

POLICY 580 - ATTACHMENT E – IMPLEMENTATION OF 12 PRINCIPLES FOR CHILDREN’S BEHAVIORAL HEALTH SERVICE DELIVERY

This attachment was created using feedback from community listening sessions on the 12 Principles hosted by the Office of Individual and Family Affairs. The principles are explained in this document as recommended by the community members. The 12 Principles can be found in policy AMPM Policy 580. The practice section outlines implementation of each principle into Child and Family Team (CFT) Practice and children’s service delivery. This information is supported by the nationally recognized best practice of Wraparound and information from the Ten Principles of the Wraparound Process guide.¹ Examples of what implementation of each principle looks like in practice were created by a stakeholder workgroup to illustrate each principle. For the purposes of this guide, family is defined as a biological, foster, adoptive, or self-created unit of people residing together and consisting of adult(s) and children, with adult(s) performing caregiver duties for the children.

	COLLABORATION WITH THE CHILD AND FAMILY
THE PRINCIPLE	1. The child and family are treated as partners in all areas of collaboration including, but not limited to: a. The assessment process, b. The service planning and delivery, and c. Evaluation of the effectiveness of behavioral health services. All aspects of treatment provide evidence that the team is engaging in intentional activities to prioritize the family perspective. The child and family are viewed as experts in their care, and preferences are honored and acted upon whenever possible. Active collaboration with the child and family is key to achieving positive outcomes.
	COLLABORATION WITH THE CHILD AND FAMILY
THE PRACTICE	A. The child and family have voice and choice. B. Child and Family Team (CFT) members intentionally elicit the child’s and family’s preferences and perspectives. C. The child and family are given choices and options for services, service providers and any other decisions to be made regarding their treatment. The choices and preferences of the family are prioritized and reflected in service plans. D. The team recognizes the importance of long-term connections between people and the bond between family members and acknowledges that these connections give people a stake in the CFT process and its outcomes. E. While teams need to work collaboratively the most influential voice in the CFT meetings and service plan shall be that of the child and family. F. Behavioral Health providers create a safe space where the family feels heard, respected and comfortable telling their story. G. Behavioral Health providers seek to decrease stigma and blame that the family may feel as a result of the challenges the child is facing. H. Providers give the family information needed for them to make informed decisions about all aspects of their treatment. I. CFT facilitators explain the roles of each team member and help the team to establish ground rules. J. Providers work to empower the child and family and encourage self-advocacy. K. In many cases, there will not be a single unified perspective provided by the child and family therefore it is important to hear all perspectives and explore options to seek consensus and compromise.

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**CONTINUED	L. Due to legal situations, such as DCS involvement or juvenile probation, families may not always have the freedom to make choices, the team will still need to hear and respect the family’s preferences even when an agency has decision making responsibilities.
	COLLABORATION WITH THE CHILD AND FAMILY
EXAMPLES	A team comes to an agreement that family therapy would improve the communication between the child and her mother. When adding this service to the plan the CFT facilitator informs the family that to get a therapist the facilitator will need to make a referral. The Facilitator explains this process and confirms that the mother is comfortable moving forward with the referral. The Facilitator gives the mother a list of agencies and asks if the mother prefers any agency. Mom states that they had a previous bad experience with one agency, so the team agrees that a referral will not be sent to that agency since it is mom’s preference not to work with that agency again. The facilitator inquiries about additional preferences such as the gender of the therapist, the location of the therapy, transportation, and frequency. After the mother and her daughter had 2 family therapy sessions, the CFT facilitator reaches out to get feedback from them about how the sessions are going.
	FUNCTIONAL OUTCOMES
THE PRINCIPLE	2. The family vision defines success from the child and family’s perspective. a. Behavioral health services in collaboration with other supports and services are delivered to aid children and family to be successful as defined by the child and family. b. The system of care includes resources and supports working together to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. c. Behavioral Health providers facilitate CFT meetings to create a service plan with goals and observable or measurable indicators of success based on what the child and family hope to accomplish. d. The child and family’s participation in the services in supports in the service plan leads to being successful in activities of daily living including social, community, health, home, school, and relationships as defined by the children and family. e. A team-based approach that has accountability to action steps and adjusts to changing needs will lead to the family's desired outcome.
	FUNCTIONAL OUTCOMES
THE PRACTICE	A. The work of the CFT is outcome-driven based on what the family hopes to achieve. B. This principle is about accountability through the monitoring goals and measures of success. C. Functional outcomes are achieved through utilizing and increasing strengths and assets. An intentional effort is made to ensure the team focus is on strengths and assets as opposed to focusing on the elimination of deficits. D. Teams utilize strategies that increase the child and family’s resiliency and build upon the existing psychological and interpersonal skills as well as their expertise, skills and knowledge. E. The service plan needs to be monitored for effectiveness and revised to meet changing needs or if any strategies are determined to be ineffective. F. Teams should track progress and celebrate successes. G. When the child and family create their goals, they have ownership of them, they are set up for success and they are more motivated to accomplish them.

