THE ARIZONA FAMILIES F.I.R.S.T. PROGRAM MANUAL

ARIZONA
DEPARTMENT
of CHILD SAFETY

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PURPOSE AND BACKGROUND

PROGRAM VISION

The vision of Arizona Families F.I.R.S.T. (Families in Recovery Succeeding Together) (AFF) is to provide timely and accessible family-focused, evidence-based, trauma-informed substance use disorder assessment, treatment, and recovery services to parents, caregivers, youth, and families to promote family stability, self-sufficiency, caregiver protective capacities, and child safety and permanency, with a preference for reunification with a child's birth family.

LEGISLATIVE INTENT AND STATUTORY MANDATES

In 2000, the Arizona Legislature established the joint substance abuse program, known as Arizona Families F.I.R.S.T. , in response to changes in federal law and practice, including:

1. the Federal Adoptions and Safe Families Act of 1997 (ASFA), which prescribes timelines for certain actions to promote the stability of families; and
2. the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), which prescribes time limits on cash assistance to families.

The AFF program is governed by A.R.S § 8-882, A.R.S § 8-883, A.R.S § 8-884, and A.R.S. § 46-300.05.

In 2000, the Arizona Legislature established the joint substance abuse program, known as Arizona Families F.I.R.S.T.

TREATMENT PROCESS STAGES

AFF delivers services in all five stages in the substance use treatment process (National Center on Substance Abuse and Child Welfare):

1. Screening: Screening is the first step that identifies potential substance use/misuse and the need for a further comprehensive assessment.
2. Comprehensive Assessment: The second stage of the process includes the parent/caregiver/client meeting with a treatment professional from the treatment agency for a comprehensive assessment. The assessment helps determine the diagnosis and individual needs.
3. Stabilization: The third step of the treatment process is stabilization, which may include detoxification from substances that are medically supervised by a physician.
4. Substance Use Disorder Treatment: This step is typically comprised of formulating a treatment plan to guide treatment, group and individual counseling, case management, relapse prevention, medication assisted treatment, education about substance use disorders, and care transitions.
5. Continuing Care and Recovery Support: The final step of the treatment process is ongoing, following treatment, and includes ongoing outreach and supportive services to maintain sobriety. This step allows the client and family to continue their recovery and provides family safety and stability through additional supports.

Following screening and referral by the Department of Child Safety or the DES/Jobs program, AFF provides:

- initial outreach to engage the client in services;
- comprehensive assessment and service planning;
- case coordination to connect the client to stabilization services, when necessary;
- case coordination to link the client to medical services (such as health care) and support services (such as housing, employment support, and concrete resources);
- substance use disorder treatment; and
- continuing care and recovery support.

GUIDING PRINCIPLES

The Contractor shall adhere to the following service principles, which are included in federal regulations at 45 CFR 1355.25 as a basis for the service array funded by title IV-B funds, and guide services provided by the Department of Child Safety.

- The safety and well-being of children and of all family members is paramount. When safety can be assured, strengthening and preserving families is seen as the best way to promote the healthy development of children. One important way to keep children safe is to stop violence in the family including violence against their mothers.
- Services are focused on the family as a whole; service providers work with families as partners in identifying and meeting individual and family needs; family strengths are identified, enhanced, respected, and mobilized to help families solve the problems which compromise their functioning and well-being.
- Services promote the healthy development of children and youth, promote permanency for all children and help prepare youth emancipating from the foster care system for self-sufficiency and independent living.
- Services may focus on prevention, protection, or other short or long-term interventions to meet the needs of the family and the best interests and need of the individual(s) who may be placed in out-of-home care.
- Services are timely, flexible, coordinated, and accessible to families and individuals, principally delivered in the home or the community, and are delivered in a manner that is respectful of, and builds on, the strengths of the community and cultural groups.
- Services are organized as a continuum, designed to achieve measurable outcomes, and are linked to a wide variety of supports and services which can be crucial to meeting families' and children's needs, for example, housing, substance abuse treatment, mental health, health, education, job training, child care, and informal support networks.
- Most child and family services are community-based, involve community organizations, parents and residents in their design and delivery, and are accountable to the community and the client's needs.
- Services are intensive enough and of sufficient duration to keep children safe and meet family needs. The actual level of intensity and length of time needed to ensure safety and assist the family may vary greatly between preventive (family support) and crisis intervention services (family preservation), based on the changing needs of children and families at various times in their lives. A family or an individual does not need to be in crisis in order to receive services.

The Contractor shall adhere to the Adult Service Delivery System Nine Guiding Principles that were developed to promote recovery in the adult behavioral health system:

1. *Respect is the cornerstone*: Meet the person where they are without judgment, with great patience and compassion.
2. *Persons In Recovery Choose Services And Are Included In Program Decisions And Program Development Efforts*: A person in recovery has choice and a voice. Their self-determination in driving services, program decisions, and program development is made possible, in part, by the ongoing dynamics of education, discussion, and evaluation, thus creating the "informed consumer" and the broadest possible palette from which choice is made. Persons in recovery should be involved at every level of the system, from administration to service delivery.
3. *Focus On Individual As A Whole Person, While Including And/or Developing Informal support*: A person in recovery is held as nothing less than a whole being: capable, competent, and respected for their opinions and choices. As such, focus is given to empowering the greatest possible autonomy and the most natural and well-rounded lifestyle. This includes access to and involvement in the informal support and social systems customary to an individual's social community.

4. *Empower Individuals Taking Steps Towards Independence And Allowing Risk Taking Without Fear Of Failure*: A person in recovery finds independence through exploration, experimentation, evaluation, contemplation, and action. An atmosphere is maintained whereby steps toward independence are encouraged and reinforced in a setting where both security and risk are valued as ingredients promoting growth.
5. *Integration, Collaboration, And Participation With The Community Of One's Choice*: A person in recovery is a valued, contributing member of society and, as such, is deserving of and beneficial to the community. Such integration and participation underscores one's role as a vital part of the community, the community dynamic being inextricable from the human experience. Community service and volunteerism is valued.
6. *Partnership Between Individuals, Staff, And Family Members/Natural Supports For Shared Decision Making With A Foundation Of Trust*: A person in recovery, as with any member of a society, finds strength and support through partnerships. Compassion-based alliances with a focus on recovery optimization bolster self-confidence, expand understanding in all participants, and lead to the creation of optimum protocols and outcomes.
7. *Persons In Recovery Define Their Own Success*: A person in recovery -- by their own declaration -- discovers success, in part, by quality of life community, and greater self-determination. Persons in recovery are the experts on themselves, defining their own goals and desired outcomes.
8. *Strengths-Based, Flexible, Responsive Services Reflective Of An Individual's Cultural Preferences*: A person in recovery can expect and deserves flexible, timely, and responsive services that are accessible, available, reliable, accountable, and sensitive to cultural values and mores. A person in recovery is the source of his/her own strength and resiliency. Those who serve as supports and facilitators identify, explore, and serve to optimize demonstrated strengths in the individual as tools for generating greater autonomy and effectiveness in life.
9. *Hope Is The Foundation For The Journey Towards Recovery*. A person in recovery has the capacity for hope and thrives best in associations that foster hope. Through hope, a future of possibility enriches the life experience and creates the environment for uncommon and unexpected positive outcomes to be made real. A person in recovery is held as boundless in potential and possibility.

The Contractor shall adhere to the 12 Principles of the Children's System of Care – Vision and Guiding Principles:

1. *Collaboration with the Child and Family*: Respect for and active collaboration with the child and parents is the cornerstone to achieving positive behavioral health outcomes. Parent and children are treated as partners in the assessment process, and the planning, delivery, and evaluation of behavioral health services, and their preferences are taken seriously.
2. *Functional Outcomes*: Behavioral health services are designed and implemented to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Implementation of the behavioral health services plan stabilizes the child's condition and minimizes safety risks.
3. *Collaboration with Others*: When children have multi-agency, multi-system involvement, a joint assessment is developed and a jointly established behavioral health services plan is collaboratively implemented. Client centered teams plan and deliver services. Each child's team includes the child, parents, any foster parent, and any individual important in the child's life who is invited to participate by the child or parents. The team also includes all other persons needed to develop an effective plan, including as appropriate, the child's teacher, the child's Child Protective Service and/or Division of Developmental Disabilities case worker, and the child's probation officer. The team develops a common assessment of the child's and family's strengths and needs, develops an Individualized Service Plan and monitors the implementation of the plan and makes adjustments in the plan if it is not succeeding.
4. *Accessible Services*: Children have access to a comprehensive array of behavioral health services, sufficient to ensure that they receive the treatment they need.

Case management is provided as needed. Behavioral health services plans identify transportation the parents and the child need to access behavioral health services, and how transportation assistance will be provided. Behavioral health services are adapted or created when they are needed but not available.

5. *Best Practices*: Behavioral health services are provided by competent individuals who are adequately trained and supervised. Behavioral health service plans identify and appropriately address behavioral symptoms that are reactions to death of a family member, abuse or neglect, learning disorders, and other similar traumatic or frightening circumstances, substance abuse problems, the specialized behavioral health needs of children who are developmentally disabled, maladaptive sexual behavior, including abusive conduct and risky behavior, the need for stability and the need to promote permanency in the class members' lives, especially class members in foster care. Behavioral health services are continuously evaluated and modified if ineffective in achieving desired outcomes.
6. *Most Appropriate Setting*: Children are provided behavioral health services in their home and community to the extent possible. Behavioral health services are provided in the most integrated setting appropriate to meet the child's needs. When provided in a residential setting, the setting is the most integrated and most home-like setting that is appropriate to the child's needs.
7. *Timeliness*: Children identified as needing behavioral health services are assessed and served promptly.
8. *Services Tailored to the Child and Family*: The unique strengths and needs of children and their families dictate the type, mix, and intensity of behavioral health services provided. Parents and children are encouraged and assisted to articulate their own strengths and needs, the goals they are seeking, and what services they think are required to meet these goals.
9. *Stability*: Behavioral health service places strive to minimize multiple placements. Service plans identify whether a class member is at risk of experiencing a placement disruption and, if so, identify the steps to be taken to minimize or eliminate the risk. Behavioral health service plans anticipate crisis that might develop and include specific strategies and services that will be employed if a crisis develops. In responding to crises, the behavioral health system uses all appropriate behavioral health services to help the child remain at home, minimize placement disruptions, and avoid the inappropriate use of the police and the criminal justice system. Behavioral health service plans anticipate and appropriately plan for transition in children's lives, including transitions to new schools and new placements, and transitions to adult services.
10. *Respect for the Child and Family's Unique Cultural Heritage*: Behavioral health services are provided in a manner that respects the cultural tradition and heritage of the child and family. Services are provided in Spanish to children and parents whose primary language is Spanish.
11. *Independence*: Behavioral health services include support and training for parents in meeting their child's behavioral health needs, and support and training for children in self-management. Behavioral health service plans identify parents' and children's needs for training and support to participate as partners in the assessment process, and in the planning and delivery, and evaluation of services, and provide that such training and support, including transportation assistance, advance discussions, and help with the understanding of written materials, will be made available.
12. *Connection to Natural Supports*: The behavioral health system identifies and appropriately utilizes natural supports available from the child and parents' own network of associates, including friends and neighbors, and from community organizations, including service and religious organizations.

