

DBHS Practice Protocol

Child and Family Team Practice



**Developed by the
Arizona Department of Health Services
Division of Behavioral Health Services**

**Effective 1/1/2008
Revised 8/15/2009**

NOTE:

This Clinical Practice Protocol has required implementation elements. Providers are required to implement the components of this protocol with special emphasis on the Required Service Expectations, as clearly identified in this document.

Title

Child and Family Team Practice

Goal/What Do We Want to Achieve Through the Use of this Protocol?

- To establish a protocol that will effectively operationalize Child and Family Team (CFT) practice in Arizona and support ongoing teaching/coaching at the provider level.
- To define and describe the activities of Child and Family Team practice in accordance with the 12 Arizona Principles.
- To describe how CFT practice activities are implemented with children and adolescents having complex needs and how they may be implemented for those identified as having standard needs.
- To describe how the Child and Adolescent Service Intensity Instrument (CASII) is utilized as one component for determining an individual's level of service intensity.

Target Audience

This Protocol is specifically targeted to Tribal/Regional Behavioral Health Authorities (T/RBHAs) and network/provider behavioral health staff who are responsible for the implementation of the:

- 12 Arizona Principles
- Child and Family Team practice model
- CASII tool
- assessment and service planning processes; and who
- supervise staff who are responsible for the above.

Target Population(s)

Child and Family Team practice is utilized with all TXIX and TXXI children, adolescents and young adults, under the age of 21, enrolled in the Tribal and Regional Behavioral Health Authority (T/RBHA) systems. CASII implementation is with all children and adolescents between the ages of 6 through 17, enrolled in the (T/RBHA) system.

Attachments

[Attachment 1: The Child and Family Team Practice Encounters/Billing Codes Matrix](#)

[Attachment 2: Arizona Child and Family Teams Proficiency Measurement Tool for Facilitation- User's Guide](#)

[Attachment 3: Arizona Child and Family Teams Proficiency Measurement Tool for Facilitation](#)

[Attachment 4: CASII Implementation Guidelines for CFT Practice 9 Essential Activities](#)

[Attachment 5: Arizona's Child & Adolescent Service Intensity Instrument Scoring Sheet](#)

[Attachment 6: Guidelines for Strengths, Needs, and Culture Discovery \(SNCD\) Domains](#)

Definitions

[Adult Clinical Team](#)

[Child and Family Team \(CFT\)](#)

[Family](#)

[Child and Family Team \(CFT\) Facilitator](#)

[Natural Support](#)

[Child and Adolescent Service Intensity Instrument \(CASII\)](#)

[Children with Complex Needs](#)

[Children with Standard Needs](#)

Background

ADHS has adopted the Arizona Vision, which 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.”*

Child and Family Team practice is based on the Arizona Vision and the [12 Arizona Principles](#):

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

ADHS’ intent is that the 12 Arizona Principles are to be universally applied to all enrolled children and families through the use of Child and Family Team (CFT) practice. CFT practice consists of nine activities that support implementation of these 12 Arizona Principles. Effective CFT practice allows teams to be structured and function in a flexible manner that includes varying levels of involvement from the behavioral health system, other child-serving agencies and natural supports. One way to evaluate the relative complexity of a child or family’s situation and the approximate level of support necessary to effectively address their needs is through the use of the Child and Adolescent Service Intensity Instrument (CASII). The structure of the CFT will depend on the complexity of needs, the child’s and family’s strengths and the goals identified by the child, family and CFT.

All families are unique and as such, each CFT experience is necessarily different from another. 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 the following:

1. The size of the team, coordination efforts required, and the ability of the CFT to work effectively together;
2. The number of distinct services and supports necessary to meet the needs of the child and family;
3. The frequency of CFT meetings necessary to effectively develop a plan, track progress and make modifications when needed;
4. The number of agencies/systems involved;
5. The severity of symptoms and the effectiveness of services;
6. The stress that is currently affecting the child and family.
7. Geographic location (rural teams may meet, discuss and plan over the phone or via telemed); and
8. The preferences of the youth and/or family

Procedures

There are nine essential activities that comprise effective CFT practice. These activities are not the goal of the CFT but are rather the process to move toward the goal of identifying and meeting the needs of the child and family. The activities are:

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. Behavioral Health Service Plan – Development
6. Ongoing Crisis, Planning
7. Behavioral Health Service Plan - Implementation
8. Tracking and Adapting
9. Transition

These essential activities of CFT practice are not strictly linear and are addressed in the order, frequency, and duration necessary. See [Attachment 1-The Child and Family Team Practice Encounters/Billing Codes Matrix](#) for available billing/encounter codes supporting each activity of Child and Family Team practice.