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**CONTINUED	H. Behavioral Health providers should express genuine curiosity and use open-ended questions to help children and families identify their goals. I. Achieving functional outcomes requires persistence, meaning that lack of progress is never seen as a failure but as an opportunity to revise the plan. J. CFT facilitators work with the team to identify the underlying needs of the child that are motivating a behavior. K. Service plans include goals that are not limited to resolving behavioral health concerns. The goals work toward the child and family vision and therefore focus on bigger long-term goals related to success in school, living with family, avoiding delinquency and becoming a stable and productive adult. L. Treatment must include unconditional care meaning that the team will adjust the service plan, creatively problem solve barriers, and not give up on the child or family.
	FUNCTIONAL OUTCOMES
EXAMPLES	In the creation of the service plan the family states that their family vision is that: “homework time will no longer be a fight and parents will not be called away from work by the school due to behavior issues.” The CFT facilitator clarifies with the family that it sounds like they would like to see the child learn skills to effectively manage his symptoms of ADHD. The parents confirm that they feel like they need to learn ways to help their son and their son needs to learn skills too. The goals: a. The parents will learn more about the members’ diagnosis and skills for effectively managing symptoms. b. The child will learn skills to effectively manage symptoms of ADHD for more productive homework time. The team discussed the possible need to involve school staff in the next CFT to better understand the behaviors that are occurring at school. The team discusses what homework time looks like for the family. After school the child has a snack, completes his homework at the kitchen table, and is then allowed to play outside. Parents report that tasks that should take 15-20 minutes take all night as the child continually gets distracted, and they shall keep making him go back to the table. In discussing strengths with the family, they identified that the child loves to run and that he is great at running. The parents have offered a reward if the child can start completing homework without being distracted, he can join the running club at school. The team discusses that the parents could benefit from psychoeducation services to learn more about ADHD and symptom management. The parents agree and feel this could be helpful. To improve homework time the provider suggests that the child run 5-10 laps around the backyard after school prior to sitting down for homework time. The child loves this idea, and the parents agree that this could help the child to focus on homework. The team also discusses using a chart to track progress in completing homework. The parents and child agree that if the child can get homework completed in 1 hour, 10 times in a month that the child will be allowed to join the running club at school. Three months later the CFT reconvenes, parents inform the team that the psychoeducation services they received have been helpful and that they feel they will be more confident in talking to the child’s prescriber about his symptoms. They planned to discuss with the prescriber if medication changes could be needed to help with the behaviors at school. After discussing it with the school it seems the child is having a hard time staying in his seat towards the end of the school