The unique strengths and needs of children and their families dictate the type, mix, and intensity of behavioral health services provided.

For more information on the Adult Service Delivery System Nine Guiding Principles and the Children's System of Care 12 Principles, go to:

https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/100/100.pdf

EVIDENCE BASED RECOVERY STRATEGIES

When implementing evidence-based recovery strategies to AFF clients, the following essential ingredients must be needed when implementing evidence-based recovery strategies incorporated into all services provided (Daley & Marlatt, 2006):

- Managing cravings & thoughts of using
- Resisting social pressure to use
- Dealing with family & interpersonal conflicts
- Building a recovery support system
- Managing emotions
- Managing co-existing psychiatric disorders
- Achieving balanced living
- Identifying & managing relapse warning signs and high-risk factors
- Interrupting & learning from a lapse or relapse
- Monitoring progress

SCREENING AND REFERRAL

ELIGIBILITY

Department of Child Safety

The following individuals served by DCS are eligible for AFF services as the primary client:

- A parent, guardian, or custodian of a child named in a DCS Hotline report as a victim of abuse or neglect; or the parent, guardian or custodian of another child residing in the household of alleged maltreatment; whose substance use is a significant barrier to maintaining, preserving, or reunifying the family.
- Other adults in the home of the parent, guardian, or custodian (as described above) whose substance use is a significant barrier to maintaining, preserving, or reunifying the family.
- A child in out-of-home care who is in the temporary custody of the Department, adjudicated dependent, or the subject of a Voluntary Placement Agreement, and whose behavior indicates a need for substance use assessment, treatment, or recovery.
- A child in a family that is receiving in-home case management services from DCS, and whose behavior indicates a need for substance use assessment, treatment, or recovery to prevent entry or re-entry into out-of-home care.

The adults and children described above are eligible for AFF services when served by the Department with an out-of-home or in-home dependency, in-home intervention, in-home service case with DCS oversight, or following case closure at investigation with no DCS oversight (for adults described above).

Family members and significant people in the client's life are eligible for AFF services and shall be included in substance use awareness, treatment, case coordination, and recovery maintenance services as indicated in the client's service plan.

Jobs Program

An individual served by the DES/Jobs Program is eligible for AFF services when substance abuse is a significant barrier to maintaining or obtaining employment and the individual is receiving cash assistance pursuant to Title 46, Chapter 2, Article 5.

SCREENING

Department of Child Safety

If the Family Functioning Assessment indicates that an adult's or child's substance use may be a danger in the home or is diminishing a caregiver's protective capacity, the DCS Specialist shall consult with a Unit Consultant to determine if the adult or child should be referred to the AFF Program for initial outreach and comprehensive assessment. When making this determination, the DCS Specialist and Unit Consultant shall consider the client's readiness for change. For more information, see the DCS Policy and Procedure Manual.

When a DCS Specialist refers a child for a Rapid Response assessment, the DCS Specialist shall indicate on the referral form if substance use by a parent or other adult in the home is a reason for DCS involvement. If so, the Rapid Response assessment shall determine if the child should be referred to the AFF Program as a client, or for other related services as a family member of a client.

Jobs Program

Jobs clients complete the Your Employment Strategies (Y.E.S.) assessment with the assigned Jobs case manager in an initial case management appointment. The assessment addresses obstacles to employment, including employability, family needs, and barriers to employment, which assists the Jobs case manager to screen for substance use issues and other barriers to success. Jobs guidelines prohibit clients from receiving TANF/Cash Assistance if they admit they are actively using substances, so substance use issues may not become known until future case management meetings with the client. A Jobs AFF referral may be submitted by the Jobs case manager following initial or subsequent appointments.

SERVICE REQUEST/REFERRAL

The DCS Specialist shall submit an AFF Service Request to the Centralized Referral Unit for assignment to an AFF provider. The Service Request shall include the client's name, address, and/or phone number, and a description of the reason for making the referral or re-referral. The DCS Specialist shall attach or provide the following documents with the AFF Service Request:

- Family Functioning Assessment or current non-confidential CSRA (no criminal history information);
- current court report (if applicable);
- current case plan (if applicable);
- Team Decision Making meeting summary (if applicable);
- any recent psychological/psychiatric evaluations (if available);
- any drug test results; and
- any supporting information related to substance use/abuse.

The DCS Referral Unit will submit service requests to the Contractor through the DCS Child Welfare Case Management System. The service request packet shall include the documents listed above.

The DES/Jobs Case Manager will submit service requests to the Contractor via email or fax. The referral packet shall include the following documents:

- Jobs AFF Referral form;
- Jobs case plan;
- Jobs Assessment form;
- Any other supporting information related to substance use/abuse.

The Contractor shall have staff available to receive and assign referrals Monday through Friday, 8:00 a.m. – 5:00 p.m., except on legal holidays recognized by the State of Arizona.

The Contractor shall acknowledge receipt of the service request within two working hours (working hours are 8:00 a.m. to 5:00 p.m., Monday through Friday).

Service requests/referrals will be valid for a one hundred and eighty day timeframe. The Contractor shall submit service request extensions to the referring DCS Specialist or assigned

staff designee, thirty days before service request expiration. Only one service request/referral unit will be paid per client in any six month period from the service request/referral date.

The DCS Specialist or DES/Jobs case manager may re-refer a client to the AFF program when:

- there has been a change in case circumstance or in the client's readiness to engage in services since a prior unsuccessful closure;
- the prior referral was closed because the AFF provider could not locate the client, and new information has been obtained about the client's location; or
- a client has relapsed since a prior successful closure and requires additional treatment.

The following are examples of changes in case circumstance that would indicate a re-referral is warranted:

- The prior referral closed because the client was detained or incarcerated for more than 30 days, and the client has now been released or is scheduled for release in 30 days or less.
- The prior referral closed because the client did not engage or refused services, and the client is now communicating readiness to participate, is court ordered to do so, or barriers to participation have been removed.
- The prior referral closed because the client could not be located, and the client's location is now known.
- The prior referral closed because the client was identified as not needing substance use disorder treatment services, and new information confirms a substance use concern or an increase in substance use.

Re-referrals from DCS must have prior approval by the Region Program Administrator, following the DCS Service Approval Matrix procedures.

OUTREACH AND INTAKE

ATTENDANCE AT TEAM DECISION MAKING MEETINGS

Each Contractor shall designate AFF staff that are familiar with the AFF program and available to attend Team Decision Making (TDM) meetings with 48 to 72 hour notice. The Contractor's designated staff shall attend all TDM meetings for which attendance is requested by a DCS TDM Facilitator.

- Attendance in-person is preferred and encouraged, but may be by telephone or video conferencing.
- The AFF staff will provide general information on substance use assessment and treatment services, specific information on services available under the AFF Program, and community-based services such as Alcoholics/Narcotics Anonymous.

INITIAL OUTREACH

The goals of initial outreach are to establish rapport with the client, address client hesitancies and any other barriers to attending treatment, and obtain consent to release confidential substance use information. Initial outreach shall be conducted by a Recovery Coach.

Initial outreach shall be conducted by a Recovery Coach.

- A telephone call to schedule the initial in-person meeting shall not be considered an initial outreach attempt.
- Attendance at a TDM is not considered an initial client contact (initial contact shall only occur once an AFF service request/referral has been submitted by the DCS Specialist and assigned to a Contractor), and will not guarantee that an AFF referral will be assigned to the Contractor that attended the TDM.

The Recovery Coach shall make reasonable attempts to hold the initial in-person contact with the client within 24 hours of receipt of the service request (excluding weekends and state holidays), to engage the client and provide information on the program. It is preferable that this contact be at the client's residence or other location convenient to the client.

If the initial in-person outreach attempt is unsuccessful, the Recovery Coach shall:

- notify the referring DCS Specialist or DES/Jobs Case Manager within three business days of receipt of the service request, to discuss alternatives for locating the client; and
- make a minimum of two additional outreach attempts within five business days of receipt of the service request, in-person whenever possible, at alternate times of day or evening to improve the likelihood of making in-person contact.

If the Recovery Coach has made reasonable attempts and is unable to make contact with the client, the Contractor shall document the contact attempts in the contract agency file, and notify the referring DCS Specialist or DES/Jobs Case Manager for approval of the closure of the referral due to inability to make client contact. If the referring/assigned DCS Specialist or DES/Jobs Case Manager or supervisor has not responded within seven calendar days of the Contractor's request, the Contractor may close the referral.

AFF clients are sometimes involved with DCS and the Jobs Program at the same time.

The Recovery Coach shall use motivational interviewing and other well-supported or supported evidence-based practices for engaging and motivating the client. If the client declines services, the Contractor shall notify the referring DCS Specialist or DES/Jobs Case Manager within two business days for assistance with engaging the client.

If the Recovery Coach has made reasonable attempts and the client declines services, the Contractor shall:

- document that the client has declined services in the contract agency file, and;
- notify the referring DCS Specialist or DES/Jobs Case Manager for approval on the closure of the referral due to the client declining services.

If the referring/assigned DCS Specialist or DES/Jobs Case Manager has not responded within seven calendar days of the Contractor's request, the Contractor may close the referral.

If a client has verbally expressed agreement to participate in the AFF program, the Contractor shall inform the client about confidentiality laws and obtain the client's written consent to release confidential substance use information on the AFF Consent/Authorization To Release Information (ROI) form (CSO-2396).

- AFF ROI CSO-2396 will allow the AFF provider to share information with other agencies whose services affect or complement AFF services (i.e. Psych/Counseling providers, etc.).
- After the client signs this form, the Contractor shall provide copies to the applicable agency Case Managers within five (5) business days.

AFF clients are sometimes involved with DCS and the Jobs Program at the same time. In these cases, the ROI shall be used to allow the AFF provider to share information with both State agencies, as well as other agencies whose services affect or complement AFF services. Other agencies may include probation/parole, other service providers involved with the client and his/her family, the primary care physician, and past substance abuse treatment providers. Information sharing between agencies can reduce the time needed to assess the client, reduce duplication of services to AFF clients, and allow updates to be provided to both DCS and Jobs case managers. After the client signs this form, the Contractor shall provide copies of all deliverables to both the DCS Specialist and DES/Jobs case manager.

