

**I. GOAL/WHAT DO WE WANT TO ACHIEVE THROUGH THE USE OF THIS PRACTICE TOOL?**

- A. To describe universal Child and Family Team (CFT) practice in the AHCCCS System of Care.
- B. To describe indicators that contribute to a child and family’s complexity of needs.
- C. To describe how the essential CFT practice activities are implemented on a continuum based on individualized needs.
- D. To describe how the Child and Adolescent Service Intensity Instrument (CASII) is utilized in the AHCCCS System of Care.

**II. Background**

The Arizona Vision as established by the Jason K. Settlement Agreement in 2001, states, *“In collaboration with the child and family and others, Arizona will provide accessible behavioral health services designed to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Services will be tailored to the child and family and provided in the most appropriate setting, in a timely fashion and in accordance with best practices, while respecting the child’s and family’s cultural heritage”*.

The Twelve Principles for Children’s Service Delivery (12 Principles) are:

- 1. Collaboration with the child and family
- 2. Functional outcomes
- 3. Collaboration with others
- 4. Accessible services
- 5. Best practices
- 6. Most appropriate setting
- 7. Timeliness
- 8. Services tailored to the child and family
- 9. Stability
- 10. Respect for the child and family’s unique cultural heritage
- 11. Independence
- 12. Connection to natural supports

The 12 Principles serve as the foundation, and are universally applied, when working with all enrolled children and their families through the use of CFT practice. Arizona’s CFT practice model was created from the tenets of Wraparound a nationally recognized team process. This is evident 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 (Bruns, E. J., Walker, J. S., & The National Wraparound Initiative Advisory Group. (2008). 10 principles of the wraparound process. In E. J. Bruns & J. S. Walker (Eds.), *The resource guide to wraparound*. Portland, OR: National Wraparound Initiative, Research and Training Center for Family Support and Children’s Mental Health).

“It has been over twenty years since the term ‘wraparound’ was used to define an intervention approach that surrounds a youth and family with customized services and supports. Since that time perhaps no other term used in the field of mental health has been more praised or embraced, redefined or misunderstood.” (Blau, G. (2008). Foreword. In E. J. Bruns & J. S. Walker (Eds.), *The resource guide to wraparound*. Portland, OR: National Wraparound Initiative, Research and Training Center for Family Support and Children’s Mental Health)

In the CFT model it is the child’s and family’s complexity of needs that drive the development, integration, and individualization of service delivery. The level of complexity is determined individually with each child and family.

One variable that is considered when determining complexity of needs for children is the involvement of other child-serving agencies, such as Juvenile Justice (Probation or Parole), Division of Developmental Disabilities (DDD), Department of Child Safety (DCS), and Education (Early Intervention or Special Education). The number of system partners involved and invited to participate in CFT practice by the child and family will contribute to the level of service coordination required, as well as consideration by team members of the individual mandates for each agency involved.

A child’s and family’s overall health status also contributes to their complexity of needs and subsequent level of service intensity. For children with a serious emotional disturbance (SED) and/or chronic physical condition, symptoms associated with their physical or behavioral health condition can impact their level of functioning in multiple life domains and may result in the use of medications that are monitored through a primary care physician and/or other qualified professional. Thus, the intensity of service integration through CFT practice is dependent on the level of coordination necessary to support the child and family in making progress toward identified goals in their AHCCCS Service Plan.

The presence of environmental stressors/risk factors is another variable to be considered by the CFT when reviewing the child’s and family’s level of complexity. The identification of potential environmental stressors is addressed during the comprehensive assessment; examples include changes in primary care giver, inadequate social support of the family, housing problems, mental health or substance use concerns in family members, etc. Other variables for consideration include children in an out-of-home setting (group home, therapeutic foster care, etc.) and use of crisis or inpatient services.

