

The AdSS shall require implementation of the following nine essential activities of CFT practice to ensure the 12 Arizona Principles are included in service delivery for all eligible children and their families:

a. Initial Engagement of the Child and Family:

i. Begin the active development of a trusting relationship based on empathy, respect, genuineness

and warmth to facilitate moving toward an agreed upon outcome.

ii. Gain a clear understanding of the needs that led the child and family to seek help from the behavioral health system and by offering and educating families on support services provided by peer and family-run organizations for self-advocacy.

iii. Address any accommodations that may be indicated, including scheduling and location of appointments, interpretation services, childcare or transportation needs.

iv. Discuss the Arizona's CFT practice model with the child and family, and the opportunity to ask questions.

v. Assist the child and family with identification and participation of additional family members, close family friends, and other persons who may become part of the CFT.

vi. If DCS is involved, communicate with the DCS case manager regarding any barriers to involvement of potential CFT members.

vii. Invite appointed counsel and Guardians ad Litem to participate in meetings and provide input to the CFT as specified in the Arizona Supreme Court Administrative Order No. 2011-16.

viii. If approved by the child and family, invite the support coordinator to participate in CFT meetings to ensure coordination of care between the Division Planning Team, CFT, and behavioral health providers.

ix. When possible, combine the CFT meetings with the Division Planning Team meetings in order to reduce the family's time commitment for meetings and also ensure a more comprehensive understanding between the team members and improved collaboration.

b. Immediate Crisis stabilization:

i. Address any immediate Crisis situations and provide services and support stabilization.

ii. Identify any immediate Crisis that requires intervention to maintain the safety of the child, family, or community.

iii. Identify and secure support Crisis intervention

services that may assist in immediate Crisis stabilization to maintain the least restrictive environment possible to provide for the safety and well-being of the child and family.

c. Strengths, Needs and Culture Discovery (SNCD):

i. Provide documentation that reflects the strengths, needs, and unique culture of the child and family, and how this information will be used within the Service Plan, Safety Plan, and transition plan.

ii. Identify extended family members, friends, and other individuals who are currently providing support to the child and family or who have been supportive in the past.

iii. Before finalizing the SNCD, review the document with the child and family to ensure that they are in agreement with the contents, and make revisions as needed to reflect the child and family's feedback.

iv. Provide the family with a copy of the completed SNCD document, and if the family agrees, provide copies to other CFT members.

v. Update the SNCD as additional needs, strengths, and

cultural elements are identified over the course of service delivery.

vi. Ask the family to review any changes made to the document for accuracy and to ensure that the contents reflect their view of the family.

d. CFT Formation and Coordination of CFT Practice:

i. Facilitate the identification, engagement and participation of additional family members, close family friends, professionals, partner agency representatives, and other potential members of the CFT in conjunction with the family.

ii. Adjust the size, scope and intensity of the involvement of CFT members based on the needs of the child and family.

iii. Respect the young person's wishes regarding team formation when working with older youth.

iv. Include the child's biological family members on the CFT, when possible and appropriate, when DCS is the identified guardian, and not limited to only those situations when reunification is the identified goal.

v. Adjust the membership of the CFT as the needs and

strengths of the child and family change over time.

vi. Schedule the frequency of CFT meetings in relation to the child and family's situation, preferences, and level of need.

vii. Provide an overview of CFT practice and clarify the Member's role and responsibilities as a team member upon initial formation of the CFT.

viii. Utilize alternative modes of communication, as appropriate, in rural areas where getting members together physically may be challenging.

ix. Assist CFT members with establishing ground rules for working together, identify their priority concerns, work proactively to minimize areas of potential conflict, and acknowledge the mandates of other involved child-service agencies.

x. Utilize consensus-building techniques, such as compromise, reframing, clarification of intent, and refocusing efforts while keeping the best interests of the child and family in mind while facilitating CFT meetings.

xi. Inform the child and family of their rights and ensure

all necessary consents and releases of information are obtained.

xii. Inquire periodically whether there is anyone else the family would like to participate in CFT practice and the nature of their participation.

xiii. Offer family or peer support services to assist the child and family with exercising their voice as described in AdSS Medical Policy 963 and 964.

xiv. Invite the full family's participation in decisions which affect the child and family.

xv. Invite the full CFT to participate in decisions affecting substantive changes in service delivery.

xvi. Adapt the CFT practice, when necessary, to accommodate parallel processes.

e. Service Plan Development:

i. Identify the child and family preferences, strengths, and culture beginning at the time of initial assessment and continuing through the development of the Service Plan.