The Contractor shall assign a Case Coordinator to the client once the ROI form is signed by the client.

- The Case Coordinator shall monitor that client contact occurs with the AFF Case Coordinator or another AFF provider staff person by telephone or in-person (based on client needs) at least twice a week until the comprehensive assessment is completed.
- Client contact may occur by the client's attendance at Substance Use Awareness and Education sessions, initial orientation, or in case management sessions with the Case Coordinator in-person and/or by telephone.
- The twice a week contact shall be documented in the AFF Monthly Client Progress Report CSO -2422, and submitted by secure email to the DES/Jobs Case Manager, or uploaded on to the DCS Child Welfare Case Management System. The DCS case management system is the central repository of all information on the case.

- If the client stops participating, the Case Coordinator shall re-engage the client through in-person or telephone contact within 24 hours.

INTAKE AND FUNDING COORDINATION

The Contractor shall maximize the use of applicable funding sources, including but not limited to Title XIX-Medicaid, Title XXI-Kids Care, and/or other existing private client health insurance prior to funding treatment and other supportive services through this contract. AFF funds shall supplement, not supplant, federal or non-federal funds for available services and activities that promote the purpose of the AFF Program.

For clients (youth and adult) who are Title XIX-eligible, the AHCCCS-contracted medical health plan shall be the funding source for treatment services and other supportive services when possible, with AFF state funding covering non-RBHA-billable services. Covered RBHA-funded behavioral health service information can be found in the AHCCCS AMPM Chapter 310B-Title XIX/XXI Behavioral Health Service Benefit

https://azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/310B.pdf

For youth in out-of-home care covered by private insurance, the private insurer shall be the primary payer and AHCCCS shall be the secondary payer. If the primary funder denies, or does not offer, some of the needed services, AHCCCS will fund all billable behavioral health services considered medically necessary, with AFF funding paying for the remainder.

For adults who are non-Title XIX-eligible, funding sources to explore prior to AFF include:

- State Opioid Response (SOR) grant,
- Substance Abuse Prevention and Treatment Block Grant (SABG), and
- Projects for Assistance in Transition from Homelessness (PATH) grant.

Information about these grants can be found at: https://www.azahcccs.gov/Resources/Grants/ . More information can also be found in Chapter 320T-Non-Title XIX/ XXI Behavioral Health Benefit Services https://azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/320T.pdf

Within two business days of the client signing the ROI, the Contractor shall complete the AFF Benefits Screening Tool CSO-2399, or other tool designated by DCS, with the client. This tool is to determine eligibility for fully- or partially-paid funding by other sources, including Title XIX/XXI, the Substance Abuse Block Grant (SABG), private insurance, Indian Health Services, or Veteran's Administration. Once the tool is completed, the Contractor shall:

The Contractor shall provide assessment and treatment services for non-Title XIX- or XXI-eligible clients using AFF state funding.

- Provide assessment and treatment services for Title XIX- and XXI-eligible clients using Medicaid funding.
- Assist clients not currently enrolled but who may be eligible for Title XIX- or Title XXI funding with the application process to determine Arizona Health Care Cost Containment System (AHCCCS) eligibility if the client requests or needs assistance. This shall include providing access to, or assistance with, the HEALTH-e-ARIZONA online application system in areas of the state in which use of this system is mandatory. If barriers exist to establishing Title XIX or XXI eligibility, the Contractor shall make reasonable efforts to overcome the barriers by proactively seeking solutions, including assisting the client with obtaining documentation of proof of citizenship, meeting the client at home to assist with the application process, and working with the Family Assistance Administration to facilitate the application process.

The Contractor shall provide assessment and treatment services for non-Title XIX- or XXI-eligible clients using AFF state funding. All services for these clients will be funded through the AFF contract unless eligibility criteria for the client changes during services. AFF funding may also be used for clients whose AHCCCS eligibility application is pending so that treatment services are not delayed.

COMPREHENSIVE ASSESSMENT

COMPREHENSIVE ASSESSMENT FOR ADULTS

Within seven calendar days of the client signing an ROI, the Contractor shall conduct a comprehensive biopsychosocial and an American Society of Addiction Medicine (ASAM) Criteria® assessment to identify whether the client requires treatment and if so, the treatment level of care and supportive services necessary to meet the client's needs.

Using a recent prior assessment shortens the assessment process and reduces the need for the client to repeat information recently provided, so the client is able to begin treatment services sooner.

- If a substance use assessment was completed within the previous six months, as identified by the client or in the AFF service request, the Contractor shall attempt to obtain the previous assessment to inform the current assessment process.
- If the previous assessment is obtained, the Contractor shall review the information with the client, complete an updated assessment using the ASAM Criteria®, and use it to develop the service plan.

The assessment shall include all six dimensions of the ASAM Criteria®.

Dimension 1: Acute Intoxication and/or Withdrawal Potential: Exploring an individual's past and current experiences of substance use and withdrawal

Dimension 2: Biomedical Conditions and Complications: Exploring an individual's health history and current physical condition

Dimension 3: Emotional, Behavioral, or Cognitive Conditions and Complications: Exploring an individual's thoughts, emotions, and mental health issues

Dimension 4: Readiness to Change: Exploring an individual's readiness and interest in changing

Dimension 5: Relapse, Continued Use, or Continued Problem Potential: Exploring an individual's unique relationship with relapse or continued use or problems

Dimension 6: Recovery/Living Environment: Exploring an individual's recovery or living situation and the surrounding people, places, and things

For more information on the ASAM Criteria, go to:

https://www.asamcontinuum.org/knowledgebase/what-are-the-six-dimensions-of-the-asam-criteria/

https://www.asamcontinuum.org/about/ https://www.azahcccs.gov/PlansProviders/CurrentProviders/ASAM.html

The ASAM Criteria® assessment shall be used to:

- determine the ASAM Criteria Level of Care recommendation;
- obtain the Addiction Severity Index (ASI) Severity Subscale Composite Scores: Medical, Alcohol, Psychological, Employment, Family/Social, and Legal; and
- complete the Clinical Institute Withdrawal/Narcotic Assessments (CIWA/CINA).

The Contractor must determine the ASAM Criteria Level of Care recommendation using the ASAM Continuum®, the LOCI-3® (Level of Care Index-3), or another standardized form or application that guides and documents the use of the 6 Dimensions assessment to identify the ASAM Criteria Level of Care. The method to determine the ASAM Criteria Level of Care recommendation must be documented in the client record. The Department may mandate that all Contractors use the ASAM Continuum®, or another single form or application of the Department's choosing, at any point in the future.

LEVEL OF CARE DETERMINATION

The comprehensive assessment shall identify the ASAM Criteria® Level of Care recommendation (American Society of Addiction Medicine, 2019). AFF provides the following levels of care from the ASAM Criteria framework.

Level 0.5: Early Intervention: This level includes assessment and education for at-risk

individuals who do not meet diagnostic criteria for substance use disorder. AFF provides early intervention services as Substance Use Awareness and Education services.

Level 1: Outpatient Services (OP): This level typically consists of less than nine hours of service per week for adults, and less than six hours per week for adolescents, for recovery or motivational enhancement therapies and strategies.

Level 2.1: Intensive Outpatient Services (IOP): This level provides nine or more hours of service per week (adults) or six or more hours per week (adolescents) to treat multidimensional instability. Services are capable of meeting the complex needs of people with substance use disorders and co-occurring conditions. It is a structured outpatient service that delivers treatment services during the day, before or after work or school, in the evening, and/or on weekends.

Level 2.5: Partial Hospitalization (PHP): This level includes 20 or more hours of service per week for multidimensional instability not requiring 24-hour care. This is an organized outpatient service that delivers treatment services usually during the day, as day treatment or partial hospitalization services.

Level 3.1: Clinically Managed Low-Intensity Residential: This level provides 24 hour living support and structure, with at least five hours of clinical service per week. Services are provided by trained substance use disorder treatment, mental health, and general medical personnel. In Arizona, facilities of this type are known as Behavioral Health Residential Facilities (BHRF).

Level 3.3: Clinically Managed Population-Specific High-Intensity Residential Services: This level provides 24-hour care with trained counselors to stabilize multidimensional imminent danger; less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community. This level provides a structured recovery environment in combination with high-intensity clinical services to meet the functional limitations of patients to support recovery from substance-related disorders. This level is not designated for adolescent populations.

Level 3.5: Clinically Managed Medium-Intensity Residential Services: This level provides 24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment; for clients able to tolerate and use full active milieu or therapeutic community. In Arizona, facilities of this type are known as Behavioral Health Intensive Facility (BHIF).

Providing assessments at times and locations convenient to the client prevents delays to the client beginning treatment. To improve the attendance rate of clients at the comprehensive assessment, the Contractor shall:

- be available to conduct assessments on evenings and weekends, at locations that are convenient for the client (such as the client's home or community), and shall consider any special needs or circumstances that prevent the client from traveling to the Contractor's office;
- communicate with the client to identify a convenient time and location for the assessment; and
- call, text, or email the client with a reminder two days in advance of the appointment (American Society of Addiction Medicine, 2019);

Substance use by one family member affects the whole family. Family-centered treatment improves engagement rates and increases the likelihood of long-term recovery by promoting the delivery of comprehensive services that can transform families into healthy, functioning entities that can raise children, reach their economic goals, and support the wellbeing of all members. (SAMHSA, 2007). Involvement of other client-serving agencies can eliminate duplication of services that may overwhelm the client, engage a support team for the client, ensure all service needs are met, and promote treatment success.

- The Contractor shall ask and encourage the client to identify people in the client's family network to participate in the comprehensive assessment and development of the service plan. The Contractor shall communicate with the DCS Specialist or DES/Jobs Case Manager to confirm that there are no legal issues or safety concerns that would contraindicate an identified person's involvement.

- As permitted and identified in the ROI, the Contractor shall gather information from family members and non-DCS professionals (such as probation/parole officers and mental health clinicians) who can provide information to inform the comprehensive assessment and service plan development.

Upon completion of the comprehensive assessment, the Contractor shall prepare a written assessment summary. The assessment summary shall follow the ASAM Criteria® Comprehensive Assessment Report outline as follows:

- Possible non-substance abuse psychological conditions
- DSM-V diagnosis or other standardized and widely accepted criteria for substance use disorder(s)
- Withdrawal risk summary
- Addiction Severity Index (ASI) composite scores for the medical, employment, alcohol, legal, family/social and psychiatric sections of the ASAM Narrative Report
- Critical considerations needing to be addressed
- Dimensional analysis for each of the six dimensions including readiness for change and accepting treatment services
- Access to treatment issues indicating any barriers to the client receiving treatment services
- Final level of care determination for the client

The assessment summary shall also include information on the following child welfare- and/or employment-related areas:

- Domestic violence
- History of trauma
- Impact of substance use on family relationships, caregiver protective capacity, and child safety
- Impact of substance use on maintaining or obtaining employment

If the determination from the substance use assessment is that substance use disorder treatment is not recommended, the clinician who completed the assessment shall contact the referring DCS Specialist or DES/Jobs case manager to discuss the original reason the referral was made and confirm that no additional information is available that would influence the determination.