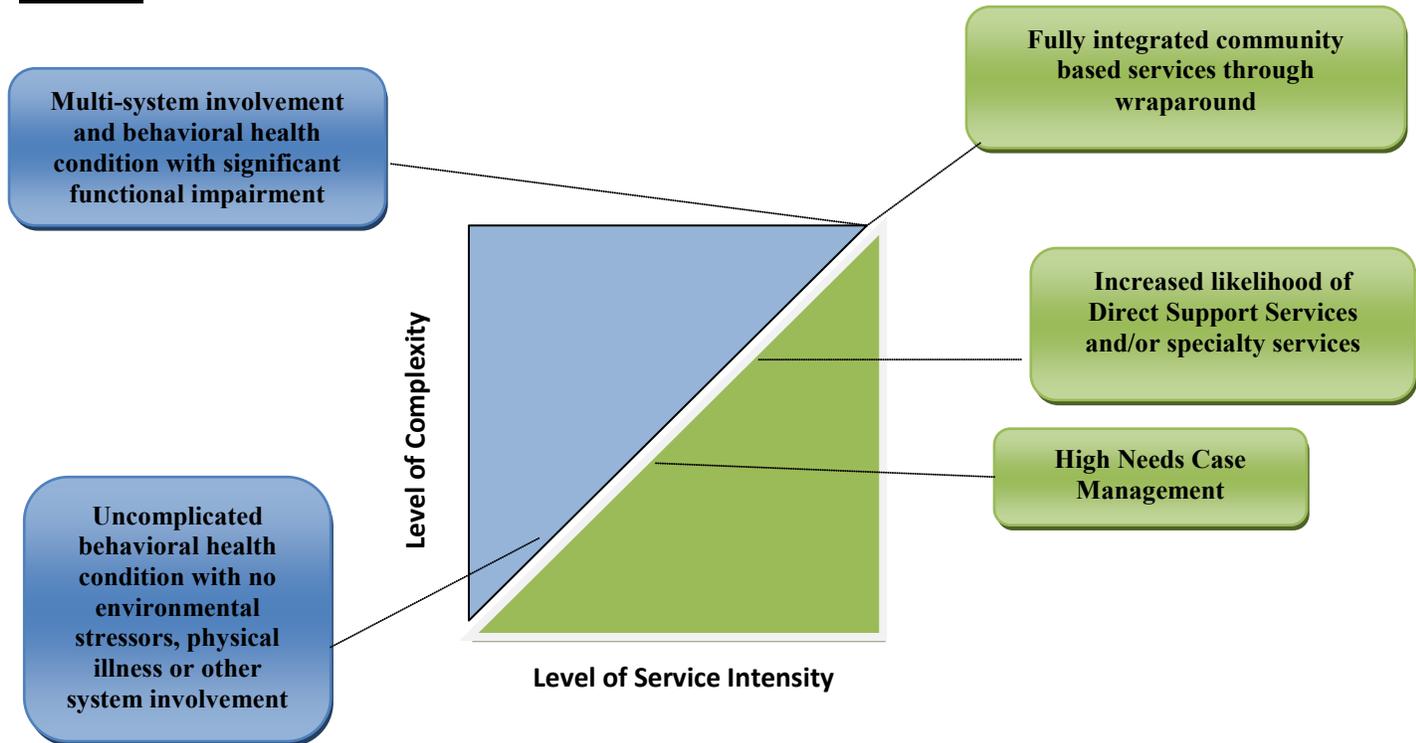
Another method for determining complexity of needs and intensity of service delivery is through the application of the CASII for children age six to 18. This instrument consists of six dimensions for assessment of service intensity: risk of harm, functional status, co-occurrence of conditions, recovery environment, resiliency and/or response to services, and involvement in services as referenced in the CASII Implementation Guide.

The application of CFT practice will vary depending on the child's and family's individualized level of need and complexity. Frequency of CFT meetings, location and nature of meetings, intensity of activity between CFT meetings, and level of involvement by formal and informal supports necessary to adequately support children and families will vary depending on:

1. The preferences of the child and family,
2. The size of the team including the number of agencies/systems involved,
3. The coordination efforts required,
4. The ability of the CFT to work effectively together,
5. The number of distinct services and supports necessary to meet the needs of the child and family,
6. The frequency of CFT meetings necessary to effectively develop a plan, track progress and make modifications when needed,
7. The severity of mental health and/or physical health symptoms,
8. The effectiveness of services,
9. Stressors currently affecting the child and family, and
10. Rural versus metropolitan location.

