

**A. SERVICE EXPECTATIONS**

1. Behavioral health Service Plans must be developed by the Child and Family Team (CFT) to address the behavioral health treatment needs of the child, and should strive to be consistent with service goals established by other agencies serving the child and/or family. The team should seek the active participation of other involved agencies in the planning process.
2. The behavioral health service provider facilitates the CFT development of a behavioral health Service Plan that is consistent with the goals of Department of Child Safety (DCS) and the juvenile court, and incorporates the family's preferences, strengths and culture in alignment with their vision for the future. The Service Plan identifies formal services and natural supports that address the identified needs.
3. The behavioral health service provider must provide behavioral health services to address critical behavioral health needs of children, youth, and/or adult family members. The CFT must identify any unmet behavioral health service needs. Contractors must ensure that needed behavioral health services are promptly provided and barriers to service are rapidly removed.
4. The behavioral health assessment process must detect both initial and delayed effects of trauma. Unless otherwise agreed upon, an urgent behavioral health assessment must be provided within 72 hours to every child removed and referred by DCS as outlined in ACOM Policy 449. When a child is placed in DCS custody, they shall receive at least one behavioral health service a month for six months in order to detect possible delayed reactions to the traumatic experience. During this assessment period the behavioral health service provider must extend clinically indicated services to out-of-home placement or adoptive parent(s) and families, and other protective caregivers; must support the child through CFT practice; and must serve as educational resources for staff from other child-serving agencies. The Behavioral Health Contractor has the discretion to implement the Urgent Response Process or other Intake timelines as outlined in ACOM Policy 417, for referrals submitted after the fifth day of a child's removal by DCS.
5. The behavioral health service provider must coordinate with staff from other child-serving agencies involved in the child's reunification process and provide clinically indicated behavioral health services. Integrated service planning and provision will include transition strategies and be implemented through CFT practice.
6. Behavioral health Service Plans developed by the CFT must consider the behavioral health needs of the child and family by specifically addressing the transitional area of permanency when adoption or guardianship processes are involved.

7. The CFT must anticipate the need to help a young person prepare for the transition to adulthood beginning at age 16. The AHCCCS Transition to Adulthood Practice Tool provides specific guidance and required service expectations to support the CFT in thorough planning and preparatory activities.
8. Contractors and behavioral health service providers must develop and furnish sufficient behavioral health services consistent with this tool that will meet the needs of the child with special attention to the timeliness, frequency, intensity, duration, and level of expertise of services provided.

**B. KEY ELEMENTS TO REMEMBER ABOUT THIS BEST PRACTICE**

1. Actively identify and remain vigilant about potential emergence of behavioral health needs of children and family members, as significant risk factors are known to be associated with involvement with the child welfare system.
2. Support enrollment of family members who have behavioral health needs.
3. Integrate/coordinate behavioral health service planning and service provision for all enrolled family members.
4. Ensure appropriate alignment of Service Plan with DCS case plan and any other pertinent plans of other involved systems.
5. Offer specific options and alternatives when out-of-home placement is being considered. The goal is to avoid congregate care settings whenever possible.
6. Plan and provide necessary behavioral health services with respect for timeframes governing DCS case planning.
7. Consider any individual needs for an extended assessment period to detect emerging behavioral health needs following the removal of children into out-of-home placement.
8. Involve any protective caregivers (e.g., out-of-home placement or adoptive parent(s) and families, relatives) in service planning and provision, and address their needs related to the behavioral health needs of children in their care.
9. Help DCS know how to quickly re-refer children for behavioral health services when clinical symptoms may manifest in the future.
10. Support appropriate family contact for children in out-of-home placement.
11. Provide behavioral health services necessary to support reunification.



**AHCCCS BEHAVIORAL HEALTH GUIDANCE TOOLS**  
**ATTACHMENT A, THE UNIQUE BEHAVIORAL HEALTH SERVICE**  
**NEEDS OF CHILDREN, YOUTH, AND FAMILIES INVOLVED WITH DCS -**  
**DESKTOP GUIDE**

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12. Help to prepare children and caregivers for permanency (e.g., adoption, guardianship).
13. Ensure specialized behavioral health service is provided when needed for infants and toddlers.
14. Help to prepare youth for transitions and be aware of the multi-dimensional needs of youth preparing for adulthood.

**C. BENEFITS OF USING THIS BEST PRACTICE**

1. Timely behavioral health service can mitigate harmful effects of trauma and other adverse experiences in children and family members.
2. Service coordination/integration increases likelihood of positive outcomes for children and families and uses limited resources most efficiently.
3. Optimal behavioral health service provision can minimize harmful instability in lives of children and families.
4. Effective behavioral health service can prevent deeper penetration of children/families into “the system”.