Within five business days of completion, the Contractor shall enter the completed assessment summary by secure email to the DES/Jobs Case Manager, or by uploading it on to the DCS Child Welfare Case Management System. The DCS case management system is the central repository of all information on the case.

COMPREHENSIVE ASSESSMENT FOR ADOLESCENTS

The Contractor shall use the ASAM Criteria® to identify whether the youth requires treatment, and if so, the treatment level of care and supportive services necessary to meet the youth's needs.

- The Contractor shall obtain information and input from the youth's parents or caregivers for the assessment and when developing the service plan.
- The Contractor shall use clinical judgement when interpreting assessment questions and results, to consider the adolescent's age and current developmental stage.
- If the youth is in out-of-home care and youth's permanency goal is family reunification, the Contractor shall communicate with the DCS Specialist to identify and obtain contact information for the parents and other family members identified by DCS to participate in the youth's assessment, and arrange for them to participate in the assessment and service plan development.
- The Contractor shall schedule the assessment at a time convenient for the family members to attend and shall seek input and approval from the parents and family before finalizing the plan.

15-DAY PLAN

One of the main principles of effective treatment is that it is readily available. Potential clients may be lost if there are delays to starting, and the earlier treatment is offered in the disease process, the greater the likelihood of positive outcomes (NIDA, 2018). To ensure AFF clients assessed as needing treatment begin therapeutic services as soon as possible after assessment, the Contractor shall develop a short-term plan with the client that includes treatment sessions and other essential services that will be provided in the next 15 days following the assessment. This 15-Day Plan shall be developed using the 15-Day Plan CSO-2464. The form shall be signed by the client, the assessing clinician, and the assigned Case Coordinator following completion of the assessment interview. These services shall begin no more than three (3) business days after the assessment interview, and last for a maximum of 15 calendar days while the service plan is being finalized. Continuing tasks from the 15-Day Plan shall be incorporated into the finalized service plan.

SERVICE PLAN CHARACTERISTICS, DEVELOPMENT, AND PROGRESS REVIEW

The service plan is based upon the comprehensive biopsychosocial and ASAM Criteria® assessment, and provides behavioral goals, intervention methods, and tasks to improve behaviors, thinking patterns, and other issues impacting the client's and family member's substance use, caregiver protective capacity, and employment. The service plan shall be strength-based, client-centered, family-focused, gender specific, culturally relevant, accessible in the client's language, community-based, and clinically supervised (see AHCCCS Medical Policy Manual (AMPM) Section 320 – Services with Special Circumstances).

The service plan shall be strength-based, client-centered, family-focused, gender specific, culturally relevant, accessible in the client's language, community-based, and clinically supervised...

AFF service plans CSO-2411 shall be developed in a team established for each client receiving AFF treatment. The team model is based on four equally important components:

- Input from the client regarding individualized needs, strengths, and preferences
- Input from collateral contacts involved in the client's care who have integral relationships with the client
- Development of a therapeutic alliance between the client and AFF provider that promotes an ongoing partnership built on mutual respect and equality
- Clinical expertise/qualifications of treatment staff developing the service plan

For children, this team is the Child and Family Team (CFT). For title XIX eligible adults, this team is the Adult Recovery Team (ART). For non-title XIX eligible adults, the Contractor shall convene a team to serve the same functions as an ART. Functions of the CFT, ART, or other team are described in AMPM Section 320 – Services with Special Circumstances, III.A.2 (https://des.az.gov/sites/default/files/media/AHCCCS-Medical-Policy-Manual_0.pdf), and include:

- Ongoing engagement of the member/Health Care Decision Maker/designated representative, family, and others who are significant in meeting the behavioral health needs of the member, including their active participation in the decision-making process and involvement in treatment.
- An assessment process that is conducted to:
    - elicit information on the strengths and needs of the individual member and his/her family,
    - identify the need for further or specialty evaluations, and
    - support the development and updating of the Service Plan that effectively meets the client's/family's needs and results in improved health outcomes.

- Continuous evaluation of the effectiveness of treatment through the CFT, ART, or other team process, the ongoing assessment of the member, and input from the client resulting in modification to the Service Plan, as necessary.
- Provision of all covered services as identified on the Service Plan, including assistance in accessing community resources as appropriate.
- For children, service provisions consistent with the Children's Services Arizona Vision – 12 Principles as specified in AMPM Policy 430 and AMPM Policy 100; for adults, service provision consistent with the Adult Service Delivery System - 9 Guiding Principles as specified in AMPM Policy 100.
- Ongoing collaboration with other individuals and/or entities for whom delivery and coordination of services is important to achieving positive outcomes (e.g. primary care providers, specialty service providers, school, child welfare, justice system and others). This shall include sharing of clinical information as appropriate.
- Assistance with continuity of care by ensuring members who are transitioning to a different treatment program, changing behavioral health providers, and/or transferring to another service delivery system (e.g. out-of-area, out-of-state or to an Arizona Long Term Care System (ALTCS) Contractor). For additional details, refer to ACOM Policy 402 and AMPM Policy 520.

For more information on Child and Family Teams, see the Child & Family Team Practice Tool at https://azahcccs.gov/PlansProviders/Downloads/GM/ClinicalGuidanceTools/ChildFamilyTeam/ChildFamilyTeam.pdf.

The client shall be included in the assessment process and development of the service plan. The Contractor shall document whether or not the client is in agreement with the service plan. Service Plans shall be finalized within 15 calendar days of assessment completion.

A copy of the signed and dated finalized AFF Service Plan CSO-2411 shall be filed in the referring agency's client case file. Within five business days of completion, the Service Plan shall be submitted by secure email to the DCS/Jobs Case Manager, or by uploading it on to the Child Welfare Case Management System. The DCS case management system is the central repository of all information on the case.

A copy of the service plan shall be provided to the client within seven calendar days following completion of the service plan and/or upon request. (AMPM Policy 320, III.B.1.d., g., h.)

The clinician and/or Case Coordinator shall review service plan progress with the client and family members monthly, and shall update and revise the service plan when a client completes a goal, requires a different level of care, or when there has been a significant change that needs to be incorporated into the plan.

At a minimum, on a quarterly basis, the AFF Service Plan CSO-2411 shall be updated and submitted to the DCS Specialist or DES/Jobs Case Manager. The submitted service plans shall describe the client's current stage of change, recent participation in treatment, behavioral progress, and any changes in needed services.

SERVICE PLAN CONTENT

The AFF Service Plan CSO-2411 shall include the following:

- The client's identifying information, including name, client number, case number, and date of birth
- The assessment date, which is the date the comprehensive assessment, including the ASAM Criteria® Assessment, was completed
- The service plan date, which is the date the client first signs the plan
- The date of the most recent plan update
- The client's current mental health diagnoses with duration &/or problem statement(s), written in non-judgmental behavioral terms
- The level of treatment recommended, identified through the ASAM assessment
- The therapeutic strengths of the client and family
- Identified barriers to treatment, if any

- Recovery/family vision and identified behavioral changes needed, which includes statements of what the client and family want to accomplish in treatment, in order of priority to address problems most acute or troubling to the client's functioning; behavioral changes identified by the referring case manager; and at least one substance use-related goal
- The client's stage of change related to substance use
- A case coordination plan, including the planned frequency of contact with the Case Coordinator and a description of services and supports to be accessed with the assistance of the Case Coordinator, such as auxiliary skill training groups, case management, employment services, legal aid, concrete services, etc.
- A drug testing plan, including the frequency, duration, and methods of testing
- A relapse prevention plan for the client and family that starts at the initial service plan and continues through recovery maintenance services, and includes the client's identified triggers to use again, high risk situations, self-regulation skills, support system, and steps to take if the client relapses
- The specific therapeutic needs and objectives of the client and family members, including UBSMART goals, client tasks, and agency tasks to accomplish change, including a description of services in which the client and family members will participate, and support services that promote whole-family adjustment
- For each task, the service frequency, intervention & modality (actions of the clinician or treatment team designed to assist the client in completing the objectives), estimated completion date, and actual completion date
- Indication that all immediate family members provided input towards the Service Plan, or if not an explanation
- Signature of the client, participating family members, Case Coordinator, referring DCS Specialist or DES/Jobs Case Manager, clinician, and other members of the client's team who participated in service plan development. If one of the people mentioned above is not available for signature, the Contractor shall notate their absence on the form and proceed. Obtaining the clients' signature should not be a barrier to starting medically necessary services, thus verbal consent that is documented by the Case Manager on the form can be used until the member is able to sign.
- A monthly review of progress, including a treatment progress description for each UBSMART goal

STABILIZATION

Medical detoxification (aka medically supervised withdrawal) safely manages the acute physical symptoms associated with discontinuing the use of substances, but is only the first stage of addiction treatment and, by itself, does little to change long-term drug or alcohol use. Although detoxification alone is rarely sufficient to help addicts achieve long-term abstinence, for some individuals it is a strongly-indicated precursor to effective addiction treatment (NIDA, 2019).

- If the ASAM Criteria® assessment indicates a need for stabilization services (medical detoxification), the Contractor shall refer the client to an appropriate detoxification facility, which may be a hospital emergency department, for this first step of treatment. The Contractor shall alert the assigned Case Coordinator, who will maintain contact with the client and the facility from intake through discharge from the detoxification program.
- Within 24 hours of discharge from stabilization services, the Case Coordinator shall connect the client to substance abuse treatment through the AFF program.
- Adolescents in need of medically supervised withdrawal shall receive Case Coordination and support to obtain the service, similar to adults, with CMDP involved as needed for adolescents in out-of-home care.

- Stabilization services are funded through AHCCCS for Title XIX-eligible clients, and may be available through the Substance Abuse Block Grant (SABG) or Mental Health Block Grant (MHBG) for non-Title XIX-eligible clients. These services are not funded under the AFF program.

SUBSTANCE USE DISORDER TREATMENT

The continuum of services provided under AFF shall be strength-based, client-centered, family-focused, gender-specific, culturally relevant, accessible in the client's language, and community based.

- The Contractor shall provide substance use disorder treatment services or coordinate care with a provider who provides substance use disorder treatment.
- AFF therapeutic interventions must be tailored to the family's needs and culture with the goal of strengthening, stabilizing, preserving, and reunifying families and promoting self-sufficiency in the workplace.
- When consistent with the client's culture and request, spiritual support of the family shall be provided to assist in the recovery process.
- Services must serve the whole client and the whole family by providing linkages to supportive services in the community to serve the range of personal and family needs.
- To support family preservation and reunification, AFF services shall not cause the unnecessary separation of children and parents; and shall not restrict parenting time, even early in treatment.