As the child's and family's level of complexity varies, the level of service intensity required to meet their needs also changes. "In a continuum based on the principles of the wraparound process described by the National Wraparound Initiative, the children and families with the most complex needs will have the most integrated and individualized services and supports, although all children and youth with behavioral health needs at any level must have individualized services and supports." (VanDenBerg, J. (2008). Reflecting on wraparound: Inspirations, innovations, and future directions. In E. J. Bruns & J. S. Walker (Eds.), *The resource guide to wraparound*. Portland, OR: National Wraparound Initiative, Research and Training Center for Family Support and Children's Mental Health) All children receiving public behavioral health services in Arizona are served according to the 12 Principles through CFT practice along a continuum of care based on their complexity of needs as illustrated through the example in Figure 1.

**FIGURE 1**



See also Attachment A, Guidelines for Strengths, Needs and Culture (SNCD) Discovery Domains; Attachment B, Arizona’s Child and Adolescent Service Intensity Instrument Children/Adolescents Age 6 through 17 Scoring Sheet, and Attachment C, Attachment C, CASII Implementation Guidelines for CFT Practice Nin Essential Activities

**A. PROCEDURES**

CFT practice consists of nine activities which will be described in further detail in this Practice Tool:

1. Engagement of the Child and Family,
2. Immediate Crisis Stabilization,
3. Strengths, Needs and Culture Discovery (SNCD),
4. CFT Formation/Coordination of CFT Practice,
5. Service Plan Development,
6. Ongoing Crisis Planning,
7. Service Plan Implementation,
8. Tracking and Adapting, and
9. Transition.

These activities of CFT practice are addressed in the order, frequency, and duration necessary depending on the child’s and family’s individualized needs.

### **ACTIVITY 1 - ENGAGEMENT OF THE CHILD AND FAMILY**

“The perspective or orientation with which providers enter into service relationships will have a major impact on the outcomes achieved through those relationships.”(Franz, J. (2008). ADMIRE: Getting practical about being strength-based. In E. J. Bruns & J. S. Walker (Eds.), *The resource guide to wraparound*. Portland, OR: National Wraparound Initiative, Research and Training Center for Family Support and Children’s Mental Health) Engagement is the foundation of CFT practice beginning with the first contact between the child/family and the behavioral health system and continuing throughout their involvement in the treatment relationship. Engagement is the active development of a trusting relationship based on empathy, respect, genuineness and warmth to facilitate moving toward an agreed upon outcome (See AMPM Policy 1040).

The initial conversations with the child and family provide opportunities for the behavioral health provider to learn and understand the child’s and family’s concerns. Primary needs may require quick action such as immediate crisis stabilization (see Activity 2). However, conversational dialogue partnered with an active listening style, rather than a structured interview, supports the development of a trusting relationship between the behavioral health provider and the child and family. During this initial engagement period, it is important for the behavioral health provider to gain a clear understanding of the needs that led the child and family to seek help from the behavioral health system and to explore how peer and family-run organizations can provide additional support.

Any accommodations that may be indicated, including scheduling/location of appointments, interpretation services, child care or transportation needs are addressed during the initial engagement period. It is important to brainstorm with the child and family to identify the most convenient meeting location and times. For example, meetings can be held at the family’s home, school, library, community center, or another location that is identified by the child and family. When meeting in public places, please ensure compliance with confidential requirements as outlined in AMPM Policy 550. Scheduling appointments or CFT meetings during school classroom hours should be avoided whenever possible.

A description of Arizona’s CFT practice model is provided to the child and family during the initial engagement period by the behavioral health provider. The behavioral health provider then assists 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. If DCS is involved with the child and family, dialogue occurs with the DCS case manager regarding any barriers to involvement of potential CFT members. To the extent possible, the attorney and Guardian ad Litem (GAL) should attend meetings or provide input to the CFT (see Administrative Order No. 2011-16 and The Unique Behavioral Health Service Needs of Children, Youth and Families Involved with DCS Practice Tool.

Subsequent contacts between the child/family and the behavioral health provider continue to reinforce engagement. This may be accomplished by using a variety of approaches such as: avoiding the use of professional/system jargon and acronyms, active listening, and responsiveness to the individualized needs as identified by the child and family. For example, responsiveness to phone messages from a child's family regarding when a service will be delivered helps reinforce a working relationship that is built on trust.

### **ACTIVITY 2 - IMMEDIATE CRISIS STABILIZATION**

A behavioral health risk assessment is one of the minimum elements of a comprehensive clinical assessment as referenced in AMPM Policy 320-O. This includes the identification of any immediate crisis that requires intervention to maintain the safety of the child, family, and/or community. The AHCCCS definition of crisis is “[A]n acute, unanticipated, or potentially dangerous behavioral health condition, episode or behavior”. Examples of crisis situations include suicidal or homicidal behaviors/intentions or the imminent risk of a child's removal from his/her home.

