

1 **II. Qualifications**

2 5. From 1997 until 2001, I was a child protection services specialist in
3 the Arizona Child Protective Services which is part of the Arizona Department of
4 Economic Security. Before I became a child protection services specialist, I held
5 positions as a behavioral health technician, a teacher, and a direct service worker in
6 a group home for developmentally disabled adults. My curriculum vita is attached
7 as Exhibit A to this declaration.

8 6. From 2001 through 2003, I was the System of Care Developer at
9 ValueOptions Arizona. ValueOptions is a national for-profit company, which
10 develops and implements publicly managed behavioral health. The State of
11 Arizona does not directly run its behavioral health system; rather, it contracts with
12 several companies to manage and deliver mental health services. ValueOptions is
13 one of these companies. ValueOptions operates the Maricopa County service
14 system, which includes Phoenix, and is the largest service system in the State of
15 Arizona.

16 7. My responsibilities at ValueOptions included serving as the liaison
17 between ValueOptions and Arizona's child welfare system (Child Protective
18 Services). In that capacity, I worked extensively with the state agency
19 administrators and front-line agency staff, clinicians, community agencies and
20 families. I also helped to develop training materials for the Arizona mental health
21 care and child welfare systems on wraparound services. I also coached
22 wraparound team facilitators across most of Arizona.

23 8. After leaving ValueOptions in 2003, I co-founded and became the
24 President and Chief Executive Officer of Child and Family Support Services
25

1 (“CFSS”). CFSS was formed to help sustain the Child and Family Team process¹
2 movement that was occurring in Arizona as a result of the implementation of the
3 J.K. settlement agreement.

4 9. CFSS has three distinct roles. First, it is service provider for children
5 with serious mental health needs. It provides in-home and community-based direct
6 support services for children who have special behavioral health or developmental
7 needs. CFSS uses the unconditional care approach for working with children and
8 families. These services include, living skills/social skills, positive behavioral
9 support/behavioral improvement programs, in-home counseling geared toward
10 preserving a placement or returning a youth to a placement. Further, because of
11 CFSS’s experience, CFSS often is asked to facilitate particularly tricky Child and
12 Family teams. In addition to providing direct services, CFSS also provides
13 extensive technical assistance such as training and support for the work of child
14 and family teams implementing and working with wraparound services in Arizona.

15 **III. The Use of Child and Family Teams in Arizona Developed out of**
16 **the Twelve Principles of the J.K. Lawsuit**

17 10. The settlement of J.K. v. Eden, a class action lawsuit filed on behalf
18 of all Arizona children seeking Medicaid mental health services, was the beginning
19 of the use of wraparound services in Arizona.

20 11. When the J.K. lawsuit settled, the State of Arizona agreed to reform
21 its children’s mental health services in accordance with twelve principles. The
22

23 ¹ In Arizona, wraparound services are referred to as the “Child and Family Team process” or just
24 “Child and Family Teams.” When I use this language in this declaration, I am referring to the
25 provision of wraparound services.

1 settlement's twelve principles are set out in Exhibit B hereto. In order to
2 implement the twelve principles, Arizona employed the use of Child and Family
3 Teams to create and put into action service plans for children with mental health
4 needs.

5 12. Among those twelve principles most directly related to wraparound
6 services are the following: (1) collaboration with the child and family; (2)
7 functional outcomes (meaning services are designed to aid children to achieve
8 success in school, live with their families, avoid delinquency and become stable
9 and productive adults); (3) collaboration with others (which requires a
10 collaborative multi-system plan for each child who is involved with multiple
11 agencies); (4) accessible services (including that children must have access to a
12 comprehensive array of services within their own homes or communities) and (5)
13 "best practices," (meaning a focus on quality services which rest on a strong
14 evidence-base), which includes the use of wraparound services.

15 13. When implementation of the J.K. settlement began, the state gave
16 priority to developing wraparound services for children in the state's foster care
17 system. As part of making wraparound care services the core of the mental health
18 service system in Arizona, the state adopted a Practice Improvement Protocol,
19 attached as Exhibit C hereto, in August, 2003. As stated in this protocol, although
20 implementation of wraparound services initially focused on children with the
21 "most complex needs," the state has now announced it will "use the Child and
22 Family Team process with every child" that is enrolled in the behavioral health
23 system. Protocol, Exhibit C, at p. 2.

24 14. Development of wraparound programs in Arizona was both a "top
25 down" and a "bottom up" effort. At the top, it was agreed that the state's Medicaid

1 agency, the Department of Health Services, would fund wraparound services.
2 Development from the "bottom" up included recruiting and training service
3 providers. The technical assistance document used for the wraparound care system
4 in Arizona is attached hereto at Exhibit D.

5 **IV. Wraparound Services are Essential Mental Health Services for**
6 **Arizona Children**

7 15. At the core of the children's mental health system in Arizona are
8 multidisciplinary child and family teams, which conduct a unique and
9 comprehensive assessment of each child, and then develop a treatment plan
10 oriented to improving the child's functioning in school, in their families and in
11 their communities. A broad array of services is available and we have worked hard
12 to makes services comprehensive in Arizona.

13 16. Usually, child and family teams are convened by a facilitator, for
14 whose work Medicaid pays. For children with less intense needs, a clinician, or in
15 some cases, a family member serves as the facilitator of team. Teams usually
16 meet from once a week to once a month, depending on the intensity and urgency of
17 the child's needs. Children ages 12 and older usually participate in the teams.

18 17. The professional members of wraparound service teams include
19 psychiatrists, psychologists, social workers, and direct service workers. The direct
20 service workers work with children to teach them self-care skills, provide in home
21 support and carry out the behavioral plan the team develops for the child and
22 family. Informal supports, such as coaches, clergy, volunteer organizations and
23 cultural groups, are also an important component of wraparound services and are
24 often are members of the wraparound team.

1 18. The team develops an intervention plan, which lists the type of natural
2 and professional support services that are needed. The funding of these services is
3 discussed in the following section.

4 **V. Wraparound Services are Funded by Medicaid in Arizona and**
5 **are Available for all Children Enrolled in the Behavioral Health System.**

6 19. Arizona's Medicaid agency funds the work of the child and family
7 team and pays for most of the services the child and family team identifies as
8 necessary for the child in the wraparounds services plans. The principal services
9 Medicaid does not pay for are school-related services, like reading tutors, which
10 are funded by the school system, and some "flex funds" for unconventional support
11 such as buying gas cards for family members or a dishwasher for a family's home.
12 On the other hand, Medicaid does pay for any decision made by the team that a
13 child needs behavioral health services, including, but not limited to, case
14 management, direct services, behavioral aides, and therapy.

15 20. In Arizona, wraparound services are available to all children with
16 serious mental health needs who are Medicaid-eligible (which includes virtually all
17 children in the state foster care system). In addition, the state is now making
18 wraparound services available to all Medicaid eligible children who are enrolled in
19 the behavioral health system. There are many reasons why Arizona decided to
20 extend wraparound to all children, including family satisfaction with the services,
21 the generally shared view that these services are effective services for the children
22 receiving them, and the desire to have one consistent statewide system. Initially,
23 wraparound services were used as part of a pilot program to gather evidence of
24 effectiveness for children with intense needs. Governor Janet Napolitano,
25 governor of Arizona, declared the pilot program a success for the three-hundred

1 children involved and supported extending the program to benefit all children
2 eligible for Medicaid and enrolled in behavioral health services. (Governor Janet
3 Napolitano, January 29, 2003).

4 **VI. Cost Effectiveness of Wraparound Services**

5 21. I am aware of at least one case in which Arizona saved over a million
6 dollars that otherwise would have been spent on inpatient psychiatric or residential
7 care for a child who, because the wraparound approach was successful and was
8 able to be cared for in his own community.

9 22. This case involved a twelve-year-old boy who had been residing in in-
10 state residential treatment. Since the in-state residential treatment center failed to
11 meet the child's needs, Arizona was considering sending him to an out-of-state
12 placement. Instead, the boy received wraparound services. Within nine months,
13 the child and family team successfully returned the boy to his home. Child and
14 Protective Services initially said his parents would never manage to keep him at
15 home. However, the boy has been living at home for half a year. Of course, there
16 are times when he struggles and may experience a need for increased services in
17 the home, but he has not had to leave the home for any significant period of time
18 since his participation in wraparound services.

19 23. In many other cases, less dramatic but nevertheless impressive cost
20 savings have been demonstrated through the use of wraparound services. For
21 example, there are several children where the main focus is to keep them out of
22 out-of-home settings. Specifically, there is a fifteen year old girl who was living in
23 a therapeutic group home at the cost of \$300 a day. Instead of removing the
24 fifteen-year-old girl from her home-based placement and placing her in a
25 residential treatment center, Arizona decided to invest in her family placement. At

1 the beginning of the wraparound services process, she received over sixty-hours a
2 week of services. After several months, she only needed about ten hours a week of
3 behavioral health services. Today, she receives her services through community
4 activities and receives support from her parents, who have been trained to help her
5 manage her behavior.

6 24. Over time, when wraparound services are used effectively, the child's
7 reliance on behavioral health services decreases and/or shifts to the child's natural
8 and family-based support system. Correspondingly, the amount of Medicaid
9 dollars invested in such children decreases over time.

10 **VI. Therapeutic Foster Care in Arizona**

11 25. The availability of therapeutic foster care is a crucial part of the
12 wraparound process and families we serve have benefited from therapeutic foster
13 care. Although I have not specifically been involved in the expansion of
14 therapeutic foster care in Arizona, I am aware that use of therapeutic foster care is
15 an important element of the Arizona

16 26. An Annual Title XIX (Medicaid) Action Plan for Children's
17 Behavioral Health is prepared each year by the Arizona Department of Health
18 Services and the Arizona Health Care Cost Containment System as part of the J.K.
19 settlement. The most recent action plan is attached hereto as Exhibit E. This
20 Action Plan describes the current implementation in Arizona of both wraparound
21 services and therapeutic foster care.

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23 I declare under penalty of perjury under the laws of the State of California
24 that the foregoing is true and correct.

25 Executed on 25 August 2005 in Tempe, AZ by Timothy Penrod.

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Timothy Penrod

Timothy W. Penrod
4700 S McClintock Suite 140, Tempe AZ 85282

Education

2001 University of Phoenix Phoenix, AZ

- Master of Counseling - Marriage, Child & Family Therapy

1996 Brigham Young University Provo, UT

- Bachelor of Science – Family Science

Professional Experience

March 2003 – Present; Child & Family Support Services, Inc.

President/CEO

- Co-founder of Behavioral Health Service Outpatient Clinic and consultation agency
- Managed general affairs of all business operations
- Child and Family Team facilitation and training
- Consultation across the state of Arizona in Child & Family Team practice and community service provision for children with special needs
- Advisor to regional and state workgroups for system of care development
- Community trainings on effective utilization of teams to provide effective care
- Consultant for practice change to Arizona State Hospital: Adolescent Treatment Unit

March 2001 – March 2003 ValueOptions Phoenix, AZ

System of Care Developer and Interagency Liaison to Child Protective Services

- Facilitated intensive Child & Family Teams
- Coached new facilitators in Child & Family Team process
- Assisted in development of job descriptions congruent with Child & Family Teams and the principles of the Arizona Vision
- Provided training and orientation regarding Child & Family Teams, the principles of the Arizona Vision, and facilitation
- Assisted in the development of supporting paper work for Child and Family Teams
- One of the key authors of the document "Questions & Answers for Facilitators: Maricopa County Child & Family Team Process"
- Assisted in development of barrier resolution process
- Co-designed training curriculum for the "Principles & Overview of Systems Change" training
- Helped lead work group for designing strength-based, family centered comprehensive assessment and treatment plan
- Helped develop case review and family interview tools for measuring integrity to the principles of the Arizona Vision
- Developed comparison grid for family-centered, strengths-based models and a process unifying the models
- Participated in facilitating Child & Family Teams in congruence with Family Group Decision Making and Person Centered Planning processes
- Developed Successes & Barriers tool for system change
- Assisted in developing the bylaws for the Child & Family Teams steering committee
- Helped orient and coordinate efforts of national consultants assisting in the process
- Assisted in coordinating the curriculum between three national consulting agencies, providing congruence with the Child & Family Team process in Maricopa County
- Assisted in development of the Family Involvement Plan

- Participated in training in strength-based supervision, wraparound facilitation, system of care change, and child & family team facilitation
- Helped author the Maricopa County Letter of Agreement in support of Child and Family Teams
- Presented at the 2002 Family Centered Conference

2000 – Present Parenting Skills Program Tempe, AZ

Counselor/Therapist

- Helped develop parent training curriculum
- Presented parent training
- Marriage, Child, & Family Therapist
- Family Preservation Counselor

1997 – 2001 Child Protective Services Mesa, AZ

Case Manager

- Managed several high profile cases in connection with central administration
- Testified in approximately fifteen separate Juvenile Court trials as a witness and participated in proceedings of hundreds of Court hearings
- Helped lead a committee for local area system change
- Commended for facilitation of cases in family centered manner

1997 AHCCMS Phoenix, AZ

Behavioral Health Technician

- Behavioral Health Technician for adult transition site for individuals with serious mental illnesses who were discharged from the Arizona State Hospital and learning to live again in the community
- Medication administration monitoring
- Assisted in development of behavior plans and case planning

1996 -1997 Church Education System Gilbert, AZ

Teacher

- Teacher for high-school adolescents in release time seminary program
- Developed daily curriculum
- Interfaced with teaching staff at Highland High School in Gilbert

1996 Beyond Ones View Chandler, AZ

Direct Service Worker

- Worked as direct care staff at group home for adults with developmental disabilities

1993 – 1996 Missionary Training Center Provo, UT

Trainer/Teacher

- Communication skills trainer/coach for hundreds of students
- Provided large group and small group trainings
- Assisted in curriculum development
- Provided feedback/coaching on training skills

Committees/Work Groups

2005

- Board of Directors for Communities Caring for Families; a community organization that supports Child and Family Team Practice
- Maricopa County Jason K. settlement planning group

2004

- Maricopa County Jason K settlement planning group
- Advisor to CFT Credentialing Committee: Northern Arizona
- Advisor for Ethical Practice Considerations in Behavioral Health Service Delivery

2003

- CFT Curriculum Planning Group – Maricopa County
- Direct Service Planning Group – Maricopa County
- Arizona Department of Health Services Assessment and Service Planning Advisory workgroup

2002

- Family Involvement Planning Work Group
- Comprehensive Assessment Revision Work Group – Maricopa County
- Barriers Workgroup, Maricopa County Child & Family Teams
- Child & Family Team Training Coordination Work Group

2001

- 200 Kids Project / Child & Family Teams Steering Committee
- 200 Kids Project Rollout Work Group
- Chair of 200 Kids Project Structure & Function Workgroup
- Job Description Revision Workgroup

Presentations

- Behavioral Health Clinic Practice Change Using Child and Family Teams, 2003-2005
- Community Based Care Using Child and Family Teams; Presenter, 2003-2004
- Child and Family Team Facilitation Training in Northern Arizona; Presenter, 2003-2004
- Northern Arizona Executive Management Planning Meeting; Presenter, 2003
- Maricopa County Child & Family Team Facilitator Training; Presenter; 2003
- Education Conference for Transitional Planning; Presenter; 2002
- DES Family Centered Practice Conference; Presenter; 2002
- Maricopa County Mental Health Principles & Systems Change Training; 2002
- Child & Family Team Orientation to Maricopa County Juvenile Justice; 2002
- Presentation on case scenario - Program Administrators for DES & DBHS; 2002

Articles/Written Materials

- Child and Family Team Facilitation, Online Training Curriculum; 2005
- Child and Family Team Facilitation for Clinical Liaisons; 2004
- Differences Between CFT Facilitation and Mediation; 2004
- Child and Family Team Facilitation for Case Managers; 2003
- Top Ten Signs About Whether Your Child and Family Team is Family-Driven; 2003
- Family Voice in Social Service System Change; 2003
- Ethical Considerations in Child and Family Team Practice; 2003
- Questions and Answers About Child and Family Team Facilitation; 2002
- Direct Support Workers and Child and Family Teams; 2002
- Maricopa County System Leaders Letter of Agreement; Co-Author with Frank Rider ADHS; 2002
- Comparisons Between Various Models of Strengths-Based Practice; Co-Author with Frank Rider ADHS; 2002

The "Arizona Vision," for children is built on twelve principles to which ADHS and AHCCCS are both obligated and committed. The Arizona Vision 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 family's cultural heritage.

1. Collaboration with the child and family: Respect for and active collaboration with the child and parents is the cornerstone to achieving positive behavioral health outcomes. Parents and children are treated as partners in the assessment process, and the planning, delivery, and evaluation of behavioral health services, and their preferences are taken seriously.

2. Functional outcomes: Behavioral health services are designed and implemented to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Implementation of the behavioral health services plan stabilizes the child's condition and minimizes safety risks.

3. Collaboration with others: When children have multi-agency, multi-system involvement, a joint assessment is developed and a jointly established behavioral health services plan is collaboratively implemented.

Client 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 persons needed to develop an effective plan, including, as appropriate, the child's teacher, the child's Child Protective Service and/or Division of Developmental Disabilities case worker, 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) makes adjustments in the plan if it is not succeeding.

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

5. Best practices: Competent individuals who are adequately trained and supervised provide behavioral health services. They are delivered in accordance with guidelines adopted by ADHS that incorporate evidence-based "best practice." 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 class member's lives, especially class members in foster care. Behavioral Health Services are continuously evaluated and modified if ineffective in achieving desired outcomes.

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

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

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

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

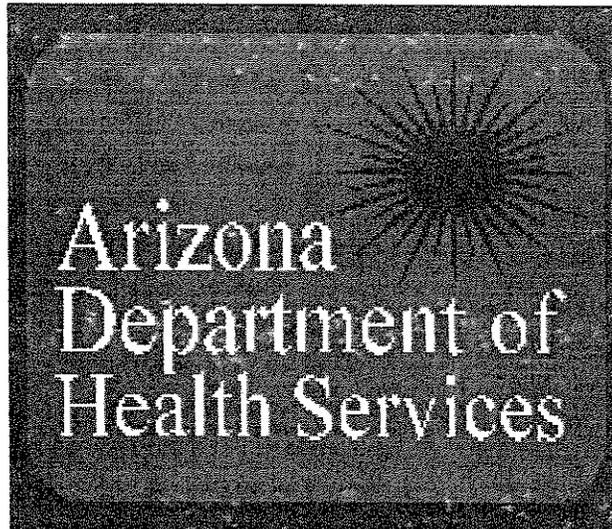
10. Respect for the child and family's unique cultural heritage: Behavioral health services are provided in a manner that respects the cultural tradition and heritage of the child and family. Services are provided in Spanish to children and parents whose primary language is Spanish.

11. Independence: Behavioral health services include support and training for parents in meeting their child's behavioral health needs, and support and training for children in self-management. Behavioral health service plans identify parents' and children's need for training and support to participate as partners in assessment process, and in the planning, delivery, and evaluation of services, and provide that such training and support, including transportation assistance, advance discussions, and help with understanding written materials, will 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.

Practice Improvement Protocol 9

The Child and Family Team



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

**Effective August 13, 2003
Last Revised August 11, 2003**

ADHS PRACTICE IMPROVEMENT PROTOCOL: THE CHILD AND FAMILY TEAM

ISSUE: The assurance that all TXIX and TXXI eligible members under the age of 21 receive behavioral health services in keeping with the 12 Arizona Principles.

PURPOSE: To establish protocols that effectively operationalize the Child and Family Team approach in Arizona.

TARGET POPULATION: All TXIX and TXXI eligible members under the age of 21 receiving behavioral health services through the T/RBHA system.

BACKGROUND: ADHS is committed to the provision of behavioral health services to children through family-centered practice. Such practice is based upon a coordinated, flexible, family-driven process that:

- Explores and documents the strengths and needs of a child and family;
- Establishes and prioritizes service goals;
- Identifies the supports necessary to meet those goals;
- Describes a course of action encompassed in a written plan developed by team members;
- Monitors accomplishments; and
- Determines the responsibilities of all team members in these efforts.

DEFINITIONS:

- **Child and Family Team:** The Child and Family Team is a group of people that includes, at a minimum, the child and his/her family, any foster parents, a behavioral health representative, and any individuals important in the child's life and who are identified and invited to participate by the child and family¹. This may include, for example, teachers, extended family members, friends and other natural supports, family support partners, healthcare providers, coaches, community resource providers, representatives from churches, synagogues or mosques, agents from other service systems like Child Protective Services or the Division of Developmental Disabilities, etc. The size, scope and intensity of involvement of the team members are determined by the objectives established for the child, and by which individuals are needed to develop and coordinate an effective service plan, and can therefore expand and contract as necessary to be successful on behalf of the child.
- **Clinical Liaison:** As the concept applies to the Child and Family Team, a Clinical Liaison is a Behavioral Health Technician or Behavioral Health Professional who has met ADHS credentialing and privileging standards and whose responsibilities are to support the family in the development of the Child and Family Team, to provide clinical oversight and consultation to the Child and Family Team process and to advise the team on services, natural supports and

¹ In the case of children who may be legally dependent or delinquent, the custodial agency participates in the selection of team membership with the child and family.

providers whose involvement may benefit the team. Clinical liaisons are the individuals also responsible for performing the initial core assessment when additionally privileged to do so. A Clinical Liaison will be involved with every Child and Family Team.