AFF clients are eligible to receive any level of service within the AFF continuum that is indicated by the client's comprehensive assessment and identified in the service plan, regardless of the client's title XIX eligibility or enrollment.

The Contractor shall notify the DCS AFF Service Coordinator within 21 calendar days of successful outreach when the Contractor and DCS Specialist or DES/Jobs Case Manager have been unable to overcome title XIX behavioral health system barriers that are preventing a client from receiving treatment. The DCS AFF Service Coordinator shall address the specific barriers to treatment and pursue actions to remove them.

The Contractor shall identify therapeutic interventions that meet the individual client's needs and the client's family's needs...

EVIDENCE-BASED TREATMENT INTERVENTIONS

Therapeutic services shall be provided using evidence-based interventions. The requirement to provide evidence-based interventions shall not prevent the Contractor from incorporating culturally relevant services, traditions, or ceremonies into the client's service plan.

The Contractor shall identify therapeutic interventions that meet the individual client's needs and the client's family's needs, using the following websites that provide evidence level ratings:

- California Evidence Based Clearinghouse (CEBC), and/or
- Title IV-E Prevention Services Clearinghouse.

Contractors and subcontractors are required to use practices that meet the therapeutic needs of AFF clients, are approved by ADCS, and:

- are rated (1) "Well-supported by Research Evidence" or (2) "Supported by Research Evidence" by CEBC; or
- are rated 'Well-Supported' or 'Supported' by the Title IV-E Clearinghouse.

Prior to use, a Contractor may submit a request for DCS to review a practice or intervention that is not listed in the CEBC or Title IV-E Prevention Services Clearinghouse. DCS will make the final determination of whether the program or intervention has sufficient evidence to be used within the AFF contract.

The Contractor shall ensure that all staff, including subcontractor clinical staff, providing therapeutic interventions have been trained in the specific intervention(s) being used, have

sufficient experience utilizing the intervention to maintain fidelity to the original intervention or program, and receive required ongoing training for each program to ensure staff meet any requirements of the program developer. The Contractor shall monitor the use and practice of the intervention to be able to demonstrate to DCS that fidelity is being maintained to the program.

TRAUMA-FOCUSED TREATMENT

The Contractor shall provide trauma-informed services. A service system with a trauma-informed service is one in which agencies, programs, and service providers (National Child Traumatic Stress Network, n.d.):

- Routinely screen every AFF client for trauma exposure and related symptoms
- Use evidence-based, culturally responsive assessment and treatment for traumatic stress and associated mental health symptoms
- Make resources available to children, families, and provider staff on trauma exposure, its impact, and treatment
- Engage in efforts to strengthen the resilience and protective factors of children and families impacted by and vulnerable to trauma
- Address parent and caregiver trauma and its impact on the family system
- Emphasize continuity of care and collaboration across child-service systems
- Maintain an environment of care for staff that addresses, minimizes, and treats secondary traumatic stress, and that increases staff wellness
- Build meaningful partnerships that create mutuality among children, families, caregivers and professionals at an individual and organizational level
- Address the intersections of trauma with culture, history, race, gender, location and language, acknowledge the compounding impact of structural inequity, and are responsive to the unique needs of diverse communities

The Contractor shall consider the *Questions to Consider When Implementing a Trauma-Informed Approach* (see Addenda A & B) to confirm that provided services are trauma-informed. These questions provide a framework of areas that need to be explored in attesting to the trauma-informed nature of the program and its implementation.

SUBSTANCE USE DISORDER TREATMENT FOR ADOLESCENTS

The Contractor shall provide substance use disorder treatment services designed for adolescents with a substance use disorder, and delivered separately from treatment services for adult clients, except when the adult and adolescent clients are participating in family counseling.

In addition to receiving treatment services as listed for adults, substance use disorder treatment services for adolescents shall:

- include family counseling, and encourage and enable family members to fully participate;
- include screening for co-occurring mental health issues, such as attention deficit disorder, oppositional defiant disorder, conduct disorder, depression, and anxiety;
- address the whole-youth in the family and social environment, recognizing that adolescents are especially sensitive to social cues, peer groups, and the influence of family;
- incorporate goals related to school success and development of prosocial peer relationships into the service plan: and
- provide treatment services that are adapted for adolescents, recognizing that the youth brain is still developing in areas of decision-making, judgment, planning, self-control.

SUBSTANCE USE AWARENESS AND EDUCATION SERVICES

AFF's Substance Use Awareness and Education Services are provided to clients whose ASAM Criteria® level of care determination is Level 0.5: Early Intervention, clients who decline assessment but are willing to attend substance use awareness sessions, and the clients' family

members. These services explore and address problems or risk factors related to substance use. Services include Screening, Brief Intervention and Referral to Treatment (SBIRT); individual, group, or family counseling; motivational interventions; and educational programs.

Substance Use Awareness and Education Services (Early Intervention services) shall be used for the following clients and family members:

- Clients whose comprehensive assessment indicates a need for early intervention services because the client is at risk of developing substance-related problems, or substance use has resulted in DCS involvement or employment instability but there is not yet sufficient information to document a diagnosable substance use disorder.
- Clients who declined to participate in the comprehensive assessment, but are willing to attend groups or individual counseling to consider the effects of substance use on their lives.
- Clients whose comprehensive assessment indicates that a higher level of service is needed, are unwilling to commit to a higher level of service, but are willing to attend groups or individual counseling to consider the effects of substance use on their lives.
- Clients whose scheduled assessment will not occur for at least one week, with the purpose of ensuring continuous engagement with the client.
- Family members, spouses, significant others, and children (when developmentally appropriate) of referred clients. Substance use awareness and education services for family members are designed to educate family members on the effects of substance abuse on the entire family, engage the children and family members in treatment, and enhance the family members' understanding of the treatment recovery process.

The Contractor shall initiate substance use awareness and education services for referred clients within three working days of a determination that this level of service is most appropriate to meet the client's needs.

Evidence-based, trauma-informed interventions shall be provided by trained personnel who can recognize addictive and substance-related disorders; can provide alcohol, drug and tobacco education; are skilled in motivational counseling; are knowledgeable about adolescent development; and understand the legal and personal consequences of high-risk substance abuse/addictive behavior. This includes certified and/or licensed addiction counselors (for screening purposes), social workers & health educators. (The ASAM Criteria, Third Edition, 2013)

Substance use awareness and education services shall be provided in groups or individual sessions a minimum of two days per week, based on client need. Groups shall be open-ended – new clients may join existing groups without having to wait for a new series to start. The client shall not be required to finish 30 days of substance use awareness services before starting treatment services.

The Contractor shall assign clients to receive substance use awareness and education services for no longer than thirty calendar days. By the 30th day, the clinician shall re-interview the client to determine the client's interest in a higher level of treatment if one was recommended following the comprehensive assessment. If the client continues to decline treatment, the Contractor shall convene a meeting with the client and the DCS Specialist and/or DES/Jobs Case Manager within five business days of declination to discuss the next steps and services for the client.

The Contractor shall provide orientation information developed by DCS to AFF clients attending substance use awareness and education services, including:

- the role of DCS Specialist or DES/Jobs case manager in the clients' involvement with the Contractor;
- the effects of substance use on the brain and resulting behaviors that can put children at risk or negatively impact individuals and families;
- the effects of substance use on in utero and newborn babies; and
- the goals of substance use treatment.

The Contractor shall provide the following information to family members of AFF clients attending substance use awareness and education services:

- what to expect when your loved one is in treatment;
- the chronic nature of substance abuse and that treatment takes a long time;
- recovery is lifelong;
- substance abuse is often intergenerational;
- substance abuse changes the brain and the way a person thinks and acts;
- definition of substance dependence;
- the role of the whole family in denial and recovery;
- effects of parent/caregiver substance use on children;
- medication-assisted treatment,
- signs of co-dependence,
- availability of community-based support groups for families.

For clients who do not have a substance use disorder diagnosis at assessment but still require intervention, substance use awareness and education services may be supplemented by case coordination and referral(s) to supportive services funded through the Substance Abuse Block Grant (SABG) as primary prevention activities. These activities may include: Education (classroom and small group sessions for all ages, parenting and family management classes, peer leader/helper programs, education programs for youth groups, and children of substance abusers groups), Information Dissemination (awareness and knowledge of the nature and extent of alcohol, tobacco, and drug use, abuse and addiction and their effects on individuals, families, and communities); Alternative Activities (activities that exclude alcohol, tobacco and drugs: drug free dances/parties, youth/adult leadership activities, community service activities) and Problem Identification & Referral (employee assistance programs, student assistance programs and DUI education programs).

OUTPATIENT, INTENSIVE OUTPATIENT, AND RESIDENTIAL TREATMENT

The Contractor shall provide all levels of service described below. Contractors may make this continuum of services available through the contractor agency or subcontract agreements.

Level 1: Outpatient Services (OP)

This level addresses major lifestyle, attitudinal, and behavioral issues that have the potential to undermine the goals of treatment or impair the client's ability to cope with major life tasks without addictive substances or behaviors. The services follow a defined set of policies and procedures or clinical protocols and include individual and group counseling, motivational enhancement and engagement strategies, family therapy, educational groups, occupational and recreational therapy, psychotherapy, and addiction pharmacotherapy. This level can be used for clients with co-occurring substance use and physical or mental health conditions (including addressing, monitoring, and managing psychotropic medications; providing mental health treatment; and coordinating with substance abuse treatment); involuntary clients; those in the early stages of readiness to change and not ready to commit to full recovery; those requiring education about addiction; and clients in ongoing recovery requiring monitoring and continuing disease management (step-down). Staff providing these services include therapists, counselors, psychologists, advanced practice mental health nurses, general psychiatrists, and general licensed addiction clinicians (American Society of Addiction Medicine/ ASAM Criteria, Third Edition, 2013).

For clients who do not have a substance use disorder diagnosis at assessment but still require intervention, substance use awareness and education services may be supplemented...

- The Contractor shall provide at least three hours, but less than nine hours, per week of face-to-face therapeutic services for adults.
- The Contractor shall provide at least three hours but less than six hours per week of face-to-face therapeutic services for adolescents.
- There services are to include a minimum of one individual and one family session per month, per client, in addition to therapeutic groups.

- Services shall include an introduction to, and encouragement of weekly client attendance in, a 12-Step or other recovery-focused, spiritual recovery, or community support group and/or weekly interaction with a Recovery Coach.
- Co-occurring issues including, but not limited to, trauma, domestic violence, and mental illness shall be incorporated into treatment for clients requiring these services.