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	COLLABORATION WITH THE OTHERS
THE PRINCIPLE	3. When children have multi-agency and multi-system involvement, assessment, service planning, and monitoring are collaboratively and jointly created with a person-centered and team approach. Each team may include the child, family, and individuals important in the child’s life who are chosen by the child and family to participate, as a member of the child and family team.
	COLLABORATION WITH THE OTHERS
THE PRACTICE	A. Team approach. B. Working collaboratively is a dynamic process where individuals come together, share knowledge, experiences, resources, and strengths to promote growth and development. C. Together with other professionals, families and/or natural supports, collaboration builds on the expertise, interests, and strengths of the multidisciplinary team. D. Team collaboration creates opportunities to set goals and objectives, establish plans to implement those goals, monitor progress, and solve problems collectively. E. Treatment and services are governed by the goals of the plan and decisions reached by the team. F. The service plan reflects a blending of team members’ perspectives, mandates, and resources. G. Multidisciplinary team members may include family members, service providers from any family serving agency involved, natural supports, and community partners. H. The collaborative process is an investment, a learning opportunity that requires time and effort. I. Building collaborative relationships often yields meaningful outcomes in terms of enhancing the overall quality of life for the child and family. J. All involved agencies work together and share responsibility in creating and implementing one unified person-centered plan. K. Clarifying statements and ensuring understanding of the unique perspective each team member brings to the meeting. L. Effective communication and information sharing both inside and outside the CFT meetings. When a child is in the custody of DCS, the DCS specialist will have a great deal of influence over CFT membership. However, CFT facilitators will make every effort to include family members and any other individuals that have a long-term commitment and/or connection to the child.

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	COLLABORATION WITH THE OTHERS
EXAMPLES	During a CFT meeting, the Facilitator checks in with the youth (14) to inquire about opportunities the CFT has not addressed for them. The youth states that they would like to build upon their relationship with their best friend, who recently joined a community youth soccer team through Arizona Youth Soccer Organization (AYSO). The best friend and family have been supportive of the youth. The CFT members discuss the benefits of the proposal. They noted pros include the development of social skills, relationship building, responsibility, accountability, and opportunities to take age-appropriate steps toward independence. Potential barriers include the family’s lack of finances to cover the cost of joining the team, transportation, and the time commitment. The grandfather volunteers to check into local AYSO chapters. The youth’s Family Support Partner offers to help the family apply for a grant that covers the cost of team fees. The best friend’s father, who participates in the CFT as a natural support, offers to take the youth to a discount sports equipment store to purchase practice equipment and gear. The best friend’s mother has already agreed to transport the youth to practice and games since she is already transporting her child, the best friend. The CFT Facilitator agrees to check in with the youth and family in 2 weeks to check in on progress made. The team recognizes and praises the youth for advocating for themselves.
	ACCESSIBLE SERVICES
THE PRINCIPLE	4. The child and family have access to developmentally appropriate services that are individualized and meet their unique needs. Barriers to services including transportation should be identified during service planning and the child and family are supported in overcoming those barriers to care.
	ACCESSIBLE SERVICES
THE PRACTICE	A. The focus of providers any each encounter with the child or family is always good clinical care. B. Providers educate the family about: i. Their rights, ii. Required timeframes, iii. Grievance and appeals processes, and iv. Escalation processes C. Providers follow health plan escalation processes to ensure timely services. D. The team works to recognize barriers to services and problem solve to overcome barriers. The team must ensure that any solutions to overcome barriers align with the identified need and that the appropriate services are provided to meet the need. E. Providers ensure that the child and family feel heard, valued, and respected as has been shown to increase the effectiveness of services. F. Providers elicit examples of resourcefulness and competency to build confidence in the child and family’s abilities. G. Natural supports are identified and utilized to support progress toward goals. H. CFT facilitators utilize brainstorming and other group decision making techniques to effectively problem solve. I. An emergency CFT is convened when needed to address barriers or capacity issues to agree upon services.

