Comparing Behavioral Health (12 Arizona Principles) and Child Welfare (AACAP/CWLA) Values and Principles

Behavioral Health; *12 Arizona Principles**	*Child Welfare:* *Values and Principles***
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.	**FAMILY PARTICIPATION IN ALL ASPECTS OF PLANNING, SERVICE DELIVERY, AND EVALUATION** Family is defined (using the Federation of Families definition) as including biological, foster, and adoptive parents, grandparents and their partners, as well as kinship care givers and others who have primary responsibility for providing love, guidance, food, shelter, clothing, supervision, and protection for children and adolescents. It is important for the family to be actively invited as part of the engagement process at ALL levels of planning, service delivery, and evaluation: e.g., the system level, organizational level, and individual child level. It is important for the family to be appreciated and involved in activities involving the child whenever possible. Families should be given the choice as to whether or not they participate. The family preference(s) and choice(s) should be considered in all planning for their child outside of situations, which might put the child at risk of harm. For child welfare services, a family-driven policy that does not compromise the child's safety is necessary. The foster care system is currently focused on the child. To really meet the needs of the child, it should place greater emphasis on the family of origin. This family-centered approach could result in a major change of cultural/mindset within the current child welfare system. The child welfare system is concerned with safety, permanency, and well-being. Every child should have a safe home as soon as possible preferably, but not necessarily with the family of origin. To every extent possible, the biological family should be involved even when it is not the custodial family. Families should be provided with advocacy and representation that increases education/communication to families.
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.	**OUTCOMES:** The child welfare system is concerned with safety, permanency, and well-being. *a. Preventing Further Maltreatment of Child Victims* *b. Achieving Permanency for Children in Foster Care* *c. Achieving Permanency in a Timely Manner* *d. Ensuring Stable, Age-Appropriate Placements for Children in Foster Care* *[See www.acf.hhs.gov/programs/cb/publications/cwo01/index.htm]*
COLLABORATION WITH OTHERS: When children have multi-agency, multi-system involvement, a joint assessment is developed and a jointly established behavioral	**INTEGRATED SERVICES WITH COORDINATED PLANNING ACROSS THE CHILD-SERVING SYSTEM** Children in the foster care system with mental health and substance use issues and their families are often involved with multiple child-serving organizations and systems. They require and deserve well

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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.	coordinated planning and integration of services to address their complex needs. To ensure the most appropriate and effective integrated service delivery for children in the foster care system with mental health and substance use issues and their families, services should be planned and coordinated across the child-serving systems. Often children in the foster care system initially access services through primary care. The EPSDT screening process should facilitate integration and coordination of services to meet the identified needs. Even when funding streams can not be combined, there is greater potential for integrating services when planning is coordinated across the child-serving systems. Such integrated planning would make better use of limited dollars and reduce the potential duplication of services while increasing the availability of services and supports for the child and family. When there are multiple systems involved, it is important for there to be consistency in planning across the various systems to ensure the child and/or family does not hear conflicting messages or has treatment approaches that are counter-indicated. It is the responsibility of all systems to work to mitigate the burden caused by uncoordinated planning between agencies and families. The goal is for there to be one document where the plans of various other child-servicing systems are incorporated into the foster care system case plan. The plan should be reasonable, useful, and respectful To ensure child safety and achieve quality services and supports for children and their families, it is crucial to expand and increase the input of both community members and expert professionals. In the child welfare system, the child is placed in a foster care environment, which is expected to address the child's safety and well-being. There may be difference in how states define safety. How local communities participate in setting the community standards further impacts the differences in definition.
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.	**A COMPREHENSIVE AND ACCESSIBLE ARRAY OF SERVICES:** Given the complexity of serving children and their families, it is crucial to have a comprehensive array of services available. This would include traditional, faith-based, and non-traditional mental health and substance use services and supports as well as formal and informal supports and services. This service array should be appropriate to address the circumstances and treatment needs of children and their families. Services chosen from the array should be age and developmentally appropriate. This service array should support children and their families in the community whenever possible. This service array should take into account the ongoing developing strengths of children and their families.
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."	**TIMELY, EFFECTIVE, EVIDENCE-BASED, OUTCOME- DRIVEN MENTAL HEALTH AND SUBSTANCE USE SERVICES AND SUPPORTS:** The child welfare system must take into account the difference between a child having a mental disorder and/or substance use problem and a child requiring mental health and substance use intervention to prevent a future disorder and address both. Currently, a mental health and/or substance use assessment is often not done until there is a crisis.

