580 – CHILD AND FAMILY TEAM

EFFECTIVE DATE: 12/13/23

APPROVAL DATE: 11/09/23

I. PURPOSE

This Policy applies to ACC, ACC-RBHA, ALTCS E/PD, DCS/CHP (CHP), and DES/DDD (DDD) Contractors. This Policy is an optional resource for Fee-For-Service Programs and is not a requirement for FFS providers. This Policy establishes the foundations of Child and Family Team Practice and describes:

A. Universal Child and Family Team (CFT) practice in the System of Care.

B. Indicators contributing to a child and family's complexity of needs.

C. How the Child and Adolescent Level of Care Utilization System (CALOCUS) is utilized in the System of Care.

D. How the essential CFT practice activities are implemented on a continuum based on individualized needs.

II. DEFINITIONS

Refer to the AHCCCS Contract and Policy Dictionary for common terms found in this Policy including:

ARIZONA DEPARTMENT OF JUVENILE CORRECTIONS (ADJC)	**CHILD AND FAMILY TEAM (CFT)**	**ARIZONA DEPARTMENT OF CHILD SAFETY (DCS)**
DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)	**FEE-FOR-SERVICE (FFS)**	**MEMBER**
SERIOUS EMOTIONAL DISTURBANCE (SED)	**SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA)**	**TEAM DECISION MAKING (TDM)**

III. POLICY

The Arizona Vision as established by the Jason K. Settlement Agreement in 2001, states, "In collaboration with the child and family and others, Arizona shall 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 shall 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".

A System of Care is 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. [i]

A System of Care incorporates mental health promotion, prevention, early identification, and early intervention in addition to treatment to address the needs of all children, youth, and young adults.

The Contractor shall ensure that services are provided in alignment with the Arizona Vision, the 12 principles, CFT practice, and a System of Care approach.

A. THE TWELVE PRINCIPLES FOR CHILDREN'S SERVICE DELIVERY (12 PRINCIPLES)

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.[ii]

Refer to Attachment E for additional information on implementation of the 12 Principles.

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

   The 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's and family's 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

   The children have access to a comprehensive array of behavioral health services, sufficient to ensure that they receive the treatment they need. The plans identify transportation the parents and children need to access behavioral health services, and how transportation assistance shall be provided. The 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. The 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. The 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 member's lives, especially members in foster care. The Behavioral Health Services are continuously evaluated and modified if ineffective in achieving desired outcomes.

6. Most appropriate setting

   The children are provided behavioral health services in their home and community to the extent possible. The 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 need.

7. Timeliness

   The 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. The 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

   The Behavioral health service plans strive to minimize multiple placements. The 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. The 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

    The 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

    The 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.

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

In the CFT practice 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), DDD, 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 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 monitored through a primary care physician and/or another qualified professional. 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 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 caregiver, 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.

C. UTILIZATION OF THE CHILD AND ADOLESCENT LEVEL OF CARE UTILIZATION SYSTEM (CALOCUS)

Another method for determining complexity of needs and intensity of service delivery is through the application of CALOCUS for children aged six through 18. This instrument consists of six dimensions for assessment of service intensity: risk of harm, functional status, co-morbidity (co-occurrence) of conditions, recovery environment, resiliency and/or response to services, and treatment acceptance and engagement (involvement in services) as referenced in Attachment B. This instrument is to be completed in collaboration with the child and family; it cannot be done without either the child or guardian present. CALOCUS is an optional resource for FFS programs and is not required for FFS providers.

D. IMPLEMENTATION OF NINE ESSENTIAL ACTIVITIES OF CFT PRACTICE BASED UPON INDIVIDUALIZED NEEDS

The application of CFT practice shall 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. Coordination efforts are required,
4. The ability of the CFT to communicate effectively between meetings, complete follow up items and work effectively together,
5. The number of distinct services and supports necessary to meet the needs of the child and family,
6. The CFT's ability to develop a person-centered 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 are currently affecting the child and family, and
10. Availability and effective use of needed services, natural support, and community resources.