For a child or family experiencing a crisis situation, immediate stabilization takes precedence over all other assessment and planning activities. When the development of a crisis stabilization plan is indicated, crisis intervention services which work in conjunction with the child's and family's strengths are identified and secured. Family support, respite, or in-home services that may assist in crisis stabilization are identified and secured in a timely manner to maintain the least restrictive environment possible to provide for the child's and family's safety and well-being.

### **ACTIVITY 3 - STRENGTHS, NEEDS AND CULTURE DISCOVERY (SNCD)**

Service planning and delivery for children and families is based on a comprehensive assessment of the child's and family's needs, as well as an understanding of their strengths and unique family culture. The minimum elements of the comprehensive behavioral health assessment for children include information related to the child's/family's medical history, social history, educational history and status, employment history and status, housing status, legal history and status, and involvement with other child-serving agencies (See AMPM Policy 320-O).

For children with complex needs, as indicated through an individualized assessment (See Background Section in this document) and/or a CASII score of four and higher for children age 6 to 18, the development of a document that reflects the strengths, needs and culture of the child and family provides a foundation for future planning. The written Strengths, SNCD summarize information on a broad range of life domains of the child and of the family and includes the following elements:

1. Identification of strengths, assets and resources that can be mobilized to address the child and family's need for support,
2. Exploration and understanding of the unique culture of the family to ensure that the Service Plan will be a plan that the child and family will support and utilize,

3. Attention to aspects of family culture influenced by family relationships, rituals, social relationships, living environment, work environment, spiritual focus, health, financial situation, and other factors;
4. Recording of the child's and family's vision of a desired future, and
5. Identification of the needs and areas of focus that must be addressed in order to move toward this desired future.

Family members are central participants in the development of the SNCD. Information used in developing the SNCD is acquired through conversations that begin at the time of initial engagement and continue over the course of service delivery. The discovery process begins with identifying presenting concerns and prioritized needs that the child and family select to be addressed in-depth through the service planning process. The SNCD identifies 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. By gaining a clear understanding of the child's and family's prioritized needs, the CFT can begin focusing on the integration of natural supports along with formal services.

Before finalizing the SNCD, the behavioral health provider reviews the document with the child and family to ensure that they are in agreement with the content. Revisions are made as needed to reflect the child and family's feedback. The family is provided with a copy of the completed SNCD document, and then, if the family agrees, copies are provided to other CFT members. The SNCD is updated as additional needs, strengths, and cultural elements are identified over the course of service delivery. Families are asked to review any changes to the document for accuracy and to ensure that the contents reflect their view of the family.

#### **ACTIVITY 4 - CFT FORMATION/COORDINATION OF CFT PRACTICE**

In conjunction with the family, the behavioral health provider facilitates the identification, engagement and participation of additional family members, close family friends, professionals, partner agency representatives (e.g., DCS, DDD, juvenile justice and education), and other potential members on the CFT. One of the goals is to strengthen or help build a natural and community based social support network for the family.

The size, scope and intensity of the involvement of CFT members are driven by the needs of the child and family. The CFT may consist of the child, a parent and the identified behavioral health provider or may involve additional participants if the child and family are involved with other systems, have complex needs, an extensive natural support system, or are involved with multiple support providers. When working with older youth, the CFT respects the young person's wishes around team formation. When DCS is the identified guardian, inclusion of the child's family members on the CFT, is critical and is not limited to only those situations when reunification is the identified goal. Membership of the CFT is adjusted as the needs and strengths of the child and family change over time.

The frequency of CFT meetings is individualized and scheduled in relation to the child and family's situation, preferences, and level of need. Policy that establishes a set time frame for frequency of CFT meetings is avoided in order to support this individualized approach. Though AHCCCS does not establish specific guidelines, Contractors are encouraged to supply guidelines that support consistent team meetings based on level of need.

Behavioral health providers who serve as the facilitator of CFT practice have the specialized training and skill set to effectively implement the activities of this practice model. For a child and family with complex needs, a CFT facilitator with the appropriate background and training is assigned.