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.	Just as it is necessary for periodic reviews to be done on individual case plans, it is necessary for systems and providers to perform effective, evidence-based, outcome-driven reviews of results to demonstrate progress in achieving the goals for the children and their families. To provide compassionate, relevant services it is essential to reach for and use feedback from the children and their families about the effectiveness of the services offered to address their needs and goals.
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.	**SERVICES IN THE LEAST INTRUSIVE COMMUNITY-BASED ENVIRONMENT:** Service planning to address the mental health and substance use needs of children should focus on providing these services and supports for children and their families at the appropriate level and intensity and in the least intrusive environment to increase the child's functioning and physical stability. Every effort should be made to keep children in their home community whenever possible. Issues of risk to the child take precedence over the placement that is least intrusive/restrictive even if that means removing a child from their home. When services are being designed and developed there should be an easily accessed array of community-based services that support children receiving treatment in the least intrusive manner. Sometimes this might be over a widespread region, in particular in rural areas where it is not financially feasible to have all services in each local community. When services are being designed and developed there should be family and community input into the planning process. When children need to be placed outside the home community, it is essential that treatment/services/supports be provided to maintain the family connection when there is no indication to the contrary.
TIMELINESS: Children identified as needing behavioral health services are assessed and served promptly.	**TIMELY, EFFECTIVE, EVIDENCE-BASED, OUTCOME- DRIVEN MENTAL HEALTH AND SUBSTANCE USE SERVICES AND SUPPORTS:** The grief and trauma children experience when they are placed into and within the foster care system must be taken into account when assessing their needs and providing services and supports. An initial mental health and substance use screening should be done within 24 hours of placement. The mental health and substance use screen is intended to identify children in urgent need of emergency mental health and substance use services. This screening would also assess the internalized and externalized levels of distress in the child regarding the separation from their family of origin. A triage

	intervention to address the child's feelings regarding the separation and help the child cope should be provided as quickly as possible based on the severity and intensity. All children in foster care and their families must have a comprehensive mental health and substance use assessment once the child is stabilized but minimally within the timeframes of EPSDT. The assessments should always address the attachment issues for the child as long as the child is in care and be done in a timely fashion especially when there is transition from placement to placement.
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.	**INDIVIDUALIZED SERVICE PLANNING:** Service planning to address the mental health and substance use needs of children should be individualized and include the following: - mental health and substance use services and supports focused on the strengths, desires, interests, values, and goals of the child and the family, - an assessment of the specific and particular mental health substance use needs of the child and the services/supports the family requires to deal with and support a child with MH and SA needs, measures to address issues of emotional distress arising as a consequence of all placement transitions, - consistency with the permanency plan for the child and the family service plan, - informal as well as formal mental health and substance use services/supports, and - goals articulated in such a way that one can measure progress towards the goals identified by the child and family. This individualized service plan should include the continuation of treatment when the child is reunified with his or her family. If a child is not receiving treatment services/supports at the time of reunification then it is an important time to initiate any treatment services that are needed as part of the reintegration process. This individualized service plan should be developed in partnership with the child and family and other professionals working with them. This individualized service plan should be regularly reviewed and updated to reflect the progress of the child or lack thereof, with input from the child and family when appropriate. This individualized service plan should include the discharge and transition plans. The child's comprehensive health assessment must include the elements of the EPSDT screening and assessment, such as physical, dental, substance use, and mental health evaluations. It must also address issues of co-morbidity.
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	**PLANNED AND COORDINATED TRANSITIONS AMONG AGENCIES AND PROVIDERS AND BETWEEN CHILDREN, FAMILIES, AND ADULT SYSTEMS:** Children and their families can suffer significant negative impact when transitions and/or discharges are not successful. Therefore, coordination, communication, and effective planning are necessary whenever children are involved in one of the following: changing providers and/or agencies, returning home, changing levels of care, changing placements or moving to their permanent placement, and/or transitioning to self-sufficiency or being transferred to another service system. Youth in care making the transition to self-sufficiency may need services provided by the adult system, such as mental health and/or substance use services and housing, financial, health, dental,