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 shall have the most integrated and individualized services and supports, although all children and youth with behavioral health needs at any level shall have individualized services and supports" (Vandenberg, J., 2008)[iii].

E. NINE ESSENTIAL ACTIVITIES OF CFT PRACTICE

CFT practice consists of nine activities and requirements for each of the identified activities as specified in this Policy.

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

CFT practice requires that all nine activities be implemented to ensure the 12 Arizona Principles are appropriately incorporated into service delivery for all enrolled children and their families.

1. Activity 1 - Engagement of the Child and Family

The 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 inclusion, empathy, respect, genuineness, and warmth to facilitate moving toward an agreed upon outcome (Refer to AMPM Policy 1040). The Contractor shall ensure that their subcontracted providers utilize the best practices outlined below for the engagement of the child and family.

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 (Refer to 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 by offering and educating families on support services provided by peer and family-run organizations for self-advocacy (Refer to AMPM BHPT 240 and AMPM Policy 963).

Any accommodations that may be indicated, including scheduling/location of appointments, interpretation services, childcare 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 and family-friendly 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. The family shall be given voice and choice in a setting that allows for openness and confidential discussions and meets the needs of the family. When meeting in public places, ensure compliance with confidential requirements as outlined in AMPM Policy 940. Scheduling appointments or CFT meetings shall not impede the child's schooling or employment, when at all possible, but refer to the caregiver's preference for a time and location that meets the needs of each individual family.

A description of Arizona's CFT practice model is discussed with the child and family during the initial engagement period. The behavioral health provider is responsible for ensuring the family understands the CFT process and are given an opportunity to ask questions. 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. The CFT shall make an effort to ensure the child is present for enough time to contribute, even if sensitive topics are being discussed and it is not appropriate for the child to attend the entire meeting. To the extent possible, the attorney and Guardian ad Litem (GAL) shall attend meetings or provide input to the CFT (refer to Administrative Order No. 2011-16).

The 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 shall be delivered helps reinforce a working relationship that is built on trust.

2. Activity 2 - Immediate Crisis Stabilization

A behavioral health risk assessment is one of the minimum elements of a clinical assessment as referenced in AMPM Policy 320-O. The Contractor shall ensure that their subcontracted providers address any immediate crisis situations and provide services and support for stabilization. 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 "An acute, unanticipated, or potentially dangerous behavioral health condition, episode or behavior". Examples of immediate crisis situations include suicidal or homicidal behaviors/intentions or the imminent risk of a child's disruption from current living environment.

For a child or family experiencing an immediate crisis situation, stabilization takes precedence over all other assessment and planning activities. The goal is to ensure a sense of support and stability within the family, enabling a focus on solutions, decision making, and active meaningful participation by the family. Family support, respite, or in-home services that may assist in immediate 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.

3. Activity 3 - Strengths, Needs and Culture Discovery (SNCD)

The service planning and treatment for children and families is based on an assessment of the child's and family's needs (Refer to AMPM Policy 320-O), as well as an understanding of their strengths and unique family culture. This CFT Activity centers on the family dynamics, allowing the family to share how to best serve them in a way that recognizes, honors their strengths and unique family culture.

The Contractor shall ensure that for all children receiving CFT practice there shall be documentation that reflects the strengths, needs, and unique culture of the child and family and how this information shall be utilized within service plan, crisis plan and transition plan (Refer to AMPM Policy 320-O).

The 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 support along with formal services. Additional areas to address within the SNCD are outlined in Attachment A.

Before finalizing the SNCD, the behavioral health provider shall review the document with the child and family to ensure that they are in agreement with the content. The behavioral health provider shall make revisions as needed to reflect the child and family's feedback. The behavioral health provider shall provide the family 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.

4. Activity 4 - CFT Formation and Coordination of CFT practice

The Contractor shall ensure that in conjunction with the family, behavioral health providers facilitate 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 of CFT practice 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, or Health Care Decision Maker (HCDM), 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 biological family members on the CFT is critical, when possible and appropriate, 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. Therefore, no time frame for frequency of CFT meetings is established to support this individualized approach. Though AHCCCS does not establish specific guidelines, the Contractor is encouraged to supply guidelines that support consistent team meetings based on level of need.