Upon initial formation of the CFT, the facilitator provides team members with an overview of CFT practice and clarifies the member's role and responsibilities as a team member. As appropriate, in rural areas where getting members together physically may be challenging, the facilitator utilizes alternative modes of communication. Facilitators 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 systems. CFT facilitators 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. In addition, the CFT facilitator informs the child and family of their rights and ensures all necessary consents and releases of information are obtained.

Depending on the level of complexity of the child's and family's needs, increasing CFT membership through the inclusion of informal supports may be beneficial for the child and family. This is accomplished by periodically inquiring whether there is anyone else the family would like to participate in CFT practice (friends, extended family, neighbors, faith community, etc.) and the nature of their participation (attend meetings, be utilized as a resource in their crisis plan, etc.). In addition, family or peer support services may be needed to assist the child and family with exercising their voice. Refer to the Family and Youth Involvement in Child Behavioral Health Services Practice Tool and AMPM Policies 961-A and 961-B.

Decisions which affect the child and family occur with the family's full participation. Likewise, decisions affecting substantive changes in service delivery are made with the participation of the full CFT. CFT practice is flexible and, when necessary, adapts to accommodate parallel processes such as Team Decision Making (TDM), Family Group Decision Making (FGDM), or permanency planning (DCS), Person Centered Planning (DDD) and Individualized Education Program (IEP) planning.

### **ACTIVITY 5 – SERVICE PLAN DEVELOPMENT**

The identification of the child and family’s preferences, strengths, and culture begins at the time of initial assessment and continues through the development of the Service Plan. CFT members engage in brainstorming options and identify creative approaches, including the use of informal supports, for meeting the individualized needs of the child and family.

The Service Plan includes a long-term family vision which identifies what the youth and family would like to occur, as a result of services; the vision should be in the family’s words to the extent possible. The Service Plan also includes goals which pertain to what needs to happen in order to obtain the identified family vision, as well as measurable objectives for each identified goal so that progress can be measured and assessed throughout the process. Therefore, the effectiveness of the services and supports can be evaluated over time, as well as revised as needs change, as progress is made, or if they are ineffective.

When the family has multi-agency involvement, every effort is made to collectively develop a single, unified plan that addresses the needs and mandates of all the parties involved. If a parent and/or other family member has needs that pertain to the child’s goals, these needs can be incorporated into the goals and measurable objectives on the Service Plan. In instances when a parent and/or family member may have individualized needs, the CFT facilitator provides information on available resources.

The assessment, SNCD and Service Plan development are ongoing based on the changing needs of the child and family; this results in plans that are continually updated to obtain desired outcomes. At a minimum, the assessment and Service Plan are updated on an annual basis as referenced in AMPM Policy 320-O. When changes in the provision of services (e.g. frequency, duration, provider agencies) or changes in identified needs occur, the Service Plan is updated.

### **ACTIVITY 6 - ONGOING CRISIS PLANNING**

CFT practice includes ongoing assessment and planning for crisis situations. The decision of whether or not a crisis plan is needed is made by the CFT based on the assessment of the child’s and family’s needs. A crisis plan is required 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 (see Background Section) and/or a CASII score of four and higher for children age six to 18.

If potential crisis situations are identified, the CFT members then develop a plan to prevent these potential crisis situations from occurring, as well as an approach for responding most effectively if one of these situations occurs. Crisis planning includes recognizing when a situation is escalating and how to best defuse the situation or obtain assistance to prevent further escalation. Services such as mobile crisis teams and urgent

care centers, as well as police intervention, are utilized as a final intervention when the situation surpasses the ability of the CFT to maintain the child's and family's safety.

As illustrated in Figure 2, crisis planning is composed of:

**Predict: What is the worst thing that could happen or what is most likely to go wrong, that would divert the CFT from successfully implementing the Service Plan?**

1. Anticipates crises based on knowledge of past behavior as an indicator of future behavior
2. Researches past crises to identify for each situation: the preceding behaviors and behavioral responses/consequences.

**Functional Assessment: What events, behaviors or behavioral sequences are associated with the initial, middle and ending phases of the actual crisis?**

1. Identifies the specific triggers of a crisis situation.
2. Describes what happens when the crisis occurs.
3. Identifies the consequences of the crisis.
4. Identifies what works to calm the child when he/she is in crisis.
5. Identifies the best people to intervene and their response actions.