Level 2.1: Intensive Outpatient Services (IOP)

This level provides structured programming provided during the day before or after work/ school, in the evenings, and/or on weekends and consisting primarily of counseling and education about addiction-related and mental health problems. Services may include individual and group counseling, medication management, family therapy (including family members, guardians, or significant others in the assessment, treatment and continuing care of the patient), educational groups, occupational and recreational therapy, motivational interviewing, enhancement and engagement strategies, as well as other therapies. Services are provided by an interdisciplinary team of appropriately credentialed addiction treatment professionals including counselors, psychologists, social workers, and addiction-credentialed physicians with experience in addiction medicine or addiction psychiatry, and if treating adolescents, experience with adolescent medicine. Program staff should have sufficient cross-training to understand the signs and symptoms of mental disorders and understand the uses of psychotropic medications and their interactions with substance use and other addictive disorders (American Society of Addiction Medicine/ASAM Criteria, Third Edition, 2013).

- The Contractor shall provide at least nine hours per week of face-to-face therapeutic services, for a minimum of eight weeks.
- Services shall include an introduction to, and encouragement of weekly client attendance in, a 12-Step or other recovery-focused, spiritual recovery, or community support group and/or weekly interaction with a Recovery Coach.
- Co-occurring issues including, but not limited to, trauma, domestic violence, and mental illness shall be incorporated into treatment for clients requiring these services.

Level 2.5: Partial Hospitalization (PHP)

This is an organized outpatient service that delivers treatment services usually during the day, as day treatment or partial hospitalization services. These programs differ in the intensity of clinical services that are directly provided by the program, including psychiatric, medical and laboratory services. This service is appropriate for clients who are living with unstable medical and psychiatric conditions. Services may include individual and group counseling; educational groups; occupational and recreational therapy; psychotherapy; MAT; motivational interviewing; motivational enhancement and engagement strategies; family therapy; or other skilled treatment services. Services are provided by an interdisciplinary team of appropriately credentialed practitioners with the ability to provide medical, psychological, psychiatric, laboratory, toxicology and emergency services (American Society of Addiction Medicine/ ASAM Criteria, Third Edition, 2013).

- This level includes 20 or more hours of service per week for multidimensional instability not requiring 24-hour care.
- The Contractor shall at a minimum provide the same level of treatment described in Level 2.1, with psychiatric and other medical consultation services available within eight hours by telephone or within 48 hours in-person. In Arizona, Adolescents needing this level of care are treated in an Intensive Outpatient level of care.

Level 3.1: Clinically Managed Low-Intensity Residential Services

- This program is appropriate for client's whose recovery is aided by time spent living in a stable, structured environment where they can practice coping skills, self-efficacy, and make connections to the community including work, education, and family systems. This program is designed to improve the client's ability to structure and organize the tasks of daily living, stabilize and maintain the stability of the client's substance use disorder symptoms, and to assist in developing and applying recovery skills. Services may include individual, group and family therapy; medication management and medication education; mental health evaluation and treatment; motivational enhancement and engagement strategies; recovery support services; counseling and clinical monitoring;

MAT; and intensive case management, medication management, and/or psychotherapy for individuals with co-occurring disorders. Services are provided by appropriately credentialed medical, addiction, and mental health professionals providing clinical services including counselors and group living workers. Clinical hours include a focus on medication management, recovery skills, relapse prevention and other similar services. (American Society of Addiction Medicine/ASAM Criteria, Third Edition, 2013).

- The Contractor shall provide individual, group, or family therapy, or some combination thereof; medication management; and psychoeducation to develop recovery, relapse prevention, and emotional coping techniques.
- The Contractor shall provide a twenty-four hour living support and structure, with at least five hours of clinical service per week, for a minimum of 90 days.

Level 3.3: Clinically Managed Population-Specific High-Intensity Residential Services

This level provides a structured recovery environment in combination with high-intensity clinical services to meet the functional limitations of patients to support recovery from substance-related disorders. For the typical client at this level, the effects of the substance use or other addictive disorder or a co-occurring disorder results in cognitive impairment so significant, and the resulting impairment so great, that outpatient motivational and/or relapse prevention strategies are not feasible or effective. Cognitive impairments can be either temporary or permanent, may result in problems in interpersonal relationships, emotional coping skills or comprehension, and may require slower-paced treatment that is more concrete and repetitive until the impairment subsides so the client can be transferred to a less-intensive level of care. Those with permanent impairment may remain at this level. Program staff include physicians and appropriately-credentialed mental health professionals, counselor aides or group living workers on-site 24 hours a day, substance abuse treatment clinicians available 24 hours a day, and clinicians knowing the biological and psychosocial dimensions of substance use and mental disorders and their treatment able to identify the signs and symptoms of acute psychiatric conditions including decompensation and who have specialized training in behavior management techniques.

- The Contractor shall provide 24-hour structure with trained counselors to provide the following: cognitive, behavioral, and other therapies administered on an individual and group basis; medication management and medication education; counseling and clinical monitoring; educational groups; occupational and recreational therapies; art, music or movement therapies; physical therapy; clinical and didactic motivational interventions; and related services directed exclusively toward the benefit of the client (American Society of Addiction Medicine/ASAM Criteria, Third Edition, 2013).
- This level is not provided to adolescent populations.

Level 3.5: Clinically Managed Medium-Intensity (Adolescents) High-Intensity (Adults) Residential Services

These services are designed to serve clients who, because of specific functional limitations, need safe and stable living environments in order to develop and/or demonstrate sufficient recovery skills so they do not immediately relapse or continue to use in a dangerous manner upon transfer to a less-intensive level of care. It assists clients whose addictions are so out of control that they require a 24-hour supportive treatment environment to start or continue a recovery process that has failed to progress otherwise. Clients at this level typically have multiple limitations including serious and chronic mental disorders and criminal behaviors coupled with limited education, little/no work history, limited vocational skills, poor social skills and inadequate anger management skills, extreme impulsivity and/or an antisocial value system. Goals at this level are to promote abstinence from substance use, arrest other addictive and antisocial behaviors, and effect change in client's lifestyles, attitudes, and values. Services may include cognitive, behavioral and other therapies administered on an individual and group basis; medication management and medication education; counseling and clinical monitoring; random screening; planned clinical activities and professional services to develop and apply recovery skills; family therapy; educational groups; occupational and recreational therapies; art, music or movement therapies; physical therapy; and related services directed exclusively toward the benefit of the client. Staffing is similar to those listed in Level 3.3 and includes licensed/credentialed clinical staff (addiction counselors, social workers, licensed professional counselors). Telephone or in-person consultation with

a physician is a required support; however, on-site physicians are not required (American Society of Addiction Medicine/ASAM Criteria, Third Edition, 2013).

- The Contractor shall provide 24-hour care with trained counselors to address the client's negative behaviors and stabilization, current severity, and preparation for continued treatment in less intensive levels of care.

PRIOR AUTHORIZATION

Residential services require prior authorization by the Medicaid plan (for title XIX eligible clients) or the Comprehensive Medical and Dental Plan (for clients under 18 who are not title XIX eligible) or the designated DCS staff (for non title XIX eligible adult clients). To obtain approval from the designated DCS staff (for adults) or from CMDP (for clients under the age of eighteen), the Contractor shall provide the following documentation prior to placement of the client in a residential facility:

- a completed AFF Residential Services Authorization Form CSO-2395.
- a current Benefit Screening Tool CSO-2399 and supporting documentation demonstrating that AFF funding will not be supplanting other available funding;
- a complete ASAM Criteria assessment indicating the level of care required by the client;
- a statement from the client's therapist or doctor attesting to the need for residential care as the least restrictive placement appropriate to meet the client's needs; and
- an updated Service Plan showing Residential Treatment as the primary intervention for the client.

When a youth is covered by private insurance, the prior authorization process for residential treatment programs begins with a medical doctor submitting a Prior Authorization request to the non-Medicaid/private commercial health plan after conducting an assessment, ensuring medical necessity, and obtaining consent from the adult caregiver holding the health insurance. If coverage is denied by the private insurer, that insurance plan must provide a Notice of Adverse Benefit Determination or Notice of Action (NOA) and then a Prior Authorization request can be submitted to the Medicaid health plan for approval.

MEDICATION-ASSISTED TREATMENT

Medication-assisted treatment (MAT) is an evidence-supported means to help clients succeed in their treatment and resume normal functioning. Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies (NIDA, 2018). Medications treat withdrawal symptoms and psychological cravings. According to the SAMHSA, research has shown that when provided at the proper dose, medications used in MAT have no adverse effects on a person's intelligence, mental capability, physical functioning, or employability (Substance Abuse and Mental Health Services Administration, 2019). MAT, including methadone maintenance, is generally needed for a minimum of twelve months, and may be necessary for several years.

Medication-assisted treatment (MAT) is an evidence-supported means to help clients succeed in their treatment and resume normal functioning.

MAT has been shown to improve patient survival, increase retention in treatment, decrease illicit opiate use and other criminal activity among people with substance use disorders, increase patients' ability to gain and maintain employment, and improve birth outcomes among women who have substance use disorders and are pregnant (Substance Abuse and Mental Health Services Administration, 2019).

- When the ASAM CRITERIA© assessment determines that the client would benefit from MAT, the Contractor shall provide MAT services or coordinate care with a MAT provider.
- MAT services can be provided to a client for up to six months following reunification of, or termination of parental rights to, all children of the client who had been in out-of-home care.
- When a client is participating in MAT, the Contractor shall simultaneously provide counseling and behavioral therapy to clients and their families. The client does not need to wait to complete MAT to begin these types of services.

MEDICATION-ASSISTED TREATMENT FOR ADOLESCENTS

Adolescents may participate in MAT when indicated by the comprehensive assessment. The Contractor must involve the adolescent's parent or caregiver in MAT to provide support and supervision to make sure the medication is taken as prescribed.

DRUG TESTING

Drug testing begins at assessment and continues during treatment to motivate treatment participation and allow early detection and response to relapse.