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	ACCESSIBLE SERVICES
EXAMPLES	An aunt and uncle had their niece placed in their home by DCS. The niece has been diagnosed with Post Traumatic Stress Disorder (PTSD) because of both the events that led to her removal as well as the trauma of being removed from biological parents. In the CFT, the aunt expresses that she feels that it is important for the family to learn more about PTSD. The therapist has explained to the family how some of the behaviors that they have seen in their home are common symptoms of PTSD. The aunt and uncle say they would like to learn more about PTSD and how parenting their niece might look different than their other children. The CFT facilitator presents the family with information for a local group therapy, called Parenting the Traumatized Child. The facilitator educates the family about the curriculum and about the support they can receive by meeting and interacting with other kinship placements that are also learning to parent a child with a history of trauma. The aunt and uncle agree that they would like to attend the group, but they have struggled to get any time alone since taking in their niece. The CFT members decided to do some research regarding childcare options for the aunt and uncle prior to the next meeting. At the next CFT meeting, each team member provides information regarding childcare options. The CFT facilitator found an open gym program offered by the local parks and recreation that provides activities on the nights that the group therapy is offered. The facilitator also provided an application for a local organization that would pay for extracurricular activities for children in the custody of DCS, to help cover the cost of the program. The DCS Specialist and the aunt had worked on getting another family member approved to take care of the niece to give the aunt and uncle some much needed respite. The CFT facilitator was able to refer the aunt and uncle to the group therapy program, as the family now had available childcare options.
	BEST PRACTICES
THE PRINCIPLE	5. Competent individuals who are adequately trained and supervised to provide healthcare services and behavioral support to children and caregivers. Training and supervision are enhanced through the use of best practices. The term “best practices” refers to treatments, services, and strategies that have been evaluated and consistently show evidence that they improve outcomes for children and caregivers.
	BEST PRACTICES
THE PRACTICE	A. These practices shall include, but are not limited to: i. Trauma Informed Care, ii. Person-centered service delivery, iii. Family and peer support, iv. Addressing Social Determinants of Health (SDOH), v. Child and Family Team practice (CFT), and vi. Strengths-based approach. B. Nationally recognized organizations for information regarding best practices, include but are not limited to: i. Substance Abuse and Mental Health Services Administration (SAMSHA), ii. Mental Health Technology Transfer Center (MHTTC), iii. National Wraparound Initiative (NWI), iv. National Training & Technical Assistance Center (NTTAC), C. Provider use of person-first and Trauma-informed language, and D. Providers do research or seek clinical consultation as appropriate.

	BEST PRACTICES
EXAMPLES	1. A mother expresses to her child’s CFT facilitator that she feels alone and ashamed that her son is experiencing mental health challenges. She is burnt out and feels like she doesn’t know how much more she can take; her own mental health is suffering. The CFT facilitator talks with the mother about her sources of natural support. The mother has a group of good friends, but she doesn’t feel comfortable talking to them about the things that are going on with her son. The mother explains that she tried to be vulnerable and open up to her closest friend about what was going on and the friend made them feel terrible. The friend had made her feel like her parenting was the problem and had also said that she is glad that their own son is so well-behaved. This experience left the mother feeling guilt and shame, she was doing her best, but often wondered if her parenting was the problem. The CFT facilitator explained that the child had a diagnosed mental health condition, and that parenting was no more likely to blame than if the child had a heart condition. The CFT facilitator provided the mother with information about Parent Peer Family Support and how she may benefit from having the support of someone that has lived experience with raising a child with a mental health condition. The mother was hesitant, but she decided it was worth a try. The CFT facilitator made a referral to Family Run Organization for the service. At the next meeting, the mother expressed how she felt that meeting her Family Support Partner for a cup of coffee had been such a great experience. The mother also explained that the Parent Peer Family Support Partner was going to help her to draft a list of questions for the Psychiatrist. The mother explained that she was somewhat intimidated by the medication appointments and would frequently forget things she wanted to talk about in the appointments. The Family Support Partner had planned to help the mother to be more prepared for these appointments to ensure that she can get the information she needs from these appointments. 2. A behavioral health provider arrives at a family’s home for a scheduled appointment. When she arrives, the grandmother opens the door with tears in her eyes and is visible, very upset. The provider has an activity organized for the family and has brought the supplies needed to complete the activity, but quickly realizes that there is a more immediate need. The provider sits down with the family and asks some open-ended questions to determine what is currently going on for the family. The grandmother explains that they received a large, unexpected bill this month and that the family now does not have money for groceries or to pay their electric bill. The provider recognizes that these immediate and most basic needs take precedence and that addressing social determinates of health (SDOH) is a best practice. The provider assists the family by calling 211, the family is given resources for food boxes and for assistance with paying their electric bill. The provider knows that the family only has one car, and that transportation can be difficult at times. The food boxes need to be picked up on specific days and times, so the provider helps the grandmother to utilize her natural supports to ensure she has transportation on the days and times needed. Once the provider feels confident that the family has the needed resources and a plan in place, she reschedules to come back another day to complete the activity with the family.