- **Family:** The primary care-giving unit, inclusive of the wide diversity of primary care-giving units in our culture. Family therefore is a biological, adoptive or self-created unit of people residing together and consisting of adult(s) and children, with adult(s) performing duties of parenthood for the children. Persons within this unit share bonds, culture, practices and significant relationships. Biological parents, siblings and others with significant attachment to the individual living outside the home are included in the definition of family.

PROCEDURES:

1. WHICH CHILDREN SHOULD HAVE CHILD AND FAMILY TEAMS?

While the original development of the Child and Family Team process has focused on children and families with the most complex needs, the intent of ADHS is to universally apply the Twelve Arizona Principles, and to use the Child and Family Team process with every child. The character of the team will vary based on the goals, needs and strengths of each child and family. As such, each team will be structured and will function in a unique and flexible manner that will require varying levels of involvement from the Behavioral Health system, other child-serving agencies, and other natural supports.

A further goal is to educate, support and empower families to eventually facilitate their own teams. Until the system has matured to this point, many situations (particularly those serving multi-system involved families, children in out-of-home placements, children transitioning into the adult system, children whose placements are at risk, or children whose service plans have been unsuccessful) will likely require teams with greater complexity, and even designated facilitators. A designated facilitator should be provided to any team requesting one.

2. HOW DO CLINICAL LIAISONS AND OTHER BEHAVIORAL HEALTH REPRESENTATIVES SUPPORT THE WORK OF THE CHILD AND FAMILY TEAM?

When a child and family enter the behavioral health system, the individual completing the initial core assessment assumes the role of Clinical Liaison. During the initial assessment, the Clinical Liaison begins to work with the child and family to develop and support the Child and Family Team, and provides clinical oversight and consultation for the Child and Family Team as an active team member. The Clinical Liaison completes any remaining unfinished necessary assessment processes, modules or addenda. After the next steps for initial services have been decided at the initial core assessment, the Clinical Liaison continues to participate in a consultative role for as long as services are provided. If the identified needs of the child and family so require, the Clinical Liaison may transfer those responsibilities to a different Clinical Liaison who may be better fitted and available to work with them on a long-term basis. In cases

where therapy is being provided, the Clinical Liaison will most likely be the therapist providing services to the child and family.

Each Child and Family Team shall have an assigned behavioral health representative as an active member. This representative may be a Behavioral Health Professional, a Behavioral Health Technician or a Para-Professional, and is responsible for assisting the Child and Family Team in treatment planning, securing behavioral health services, and any other processes requiring involvement or facilitation from the behavioral health system. In most cases, the behavioral health representative will be the Clinical Liaison for that Child and Family Team. With the assistance of the behavioral health representative, the Child and Family Team completes the Strengths and Culture Discovery and assumes responsibility for overseeing and facilitating decision-making regarding the child's behavioral health services and other identified areas of need.

Families have a powerful role in the Child and Family Team process, actively participating in the process of assessing needs, identifying team members, developing and implementing the plan. A key element of enlisting the family's participation is engaging the family with warmth, empathy, genuineness and respect.

The Child and Family Team is responsible for the supportive aspects of service provision and determines which of its members will oversee:

- Ongoing revisions as necessary to the assessment and treatment plan;
- Collaboration with other child-serving agencies or individuals identified as supports to the treatment process;
- Communication within the Child and Family Team;
- Ensuring the maintenance of continuity of care between behavioral health care providers and primary care providers and out-patient and in-patient behavioral health care providers; and
- Ensuring that appropriate covered services and supports are provided.

If the behavioral health representative is not also the Clinical Liaison for the Child and Family Team, their respective responsibilities will be coordinated.

3. WHAT AUTHORITY DOES THE CHILD AND FAMILY TEAM HAVE IN SECURING SERVICES?

The Child and Family Team, with the assistance of the behavioral health representative, is responsible for overseeing and facilitating decision-making regarding the child's behavioral health services. Based upon the recommendations and decisions of the Child and Family Team, the behavioral health representative will formally secure any and all covered services (barring the exceptions listed below) that will address the needs of the child and family. The Child and Family Team is expected to carefully consider and give substantial weight to family preferences in formulating its views on the developing service plan, *acknowledging the family's expert knowledge of their child.*

In determining how to successfully meet its objectives, the Child and Family

Team should not begin by identifying specific interventions, placements or services, but rather on the underlying needs of the child (and of the family in providing for the child) and on the type, intensity, and frequency of supports needed. As long as decisions are based on comprehensive reviews of the strengths and needs of the eligible child, are in accordance with the Twelve Principles of the Arizona Vision, and have objective and measurable outcomes, the RBHA should provide all covered services decided upon by the Child and Family Team with the following exceptions:

- Level I services which must be prior authorized in accordance with ADHS' policy on prior authorization.
- Covered services that the ADHS/DBHS Medical Director has approved for T/RBHA prior authorization processes in accordance with ADHS' policy on prior authorization.
- Service recommendations that the Clinical Liaison believes to be inconsistent with the Twelve Principles. In such a case, the Clinical Liaison attends all Child and Family Team meetings and actively participates in the service planning process until consensus is reached on a new plan that meets the needs of the child and the family.
- Services not covered by TXIX and TXXI funds.

4. WHAT ARE THE NON-NEGOTIABLES?

Other child-serving systems maintain processes that closely approximate the Child and Family Team process. Although they may use different terminology, (e.g. Person-Centered Planning Processes in developmental disabilities, or Family-Group Decision making processes in child-welfare), these processes can be embraced by the Behavioral Health System as legitimate Child and Family Team processes. What distinguishes a legitimate Child and Family Team process (by any name) is its inclusion of each of the following "non-negotiable" and distinct elements:

- **Strengths and Needs-Based Planning.** A Strengths and Culture Discovery is to be completed for each child and family. This discovery becomes part of the foundation for treatment planning. All services should be customized to creatively reflect the child and family's unique culture and individual strengths in addressing the behavioral health needs of the child.
- **Partnerships with Families.** All plans resulting from the Child and Family Team process must incorporate identified strengths and address the identified behavioral health needs of the child and family. Professional members of the team must therefore be active partners with family members, ensuring that all agreed-upon plans reflect their values, priorities, strengths and needs. An initial goal of the process may therefore be to assist the family in discovering and articulating these factors.
- **Consensus.** All Child and Family Teams strive to reach consensus on the needs of the child and family, on the findings of the assessment process and on the service plan. No decision of the Child and Family Team is to be made

without the approval of the parent or guardian, or, when appropriate, of the child or adolescent him/herself.

- **Jointly Established Behavioral Health Service Plans.** When children have multi-agency, multi-system involvement, a joint assessment is developed and a jointly established behavioral health service plan is collaboratively implemented.
- **Natural and Informal Supports.** Although Child and Family Team membership may vary with changing needs and developing strengths, teams are encouraged to strive towards memberships that are at least 50% natural and informal supports.
- **Collaboration.** Cooperation must be sought beyond the family itself and from other involved agencies, and from the community at large. The team should strive to promote positive connections with all the community has to offer rather than, for example, relying solely on paid supports. When children and families are involved with multiple child-serving systems at once, then collaboration demands the team's full respect for the societal mandates of each involved system (e.g. safety, for child welfare; learning, for education).
- **Ongoing Assessment.** The underlying needs and strengths of each family must be continually reassessed and addressed on an ongoing basis. While the *initial* assessment will always be completed within 45 days after the child and family enter the behavioral health system, the assessment process, including the Strengths and Culture Discovery, must be a continual, evolving course of action, and treatment planning an open-ended process. The Child and Family Team serves as the key point in making adjustments as may be needed to ensure successful goal attainment.
- **Child-Family Team Participation in All Decisions that Affect Them.** Providers must by necessity be able to interact, communicate and consult in the absence of a Child-Family Team. However, no meetings that result in decisions affecting the child and family should occur without the family's full participation. Decisions affecting substantive changes in service delivery should not be made without the participation of the full Child and Family Team.
- **Crisis Planning.** The Child and Family Team develops a crisis plan that predicts the most likely worst case scenario, includes strategies intended to prevent or mitigate that scenario, and a specific plan for what will happen if the crisis nevertheless occurs. Crisis planning seeks only to stabilize the crisis, not to change the overall plan; and incorporates family, friends and natural supports, as well as formal supports if necessary.
- **Flexibility that Avoids Redundant Processes.** Child and Family Teams must be flexible, and when necessary adapt their processes to accommodate parallel processes like DES Family Decision Making or permanency planning meetings, DDD Person-Centered Planning Meetings and Individualized Education Plan (IEP) meetings in special education.

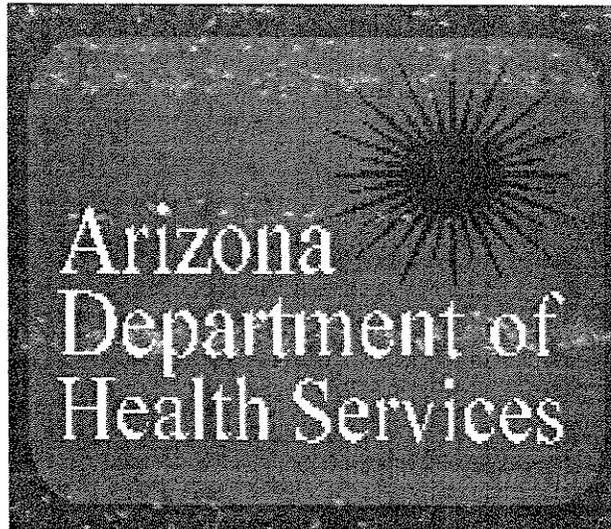
- **Single Point of Contact.** One member of the Child and Family Team is assigned as the single point of contact, and assumes responsibility for coordinating information exchange among Child and Family Team members and providers regarding the provision of service.
- **Cultural Competency.** The Child and Family Team process, from the facilitation of Child and Family Team meetings to the provision of services, should be culturally competent and linguistically appropriate, building on the unique values, preferences and strengths of the child and family and of their community.

5. WHEN DOES THE CHILD AND FAMILY TEAM END?

The Child and Family Team process will be used with all children, regardless of the intensity of their needs. Although the character, frequency, and intensity of the process will vary over time and with changing family needs, the Child and Family Team does not "end" before the child is disenrolled from services or transitioned to the adult system (at which point, ideally, and according to need, the process will continue). Before any child is disenrolled, a crisis plan should be developed that outlines the specific steps that are to be taken to reconvene the Child and Family team, re-establish services and supports should it become necessary. Even at the point that behavioral health services are no longer necessary, or provided through the T/RBHA system, ADHS envisions the ongoing use of the skills, values and activities reflected in the Child and Family Team process.

Technical Assistance Document 3

THE CHILD AND FAMILY TEAM PROCESS



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

**Effective September 17, 2004
Last Revised September 17, 2004**

Purpose

To define and describe the steps of the Child and Family Team process, and ADHS expectations for application of this approach with every enrolled child. This information is intended to operationalize The Child and Family Team Practice Improvement Protocol and to support (but not substitute for) specific teaching/coaching on the Child and Family Team process.

Targeted Population(s)

All TXIX and TXXI eligible members under the age of 21 receiving behavioral health services through the T/RBHA system.

Definitions

Child and Family Team (CFT) - a group of people that includes, at a minimum, the child and his/her family, any foster parents, a behavioral health representative, and any individuals important in the child's life and who are identified and invited to participate by the child and family. This may include, for example, teachers, extended family members, friends and other natural supports, family support partners, healthcare providers, coaches, community resource providers, representatives from churches, synagogues or mosques, agents from other service systems like Child Protective Services or the Division of Developmental Disabilities, etc. In the case of children who may be legally dependent or delinquent, the custodial agency participates in the selection of team membership with the child and family. The size, scope and intensity of involvement of the team members are determined by the objectives established for the child, and by which individuals are needed to develop and coordinate an effective service plan; and can therefore expand and contract as necessary to be successful on behalf of the child.

Child and Family Team (CFT) Facilitator – a person who ensures that the 12 Arizona Principles and the steps of the Child and Family Team process are delivered in a timely and effective way for the child and family, with high fidelity to and appropriate individualization of this process. A behavioral health representative – most often the Clinical Liaison -- will usually assume the role of CFT facilitator, but any member of the Child and Family Team can potentially do so.

Procedures - Steps in the CFT Process:

Nine essential steps make up the CFT process:

1. Engagement of the Child and Family
2. Immediate Crisis Stabilization
3. Strengths, Needs and Culture Discovery
4. CFT Formation
5. Behavioral Health Service Plan - Development
6. Behavioral Health Service Plan - Implementation
7. Ongoing Crisis and Safety Planning
8. Tracking and Adapting
9. Transition

The steps of the CFT process are not strictly linear, and are managed by the CFT facilitator based on the immediate needs and preferences of the child and family. (Examples of billing/encounter codes supporting each step in this process are included at the end of this document as Attachment 1.)

Step 1: Engagement of the Child and Family

"Engagement" is the active development of establishing trust in the helping relationship based on personal attributes including empathy, respect, genuineness and warmth.¹ The success of the CFT process depends on a foundation of trust that is built on effective engagement. The CFT process is a partnership, and engagement is the beginning of that partnership.

When and how should engagement of the child and family begin?

Engagement begins during the very first contact between the person/family and the behavioral health system. The behavioral health representative who first communicates with the child/family or other referral source is welcoming, engaging, non-judgmental, and responsive (including attentive to any immediate needs). From the beginning, all behavioral health representatives interact with the child/family or other referral source with respect and compassion, taking responsibility to understand any accommodations (e.g. in scheduling, location of appointments, child care or transportation needs) that may be required to support their engagement. This stance is maintained through any intake, early assessment, crisis stabilization and next steps/interim service plan activities that may precede formation of the CFT.

Engagement is evident during the Clinical Liaison's very first communication with the child and family. Whether in person or by telephone, that initial communication usually includes a short, clear explanation of the CFT process, avoiding the use of professional/system jargon. The Clinical Liaison sets a meeting with the child and family for a time and at a place of convenience for them, encourages the participation of additional family members and close family friends, and determines if additional assistance (e.g. family support services) are required to support their engagement in the process. There is no firm rule about the length of engagement conversation.

The first meeting continues the engagement process. The Clinical Liaison strives to get to know the child and family better and promotes the development of trust through *conversation* -- not a structured interview. The Clinical Liaison encourages the family to share its story through compassionate listening. The Clinical Liaison explores the primary family needs, long-term vision, and potential short-term goals that might become part of the developing service plan. While primary needs may require quick action (see Step 2), the Clinical Liaison 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.

Step 2: Immediate Crisis Stabilization

Crisis stabilization describes actions that address concerns about immediate safety, security and well-being such as those relate to medical needs, severe psychiatric symptoms, homelessness, behaviors of a child that might place others in jeopardy, or ongoing domestic violence. Any child entering foster care because of abuse or neglect is considered to be in crisis, due not only to the abuse or neglect, but also to the trauma of removal from one's family, and the needs of the child and the child's new caregivers to adapt to their new situation together. In addition to the immediate relief of existing concerns, crisis stabilization attempts to predict potential areas of crisis that may require preventive measures, stabilization, and clearly identified steps to respond should a future crisis occur.

¹ Vroon VanDenBerg LLP, *The Basics of the Child & Family Team Practice Model*, Arizona 2003

When and how should immediate crisis stabilization be accomplished?

For a child or family in great distress or immediate peril, crisis stabilization takes precedence over all other assessment considerations. Safety issues and crisis situations often include concerns about the child being in a potentially unsafe environment (child protection), or about the child potentially placing others in jeopardy (community safety). Other child serving systems (e.g. child welfare, juvenile probation) that may already be involved, may already have developed a safety plan, or may have initiated the child's referral to the behavioral health system, and are expected to be invited to help shape crisis stabilization and safety plans. The initial assessment helps the Clinical Liaison to identify safety issues, crisis situations and any needs for particular assistance (e.g. family support) by formulating the Next Steps/Interim Service Plan. The crisis stabilization plan includes specific objectives and strategies to support the design and timely availability of all necessary supports and interventions. When assistance may be needed to stabilize a crisis, it is the Clinical Liaison's responsibility to secure it.

Step 3: Strengths, Needs and Culture Discovery

The Strengths, Needs and Culture Discovery is the transition from immediate crisis stabilization to information gathering that will support service planning and delivery. It provides essential information from which to build strength-based, customized individual service plans that respect the unique cultures of children and their families. It is arguably the most important step in the CFT process. It allows the CFT to develop options, and ultimately a highly individualized plan that is likely to "fit" with *this* child and family in a way that attracts their commitment to and investment in its success.

By identifying strengths, assets and sources of support, the Strengths, Needs and Culture Discovery expands the array and volume of resources available to the team beyond formal, categorical services.

What are the specific purposes of the Strengths, Needs and Culture Discovery?

There are three overall goals of the Strengths, Needs and Culture Discovery:

1. Identify strengths, assets, and resources that may be mobilized to meet family needs for support.
2. Learn about and understand the culture of the family so the eventual CFT plan "looks like" and "feels like" the family (i.e. is culturally sensitive, and therefore likely to be a plan the child and family will support and participate in).
3. Record the child and family vision of a desired future, and any needs that must to be initially satisfied to begin achieving this desired future. A clear vision provides the context for what the child and family will work to achieve. Needs are immediate areas of focus, usually identified by the child and family.

Needs should not be framed in terms of formal services. Needs are sometimes primary (e.g. medical attention, shelter), but usually identification of needs will stem from the behaviors seen by the family or team as problematic, and from exploring the reason for/function of such behaviors.

Although the Strengths, Needs and Culture Discovery should examine all of the family's major life domains (e.g. family, social, residential, behavioral/emotional/psychological, spiritual, cultural, educational/vocational, safety, legal, health, financial, recreational), needs are not expected to be identified in every domain explored. People and families tend to identify needs they are experiencing in only one or two domains at a time. Once initial needs are addressed (and/or new strengths and resources identified), then additional needs are likely to be identified.

A thorough Strengths, Needs and Culture Discovery allows the service plan to include strength-based options that reflect the culture of the family. Rather than focusing exclusively on "fixing" the child's problems (an approach which has likely already failed) this process allows the CFT to identify the unique skills, talents, interests and resources that the child and family can engage and enhance to overcome and compensate for the deficits that may exist. This will better allow the child and family to create more meaningful and longer lasting change than would a deficit-based approach.

When and how should one facilitate the Strengths, Needs and Culture Discovery process?

The Strengths, Needs and Culture Discovery begins with an interview. Although the length may vary, the interview generally takes between one and two hours. It may occur over several sessions. The interview is conducted in a safe and comfortable place, and at a convenient time, as chosen by/with the family. Individuals who know the child and family well enough to substantially contribute should be invited to participate in the Strengths, Needs and Culture Discovery interview.

The findings of the Strengths, Needs and Culture Discovery interview are recorded in narrative format. (The Family/Community Involvement Addendum may seem similar to, but does not alone complete, the Strengths, Needs and Culture Discovery interview.) The Clinical Liaison provides the written discovery to the family and other participants for review in a follow-up meeting. Additional strengths often occur to the family after the interview that they would like to add to the discovery. Such additions can be made to the Strengths, Needs and Culture Discovery at any time. Families are asked to check the document for accuracy. It is recommended that the written discovery document be completed within three business days of completion of the interview, as the richness of the interview may be lost if extended longer.

What is the relationship between the behavioral health assessment and the Strengths, Needs and Culture Discovery?

When a child enrolls in the behavioral health system, the initial assessment (refer to [ADHS or T/RBHA specific version of Provider Manual Section 3.9](#)) is completed within 45 days of the child's referral to the behavioral health system. The "core" assessment, usually completed at the initial ("intake") appointment, is intended to identify the immediate needs and strengths of the child/family, and provides a foundation for ongoing assessment. The core assessment is intended to support the development of the CFT itself, and to produce enough information to decide what, when and how initial care ("Next Steps/ Interim Service Plan") should be delivered.

The core assessment and any addenda completed at the initial/intake appointment should serve as building blocks for the Strengths, Needs and Culture Discovery process the Clinical Liaison then carries forward. The complete initial assessment comprises the "core," the Strengths, Needs and Culture Discovery; and any addenda relevant to the child and family.

Strengths, Needs and Culture Discovery is both an event and an ongoing process. As an event, it calls for a planned meeting and interview process with the child, family, and others who know well and care about the family. As an ongoing process, it expects that the CFT will be facilitated to continue to discover family strengths and important aspects of family culture for as long as it supports the child and family. New strengths will frequently emerge as earlier plans are successfully implemented, and should update the narrative document. The narrative document should also serve as a basis for the clinical formulation developed in the initial assessment.

The Strengths, Needs and Culture Discovery process ultimately weaves all information developed in the core assessment and addenda, and sometimes from other documents/collateral information², together with the family's story, and input from members of the team that forms around the child and family.

Due to its importance, a Strengths, Needs and Culture Discovery should be completed for each enrolled child as part of the initial assessment. The Strengths, Needs and Culture Discovery process must therefore be completed within 45 days of the initial/intake appointment.

Step 4: CFT Formation

The size, scope and intensity of involvement of the team members are driven by the objectives established for the child, reflecting those individuals needed to develop and coordinate an effective service plan. A CFT may consist of as few members as the child, a parent and a behavioral health representative. Ideally, it consists of between four and eight members, but expands and contracts as necessary to succeed on behalf of the child and family. Thus, some members of the team may be added or subtracted as the needs and strengths of the child and family change over time.

When and how should one facilitate formation of the CFT?

Building upon information developed during the initial core assessment, the Strengths, Needs and Culture Discovery results in the identification of individuals who care about, know well, and provide support to the child and family, who reflect their values and culture, and who are willing and able to participate. Friends, extended family, neighbors, members of the family's faith community, teachers, social workers, therapists and co-workers might be among those invited to join.