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

Activity 1 - Engagement of the Child and Family

Engagement is the centerpiece of CFT practice. Engagement begins during the first contact between the child/family and the behavioral health system and continues throughout the family's involvement with the behavioral health system. Engagement is not a one time event. The success of CFT practice depends upon a foundation of trust between the child/family and other team members. CFT practice is a partnership, and engagement is both the beginning and the sustaining characteristic of that partnership. These initial communications with the child and family provide opportunities for the behavioral health service provider to learn and understand the family's concerns. The behavioral health service provider is also expected to introduce the child and family to the behavioral health system and provide them with a clear explanation of CFT practice through conversation and active listening rather than a structured interview. Initial communications with the child and family should include a clear explanation of CFT practice and avoid the use of professional/system jargon when describing the activities ahead.

It is important that the behavioral health service provider address any accommodations that may be indicated, including scheduling/location of appointments, interpretation services, child care or transportation needs. The behavioral health service provider should schedule meetings with the child

and family for a time and place convenient for the family. It should not be assumed the most convenient place for a family to meet is at a provider's office. Meetings could be held at the family's home, school, library, community center, or even a favorite coffee shop. It is important to brainstorm with the family and youth to identify the most convenient meeting location (When meeting in public places ensure compliance with [Provider Manual Section 4.1 Disclosure of Behavioral Health Information](#)). The behavioral health service provider should also encourage identification and participation of additional family members, close family friends, and other potential CFT members. If Child Protective Services (CPS) is involved with a child and family, dialogue must occur with the CPS case manager about any barriers to involvement of potential CFT members.

For children identified as having standard needs, team meetings may simply be held during the scheduled appointment time with the behavioral health provider. However, even in these instances, the behavioral health representative or provider should be sensitive to the scheduling needs of the family and child and accommodate them as much as possible. With these children, there may be a limited number of individuals participating on the team, perhaps just the child, their parent/caregiver and a "counselor" or medical professional (perhaps both).

As mentioned earlier, one of the ways to determine service intensity is through the application of the CASII. (See [Attachment 4: CASII Implementation Guidelines for CFT Practice 9 Essential Activities](#) and [Attachment 5: Arizona's Child & Adolescent Service Intensity Instrument Scoring Sheet](#)). The CASII is to be completed by a trained and certified behavioral health service provider, in collaboration with the child/adolescent and family, and other members of the CFT. The CASII must be conducted in a manner which is strengths-based, family friendly, culturally sensitive, and clinically sound and supervised. The CASII shall be completed within the initial 45 day assessment period (see [Provider Manual Section 3.9 Intake, Assessment, and Service Planning](#)) and every six months thereafter. It can also be used anytime a CFT feels updated information would benefit service planning. A final CASII must be completed as part of the disenrollment process from behavioral health services for the child/adolescent (see [Provider Manual Section 3.8 Outreach, Engagement, Re-engagement, Closure, and Re-enrollment](#)).

Subsequent contacts with the behavioral health system continue the engagement process. The behavioral health service provider encourages the family to share their story and demonstrates compassionate listening. Through engagement, the behavioral health service provider is able to explore strengths, resources, long-term vision, primary family needs, and potential short-term goals that might become part of the developing Strength, Needs and Culture Discovery and Service Plan. While primary needs may require quick action (see [Activity 2: Immediate Crisis Stabilization](#)), the behavioral health service provider should not move prematurely toward solutions. Activities and behaviors that promote engagement should be evident throughout all subsequent work with the child, family and CFT. In summary, 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 [Provider Manual Section 3.8 Outreach, Engagement, Re-Engagement, and Closure](#)).

Service Expectations: The behavioral health service provider begins the engagement process with the child and family at the time of first contact and provides a clear explanation of CFT practice. Accommodations such as scheduling and location of appointments or transportation needs are addressed. Engagement practices are evident throughout all subsequent work with the child and family. The CASII shall be completed by the behavioral health service provider, who is trained and certified, in collaboration with the child/adolescent and family, and other members of the Child and Family Team. The CASII shall be completed as part of the initial 45 day assessment period and every six months thereafter. The composite score and date of CASII administration shall be entered into the Client Information System.

Activity 2 - Immediate Crisis Stabilization

The behavioral health service provider, with the child and family, identifies any risks that require immediate intervention. Examples include immediate safety risks such as 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 critical 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 a child/family's strengths are identified and secured. Also additional supports, such as family support, respite, or in-home services that may assist in crisis stabilization must be identified and secured as quickly as possible.

A child entering foster care due to abuse or neglect is not automatically considered to be in an acute crisis situation. The completion of a clinical assessment and prompt formation of a CFT may adequately meet the child's initial needs if s/he does not present with immediate safety risks (See [ADHS/DBHS Practice Protocol: The Unique Behavioral Health Service Needs of Children, Youth, and Families Involved with CPS](#)).