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	MOST APPROPRIATE SETTING
THE PRINCIPLE	6. Children and caregivers are provided services in their home, community, school, or the most suitable environment of choice. Behavioral health services are provided in the most integrated setting appropriate to the child’s needs. When the need for a residential setting is identified, the setting is the least restrictive and most home-like setting that is appropriate to the child needs.
	MOST APPROPRIATE SETTING
THE PRACTICE	A. Services and support are provided in the most inclusive, responsive, accessible, and least restrictive setting. B. The team prioritizes services that are provided in the family home and community. C. The location of CFT meetings and other services are provided in a convenient and family friendly location. D. The family’s input is prioritized when scheduling the location of CFT meetings and other services. E. Children are supported in the least restrictive environment to meet their needs. F. Effective collaboration and effective discharge planning to prevent unnecessary days in a higher level of care.
	MOST APPROPRIATE SETTING
EXAMPLES	1. A child is referred for service by the school and at the CFT dad reports that the behaviors that the school is concerned about are not an issue at home. Dad and mom both work full-time and have missed work frequently due to being called to the school for disruptive behaviors. Dad reports that they cannot take time off work to take the child to the office for appointments and that the family believes that the services are needed in school since this is where the behaviors are occurring. The CFT facilitator schedules a team meeting to include the family, school, and service providers. Together the team develops a plan with goals that support the child in having success in school. The service plan and 504 plan are aligned to have the same goals and supports to ensure the success of the plan. The team collaborates and meets regularly to coordinate and monitor the progress of services implemented in the school by both the service providers and school staff. 2. A child is engaging in self-injurious behaviors and is taken to the hospital for stitches. The child expresses some suicidal ideation but no active plan. A member of the CFT suggests that the child be placed in an out-of-home setting. The CFT facilitator and other members of the team take the time to evaluate all possible options. The child currently has therapy in place 1 time per week, the team discusses increasing this service to 2 times per week. The team explores intensive outpatient services that include individual living skills sessions in the home 4 times per week, family support sessions 2 times per week and group dialectical behavior therapy. The child is also already attending a weekend respite program 1 time per month that the child and family feels is very helpful. The team determines that the child can remain safe in her home with additional support and services in place. Since the child is in crisis, the team expedites the services to begin the next day starting with the therapy. Also, the team identifies a safety plan that utilizes the family’s natural support to ensure that the child is not left alone. Additionally, the safety plan identifies triggers for self-injurious behaviors, as well as preventative measures and helpful coping skills that the child and her mother feel will help the child to remain safe in the home.