Experience has shown that a team comprised primarily by professionals tends to discourage family voice and choice, and results in a plan that relies solely on existing, formal services, and which fails to closely reflect the individual needs of the child and family. The Clinical Liaison should therefore establish as a goal the recruitment of more natural supports over time. When a child or family appears isolated (e.g. a single parent, a child in foster care), the Clinical Liaison may use genograms or other tools and techniques to help expand the number of team members or potential natural supports. The Clinical Liaison may also identify family support, peer support or other "system" resources that can help the child/family members to exercise effective voice in the CFT process.

In all cases, the Clinical Liaison should contact potential team members identified by the family (or guardian), to explain the CFT process, and the specific reasons they are needed on the team. The Clinical Liaison in attracting identified individuals to join the team will apply many of the same practices and skills described in Step 1: Engagement. Information about the date/time and location of the next team meeting should be shared. Sometimes team members may not need to, or may be unable to, attend every team meeting. In such instances, the Clinical Liaison should discuss the team's meeting agenda with the absent member in advance, and obtain information to be shared at the meeting on the member's behalf. The Clinical Liaison would subsequently call that member after the meeting to advise them of any decisions, outcomes and/or assignments.

Once the CFT is formed, its members will decide who will perform necessary roles over time. The Clinical Liaison may or may not continue to serve as the CFT facilitator.³

² Typically the Clinical Liaison reviews any previous assessments and evaluations, bringing pertinent information to the CFT to consider.

³ The remainder of this document will refer to the "CFT facilitator," recognizing that the team may choose any member – including but not necessarily the Clinical Liaison – to fulfill the responsibilities of the CFT facilitator.

It is clearly expected that the CFT process will shift reliance over time from formally to informally facilitated support. That shift should be promoted and encouraged from early in the CFT process. The CFT facilitator should therefore model the skills needed to facilitate this process, so that team members may become aware of those skills and have opportunities to practice them as the team works together.

Step 5: Behavioral Health Service Plan – Development

A Behavioral Health Service Plan describes the needs, long-range vision and short-term objectives for the child and family, and the services that will best fit their needs. The plan must reflect the family's prioritization of needs, goals and significant cultural considerations; should incorporate pertinent, identified strengths within its strategies; should include clear assignments of team member responsibilities, with timeframes; and should include measures or other means by which the child/family and CFT can monitor accomplishments and progress. In the event that a family member (e.g. a parent) is receiving behavioral health services, the Behavioral Health Service Plan should also include the family member's plan, including involvement and information from the family member's clinical team whenever appropriate. The Behavioral Health Service Plan should serve as a single, unified guide for the child and family, even in cases where the child/family is involved with multiple child-serving systems at once.

The Behavioral Health Service Plan begins with the family's long-term vision of their desired future, and describes a realistic course of action, written so the child and family can understand the short term steps that will help them move forward, building and sustaining a realistic sense of hope. The Behavioral Health Service Plan should set objectives that can be readily accomplished and celebrated within a short timeframe. The intent of this approach is to encourage involvement, achievement and success, continually building on the strengths of the child and his/her family.

The initial Behavioral Health Service Plan should always be completed within 90 days of the child's initial referral to the behavioral health system.

When and how should one facilitate the development of the Behavioral Health Service Plan?

Once the CFT is formed, the team begins to work together to develop a Behavioral Health Service Plan. The first element of plan development is assisting the child and family to identify their needs, and their long-range vision of a desired future. "Long-range vision" might be imagined as the completion to the sentence, "Life would be better (in this domain) if..."

Once the family's prioritized areas are identified, the CFT facilitator then guides the planning process to long-range vision clarification, and short-term goal/objective setting. Long-range vision and short-term objectives can be identified or modified at any point during the CFT process. The modification of long-range vision and short-term objectives should be an ongoing process.

When needs, long-range vision and short-term objectives have been established, the next task of the CFT is to brainstorm strengths-based *options* to achieve the short-term objectives. The CFT facilitator shares the written Strengths, Needs and Culture Discovery narrative with the team members. This not only provides resources with which the team members can work to build realistic and effective strategies – it also can counterbalance any predominantly deficit-based perspectives a team member may have about the child/family, and it further incorporates strengths-based work into the "culture of the team" itself.

What is the essential content of the Behavioral Health Service Plan?

The Behavioral Health Service Plan describes the vision/goals, needs and objectives, and quantifiable measures and interventions, and is stated in the family's language. It is used by the behavioral health system as the format for documenting the plan's required elements. Some of the required elements of the Behavioral Health Service Plan exist to help make the plan more "concrete" – that is, practical and measurable (see Step 8: Tracking and Adapting). In specific cases, the CFT might add other documents to the Behavioral Health Service Plan format (e.g. a daily routine schedule, a specific strategy to address a particular behavior, terms and conditions of probation), to the extent the team feels it helps the child/family or other team members understand, embrace and carry out the plan as intended. All required elements are described in the *ADHS/DBHS Instruction Guide for the Assessment, Service Plan and Annual Update*.

ADHS intends that assessment and service planning be ongoing processes, resulting in plans that are continually changed to meet the changing needs of the child and family. Although technically the Behavioral Health Service Plan in Arizona is good for a maximum of one year, the CFT sets objectives that can be accomplished and celebrated in a much shorter timeframe, and that continually builds on the strengths of the child and family. The initial Behavioral Health Service Plan must be completed within 90 days of the person's initial appointment.

What are the CFT facilitator's essential responsibilities in supporting development of the Behavioral Health Service Plan?

The CFT facilitator bears primarily responsibility for building and sustaining an effective team culture. The CFT facilitator builds on earlier engagement and team formation experiences, and may further help shape the team by inviting its members to propose, discuss and accept ground rules for their work together. The CFT facilitator's own handling of logistics, details and team member interactions all present opportunities to enhance the effectiveness of the CFT. The CFT facilitator's essential skills can be divided into three areas:

1. **CFT Meeting Preparation.** The CFT facilitator informs the child and family of their rights, of the CFT facilitator's duty to report abuse and/or neglect of minors,⁴ and obtains all necessary consents and releases of information prior to the team meeting. The CFT facilitator provides all information and guidance necessary for the development of a service plan. CFTs must be flexible, and when necessary adapt to accommodate parallel processes like Family Group Decision Making or permanency planning meetings (DES-ACYF), Person Centered Planning meetings (DES-DDD) and Individualized Education Plan meetings (special education). Likewise, it would be important to coordinate existing service plans for any other family members through a unified service planning process.

With input from the child, family and others, and after the family has reviewed the information for accuracy, the CFT facilitator prepares the Strengths, Needs and Culture Discovery document for distribution and discussion at the team meeting. The CFT facilitator identifies the priority concerns of each team member, works proactively to minimize areas of potential conflict, and identifies mandates or "bottom lines" of any other involved child-serving systems. With input from the child and family, the CFT facilitator develops an agenda for the team meeting, schedules the meeting at a place and time that is comfortable for the family and

⁴ Any person who reasonably believes that a minor is or has been the victim of physical injury, abuse, child abuse, a reportable offense or neglect that appears to have been inflicted on the minor by other than accidental means shall immediately report or cause reports to be made of this information to a peace officer or to the Department of Economic Security/Child Protective Services (DES/CPS). For further information, consult A.R.S. § 13-3620.

team members. The CFT facilitator attends to family members' needs (e.g. transportation, child care) to enable their full and active participation in the team meeting. The CFT facilitator invites all team members to the meeting. Team members who cannot attend are contacted in advance to elicit their input, as the team should make no decision without essential input from team members who may not be present. The CFT facilitator prepares any visual aids or tools to facilitate the meeting process. After the CFT meeting, team members who were unable to attend are contacted and informed of the meeting's results.

2. CFT Meeting Facilitation. The CFT facilitator helps the team to review and clarify the child and family's long-range vision, and uses it to guide the team in developing appropriate short-term objectives. The CFT facilitator manages the meeting effectively and efficiently, so that planned agenda items are completed during the meeting. During the meeting, options to achieve short-term objectives are developed and reviewed for effectiveness, for "fit" with the child and family, and with awareness of available resources and service capacity. Selected options are concrete, with clearly defined timelines for completion, and assigned responsibilities among team members for implementation. After the initial plan is developed, in subsequent team meetings the CFT facilitator leads a celebration of successes and accomplishments, reviews the status and outcomes of the written plan since the previous team meeting, guides the team in addressing any crises since the previous team meeting, guides the team in identifying any challenges or barriers, and in undertaking barrier resolution planning that is required.

In all CFT meetings and activities, the CFT facilitator guides the team towards consensus. This task may be challenging at times. An effective CFT facilitator uses and promotes consensus-building techniques (e.g. compromise, reframing, clarification of intent, frequent refocus on the best interest of the child, and stepping back from "positions" to underlying principles) to meet such challenges.

CFT Documentation. The CFT facilitator documents the plan, using the words of the child/family, using the Behavioral Health Service Plan format to denote required elements, and attaching any additional items to the Behavioral Health Service Plan as a single, cohesive and complete document. The plan defines the long-range vision of the family, identified needs, corresponding strengths, short-term objectives and selected options that reflect the culture of the child/family. The Plan is appropriately updated at each subsequent team meeting. Additions to the Strengths, Culture and Needs Discovery at subsequent team meetings are documented in progress notes so that the CFT can always work from an up-to-date narrative of strengths, resources, cultural considerations, and identified needs. Other important documentation (e.g. CFT meeting notes) can also be recorded in progress notes.

The written plan assigns responsibility to team members or each task, contains timelines for implementation, and includes indicators or measures of effectiveness. The CFT facilitator enables team members to leave the meeting with any assignments and timeframes written down. The CFT facilitator informs team members unable to attend the meeting of decisions, outcomes and/or assignments. The CFT facilitator should furnish team members with an up-to-date copy of the Behavioral Health Service Plan within seven (7) days after the most recent CFT meeting.

Step 6: The Behavioral Health Service Plan - Implementation

Once the Behavioral Health Service Plan is established, those team members with specific assignments carry out their assigned responsibilities within the agreed timeframes. It is helpful for the CFT facilitator to arrange for team members to leave planning meetings with any assignments and

timeframes already written down. The CFT facilitator furnishes team members with an up-to-date copy of the Behavioral Health Service Plan within 7 days after the most recent CFT meeting.

Based on the recommendations and decisions of the CFT regarding the type, intensity and frequency of supports and services needed, the behavioral health representative formally secures any and all covered behavioral health services that will address the needs of the child and family. (A list of exceptions is included in *The Child and Family Team Practice Improvement Protocol*.) Any team members may accept assignments to secure other services and supports, sometimes from other involved public systems, often from community and other informal sources.

Some assignments may take the form of activities, or even of ways of interacting with a child. Designated team members also carry out these types of assignments. A Behavioral Health Service Plan may, for example, include a specific strategy that individuals interacting with the child will use to reinforce a particular behavior the child is learning. A plan may also include as a strategy that the child's Uncle will take him bowling each Friday evening.

Team members carry out assignments with diligence, and contact the CFT facilitator in a timely manner when an assignment appears unable to be completed. The CFT facilitator may draw from the CFT members, from supervisory or other resources as necessary, to help Plan assignments to be completed. There may be instances when a particular activity, support or service cannot be timely secured, even with such assistance. In those cases, the CFT facilitator elevates the "barrier" within the T/RBHA's Barriers Identification and Resolution process. Alternative or interim strategies, or other appropriate decisions, are made by the CFT to address identified needs in such circumstances.

Step 7: Ongoing Crisis and Safety Planning

Every Behavioral Health Service Plan includes a Crisis Plan component. The Crisis Plan addresses the question, "What might go wrong that might divert the CFT from successfully implementing the Behavioral Health Service Plan?" Proactive planning avoids poor decisions being made "in the heat of the moment," and instead capitalizes on the best creative thinking of the CFT members.

When and how should one facilitate the development of Crisis and Safety Plans?

After the initial Behavioral Health Service Plan is developed, the CFT facilitator next leads the CFT through a crisis planning process. Typically, a CFT meeting will be held to develop the Crisis Plan within a few days after the initial Behavioral Health Service Plan is developed. (The CFT facilitator understands that the steps of the CFT process are not strictly linear, and should be managed based on the immediate needs of the child and family.)

Crisis planning is often conducted with the child and immediate family, though other members may participate based on the family's preference, and the availability and expertise of those other members. Remember, other child serving systems (e.g. child welfare, juvenile probation) may already be involved, and may even already have developed a safety plan. Representatives from other involved child-serving systems are invited to help shape crisis stabilization and safety plans.

When Crisis Plans are developed by a subset of the CFT, the Crisis Plan is shared with the full team in an appropriately timely manner.

Crisis Planning follows a four-step model:

1. Prediction: At this point in the CFT process, the team responds to the question, "What is the worst thing likely to go wrong?"

2. **Functional Assessment:** The CFT facilitator guides the CFT in deconstructing the predicted crisis to gain an understanding of the unique elements and characteristics of the crisis process. What events, behaviors or behavior sequences are associated with the initial, middle and ending phases of the crisis?
3. **Prevention:** Based on learning during the functional assessment, what options, drawn primarily from the child/family strengths and community supports, can help to prevent those events, behaviors or patterns of behavior associated with the crisis process? Prevention strategies are described in the ensuing Crisis Plan.
4. **Crisis Planning:** The CFT facilitator leads the CFT in developing steps for managing the crisis in the event it occurs despite the prevention strategies. Crisis Plan steps specifically describe who will do what, when, and where. Crisis Plans often include specific names and phone numbers, as well as contingencies.

Safety Planning is similar to Crisis Planning. Safety Plans address ongoing conditions that pose significant risk to the child, family members or the community. Such high-risk conditions are not present with most children and families. While every Behavioral Health Service Plan includes a Crisis Plan component, Safety Plans are required only when high-risk conditions (e.g. sexual acting out, or suicide ideation) are present. In such cases, there is usually a great deal of overlap in the content of the Crisis and Safety Plan components.

Step 8: Tracking and Adapting

The CFT facilitator is responsible for creating an effective loop between the Behavioral Health Service Plan, its implementation, its effectiveness, and its modification when appropriate.

When and how should one facilitate Tracking and Adapting of the Behavioral Health Service Plan?

A significant failure of a CFT member to follow through on an important element of the Behavioral Health Service Plan will impede the momentum of the CFT, may threaten the commitment of other team members to the process, and may injure the child's/family's sense of hope. The CFT facilitator ensures that the CFT members carry out the Behavioral Health Service Plan.

The importance of *tracking assignment completion* is particularly essential early in the CFT process. The child's enrollment in the behavioral health system often occurs when needs are relatively high. As the CFT facilitator and team members develop closer relationships through engagement, interactions and collective accomplishments over time, CFT members will increase their understanding of each member's strengths and weaknesses, and realistic commitments and assignments will more naturally emerge in the continually evolving plan. Until then, the CFT facilitator invests time between team meetings to contact team members, offering gentle reminders and quick "Thank You's" to shape their follow-through behavior.

The CFT facilitator is also responsible for *tracking progress* on short-term objectives, and toward long-range goals. The Behavioral Health Service Plan includes short-term, observable and measurable objectives, and measurement indicators that will objectively reflect progress over time.

The CFT facilitator is responsible for *tracking effectiveness of Crisis and Safety Plans*. After a Crisis or Safety Plan is used, the CFT facilitator ensures that the CFT reviews its effectiveness.

The CFT facilitator works with the CFT to modify the Behavioral Health Service Plan when effectiveness or progress is not evident. Both lack of progress and follow-through on assignments by CFT members may indicate that certain options are not sufficiently individualized or customized to the

important cultural considerations of the child and family. Whatever the explanation is for a lack of progress, the CFT facilitator guides the team in refining existing strategies, or developing new options, thereby revising the Plan.

The CFT facilitator may delegate tracking functions to other willing members of the CFT, but when doing so should monitor to ensure that the designee is carrying out such tracking functions until reasonably assured that conscientious tracking will continue.

Step 9: Transition

ADHS universally applies the 12 Arizona Principles, and intends to use the CFT process with every child. The CFT does not "end" before the child is disenrolled from services or transitioned to the adult service system. The character of the team varies based on the goals, needs and strengths of each child and family, and each team functions in a unique and flexible manner, that may require varying levels of involvement from the behavioral health system, other child-serving agencies, and other natural supports. Some situations and some teams may, at least for a period of time, require designated CFT facilitators with specialized skills.

The final step of the CFT process is transition out of a formally supported process, sometimes from all formal services, and sometimes from child-oriented to more adult-oriented services as the child leaves adolescence for young adulthood (see *Transitioning to Adult Services Practice Improvement Protocol*). While many children and families are likely to experience some ongoing needs, they will often be able to capitalize on the identification and mobilization of informal supports and resources, and may continue to work with a support team that remains available to them after the CFT facilitator is no longer needed.

When and how should one facilitate the transition from a formally facilitated CFT process?

A further goal is to educate, support and empower families to eventually facilitate their own teams. Several guidelines help the CFT facilitator to know when to begin a gradual process of discontinuing formal facilitation of a CFT for the child and family. First, when sufficient informal support is available, transition is more likely to succeed. Team membership offers evidence of sufficient informal support. A CFT composed mostly of paid professionals does not indicate readiness for transition, and the CFT facilitator is reminded that team membership should be dynamic, working toward increasing participation of informal support persons over time. In some cases, the CFT facilitator may need to develop family advocates or mentors to support the team's necessary work. In general, CFTs composed of at least 50% informal support persons are best prepared for transition.

Youth and families who have assumed increasing responsibility for facilitation of their CFTs are approaching readiness for transition. The CFT facilitator should be consistently dedicated to the goal of helping the youth and family members to assume increasing responsibility for managing and facilitating their own CFT. Alternatively, another CFT member who is not a paid professional may be groomed by the CFT facilitator to assume that role. This requires that the CFT facilitator teaches the steps of the CFT process, models application of pertinent skills, provides constructive feedback and encouragement to team members intending to assume some, or all, facilitation responsibilities. Sometimes, youth and family members who have already become their own CFT facilitators may later be recruited to play a similar role with other families' teams.

When priority goals of the CFT have been achieved, as supported by tracked data, transition should be considered.

Finally, when a youth who has been involved in long term or intensive behavioral health care reaches the age of 16, planning for the transition into the adult behavioral health system must begin (refer to the [T/RBHA specific version of the ADHS/DBHS Provider Manual](#) Section 3.17, Transition of Persons for specific requirements). As the youth approaches his/her 18th birthday, and significant needs remain for formal support and services, the CFT facilitator works with the CFT to begin to invite one or more key contacts from adult service systems to join the dynamic team, laying the foundation for a smooth transition from the child-oriented service structure to the adult-oriented service structure. In such instances, the goal is to support continuity in the team process, including the provision of supports and services, plan components, and tracking and adapting processes.

The CFT facilitator begins to discuss the goal of transition from a formally supported CFT process with the child, family and CFT members relatively early in their relationships. As essentially a "secondary goal" of the CFT process from that early point, a clear expectation is set that guides the dynamic of the CFT process to change over time, gradually shifting reliance from formal to informal facilitative support.

Before any child is disenrolled, a crisis plan is developed that outlines the specific steps to be taken to reconvene the CFT, to re-establish services and supports should it become necessary.