- During the assessment, the Contractor shall ask the client whether drug testing is occurring through DCS or other agencies, and develop a coordinated drug testing plan that does not require more testing than necessary and requires results be shared between the Contractor and DCS and/or DES/Jobs.
- The Contractor shall include a drug testing plan in each client's service plan, to include frequency, duration, and method of testing.
- The drug testing plan shall be tailored to the individual client.
- Drug testing shall be randomly scheduled (not be scheduled to occur only at the time of the AFF service appointment).
- The Contractor shall determine and modify testing frequency or intensity with client and CFT or ART member input, considering these factors:
    * The type of substance used and length of time it can be detected
    * Clinical diagnosis regarding the severity of the substance use
    * Patterns of use (weekends, after stressful events)
    * Results of testing – both positive and negative
    * Consistent attendance/participation in substance abuse treatment and other services
    * Observed changes in affect and physical appearance
    * Level of cooperation and engagement in case plan activities

The following frequency is recommended when a client is progressing well in treatment and/or behaviorally:

TIME FROM TESTING START	SUGGESTED FREQUENCY
0 – 30 days	2 times per week
31 – 60 days	1 time per week
61 – 120 days	2 times per month
121+ days	Monthly (until behaviors indicate no further use)

- The Contractor shall communicate via e-mail to the assigned DCS Specialist or DES/Jobs Case Manager when the Contractor would like drug testing to begin for the client, and the planned frequency of drug tests.
    * For DCS clients, the DCS Specialist **will submit the service request for drug testing to the DCS contracted providers** in the appropriate portal. DCS and the Contractor shall have access to the test results.
    * For DES clients, the Contractor shall set up the drug testing dates and frequency with a vendor, and the cost of the services shall be passed back to DES.
- The Contractor shall discuss any proposed changes in frequency of drug testing with the client, DCS Specialist or DES/Jobs Case Manager, and the CFT or ART members. These changes shall be documented in the service plan; and approved by the referring DCS Specialist or DES/Jobs case manager. If the Contractor is unable to obtain approval from the referring/assigned DCS Specialist or DES/Jobs Case Manager within seven business days, the Contractor may proceed with the change.
- If the client misses two drug tests in a month, the Contractor shall communicate this via secure email to the assigned DCS Specialist or DES/Jobs Case Manager within one business day of the second missed drug test.

- If a client submits a positive test, the Contractor shall contact the DCS Specialist or DES/ Jobs Case manager via secure email within one business day of receipt of the test results.
- The Contractor shall report all drug tests and results in the monthly report.
- The Contractor shall use the results of drug tests to inform the service plan, but shall not use the results exclusively to determine the client's progress in recovery.

SENSE PROGRAM INTEGRATION

Contractors shall participate in the development, implementation, and on-going delivery of services within the SENSE model. The Contractor shall perform the following tasks:

1. Utilize priority outreach status for SENSE cases. The Contractor shall contact the client within 24 hours of receiving the SENSE referral to introduce the SENSE program and inform the client of available services.
2. Verify contact information for all agencies currently involved in the SENSE team.
3. Have the client sign a Release of Information if one was not provided in the Service Request information from DCS or DES.
4. Conduct a substance use assessment with the client within five (5) calendar days of successful outreach to determine the treatment level of care needed, as well as supportive services to be provided to support the client in treatment.
5. Notify all SENSE team members of the outcome of the assessment including treatment recommendations and level of care.
6. Develop a family-centered service plan within three (3) calendar days of completion of the assessment.
7. Attend the 10-Day SENSE staffing at the client's home to share and incorporate AFF service plan goals, objectives, and tasks developed from the service plan into the joint SENSE Case Plan.
8. Provide updates of the client's substance treatment progress within the SENSE Team joint email each week, and on the Client's Monthly Progress note. The update shall including successes, barriers to treatment, additional needs, and/or issues with client participation. These updates shall continue for the full SENSE referral term (a minimum of 120 days, with an option of an additional 45-day extension, if needed). AFF treatment services shall continue past the SENSE referral closure if the client has not successfully completed all tasks and objectives regarding substance abuse.
9. Participate in the 45-day and 90-day SENSE Team meetings at the client's home to review progress of all SENSE services being provided.

CASE COORDINATION TO SUPPORT CLIENT RETENTION

Retention in treatment is influenced by the client's motivation to stop using substances; degree of support from family/friends; pressure from the criminal justice system, DCS, employers, or family; and involvement of the client in individualized assessment and service planning.

The Contractor shall provide case coordination to all referred clients and their families from the initial referral through completion of recovery maintenance services. A Case Coordinator shall be assigned and provide coordination from the time the client signs the Release of Information until AFF service closure. Case Coordination shall include all of the following:

- Confirmation that all required outreach activities have been conducted, preferably by a Recovery Coach as described in this AFF Program Manual
- Asking the client to identify members of the client's family network to be involved in assessment, service planning, treatment services, and recovery maintenance (the Case Coordinator shall communicate with the DCS Specialist and/or DES Case Manager to confirm that there are no legal issues or safety concerns that would contraindicate a family member's involvement)

- Coordination of the exchange of information among the CFT or ART members and with the referring agency (this includes communication with the DCS Specialist or DES/Jobs Case Manager to exchange current client contact information, DCS safety plans, DCS case plans, Employment and Career Development Plans, AFF assessment results, and AFF service plans)
- Assisting the client to obtain stabilization (detoxification) services if needed, and to transition into AFF services when stabilization services are complete
- Reviewing and providing input into the AFF service plan to prevent duplication of services and conflicting services and expectations
- Monitoring to confirm that AFF services are scheduled to allow clients to be able to attend work, court, and parenting time without conflicts
- Identifying auxiliary groups and support services that assist the client and family members to remain engaged in services and achieve treatment goals, and connecting the client and family members to these groups and services
- Participation in case plan staffings, TDM meetings, ART meetings, CFT meetings, and other staffings or meetings at which behavioral goals and services for the client and client's family are discussed and/or identified
- Monitoring timely completion of tasks in the Service Plan, and coordinating with the family and team to solve barriers to task completion
- Arrange re-engagement services by a Recovery Coach, if the client misses appointments, within two days of the client disengaging
- Submitting the AFF Monthly Progress note to the DES/Jobs Case Manager by secure email, or to the DCS Specialist by uploading it on the DCS Child Welfare Care Management System. The AFF Monthly Progress notes shall be submitted for the full length of AFF services, whether or not the DCS case has officially closed. AFF services can, and should, continue if the client is willing to participate, regardless of the case status.
- Approving AFF program closure after confirming that all required outreach and engagement activities have been conducted, or treatment and recovery maintenance services have been completed, or other case closure criteria have been met as described in this AFF Program Manual.

Most clients are fragilely balanced between recovery and re-addiction in the weeks, months, and early years following their discharge from addiction treatment.

RECOVERY MAINTENANCE SERVICES

RECOVERY MAINTENANCE SERVICE COMPONENTS

Recovery Maintenance services provide continuing care and recovery support to maintain sobriety. Most clients are fragilely balanced between recovery and re-addiction in the weeks, months, and early years following their discharge from addiction treatment. Recovery becomes more solidified and sustainable, and the risk of relapse declines with the passage of time in recovery (ATTC, 2008). This last phase of treatment is essential while the client successfully transitions back into the community and achieves recovery stability. It also provides quick access to return to treatment if relapse occurs while recovery maintenance services are being provided.

The Contractor shall provide recovery maintenance services to all clients who complete treatment services, to begin immediately after completion of therapeutic treatment. The Contractor shall not present this phase of treatment as optional.

Recovery maintenance services shall continue for a minimum of six months, but shall not exceed 12 months following completion of treatment, and shall cease after termination of parental rights to all children of the client who had been in out-of-home care. If a client needs to return to treatment, the six to twelve month period for subsequent recovery maintenance services shall restart.

The Contractor shall involve the client, family, and team to develop a Recovery Maintenance Service Plan prior to completing treatment.

- Preparation and planning for recovery maintenance services shall begin during formation of the client's initial service plan, as part of the relapse prevention plan.
- The plan shall be developed with consideration of the client's level of engagement in treatment, degree of problem severity, amount of available supportive services outside of treatment, and stability or instability of the client's recovery program.
- The Recovery Maintenance Plan shall include contact information for services and supports that household members can access in times of difficulty or need.
- Within five business days of completion, the Contractor shall submit a copy of the Recovery Maintenance Plan by secure email to the DES/Jobs Case Manager or by uploading it on to the DCS Child Welfare Case Management System.

At a minimum, the client's Recovery Coach or Case Coordinator shall provide the following Recovery Maintenance services:

- *Recovery Checkups:* The Recovery Coach or Case Coordinator shall conduct recovery checkups, which consist of scheduled and/or unscheduled contacts (phone calls, e-mails, teleconference, home visits and/or in-person meetings/groups), at least weekly for the first 90 days after the client completes treatment, decreasing to twice monthly after 90 days as the client incorporates into community support groups and shows no indicators of relapse. Each checkup contact shall address the areas stated below, and shall be documented in the client's AFF Monthly Report form CSO-2422:
    * health (managing one's disease/symptoms and making healthy choices),
    * home (having a safe and stable place to live),
    * purpose (conducting meaningful daily activities),
    * having independence (income and resources to participate in society), and
    * community (having relationships and social networks to provide support, friendship, love, and hope).
- *Relapse Prevention*: The Recovery Coach or Case Coordinator shall:
    * assist the client with transferring the information and skills learned in treatment to life in the community without the use of substances;
    * provide ongoing relapse prevention education and coaching;
    * confirm and/or reinitiate linkage to recovery support groups and recovery activities; and
    * assist the client to resolve personal and environmental obstacles by developing healthy responses to challenges that may arise in this stage of recovery.
- *Relapse Intervention:* When a client indicates relapse is likely, or has relapsed, the Recovery Coach or Case Coordinator shall:
    * provide recovery re-stabilization when problem severity has not fully re-escalated and when the client still has recovery assets that can facilitate long-term recovery (recovery assets, such as steady employment, improved family/intimate relationships, and restoration of trust levels, are depleted over time with re-addiction);
    * diminish the shame that follows relapse by discussing the role of relapse in overall recovery, praising continued commitment to recovery, and re-affirming the recovery support partnership;
    * review areas of difficulty for the client in transitioning from treatment to maintenance in the client's natural environment by building recovery assists to support a sobriety-based lifestyle and teaching sobriety-based skills to resolve problems in daily living; and
    * make a referral back to treatment if warranted.

- *Community Sobriety Supports:* The Recovery Coach or Case Coordinator shall:
  * encourage client participation in community support groups for long-term integration into the recovering community;
  * familiarize clients with support groups that would meet the client's preferences;
  * provide information on sobriety support meeting dates, times and locations;
  * directly connect the client with the recovery group either through contact with a current support group member, or by attending a meeting with the client; and
  * provide information about internet-based and phone-based support group meetings, and alumni support groups within the contractor's agency if a client is unable to attend in-person support groups.

RECOVERY MAINTENANCE SERVICES FOR ADOLESCENTS

Recovery maintenance services for adolescents shall be provided and encouraged for at least a year because their developmental stage puts them at greater risk of being influenced by their peers into resuming substance use. Recovery maintenance services through the AFF program shall be provided for no more than twelve months following DCS case closure after investigation or provision of in-home or out-of-home services.