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 in person may be challenging, the facilitator utilizes alternative modes of communication. Facilitators assist CFT members with establishing ground rules for working together, identifying their priority concerns, working 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 support 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, providers shall offer family or peer support services to assist the child and family with exercising their voice. Refer to BHPT 240, AMPM Policy 963, and AMPM Policy 964.

The 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 as it relates to DCS, Person Centered Planning as it relates to DDD and Individualized Education Program (IEP) planning.

5. Activity 5 – Service Plan Development

The identification of the preferences, strengths, and culture of the child and family 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 Contractor shall ensure subcontracted providers follow the best practices outlined below in the developing and adjusting service plans in conjunction with children and families.

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 will be in the family's words to the extent possible. The service plan also includes goals which pertain to the identified family vision, as well as measurable objectives for each identified goal so that progress can be measured and assessed throughout the process. The effectiveness of the services and support shall be evaluated over time and revised as the child's needs change.

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 regularly 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. The Contractor shall require providers to update the service plan when changes in the provision of services (e.g., frequency, duration, provider agencies) or changes in identified needs occur.

6. Activity 6 – Ongoing Safety Planning

The CFT practice includes ongoing assessment and planning for crisis situations. The Contractor shall ensure that a safety plan is provided to 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 and/or a CALOCUS score of four and higher for children aged six through 18. Providers shall offer a safety plan for all members and shall facilitate a decision of whether or not a safety plan is needed based on the needs of the child, the preference of the family and the clinical indicators listed in AMPM Policy 320-O. For those children without an immediate clinical need for a safety plan, a wellness plan can be created as a preventative measure to prevent crisis before they start.

When an immediate clinical need is identified, the CFT facilitator shall ensure that the need is addressed in a current safety plan and that the plan is reviewed with the CFT members. Safety 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 crisis mobile 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.

7. Activity 7 – Service Plan Implementation

The Contractor shall ensure the behavioral health provider facilitating CFT practice for a child 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 (refer to ACOM Policy 417).

A service plan may include interventions provided by the child's/family's natural support or participation in activities within their community. For example, the child's involvement in extracurricular activities can be used to support social skills development with peers.

Effective implementation requires a plan of action that shall include CFT members to be assigned follow-up tasks. Between meetings, CFT members will make reasonable efforts to carry out their assigned tasks within the agreed upon timeframes. It is critical to timely service delivery, in accordance with timeframes outlined in ACOM Policy 417, that referrals are made and followed up on immediately following a CFT meeting in which a service has been agreed upon. 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 a 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 to the member's health plan. The Contractor shall provide additional assistance and resolution, to secure medically necessary services.

8. Activity 8 - Tracking and Adapting

The Contractor shall ensure the behavioral health provider tracks and adapts the service plan and its implementation to meet the changing needs of the child and family, as outlined below. During subsequent meetings, the CFT evaluates the effectiveness of the service plan to meet the child and family's needs; 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 changes, progress, or barriers to progress. 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 CFT facilitator continues to engage the child, family, and other team members to determine if: services being implemented are achieving the expected results, and 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 CFT facilitator assists the CFT in refining existing strategies or developing new interventions. Monitoring between meetings shall allow the CFT facilitator to determine if an additional meeting is needed prior to the next scheduled meeting.

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 completing tasks,
d. Anticipating and addressing transitions,
e. Reviewing and updating the CALOCUS every six months, and
f. Tracking task assignments and their completion.