Attachment 1: The Child and Family Team Process Encounters/Billing Codes Matrix

This table lists the nine essential steps of the Child and Family Team (CFT) process as described in ADHS clinical guidance documents. It identifies billing codes that can be used to reimburse qualified personnel carrying out those steps and their included activities. The table contains examples of codes that may be billed, but is *not* intended to be exhaustive. For more detailed information, please refer to the [ADHS/DBHS Covered Behavioral Health Services Guide](#). Note that sometimes Child and Family Team (CFT) process activities do not actually occur in a linear (step by step) fashion, and also that there may be more than one appropriate choice for a billing code in some circumstances. Transportation, flex funds, and other covered services codes may also be furnished in support of the following steps and activities. Note: Providers may not bill separately for time spent documenting the activities and accomplishments of the CFT. Time associated with note-taking and/or medical record upkeep has been included in the rates for the billing codes listed.

| Child & Family Team Process: Steps | Billing Codes Include: |
|---|--|
| <p>1. Engagement of the Child and Family (and of extended family, informal and community supports, and representatives of from other involved child-serving entities)</p> | <p>H0002- Behavioral Health Screening H0031-Mental health assessment by non-physician T1016H0-Case Management Behavioral Health Professional (Office) T1016H0-Case Management Behavioral Health Professional (Out of Office) T1016HN-Case Management Behavioral Health Technician (Office) T1016HN- Case Management Behavioral Health Technician (Out of Office) S5110-Home Care Training Family (Family Support) H0038 – Self-Help/Peer Services (Peer Support) Behavioral Health Counseling and Therapy codes as appropriate (see ADHS/DBHS Covered Behavioral Health Services Guide for particulars)</p> |
| <p>2. Immediate Crisis Stabilization</p> | <p>H0002- Behavioral Health Screening H0031-Mental Health Assessment by non-physician T1016H0-Case Management Behavioral Health Professional (Office) T1016H0-Case Management Behavioral Health Technician (Out of Office) T1016HN-Case Management Behavioral Health Technician (Office) T1016HN- Case Management Behavioral Health Professional (Out of Ofc) S5110-Home Care Training Family (Family Support) H0038 – Self-Help/Peer Services (Peer Support) S9986 - Non-Medically Necessary Covered Services (Flex Fund Services) Behavioral Health Counseling and Therapy codes as appropriate (see ADHS/DBHS Covered Behavioral Health Services Guide for particulars)</p> <p>Specific covered services to help stabilize crises, contingent on the specific needs of individual children and family members.</p> |

| Child & Family Team Process: Steps | Billing Codes Include: |
|---|---|
| 3. Strengths, Needs and Culture Discovery | H0031 - Mental Health Assessment by non-physician T1016H0 -Case Management Behavioral Health Professional (Office) T1016H0 -Case Management Behavioral Health Professional (Out of Office) T1016HN -Case Management by Behavioral Health Technician (Office) T1016HN - Case Management by Behavioral Health Technician (Out of Office) H0004HR - Family Behavioral Health Counseling (Office – client present) H0004HR - Family Behavioral Health Counseling (Out of Office – client present) H0004HS - Family Behavioral Health Counseling (Office - without client) H0004HS - Family Behavioral Health Counseling (Out of Office - without client) |
| 4. Child and Family Team Formation | S5110 - Home Care Training Family (Fam. Supp.) H0038 – Self-Help/Peer Services (Peer Support) T1016H0 -Case Management Behavioral Health Professional (Office) T1016H0 - Case Management Behavioral Health Professional (Out of Office) T1016HN -Case Management Behavioral Health Technician (Office) T1016HN -Case Management Behavioral Health Technician (Out of Office) H0004HR - Family Behavioral Health Counseling (Office – client present) H0004HR - Family Behavioral Health Counseling (Out of Office – client present) H0004HS - Family Behavioral Health Counseling (Office - without client) H0004HS - Family Behavioral Health Counseling (Out of Office - without client) H2016 -Comprehensive Community Support (Peer Support) |
| 5. Behavioral Health Service Plan – Development | T1016H0 -Case Management Behavioral Health Professional (Office) T1016H0 -Case Management Behavioral Health Professional (Out of Office) T1016HN -Case Management Behavioral Health Technician (Office) T1016HN - Case Management Behavioral Health Technician (Out of Office) H0004HR - Family Behavioral Health Counseling (Office – client present) H0004HR - Family Behavioral Health Counseling (Out of Office – client present) |

| Child & Family Team Process: Steps | Billing Codes Include: |
|--|--|
| | <p>H0004HS- Family Behavioral Health Counseling (Office - without client) H0004HS- Family Behavioral Health Counseling (Out of Office - without client) S5110- Home Care Training Family (Family Support) H0038 – Self-Help/Peer Services (Peer Support)</p> <p>*Providers may not bill separately for time spent documenting the activities and accomplishments of the CFT. Time associated with note-taking and/or medical record upkeep has been included in the rates for the billing codes listed.</p> |
| 6. Behavioral Health Service Plan – Implementation | <p>T1016H0-Case Management Behavioral Health Professional (Office) T1016H0-Case Management Behavioral Health Professional (Out of Office) T1016HN-Case Management Behavioral Health Technician (Office) T1016HN – Case Management Behavioral Health Technician (Out of Office)</p> <p>All covered services identified as needed by the Child and Family Team (CFT)</p> |
| 7. Ongoing Crisis and Safety Planning | <p>T1016H0-Case Management Behavioral Health Professional (Office) T1016H0-Case Management Behavioral Health Professional (Out of Office) T1016HN-Case Management Behavioral Health Technician (Office) T1016HN- Case Management Behavioral Health Technician (Out of Office) H0004HR- Family Behavioral Health Counseling (Office – client present) H0004HR- Family Behavioral Health Counseling (Out of Office – client present) H0004HS- Family Behavioral Health Counseling (Office - without client) H0004HS- Family Behavioral Health Counseling (Out of Office - without client) S5110- Home Care Training Family (Family Support) H0038 – Self-Help/Peer Services (Peer Support) H2014 – Skills Training and Development - Individual S9986 - Non-Medically Necessary Covered Services (Flex Fund Services)</p> |
| 8. Tracking and Adapting | <p>T1016H0-Case Management Behavioral Health Professional (Office) T1016H0-Case Management Behavioral Health Professional (Out of Office)</p> |

| Child & Family Team Process: Steps | Billing Codes Include: |
|------------------------------------|--|
| | <p> T1016HN-Case Management Behavioral Health Technician (Office) T1016HN- Case Management Behavioral Health Technician (Out of Office) H0004HR- Family Behavioral Health Counseling (Office – client present) H0004HR- Family Behavioral Health Counseling (Out of Office – client present) H0004HS- Family Behavioral Health Counseling (Office - without client) H0004HS- Family Behavioral Health Counseling (Out of Office - without client) S5110- Home Care Training Family (Family Support) H0038 – Self-Help/Peer Services (Peer Support) </p> <p>* Providers may not bill separately for time spent documenting the activities and accomplishments of the CFT. Time associated with note-taking and/or medical record upkeep has been included in the rates for the billing codes listed.</p> |
| 9. Transition | <p> T1016H0-Case Management Behavioral Health Professional (Office) T1016H0-Case Management Behavioral Health Professional (Out of Office) T1016HN-Case Management Behavioral Health Technician (Office) T1016HN- Case Management Behavioral Health Technician (Out of Office) H0004HR- Family Behavioral Health Counseling (Office – client present) H0004HR- Family Behavioral Health Counseling (Out of Office – client present) H0004HS- Family Behavioral Health Counseling (Office - without client) H0004HS- Family Behavioral Health Counseling (Out of Office - without client) S5110- Home Care Training Family (Family Support) H0038 – Self-Help/Peer Services (Peer Support) </p> |

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**TITLE XIX
CHILDREN'S BEHAVIORAL HEALTH
ANNUAL ACTION PLAN ***

**November 1, 2004
To
October 31, 2005**

Submitted By

**Arizona Department of Health Services
And
Arizona Health Care Cost Containment System**



**In compliance with June 2001 Jason K. Settlement Agreement*

**Annual Action Plan
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and
Arizona Health Care Cost Containment System**

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Introduction

In November of 2001, the Arizona Department of Health Services (ADHS) and the Arizona Health Care Cost Containment System (AHCCCS) provided the first Annual Action Plan to Plaintiffs' Counsel under the Jason K. Settlement Agreement. Under the Settlement, ADHS and AHCCCS are required to meet the obligations set forth in Section III, paragraphs 14 through 17 by July 1, 2007.

Many of the obligations must be addressed through simultaneous efforts and activities. Over the past three years, several obligations outlined in Section III of the settlement agreement have been met, and those that remain are being substantially addressed. This fourth Annual Action Plan reviews these accomplishments and presents both continuing and new strategies and action steps to meet obligations noted in paragraphs 15 and 16. Paragraph 14 is met by the extent of effort put forth to achieve the obligations stated in paragraphs 15, 16, and 17.

In meeting the requirements of the agreement, ADHS and AHCCCS are both committed to and expect that all Title XIX eligible children will be evaluated, treated and supported by approaches that are consistent with the Arizona Vision, within a system of care that supports and sustains such practice.

The initial emphasis was intended to target children and families with multiple and/or complex needs who are enrolled in the behavioral health system. ADHS and AHCCCS tested new strategies for children in the Maricopa County's 200 Kids Project, in Northern Arizona's 100 Kids Project, and within Project MATCH in Pima County. Important lessons learned through those early efforts continue to be applied as practice improvements spread and as infrastructure continues to be developed, to foster and sustain progress.

This year's Annual Action Plan will continue to direct efforts to assure that, regardless of intensity of need and level of acuity, the care provided to all Title XIX eligible children throughout Arizona will reflect and maintain our obligation to the Arizona Vision and its 12 Principles. In particular, this year's plan is intended to culminate in the application of the Child and Family Team (CFT) process Arizona has now developed and described for 50% of the enrolled Title XIX children and their families by December 31, 2005. ADHS' strategic goal is that Title XIX children and their families enrolled in the behavioral health system will be served in accordance with the 12 Arizona Principles by December 31, 2006.

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Annual Action Plan and Strategies for the Future:

The six-pronged strategy has been updated and extended in this fourth Annual Action Plan, with the addition of a seventh prong targeting specific service capacity priorities necessary to address the needs of children and families. Within these strategies attention remains focused on implementation requirements at the individual team, the local/regional and state levels.

Over the next year, ADHS will make measurable progress in implementing seven key strategies to foster statewide implementation of the Arizona Vision and its 12 Principles. These strategies, and the principles they most directly support include:

1. Create sustainable and trusting partnerships with families and other child-serving systems.
(Principles: collaboration with the child and family, respect for unique cultural heritage, connection to natural supports independence, collaboration with others, and functional outcomes)
2. Develop, train, and implement effective practice improvement protocols.
(Principles: best practices, services tailored to the child and family, stability, and collaboration with others)
3. Continue to train and coach system staff, partners, and families.
(Principles: collaboration with the child and family, collaboration with others, independence)
4. Improve the effectiveness of barriers identification, resolution and feedback processes.
(Principles: accessible services, collaboration with the youth and family, collaboration with others)
5. Improve the quality management system.
(Principles: accessible services, timeliness, and functional outcomes)
6. Internalize the understanding of system reform.
(Principles: collaboration with the child and family, respect for unique cultural heritage, and collaboration with others).
7. Expand available capacity to furnish critical services and supports.
(Principles: services tailored to the child and family, accessible services, timeliness, best practices, most appropriate setting, stability, functional outcomes and independence.)

ADHS and AHCCCS remain responsible for overall implementation of these strategies. Their successful implementation, however, also demands vital input and strong support from key stakeholders, and will be optimized if congruent changes among other child-serving systems are made.

Implementation of these strategies will occur through a variety of actions at local, regional and statewide levels. In some instances different approaches may be used in certain geographic service areas reflecting their varying developmental statuses. ADHS and AHCCCS intend that this fourth Annual Action Plan will lead to more even system development in all regions of the state.

The plan is divided into two parts: a description of the fourth year strategies and major action steps; and a review of the past year's accomplishments.

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Strategy 1. Create Sustainable and Trusting Partnerships with Families and Other Child-Serving Systems

Successful reform of the public behavioral health system for children and families in Arizona is based on building and maintaining strong, sustainable partnerships with all fellow stakeholders in our system of care. Partnership begins primarily with the children and families our system serves, and extends across other child-serving agencies, among contractors and service providers, and throughout the communities in which they work.

In the first Annual Action Plan, the action steps were largely targeted within the behavioral health system. During years two and three, focus expanded toward better understanding the mandates, needs and expectations of other child-serving systems that interact with the same children and families served by the behavioral health system. Over the same period of time, family members have been increasingly asked to share their input, and to help shape and support implementation of efforts to improve intake, assessment, service planning, service delivery and performance improvement processes.

During the next year ADHS and AHCCCS will continue to foster cross-system understanding of the needs and cultures of families as well as of the expectations of child-serving system partners. This work will further deepen and strengthen our essential collaborative partnerships, and will ultimately contribute toward improving outcomes for children and families. This will happen in a variety of ways.

Improve understanding of the unique cultures of families, their traditions and heritage.

Appreciating and respecting the cultures of families is essential to creating true partnership with families. ADHS will ensure that its Cultural Competency Plan will be understood and embraced by its own workforce. ADHS will develop and communicate to the RBHAs standards of care (e.g. CLAS standards) designed to specifically improve cultural and linguistic competency. These expectations will be incorporated into ADHS contracts with RBHAs and throughout the ADHS clinical guidance documents and its quality management processes. Understanding of cultural diversity within each region of Arizona will be reflected in provider networks and will be evident in quarterly network analysis and development reports.

Advance the focused work of leadership through the Executive Committee.

In early 2004, the Arizona Children's Executive Committee reviewed its influential role in leading development of a statewide system of care for children and families, and determined to be proactive by focusing on a clear set of priorities. The Executive Committee will extend its leadership in four specific ways:

1. Assist the Department of Economic Security (DES) to implement Governor Janet Napolitano's Child Protective Services (CPS) reforms;
2. Increase family involvement in all of Arizona's child-serving agencies;
3. Identify and work toward resolution of cross system issues and barriers; and

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4. Guide the development of statewide infrastructure that supports implementation of the JK Settlement agreement (SIG).

Already, the Executive Committee has reviewed an action plan to address the unique behavioral health needs of children involved with CPS which will:

- Sensitize the behavioral health workforce on the child welfare context for those children through new practice improvement protocols, and
- Develop behavioral health system capacity to provide clinical “best practices” to children involved with CPS, their families and caregivers.

The Executive Committee will act in accordance with the family involvement framework it adopted in 2004. According to that framework, family members should be recognized as experts, and be utilized in training and consultative roles within the behavioral health and related child-serving systems. Family involvement requires a sacrifice of time and energy on the part of family members, so ADHS will continue to support the contributions of families with stipend and travel reimbursements, tele-communications access and sensitive scheduling consideration. The Family Involvement subcommittee will expand its partnership with ADHS, the RBHAs and other Executive Committee member systems by:

- Recruiting and equipping family members to participate in policy development and review, provider capacity development, quality improvement and systems advocacy activities;
- Ensuring that families are aware of the wide array of covered behavioral health services available;
- Contributing teaching (training) and consultative expertise to service systems.

ADHS and AHCCCS will participate in Governor Janet Napolitano’s statewide summit on Family Involvement in April 2005. New efforts will begin to encourage youth involvement in many comparable aspects of policy and systems development, quality improvement, teaching and advocacy activities. ADHS will coordinate its efforts with those of DES and other agencies encouraging youth involvement, in order to access youth already participating in such activities. Those young people will be actively recruited to participate in leadership development activities and focus groups designed to bring their primary perspectives to system reform.

Specific emphasis will encourage education systems to understand and participate in the Child and Family Team Process to more effectively address the learning needs of children served by multiple agencies. ADHS will also participate in the cross-system transition leadership workgroup, and will spread understanding of its practice improvement protocol, Transitioning to Adult Services.

Continue to make system improvements for children in foster care.

In the coming year, ADHS and RBHAs will work closely with DES-ACYF to develop effective

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family support and preservation, placement strengthening and family reunification services in the behavioral health system to:

- Help minimize the number of children who must be removed from their families to remain safe,
- Reduce unintended harm to children placed in the protective custody of the state, and
- Expedite the connection of foster children to strong, stable permanent families.

ADHS and ValueOptions will partner with DES-ACYF to implement a family reunification pilot supported by Arizona's new Title IV-E waiver opportunity in Maricopa County, intending to expand its potential to more broadly benefit children and families across Arizona. Similarly, ValueOptions and ADHS will work closely with DES-ACYF to begin implementing a Family-to-Family approach to foster care in Maricopa County.

The behavioral health system will help foster parents understand the Arizona Vision and its 12 Principles, how to participate effectively as members of Child and Family Teams, and how to serve as vital resources for the birth families of children involved with CPS, as well as for kin, legal guardians and adopting families who may raise these children permanently.

ADHS will continue its many current initiatives to improve service for children involved with CPS, and will encourage new, related initiatives at the RBHA level. With input from DES-ACYF, development priorities are currently being identified, and regional network development plans are now funded in order to address service gaps for CMDP-enrolled children, their families and caregivers.

Expand co-location of behavioral health staff with partnering child-serving agencies.

Co-location, already successfully implementing in several Pima County and Maricopa County child welfare and juvenile court sites, will be expanded, including in several northern Arizona communities where it is appropriate to support cross-system teams to serve youth and families receiving behavioral health and other public (e.g. child welfare, juvenile justice) services. In Maricopa County, ValueOptions will establish new co-location sites with CPS in Mesa, in Tempe, in South Phoenix, at Thunderbird and in Maryvale by 7/1/05, while maintaining its existing CPS co-location in Tempe. ValueOptions will also establish "detention teams" to be located at both Maricopa County (Durango and SEF) juvenile justice facilities by 7/1/05. In Pima County, CPSA will maintain the existing four CPS co-location sites, as well as the current co-location of behavioral health providers at the Pima County Juvenile Court Complex. In Northern Arizona, NARBHA will maintain its Fredonia co-location with CPS, and will implement new co-locations in two other communities jointly prioritized with CPS by 11/1/05.

Support and encourage ongoing implementation of joint behavioral health assessment and behavioral health service planning processes.

ADHS and RBHAs will continue to work with child welfare, juvenile justice and other child-serving systems to achieve this goal. Collaborative agreements have already been established

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between ValueOptions and Child Protective Services. Collaborative letters of agreement supporting the Child and Family Teams process have been developed and endorsed by multiple child-serving agencies in Arizona's five southeastern counties. ADHS contracts with RBHAs in effect on 7/1/05 will require development and implementation of collaborative protocols with regional child welfare and juvenile justice systems.

Strategy 2: Develop, Train, and Implement Effective Practice Improvement Protocols

ADHS will continue to lead the development of clinical guidance documents, tools and teaching resources to support practice approaches that effectively actualize the Arizona Vision and Principles for children and families served. Concerted efforts will be made to ensure consistency and compatibility between ADHS clinical guidance and parallel guidance of other child-serving systems (e.g. DES-ACYF's Family to Family initiative). Practice Improvement Protocols [PIPs] and, when necessary to support their implementation, Technical Assistance Documents [TADs], will be shaped with appropriate consumer, family and stakeholder input; published at the ADHS website; incorporated by reference into ADHS contracts with RBHAs; integrated into ongoing teaching/training and supervision processes at the RBHA and service provider levels; and will progress from "desired" to "expected" status when appropriate.

Ensure clinical guidance on prioritized topics is available to frontline workers.

ADHS will complete statewide training on the recently completed clinical guidance documents:

- Therapeutic Foster Care Services PIP
- Transitioning to Adult Services PIP

In addition, ADHS will develop clinical guidance surrounding:

- Use of out-of-home services by 4/1/05, and will train and implement by 7/1/05.
- Unique behavioral health needs of children involved with CPS by 2/1/05, and will train and implement by 5/1/05.
- Assessing behavioral health needs of infants, toddlers and preschoolers (birth to 5), their families and other caregivers by 7/1/05.
- Treating children and youth who act out sexually by 4/1/05, and will train and implement by 7/1/05.

Teaching to improve practice will target a broad array of CFT members and other key players.

ADHS will demonstrate the application of the new practice improvement protocol, Use of Out-of-Home Services, at the Adolescent Treatment Unit of the Arizona State Hospital.

Establish a Best Practice structure within ADHS.

The ADHS Clinical Coordinators Committee has developed clinical guidance for RBHAs and behavioral health service providers since the beginning of this Settlement. Its new Best Practice

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Subcommittee will strengthen the impact of ADHS clinical guidance on practice. Convening in December 2004, the Best Practice Subcommittee will:

- Help to identify areas where clinical guidance should be developed, or updated to reflect emerging strides in the behavioral health field;
- Define specific factors that might necessitate adjustments to best practices;
- Monitor application of best practices in each geographic service area, assuring that application is sensitive and responsive to individual, family and community cultural considerations and other unique factors;
- Involve consumers and family members, arranging for their direct participation on the Subcommittee;
- Implement a process that helps clinical guidance and other best practice expectations to move from desired/optional to expected/required status in predominant behavioral health system practice as appropriate; and
- Use the Higher Education Partnership to help spread knowledge of best practices.

Strategy 3: Continue to Train and Coach System Staff, Partners and Families

RBHAs are required to develop and implement workforce development plans. ADHS will play a strong role in shaping those plans, helping to design, approve, and provide resource support by 2/15/05. ADHS will then monitor implementation and effectiveness of overall workforce and CFT capacity development. At a minimum, each RBHA's approved workforce development plan will:

- Focus on development of effective supervision skills and process;
- Continue to involve system partners in training and coaching; and
- Involve youth and families in training and coaching.

Calibrate training and coaching to a 50% CFT capacity target.

ADHS will require that each RBHA's plan be designed to reach the intermediate target that functioning Child and Family Teams will serve at least 50% of enrolled children by 12/31/05. In addition to learning to implement the CFT process in general, training and coaching will also need to account for the prioritization of specific subpopulations in building to that 50% level (see Strategy 7).

Support and share an integrated basic training template.

To streamline trainings and increase efficiency, ValueOptions will develop and deliver integrated curriculum covering strength-based assessment and CFT facilitation for new clinical liaisons by 5/1/05. Upon approval by ADHS, the integrated curriculum template will be shared to support initial training for new clinical liaisons in the remaining geographic service areas by 9/1/05.

Implement the Higher Education Partnership's strategic plan.

In April 2004 ADHS initiated a watershed meeting with representatives from Arizona's higher education community, including university and college professors, deans and department heads. The purpose was to create a collaborative partnership between the Arizona's behavioral health

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system and its higher education resources intended to provide an early staging ground for system of care development, as well as specific educational opportunities to teach the Arizona Vision and 12 Principles prior to individuals entering the workforce. Further meetings of this group have been scheduled in the coming months.

Strategy 4: Improve the Effectiveness of Barriers Identification, Resolution and Feedback Processes

Directly involved behavioral health leadership.

ADHS will require its own management personnel and RBHA chief executive officers to periodically participate in the Child and Family Teams process, and conduct record reviews as a specific means of identifying challenges and to model resolution and feedback processes. The first review, examining cases of children involved with Child Protective Services in the behavioral health system, will be completed by 2/15/05.

Establish processes in all regions.

In its contract for the regional behavioral health authority for Maricopa County effective July 1, 2004, ADHS has required that ValueOptions establish collaborative protocols with each major child-serving system by 12/31/04 that shall address several items, including mechanisms for solving problems. Contracts for regional behavioral health authorities for all other geographic service areas of Arizona will be established effective 7/1/05, and will include this same requirement. Through this mechanism, ADHS will request and support development of effective methods for identifying challenges, providing feedback and creating opportunities for resolution.