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.	and educational and/or employment assistance. It is therefore important that effective coordination take place between these child and adult systems. Key to ensuring successful transitions and discharges are early planning, ongoing coordination of services to address all needs, effective monitoring of plan implementation, and appropriate sharing of the case record information at the time of transition/discharge. Each child leaving the child welfare system must have a developmentally and age appropriate transition and/or discharge plan. Such planning must provide the skills, information, services, and supports that allow young people to successfully transition to adulthood, where they can provide for their own permanency, safety, and well-being. Transition can have a significant impact on the child and their family. Therefore, to ensure successful transitions, it is important that the child's needs and wishes (expressed either verbally or through behavior) be considered and take precedence over the system's needs whenever possible. If a child experiences more than two placements, the child welfare system should have a process in place to review the reasons and the impact to the child to ensure attachment issues and the child's mental health and substance use needs are being adequately addressed/ considered. To minimize the potential negative impact of changes/turnover in workers, it is recommended training be provided to workers on such issues as the impact of removal from home and/or transitions on children and their ability to form attachments, assessing the trauma of removal/placements on the child, effective interventions for dealing with attachment trauma, and signs for when a child should be referred for mental health and substance use treatment/services/supports.
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.	**CULTURALLY COMPETENT, SENSITIVE, RELEVANT, AND STRENGTH-BASED MENTAL HEALTH AND SUBSTANCE USE SERVICES AND SUPPORTS PROVIDED BY KNOWLEDGABLE AND SKILLED STAFF AND SERVICE PROVIDERS WHO ARE AWARE AND UNDERSTAND THE CULTURAL DIVERSITY OF THAT COMMUNITY:** It is crucial that assessment tools and mental health and substance use services and supports be not only culturally competent, but also culturally sensitive and relevant to children and their families. Assessments and mental health and substance use treatment/ service/ support planning should take into account the strengths of the children and their families. Assessment and mental health and substance use treatment/ services/ supports should take into account the cultural status, economic status, and the diversity of the community and the population being served. There should be culturally competent policies and professional competence in procedures, outreach, advocacy, and training throughout the service delivery system. To facilitate rapport and successful outcomes, the team engaging and delivering services/supports to children and their families should, to the extent possible, represent the diversity of the community and the population served. Cultural competence, sensitivity and relevance is demonstrated through the array of services, the design and delivery system, and by recognizing the importance of existing community-based, informal support networks such as churches, extended kinship networks, and social organizations.