**Prevent: What can be changed or added to the daily routine to prevent the crisis?**

Encompasses the bulk of the plan by identifying the options, drawn primarily from the child's and family's strengths and community supports, which can be used to mitigate the triggers, events or behaviors associated with the crisis situation.

**Plan: What are the effective or ineffective interventions? What are the steps to be initiated based on the severity level of the crisis?**

1. Anticipates a 24-hour crisis response.
2. Triage the intensity of response actions to align with the severity level of the crisis situation.
3. Clearly defines roles of the CFT members, including family members and other natural supports.
4. Includes specific names, agency represented (if applicable), and phone numbers.
5. Contains clear behavioral benchmarks.
6. Evaluates the management of the crisis and effectiveness of the plan once the crisis has stabilized.
  - a. Utilizes input from the child and family.
  - b. Information obtained from evaluation is utilized to update the plan.

**FIGURE 2**



A specific type of crisis plan, sometimes called a safety plan, may be required when there is an immediate concern regarding the safety of others or when there is evidence of prior unsafe behavior toward others that threatens the child’s ability to remain or return to living in his/her community. This type of planning identifies interventions to be implemented and the persons responsible for each intervention when the unwanted behavior is attempted or occurs. This type of planning:

1. Clearly describes the situation,
2. Clarifies the goals,
3. Defines inappropriate and appropriate behaviors,
4. Establishes family and community rules,
5. Is proactive about educating siblings and others,
6. Plans for community safety,
7. Plans for the 24 hour day,
8. Has a back-up plan,
9. Creates a plan for negative community reactions, and
10. Supports and builds the family through teaching healthy alternatives through the CFT practice.

**ACTIVITY 7 – SERVICE PLAN IMPLEMENTATION**

Based on the decisions of the CFT, the behavioral health provider and/or case manager is responsible for overseeing and facilitating the implementation of the Service Plan. Effective implementation includes the provision of covered behavioral health services within an appropriate timeframe (see ACOM Policy 417). For example, when a child needs to be evaluated by a BHMP as indicated in the Service Plan, the child is scheduled for an appointment within a timeframe that ensures:

1. The child does not run out of any needed psychotropic medications; or

2. The child is evaluated for the need to start medications so that the child does not experience a decline in his/her behavioral health condition.

Specific services on the Service Plan may require prior authorization (See AMPM Policy 1110). Services requiring prior authorization include:

1. Non-emergency admission to and continued stay in a Behavioral Health Inpatient Facility (BHIF),
2. Admission to and continued stay in a Behavioral Health Residential Facility (BHRF),
3. Admission to and continued stay in treatment for Home Care Training to Home Care Client (HCTC) services,
4. Non-emergency services outside the geographic service area of the Contractor.

Other than services from agencies, Service Plan may include interventions provided by the child's/family's natural supports or participation in activities within their community. For example, an intervention may outline specific ways of interacting with the child to reinforce a particular behavior or the child's involvement with a community arts or sports program to support his/her social skills development with peers.

Some services or interventions may require the completion of specific tasks by assigned CFT members in order to support the implementation of the Service Plan. Between meetings, CFT members make reasonable efforts to carry out their assigned tasks within the agreed upon timeframes. If barriers arise and a task cannot be completed or a service cannot be provided, the CFT member contacts the CFT facilitator to brainstorm solutions. If unsuccessful in addressing these barriers, the CFT facilitator explores options for resolution with the team, supervisors, or other resources. When an activity, support or service cannot be secured in a timely manner, even with such assistance, or the barrier is a system's issue, the behavioral health provider elevates the issue within the children's behavioral health system for additional assistance and resolution.

### **Coaching Facilitators of Child and Family Team Practice**

As part of their training, CFT Facilitators are provided coaching from individuals who have achieved a high level of expertise regarding the facilitation of Child and Family Team Practice. These individuals may have various job titles (CFT Coach, Team Coach, Provider Mentor, Supervisor, etc.) but they each perform the same role when it comes to coaching. After an employee completes the initial required CFT training, the Coach/Supervisor works with that individual to make sure they are competent facilitators of CFT practice. This work may entail shadowing, modeling, 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.