Processes, both within the behavioral health system, and among other child-serving and community agencies, should start with the fundamental question “What can be done to address impediments to children and families’ meeting their objectives and achieving their goals?”

Within provider agencies, RBHAs will encourage processes that build on existing relationships based on trust and respect, to create needs identification-resolution-feedback loops that join direct care, supervisor, administrative, clinical, support and executive personnel. Effective processes must invite discovery beginning at the CFT level, and analysis and action at each successive higher level as may be necessary to resolve identified challenges, even connecting to the Children’s Executive Committee.

Provide training to support effective processes.

Training needs to equip the behavioral health workforce and the system’s many stakeholders, including family members, with skills of “win/win” conflict resolution. By 7/1/05 ADHS will develop curriculum components to teach these skills. RBHAs will be expected to apply these lessons within their own systems, and to offer similar training in appropriate local forums for cross-system and community audiences. Participants will learn how adversarial approaches to

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needs identification and problem-resolution are often counterproductive, that it is both possible and usually preferable to reach consensus solutions by following strength-based principles.

Strategy 5: Improve the Quality Management System

A strong Quality Management (QM) System is capable of accurately measuring the Arizona Vision and the 12 Principles and is a critical link in a feedback loop that supports continuous practice improvement and ongoing system reform. Quality Management processes should identify areas for targeted improvement efforts, and be able to confirm their effectiveness. Current quality measurement processes that assess the behavioral health system's performance include:

- *Independent case reviews.* Required by AHCCCS and carried out by an independent contractor on a statistically significant sample of Title XIX/XXI members statewide, this includes a review of records and interviews with the child/family/guardian and the behavioral health representative (e.g. CFT facilitator, clinical liaison).
- *Monitoring key indicators.* ADHS produces regular reports of key indicators (e.g. growth in CFT facilitation capacity each quarter; measures of access to and timeliness of care, of lengths-of-stay in acute care settings, data on the financial stability and spending patterns of the RBHAs). Key indicators are trended over time and reviewed by ADHS' QM/UM Committee, which identifies areas for improvement.
- *Utilization review.* These data measure how covered behavioral services are used, offering insight into over- or underutilization of particular services, and supporting prioritization of provider network capacity development activities.
- *Complaint review.* Consumer complaints, grievances and appeals are included as key indicators and are reviewed quarterly.
- *Provider network review.* RBHA provider network gains and losses are monitored on a quarterly basis and compared against network development plans approved by ADHS and by AHCCCS.
- *Consumer satisfaction survey.* ADHS conducts this survey every two years of a statistically significant sample of consumers, using standardized national measures. Resultant data is also compared with behavioral health systems in other states.
- *Operational/administrative reviews.* Conducted annually of the RBHAs by ADHS, and of ADHS by AHCCCS, these audits focus on overall contract compliance, and include clinical, financial, administrative, data and quality management measures.

When quality improvement issues emerge from such measurement processes, AHCCCS and ADHS contracts call for development, implementation, monitoring and enforcement of performance improvement plans.

In addition to these established approaches, significant experimentation with additional quality measurement efforts in the context of the 300 Kids Pilot, Project MATCH and subsequent regional system development, as well as broad efforts by system reformers to identify and study similarly-intended approaches beyond Arizona's borders, have brought Arizona's behavioral

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health system to the point where it is poised to adjust its quality management system to more substantially support the practice improvement and overall system reform work now well underway. During the next year ADHS and AHCCCS, with input from youth/families and other stakeholders, will:

Monitor growth of Child and Family Teams process and related covered services capacity. Beginning 1/1/05 each RBHA will submit data on a monthly basis quantifying the number of children participating on Child and Family Teams, and of qualified staff available to support those teams. RBHAs will also provide monthly reports of the use of out-of-home (that is, Level I, II and III residential) services, as well as therapeutic foster care services. ADHS will provide regular reports of encounters of targeted (see Strategy 7) covered services, and of out-of-state placements. Data will be trended quarterly to identify areas in need of improvement, and will be published at the ADHS website.

Make decisions to change the overall QM system.

By 2/15/05 a small but representative ADHS workgroup will propose a system of monitoring and measuring practice that defines responsibility at all levels: CFT, work unit, provider agency, RBHA, ADHS and AHCCCS. The proposal will identify specific tools and processes for clinical supervision, and to measure our obligation to the 12 Principles, and will determine substantive roles for youth/families and community leadership teams within the recommended system.

By 5/1/05, the ADHS workgroup will propose a set of quantifiable indicators of the following outcomes: that children are aided to achieve success in school, live with their families, avoid delinquency and become stable and productive adults. By 7/1/05 application of outcomes indicators will be supported by contract requirements and any necessary ADHS data system changes.

Determine feedback processes to ensure that data on functional outcomes and practice will underpin performance improvement strategies.

This strategy as a whole intends to support data-driven performance improvement. Collecting and analyzing data purposefully identifies the need for, and helps to inform, specific methods of corrective response. Based on data analysis, ADHS, the RBHAs and other key stakeholders will identify opportunities for improvement. ADHS will then review and monitor performance improvement activities.

Improve effective supervision capacities within the behavioral health workforce.

ADHS will require that RBHA workforce development plans increasingly concentrate on building effective (clinical) supervision and leadership skills. ADHS will develop and support processes/ tools and expectations upon consideration of the earlier identified workgroup whose task involves proposing tools and processes for clinical supervision by 2/15/05. The targeted date for implementation is 7/1/05.

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Strategy 6: Internalize the Understanding of System Reform.

In progressing from the original, discrete 300 Kids and Project MATCH pilots toward statewide spread of practice improvement, the importance of this strategy becomes increasingly important. When personnel at all levels and within all parts of the system demonstrate internal understanding of the principles and the further sense of personal ownership, urgency and commitment to action then a huge force of reformers will take the place of the initially small core of champions, early adopters and external experts. The myriad daily decisions they make in their respective roles – large or small, central to or at the periphery of the core change – will create incremental, relentless and cumulative momentum in the direction of the Arizona Vision.

Deep internalization may not fully develop in a single year or two, but will require persistent encouragement and pressure over time to take root. ADHS and AHCCCS will continue and expand efforts to support internalization of behavioral health system reform. Some of the other strategies support this, including:

- Strategy 2, in which ADHS will continue to ensure that its policies and clinical guidance align with the 12 Arizona Principles
- Strategy 3, in which ADHS will require that RBHA workforce development plans will accelerate the transfer of CFT process expertise from external consultants and internal coaches to the supervisory staff, and
- Strategy 4, in which ADHS and RBHA leadership will be directly involved in reviewing records.

ADHS and AHCCCS will influence RBHA executive and administrative personnel to understand their key roles in supporting practice improvement.

Periodic leadership meetings, already occurring within the Maricopa County region, focus on communicating expectations and key responsibilities, have participatory learning components, and incidentally provide AHCCCS and ADHS with feedback on the effectiveness of current efforts. These events will now be extended to statewide scope. ADHS will work with RBHAs to train administrative (e.g. reception, monitoring, claims audit, human resources) personnel and all service providers in the 12 AZ Principles and the CFT process. In addition, ADHS will request that RBHAs conduct cross-departmental planning and policy development, so that leadership within the organization can understand interconnected operations vital to successful implementation of the reform.

ADHS, RBHA and service provider administrative and support personnel will avail themselves of opportunities to observe and experience the Child and Family Teams process firsthand. One expects that all deliberate teaching/learning activities, over time, contribute toward internalization of the principles and values that underpin the Settlement Agreement. But opportunities to “get out” will allow personnel outside the direct sphere of clinical work to see

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the Arizona 12 Principles in action, to gain deep appreciation for the work they support, and to bolster their personal investment in the process.

ADHS and RBHAs will spread understanding of system reform beyond the behavioral health community.

At every opportunity, behavioral health system employees will work to educate judges, CPS workers, probation officers, teachers, community leaders and other partners about the 12 Arizona Principles and the Child and Family Teams process.

Strategy 7: Expand Available Capacity to Furnish Critical Services and Supports.

A final critical consideration in implementing the Settlement Agreement is development of sufficient capacity in the statewide behavioral health provider network to make available the full range of services and supports needed by the children and families that we serve. The fourth and fifth years of the Settlement Agreement will see a dramatic increase in the number and percentage of children and families directly affected by improvements in behavioral health practice and service delivery.

Every RBHA will be required to reach a 50% target of Child and Family Teams functioning in accordance with the 12 Principles by 12/31/05.

Regional workforce development plans (see Strategy 2) will be implemented to accomplish this capacity milestone. Sufficient case management services will be reflected in workforce development and training plans. In developing new CFT capacity, RBHAs will prioritize:

- children in out-of-home care services,
- children involved with CPS,
- children in the Adoption Subsidy program,
- youth who are leaving juvenile detention or correctional settings, and
- children and youth who are identified (e.g. by families, other child-serving systems, or through initial or ongoing behavioral health assessment) as at risk of out-of-home placement.

Critical services and supports will be targeted for expedited capacity expansion.

ADHS, AHCCCS and RBHAs will, through the Annual Provider Network Sufficiency planning process, and utilizing input from families, advocates, and state agency partners, set region-specific capacity targets and timeframes by 5/1/05, and will monitor network development accomplishments against capacity targets, prioritizing especially:

- Home and community-based rehabilitation services (skills training and development, health promotion)
- Home and community-based support services (case management, home care training family [family support], unskilled respite care and therapeutic foster care),

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- Specific applications of covered behavioral health services (e.g. family support and preservation, placement stabilization, family reunification and adoption supports) that address unique behavioral health needs of children involved with CPS, and
- Specific applications of covered behavioral health services (e.g. multi-systemic treatment, functional family therapy) that address specific behavioral health needs of youth in counties targeted by Arizona's juvenile justice systems.

ADHS and RBHAs will continue all current initiatives (e.g. development of therapeutic foster care, respite care, multi-systemic treatment, functional family therapy, youth transitioning to adulthood) that address the needs of children and youth involved with CPS and/or the juvenile justice system, their families and caregivers. In addition, ADHS and its system partners will work together to implement the action plan to address the unique needs of children involved with CPS. RBHAs will submit network development plans to ADHS by 3/1/05 that reflect appropriate targeting of CMDP funds to address identified gaps and to increase needed capacity to meet the needs of children involved with CPS.

Conduct rate study.

ADHS will re-assess rates for services for targeted covered services to ensure their adequacy to support necessary release time for training and clinical supervision activities described earlier in this Action Plan.

Examine staff retention issues.

ADHS will gather information (e.g. targeted employee survey, focus group) to identify factors associated with personnel satisfaction, retention and mobility; as well as suggestions to maximize retention of competent, effective personnel; and to reduce undesirable turnover.

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November 1, 2003 through October 31, 2004 Accomplishments

Settlement Agreement paragraph 14: Defendants agree to foster the development of a Title XIX behavioral health system that delivers services according to the Principles set forth in Section V

Status: Partially met and ongoing

Settlement Agreement paragraph 15: Defendants will move as quickly as is practicable to develop a Title XIX behavioral health system that delivers services according to the Principles. Once developed, Defendants will maintain the system in accordance with the Principles for the term of this Agreement.

Status: Partially met and ongoing

During the first three years of the Settlement Agreement, ADHS and AHCCCS have made significant strides toward development of the Title XIX behavioral health system to deliver services according to the 12 Arizona Principles. This consistent commitment is evidenced by the amount of energy and initiative displayed by the staff at all levels of the system, as well as the attraction and dedication of targeted resources to support system transformation, and the growing incorporation of congruent expectations in system structure, policy and procedure, and contracting processes. The commitment of ADHS and AHCCCS, as well as various other key stakeholders throughout the state, is evidenced by the following:

- 1 Dedication of Governor Napolitano's Children's Cabinet to the 12 Arizona Principles, inclusion of the behavioral health system in shaping and carrying out the concurrent Executive-driven reform of Arizona's child welfare system, and implementation accomplishments in all regions of Arizona to fulfill Governor Napolitano's 2003 direction to spread Child and Family Team practice developed in the 300 Kids Pilot statewide.
- 2 The expanding buy-in by other state agencies and their employees to implementation of the behavioral health system reform, as especially reflected in multiplying cross-system practice protocols, local/regional collaborative agreements, establishment and strengthening of cross-system leadership teams in local regions, and focused leadership at the Children's Executive Committee level and throughout the respective systems represented there.
- 3 The commitment of over \$400,000 in CMHS block grant funds to support statewide training and consultative services to implement the system reform.
- 4 The successful application, endorsed by other major child-serving systems, resulting in the award to ADHS of one of seven five-year statewide infrastructure grants by SAMHSA, specifically underwriting up to \$3.75-million in costs associated with the strategies and action steps in the JK Settlement Agreement, predicated on federal recognition of the effective foundation of collaboration now existing in Arizona, and on the wisdom of the strategies in the Annual Action Plan; and

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- 5 Auditor General Report NO. 02-12, its subsequent and final reviews, confirming substantial completion of ADHS' commitments using appropriated HB 2003 funds supporting JK Action Plan strategies in the areas of collaboration, coaching, and training.

Settlement Agreement paragraph 16: As quickly as practicable, Defendants will conform all contracts, decisions, practice guidelines and policies related to the delivery of Title XIX behavioral health services to be consistent with an designed to achieve the Principles for class members

Status: Partially Met and ongoing

In 2003 ADHS reorganized its hierarchy of documents to provide a set of clear, concise documents, eliminating redundancies, directing requirements to their intended audiences, and, most importantly, clearly stating ADHS' policy regarding key clinical and administrative practices in alignment with the 12 Principles.

One of the most significant changes in the ADHS document organization included developing a Provider Manual with specific information for Providers. Since institution of the Provider Manual in January 2004, the RBHAs no longer develop their own policies and procedures related to specific content areas. Instead, ADHS' now focuses on implementing consistent policy and strong clinical practices statewide. [RBHAs continue to develop policies and procedures that guide their internal operations only.]

Another significant change to ADHS' reorganization of documents includes the complete rewriting and restructuring of ADHS' contracts with the RBHAs. Following is a summary of the work towards and status of this endeavor.

Beginning in 2001, ADHS began a process to write a Request for Proposals (RFP) for RBHA services that would ultimately result in new contracts for all geographic service areas. For Maricopa County, a RFP was issued in September of 2003 and a contract award was made early 2004 with the new contract in effect for July 1, 2004. For the remainder of the state, a RFP for Greater Arizona was issued for all geographic service areas except Maricopa County. ADHS will make a contract award in the first quarter of the 2005 calendar year for contracts to be effective July 1, 2005 in Greater Arizona. Therefore, all Contractors statewide will be operating under the new contracts by July 1, 2005.

Following is a summary of some new contract language that was written for the purpose of addressing the needs of Title XIX children and addressing ADHS' obligations under the Settlement Agreement.

- In listing the eligibility groups that are covered under the contract, language was added to specifically identify Title XIX coverage for children who are in the care in custody of the state including Child Protective Services, Juvenile Corrections and Juvenile Probation.

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- In addition to the general clinical services section, the contract contains a section regarding the specific service delivery requirements for services delivered to Title XIX children. Content within this section includes the following requirements:
 - The Contractor shall operate a delivery system in accordance with the Arizona Vision set forth in the JK Settlement Agreement. The vision is included verbatim in the contract.
 - The Contractor shall serve all children in accordance with the Arizona Children's Principles. The Principles are listed verbatim from the JK Settlement Agreement.
 - The Contractor shall ensure that all children are served through child and family teams.
 - The Contractor shall meet the unique service needs of children in the care and custody of state and minimize placement disruptions.
 - The Contractor shall ensure the delivery of all services including support services and in a timeframe needed by the child and family.
 - The Contractor shall provide Contractor personnel, service providers and family members training to ensure practice in accordance with the Arizona Vision and Principles
 - The Contractor shall seek and utilize stakeholder input in designing and managing the behavioral health delivery system.
 - The Contractor shall provide services to children to the extent possible in their home and community.
- Other sections of the contract include the following requirements:
 - The Contractor shall be administratively organized to achieve the Arizona Children's Vision and Principles.
 - The Contractor shall have processes to rapidly adjust subcontracts to meet the needs of individuals.
 - The Contractor shall have written protocols with the local administration of state agencies that jointly serve children including Child Protective Services, Division of Developmental Disability, Administrative Office of the Courts, and Juvenile Corrections.

As specified in paragraph 16, for the past two and a half years ADHS has consistently acted to ensure that all policies and procedures reflect the Arizona Vision and its 12 Principles, including modifications when they are indicated. As all existing clinical guidance documents are reviewed, for example, attention is given to ensure that they focus not only on the specific treatment needs of the child, but as well on the service and support needs of the family and other caregivers related to the behavioral health needs of that child. Following is a list of policies modified during the third year of the Settlement Agreement that impact the children's delivery system:

Provider Manual Sections:

- PM Section 3.2: Appointment Standards and Timeliness of Service
- PM Section 3.14: Securing Services and Prior Authorization
- PM Section 3.15: Psychotropic Medications: Prescribing and Monitoring
- PM Section 3.17: Transition of Persons

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- PM Section 3.22: Out-of-State Placements for Children and Young Adults
- PM Section 4.3: Coordination of Care with AHCCCS Health Plans and Primary Care Providers
- PM Section 4.4: Coordination of Care with Other Governmental Entities
- PM Section 5.5: Notice and Appeal Requirements (SMI and Non-SMI/ Non-Title XIX/XXI)

Policies and Procedures:

- CO 1.1: Inter-RBHA Coordination of Services
- GA 3.7: Reporting and Review of Deaths of Enrolled Children and Persons with Serious Mental Illness

Supplemental to the Provider Manuals are ADHS clinical guidance documents, which are categorized as:

- Clinical Practice Guidelines (usually nationally developed practice guidelines such as those published through the American Psychiatric Association);
- Practice Improvement Protocols [PIP]; and
- Technical Assistance Documents [TAD].

All ADHS clinical guidance documents are accessible at the agency website (www.azdhs.gov/bhs), and each is developed by an appropriate team including individuals with relevant professional expertise, as well as family members and other stakeholders. Developing clinical guidance documents are rigorously vetted and refined through internal ADHS committees, and through a public input process. A tailored training plan/strategy supports each document, and RBHAs are then expected to incorporate new guidance into existing curriculae, showing ADHS how such content will be incorporated into RBHA training, quality management and other relevant processes to ensure that awareness of the guidance persists and is regularly applied to benefit children and families served.

During this past year, the following new clinical guidance documents were created:

- PIP 7: The Adult Clinical Team
- PIP 10: Substance Abuse Treatment in Children
- PIP 12: Therapeutic Foster Care Services for Children
- TAD 3: The Child and Family Team Process
- TAD 8: Informed Consent for Psychotropic Medication Treatment

In addition, ADHS consolidated a major strategic initiative begun in July 2002 when it unveiled and began statewide implementation of a standard intake, assessment and service planning process that is strength-based, family friendly, culturally sensitive, clinically sound and supervised -- in short, directly supportive of the Child and Family Team practice developed to ensure children and families are served in accordance with the 12 Arizona Principles. ADHS delivered training in all regions of Arizona late in 2003 and began to require, effective January 1,

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2004, that all new children and adults enrolling in the behavioral health system be thoughtfully considered within the context of:

- Input from the person and family/significant others regarding their special needs, important cultural considerations, strengths and preferences;
- Input from other individuals who have integral relationships with the person; and
- Informed clinical expertise, offered primarily via the behavioral health clinical liaison.

The assessment process is specifically designed to support and begin the Child and Family Teams process. The Child and Family Teams technical assistance document clearly integrates the new assessment approach within the CFT process. An additional full-day training component helps to qualify certain behavioral health technicians to be able to facilitate the assessment process. All necessary training required to support use of the new assessment is now being sustained at the RBHA/provider level and strengthened through supervision. Some RBHAs are now beginning to integrate training in the assessment and the CFT process (see Strategy 3), and such integration will be expected in this 4th Annual Action Plan. ADHS maintains a quality management process to ensure that the new assessment approach is being used with fidelity in all regions of Arizona.

Statewide Training Program: Settlement Agreement Paragraph 17 (a) Develop and implement a statewide training program, as described in paragraphs 32-39

Status: Met

Background

During 2001-2002 the 300 Kids Pilot and Project MATCH sites served as laboratories for the development of the Child and Family Team approach. VVDB guided the initial development of this approach through a combination of training and coaching activities. By mid-2002 early transfer of “ownership” of the process, supportive curriculum and coaching methods began to emerge, first within Maricopa County. ADHS identified compatible processes within other child-serving systems (notably DES-DDD and DES-ACYF). Those early sites developed and began to implement approved workforce development, training and coaching plans as the first efforts to grow CFT practice from early pilots toward statewide spread. Maricopa County became the first region to assume local responsibility for providing training and coaching support, to which ADHS had allocated a total of \$1,711,000 between April 2002 and June 2004.

By early 2003 both Maricopa and Pima Counties had accessed and/or developed curriculae to teach individuals how to facilitate the Child and Family Team process with families, had begun to develop training focused primarily for supervisory personnel, and had also begun to specialize training for certain other members of the behavioral health workforce – notably psychiatrists. Both regions had begun to offer an overview of the 12 Arizona Principles and an orientation to the Child and Family Team process broadly throughout the behavioral health workforce, partners from other child-serving systems, family and community members. Both regions, in fact, had begun to offer

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the overview training in Spanish as well as in English. Each round of CFT facilitation training in the early pilot sites had been closely monitored and analyzed by VVDB, ADHS, local leaders and participants to identify lessons learned, and those lessons have been routinely incorporated into improved design of subsequent teaching and coaching across Arizona. [Based on early learning in Maricopa County, for example, ADHS worked with CPSA, Excel and PGBHA regions to ensure early training for supervisors, and their close inclusion in the teaching and coaching their direct line staff have been receiving.]