Service Expectations: Along with the child and family, the behavioral health service provider identifies any risks that require immediate intervention. Immediate crisis stabilization takes precedence over all other assessment and planning activities. Crisis stabilization is addressed through the development of a crisis stabilization plan that utilizes services which work in conjunction with the child/family's strengths.

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

The Strengths, Needs and Culture Discovery (SNCD) provides essential information used to develop a strengths-based, individualized service plan that respects the unique culture of the child and family. It allows the CFT to develop a highly individualized plan which *fits* with *this* child and family in a way that encourages their commitment to success. By identifying strengths, assets and sources of natural support, the SNCD can facilitate an expansion of the array and volume of resources available to the CFT beyond formal, categorical services. Strengths, when understood in a functional context, serve as practical resources and service-substitutes in the planning process. Having a written document will reflect back to the child and family their strengths, needs and culture. The SNCD shifts the focus of the CFT to allow team members, including the family, to obtain a balanced perspective of the family's strengths, needs and history of solution finding. This process acknowledges family voice which builds engagement and trust. Family members are central participants in the development of the SNCD (see [Attachment 6- Guidelines for Strengths, Needs, and Culture \(SNCD\) Domains](#)).

The elements of the Strengths, Needs and Culture Discovery include:

1. Identification of strengths, assets and resources that can be mobilized to address family needs for support.
2. Exploration and understanding of the unique culture of the family, so the service plan will be a plan the child and family will support and utilize. The family's culture is influenced by family relationships, rituals, social relationships, living environment, work environment, spiritual focus, health, financial situation and other factors.
3. Recording of the child and family's vision of a desired future.
4. Identifying the needs and areas of focus that must be addressed to move toward this desired future.

The SNCD acquires information on the various aspects of both the child's and family's life situation through conversations that begin at intake and continue over the course of service delivery. Initially, this discovery identifies the presenting concerns and current needs. The family then prioritizes those needs and selects the top two or three which the child and family believe requires foremost attention.

Specific examples of the child/family's strengths and culture are explored in depth as they relate to their prioritized needs. Other life domains may not require the same depth of information initially as the ones related to needs. However, they will still require general coverage. The SNCD begins to identify extended family members, friends and other individuals who are currently providing support to the child and family or have done so in the past. By gaining a clear understanding of the child/family's defined priority needs, the CFT can begin focusing the use of natural supports and formalized services on addressing these needs. The behavioral health service provider reviews the written SNCD with the child and family to ensure they agree with the content of the document before it is considered finalized. The family must be provided a copy of the completed document and, if the family agrees, it should be distributed to other CFT members as well.

When children are identified as having standard needs, the SNCD may not be as extensive but should still contain the four elements listed above. There are likely to be fewer needs identified, especially in domains other than behavioral health. Many natural and community supports may already be supporting the child and family, reducing the necessity for extensive exploration of how the family's strengths, culture, and natural supports can address their needs.

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 see if it represents or fits with how they view their family.

Service Expectations: The behavioral health service provider is responsible for completion of the initial Strengths, Needs and Culture Discovery within 45 days of the intake appointment.

Activity 4 - CFT Formation/Coordination of CFT Practice

In conjunction with the family, the behavioral health service provider facilitates the identification, engagement and participation of additional family members, close family friends, appropriate clinical expertise, and other potential CFT members including partner agencies such as CPS, DDD, juvenile justice and education. One of the goals is to strengthen or help to build a natural and community based social support network for the family.

The CFT, led by the behavioral health provider, is also expected to use the CASII to inform case manager assignment for children/adolescents identified as having complex needs. The CASII is not the sole determinant of case management assignment nor is it to be used to determine eligibility for specific levels of care, types of services, or particular service models (see [Provider Manual Section 3.14, Securing Services and Prior Authorization](#)). The CASII recommends the level of intensity while the Child and Family Team identifies the services and supports to best meet the identified needs. Children/adolescents identified at CASII levels 3, 4, 5, and 6 of service intensity, should consider the need for a designated case manager to coordinate services and activities of Child and Family Team practice. Crisis planning is required at these levels of intensity.

The size, scope and intensity of the involvement of CFT members is driven by the needs and desires of the child and family. The CFT *may* consist of only the child, a parent and the identified behavioral health service 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 if they have multiple support providers. When Child Welfare is the identified guardian, inclusion of the child's family members in the CFT is critical especially, but not limited to, when reunification is an identified goal. Members of the CFT may be added or removed as the needs and strengths of the child and family change over time.

Meetings that result in decisions which affect the child and family cannot occur without the family's full participation. Decisions affecting substantive changes in service delivery should not be made without 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 (DES/DCYF), Person Centered Planning (DES/DDD) and Individualized Education Programs (IEP) (Special Education).