In order to function as Coaches/Supervisors, and to evaluate competency of potential facilitators, staff must meet the following criteria:

1. Must have completed a CFT Facilitators training approved by AHCCCS.
2. Must have demonstrated competency as a CFT Facilitator thru a process approved by AHCCCS
3. Must have a minimum of 1 year of experience facilitating Child and Family Teams (Agencies may request an AHCCCS waiver of these requirements based on individual circumstances)

### **ACTIVITY 8 - TRACKING AND ADAPTING**

During subsequent meetings, the CFT evaluates the effectiveness of the Service Plan; this includes celebrating successes and addressing crises, challenges and/or barriers. CFT activities are documented and the Service Plan is updated and modified to reflect positive changes or when progress has not occurred. The frequencies of ongoing meetings are individualized and scheduled based on the child's and family's needs, level of progress, and/or the Service Plan's target dates.

Between meetings, the behavioral health provider continues to engage the child, family and other team members to determine if:

1. Services being implemented are achieving expected results, and
2. Tasks are being completed. The CFT is responsible for tracking and monitoring outcomes related to goals/objectives in the Service Plan. A lack of progress towards meeting the goals and/or objectives can indicate that certain strategies or interventions need to be reevaluated. The behavioral health provider assists the CFT in refining existing strategies or developing new interventions. As indicated in Activity 6, Ongoing Crisis Planning, the CFT also tracks the effectiveness of crisis planning interventions and implements modifications when needed.

In summary, tracking and adapting for all children and families includes:

- a. Tracking progress and outcomes, keeping the child's and family's vision of the future in mind,
- b. Adapting the Service Plan as necessary to address barriers, lack of progress, or new situations,
- c. Monitoring timelines for activities,
- d. Anticipating and addressing transitions,
- e. Reviewing and updating the CASII every six months, and
- f. Tracking task assignments and their completion.

### **ACTIVITY 9 – TRANSITION**

Child and Family Teams develop plans that support the child and family to maintain positive outcomes throughout periods of transition. Examples of potential types of transitions are illustrated in Figure 3.



**Figure 3**

**A. CHANGE IN LIVING ENVIRONMENT, RELATIONSHIPS OR SCHOOL SETTING**

For children and teenagers, moving to new neighborhoods, leaving friends, and changing schools or even just changing grade level can be very stressful and cause great anxiety. These transitions, especially when a youth has existing behavioral health issues, may result in increased academic problems, social/emotional difficulties, isolation, lower motivation, and decreased school attendance. There are numerous resources available for the family and CFT to help them prepare for these common transitions, including *Helping Your Child with Transitions* and *Successful Transitions for High Conflict Families*.

**B. CHANGE IN INTENSITY OF SERVICES**

Transitions between various levels of service intensity can be extremely challenging for youth and their families or caregivers. This is especially true when the young person is moving from high intensity services to less intense services. An extreme example of this would be when a youth returns to their family after a period of treatment in an out-of-home facility (see *Child Out of Home Services Practice Tool*) but less extreme examples,

such as reducing the amount of contact a child has with their therapist, case manager, or direct service provider can also be stressful. Paradoxically, these reductions in intensity are generally a function of the child and/or family making progress towards their treatment goals but it is important for the team to recognize the potential for regression during these periods and plan accordingly.

### **C. TRANSITIONING TO ADULT BEHAVIORAL HEALTH SYSTEM**

Planning for transition into the adult behavioral health system must begin for any child involved in behavioral health care when the child reaches the age of 16 (see Transition to Adulthood Practice Tool). However, if the CFT determines that planning should begin prior to the youth's 16<sup>th</sup> birthday, the team may proceed with transition planning earlier (e.g., as young as age 14) to allow more time for the youth to acquire the necessary life skills, while the team identifies the supports that will be needed. A request to determine eligibility as a person with a Serious Mental Illness (SMI) can occur at age 17 (for eligibility criteria, refer to AMPM Policy 320-P, Serious Mental Illness Eligibility Determination). The young adult, in conjunction with other involved family members, caregivers or guardian, may, in many cases, request to retain his/her current CFT until the youth turns 21. If the CFT is not retained when the youth turns 18, an Adult Recovery Team (ART) is created to support the individual. ART membership may change based on the needs of the young adult as they mature out of the children's system. If a new provider will be involved with the young adult who is transitioning to the adult behavioral health system, key professionals from the adult service system are invited to join the CFT in order to facilitate a smooth transition and support the continuity of team practice.