Following a major statewide kick-off event in March 2003, the Child and Family Teams training program has now been extended into every region of Arizona. All RBHA regions have received combinations of HB 2003, CMHS block grant and/or Project MATCH federal grant funds to support regional training, coaching and consultation plans approved and monitored by ADHS. Beginning October 1, 2004, a new federal statewide infrastructure grant (SIG) is now infusing additional federal funds into the regional workforce development efforts. The Excel Group, PGBHA and CPSA 3 regions began initial Child and Family Team process training in 2003, and robust workforce development guided by these plans continues in all regions of the state. Experts from VVDB, from the Child Welfare Policy & Practice Group, from Child & Family Support Services Inc., from Native American Training Institute (Pascua Yaqui Tribe), Four Directions Consulting LLC/Human Service Consultants, and occasional other experts (e.g. Karl Dennis, Jon Eagle Susan Smith, Pat Miles, are providing and guiding instruction, coaching and consultative support. The Gila River TRBHA began working with VVDB in a parallel effort in June 2004.

An amount of \$350,000 in CMHS block grant funds were applied to support the approved regional plans between December 2003 and September 2004 in the EXCEL, PGBHA, CPSA-3, NARBHA and Gila River regions. An identical allocation of block grant funds is being made during autumn 2004, now enhanced by more than \$480,000 in new federal grant funds secured from CMHS as part of Arizona's state infrastructure grant (SIG). In addition, CMHS approval was secured effective September 1, 2004 to include the CPSA-3 region within the jurisdiction of Project MATCH, allowing final year federal funding under that grant to extend beyond Pima County. By 1/31/05 ADHS will formally request that CMHS grant access to unspent funds accumulated in this grant program since 1999 to be invested in capacity development in this final year of that grant. ValueOptions has made a significant commitment of its own funds to support continuing teaching and coaching within its new contract with ADHS effective July 1, 2004. In every region, personnel from partnering child-serving systems (including, for example, CPS caseworkers and juvenile probation officers) have participated in CFT facilitation training.

Continuous improvements in the effectiveness of training and coaching approaches have been made by VVDB, by several RBHAs, and with support from other experts. At the same time, supplemental training on specific related topics (e.g. addressing the needs of children in foster care, by Rick Delaney PhD in the NARBHA region during April 2004) is routinely adjusted now to integrating material within the context of the 12 Arizona Principles and the Child and Family Teams process, minimizing the burden on the RBHA/provider workforce to have to translate or interpret such learning to Arizona-specific practice and therefore optimizing its positive impact on change in actual practice.

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In July 2003 VVDB delivered complete Child and Family Team facilitation training kits to each RBHA region that provide portable, multi-media support for sustainable training and coaching in Child and Family Team facilitation processes and skills. These useful teaching materials have been incorporated into local coaching work by supervisors in some communities, and have also been applied by ADHS to support training in the statewide assessment process. In Maricopa County, ValueOptions and the Family Involvement Center (FIC) developed and regularly deliver intensive classroom training to all incoming staff who will work with more complex CFTs. In addition, VO and FIC have partnered to prepare over 165 Clinical Liaisons to facilitate the statewide assessment and the CFT process for children and families with less complex needs.

All Children's Program staff in Yuma and Parker completed the four-day VVDB CFT training and received subsequent coaching from VVDB, including supervisory coaching in the use of coaching/supervision tools to monitor fidelity to the Arizona Vision. New employee orientation now includes specific training on the 12 Arizona Principles and a basic overview of the CFT process. As a step toward transferring practice expertise to internal staff, EXCEL contracted with an internal coach, whose initial CFT training was conducted in October 2004. Internally delivered training will continue on a quarterly basis.

In September 2004 ADHS published a technical assistance document (TAD) on the Child and Family Teams process, detailing effective facilitation of CFTs in a step-by-step process. The final step of the CFT process is transition, as when a young person leaves adolescence for adulthood. ADHS also developed a practice improvement protocol (PIP) to guide transitions for youth to adult services. In late summer ADHS provided statewide training about these processes.

ADHS (Frank Rider) and Family Involvement Center (Josie Bejerano, Jane Kallal) representatives have actively participated in the National Wraparound Initiative (NWI), hosted by Portland State University's federally funded research and training center to develop a consensus definition of the wraparound (in Arizona, the Child and Family Teams) process and supportive teaching and technical assistance materials. Arizona's representatives have helped to shape the national model (e.g. reflects clinical liaison concept, and mirrors Arizona's CFT PIP and TAD). In October 2004 the NWI published its first three work products. ADHS is currently comparing these documents to its existing clinical guidance, expecting that initiative's publications will be able to serve as additional curriculum to support Arizona's workforce development.

Over 500 CFT facilitators had completed training and were available to facilitate the Child and Family Teams process in Arizona as of October 1, 2004:

| | |
|--------------|-----|
| CPSA-3 | 44 |
| CPSA-5 | 139 |
| NARBHA | 39 |
| ValueOptions | 203 |
| PGBHA | 27 |
| EXCEL Group | 50 |

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Increasing attention continues to be paid to the development of supervisor skills and capacity to support effective Child and Family Team practice in Arizona. In Maricopa County, ValueOptions and the Child Welfare Policy and Practice Group developed a three-day supervisory training curriculum, whose elements will now be integrated into a more effective teaching approach to ensure sufficient support for facilitators of Child and Family Teams. In Pima, Graham, Greenlee, Yuma, LaPaz, Santa Cruz and Cochise counties, VVDB has developed and is teaching the use of a set of supervision tools and methods intended to build self-perpetuating capacity within supervision structures to coach, mentor and guide CFT facilitators. In September 2004 a special leadership event hosted by ADHS and ValueOptions represented the beginning of a new intensity of focus on the importance of effective clinical supervision to support continuous performance improvement.

Maricopa, Pima, Mohave, Coconino, Navajo, Apache and Yavapai Counties have matured to the point where they are now producing internally sustainable teaching capacities to help spread and maintain Child and Family Teams practice.

ADHS' collaboration with the DES Child Welfare Training Institute (CWTI) has now devolved to coincide with the decentralization of that training program to the regional CPS districts. Curriculum content initially created by ADHS to help CPS workers to understand and effectively participate in the CFT process has been passed to the local CPS districts who now host that training for new child welfare workers. RBHA representatives have been encouraged to co-teach some of the training for CPS workers. In Maricopa County, a detailed protocol developed jointly by ValueOptions and CPS now describes how the two systems work with the Child and Family Teams process. This protocol was made official CPS policy in Maricopa County during summer 2004, accompanied by a joint training effort by the two partnering systems. Similarly, CPSA and CPS have developed and regularly deliver cross-system training in Pima County.

NARBHA's preparation of CFT trainers has included child welfare as well as behavioral health personnel. Its April 2004 training by national expert Rick Delaney PhD on the needs of children in foster care attracted dozens of child welfare workers alongside their behavioral health partners, and was customized by the instructor so that participants can understand how to most effectively use Arizona's CFT process to effectively serve this special population.

A joint training plan developed by ADHS, ValueOptions and the Arizona Department of Juvenile Corrections [ADJC] applies HB 2003 funds to support training for parole officers and for ADJC employees in secure settings to be able to participate in, and to facilitate, the CFT process for youth served by that system. ADHS approval of regional workforce development, teaching, coaching and consultation plans has routinely required such outreach to child-serving system partners in all regions of Arizona.

In regions such as Pima County and northern Arizona, local cross training initiatives with DES have begun. The CPSA training team has partnered with representatives of DES developing two cross-training curricula focused on integrating the work of both systems on behalf of victims of

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abuse and neglect, their families and protective foster caregivers. The new training classes were first delivered during the summer of 2003. NARBHA and DES District III are jointly training all of the NARBHA Service Area Agencies on the purpose of the Child and Family Team process as a precursor to the full facilitation training.

As in previous years, ADHS and RBHAs have sought out opportunities to promote practice changes congruent with the 12 Arizona Principles through several cross-system training events around the state. These included:

- 11/20/03 – DES-ACYF Management Team, at Family-Group Decision-Making summit
- 12/02/03 – DES-ACYF Child Welfare Training Institute – Tucson
- 12/04/03 – Child and Family Teams PIP for CPSA/Providers and DES-ACYF Districts II and VI leadership – Tucson
- 12/05/03 – Administrative Office of the Courts - juvenile court judges
- 01/08/04 – Child Abuse Prevention Conference, Mesa
- 02/03/04 – DES-ACYF Child Welfare Training Institute – Phoenix
- 02/04/04 – Arizona State University School of Social Work – integrating 12 Arizona Principles & CFT concepts into pre-service curriculum
- 02/06/04 – Juvenile court judges training conference at ASU Downtown
- 02/11/04 – ASU Graduate School of Social Work curriculum (Scott Okamoto PhD)
- 02/19/04 – ASU Social Work undergraduate curriculum (Layne Stromwall PhD)
- 03/23/04 – Juvenile court judges training conference at ASU Downtown
- 05/04/04 – ALTCS Program Contractors @ AHCCCS
- 05/04/04 – South Mountain Community College
- 05/21/04 – Foster Care Review Board 25th Anniversary Statewide Conference (2 sessions) in Chandler
- 05/26/04 – DES Adoption Subsidy/DES-ACYF/ValueOptions/CSPs in Phoenix
- 05/27/04 – DES Adoption Subsidy/DES-ACYF/RBHAs – statewide telemedicine
- 07/26/04 – Summer Institutes (Sedona) – Substance abuse treatment via CFTs
- 09/27/04 – Pilot for Birth to age five PIP – ADHS, Arizona’s Children Association, Blake Foundation, Child Crisis Center, CPSA, Ebony House and ValueOptions
- 09/30/04 – Functional Assessment of Challenging Behavior – ADHS, DDD and NARBHA
- 09/04-10/04 – Child and Family Teams process technical assistance document: cross-agency training audiences attended these 7 training sessions by the ADHS Bureau for Children’s Services in Nogales, Yuma, Tucson (2), Flagstaff, Phoenix and Apache Junction

The family perspective is increasingly reflected in the statewide training program, a perspective expected to proliferate both within behavioral health capacity development, and across other child-serving systems. Early in 2004 the Children’s Executive Committee adopted a Family Involvement Framework detailing a list of specific means for integration of the expertise of family members into outreach, training and coaching, policy development and other system-building

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work. During summer/fall 2004 the Executive Committee's family involvement subcommittee began to focus its attention on increasing family involvement in CPS reform and foster parent training. CPS' new "Family to Family" Initiative (Casey Family Foundation) pilot, soon to begin in Maricopa County, has already invited participation from MIKID and the Family Involvement Center.

The new statewide infrastructure grant (SIG) awarded to ADHS by SAMHSA on October 1, 2004 has developed contracts with both MIKID and Family Involvement Center to serve as the state's primary sources of expertise in continuing to infuse family expertise in the development of expanding system capacity. MIKID was also awarded a statewide family network grant by SAMHSA in August 2004, which includes a specific dedication of resources to build family involvement infrastructures in some of Arizona's rural [e.g. Colorado River, White Mountains] communities.

Most RBHAs have now established contracts or other effective partnerships with family organizations (e.g. Family Involvement Center in Maricopa County, MIKID in Pima County, in the PGBHA and NARBHA regions, OCSHCNs in NARBHA region). These family-run organizations, in addition to other system-building work, now recruit and train qualified family members for positions within the behavioral health workforce. MIKID and Family Involvement Center have both developed and delivered specialized training for behavioral health workers to help them to understand how to provide truly family-centered practice, and how to effectively use the Child and Family Team process.

Teaching, coaching and consultation efforts have multiplied geographically and geometrically during the past year that substantially address the obligation for a statewide training program. During this upcoming year, ADHS and AHCCCS will continue statewide implementation of the strategies and action steps outlined in this 4th Annual Action Plan.

ADHS has also organized a Higher Education Partnership to build, in collaboration with Arizona community colleges, universities and others, a future behavioral health workforce that will meet the needs of children, their families and communities in the years to come. In October 2004, this partnership adopted as its three strategies:

- Promote integration of Arizona practice models (primarily Child and Family Team process, Adult Clinical Teams process, Recovery Model, and nationally accepted best practices) into higher education curriculae;
- Recruit students who represent the composition of local communities; and
- Market human service academic/training programs to prospective students.

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Respite Care: Settlement Agreement paragraph 17(b) add respite to the list of covered services as described in paragraph 40

Status: Met

Background

As specified in paragraph 40 of the Settlement, respite was added as a covered service. Since 2002 respite capacity development has been a priority for all regions.

The EXCEL Group in Yuma and LaPaz counties has built regular respite activities to offer planned, scheduled relief for family caregivers and constructive activities for their enrolled children. EXCEL also contracts with Child and Family Services to provide out-of-home, overnight respite in the Yuma region. In GSA-3, CPSA's provider network has subcontracted with a variety of outpatient clinics, community service agencies and habilitation providers to expand available respite capacity. CPSA Region 5 (Pima County) has develop outpatient respite options, but also crisis respite capacity through Intermountain Centers for Human Development, and through its Sandero crisis stabilization facility. Mary's Mission also provides overnight respite and therapeutic day services in a Level II DES shelter, and a recent Habilitation Provider fair promises to add additional respite capacity through existing DDD providers.

NARBHA continues to prioritize non-skilled respite services within its network development plan, and currently offers respite capacity through its service area agencies, and through subcontracts with Creative Networks, ASKAN Foundation and Arizona's Children Association. NARBHA convened family members and respite providers to develop guidance about respite practices. PGBHA has developed a uniquely rich program through Red Mountain Respite, a community service agency, combining family therapy, family support, living skills training and other active treatment with its respite program. PGBHA has in-home respite available across its region, and also offers facility-based respite through subcontractor Devereux.

As part of a \$12-million dollar contracting effort in FY 2005 to rapidly ramp up capacity to provide direct supports, ValueOptions continues to develop and refine its network of respite providers, to meet both *ad hoc* needs as well as offer planned day program activities on weekends and after school to provide rest and relief to family caregivers. Many of the Comprehensive Service Providers (CSPs) have developed respite capacity within their agency or subcontract with other providers (e.g. Arizona's Children Association, Rio Salado Behavioral Health, Family Support Resources, MARC Center) to deliver in-home respite. MIKID's new contract with ValueOptions will provide a respite group on Saturdays for children ages three to 12, offering not only rest and relief for primary caregivers, but also social activities and skill-building opportunities for the children.

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2004

During the period July 1, 2003 through June 30, 2004, the total value of encountered respite services for 1,502 children's family caregivers reported to ADHS by RBHAs was over \$2.2-million:

| RBHA | Members | Service Code | Units of Service | Value |
|-------------------|---------|--------------|------------------|----------------|
| ValueOptions | 694 | 5150 | 76,033 | \$1,215,643.92 |
| | | 5151 | 726 | |
| CPSA-3 and CPSA-5 | 90 | 5150 | 1,474 | \$74,427.76 |
| | | 5151 | 289 | |
| NARBHA | 277 | 5150 | 16,572 | \$304,926.25 |
| | | 5151 | 427 | |
| EXCEL Group | 191 | 5150 | 817 | \$11,441.50 |
| | | 5151 | 0 | |
| PGBHA | 250 | 5150 | 38,794 | \$615,457.00 |
| | | 5151 | 161 | |

**5150 units represent 15 minutes; 5151 units represent 1 full day*

ADHS continues to monitor the use and availability of respite services through a number of different mechanisms. This includes utilization data reflected in submitted encounters, quarterly Network Development meeting with each RBHA and consumer complaints.

Two additional approaches augment the provision of nonskilled respite services to provide critical relief and rest for family caregivers. First, the provision of living skills training, personal assistance and similar active treatment strategies are often scheduled to provide incidental relief to caregivers as a more efficient use of covered services. Second, as the Child and Family Team proliferates, and as its full potential for effective practice is reached, the identification, attraction and accommodation of natural supports and other informal resources becomes an increasingly viable avenue through which families of children needing mental health services can enjoy opportunities to "recharge their batteries."

Specialty Providers: Settlement Agreement paragraph 17 (c) devise and implement a means of allowing RBHAs to contract with certified Masters level behavioral health professionals as described in paragraph 41

Status: Met

AHCCCS and ADHS have employed a variety of strategies to meet this specific objective and increase availability of access for children and families to clinical professionals with special areas of expertise.

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In January of 2001, AHCCCS began expanding the number of Independent Biller provider types to include certain types of so-called specialty providers. In April 2002, AHCCCS further expanded the definition of Independent Biller to include Masters level behavioral health professionals who are certified by the Arizona Board of Behavioral Health Examiners (AZBBHE) as Certified Independent Social Workers (CISW), Certified Professional Counselors (CPC) and Certified Marriage and Family Therapists (CMFT). These professionals may now register with AHCCCS as Independent Billers, allowing RBHAs more options to secure access to their services.

Regular tracking by ADHS and AHCCCS shows that these changes have, in fact, helped to enrich RBHA provider networks with clinicians who can provide services relevant to identified member needs. AHCCCS has monitored its ALTCS Program Contractors on the development of capacity and implementation of this Masters level provider type. The Program Contractors have actively recruited these individuals, and have been successful in expanding their networks to include clinicians who can meet the unique needs of their members. ADHS continues to require the RBHA's to have a tracking system in place to monitor the capacity and availability of providers with one or more of six long-established areas of special expertise: PTSD, attachment and bonding, sex offender, sexual abuse survivor, eating disorders and adoption. In addition, ADHS tracks RBHA capacity to meet the needs of persons with developmental disabilities. Reporting of such capacity is included in quarterly network development meetings between ADHS and its contracted RBHAs.

In addition to the specialty providers identified in paragraph 41 of the Settlement Agreement, RBHAs have expanded their networks to include other specialty providers. ValueOptions offers dialectic behavioral therapy. NARBHA and ValueOptions offer multi-systemic treatment [AHCCCS established a special rate code for MST in 2004 to better support cost-effective provision of this highly effective service approach] through highly trained and certified teams. ValueOptions likewise offers functional family therapy, and other RBHAs are currently considering the need to add either or both of these evidence-based intervention approaches to address the needs of children/adolescents with conduct-related problems, and their families. PGBHA, CPSA and ValueOptions offer "equine therapy" (therapeutic horsemanship) services. CPSA provides specialized services for pregnant teenagers. CPSA also contracts to provide assessments through the 24-hour urgent response protocol for children age birth through four who have been removed from their homes. CPSA maintains a psychologist and master's level staff within each of its provider networks with expertise in working with CPS-involved children.

ValueOptions now contracts with the East Valley Child Crisis Center to provide specialized services for children between birth and 11 years of age who have attachment and bonding problems, as well as specialized services for children ages birth to five. Specialized respite, living skills training, family support, home care training and personal assistance supports are furnished. ValueOptions provider Christian Family Care Agency Inc. offers expertise to children with disorders of attachment and bonding and their families or other caregivers. Looking first to existing providers whose track records have satisfied CPS, ValueOptions has already begun to establish, and NARBHA and CPSA are exploring potential, contractual relationships to

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appropriately apply Medicaid funding for family support and family preservation services for eligible families involved with CPS. Similarly, ADHS is examining the clinical components of traditional AOC RAFT (Renewing Arizona Family Traditions) programs to explore appropriate applications of Medicaid funding for similar services to families of youth involved with juvenile justice systems.

Expansion of Title XIX Services: Settlement Agreement Paragraph (d) expand Title XIX services as described in paragraphs 42-45

Status: Met

ADHS and AHCCCS use an Annual Provider Network Sufficiency planning process to ensure the development and availability of covered behavioral health services for children and their families. ADHS network development teams meet with each RBHA through this process on a quarterly basis. A logic model is applied by the RBHAs to bring data from multiple points (especially quality management and utilization data, but also stakeholder input, complaints, and integration of statewide best practice initiatives) together for analysis and prioritization of service development priorities. Dynamic rate study and capitation work helps ensure financial resources will support needed service development, and active development of clinical guidance by ADHS provides technical assistance in optimizing the potential of Arizona's wide service array.

Beginning July 1, 2004, for example, ADHS and AHCCCS instituted a targeted capitation rate for children in the child welfare and juvenile justice systems covered by the CMDP health plan, offering RBHAs a significantly enhanced level of funding to support the special needs of that target population. During the two previous years capitation rates had been increased predicated on planned rises in the number of behavioral health Level I, Level II and therapeutic foster care placements to address specific capacity needs identified in the child welfare and juvenile justice populations.

Effectiveness of behavioral health services for children involved with CPS depends in part on earlier interventions, so as part of the behavioral health system's role in Governor Janet Napolitano's CPS reform, ADHS instituted an August 2003 change in its policy to require an urgent (that is, within 24 hours) response by RBHAs for all children entering foster care who are referred by CPS. (CPS, for its part, made a parallel policy change requiring its workers to refer all children being removed into foster care to the RBHA in anticipation of the RBHA's urgent response.) Initiation of the ADHS policy change was described in the Year Three Action Plan. Since the inception of that change, and through October 31, 2004, fully 2,975 new foster children have received the urgent response:

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| RBHA | Urgent Responses for Children Entering Foster Care |
|---------------------|---|
| ValueOptions | 1,265 |
| CPSA-3 | 223 |
| CPSA-5 | 853 |
| NARBHA | 366 |
| EXCEL Group | 117 |
| PGBHA | 151 |

Focused efforts to develop capacity for direct support services (e.g. unskilled respite, living skills training, personal assistance) often needed for children and families began in 2002. AHCCCS added Habilitation providers to the array of allowable behavioral health providers effective April 1, 2003. With the addition of that provider type, RBHAs gained a new way to increase the available pool from which support services (i.e. unskilled respite care, living skills training, personal assistance and non-emergency transportation) can be delivered. When the inclusion of habilitation providers proved to be slow, ADHS completed a RBHA-by-RBHA analysis during April 2004 to identify impediments. Most RBHAs reported that support services were already being developed and offered by outpatient clinics in their regions, and that few specific requests for habilitation providers had been received. CPSA held a successful Habilitation Fair and all RBHAs were encouraged once again to explore potential to enhance their support service capacities through this provider type.