The identified behavioral health service provider has the following responsibilities:

1. Serve as the facilitator of CFT Practice. [Attachment 2: Arizona Child and Family Teams Proficiency Measurement Tool for Facilitation- User's Guide](#) and [Attachment 3-Arizona Child and Family Teams Proficiency Measurement Tool for Facilitation](#) may be utilized to document the behavioral health service provider's acquisition of the skills necessary to be considered a proficient facilitator. If this tool is not utilized, RBHAs must ensure that providers have established another method for demonstrating facilitator proficiency. Effective facilitators:
 - a. encourage each CFT member to identify their priority concerns, work proactively to minimize areas of potential conflict, and acknowledge the mandates of others involved in child-serving systems;
 - b. utilize consensus-building techniques, such as compromise, reframing, clarification of intent, and refocusing efforts on the best interest of the child/family. In addition the behavior health service provider is expected to avoid any "positions" or predetermined solutions in meeting the needs of the family;
 - c. establish and sustain an effective team culture by inviting CFT members to propose, discuss and accept ground rules for working together.
2. Engaging all CFT members and identifying their needs for meeting agency mandates and the strengths that each person brings to the team. The behavior health service provider is expected to identify their perspectives on the child/family's strengths and needs, provide CFT members with an overview of CFT practice, and clarify their role and responsibilities as a team member in this process.
3. When Child Protective Services (CPS) is the identified guardian, inclusion of the child's family members in the CFT is critical. Dialogue must occur with the CPS case manager about any barriers to involvement of the biological family in CFT practice.
4. Increasing the "natural support" in CFT membership and the child/family's integration into their community. This is accomplished by periodically inquiring whether there is anyone else the family would like to invite to CFT meetings, (i.e. friends, extended family, neighbors, members of the family's faith community, co-workers). Experience has shown that a CFT comprised primarily of paid professionals tends to result in a service plan that relies heavily on existing, formal services. With children identified as having standard needs, natural and community supports may already be in place thereby focusing the planning process on the establishment of formal behavioral health services rather than the identification of additional community or natural supports.
5. Identifying family support, peer support or other "system" and community resources that can assist the child/family with exercising their voice in the CFT process, if needed.
6. Developing a meeting agenda with the child, family, and other CFT members. Also for scheduling meetings at a place/time that is comfortable and convenient for all CFT members while giving special consideration to the preferences of the family. Visual aids or tools to facilitate the meeting process should also be prepared.
7. Attending to the needs of the child/family for transportation to facilitate their participation. Informing all CFT members of the date, time and location of each meeting.
8. Contacting CFT members who are unable to attend a meeting, in advance, to elicit their input.
9. Ensuring all CFT members receive documentation of CFT meeting activities, discussions and task assignments.
10. Sensitivity to the needs of team members when working in rural areas where getting members together physically may be challenging. The facilitator must be creative in establishing a team that may meet via phone or through teleconferencing. A team using these technologies must still be sensitive to working according to the 12 Arizona Principles, especially around family voice and choice in the planning process. Decisions must not be made without the input of the youth and family.
11. When working with older youth, the facilitator and team must respect the young person's wishes around team formation.

12. Informing the child and family of their rights and obtaining all necessary consents and releases of information.

Some of the responsibilities listed above may be different for the behavioral health representative working with children identified as having standard needs and their families. Many of the responsibilities noted are specific to the details involved in organizing and conducting Child and Family Team meetings. For children with standard needs some of these details may not necessarily apply. For example, there are typically no agendas necessary because the next CFT “meeting” is simply the next regular appointment with the behavioral health provider. Likewise, scheduling is probably not going to require a great deal of coordination with others, perhaps just with the parent/caregiver and child.

Service Expectations: The behavioral health service provider ensures all persons needed for planning are included, engaged and invited to CFT meetings. The behavioral health service provider also serves as facilitator of meetings if the CFT requests, handles the logistics for scheduling team meetings, obtains the appropriate consents/releases of information and provides documentation of CFT meeting activities to all members. The CASII is not to be used to determine eligibility for specific levels of care, types of services or particular service models.

Activity 5 - Behavioral Health Service Plan – Development

The foundation for plan development begins when the child and family participate in the assessment process (see [Provider Manual 3.9, Intake, Assessment, and Service Planning](#)). The Behavioral Health Service Plan (see [Provider Manual Form 3.9.1, Part D](#) and [Provider Manual Form 3.9.2, Part C](#)), describes the family’s vision for the future (stated in their own language) and identifies the short-term objectives, interventions, supports and services that will address their identified and prioritized needs. The CFT members engage in brainstorming options and identify creative and nontraditional approaches, including formal and natural supports, for meeting the needs of the child and family. During this activity the CFT is to give careful consideration and weight to the child and family’s preferences, strengths, culture and the parent’s expert knowledge of their own child. Objectives that can be readily accomplished and celebrated within a short timeframe are identified to encourage early success and continued involvement and achievement. For children with standard needs, the service planning process may be less complex and involve only the parent/caregiver, child and their behavioral health provider. However the idea of brainstorming options and being sure to strongly consider the child and parent’s preferences, strengths, culture and the parent’s expert knowledge of their own child is still applicable.