ii. Engage CFT members in brainstorming options and identifying creative approaches, including the use of

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265 informal supports, for meeting the individualized
266 needs of the child and family.
267 iii. Develop a Service Plan that includes:
268 1) A long-term family vision which identifies
269 what the youth and family would like to occur,
270 as a result of services.
271 2) Goals which pertain to what needs to happen
272 in order to obtain the identified family vision.
273 3) Measurable objectives for each identified goal
274 so that progress can be measured and
275 assessed throughout the process.
276 iv. Develop a single, unified plan that addresses the
277 needs and responsibilities of all parties involved
278 when the family has multi-agency involvement.
279 v. Incorporate the needs of a parent or other family
280 member that pertain to the child's goals into the
281 goals and measurable objectives on the Service
282 Plan.
283 vi. Provide information on available resources to the
284 parent(s) or family members when a parent or
285 family member has individual needs.

vii. Update the assessment and Service Plan, at minimum, on an annual basis or when changes in the provision of services occur.

f. Ongoing Safety Planning:

i. Conduct ongoing assessment and planning for Crisis situations.

ii. Determine if a Safety Plan is needed, in conjunction with the CFT, based on an assessment of the child and family needs, the preference of the family, and the clinical indicators listed in AdSS Medical Policy 320-O.

iii. Develop a Safety Plan for children, youth, and young adults under the age of 21 with complex needs who are receiving services through the children's behavioral health system as indicated by an individualized assessment or a CALOCUS score of four and higher for children aged six through 18.

iv. Utilize services such as mobile Crisis teams, urgent care centers, and police intervention as a final intervention when the situation surpasses the ability of the CFT to maintain the safety of the child and

family.

g. Service Plan Implementation:

i. Oversee and facilitate the implementation of the Service Plan based on the decisions of the CFT.

ii. Monitor and ensure the provision of covered behavioral health services within the timeframes outlined in AdSS Operations Policy 417.

iii. Include interventions provided by natural supports or participation in activities within the community in the Service Plan.

iv. Monitor completion of tasks, implementation of services or interventions by assigned CFT members in order to support the implementation of the Service Plan.

v. Make reasonable efforts to carry out CFT assigned tasks within the agreed upon time frames between CFT meetings.

vi. Contact the CFT facilitator if barriers arise and a task cannot be completed or a service cannot be provided.

vii. Explore options for resolution with the CFT,

supervisors, or other resources if the CFT is unsuccessful in addressing identified barriers.

viii. Elevate issues within the children's behavioral health system for additional assistance and resolutions when an activity, support or service cannot be secured in a timely manner or the barrier is a system's issue.

h. Tracking and Adapting:

i. Evaluate the effectiveness of the Service Plan during CFT meetings.

ii. Document CFT activities in the Member's record.

iii. Update the Service Plan, as needed, to reflect positive changes, a lack of progress, address barriers or new needs.

iv. Schedule the frequency of ongoing meetings based on child and family needs, level of progress, and Service Plan target dates.

v. Monitor the following between CFT meetings:

1) Progress towards achieving expected outcomes;

2) Timelines for completion of tasks and

implementation of services;

3) Review and update the CALOCUS every six months; and

4) Anticipate and address transitions.

vi. Assist the CFT in refining existing strategies or developing new interventions.

vii. Track the effectiveness of safety planning interventions and implement modifications when needed.

i. Transition:

i. The CFT facilitator collaborates with the CFT members to anticipate transitions and prepare to adjust to meet the changing needs of the child, including:

1) Change in living environment, relationships, or school setting.

2) Change in intensity of services.

3) Transitions between various levels of service intensity.

ii. Plan for transitions between various levels of service intensity and recognize the potential for regression

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375 during these periods and plan accordingly.

376 iii. Transition to the Adult Behavioral Health System:

377 1) Begin planning for transition into the adult
378 behavioral health system for any child involved
379 in behavioral health care when the child
380 reaches the age of 16.

381 2) A youth in transition may request to retain
382 their current CFT until the youth turns 21 years
383 of age.

384 3) If the CFT is not retained when the youth turns
385 18 years of age, invite key professionals from
386 the adult behavioral health system to join the
387 CFT in order to facilitate a smooth transition
388 and support the continuity of team practice.

389 iv. Successful Completion of Goals and Transitioning Out
390 of Behavioral Health Services:

391 1) Utilize effective planning and family vision to
392 prevent premature closures.