For additional information related to transition, planning that will assist youth in acquiring the skills necessary for self-sufficiency and independence in adulthood refer to Transition to Adulthood Practice Tool. For resources related to transition planning refer to Transition to Adulthood Resources.

### **D. Successful Completion of Goals and Discontinuation of Behavioral Health Services**

One goal of service planning that involves transition is building independence. Youth and families who have assumed some or all responsibility for facilitating their CFTs and are close to successful completion of their goals may be approaching readiness to transition out of the behavioral health service system. Advocates or mentors can provide additional natural support during times of transition. If needed, a plan outlining the specific steps necessary to reconvene the CFT and the re-establishment of behavioral health services and supports is completed by the CFT prior to any child's/youth's disenrollment. Indicators that show a family may no longer need the support of the behavioral health system may include:

- 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 supports and services are from resources within their own family and community rather than paid and professional services,
- d. Frequency of meetings have decreased,
- e. There are no longer major safety or crisis concerns, and/or
- f. Successful completion of the child's and family's goals.

#### **E. OTHER TRANSITIONS**

When a youth is adjudicated and sentenced to the Arizona Department of Juvenile Corrections (ADJC) they are ineligible for services through our public behavioral health system while in the juvenile facility. This transition requires careful planning to ensure information is shared with ADJC regarding the youths mental health needs including any medications the youth may be prescribed. Likewise, when the youth returns to the community, transition planning is crucial in order to enhance the individual's chances of success by providing strong support of the behavioral health system. Another significant transition is a child entering or leaving the custody of DCS. For children removed from their family, the planning needs are more obvious but it is also important to understand that a child leaving DCS custody, in and of itself, is not a reason to end collaborative practice through the CFT. Often times, the end of involvement from DCS can mean that a child and family need more support from the CFT in order to maintain successful outcomes. One transition which commonly occurs due to the way Arizona structures the delivery of behavioral health services, is when a youth moves from one geographic region to another (see). Again, this type of transition requires careful planning by the CFT in order to maintain necessary behavioral health services.

For additional information related to transition, planning that will assist youth in acquiring the skills necessary for self-sufficiency and independence in adulthood refer to Transition to Adulthood Practice Tool. For resources related to transition planning refer to Transition to Adulthood Resources.

#### **F. TRAINING AND SUPERVISION EXPECTATIONS**

Contractors shall establish their own process for ensuring that all clinical and support service agencies' staff working with children and adolescents implements the practice elements as outlined in this document. In addition, per ACOM 407, staff designated to facilitate Child and Family Teams must;

1. Be trained on the elements of this Practice Tool within 90 days of their hire date
2. Complete an in-person, 2 day CFT facilitator training via AHCCS approved curricula
3. Demonstrate competency via the *Arizona Child and Family Teams Supervision Tool* (attachment D) or another process approved by AHCCCS
4. Achieve basic proficiency within 6 months and maintain or enhance proficiency as attested to by a supervisor, annually thereafter

Behavioral health staff must also participate in AHCCCS designated CASII training, education, and technical assistance. This six to eight hour training must be completed prior to the administration of the CASII. Only persons who have attended a two-day training containing a “teach back” method are authorized to train the CASII through the American Academy of Child and Adolescent Psychiatry (AACAP). These “master trainers” can then train other staff on the use and implementation of the CASII, as well as train new trainers by having them participate in two, one-day training sessions that include a “teach back” component.

Documentation of initial training, CFT competency evaluation and follow-ups shall be provided via electronic training record (e.g. Relias).

Contractors are required to provide documentation, upon request from AHCCCS, demonstrating that all required network and provider staff have been trained on the practice elements in this Practice Tool. Whenever this Practice Tool is updated or revised, Contractors must ensure their subcontracted network and provider agencies are notified and required staff is retrained as necessary on the changes. The supervision for implementation of this Practice Tool is to be incorporated into other supervision processes which Contractors and their subcontracted network and provider agencies have in place for direct care clinical staff.

## **G. ANTICIPATED OUTCOMES**

Anticipated outcomes include:

1. Increased statewide practice in accordance with the 12 Principles for Children’s Service Delivery,
2. Improved functional outcomes for children,
3. Improved engagement and collaboration in service planning between children, families, community providers and other child serving agencies,
4. Improved identification and incorporation of strengths and cultural preferences into planning processes, and
5. Coordinated planning for seamless transitions.