The Behavioral Health Service Plan must be completed no later than 90 days after the initial appointment and must:

1. reflect the family’s prioritization of needs and goals;
2. incorporate pertinent, identified strengths and cultural considerations within its strategies to achieve successful outcomes;
3. be individualized and responsive to the child and family’s needs;
4. assign responsibility to CFT members for each strategy/intervention/task and establish timelines for implementation;
5. utilize both formal and informal/natural supports and services as indicated;
6. identify natural supports and connections to community supports which may need to be developed or re-energized;
7. identify outcomes, actions and strategies/interventions/tasks related to the family’s vision for the future;
8. include measures by which the child/family and CFT can monitor progress; and
9. be signed by the parent/guardian and youth (if developmentally appropriate).

Other elements that can be incorporated into the child and family’s service plan include:

1. Daily activities schedule

2. Specific strategies to address a particular behavior
3. Special instructions or guidance for implementing service plan strategies/interventions

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 family member (e.g., parent) is also receiving behavioral health services, inclusion of the behavioral health goals and objectives for that family member may be incorporated into the child's Service Plan, when agreeable with the family.

Both the assessment (including the Strengths, Needs, and Culture Discovery) and service planning are ongoing processes, which result in plans that are continually updated as needed to obtain desired results and meet the changing needs of the child and family. The behavioral health service provider should ensure that the service plan is consistent with the 12 Arizona Principles. If recommendations are made that the behavioral health service provider thinks are inconsistent, he/she should say so during the meeting. If the CFT cannot reach consensus, he/she should ask his/her supervisor for advice about how to achieve consensus.

Service Expectations: The behavioral health service provider facilitates the CFT development of a Behavioral Health Service Plan which incorporates the family's preferences, strengths and culture in alignment with their vision for the future. The Service Plan identifies formal services and natural supports, as indicated, that address the identified needs as well as the methods to monitor progress.

Activity 6 - Ongoing Crisis Planning

CFT practice includes planning for crisis situations and addressing ongoing safety issues. Crisis planning includes specific objectives and strategies to ensure timely availability of necessary supports and interventions in a crisis situation. Crisis situations refer to situations which pose a significant safety risk to the child, family, or community, including violent behaviors, self-injurious behaviors, running away, setting fires, etc. Crisis plans provide for 24 hour-a-day responsiveness and address the question, "What might go wrong that would divert the CFT from successfully implementing the activities in the Service Plan?" Through using creative thinking the CFT members identify the most likely crisis situations for a particular child and/or family. The CFT members then develop a plan to prevent these potential crisis situations from occurring, as well as an approach for responding most effectively should one of these situations occur. Crisis planning includes recognizing when a situation is escalating and how to best defuse the situation or obtain assistance to prevent further escalation. There is less likelihood that children having standard needs will need a crisis plan but when necessary or desired by the parent/guardian, the planning process should follow the outline described below.

Effective crisis planning:

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, impulsive behavioral responses (thought and action) and the consequent behaviors which follow as a natural result;
3. Changes over time in response to what is known to be effective or ineffective interventions;
4. Contains clear behavioral benchmarks that change over time to reflect progress, changing capacities and changes in the child/family's expectations;
5. Triages the intensity of response actions to align with the severity level of the crisis situation;
6. Anticipates a 24 hour crisis response;
7. Builds roles for family members and other natural support people as responders in crisis situations;
8. Clearly defines roles of other CFT members and how they support the mission of the crisis plan;

9. Utilizes input from the child/family on what can go wrong with the plan and responds accordingly; and
10. Evaluates the management of the crisis and effectiveness of the plan once the crisis has stabilized.

Generally, an effective approach to crisis planning includes the following format:

1. Predict: “What is the worst thing that could happen or what is most likely thing to go wrong, that would divert the CFT from successfully implementing the Service Plan?”
2. Functional Assessment: What events, behaviors or behavioral sequences are associated with the initial, middle and ending phases of the crisis? What triggers a crisis situation? What are the consequences? What happens when the crisis occurs?” What works to calm the child/youth when s/he is in crisis? Who are the best people to intervene and what are their response actions?
3. Prevention: Encompasses the bulk of the plan by identifying the options, drawn primarily from the child/family’s strengths and community supports, which can be used to mitigate the triggers, events or behaviors associated with the crisis situation. “What can be changed or added to the daily routine to prevent the crisis?”
4. Plan: “What are the steps to be initiated based on the severity level of the crisis?” Crisis Plan steps include specific names and phone numbers, as well as contingencies. The CFT is the primary/first responder in a crisis. 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 capacity of the plan’s ability to safely and adequately defuse the crisis.