Case management and therapeutic foster care capacity have also been early priorities. Since late 2002 ADHS has worked with DES-ACYF to review all children in Level I and II placements for potential Medicaid funding or for viable community-based alternatives. ADHS' recent Out of State Placement Policy (Policy 2.11) sets clear guidelines surrounding the use of out of state placements, striving to keep children in Arizona. Many are children in the foster care system. Significant progress has been made by the RBHAs to return children to Arizona and to avoid making new placements outside the state. Since June 2002, the total number of out-of-state placements by the behavioral health system has decreased from 100 to 23. The behavioral health and child welfare systems have worked to identify all existing professionally licensed foster care homes for potential Medicaid funding, and many of those homes are subsequently being funded through Medicaid.

Given the demonstrated effectiveness and cost-effectiveness of therapeutic foster care services, several RBHAs (e.g. NARBHA, ValueOptions, CPSA) during 2004 have also undertaken initiatives to recruit new families to provide those services in their regions. Through a collaborative process involving foster parents, DES-ACYF and others, ADHS developed a

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practice improvement protocol to guide use of these services in October 2004. That protocol will be supported with statewide training by April 2005. 232 TFC beds were available statewide by October 31, 2004.

ADHS recognized last year that, for most RBHAs, the cost of serving individuals with developmental disabilities significantly exceeds the capitation amount they receive for this purpose. ADHS analysis and requests for program enhancements from the Division of Development Disabilities (DDD) combined to support a proposal to AHCCCS to adjust the capitation rate. Effective January 1, 2005, the rate will increase by more than 40% (from \$66.35 to \$95.06 per DDD-ALTCS member per month) to reflect actual costs plus substantial program enhancements. ADHS studied the service needs of this population. ADHS will work with RBHAs to implement program enhancements in several areas, including contracts with DDD specialists and additional specialized services to assist with behavior management.

2004 covered services development highlights in each region are outlined below:

EXCEL

Therapeutic Foster Care Homes (TFCH):

In 2004, EXCEL developed a contract with Arizona Children's Association (AzCA) to create Therapeutic Foster Care homes. Currently, EXCEL has one TFCH with two beds available in region. EXCEL has also contracted with Providence and Touchstone Behavioral Health for additional TFCH capacity out of region.

Family Support:

EXCEL has contracted with MIKID to provide training, beginning in January 2005, to volunteers who will serve as mentors to others with children receiving behavioral health services.

Level I and II Residential Programs:

The EXCEL Group opened a Level I facility in Yuma during 2003. As a 24-bed facility, the Bridges RTC has allowed EXCEL to provide intensive out of home services to children and families within their own community/region, instead of travel at least 180 miles away in Phoenix, Tucson or beyond. The Bridges program is designed to allow for short-term/crisis stabilization (1-7 days) as well as for longer stays, and uses an integrated CFT approach for community transitioning. EXCEL has successfully used the Bridges resource to return virtually all youth from distant placements back to their own region, and is currently considering a reduction in the number of permanent Level I beds, perhaps creating an adolescent Level II substance abuse treatment resource by separating part of the facility.

GILA RIVER RBHA

The Gila River RBHA has expanded its provider network to include implementation of a 24/7 on-reservation crisis response network, expansion of in-home treatment and support services,

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implementation of best practice prevention programming in schools, and the development of dedicated therapeutic foster care homes for children. During Year Three Gila River has developed Red Mountain respite as a community service agency providing respite and other support services.

CPSA

Direct Support Services:

ADHS and the Project Match grant have supported development of MIKID as a family involvement resource in Pima County. Family members can receive information and support, training about participating in the CFT process, and training to fulfill family mentoring and leadership roles within CPSA's provider network. MIKID has actively collaborated with the FIC to support multiple roles for family members within the behavioral health system. MIKID provided its inaugural Pima County training during 2003, adapting and creating curriculum in consultation with national consultant Pat Miles. Pat provided direct training for MIKID and for Project MATCH staff to improve their engagement skills and to teach of the expertise, perspectives and voices of families. Currently CPSA-5 employs 13 family support specialists and CPSA-3 employs four.

Therapeutic Foster Care Homes:

Therapeutic Foster Care is a priority for capacity development at CPSA. Pima County has the largest total number of DES professionally licensed homes in the state. Like all RBHAs, and as an ADHS expectation underlying the CMDP-specific RBHA capitation rates that became effective 7/1/04, CPSA is, in partnership with DES-ACYF District II personnel, continuing to assess the status of all DES-ACYF foster children currently placed in its licensed professional family foster homes, to convert such placements to RBHA funding and management and optimize Medicaid funding. CPSA providers hold current capacity for over 110 children and adolescents in therapeutic foster care beds. CPSA has led a very rich cross-system foster family recruitment initiative during fall 2004, applying Project MATCH grant funds to enhance other resources offered by DES-ACYF and a number of community organizations.

Community Service Agencies (CSA):

CPSA boasts ten separate community service agency providers of respite and other support services throughout the five southeastern Arizona counties, including several Boys and Girls Clubs, the Tucson Urban League, multiple therapeutic horsemanship programs and several other innovative programs (e.g. mentoring through University of Arizona, supervised day programming through the Humane Society of Southern Arizona). The Boys and Girls Club of Tucson specifically target the Latino and Pascua Yaqui youth population. Another contracted CSA, MIKID provides support to CPS-involved children and their families.

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Crisis Services:

In the fall of 2003, CPSA opened its Sandero Adolescent Crisis Stabilization Unit, a 10 bed facility for children 12 years and older. The facility is located at CPSA's Plaza Arboleda and operated under a contract with Sonora Behavioral Health. The purpose of this facility is to maintain children in a community setting. Admissions are predicated on active CFT participation in both the placement and course of treatment, as well as post-discharge support and strengthening activities.

Tohono O'odham

CPSA continues to support the partnership among Intermountain Centers for Human Development, the Pantano Network, tribal agencies and the Tohono O'odham community, providing home and community based supports and services for over 70 on-reservation children and families. Creative use of Project MATCH grant funds led to the establishment of a satellite-based tele-medicine connection in Sells that now allows direct services (e.g. medication monitoring) to be furnished far more frequently and readily than had previously been the case, when residents would travel over 100 miles to Tucson or await the twice-monthly visit by the traveling psychiatrist.

NARBHA

Therapeutic Foster Care Homes:

NARBHA continues to expand capacity for Therapeutic Foster Care (TFC) services, with 11 family homes and 34 total beds by 10/31/04.

Community Service Agencies:

NARBHA has added Parenting Arizona Inc. (formerly Parents Anonymous) and MIKID to join Creative Networks and ASKAN Foundation as community service agencies providing respite and other support services.

Multi-Systemic Therapy (MST):

NARBHA has contracted with Touchstone Behavioral health for the provision of MST, and monitors utilization and outcomes of youth receiving this service. In addition, Apache Behavioral Health Services (Fort Apache Reservation) has received a grant to develop MST within its service area.

Level I and II Residential Programs:

NARBHA has expanded its local capacity for Level II residential programs, in order to help local youth needing intensive treatment to remain close to their home communities and families, instead of being placed in Phoenix, St. George or other distant locations. In September 2004, Daybreak Behavioral Resources opened a new home in Dewey serving female youth, including some with sexual acting out behaviors. NARBHA and DDD are combining efforts to open a home for children who have a lower level of functioning. At this time NARBHA and DDD have

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developed and executed a Memorandum of Understanding specifying program admission, coordination and evaluation. They have also begun to solicit interest from providers for this home.

PGBHA

Therapeutic Foster Care Homes:

PGBHA contracts with Arizona Children's Association, Devereux, Human Service Consultants and Providence to provide Therapeutic Foster Care (TFC) homes within its region. Sixteen TFC homes have been added to PGBHA's capacity in the past year, bringing total capacity in the region to 24 beds.

Community Service Agencies:

PGBHA increased its contracts with Community Service Agencies to four this year, adding Presbyterian Service Agency/Art Awakenings to provide art therapy to children and families, Red Mountain Respite (three sites), Maricopa ACE Foundation/Ak Chin CAASA and MIKID to provide respite and other support services. MIKID specifically provides family and peer support, living skills training, health promotion, supervised day and personal assistance. MIKID is now developing and facilitating local family support groups in Apache Junction and Eloy. PGBHA funds a full-time position to coordinate these activities. In order to provide more culturally appropriate services for this region, MIKID has also added an additional Spanish-speaking family support partner to its team.

ValueOptions

Direct Support Services:

ValueOptions has set aside twelve million dollars this year to provide direct support services for children and their families via direct contracts with the RBHA, in addition to those support services already provided by its Comprehensive Service Providers [CSPs]. Efficiency savings through this direct contracting mechanism in turn free up resources that are invested in building case management, family support and other needed capacity within the CSPs. CSP staff are able to refer directly to any of more than 20 new contractors for support services. ValueOptions is monitoring usage of the new providers and allowing for expansion of initial contracts within the agencies that prove to be in the most demand.

One new support service provider, MIKID, has launched an innovative program to provide special support for caregivers of young children from birth to age five. This program provides parenting skills classes, a parent support group and parent mentors for individuals who are substitute caregivers such as grandparents.

Recently, FIC also contracted with ValueOptions to become a direct service provider. FIC has created a new branch, called "Family-to-Family Services," to provide in-home and community-

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based supports for biological parents, foster parents and adult caregivers. All staff hired to provide services within this program are parents of persons with mental illness.

Therapeutic Foster Care Homes (TFCH):

By October 31, 2004, ValueOptions had contracts with nine agencies to develop TFC homes. ValueOptions has contracted with Valle del Sol to recruit homes for Latino children, Black Family and Children's Service to recruit homes for African American children and Prehab of Arizona to recruit homes for children who act out sexually. Currently, ValueOptions has 88 licensed homes providing a total of 109 beds.

Family Support:

ValueOptions deploys 58 Family Support Partners (FSPs), who are directly employed by the Comprehensive Service Providers (CSPs). ValueOptions has given approval for an additional 14 FSPs to be hired.

The Family Involvement Center (FIC) is a not-for-profit, parent-run resource and training center focused on the issues of children and youth with behavioral health needs and their families. ValueOptions continues to support FIC and vice versa. FIC partners with ValueOptions in recruiting and training Family Support Partners, in training new Case Managers and Clinical Liaisons. In November 2004, ValueOptions will begin to hold its monthly Children's Advisory Council meetings at FIC. The intent of this change in location is to increase parent participation in, and therefore the effectiveness and credibility of the advisory council.

Community Service Agencies:

ValueOptions has, in the past year, increased its contracts with Community Service Agencies from one (Rio Salado Behavioral Health) to five, adding MARC Center – Mesa, FIC, MIKID and Aid to Adoption of Special Kids [AASK] to provide support and respite services.

Some of ValueOptions' earlier CSA subcontractors have now become OBHL-licensed clinics, expanding the array of services they can provide. Child and Family Support Services (CFSS), for example, originally contracted with ValueOptions to provide only direct support services. Since obtaining behavioral health licensure CFSS now provides case coordination (e.g. CFT facilitation), in-home counseling, living and social skills training, positive behavior support programs and respite care. CFSS particularly focuses on supporting children in out of home placements to remain stable and successful in their placements, and also supports children as they return home to their families. Youth Etc. is another example of a CSA turned licensed behavioral health provider. Youth Etc. provides direct support services for youth ages eight to 17 who are at high risk for residential treatment. Youth Etc. provides in-home behavior management, family support, therapy, mentoring, substance abuse treatment, family nights and structured recreational activities.

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Crisis Stabilization Services:

ValueOptions considerably strengthened its crisis services this fall, when Empact added two crisis teams to its existing ones. Empact is now able to serve 160 families. Terros also now has two crisis teams serving 80 families. Both Empact and Terros crisis teams have shifted their focus from purely crisis management to include crisis prevention, and are now being referred to as "DES Stabilization Units." The Stabilization Units regularly visit children placed out of their homes by CPS who are at high risk for disrupting their placement. These units help to assess needs and identify ways to help maintain placements. Stabilization teams may develop crisis plans, teach behavior modification techniques to caregivers and teachers and support children and families as reunification occurs.

Flex Funds: Settlement Agreement paragraph 17 (e) designate \$600,000 for use as flex funds as described in paragraphs 46-47

Status: Met

Background

Beginning in March 2001, ADHS had allocated \$600,000 of flexible funds to ValueOptions and NARBHA for use in the 300 Kids Pilots. A similar pool of flex funds was created in Pima County through the federal grant-funded Project MATCH. Those funds were established to supplement any necessary covered services and supports not reimbursable through Medicaid. Regular reports about the use of flex funds from both 300 Kids Pilot sites were made to the Children's Executive Committee between through and March 2002, and by Project MATCH to grantee ADHS. The Children's Executive Committee and ADHS both agreed that flex funds are an important component of the Child and Family Team process, and those initial pilot experiences led to ADHS' decision to make flex funds available through every RBHA. In May 2002, ADHS secured CMHS block grant funding for statewide availability of flex funds, and made its first statewide allocation for state FY 2003. Nearly \$285,000 were expended by the RBHAs as flex funds that year, and ADHS subsequently allocated an additional \$729,700 in flex funds for children and families for FY 2004.

2004

Use of flex funds is one of several areas (family involvement, adult clinical teams process) where implementation of the Settlement Agreement is impacting Arizona's entire behavioral health system. ADHS has begun to allocate federal block grant funds as flex funds to RBHAs to serve persons age 18 and over, and significantly increased that allocation for RBHAs for FY 2005. In addition, RBHAs have discretion to apply additional funds as flexible funds, and ValueOptions has supported significant spending beyond funds allocated by ADHS.

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| Regional Behavioral Health Authority | FY 2005 Allocations |
|---|----------------------------|
| CPSA5 | \$114,200 |
| EXCEL | \$ 27,947 |
| ValueOptions | \$458,171 |
| NARBHA | \$ 67,938 |
| PGBHA | \$ 30,043 |
| CPSA3 | \$ 31,401 |
| Grand Total | \$729,700 |

ADHS tracks RBHA flex funds encounters and expenditures. In June 2003, ADHS featured more than a dozen actual examples of effective uses of flex funds for an audience of about 70 practitioners at the annual Family-Centered Practice conference it co-sponsors with DES-ACYF.

In 2003 ADHS met with RBHA CEOs to reinforce the importance of these flex funds as a tool available to child and family teams. Several instructive examples of effective uses of flex funds have been furnished to RBHAs as technical assistance. Guidelines for use of flex funds are publicly available in the ADHS Covered Services Guide (on-line). Flex funds are cited in the ADHS practice improvement protocol for Child and Family Teams. In the coming year ADHS and RBHAs will continue to integrate strategies on the use of flex funds in both training and technical assistance opportunities. Contingent on availability of funds, ADHS will seek to allocate at least the same aggregate level of flex funds to RBHAs in FY 2006 as in FY 2005.

Some other child-serving systems have shown interest in making some flexible funds available to children and families they serve (in common with ADHS). The Administrative Office of the Courts (AOC)' guidance to all county juvenile probation offices, and DES-ACYF family preservation service contracts are two examples. DES-ACYF is currently negotiating a Title IV-E funding waiver with the DHHS Administration for Children, Youth and Families to support expedited reunification of children from foster care with their families of origin. Flex funds are one of three primary waiver strategies, and federal approval and Maricopa County pilot implementation are said to be imminent.

Medication Practices: Settlement Agreement paragraph 17 (f) develop practice guidelines for the monitoring of medications as described in paragraph 48.

Status: Met

The Practice Improvement Protocol for Psychotropic Medication Use in Children and Adolescents was finalized and training was completed in each RBHA during 2003. ADHS Policy 1.16, Psychotropic Medication Prescribing and Monitoring, was also finalized and training completed.

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In March 2003, ADHS began a Quality Improvement Project (QIP), "Informed Consent for Psychotropic Medication Prescription", in order to improve the acquisition and documentation of informed consent for medications prescribed by behavioral health providers. This effort is in accordance with ADHS Policy 1.16 and 1.7 (Consent to Treatment), as well as the related ADHS Practice Improvement Protocol (The Use of Psychotropic Medications in Children and Adolescents). The statewide work group includes the ADHS Medical Director as the Chair, RBHA Medical Directors or their designees, and a consumer/family representative. As of September 2003, the project workgroup developed a standardized format for documenting informed consent and a detailed set of guidelines for the process. The format and guidelines have been aligned with ADHS policies and protocols, as well as newly revised AAC R9-20 licensing requirements. Statewide implementation of the new format and guidelines began in late 2003.

During 2004, several RBHAs (PGBHA, CPSA, ValueOptions) have reported measurable reductions in the incidence of polypharmacy.

300 Kids Project: Settlement Agreement paragraph 17 (g) initiate a 300 Kids Project as described in paragraphs 49-51

Status: Met

Background

The 300 Kids Project began in spring of 2001 as a way to test strategies for providing behavioral health services according to the 12 Arizona Principles. The two initial sites in Northern Arizona (NARBHA) and Maricopa County (ValueOptions) served as a first phase of statewide effort to serve children and families according to those Principles. The 300 Kids Pilot, and beginning in fall 2001 Project MATCH in Tucson, all began serving as laboratories for the development and refinement practice methods to actualize the 12 Arizona Principles. Arizona's Child and Family Teams process (see ADHS CFT practice improvement protocol of August 2003, and ADHS CFT technical assistance document of September 2004) is a direct, perhaps most significant outgrowth of the 300 Kids Pilot.

One early strategy established a learning community to share best practices and lessons learned among these pilot efforts, in order to help promote the continued infusion of the 12 Principles into increasingly unified work among several child-serving systems. Several activities begun during that era have persisted and evolved, including:

- ADHS is using its website and the Children's Executive Committee as vehicles to share progress reports, technical assistance guides, success stories and other information that that supports Arizona practitioners in the emerging system of care.
- Each region has developed a core team of system developers who work closely with external consultants and ADHS Bureau for Children's Services to create and compile

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tools, processes, guides, training curriculae, job descriptions and supervision other and quality improvement tools.

- The ADHS Children’s Bureau Chief conducts periodic meetings with all RBHA Children’s Services Coordinators to systematically transfer lessons and technologies from the early pilots, from ADHS, from national technical assistance resources and from one region of the state to all. These meetings will be accelerated from quarterly to six times a year in 2005 to reflect the accelerating need for robust cross-teaching as early experimentation and development has evolved to full-scale statewide implementation

On January 29, 2003, Governor Janet Napolitano issued a press release announcing that the Arizona Department of Health Services was expanding statewide the “300 Kids Project” - a new approach to providing mental health services to children. The approach endorsed by the Governor “seeks to involve the entire family in a child’s treatment, as well as neighbors, community organizations and even churches.”

The initial purposes of the 300 Kids Pilot have been largely fulfilled. More and more, desired practice stemming from the Child and Family Teams process developed within it is becoming systematized, documented and integrated into RBHA human resource, training, supervisory, clinical, financial, quality management, operational and executive functions. Testing of new strategies to help realize the full Arizona Vision now occurs in the context of the statewide spread of practice changes.

Applying uniform statewide definitions setting minimum criteria¹, RBHA regions currently (as of September 30, 2004) report the following extent of Child and Family Team practice:

| | |
|-------------------------|--|
| CPSA-3 | 122 Children currently have functioning CFTs. |
| CPSA-5 | 873 Children currently have functioning CFTs. |
| NARBHA | 247 Children currently have functioning CFTs. |
| ValueOptions | 1,496 Children currently have functioning CFTs. |
| PGBHA | 45 Children currently have functioning CFTs. |
| EXCEL Group | 60 Children currently have functioning CFTs. |
| Statewide Total: | 2,843 Children currently have functioning CFTs. |

¹ “functioning Child and Family Team,” as defined by ADHS April 2004:

- a. is facilitated by a trained person;
- b. the CFT has met at least one time; and
- c. an initial strengths, needs and culture discovery has been completed.

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*Annual Action Plan and Substance Abuse Plan as Part of the First Annual Action Plan:
Settlement Agreement Paragraph (h) develop annual action plans as described in paragraphs
53-54*

Status: Met

Background

AHCCCS and ADHS prepared the first Annual Action Plan in accordance with paragraph 17 (h). Additionally, in paragraph 52, a Substance Abuse Plan was required in the first year. This requirement has been met. A Substance Abuse Plan was developed and implemented for the expansion of substance abuse treatment services. Targets for capacity were established in year one and achieved.

During the second year, once again RBHA-specific capacity targets were established through ADHS' Network Sufficiency process. Each RBHA met its capacity development target, and ADHS continued to monitor access to substance abuse services through quarterly RBHA reporting and RBHA Network Development Team meetings.

During Year Three, ADHS published clinical guidance and provided training on practice improvement protocol #10, Substance Abuse Treatment in Children.