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	NONDISCRIMINATION IN ACCESS TO SERVICES FOR CHILDREN IN CARE Non-discrimination in the provision of services on the basis of race, religion, ethnicity, language, gender, age, sexual preference, marital status, national origin, or disability whether or not illegal. Providers should deliver mental health and substance use services and supports to children and their families in compliance with the Americans with Disabilities Act. Families can choose mental health and substance use service providers who respect and value their language, culture, and spiritual beliefs. As emphasized in the Surgeon General's Report on Children's Mental Health, it is important for public and private providers to ensure services are provided and accessible without any discrimination, including interpreters when necessary.
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.	**HUMAN RIGHTS AND RESPONSIBILITIES REGARDING PROTECTION AND ADVOCACY** All children in foster care have the right to have their views expressed directly through their words and behavior to the extent that is developmentally and age appropriate or have representation by an adult whose primary role is to offer the child's perspective for the following: Have access to and be provided with quality mental health and substance use services and supports. Have a say in which mental health and substance use services and supports will be of assistance to them based on their own strengths and needs. Have a say in the development, monitoring, and revision of their mental health and substance use treatment plan, which is in keeping with their permanency plan and the family service plan. Have a say in what mental health and substance use services and supports are or are not working for them. Refuse mental health and substance use services and supports unless their refusal would put them at risk of harm. Be provided mental health and substance use services and supports in the least intrusive community-based environment that is possible. Retain their constitutional rights when placed in foster care. Have input into the impact of placement decisions on their emotional/mental health. When very young or developmentally immature, have representation to ensure consideration of the impact of placement decisions on their emotional/mental health. Maintain frequent and regular, ongoing contact with sibling(s) and other family members when the family cannot be maintained as a single unit. All families with children placed in foster care (except when parental rights are terminated or other legal decisions take precedence while weighing the best interests of the child) have the right to: Have a say and participate in which mental health and substance use treatment services and supports will be of assistance to them and their child based on their strengths and needs. Have a say and participate in the development, monitoring, and revisions of their child's mental health and substance use treatment plan, which is in keeping with their child's permanency plan and their own family service plan. Have a say and participate in decisions about what mental health and substance use services and

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<tr><td></td><td>supports are or are not working for them.
Refuse their own mental health and substance use services and supports, when their refusal would not put their child at risk of harm.
Have access to and be provided with quality mental health and substance use services and supports.
Be provided mental health and substance use services and supports in the least intrusive environment possible.
Retain their constitutional rights when their child/children are placed in foster care.
Through a release of information form, emancipated youth and family members can provide consent on who gets what information.
Children and their families have the right to be treated in compliance with federal, state, and local policies and standards.
Children and their families have the right to seek advocacy support.
Children and their families have the right to make complaints/raise concerns about the mental health and substance use services and supports that they are receiving without retribution. All agencies/providers should have a defined process for how such complaints/concerns can be raised and addressed.
Children and their families have the right to receive services that are culturally competent/relevant and to choose providers who respect and value their language, culture, and spiritual beliefs.
Children and their families have the right to access to the courts to address any concerns they might have about the mental health and substance use services they are receiving or believe they should be receiving.

PARENTS' NEED FOR TRAINING AND SUPPORT:
Foster parents must be informed of the mental health and substance use needs of the child that they are caring for. They must also be provided with education and information as to effective ways these needs can be met to support the key role foster parents have addressing the mental health and substance use needs of the child.</td></tr>
<tr><td>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.</td><td>INFORMAL SUPPORT NETWORKS:
Cultural competence, sensitivity and relevance is demonstrated through the array of services, the design and delivery system, and by recognizing the importance of existing community-based, informal support networks such as churches, extended kinship networks, and social organizations.</td></tr>
<tr><td>*Source: J.K. vs. Eden et al. Settlement Agreement, in the U.S. District Court – District of Arizona (6/26/01) at www.azdhs.gov/bhs/principles.pdf</td><td>**Source: American Academy of Child and Adolescent Psychiatry/Child Welfare League of America - Values and Principles for Mental Health and Substance Abuse Services and Supports for Children in Foster Care (9/19/02) at www.aacap.org/publications/policy/collab01.htm (final version 2003 via Julie Collins, CWLA)</td></tr>
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A collaborator's footnote:

It is not uncommon for professionals within the child welfare system and the behavioral health system to recognize differences in orientation, language, culture and public mandates of the two systems. The tendency to emphasize such differences overlooks what the present analysis shows with remarkable clarity: fundamentally, both systems share an overwhelming commonality of purpose, vision and values. Both systems are committed to team decision-making approaches recognized as best practices in their respective disciplines as a primary vehicle to actualize these values and principles. The two systems serve overlapping clientele. The success of each system is substantially interdependent with the success of the other. There is compelling rationale for professionals within each system to honor, respect and deemphasize the differences of the other system, to recognize that, fundamentally, both are about the same work in support of the same children and families. The needs are too great, and the formal resources too finite, for either system to afford the luxury of behaving as though it is too unique to fully adjoin its efforts to support the success of the other, and is so doing, optimizing its own success as well.