A 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 solid evidence of prior unsafe behavior toward others that threatens the chance the child/youth can remain/return to living in his/her community. Effective crisis planning under these circumstances includes preventive approaches for potential unsafe behaviors or situations. This type of planning also identifies interventions to be implemented and the persons responsible for each intervention when the unwanted behavior is attempted or occurs.

Generally, an effective approach to crisis planning that involves community safety includes the following elements:

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
10. Supports and builds the family through teaching healthy alternatives through the CFT process

Not all children will need a Crisis Plan. The decision of whether or not a Crisis Plan is needed is made by the CFT based on the complexity of the child’s unique situation. However, a Crisis Plan must be developed for CASII levels 3 and higher.

Service Expectations: When identified as a need, the behavioral health service provider facilitates crisis planning when there are identified risks and/or safety concerns that threaten the stability of a child in his/her community setting. Effective crisis planning includes the elements noted in this protocol. A Crisis plan is required for all children identified at Service Intensity levels 3, 4, 5, or 6.

Activity 7 - The Behavioral Health Service Plan - Implementation

Based upon the recommendations and decisions of the CFT, the behavioral health service provider is responsible for overseeing and facilitating the effective implementation of the Service Plan. Effective implementation includes the provision of covered behavioral health services, and initiating action for those services requiring prior authorization in accordance with ADHS/DBHS' policy (see [Provider Manual Section 3.14 Securing Services and Prior Authorization](#)). Services requiring prior authorization include:

1. Level I services (psychiatric acute hospital, sub acute facility, residential treatment center)
2. Level II Residential services
3. Level III Residential services
4. HCTC services
5. Other covered services identified by the T/RBHA with the written approval of the ADHS/DBHS Medical Director

Some assignments may consist of specific activities or ways of interacting with the child. The Service Plan may include a specific strategy that caregivers will use to reinforce a particular behavior or an agreement. For example, reinforcement might be a child's Uncle taking him bowling each Friday evening.

Before leaving a planning meeting, it is helpful for CFT members to have their personal assignments and timeframes written down. In the event a member is participating by phone or telemed, the facilitator is responsible for making sure that individual is clear about their responsibilities and is sent copies of appropriate documents. The behavioral health service provider must also furnish CFT members with an updated copy of the Service Plan or progress report within 7 days after the CFT meeting. Team members should carry out assignments promptly and contact the behavioral health service provider if barriers arise or when an assignment cannot be completed.

Behavioral health service planning includes tasks or activities assigned to specific CFT members for completion outside of planning meetings. Some assignments may consist of specific activities or ways for interacting with the child to reinforce a particular behavior. CFT members are expected to make reasonable efforts to carry out their assigned responsibilities within the agreed timeframes. In a situation where a particular CFT member fails to complete an assigned task, the behavioral health service provider is responsible for taking two actions. First, to determine if there is a barrier or a change in priorities/needs that is preventing completion. And second, to explore and implement 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 service provider elevates the issue within the T/RBHA system for additional assistance and resolution (see [Provider Manual 5.1 Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons](#)). Alternative or interim strategies may be presented to the CFT for consideration.

During subsequent CFT meetings, the status and outcomes of the Service Plan's interventions are reviewed, successes are recognized and celebrated and crises, challenges and barriers are addressed. Modifications to the SNCD are documented to provide the team with an up-to-date narrative of strengths, resources, cultural considerations and identified needs. CFT meeting notes are recorded and the Service Plan is updated and modified to reflect positive changes or when progress has not occurred.

Service Expectations: The behavioral health service provider is responsible for securing and implementing the covered behavioral health services identified in the Service Plan.

Activity 8 - Tracking and Adapting

Child and Family Teams require ongoing follow-up between meetings. The behavioral health service provider ensures: that engagement continues with the child, family and other team members; services are being implemented and are achieving expected results; and assignments are completed. The frequency of ongoing meetings are scheduled in relation to the child/family's situation, preferences, severity of need, level of progress or barriers to progress, and the plan's target dates.

The Service Plan includes short-term, observable/measurable goals with indicators to objectively track progress made over time.

The CFT is responsible for tracking and monitoring outcomes related to goals/objectives in the Service Plan. A lack of progress and/or incomplete follow-through on assignments can indicate that certain strategies or interventions are not working. The behavioral health service provider facilitates the CFT in refining existing strategies or developing new interventions.