393 2) Consider the following indicators that a family
394 may no longer need the support of the
395 behavioral health system:

a) The presence of a high percentage of CFT members who are from the family's own informal support system.

b) The family notes they no longer need the same level of assistance.

c) The majority of their support and services are from resources within their own family and community rather than paid and professional services.

d) Frequency of meetings has decreased.

e) There are no longer major safety or Crisis concerns.

f) Successful completion of the child and family goals.

v. Other Transitions:

1) If a youth is adjudicated and sentenced to the Arizona Department of Juvenile Corrections (ADJC), ensure information is shared with ADJC regarding the youth's mental health needs, including any medications the youth may be prescribed.

2) Engage in transition planning when a youth is preparing to return to the community from ADJC to enhance the youth's chances of success by providing strong support of the behavioral health system.

3) Engage in transition planning when DCS involvement is ending.

4) Engage in transition planning for other commonly occurring transitions, for example, a youth transitions between the AdSS and FFS Programs, different service areas or subcontractors, as specified in AdSS Medical Policy 520, to maintain necessary behavioral health services.

## D. TRAINING AND SUPERVISION EXPECTATIONS

1. The AdSS shall establish a process for ensuring that all clinical and support service agencies' staff working with children and youth implement the practice elements as specified in this policy, and behavioral health staff receive competency-based training in implementation of the 12 principles into practice as outlined in

AMPM 580 Attachment E.

2. The AdSS shall require individuals designated to facilitate CFTs meet the following requirements:
   a. Trained in the elements of this policy within 90 days of their hire date.
   b. Complete the AHCCCS approved two-day, in-person, CFT facilitator training.
   c. Demonstrate competency via the Arizona Child and Family Teams Supervision Tool or another process approved by AHCCCS within 90 days of their hire date.
   d. Achieve proficiency within six months and maintain proficiency, as demonstrated via the Arizona Child and Family Teams Supervision Tool, and attested to by a coach or supervisor annually thereafter.

3. The AdSS shall establish a process to ensure applicable behavioral health staff receive AHCCCS-approved CALOCUS training prior to the administration of the CALOCUS.

4. The AdSS shall require behavioral health providers to maintain documentation of the initial training and CFT competency

evaluation and follow-ups, to be provided via an electronic learning management system.

5. The AdSS shall provide documentation, upon request from the Division or AHCCCS, demonstrating that all required network and provider staff have received training in the practice elements listed in this policy.

6. The AdSS shall notify providers and provider agencies whenever this policy is updated or revised, and require staff to be retrained as necessary on the changes.

7. The AdSS shall require the supervision for implementation of this policy to be incorporated into other supervision processes that the AdSS' provider network and provider agencies have in place for direct care clinical staff.

## E. COACHING FACILITATORS OF CHILD AND FAMILY TEAM PRACTICE

1. The AdSS shall require staff functioning as a coaching facilitator, and evaluating competency of potential facilitators, meet the following requirements:

   a. Complete the Supervisor CFT Facilitator training approved by AHCCCS;

b. Demonstrate competency as a CFT Facilitator through the Arizona Child and Family Teams Supervision Tool; and

c. Have a minimum one year of experience successfully facilitating CFTs.

2. The AdSS may request AHCCCS to waive the coaching facilitator requirements, on behalf of a subcontracted provider, based on individual circumstances.

3. The AdSS shall maintain documentation for each AHCCCS-approved waiver and available upon request from the Division request.

**SUPPLEMENTAL INFORMATION**

**THE 12 PRINCIPLES FOR CHILDREN'S SERVICE DELIVERY**

In alignment with the Arizona Vision, the 12 Principles serve as the foundation and are universally applied when working with all enrolled children and their families using CFT practice. Arizona's CFT practice model was created from the tenets of Wraparound, a nationally recognized team process through the shared concepts of the 12 Principles with the 10 Principles of Wraparound: family voice and choice, team-based, natural supports, collaboration, community based, culturally competent,

individualized, strengths based, unconditional, and outcome based.

1. **Collaboration with the child and family:** Respect for and active collaboration with the child and parents is the cornerstone to achieving positive behavioral health outcomes. Parents and children are treated as partners in the assessment process, and the planning, delivery, and evaluation of behavioral health services, and their preferences are taken seriously.
2. **Functional outcomes:** Behavioral health services are designed and implemented to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Implementation of the behavioral health services plan stabilizes the child's condition and minimizes safety risks.
3. **Collaboration with others:** When children have multi-agency, multi-system involvement, a joint assessment is developed and a jointly established behavioral health services plan is collaboratively implemented. Person-centered teams plan and deliver services. Each child's team includes the child and parents and any foster parents, any individual important in the child's life who is invited to participate by the child or parents. The team also includes all other people needed to develop an effective

plan, including, as appropriate, the child's teacher, Department of Child Safety (DCS) and/or Division of Developmental Disabilities (DDD) caseworker, and the child's probation officer. The team:

a. Develops a common assessment of the child and family strengths and needs,

b. Develops an individualized service plan,

c. Monitors implementation of the plan, and

d. Make adjustments in the plan if it is not succeeding.