9. Activity 9 – Transition

The Contractor shall ensure that CFT facilitators collaborate with CFT members to anticipate transitions and prepare to adjust to meet the changing needs of the child. Some examples of transitions are included below however this is not an all-inclusive list. The team recognizes that each individual child is unique, and their experiences and the impact of transitions may be different:

a. Change in living environment, relationships, or school setting: The children and youth experience various life transitions such as moving to new neighborhoods, changes in primary caregivers, leaving friends, and changes in school settings or environments. The CFT shall consider the resources available for the child, family and CFT to help prepare for these common transitions,
b. Change in Intensity of Services: The transitions between various levels of service intensity can be extremely challenging for youth and their families. This is especially true when the young person is moving from high intensity services to less intense services. Considerations shall be made for how to appropriately taper services off and make these transitions as smooth as possible for the child and family. 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. The transitioning to the adult behavioral health system refer to AMPM Policy 587,
d. Successful completion of goals and transitioning out of behavioral health services: The Transitioning to independence is one goal of service planning and providers shall support this transition by utilizing the family vision. Youth and families who are close to successful completion of their goals may be approaching readiness to transition out of the behavioral health service system. Every effort shall be made to prevent premature closures, this shall be done through effective planning. Transition out of services shall be considered when the child, youth and/or family feel they have achieved success as it is defined by them. When a team is considering a transition out of services, the CFT facilitator and other providers shall assist the family with connection to additional natural support to help maintain success. Indicators that show a family may no longer need the support of the behavioral health system may include:
    i. The presence of a high percentage of CFT members who are from the family's own informal support system,
    ii. The family notes they no longer need the same level of assistance,
    iii. The majority of their support and services are from resources within their own family and community rather than paid and professional services,
    iv. The frequency of meetings has decreased,
    v. There are no longer major safety or crisis concerns, and
    vi. 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. This transition requires careful planning to ensure information is shared with ADJC regarding the youth's mental health needs including any medications the youth may be prescribed. Likewise, when the youth return 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 additional information in supporting transitions for children and families involved with DCS, refer to BHPT 260. Other commonly occurring transitions may include but is not limited to: when a youth transitions between the Contractor and FFS Programs, different service areas, and/or sub-contractor as specified in AMPM Policy 520. Again, these types of transitions require careful planning by the CFT facilitator in order to maintain necessary behavioral health services.

F. TRAINING AND SUPERVISION EXPECTATIONS

The Contractor 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. The Contractor shall ensure that all behavioral health staff receive competency-based training in implementation of the 12 principles into practice, as outlined in Attachment E. The Contractor shall ensure that staff designated to facilitate Child and Family Teams:

1. Be trained in the elements of this Policy within 90 days of their hire date.

2. Complete an in-person, two-day CFT facilitator training via AHCCCS approved curricula.

3. Demonstrate competency via the Arizona Child and Family Teams Supervision Tool (Attachment C) or another process approved by AHCCCS within 90 days of their hire date.

4. Achieve proficiency within six months and maintain proficiency as demonstrated via the Arizona Child and Family Teams Supervision Tool (Attachment C) and attested to by a coaches/supervisor, annually thereafter.

The Contractor shall ensure behavioral health staff participate in AHCCCS designated CALOCUS training, and that this training is completed prior to the administration of the CALOCUS.

The documentation of initial training, CFT competency evaluation and follow-ups shall be provided via electronic learning management system.

The Contractor is required to provide documentation, upon request from AHCCCS, demonstrating that all required network and provider staff have been trained in the practice elements in this Policy. Whenever this Policy is updated or revised, the Contractor shall 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 Policy is to be incorporated into other supervision processes which the Contractor and their subcontracted network and provider agencies have in place for direct care clinical staff.

G. COACHING FACILITATORS OF CHILD AND FAMILY TEAM PRACTICE

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 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.

The Contractor shall ensure that providers are aware of the expectation for provider agencies to vet their designated coaches, supervisors, mentors, etc. 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 (Attachment C) and the user guide (Attachment D).

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.

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

1. Complete a Supervisor CFT Facilitators training approved by AHCCCS.

2. Demonstrate competency as a CFT Facilitator through via the Arizona Child and Family Teams Supervision Tool (Attachment C).

3. Have a minimum of one year of experience successfully facilitating Child and Family Teams (The Contractor may request an AHCCCS waiver of these requirements on behalf of a subcontracted provider based on individual circumstances)

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[i] Stroul, B.A., Blau, G.M., & Larsen, J. (2021). The Evolution of the System of Care Approach. Baltimore: The Institute for Innovation and Implementation, School of Social Work, University of Maryland.

[ii] 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

[iii] 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.