The behavioral health service provider is also responsible for tracking the effectiveness of the crisis planning interventions. After these actions or interventions have been implemented and "tested", the CFT reviews their effectiveness and when indicated incorporates modifications to interventions that did not work. A Team's review of a plan's effectiveness should occur once the crisis situation has stabilized.

Tracking and adapting for all children and families should include:

1. Tracking progress and outcomes, keeping the family's vision of the future in mind;
2. Adapting the Service Plan as necessary to address barriers, lack of progress, or new situations;
3. Monitoring timelines for activities;
4. Anticipating and addressing transitions;
5. Reviewing and updating the CASII every 6 months; and
6. Tracking task assignments and their completion.

Service Expectations: The behavioral health service provider ensures implementation and effectiveness of service and crisis planning through CFT facilitation of tracking and monitoring activities. Lack of progress in reaching identified goals or ineffective services and supports require modifications to the Crisis and Service Plans, in alignment with behavioral health policy requirements.

Activity 9 – Transition

Child and Family Teams develop plans that support the child and family by maintaining positive outcomes throughout periods of transition. Transition planning activities can include some of the following situations:

1. Changes in living environment, relationships and school settings
2. Admission/discharge to and from higher levels of care
3. Shifting from the children's service delivery system into the adult service system
4. Transforming Child and Family Teams into functioning Adult Clinical Teams
5. Successful completion of goals and disenrollment from behavioral health services

Planning for transition when a youth has been receiving long-term or intensive behavioral health services begins at the age of 16 (See [ADHS/DBHS Practice Protocol – Transition to Adulthood](#)). When planning for transition into the adult behavioral health system a request to determine SMI eligibility can occur at age 17 (for eligibility criteria, refer to [Provider Manual Section 3.10, SMI Eligibility](#))

[Determination](#)). The youth and legal guardian, if involved, may request to retain his/her current Child and Family Team until the youth turns 21. Adult Clinical Team membership may change based on the needs of the youth as she/he matures out of the children's system. If a new provider will be involved with a youth in the adult behavioral health system, key professionals from the adult service system are invited to join the CFT to facilitate a smooth transition and support the continuity of team practice.

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 services 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/youth's disenrollment. It is important to understand a child leaving CPS custody, in and of itself, is not a reason to end collaborative practice through the CFT. Often times, the end of involvement from CPS can mean that a child and family need more support from the CFT in order to remain successful. Indicators that show a family may no longer need the support of the behavioral health system may include:

1. The presence of a high percentage of CFT members who are from the family's own informal support system
2. The family notes they no longer need the same level of assistance
3. The majority of their supports and services are from resources within their own family and community rather than paid and professional services
4. Frequency of meetings have decreased
5. There are no longer major safety or crisis issues
6. Successful completion of the child and family's goals.

Service Expectations: Child and Family Teams, under the guidance of the behavioral health service provider, develop plans that support the youth/family during times of transition.
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Training and Supervision Expectations

This Practice Protocol applies to T/RBHAs and their subcontracted network and provider agencies for all behavioral health service providers who have direct contact with or provide services to children, adolescents and their families. Each T/RBHA shall establish their own process for ensuring all agency clinical and support services staff working with children and adolescents understands the required service expectations and implements the practice elements as outlined in this document. The service expectations and guidance outlined in this protocol will be incorporated into T/RBHA Child and Family Team trainings. Staff will be trained on the elements of this protocol within the first 90 days of providing direct services.

Behavioral health agency staff must also participate in DBHS designated Child and Adolescent Service Intensity Instrument (CASII) training, education, and technical assistance (see [Provider Manual Section 9.1 Training Requirements](#)). This 6-8 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.

Each T/RBHA is required to provide documentation, upon request from ADHS, demonstrating that all required network and provider agency staff have been trained on the service expectations and guidance contained in this Protocol. Whenever this Practice Protocol is updated or revised, T/RBHAs must ensure their subcontracted network and provider agencies are notified and required staff is retrained as necessary on the changes. In alignment with [A.A.C. R9-20-205 Clinical Supervision](#)

requirements, the supervision for implementation of this Protocol is to be incorporated into other supervision processes which the T/RBHA and their subcontracted network and provider agencies have in place for direct care clinical staff. [Attachment 2: Arizona Child and Family Teams Proficiency Measurement Tool for Facilitation- User's Guide](#) and [Attachment 3-Arizona Child and Family Teams Proficiency Measurement Tool for Facilitation](#) may be used to document an adequate level of skill before a behavioral health service provider engages in Child and Family Team practice facilitation.

Anticipated Outcomes and How they will be Measured

Anticipated outcomes include:

- Increased statewide practice in accordance with the 12 Arizona Principles;
- Improved functional outcomes for children;
- Improved engagement and collaboration in service planning between children, families, community providers and other child serving agencies;
- Improved identification and incorporation of strengths and cultural preferences into planning processes;
- Coordinated planning for seamless transitions.