The EXCEL Group in Yuma and Arizona's Children Association trained 16 families specifically to provide therapeutic foster care services to youth from substance abuse backgrounds. Additionally, EXCEL has developed a program specifically for substance abuse treatment for children and adolescents, as well as a curriculum to train staff on this program. CPSA initiated a contract to provide 5 Level II adolescent substance abuse beds within its service area.

In Maricopa, many new direct support service providers, as well as new MST and FFT teams described elsewhere in this plan, represent expanded new options to address the needs of young substance-abusing youth. PGBHA has developed several intensive outpatient programs and groups for adolescent substance abuse treatment. Superstition Mountain Mental Health in Apache Junction added a youth substance abuse group and an intensive outpatient program to the array of services they provide. Arizona Children's Association and Corazon both developed substance abuse programs for adolescents. Furthermore, Horizon Human Services developed a bicultural/bilingual intensive outpatient substance abuse program for adolescents.

In Yavapai County, a juvenile drug court program has been active for the past three years, with active participation by NARBHA's local service area agency. In southeastern Arizona, CPSA recently began to leverage Project MATCH grant funds to support a juvenile drug court enhancement effort to better address the needs of youth who become involved with the courts due to substance abusing behaviors. This collaborative effort between CPSA, several public schools and the Pima County juvenile court provides valuable new opportunities for participating children and families. The juvenile court is committed to providing weekly status hearings, intensive probation surveillance, parent education classes and randomized drug screenings, while

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CPSA provides an array of appropriate services to therapeutically impact and support the child and family. A Drug Court Liaison oversees the referral and placement of the youth into the program. CODAC's Step Forward program (federally funded through a Strengthening Community Youth /SCY grant) provides an evaluation component to track each participant to measure treatment efficacy across the various participating providers. Meanwhile, the University of Arizona's evaluation team, through a subcontract with CODAC, tracks Title XIX and non-Title XIX youth who are participating in Step Forward's treatment programs.

Arizona's new 5-year statewide infrastructure grant from SAMHSA has as one of its four specific focus areas the further development of effective substance abuse treatment capacity. Grant funds and concomitant national technical assistance resources bring with them the promise of additional enhancement of the behavioral health system's capacity to address the needs of substance-abusing youth.

Quality Management and Improvement System: Settlement Agreement paragraph 17 (i) change their quality management and improvement system as described in paragraph 55

Status: 2nd Year of Development

The ADHS Quality Management System measures the quality of behavioral health services to enrolled members and makes recommendations for improvements in care, administrative management and fiscal efficiency. This process is conducted under a Quality and Utilization Management (QM/UM) Plan that is developed on an annual basis. This plan identifies monitoring and other activities that ADHS will undertake throughout the year.

As part of the Quality Management System, information is obtained through various monitoring and other data collection activities. This information is analyzed by staff in the Bureau of Quality Management and Evaluation and is subsequently presented to the ADHS QM/UM Committee for further analysis, review and direction. ADHS and the RBHAs develop plans to alleviate problems or improve processes in order to achieve the overall goal of improved quality of care, administrative management and fiscal efficiency. Plans of correction or improvement are monitored and effectiveness is evaluated.

Background

During the first year following the settlement agreement, ADHS began a review of the quality management system in light of the 12 Principles. As adjustments to the quality management system are made to focus more substantially on practice improvements stimulated by the Settlement Agreement, ADHS intends to avoid increases in reporting/monitoring requirements, by utilizing an "adjust/replace" approach to achieve desired monitoring efforts.

The ADHS QM/UM Plan includes a QM/UM Committee that is chaired by the Medical Director and has representatives from throughout the organization, including consumer representation. This allows a systematic approach to analysis of trends analysis in data generated about an array

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of aspects of system performance, in order to focus performance improvement activities. Service network development, utilization of services and the *in vivo* effects of all key clinical initiatives are reviewed and discussed during by this Committee.

ADHS and AHCCCS have undertaken the following activities in reviewing and changing the quality management system:

- A review of performance measures and other monitoring activities for alignment with the 12 Principles was completed in 2002. That review informed subsequent amendments to ADHS contracts with all RBHAs. Effective July 1, 2002 were substantive contract changes negotiated by AHCCCS and ADHS establishing new performance measures and reporting of minimum performance expectations, goals, and benchmarks. At present, ADHS and the RBHAs have begun to collect and report quality management data representing the following aspects of care germane to the Arizona 12 Principles: access to care/appointment availability; coordination of care with AHCCCS acute contractor primary care providers; sufficiency of assessments; member/family involvement in developing treatment recommendations; considering member/family cultural preferences in treatment/service planning; appropriateness of services; informed consent; and effectiveness as indicative by positive clinical outcomes.

Though more focused than prior measures and reporting on Principles and actions required in the Settlement Agreement, subcontractors still have fewer reporting requirements overall than before the Settlement Agreement date. While monitoring, measurement and reporting are integral activities within Quality Management and Improvement systems, efficient processes and reporting can allow contracted RBHAs to devote more efforts and resources to overall systems improvement.

- ADHS' two most recent annual Independent Case Review (conducted in 2003 and 2004) have included specific samples of children and families experiencing practice changes developed precisely to apply the 12 Arizona Principles. In 2003 a sample of children and families were reviewed to test strategies and review tool questions for monitoring the Child and Family Team process. 25 Child and Family Teams were reviewed within the NARBHA region in 2004, applying a guided interview tool based on the Wraparound Fidelity Index (3.0) also used by the Assessment and Outcomes subcommittee of the Maricopa County Collaborative for similar purposes. Overall, both families and facilitators expressed a positive view regarding the impact of the Child and Family Teams process. Of the twenty-four minimum performance scores, the CFT population met or exceeded sixteen.
- In addition to the Child and Family Teams interview process, 30 chart reviews were completed for children receiving treatment in residential treatment centers. Review questions include standards from the Independent Case Review (ICR) in addition to nine RTC-specific standards. Overall, six of the nine RTC-specific addendum questions met or exceeded the overall score of 76.7 percent. One hundred percent of the records

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reviewed indicated that services provided at the RTC reflect the goal of preparing the child to return home expeditiously. The lowest score was related to cultural competency, and is consistent with the results of the ICR.

Systematic Quality Improvement Example - Assessment Process:

The following example illustrates how AHCCCS and ADHS use quality management processes as effective links within a practice improvement feedback loop.

AHCCCS included a standard in its ALTCS Program Contractor Operational and Financial Review for FY 2003 related to including the child and family in assessment and treatment planning processes. Findings showed a need for significant improvement in this area. At the same time, feedback from the growing statewide learning community supporting development of Child and Family Team practice concluded that existing RBHA assessment traditions were not only not supportive of, but in many cases actually contradicted some of the principles and key steps of the developing practice approach. Consumers' diagnoses and functional deficits were being traditionally identified by professionals and served as the basis for fairly standard treatment plans, while the emerging practice approach featured discovery of consumers' own goals, needs, strengths and available and potential natural supports as the basis for planning.

As a consequence, ADHS made a Strategic Plan commitment to develop and implement a standardized statewide assessment process that would identify goals and needs from the standpoint of the client and family, build on individual and familial strengths, provide timely crisis intervention, lead to highly individualized service planning and provision respectful of their important cultural and linguistic considerations, and do so in a manner consistent and congruent with the mandates and interests of other involved systems (e.g. health care, juvenile justice, corrections, education and protective services).

In 2003, as part of the ADHS Strategic Plan, a standardized assessment process was developed with input from over 100 staff, providers, consumers, family members and stakeholders. Members of the informal 300 Kids learning community, including consultant John VanDenBerg PhD, helped to develop the assessment process, its supporting tool and guide. Statewide training in the new assessment was completed over the four month period immediately preceding statewide implementation of the new assessment. A subcommittee of the Assessment Workgroup was established to review data requirements and outcome reporting.

The resultant, uniform statewide behavioral health assessment has been required for use with all clients of the behavioral health system since January 1, 2004. ADHS modified its existing administrative review process for RBHAs to gauge the implementation and early quality of the new assessment process. Quarterly meetings of ADHS' residual Assessment Workgroup review those results, and other ongoing feedback from the assessment to feed and focus performance improvement planning. Based on that feedback, the statewide assessment process has been specifically adapted to two specific situations during 2004:

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- In support of ADHS' Urgent Behavioral Health Response for Children Entering Foster Care, and
- For infants, toddlers, preschoolers and their families (pilot completed in Fall 2004, statewide training and full implementation of the Birth through Four assessment is scheduled for Summer 2005).

Additional accomplishments, including changes to improve the Quality Management and Improvement System during the past year, include:

- Modification of the biennial consumer satisfaction survey to better reflect the Arizona Principles and the set of functional outcomes it incorporates.
- Involvement in and dissemination of empirical research triangulating Wraparound Fidelity Index measurements with several elements of outcome data on 63 Project MATCH families. This research, involving Jim Rast PhD of VVDB and the University of Arizona, demonstrated a strong association between high fidelity CFT practice and positive child and family outcomes, and was shared at the annual national research conference on children's mental health in Tampa (March 2004).
- Maricopa County's Steering Committee's Assessment and Outcomes Subcommittee has piloted both Child and Family Team service plan reviews and guided interviews with families and other team members to assess application of several of the 12 Arizona Principles in emerging practice. This effort continues in Maricopa County.
- ADHS has established a dedicated position in its Bureau of Quality Management and Evaluation to support the development and implementation of changes to improve that system's adherence to the 12 Arizona Principles as described in Strategy 5.

Stakeholder Participation: Settlement Agreement paragraph 17 (j) involve Plaintiffs' counsel and other stakeholders as described in paragraph 73 and 74

Status: Met and ongoing

2004

ADHS, AHCCCS and Plaintiffs' Counsel continued to meet regularly during Year Three of the Settlement Agreement, at least once each quarter and in a variety of forums, to discuss the status of Settlement Agreement actions, implementation, challenges and emerging lessons. Plaintiffs' Counsel continued to access a multiple system development venues, especially within Maricopa County, including playing an active role in the Maricopa County Collaborative's assessment and outcomes subcommittee to pilot and apply guided interviews and related case reviews to measure the experience of children and families against the 12 Arizona Principles. All these parties joined together for a series of leadership meetings designed through interactive activities to bring

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to life aspects of the essential changes in values and practice required by the Settlement Agreement.

Plaintiffs' counsel also participated in developing new ADHS clinical guidance surrounding the use of out-of-home services.

Efforts to involve other stakeholders in implementation of the Settlement Agreement were plentiful at both the state and regional/local levels.

Children's Executive Committee

Throughout the year, ADHS and AHCCCS continued their participation on the Children's Executive Committee and its Clinical and Family Involvement subcommittees. The Executive Committee established three priorities for its work in 2004, beginning with support for Governor Janet Napolitano's reform of Arizona's child welfare system. ADHS and AHCCCS had participated fully in the work of Governor Janet Napolitano's Advisory Commission on Child Protective Services since its creation in January 2003. The Executive Committee agreed to oversee implementation of the ADHS policy change requiring an urgent behavioral health response for all children entering foster care referred to the behavioral health system by DES-ACYF. (The success and status of that effort are described on Pg. 27.)

In August 2004 the Executive Committee endorsed a paper describing the unique behavioral health needs of children involved with CPS that its clinical subcommittee had developed. At the same time, it endorsed an action plan to translate the "unique needs" paper into clinical guidance by ADHS to serve as a basis for statewide training and capacity building within the behavioral health system.

The clinical subcommittee also developed a cross-system consensus on the treatment of youngsters who commit sexual offenses, described in a new ADHS practice improvement protocol whose final publication is anticipated in 2005.

In addition, the Executive Committee adopted a Family Involvement Framework in 2004, which describes a multitude of specific actions and activities that make up a full spectrum of family involvement. Guided by this framework, the Executive Committee's Family Involvement subcommittee works both to involve families in system reform, and to support family voice throughout the statewide system of care. During 2004 this subcommittee increased its membership numerically, geographically and horizontally across additional child-serving systems. Most monthly meetings are now held via telemedicine, so involvement of family members from even remote corners of Arizona is becoming more regular.

The Executive Committee serves as a standing, high-level venue for barriers identification and resolution (Strategy 4), and began its new oversight role within ADHS' 5-year statewide infrastructure grant on October 1, 2004.

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Child-Serving System Stakeholders

ADHS required, in its solicitation for behavioral health services in Maricopa County, the development of joint protocols between the successful offerer and all major child-serving stakeholders by 12/31/04. When the Greater Arizona RFP was issued in August 2004, the same requirement was included to apply to successful offerers in all other regions of Arizona. At a minimum, the collaborative protocols must address:

- how the RBHA contractor will work with each entity in coordinating the delivery of behavioral health services to persons served by both entities
- mechanisms for resolving problems
- information-sharing
- resources each contributes to the care and support of persons mutually served, and
- arrangements for co-location, if applicable.

State and local behavioral health entities regular invited child-serving stakeholders to participate in training about the Arizona Vision and 12 Principles, the Child and Family Teams process and related topics.

ADHS and DES-ACYF officials met frequently throughout the year to align their activities in a series of joint efforts, including unified case planning, actualization of capitation rate assumptions, problem-solving, prioritization of service capacity development, shared development of therapeutic foster care resources, implementation of the urgent behavioral health response for children entering foster care, cross-system training in support of service to children and families in the adoption subsidy program, and development of clinical guidance surrounding the use of out-of-home services. [ADHS used a representative workgroup including residential service providers, representatives of juvenile justice and child welfare systems, and family members to work with consultants Pat Miles and Genie Taylor to develop a new practice improvement protocol for the use of out-of-home services.]

ADHS and juvenile justice stakeholders worked together through development of mutual clinical guidance, joint training events (see list on pg. 21) and coordinated prioritization of behavioral health service development (e.g. MST, FFT and therapeutic foster care services). Opportunities to provide information and training for juvenile court judges were especially valuable.

In addition, as the behavioral health system faced specific challenges in supporting youth and families involved with multiple systems in a collaborative manner, ADHS took new initiative to reach out and join with those systems within pre-existing venues. ADHS joined the Interagency Coordinating Council supporting the Arizona Early Intervention Program (AZ-EIP), was an active participant in a CPS-reform related workgroup on dually adjudicated youth led from the Governor's Office of Children, Youth and Families; and joined representatives of the Arizona Department of Education (ADE), the DES Rehabilitation Services Administration (RSA) and the DES Division of Developmental Disabilities (DDD) on a transition-to-adulthood leadership team. ADHS also maintained its active involvement in the Court Improvement Advisory Group led by the Administrative Office of the Courts (AOC). In each of these venues, ADHS found

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opportunities to help partners in the other child-serving systems to understand the Arizona Vision and Principles, and how to participate in and use the Child and Family Teams process.

Executive leadership continued to play a key supportive role. During the summer 2004, for example, Governor Janet Napolitano's Children's Cabinet hosted representatives from MIKID, FIC and the ADHS Office of Children with Special Health Care Needs in a conversation that led to her commitment to host a cross-system summit on family involvement, scheduled for April 2005.

Following are some regional highlights of additional collaborative efforts during the past year:

CPSA

CPSA has maintained and strengthened its robust Pima County Children's Council, a broadly representative team of community leaders with a monthly meeting and an extensive task-oriented subcommittee structure.

CPSA has established four staff positions co-located positions at the juvenile justice centers in GSA 3 (serving Cochise, Santa Cruz, Graham and Greenlee counties). In Pima County, three staff positions are now co-located at CPS offices, and four more at the Pima County Juvenile Court Center. The primary roles of these liaisons are to identify child and family needs, coordinate behavioral health services through CPSA's provider networks and to support successful release/discharge for adjudicated youth along with staff from parole/probation and child welfare systems.

Between August and November, CPSA sponsored and hosted a series of cross-system collaboration seminars by Tentmakers Inc. of North Carolina. Over 340 individuals representing 27 different agencies participated in this process, and will remain invested in periodic follow-up events. Evaluations of the process by participants were extraordinarily positive.

CPSA and its provider networks continue to provide and participate in reciprocal training with local CPS counterparts to use the CFT process to meet the identified needs of dependent children, and to develop specialized team facilitation skills among behavioral health personnel to effectively support mandates of safety and permanency for children involved in the child welfare system.

EXCEL

EXCEL recently established a community collaboration team, called Yuma Community Alliance for Resources, Education and Supportive Care (Yuma CARES), a joint effort with juvenile justice, child welfare, local school districts and other community members. Yuma CARES meets on a monthly basis to focus on identifying and addressing system barriers, identifying

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community resources and how to better support children and families receiving services in the community.

EXCEL welcomes other agencies to the trainings it offers, sharing monthly training calendars with local service providers, CPS, Juvenile Probation, the local hospital and nearby colleges. Many CPS workers and supervisors, juvenile probation officers and local special education teachers have attended CFT trainings since early 2004.

In a unique arrangement, EXCEL now contracts with the Yuma Juvenile Detention Facility to provide services to children at the detention center who are ineligible to receive Medicaid-funded services while they are “inmates of public institutions.”

EXCEL has made proactive efforts to foster a constructive partnership with the local CPS system, joining forces to meet with foster parent groups and providers to improve awareness and understanding of the 24-hour Urgent Response process. In addition, CPS and EXCEL have agreed to create a co-location site. To better coordinate care, primary care physicians have been located within EXCEL health clinics and see children and adults on an as needed basis.

Gila River RBHA

Members of the Gila River community were given the opportunity to interview four potential training and technical assistance resources to help choose the best fit for their community. When the resultant decision selected VVDB, six community forums involving community leaders and members, traditional healers, representatives of tribal probation, parole, social services and education entities and even law enforcement, met with consultant John VanDenBerg Ph.D. to acclimate him to the strengths, needs and culture of their community as a strong foundation for his firm’s subsequent work with the Gila River RBHA’s development efforts.

Once trainings were scheduled, family and community members were invited to participate, along with representatives from local child-serving partners. Several family members, probation employees and other community members accepted the invitation and attended the first training session.

The Gila River RBHA also worked with both the tribal social services agency and with Arizona’s Children Association to develop culturally appropriate training for prospective therapeutic foster care providers. The RBHA began to participate regularly in periodic meetings with ADHS and other RBHAs’ children’s system leaders.

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NARBHA

NARBHA holds quarterly meetings of its cross-system Regional Children's Council, which recently established a discrete barriers identification and resolution component. NARBHA holds regular bilateral meetings with DES and DDD to work out systemic problems. During the quarterly meetings with DDD, joint trainings ("brown bag lunches") are planned. NARBHA continues to meet as needed basis with AOC and ADJC.

NARBHA's partnership with the Office for Children with Special Health Care Needs (OCSHCN) parent-led community teams focuses on community development (conducting community needs assessment, administering contracts for service coordination and supporting parent leadership development. In five northern Arizona communities, family members lead the local community teams. Participants represent DES-DDD, Arizona Early Intervention Program (AzEIP), Success by Six, school districts, Healthy Families, Head Start, local Parks and Recreation programs and many other community based organizations. The goals of the teams are "to develop a family-focused, comprehensive, home and community based system." Primary emphasis is to develop and enhance informal supports in the communities where needs arise.

NARBHA hosted significant cross-training events focused on attachment for children involved with CPS (April) and effective interventions for children with autism-spectrum disorders (October), attracting strong participation from system partners to learn from nationally acclaimed experts in both events.

PGBHA

PGBHA continues a number of on-going meetings with local DES/CPS, ADJC, AOC, DES/DDD and school districts focusing on enhancing collaboration and better integration of services. PGBHA held multiple meetings with Pinal and Gila County Judges to explain and discuss eligibility and referral processes, service plan development, and other items and issues of concern. Specific focus on collaboration has occurred with DES District 5 through monthly meetings to address region issues that affect both agencies. This includes incorporation of the 24-hour response for children being removed from their home.

ValueOptions

ValueOptions continued to support stakeholder involvement in numerous ways. In 2001 family members joined with representatives from all major child-serving systems to accept VO's invitation to form the 200 Kids Steering Committee. Over the past three years this leadership team has evolved into its current Maricopa County Collaborative, and continues to function effectively to help ensure that children are served in accord with the 12 Arizona Principles. The Maricopa County Collaborative has several active subcommittees drawing voluntary participation from all participating entities, including:

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- Assessment and Outcomes subcommittee, current evaluating practice at each of ValueOptions' seven comprehensive service providers;
- Barriers subcommittee, charged with identifying and resolving barriers identified within each of the systems making up the Collaborative; and
- Education subcommittee, seeking to involve school systems more meaningfully in both system reform and in individual Child and Family Teams. This subcommittee has planned three forums for school personnel across Maricopa County in January 2005 to learn more about their needs and to discover effective means to involve them.

ValueOptions provided initial and now ongoing financial support to the Family Involvement Center (FIC), an independent family-run organization that helps to ensure meaningful family voice at all levels of the developing system of care. FIC invites staff from all local child-serving systems to participate in its many training opportunities. FIC recruits and trains family members to participate in many roles within the system, and has already received national recognition for its accomplishments.

A Children's Advisory Council meets monthly to advise ValueOptions. The meetings are now held at FIC and family participation in the Council has significantly increased as a result.

Significantly, and in fulfillment of a new ADHS contract requirement, ValueOptions is developing collaborative protocols with each major child-serving system in Maricopa County. These protocols outline roles and responsibilities of staff, and describe problem-solving mechanisms. The first protocol has been completed, describing the Child and Family Teams process within the context of the child welfare system. Protocols are currently being developed with local juvenile justice and developmental disabilities systems as well.

ValueOptions has pioneered successful co-location with the child welfare system, and has maintained a presence at the juvenile court as well. Firm commitments for expansion of co-location venues with child welfare offices and at the Maricopa County Juvenile Probation facilities on both sides of the Valley have been made for the coming year.