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	TIMELINESS
THE PRINCIPLE	7. The child and family’s need for services and supports are assessed according to and tailored to a child and family’s unique needs. The services are provided promptly, as expediently as required by the child’s condition and in accordance with requirements. AHCCCS and state regulations about timeliness of services (refer to ACOM Policy 417) should be discussed with the child and family at the time of referral, intake, and as needed during the assessment and service planning process. Providers are aware of timeliness requirements and make the child and family aware of their rights and resources available when they experience barriers to timely care.
	TIMELINESS
THE PRACTICE	A. Providers are aware of policy and procedures (AHCCCS, Health Plan, and agency) for timely service delivery. B. Providers work collaboratively with the family to ensure timely service delivery. C. Providers escalate to the health plan as appropriate when assistance is needed with securing services in a timely manner. D. Providers follow their agency’s escalation process to ensure timely delivery of services. E. If a provider is working the escalation process but the needed services are not available in time, a plan will be created to address the need until all identified services can be put into place. F. Providers give families information for the formal grievance and/or appeal processes, as needed. G. Providers complete referrals and follow up on referrals promptly. H. The team is updated regarding any referrals or barriers to timely service delay, as soon as possible. I. The team sets due dates for assigned tasks and tasks are completed within the agreed upon timeframe. J. All phone calls and emails from team members are responded to promptly.
	TIMELINESS
EXAMPLES	1. A 9-year-old boy is living with his foster family. His foster mother is concerned that the behaviors the child is displaying are common responses to trauma. At the CFT meeting the foster mother requests trauma therapy services for her foster child. According to Jacob’s Law, services shall be provided within 21 days of an identified need. The CFT Facilitator prepares and submits several referrals for services. After 11 days, no provider agency accepted the referral for service. At this point, the CFT facilitator escalates the needed service internally following the agency’s process. The agency then contacts the child’s health plan for assistance in finding a provider who can assign a therapist within the appropriate time frame. The CFT Facilitator worked with the health plan to identify an agency that could see the child within 21 days. 2. Mom calls the health plan to request behavioral health services for her child, as the school indicated that her child has behaviors that require further evaluation. The health plan provides a list of providers in their area. The mom chooses a provider closest to her home and calls to schedule an appointment. The provider’s intake department offers the mother an initial appointment within 7 days from the time of the call. At this appointment, a need

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	SERVICES TAILORED TO THE CHILD AND FAMILY
THE PRINCIPLE	8. The unique needs and strengths of the child and family determine the different types and intensity of services provided. Children and caregivers are empowered to fully understand and share their own unique needs and strengths to accomplish their goals. The Child and Family work together with their team to decide what services are necessary to assist in achieving their goals.
	SERVICES TAILORED TO THE CHILD AND FAMILY
THE PRACTICE	A. The services and support are customized and individualized to the child and family based on the needs and preferences. B. The child and family are treated as experts in their life and current situation; in how they would like things to be and what do they feel is the best way for them to get there. C. The service plan is created with a strength-based approach that incorporates the unique strengths of the child and family. D. The team takes time to recognize and validate the skills, knowledge, insight and strategies that each team member has used to meet the challenges that they have encountered in their life. E. The service plan utilizes a system of care approach which means that the team incorporates the unique resources and assets available within the community. F. This requires that CFT facilitators have knowledge about the behavioral health services in the area as well as community resources. G. The child and family define what success looks like and what they feel needs to happen in order for them to achieve their goals. H. The service plan for each child is unique to that individual child. Tailoring the service to the child and family is dependent upon successful implementation of the other principles. It requires collaborating with the child and family to ensure their voice and perspectives are known and prioritized. When services are tailored to the family it means that the family’s natural supports have been identified and utilized, and that the team is collaborating well with all others, including other involved child-serving agencies and helpful resources within the child’s community.
	SERVICES TAILORED TO THE CHILD AND FAMILY
EXAMPLES	1. A young single father enrolls their 3-year-old son in services. He is very energetic and eagerly moves from one activity to the next. His father tells the behavioral health provider that he is concerned that his son has attention deficit hyperactivity disorder (ADHD). The behavioral health provider completes a developmental screening and does provides educational

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	STABILITY
THE PRINCIPLE	9. Behavioral health care teams utilize whole person care to wrap the child and family in a supportive environment that provides access to care in a way that minimizes risk in the least restrictive setting. Behavioral health services strive to minimize placement disruptions and seek to keep children in their homes and communities. Service plans identify the steps to be taken to minimize or eliminate the risk. Providers anticipate crises that might develop and include specific strategies and services that will be employed if a crisis develops. Providers ensure the appropriate behavioral health services are provided with consistency and continuity. Teams anticipate and appropriately plan for transitions in children’s lives. Service planning builds on strengths and cultural considerations of the child and family to encourage resilience.
	STABILITY
THE PRACTICE	A. The team recognizes and explores potential risks to service interruption and out-of-home placement with the child, family, and team and incorporates steps to minimize risk, when applicable. B. The team encourages the identification processes to support consistent and stable delivery of services. C. The team supports each other in the utilization of available resources to help minimize or prevent potential involvement with police and criminal justice systems when applicable. D. The team anticipates potential crises and addresses those situations through crisis and safety planning. E. The team anticipates and plans for any transitions. F. For children in DCS custody, the team makes all necessary efforts to prevent placement disruptions and work to ensure a stable foster home and school environment. G. The team response immediately to crisis situations and provides all supports and services needed for crisis stabilization as expediently as the child’s needs requires.

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	STABILITY
EXAMPLES	A youth and family met with the CFT to discuss recent disruptions the youth has been having at home, as well as in the community. The youth’s parents shared that they have recently decided to divorce, and it has been hard on the whole family, especially the youth. The facilitator and CFT stakeholders collaborate with the family in recognizing potential triggers for the youth in moments of crisis, as well as prioritize them based upon potential likelihood and impact, identify immediate strengths and resources available as responses, and assign roles and responsibilities and document them within a proactive action plan that is easily supported by and accessible to the family. The CFT also helps the family brainstorm what will change as well as what will remain the same during the time of transition, so that the youth have a sense of what will remain familiar, thus helping provide a sense of stability for the youth and family.
	RESPECT FOR THE CHILD AND FAMILY’S UNIQUE CULTURAL HERITAGE
THE PRINCIPLE	10. Behavioral health services are provided in a manner that respects the culture. These include but are not limited to traditions, heritage, belief systems, social, racial, or ethnic family of origin. Services are provided in the child and family’s primary language or through interpretation and/or translation as requested or appropriate.
	RESPECT FOR THE CHILD AND FAMILY’S UNIQUE CULTURAL HERITAGE
THE PRACTICE	A. CFT Facilitators ensure a quality SNCD process is completed with the child and family in a timely fashion so that all remaining CFT processes honor the discoveries and preferences of the child and family. B. Following the initial completion of the SNCD process, CFT Facilitators ensure ongoing opportunities to update the original SNCD documentation are made available during subsequent CFT meetings. C. The child and family’s cultural heritage is treated as a strength-based resource and is incorporated into all planning processes. D. Aspects of the child’s individual cultural identity, separate from that of the family, are validated and given consideration, particularly as the child ages into adolescence.
	RESPECT FOR THE CHILD AND FAMILY’S UNIQUE CULTURAL HERITAGE
EXAMPLE	Upon completion of the SNCD process for a family, it is noted that while the child, who is 12 years old, and parents speak and read English, the grandmother living in the home does not. The grandmother is the central caregiver in the family as she takes care of the child and siblings’ weekdays after school until the parents arrive home from work. The family asks that written material provided during the CFT meeting be provided in both English and Spanish, so that the grandmother can engage accordingly. The family identifies with the Seventh Day Adventist faith and requests that no clinical services or service plan activities are arranged for the child or family on Saturdays, to align with their ability to attend services. The child is a lover of all animals and over the past year has decided to practice veganism, although the remainder of the family does not. The child asks if refreshments are served during CFT meetings that vegan options are available. These cultural aspects are shared by the CFT Facilitator with all CFT members during the initial team meeting. The CFT Facilitator ensures written materials are made available in both English and Spanish so the grandmother can be included. A note is placed in the family’s chart designating the child’s vegan food preference.

**POLICY 580 - ATTACHMENT E – IMPLEMENTATION OF 12 PRINCIPLES FOR
CHILDREN’S BEHAVIORAL HEALTH SERVICE DELIVERY**

	INDEPENDENCE
THE PRINCIPLE	11. All services and supports are individualized based on the child and family needs to ensure growth and encourage self-management. This includes child, youth, and family’s input on the unique needs for the child. The child and family shall have training in tools, support, and services, as well as advocacy. As the child ages, the focus will include individualized tools and support to foster a successful transition to adulthood.
	INDEPENDENCE
THE PRACTICE	A. Service and supports aid children in achieving their goals. B. The child and family are able to obtain a realistic desired level of independence determined by the family vision. C. As a child and family makes progress toward their goals, the amount of formal services decreases and the family’s use of natural and community supports increases.
	INDEPENDENCE
EXAMPLE	A mom requested a meeting with the CFT facilitator to express her concern that her 16-year-old foster daughter seems unaware of what will happen when she ages out of foster care. The CFT facilitator schedules a CFT meeting with the team to discuss transition aged youth services and how to support the youth and family during the transition period. The team agrees to add living skills services to the service plan to help the youth prepare for the transition. The team also explores the youth’s natural supports and community resources available. The Department of Child Safety (DCS) specialist shares information about the Young Adult Program (YAP) and the added benefits of choosing extended foster care with the youth. The CFT facilitator asks if there is anyone from the youth’s past that is involved. The youth expressed that most of her support comes from her foster parents. The team discussed the benefits of a living skills worker to help the youth to make some additional connections. The CFT facilitator discussed the utilization of the Casey Life Skills Assessment to better help the team understand the youth’s needs for transitioning to independence. The team agrees with the assessment.
	CONNECTIONS TO NATURAL SUPPORTS
THE PRINCIPLE	12. Natural support is any person associated with the child and family that has developed a relationship that enhances their quality of life. Providers shall support the child and family in identifying and encouraging a broad spectrum of natural support. These relationships shall enhance the child and family’s resources and support in the community.
	CONNECTIONS TO NATURAL SUPPORTS
THE PRACTICE	A. Natural support is sustainable and available to children and families even after formal behavioral health services are no longer needed. B. Natural support can be individuals, organization, or community resources. C. CFT facilitators shall be intentional in their efforts to include a child and family’s natural supports. D. The family shall always be given the option in which natural support is included in their child and family team. E. CFT facilitators shall identify a child and family’s natural support even if the family doesn’t wish to have those supports participate in the child and family team meeting.

*CONTINUED	F. CFT facilitators shall educate children and families on the benefits of involving their natural support. G. Natural supports and community resources are key in the child and family achieving independence and reducing formal services.
	CONNECTIONS TO NATURAL SUPPORTS
EXAMPLE	A youth in the custody of DCS is placed in a group home. The youth expresses that he is sad about losing his connection to everyone that he knew before he was removed from his home. The team explores who from this youth’s past is a safe source of support. The DCS specialist reports the department is not able to allow contact with any family members due to safety concerns. The CFT facilitator meets with the youth one on one to talk about individuals that had been supportive in the past. The youth talked about a friend he made on the school bus, the family lived only a couple of houses down the street. The youth explained that he felt safe when he visited their house. His friends’ parents had been very nice to him, and he had confided in them about things that were going on in his family home. They had allowed him to stay at their house whenever he wanted. The family had moved away from the area only a few months before the youth was removed by DCS. His friend’s mother had told him that if he ever needed help to call her, but he had left the number at his house when he was removed by DCS. The DCS Specialist contacted the youth’s mother and was able to get the phone number. After obtaining a release of information from DCS, the CFT facilitator invited the friend and his family to join the team. Having these supportive individuals involved in his life again has a positive impact on the youth’s wellbeing.

¹ Bruns, E. J., Walker, J. S., & The National Wraparound Initiative Advisory Group. (2008). Ten principles of the wraparound process. In E. J. Bruns & J. S. Walker (Eds.), The resource guide to wraparound. Portland, OR: National Wraparound Initiative, Research and Training Center for Family Support and Children’s Mental Health.