Outcomes will be measured through the use of one or more of the following:

- Consumer/family satisfaction surveys
- T/RBHA reviews of CFT practice
- Random audits completed by ADHS/DBHS
 - Administrative Reviews (chart reviews)
 - Monitoring and Oversight Department audits (chart reviews)
 - Morbidity/Mortality reviews

How will Fidelity be Monitored?

Fidelity will be monitored by:

- The CFT Practice Review Process
- Review of T/RBHA documentation of training for network and provider agencies
- T/RBHA monitoring and supervision
- Audits completed by ADHS/DBHS
 - Administrative Reviews (chart reviews)
 - Monitoring and Oversight Department audits (chart reviews)
 - Participation by DBHS staff in T/RBHA site/record reviews

Child and Family Team Practice Desktop Guide

Service Expectations:

- CFT practice requires that all nine activities of effective practice be implemented to ensure the 12 Arizona Principles are appropriately incorporated into service delivery for all enrolled children and their families.
- The behavioral health service provider begins the engagement process with the child and family at the time of first contact and provides a clear explanation of CFT practice. Accommodations such as scheduling and location of appointments or transportation needs are addressed. Engagement practices are evident throughout all subsequent work with the child and family.
- The CASII shall be completed by the behavioral health service provider, who is trained and certified, in collaboration with the child/adolescent and family, and other members of the CFT. The CASII shall be completed as part of the initial 45 day assessment period and every six months thereafter.
- The composite score and date of CASII administration shall be entered into the Client Information System.
- The CASII will not be used to determine eligibility for specific levels of care, types of services, or particular service models.
- Along with the child and family, the behavioral health service provider identifies any risks that require immediate intervention. Immediate crisis stabilization takes precedence over all other assessment and planning activities. Crisis stabilization is addressed through the development of a crisis stabilization plan that utilizes services which work in conjunction with the child/family's strengths.
- The behavioral health service provider is responsible for completion of the initial Strengths, Needs and Culture Discovery within 45 days of the intake appointment.
- The behavioral health service provider ensures all persons needed for planning are included, engaged and invited to CFT meetings. The behavioral health service provider also serves as facilitator of meetings if the CFT requests, handles the logistics for scheduling team meetings, obtains the appropriate consents/releases of information and provides documentation of CFT meeting activities to all members.
- The behavioral health service provider facilitates the CFT development of a Behavioral Health Service Plan which incorporates the family's preferences, strengths and culture in alignment with their vision for the future. The Service Plan identifies formal services and natural supports that address the identified needs as well as the methods to monitor progress.
- When identified as a need, the behavioral health service provider facilitates crisis planning when there are identified risks and/or safety concerns that threaten the stability of a child in his/her community setting. Effective crisis planning includes the elements noted in this protocol. A Crisis plan is required for all children identified at Service Intensity levels 3, 4, 5, or 6.
- The behavioral health service provider is responsible for securing and implementing the covered behavioral health services identified in the Service Plan.
- The behavioral health service provider ensures implementation and effectiveness of service and crisis planning through CFT facilitation of tracking and monitoring activities. Lack of progress in reaching identified goals or ineffective services and supports require modifications to the Crisis and Service Plans, in alignment with behavioral health policy requirements.
- Child and Family Teams, under the guidance of the behavioral health service provider, develop plans that support the youth/family during times of transition.

❖ Key elements to remember about this best practice:

- ADHS intends the 12 Arizona Principles to be universally applied to all enrolled children and families through the use of Child and Family Team practice.
- The 12 Principles are: Collaboration with child/family, functional outcomes, collaboration with others, accessible services, best practices, most appropriate setting, timeliness, services tailored to the child/ family, stability, respect for the child/family's unique cultural heritage, independence, and connection to natural supports.
- There are nine essential activities that create effective CFT practice: Engagement, Immediate Crisis Stabilization, Strengths, Needs and Culture Discovery, CFT Formation, Service Plan Development, Service Plan Implementation, Ongoing Crisis and Safety Planning, Tracking and Adapting, and Transition.
- The key factor that establishes a best practice is high fidelity implementation of the essential phases and underlying principles of the practice model. Fidelity to this protocol is essential for insuring this is a best practice and achieves the outcomes desired.

❖ Benefits of using this best practice:

- Promotes overall children's behavioral health system transformation and increased statewide practice according to the 12 Arizona Principles;
- Improved functional outcomes for children;
- Improved engagement with children and families;
- Improved identification and incorporation of strengths and cultural preferences into service planning;
- Coordinated transition out of behavioral health services and into the adult behavioral health system.