4. **Accessible services:** Children have access to a comprehensive array of behavioral health services, sufficient to ensure that they receive the treatment they need. Plans identify transportation the parents and child need to access behavioral health services, and how transportation assistance shall be provided. Behavioral health services are adapted or created when they are needed but not available.

5. **Best practices:** Competent individuals who are adequately trained and supervised provide behavioral health services. Behavioral health services utilize treatment modalities and programs that are evidenced based and supported by Substance Abuse and Mental Health Services Administration (SAMSHA) or

other nationally recognized organizations. Behavioral health service plans identify and appropriately address behavioral symptoms that are reactions to death of a family member, abuse or neglect, learning disorders, and other similar traumatic or frightening circumstances, substance abuse problems, the specialized behavioral health needs of children who are developmentally disabled, maladaptive sexual behavior, including abusive conduct and risky behavior, and the need for stability and the need to promote permanency in members' lives, especially members in foster care. Behavioral Health Services are continuously evaluated and modified if ineffective in achieving desired outcomes.

6. **Most appropriate setting:** Children are provided behavioral health services in their home and community to the extent possible. Behavioral health services are provided in the most integrated setting appropriate to the child's needs. When provided in a residential setting, the setting is the most integrated and most home-like setting that is appropriate to the child's needs.

7. **Timeliness:** Children identified as needing behavioral health services are assessed and served promptly.

8. **Services tailored to the child and family:** The unique strengths and needs of children and their families dictate the type, mix, and intensity of behavioral health services provided. Parents and children are encouraged and assisted to articulate their own strengths and needs, the goals they are seeking, and what services they think are required to meet these goals.

9. **Stability:** Behavioral health service plans strive to minimize multiple placements. Service plans identify whether a member is at risk of experiencing a placement disruption and, if so, identify the steps to be taken to minimize or eliminate the risk. Behavioral health service plans anticipate crises that might develop and include specific strategies and services that shall be employed if a Crisis develops. In responding to crises, the behavioral health system uses all appropriate behavioral health services to help the child remain at home, minimize placement disruptions, and avoid the inappropriate use of the police and criminal justice system. Behavioral health service plans anticipate and appropriately plan for transitions in children's lives, including transitions to new schools and new placements, and transitions to adult services.

10. **Respect for the child and family's unique cultural heritage:** Behavioral health services are provided in a manner that respects the cultural tradition and heritage of the child and family. Services are provided in the child and family's primary language.
11. **Independence:** Behavioral health services include support and training for parents in meeting their child's behavioral health needs, and support and training for children in self-management. Behavioral health service plans identify parents' and children's need for training and support to participate as partners in assessment process, and in the planning, delivery, and evaluation of services, and provide that such training and support, including transportation assistance, advance discussions, and help with understanding written materials, shall be made available.
12. **Connection to natural supports:** The behavioral health system identifies and appropriately utilizes natural supports available from the child and parents' own network of associates, including friends and neighbors, and from community organizations, including service and religious organizations.

## COACHING FACILITATORS OF CHILD AND FAMILY TEAM PRACTICE

1. As part of their on-going training, CFT Facilitators are provided with coaching from individuals who have achieved a high level of expertise regarding the facilitation of CFT Practice. These individuals may have various job titles (CFT Coach, Team Coach, Provider Mentor, Supervisor) but they each perform the same role when it comes to coaching.
2. The Contractor shall ensure that providers are aware of the expectation for provider agencies to vet their designated coaches, supervisors, mentors, for competency in CFT standards and their ability to coach and mentor. Staff fulfilling this role shall complete the Supervisor CFT Facilitator training which provides education on coaching skills and instructs coaches/supervisors on the use of Arizona Child and Family Teams Supervision Tool and the user guide.

   After an employee completes the initial required CFT training, the Coach/Supervisor works with that individual to ensure they are competent facilitators of the CFT practice. This process may entail shadowing other facilitators, modeling each process, observation, group coaching, one-on-one debriefing, and other

methods aimed at supporting the facilitator's growth and development. In addition to the initial coaching to achieve competency, the coaches are available to support and guide experienced facilitators when they encounter situations where they may request or require additional assistance.

Signature of Chief Medical Officer: