ARIZONA DEPARTMENT OF HEALTH SERVICES

DIVISION OF BEHAVIORAL HEALTH SERVICES

INSTRUCTION GUIDE

FOR THE

ASSESSMENT: BIRTH – 5,

SERVICE PLAN

AND ANNUAL UPDATE

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INTRODUCTION

The promotion of mental health in infants and toddlers is key to the prevention and mitigation of mental disorders throughout the lifespan. In the past, Tribal and Regional Behavioral Health Authorities (T/RBHAs) and their contracted providers had to modify assessment and service planning protocols to meet the needs and challenges presented by this unique population. With their participation, and the involvement of other child-serving agencies, specialists in infant mental health, parent advocates, and the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS), a new, innovative and uniform approach to assessments, service planning and service plan updating has been developed for the State of Arizona.

Although the same core priorities of ADHS/DBHS remain intact in the approach to infants and toddlers, the Birth to Five assessment and service planning process differs from those for the general population in two major areas. First, the approach to children in this age group must focus not on a particular attribute of a child, but on the context of the child's life; on the child's parents/caregivers, extended family, and community; on patterns and sequences of behaviors; on the interpersonal factors that either support growth and adaptive behavior or that fail to do so. The focus of assessment, to a far greater extent than with other populations, extends beyond the child as an individual unit, to the child as a product of the environment in which he/she is immersed.

The second difference relates to service plans. Service plans must be written to support and reinforce normalized child development; to promote and reinforce health-promoting parenting and child rearing skills; to enhance child/parent attachment and bonding; and to reduce the long-term effects of any trauma. In regards to infants and toddlers, then, behavioral health interventions must include preventive as well as corrective measures, and like the assessment, must target the family as well as the individual.

The ADHS model for intake, assessment, service planning and service delivery must therefore extend to the relationships that young children have developed and are developing with their families and caregivers; to the social, physical, cultural and economic environments in which they develop; to the physical and emotional well-being of those on whom they depend; to the parenting skills and emotional needs of primary caregivers; and to the presence of factors that may predispose children to developmental delays or future emotional distress.

The assessment model is based on five vitally important components:

1) Input from numerous sources (family, child serving agencies, caregivers, daycare providers, etc.) regarding history, special needs, strengths, preferences, behavioral, emotional and physical health concerns;
2) A detailed exploration of family history and living environment;
3) Direct observation of the child;
4) Direct observation of the child's interactions with family, current caregivers and/or others; and

5) A detailed developmental assessment.

This framework insists that behavioral health assessments and service plans:

- Are developed with an unconditional commitment to those enrolled in the behavioral health system and their families;
- Begin with empathetic relationships that foster ongoing partnerships and an expectation of equality and respect throughout the service delivery system;
- Are developed collaboratively with families and/or caregivers to engage and empower their unique strengths and resources;
- Include all appropriate and available individuals important to the child and family members;
- Are individualized, strength-based, culturally appropriate, and clinically sound; and
- Are developed with the expectation that children and those that they depend on are capable of positive change, growth and leading a life of value.

In order to support this approach, ADHS has developed standardized tools to be used by the T/RBHAs and providers when conducting assessments, developing service plans and conducting annual updates on infants and newborns aged birth to 5 enrolled in the ADHS behavioral health system. These standardized tools include:

- Behavioral Health Client Cover Sheet
- Behavioral Health Assessment and Service Plan Checklist
- Core Assessment
- Addenda
- Behavioral Health Service Plan
- Annual Update

The purpose of this instruction manual is to provide practitioners (i.e., clinical supervisors, assessors and/or clinical liaisons) with an in-depth understanding about how to effectively and efficiently put these tools to use. To this end, the guide addresses the purpose of the each component of the tools along with the intent of individual questions. For individual assessment-related questions, examples of additional probing questions may be provided that assessors may choose to use to solicit information.

In addition to this instruction manual, information regarding the assessment, service planning and annual update process can also be found in the ADHS Provider Manual, ADHS policies and procedures, and ADHS Covered Services Guide. All of these documents can be found on the ADHS/DBHS web site (www.azdhs.gov/bhs).

ASSESSMENT TOOL

General Information

The overall assessment tool is made up of two basic components:

I. A **Core Assessment** is completed at the initial assessment interview and focuses on collecting enough information to get the child to the appropriate next service(s). If some part of the Core Assessment cannot be completed at the initial appointment (e.g. crisis situation), this should be documented on the Assessment and Service Plan Checklist and the section flagged to be completed some time within the ensuing 45 days.

II. Relevant or required **Addenda** must be completed at a follow-up meeting(s). Addenda facilitate the building of a complete picture of the child/family by further identifying strengths and additional supports through the examination of a broader view of life domains.

While the assessment tool has been specifically designed to apply to all infants and children aged birth to 5, addenda have been developed for specific subpopulations (e.g., children for whom their challenging behaviors are of primary concern; children who have been hospitalized, reside outside the home for medical reasons or who have been treated for seizures; children who have been removed from their primary care giver(s) for child welfare reasons). These addenda are triggered by specific questions in the Core Assessment that may identify the need to pursue a given domain more thoroughly. The Developmental Addendum, to be completed for all children, may be deferred to future appointments unless specific developmental issues are identified at the initial interview.

Although all questions were carefully crafted to be strengths-based and engaging, their wording serves as a guide rather than a rigid formula and often requires further levels of inquiry. The questions focus on capturing family culture, strengths and supports, identifying precursors to future developmental or emotional problems, discerning significantly problematic child/caregiver dynamics, medical needs, trauma, and parental stressors that put the child at risk, and determining the internal and external supports, community services, generic services and covered services which may assist a child and family in developing their full potential. The assessment tool encourages an ongoing process of implementing and revising clinical, case management, support and medical services through the continual assessment, re-evaluation, clarification and identification of the child and family's/caregiver's strengths and needs.

While assessments should be continuous in nature, all required elements of the initial assessment must be completed on children entering the system within 45 days after their initial intake/assessment appointment. All demographic data must likewise be submitted to ADHS/DBHS within 45 days of the intake appointment.

Behavioral Health Client Cover Sheet

Prior to the initial assessment interview, the intake worker should, if necessary, assist the adult accompanying the child to complete the Behavioral Health Client Cover Sheet (see Appendix A). The purpose of the Cover Sheet is to record the special needs, key contacts and insurance coverage of the child. Based on discussions with the person/family during the assessment interview, additional information (such as other key contacts) may be added to the Cover Sheet at a later date.

Assessment and Service Plan Checklist

At the end of the initial assessment interview, the assessor must complete the Assessment and Service Plan Checklist (see Appendix B). The purpose of the Checklist is to record which components of the assessment were completed at the initial assessment interview. If not completed at the initial interview, the assessor must indicate which additional Addenda will be completed at a later date and which are not applicable. In most cases the Service Plan should be completed during subsequent Child and Family Team (CFT) meetings following the initial assessment interview. However, in the unusual circumstance of the Service Plan being completed at the initial appointment, the assessor should so indicate on the Assessment and Service Plan Checklist.

The assessor completing the initial assessment interview must sign the bottom of this Checklist. If the assessor is not a Behavioral Health Professional, a Behavioral Health Professional reviewer must sign as well. For any Addenda and/or Service Plan that are completed at a later date, the assessor completing those sections must sign them.

In addition to the assessor's signature, it is important for the assessor to complete the client identifying information on the top of the Checklist along with filling in the child's name on the top of each page of the assessment tool.

PART A: CORE ASSESSMENT

Although assessment is an ongoing process that continues throughout the child's duration of care, the assessor should, in most cases, complete the Core Assessment at the initial assessment interview. Two possible exceptions would be: 1) a crisis situation where the assessor must first focus on resolving the immediate crisis; and 2) a 24-hour urgent response for children removed from the home by Child Protective Service (CPS). In these situations, while the assessor should try and complete as much of the Core Assessment as possible, it may require that some sections of the Core Assessment are completed at the next appointment. (See Addendum: Child Protective Services for more specific information regarding requirements associated with urgent response to CPS removal cases.)

The Core Assessment is designed with a limited focus and specific goals, allowing ongoing evaluation to progress and create a more comprehensive portrait of needs and strengths. While serving to engage and support the child and family, it is meant to explore information about immediate risks and needs, to support the development of a meaningful clinical team, and to determine what the next service needs to be. The Core Assessment, in essence, fulfills a triage role, determining the next appropriate clinical steps, when and how those steps will be implemented, and by whom. Additional Addenda, completed over time, augment the content of the Core Assessment.
The Core Assessment is sub-divided into the following 10 sections:

- Reason for Assessment
- Child's Routines/Activities
- Developmental Issues
- Child's Medical History
- Risk Assessment
- Family Information
- Observations and Reported Observations of the Child
- Observations of the Family/Child Interactions
- Clinical Formulation and Diagnoses
- Next Steps/Interim Service Plan

For each Core Assessment section, a brief statement of its purpose is provided below. To further assist the assessor, the intent of most questions and opportunities to further probe and elaborate are also provided.

Reason for Assessment:

This section begins the core assessment. It is designed to elicit the immediate concerns, needs or questions of the adults presenting with the child that encouraged them to seek services at that point in time. These may stem from observable behaviors or developmental delays, or may be extracted from an event or situation the child has experienced (e.g. a CPS removal or physical abuse) that may put the child at risk for future problems- even if symptoms are not present. The questions in this section serve to draw out information on the status of the child and why services are being requested at this time (question 1); the impact of the primary concerns on the family or caregivers (question 2): the attempts that have been made, successfully or otherwise, to

mitigate the concerns (questions 3 and 4); and the specific expectations and desired outcomes of the services to be provided (questions 5 and 6).

While occasionally the accompanying adult may have limited if any background information about the child (as in a recent CPS removal), the assessor should extrapolate the concerns, needs or questions from the history available. For example, although there may be little clinical or background information immediately available about a child removed from home secondary to sexual abuse, the likely issues, concerns and needs for services to mitigate the trauma of abuse and removal, and the need for ongoing assessment for future emotional and developmental problems, should be noted by the assessor in this section.

Child's Routines/Activities:

The assessment of very young children must be based on an integrated developmental model that draws information from multiple sources of information and multiple components. To the extent that it is available, a detailed history of the child's daily routines and activities provides insights into the child's interests, skills, biological functioning, level of adaptability, sensitivities and degree of maturity. Sleeping and eating patterns, response to new situations and activities, response to everyday activities, and patterns of play are explored in this section.

Besides beginning to create a portrait of the child as defined by his/her life experiences, the assessment of routines and activities provides the clinical liaison with information about the child's sensory and motor characteristics that add to a developing formulation. Atypical responses to questions in this section may be the first indication of a regulatory disorder.

Development Issues:

This section allows the assessor to understand and document key elements of the child's social, emotional, cognitive and physical development. It should be reviewed and assessed with additional information obtained in the Child's Medical History and Family History sections, and the Developmental Checklist Addendum or the Ages and Stages Questionnaire (ASQ) Addendum in order to generate a comprehensive portrait of the child's developmental status. The Clinical Liaison has the choice of filling out either of these two tools. If there are positive responses to trigger questions in the Developmental Issues section, reflecting specific developmental concerns, either the Developmental Checklist or the ASQ should be filled out at the first meeting. Otherwise, their completion can be delayed until the CFT has been convened. In all cases however, one or the other must be completed within 45 days.

Assessment of Developmental Issues is useful in:

- Identifying possible developmental problems and the need for further diagnostic evaluation;
- Providing an objective description of a child's abilities and deficits;
- Determining the need for other programs (e.g., Developmental Disability services, Arizona Early Intervention Program (AzEIP); evaluation by the child's school district;
- Defining the most appropriate diagnostic classification;
- Developing a developmental framework for understanding the child's mental health in the earliest years; and
- Assisting in planning for appropriate interventions.

Child's Medical History:

A thorough evaluation of health status yields understandings of the child on multiple levels. From an assessment perspective, medical conditions can both provoke and pose as behavioral health concerns. From a diagnostic perspective, they can easily be confused with regulatory disturbances, attentional concerns, anxiety and mood disorders, and disorders of sleep and eating behavior. From a service planning perspective, promoting and maintaining optimal health advances optimal emotional functioning and development.

This section explores information about current and past medical issues and services the child is receiving or has received to address these issues. Questions review the child's overall health, specific medical conditions that have been diagnosed and/or treated, allergies, head injuries, medication histories (including natural, herbal or alternative medical approaches), treatments received outside the home, and seizures.

The Medical Addendum must be completed if the child has ever been hospitalized or required medical service provision outside the home, or if the child has been treated for seizures. The Medical Addendum must be completed either at the time of the core assessment or at an appropriate follow up appointment. Otherwise, the Medical Addendum should not be completed.

Risk Assessment:

The purpose of the Risk Assessment section is to determine the child's over-all ability to be safe in the community and, by balancing all known factors, to assess the need for immediate intervention. Factors to be considered include a past history of physical, sexual or emotional abuse, neglect or deprivation of proper care giving, a history of harming others, sexually-inappropriate behavior, or violent experiences.

Trigger questions prompt further explorations of the effects of experiences on the child, the focus that treatment should take, and the presence of immediate safety risks for the child or caregiver that would lead to prompt interventions.

Family Information:

As the primary environment in which children learn and grow, families can present both protective and risk factors for normal development and mental health. A thorough exploration of

available family information broadens the context of this environment. The presence of close, cohesive relationships, economic and educational resources, problem solving skills, etc. are protective at the family level. Poor parenting skills, family struggles, negative life events, poverty, etc. all present risks.

Children acutely shape their families as their families shape them. Dispositional traits such as noncompliance or irritability for example, may provoke parents into punitive or coercive parenting patterns that reinforce these traits, and ultimately place the child at greater risk for behavioral problems and developmental deviations at a later age. The Family Information section therefore explores both protective and risk factors that influence the transitional nature of family dynamics, and the overall health of the child's primary environment.

The fact that caregivers are in substantial distress may be a more critical diagnostic factor than specific symptoms or observable signals of distress in a child. Thus, questions in this section have been carefully crafted to explore family mental and medical health history, legal history, and other stressors that may impact family functioning.

Observations and reported observations of the child:

The overall purpose of this section is to summarize the assessor's observations and impressions of the child, as well as observations made by family members or other caregivers that may not be readily discernable at the time of the core assessment. Similar to a mental status examination, the data to be reported does not emerge in any special sequence or order. It describes the child's:

- appearance (dress, cleanliness, overall demeanor);
- general presentation (broken down by age-appropriate cues);
- responses to change, such as to the presence of strangers, a change of activity, or separation and reunion with parents);
- self regulation (over reacts to stimuli, easily frustrated, atypical movements or behaviors);
- the quality, quantity, appropriateness and normalcy of speech;
- motor activity and coordination;
- thoughts (if determinable);
- mood and affect (including verbalized and non-verbalized communication);
- relatedness (to parents, other caregivers, the assessor);
- play**;** and
- level of consciousness (alert, sleepy).

For each trait to be evaluated, the Assessment Tool offers a number of prompts. These prompts are not meant to serve as shortcuts to be circled, but merely as aids to help the assessor consider and describe the child in a comprehensive and thoughtful manner.

Observations of Family-Child Interactions:

The relationship children have with their parents/caregivers serve as essential and primary regulators of development for critical processes in the first several years of life. The observations of family-child interactions therefore serve as the first clues to the health of a child's emotional, intellectual and physical development. How a family plays together, the quality of a child's

interactions with siblings, the level of parental/caregiver affection, their level of engagement, the parent's/caregiver's ability to respond appropriately and sensitively to a child's cues, the reactions to a child's behavior, etc. are at least as significant to one's understanding of the child as the presentation and history of the child. This section of the Core Assessment assists the assessor in organizing and documenting these essential components. It may be considered a "family mental status evaluation."

Clinical Formulation and Diagnoses:

The Clinical Formulation and Diagnoses section functions as the bridge between the Core Assessment and the Service Plan. The purpose of this section is to summarize the information gathered in the Core Assessment, to make one or more provisional diagnoses and to summarize other diagnostic factors, such as the medical condition of the child. The section is divided into two parts:

- Clinical Formulation/Case Summary
- Diagnostic Summary

Clinical Formulation/Case Summary:

This section is meant to define a preliminary construct of the nature of the child's strengths and weaknesses, and the relative contribution of all assessed areas (developmental, health and social history, family relationships, family functioning and cultural patterns, family psychosocial and medical history and personal traits, etc.) to these strengths and weaknesses. In a succinct paragraph, the assessor should provide a descriptive picture of the child by summarizing, not repeating, accumulated data collected and most importantly, making sense of it. If done correctly, this section will tie together disconnected details, historical facts and observations that have been collected to this point, organize them to create a conceptual portrait of the child, and render them clinically pertinent and useful in service plan development.

It is important to know, for example, that a parent died when a child was 3 years old; it is more important to explain how this fact assists in making sense of the child's presentation today. Was the death experienced as a traumatic loss, a welcome relief from abuse, or both? Did it result in an adjustment disorder, a long-standing problem with attachments, or enhanced feelings of security and trust? How does it impact the child's current needs, strengths and resources? How was that impact affected by the relationships with caregivers that followed?

Diagnostic Summary:

Axis I and II: A DSM IV-TR diagnosis is required for both billing purposes and data reporting. It is quite possible that the core assessment will not provide enough information to clarify a diagnosis at this point in the ongoing assessment process. In these cases, clinicians are encouraged to use V codes (used to define relationship problems, issues relating to abuse or neglect, or other general problems or concerns that require clinical attention). Although diagnoses are required in DSM IV-TR format, clinicians are encouraged to consider the diagnostic frameworks presented in *Diagnostic Classification: 0-3* for their own conceptual understanding of the child.

Axis III is used to summarize the person's specific physical health conditions, based on information the assessor obtained through the Medical History section. This information should be used to determine if a referral to a PCP is needed. The clinician is therefore asked to apply the child's identified medical conditions to a categorized checklist provided in this section.

On *Axis IV*, the clinician is asked to define any and all psychosocial or environmental stressors that affect the child and/or the family.

On *Axis V*, the Children's Global Assessment Scale (CGAS) reflects the assessor's judgment of the child's overall level of functioning. This information will be useful in service planning and prognoses, and is reported to ADHS/DBHS as a primary source for measuring outcomes. The clinician should be aware that the CGAS has been modified to accommodate the early childhood population.

Next Steps/Interim Service Plan:

Purpose

The purpose of the Core Assessment until this point has been to identify the immediate needs and strengths of the child/family/caregiver, to provide a foundation for ongoing assessment, and to produce enough information to decide what, when and how initial care should be delivered. The Next Steps/Interim Service Plan section serves as a way of organizing and documenting these tasks and triaging the child/family/caregiver to the most appropriate next service. By completing this section, the assessor will design the service array that will be put into place *until* a full assessment is completed. Individuals who can serve as resources to the child/family/caregiver and who may serve on the CFT will be identified, the need for additional information will be established and a contact person within the provider system will be determined. The parent or guardian's signature reflects their endorsement and participation in the development of the recommended next steps.

Depending on the individual circumstances and needs of the child/family/caregivers, the plan should include:

- Steps to address any concerns about the child's immediate safety and security;
- Medical referrals for children who have an Axis III diagnosis or condition, who have not had regular well-child Early Periodic Screening and Diagnostic Treatment (EPSDT) visits or need a physical examination;
- Psychiatric referrals for children taking/needing psychiatric medication;
- Referrals of any child under the age of 3 to AzEIP, if triggered by the *Developmental Checklist* or *ASQ*;
- Specific recommendations as described below for children removed by CPS.

For urgent responses to children removed from their home by CPS, specific considerations come into play. These must at a minimum include the traumatic impact of the removal process, the potential return of the child to his/her family, the needs of the child's new caregivers as they accommodate to the situation, and the needs of the child to maintain contact with those individuals important to his/her life. In the case of a CPS removal the Next Steps/Interim Service Plan must consider:

- Actions needed to be taken immediately to mitigate the effects of the removal itself;
- Supports and services the child's caregivers may need;
- Plans to ensure that even asymptomatic children are reassessed and observed for surfacing behavioral and/or developmental needs within the next 30 days (or sooner if indicated).

The assessor may also provide input to the CPS worker or court regarding the types and amount or frequency of contacts (phone calls, visits, emails, etc.) the child should have with parents, siblings relatives and other individuals important to the child.

Coordination of Services:

The entry of a young child into the behavioral health system defines a point where services provided by numerous child-serving agencies intersect. ADHS/DBHS, Child Protective Services (CPS), Children's Medical and Dental Plan (CMDP) and other health plans, school districts, Arizona Early Intervention Program (AzEIP), Division of Developmental Disabilities (DDD) and others all contribute to the emotional, physical, and developmental well-being of infants and toddlers, and their evaluation processes and services are mutually interdependent. The Clinical Liaison assumes the vital role of ensuring that the efforts of all agencies are coordinated and that referral and communication processes are seamless.

For Children in Foster Care: If health concerns are identified during the assessment process (see Child's Medical History section of the Core Assessment), or EPSDT visits have been neglected, a referral should be made to the CMDP PCP. Although Arizona Child Youth and Families (ACYF) policy requires that children receive a comprehensive health assessment within 30 days, immediate services can be requested upon entry if necessary.

If a child under the age of 3 demonstrates developmental delays on a CPS Urgent Response evaluation (see Developmental Issues section of Core Assessment and the Developmental Checklist or Ages and Stages Questionnaire), a referral should be made directly to a PCP. The PCP will coordinate and expedite evaluations, services, and referrals to AzEIP or other providers as appropriate.

In some areas of the State, CMDP has organized a specialized network of providers that has expertise in areas of child abuse, special health care needs and developmental issues, and is able to provide expedited assessments. The Clinical Liaison should determine the immediacy of needs and coordinate the referral process to these networks where available with the CPS caseworker or foster family.

Children over the age of 3 who demonstrate evidence of developmental delays that may impact their learning capacity and future academic success should be referred to the local school district for an IEP evaluation. If the Clinical Liaison believes that the delays may warrant the services of DDD, a referral should be made directly to that Department.

If CPS is considering a case of substantiated or proposed substantiated child abuse, the Clinical Liaison should not make a referral immediately to AzEIP. In practice, the CPS

caseworker makes the referral some time following removal due to the CPS focus on immediate safety issues, and the need to identify a legal guardian or to have a court-appointed surrogate before an AzEIP evaluation can be initiated. An AzEIP referral should appear, however, on the child's interim service plan and should be coordinated with the CPS worker.

For Children not in Foster Care: If health concerns are identified during the assessment process (see Child's Medical History section of the Core Assessment), or EPSDT visits have been neglected, a referral should be made directly to the child's PCP. The clinician should encourage the parents to take the child to the PCP and explain why it is critical that they do so.

If a child under the age of 3 demonstrates developmental (see Developmental Issues section of Core Assessment and the Developmental Checklist or Ages and Stages Questionnaire), a referral should be made directly to the child's PCP and/or AzEIP.

Children over the age of 3 who demonstrate evidence of developmental delays that may impact their learning capacity and future academic success should be referred to the local school district for an IEP evaluation. If the Clinical Liaison believes that the delays may warrant the services of DDD, a referral should also be made directly to that Department.

PART B: ADDITIONAL ADDENDA FOR BIRTH –5

The assessor is encouraged to complete additional addenda at follow-up meetings. This allows the CFT to develop and to participate in a more comprehensive assessment of additional life domains unless otherwise indicated.

Family Culture and History Addenda:

The understanding of children must be guided by awareness that they are active participants in relationships with their caregivers. These addenda explore the variables that define these relationships by reviewing multiple spheres of influence on the feelings, patterns and priorities of the family as it forms the community and culture in which the child grows, learns and develops. They include experiences that may underlie a parent's feelings about a child, the child's history with caregivers, the family's experience of pregnancy, the effects of a child entering a new family on both the child and the family, the strengths, supports and resources of the family, important historical events, and the recollection of family members of their own upbringing.

The Family Culture and History Addenda has been tailored to apply to families of biological and adoptive families and to foster families. In this manner, experiences specific to all subgroups can be explored.

The Family Culture and History Biological and Adoptive Family Addendum should be completed with biological and adoptive family members. The Family Culture and History Foster Family Addendum should be completed with foster family members.

Developmental Checklist or Ages and Stages Questionnaire:

One of these two developmental questionnaires must be filled out on each child, based on the individual preference of the clinician. The *Developmental Checklist* is not proprietary and is included in the assessment packet. The *ASQ*, while proprietary, is favored by many clinicians who have experience in its use. If triggered by concerns in the Core Assessment's Developmental Issues section, one of these developmental questionnaires should be completed at the initial visit. Otherwise it should be delayed until the CFT has been developed and, with their input, a more comprehensive overview of the child's development can be attained.

The need for further ongoing assessment and referrals are determined by "red flags" on the *Developmental Checklist* or by scores that fall below a designated cutoff on the ASQ scoring tool. Concerns on either questionnaire must trigger an automatic request to the primary caregiver to seek services through AzEIP (for children under three), or through DDD (for children age three and older). Alternatively, children three or over can be referred by their primary care giver directly to their PCPs for further developmental evaluation and coordination of helpful interventions.

Behavioral Analysis:

Challenging behaviors, like appropriate behaviors, are maintained by environmental, social and physical reinforcers. The Behavioral Analysis Addendum enables the clinician to determine

what functions challenging behaviors play in the child's daily routine and allows them to be assessed through the situational and environmental context in which they occur, and in relation to the influences that manifest before, during and after. Questions focus on the quality and patterns of challenging behavior, the antecedents and/or consequences that effect or control a behavior, possible reinforcers that maintain the behavior, and potential alternative behaviors that may be used in the treatment plan to replace challenging behaviors. The Addendum also explores the effects that challenging behaviors have on caregivers, and who is most challenged by the behaviors. This allows service providers the opportunity to support and promote the most effective caregiver responses and the opportunity to not only change behaviors but also to shape and enhance the interpersonal environment in which they occur.

The Behavioral Analysis Addendum should be completed on all children whose primary need is a behavioral issue. Unless otherwise indicated, it should be completed after a CFT has been developed and, with their input, a more comprehensive picture of the child's behavior can be developed.

Medical Care:

The Medical Care Addendum must be filled out for all children who have been hospitalized, have resided outside the home for medical reasons, or who have been treated for seizures. Specific questions relating to seizure history explores the details of presentation, diagnosis, treatment and secondary behavioral changes. Seizure activity can both mimic and lead to the development of coexisting behavioral health disorders, and the treatment of seizure disorders can likewise confuse the behavioral health presentation. Thus, the interplay between physical and mental health must be carefully evaluated, and care must be closely coordinated between behavioral health and both primary care and specialty providers.

Hospitalizations for medical concerns, especially in the very young, can be traumatizing. Children who experience surgery, pain, or extended disruptions of normal child-parent intimacy are susceptible to future behavioral and developmental complications. Questions in this section explore medical care, regardless of the lack of current related symptoms.

Child Protective Services:

The Child Protective Services Addendum was developed for the purpose of ensuring that the urgent responses to children removed from their homes by Department of Economic Security, Child Protective Services (CPS) adequately determines the status of the child in the midst of a crisis, assesses and supports the child in a manner that mitigates the trauma of the removal itself, determines the most appropriate immediate interventions, and ensures that appropriate information is obtained to help inform the CPS case manager, and the Court at the child's Preliminary Protective Hearing.

Recognizing that an accurate portrait of the child's overall strengths and needs will likely be overshadowed by the immediate crisis at hand, the priority at this initial interview is to address the child's immediate needs. The assessor should complete the Addendum and the Behavioral Health Client Sheet, the Client Demographic Information Sheet and the following sections in the Core Assessment: Risk Assessment, Observations and Reported Observations of the Child (and if possible, Observations of the Family-Child Interaction), Diagnostic Summary and the Next

Steps/Interim Service Plan. Only then, as the situation allows, should the remainder of the Core Assessment be finished with and for the child.

The Addendum includes a brief checklist of a child's likely immediate response to the removal process itself, correlated to age. The assessor's observations and impressions of these responses, in conjunction with other data obtained through this Addendum, should serve as the basis for completing the Next Steps/Interim Service Plan.

The questions contained in this Addendum are primarily intended to be responded to by the Child Protective Service specialist involved with the child's case. In addition the assessor should make sure that the Child Protective Service specialist's name and phone number is recorded on the Cover Sheet that is placed in the child's behavioral health record.

PART C: BEHAVIORAL HEALTH SERVICE PLAN

In tandem with the assessment process, service planning should be an ongoing process resulting in an individual service plan for the child and family that is a living clinical document continually being changed to meet the needs of the child and his/her family. It is important to view the Behavioral Health Service Plan as the child's (and families') service plan, not the provider agency or clinician's plan. To that end, the Plan should be written so the child's family can readily understand the service/treatment objectives and when they have met the objectives, as well as their responsibility to follow through with their plan. The plan must be directly linked to the results of the Clinical Formulation that was previously discussed.

Although service planning is an ongoing process, the life of any single service plan must be brief in its orientation. While they are technically good for a maximum of one year, Clinical Liaisons are encouraged to set objectives that can be readily accomplished and celebrated with in a much shorter timeframe. In this way, small but realistic accomplishments can be built upon sequentially with feelings of success continually reinforcing accomplishments.

There are two sections to the overall Behavioral Health Service Plan, the actual Service Plan and a Review of Progress that is used to document the ongoing assessment process and evaluation of progress toward meeting service planning goals.

SERVICE PLAN SECTION:

The instructions for the Service Plan follow the Service Plan form, starting at the top and moving left to right across the document.

Recovery Goal/Child-Family Vision: This section should describe the outcome the family/caregivers would like to see occur from the services you will provide and how they will know when a service is no longer needed. The goal should provide a vision of how those involved would like their child, life, family and environment to be. While the goal does not initially have to be realistic, the Clinical Liaison should assist the family/caregivers in identifying what will be needed for them to move toward their vision and encourage the understanding that the Recovery Goal and Vision will continue to be modified and changed frequently.

Child's Strengths: The Clinical Liaison should summarize child/family strengths that have been identified through the assessment process with the expectation that one will continue to add to this area as other strengths are identified in the future. Strengths may include internal strengths of the child, the application of these strengths, and the supports available to the child and family in times of distress.

Identified Needs and Specific Objectives: When identifying the needs and developing the specific objectives to address these needs, the Clinical Liaison should refer to the Clinical Formulation/Case Summary and Diagnoses section of the Core Assessment. Emergent or health needs or safety factors (e.g., abuse, risk, living arrangements, and medications) must be addressed first. Objectives should be brief, clear statements that are measurable, make practical, common sense to the child and family and can be accomplished in a short period of time. It is recommended that the Service Plan contain no more than 3-5 objectives at one time.

Measure (Current, Desired and Achieved): A quantifiable means to measure each objective needs to be established:

- Under "**Current Measure**" the Clinical Liaison should describe, in measurable units, the current status (e.g. the number of times per day a child is misbehaving at the present time; the length of time a child cries before he can be soothed) for each identified need and service objective.
- The "**Desired Measure**" defines the realistic target the CFT has established for each need and objective (e.g. the family would like the child to misbehave only 2 times per day; the family hopes it will take only 1 minute to soothe the child's crying).
- During later reviews of the service plan, the current status of the need and objective is recorded under **"Achieved Measure"** (e.g. child is now misbehaving 1 time per day; the child now takes only 2 minutes to soothe).

Interventions to Meet Objectives:
This section should describe specifically how each of the service objectives would be met. Covered behavioral health services, including type and frequency, as well as other non-professional or community services that might be drawn upon (e.g., assistance from IEP team from the child's school; pre-school or childcare services; care or activities provided by relatives) should be identified. Strengths and resources identified in the core assessment and addenda should be utilized to the extent possible.

Interventions should serve as practical guides to family/caregivers and to the child. By reading this section, all participants in care should have a clear understanding about their role in the child's care. Generic, but vague references to covered services (e.g. individual therapy bi-weekly) must be avoided.

Discharge Plan:
The discharge plan describes in detail the aids, services and provisions that must be in place before a behavioral health service is discontinued. It should be comprehensive and broad in scope, and inclusive of necessary covered services and the non-professional and community services that will be drawn upon to maintain a healthy status quo. Like the rest of the Service Plan, the discharge plan can be changed as necessary and appropriate. The discharge plan should be brief and understandable to the person/family. While discharge planning should begin at intake, it can be completed at a later date if the Clinical Liaison feels a reasonable plan cannot be initially formulated.

Child/Family Signatures:
It is important that the Clinical Liaison ensures that family/caregivers or, when appropriate, the child, signing the Service Plan understand and agree to all of the provisions of the plan.

Behavioral Health Service Plan Review of Progress, Birth-5

Section I, Review of Progress: This section provides a summary of the progress the child and family/caregivers have made toward meeting the objectives identified on the service plan. Additionally, adjustments that are being made to the service plan objectives and/or measures are indicated, including their justification and any additional needs or strengths that have been identified.

Instead of making additions and deletions on the original Service Plan, the Clinical Liaison should ensure that the summary provided in this section identifies additional needs, strengths and concerns that have arisen as well as significant accomplishments and changes. The summary may also include how any additional needs that have been identified will be prioritized on the next Service Plan.

Section II, Current Diagnostic Summary: Any changes in diagnoses and functioning should be described. If diagnoses have been deferred until now on either Axis I or II, they should be revisited and fitting diagnoses entered. V codes at this point may be replaced or supplemented with diagnoses of specific behavioral health conditions.

Section III, Team Members Present at Plan Review Meeting (CFT Planning): Individuals present at CFT meeting at which the plan is reviewed should be identified.

Section IV, Date of Next Plan Review: The date of the next planning meting should be identified.

Section V: Clinical Liaison. The CL responsible for reviewing the service plan with the CFT should be identified.

Signatures: If the CL is not a Behavioral Health Professional, the BHP reviewing the document must sign in addition to the CL.

PART D: ANNUAL BEHAVIORAL HEALTH UPDATE AND REVIEW SUMMARY

The Annual Behavioral Health Update and Review Summary (a.k.a. Annual Update) should be completed with all members of the CFT present or represented. Its purpose is to record a chronicle of the significant events that have transpired during the past 12 months, to describe the child and family's response to the services/treatment provided and to aid in the development of future treatment goals and strategies. It should be inclusive of the child and family's ongoing service needs, resources and strengths, and cultural preferences and considerations. Current functioning and risk factors should be identified and assessment information and diagnostic information should be updated. Necessary adjustments or changes to be made to the current service plan should be documented.

The Services and Treatment Summary section is divided into two components:

- Status Review, including Emotional, Medical, Environmental, Progress, and Risk Factors, and;
- Current Diagnosis;

    - The Emotional section should document therapeutic interventions, services or supports provided over the past year and the child's treatment (e.g., what helped? what did not help or made condition worse?); the child's overall functioning over time since the last assessment/review ; and the child's current status.
    - The Medical section should document medications tried and symptomatic response to medication interventions over the past year; significant medication side effects or adverse drug reactions; the results of AIMS testing if applicable; significant changes in medical condition and hospitalizations; and physical development. A list of current medications and dosages must be completed.
    - The Environmental section should document significant events or trauma since the last assessment/review; placements outside the home; the family's cultural preferences and considerations for service provision.
    - The Progress section describes the progress the child and the family have made in reaching treatment objectives. The child and family's functioning related to living environment, activities of daily living, school preparation, interpersonal relationships and developmental progress should be considered.
    - The Risk Factor section should define any long-term chronic risk factors such as harm to self or others, exposure to drug use, nutrition, exploitation, abuse, or neglect. These must be considered in any recommendations for current and ongoing services (below).

A review of the highlights of these sections should enable a new service provider to be quickly brought up to date and to rapidly develop an understanding of a child's service history and responses.

Current Diagnostic Summary:

Axis I and II: Any changes in diagnoses should be documented. Deferred diagnoses on both Axis I and II should be replaced with specific behavioral health diagnoses at this point. V codes should be revisited and, when appropriate, replaced or supplemented with diagnoses of specific behavioral health conditions.

Axis III: The child's physical health condition should be summarized. As this information is reported to ADHS/DBHS as part of the demographic data submittal, the CL is asked to apply the child's identified medical conditions to a categorized checklist provided in this section. Information from Axis III should be used to determine if a referral to a PCP is needed.

Axis IV: Any and all psychosocial or environmental stressors that affect the child and/or the family should be described.

Axis V: The Children's Global Assessment Scale (CGAS) should reflect the CL's judgment of the child's overall level of functioning at this point in time. The clinician should be aware that the CGAS has been modified to accommodate the early childhood population.

Recommendations for current and ongoing service/treatment:
Recommendations should consider the following:

- Goals that have not been achieved that still need to remain a focus of services/treatment;
- Any new goals for the service plan;
- Other ongoing needs or concerns that need to be addressed, including coordination of care with PCP; AzEIP, DDD, school districts and/or child care providers; and
- Any areas in the assessment that need to be reassessed due to significant changes, e.g., person's condition, living environment, support structure.

APPENDIX A: BEHAVIORAL HEALTH CLIENT COVER SHEET

ADHS-DBHS BEHAVIORAL HEALTH CLIENT COVER SHEET

Name_____ DOB_____ Client CIS ID#_____
Address _____ Client SS#_____
City_____ State_____ Zip _____ AHCCCS ID#_____
Phone_____ E-Mail_____ AHCCCS Health Plan_____
Gender: □ Male □ Female Primary/Preferred Language_____

Special Needs:

Interpreter	□ No	□ Yes, specify language_____
Mobility Assistance	□ No	□ Yes, identify assistance needed_____
Visual Impairment Assistance	□ No	□ Yes, identify assistance needed_____
Hearing Impairment Assistance	□ No	□ Yes, identify assistance needed_____
Need Childcare Arrangements	□ No	□ Yes, identify need_____

Key Contacts:
PCP/Physician: _____ Phone_____ Fax_____
PCP/Physician Address: _____
Legal Guardian: _____ Phone_____
Custody: □ Sole □ Joint □ Ward of Court (DES Legal Guardian)_____
Parent(s)/Step Parent(s) _____ Phone_____
_____ Phone_____
_____ Phone_____
Emergency Contact: _____ Phone_____
Address_____

Other Key Contacts (e.g., school, probation/parole officer, other involved agencies (CPS, DDD), neighbors, grandparents):

Name and Relationship to Person _____
Phone_____ Fax_____
Name and Relationship to Person _____
Phone_____ Fax_____
Name and Relationship to Person _____
Phone_____ Fax_____
Name and Relationship to Person _____
Phone_____ Fax_____

Insurance Coverage: □ Medicare □ Private (self-pay) □ TriCare □ Blue Cross □ HMO □ Other □ None
Insurance Co_____ Insurance ID #:_____ Policy No:_____
(Attach copy of insurance card)

Individual Completing Form and Title:_____ Date_____

APPENDIX B: BEHAVIORAL HEALTH ASSESSMENT: BIRTH-5 AND SERVICE PLAN CHECKLIST

ADHS-DBHS BEHAVIORAL HEALTH CLIENT COVER SHEET

Name_____ Date of Birth_____ Client CIS ID#_____

Accompanying Parent/Caregiver (note relationship to child):_____

Part A: Core Assessment (must be completed at this initial interview) **Pages 3 - 16**

- Reason for Assessment
- Child's Routines/Activities
- Developmental Issues
- Child's Medical History
- Risk Assessment
- Family Information
- Observations and Reported
- Observations of the Child
- Observations of the Family-Child Interaction
- Clinical Formulation and Diagnoses
- Next Steps/Interim Service Plan

Part B: Addenda (may be completed at subsequent appointment) **Pages 17 - 42**

Indicate below, which of the addenda you as the assessor have completed on the child during this interview

Yes	To Be Completed Later	Not Applicable	Name of Addendum
☐	☐	☐	Family Culture and History Biological and Adoptive Families
☐	☐	☐	Family Culture and History Foster Families
☐	☐	-------	Developmental Checklist (or Ages and Stages Questionnaire) by age of child. (For all children, but if developmental issues are indicated at initial interview must be completed as part of Core Assessment.)
☐	☐	☐	Behavioral Analysis (For children in which primary need identified is a behavioral issue(s).)
☐	☐	☐	Medical Care (For children who have been hospitalized, resided outside of home for medical reasons or have been treated for seizures.)
☐	-------	☐	Child Protective Services (Used for 24-hour urgent response for children removed by Child Protective Services.)

Part C: Behavioral Health Service Plan (may be completed at subsequent appointment) **Page 43**

☐ Completed at initial interview ☐ Will be completed later

Part D: Annual Update and Review Summary **Pages 44 - 47**

_____ _____ _____

Assessor's Name (print) / Signature Credentials/Position Date

_____ _____ _____

Behavioral Health Professional Reviewer Name (print) / Signature Credentials/Position Date

_____

Agency