CASE CLOSURE AND RECORDS RETENTION

CASE CLOSURE

The Contractor shall close the AFF services case when any of the following conditions are met:

- All outreach activities were conducted and the Contractor was unable to locate or contact the client.
- All outreach and engagement activities were conducted, including offering substance use awareness services when substance use is suspected, but the client did not engage or the client refused services.
- The client was assessed as not needing substance use treatment services or substance use awareness services.
- The client successfully completed treatment and recovery maintenance services.
- The client no longer resides in the geographic service area.
- The client will be detained or incarcerated for more than 30 days.

Before closing a case due to lack of contact, refusal to participate, or lack of engagement, the Contractor shall:

- confirm or obtain the most up-to-date client contact information from the DCS Specialist or DES/Jobs Case Manager;
- determine if any upcoming meetings involving the client are scheduled where contact might be made;
- allow DCS or DES/Jobs an opportunity to facilitate a meeting between the client and the AFF provider to assist with engagement.

Before closing a case because the client was assessed as not needing substance use treatment services, the Contractor shall:

- discuss the assessment results with the DCS Specialist or DES/Jobs Case Manager;
- obtain and consider all available information about the client's substance use, including information from collateral contacts, client interviews, and written documentation.

Prior to closing the AFF services case for a client who has not completed services and is suspected to be using substances, the Contractor shall send the client a certified letter at the last known address, advising of the pending closure and requesting a response within ten calendar days to avoid closure. The Contractor shall send a copy of the letter to the assigned DCS Specialist or DES/Jobs Case Manager.

Whenever possible, an aftercare plan should be developed with all AFF clients who are discontinuing services. The aftercare plan should:

- allow the family and its informal support system time prior to the planning meeting to consider the family's circumstances so they can anticipate issues that may arise and how they would resolve them;
- anticipate other possible future difficulties and ways the family would resolve them using available resources and supports;
- include steps to plan for potential relapses to ensure family members have access to services and supports available in the community;
- be tailored to the individual needs of the client and family members;
- include input from all family members age six and older, including supportive extended family members;
- include names and contact information for specific resource agencies and provide a copy of the plan to the client and family members as a ready reference.

In the final Monthly Report, the Contractor shall document the outreach and re-engagement efforts with a client who did not attend service appointments or left treatment prior to discharge. Within ten working days following the end of the month when the case closure is completed, the Contractor shall submit a copy of the final Monthly Report by secure email to the DES/Jobs Case Manager or by uploading it on to the DCS Child Welfare Case Management System.

The Case Coordinator shall provide or connect the client to auxiliary groups and support services that are individualized to the client's needs and assist the client to remain engaged in services and achieve treatment goals.

AUXILIARY GROUPS AND SUPPORT SERVICES

The Case Coordinator shall provide or connect the client to auxiliary groups and support services that are individualized to the client's needs and assist the client to remain engaged in services and achieve treatment goals. The Case Coordinator shall identify services already provided to the client and family through other agencies (DCS, DES/Jobs, family court, etc.) to avoid duplication of services. Title XIX funding and other sources shall be accessed prior to using AFF funds for these services.

Auxiliary Groups

- Auxiliary groups may include parenting education, domestic violence interventions and/or education, legal services, vocational training, job seeking groups/sessions, and any other services needed by the client to accomplish the goals within the service plan.

Concrete Services

- Concrete services include, but are not limited to, childcare, car repair, utility assistance, rent assistance, clothing/uniform vouchers, food boxes and nutrition, cell phone minutes.
- The Contractor shall assist the client to obtain concrete services when a client is engaged in treatment and a concrete need is identified as a barrier to achieving and/or maintaining sobriety.
- Use of AFF flex funds for concrete services shall be restricted to those services that are not available through other sources, including the RBHA as a covered service, or in-kind donations from community collaborators.
- The Contractor will be reimbursed for the actual cost of the concrete service, not to exceed $400 per state fiscal year for each referred client. Expenses, including copies of receipts, shall be submitted for reimbursement to DCS via the monthly billing. The Contractor shall maintain in the client record original receipts for all concrete supportive services paid through the AFF contract.

Transportation

- The Case Coordinator shall assist the client to obtain transportation to attend all AFF appointments when the client does not have a means of transportation and use of public transportation is not feasible. Transportation shall be obtained through Medicaid-funded transportation services for eligible clients. The Case Coordinator shall contact

the DCS Specialist for transportation services for DCS-referred clients who are not title XIX eligible.

If transportation is needed for a DES/Jobs-referred client to attend AFF services, the Case Coordinator shall contact the DES/Jobs case manager to initiate the use of bus passes, travel reimbursement, taxis, ride shares, or other available means through Jobs program resources.

Psychiatric Services

- The Contractor shall provide psychiatric services to treat co-occurring disorders for clients who have been diagnosed, or are suspected of having, a co-occurring psychiatric disorder. Services include psychiatric evaluations, psychotropic medications, and medication monitoring for individuals ineligible for title XIX or XXI services and/or no private health insurance coverage to pay for necessary services.
- AFF funds cannot be used to supplant other available funding options such as title XIX or private insurance. Identify and facilitate services through other sources, including but not limited to RBHA-funded services, federal grants (e.g. Substance Abuse Prevention and Treatment Fund [SAPT]), Veteran's benefits, private insurance, and Indian Health Services, before utilizing AFF funds.
- For clients who are not title XIX eligible, prior authorization from the designated DCS staff is required for psychiatric services. The Contractor shall submit the Psychiatric Services Authorization Form CSO-2397 to request prior authorization.

Physical Health Services

The Contractor shall assist the client to locate necessary physical health care services, to include HIV and STD testing. AFF funds cannot be used for physical health services. Per ARS 46-300.05, money provided for these services shall not be used for medical treatment.

RETENTION INCENTIVE PAYMENTS

The Contractor shall provide incentive payments to clients who reach treatment or recovery milestones as identified in the AFF Program Manual.

- The Contractor shall submit a retention incentive payment plan that conforms with the instructions in the AFF Program Manual to the DCS AFF Program Development Specialist for approval prior to receiving the retention incentive payment funds.
- Incentive payments are subject to the availability of funds, and the Department may put a cap based on the availability of funds.

PROGRAM AND STAFF QUALIFICATIONS

STAFFING

Ensure that employed or contracted staff meet the following qualifications:

- Have a clear Central Registry Background Check and a Level One fingerprint clearance card prior to delivering services to ADCS clients, which is to be reviewed and updated annually.
- Have not been placed on probation or parole for the last ten (10) years from present date.
- Have no civil, criminal, or juvenile restraining orders within the last ten (10) years from present date.
- Have a clear pre-employment drug test result, as well as clear random annual drug testing results.
- Verification is to be kept in the Personnel File.

LICENSURE

- The Contractor shall comply with Arizona state licensure requirements for any service requiring a license, which includes services provided by collaborative partners and sub-contractors.
- The Contractor shall ensure that staff providing assessment and/or direct substance use disorder treatment services meet the minimum standards set forth by:

* the Arizona Board of Behavioral Health Examiners and A.R.S. Title 32, Chapter 33/ Behavioral Health Professionals (https://www.azbbhe.us/pdfs/rules/proposedrules/BOARD%20STATUTES%20123117%20for%20website.pdf),
* AHCCCS credentialing and privileging requirements of A.A.C. Title 9 Health Services, Chapter 22, Article 12/Behavioral Health Services (https://apps.azsos.gov/public_services/Title_09/9-22.pdf), and
* the qualifications in the AHCCCS AMPM Chapter 310B-Title XIX/XXI Behavioral Health Service Benefit-Medical Policy for Covered Services https://azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/310B.pdf, and
* AMPM Chapter 320T-Non-Title XIX/XXI Behavioral Health Benefit Services https://azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/320T.pdf policies.

CLINICAL TREATMENT STAFF QUALIFICATIONS

The Contractor shall ensure that all clinical treatment staff directly serving AFF clients have a minimum of a Master of Social Work, Counseling, Marriage and Family Therapy, or Substance Abuse Counseling degree and experience that meets the standards to comply with:

- State licensing requirements for any service requiring a license;
- State statute, state rule, and AHCCCS policy on qualification for the provision of, and ability to bill for, the service delivered by the clinician; and
- requirements identified by the developer of an evidence-supported or well-supported program delivered by the clinician.

CASE COORDINATOR QUALIFICATIONS

The Contractor shall ensure that all non-licensed case coordination staff directly serving AFF clients have:

- an associate degree in a human service or behavioral health-related area of study, and at least three years of related experience including working with multi-problem families in the field of substance abuse, child welfare, or behavioral health, or
- a bachelor degree in a human service- or behavioral health-related area of study.

RECOVERY COACH QUALIFICATIONS

The Contractor shall recruit, hire, and train Recovery Coaches to provide outreach, orientation, engagement, and re-engagement services. The Contractor shall make continual, concerted efforts to employ a sufficient pool of Recovery Coaches to serve the clients and families within the AFF program.

The Contractor shall ensure that all Recovery Coaches meet the following qualifications:

- Has been a behavioral health service recipient or substance use treatment recipient;
- Has been a parent, guardian, or custodian in a DCS investigation or ongoing services case, and has completed the goals and objectives related to substance abuse treatment and recovery maintenance, resulting in the AFF client and clinician agreement of AFF case closure, and whose DCS case has been closed for at least one year;
- Has remained substance-free for a minimum of one year following treatment;
- Is at least 21 years of age;
- Has one year of continuous work experience; and
- Is a paraprofessional with training and/or certification in a substance use disorder or Recovery Coach Program. All Recovery Coaches shall meet the requirements and qualifications as outlined in AHCCCS AMPM963 policy, see: https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/900/963.pdf.

All Recovery Coaches shall have a valid Level One fingerprint clearance card if their duties involve them having direct contact with children. Recovery Coaches shall not have been placed on probation or parole for the last thirty-six months from present date, and shall not have any civil, criminal, or juvenile restraining orders within the thirty-six months from present date. Recovery Coaches who are not authorized to have direct contact with children shall

only work with the parent(s)/caregiver(s). If serving a parent/caregiver who is a vulnerable adult, the Recovery Coach shall be cleared on the Adult Protective Services Registry at https://des.az.gov/services/aging-and-adult/arizona-adult-protectiveservices-aps in order to provide services.

TRAINING

Treatment staff with active licensure shall comply with all required Continuing Education (CEU) requirements set forth by the Arizona Board of Behavioral Health Examiners at https://www.azbbhe.us/node/557, as well as the ADHS/DBHS credentialing and privileging requirements at https://www.azahcccs.gov/PlansProviders/Downloads/GM/bhs-definitions.pdf.

All AFF staff, and all subcontractor staff providing AFF services, have at least eighteen hours of training within thirty days after hire and annually by contract year thereafter.

The initial training within thirty days of hire shall be provided by DCS using a curriculum provided or approved by DCS. The training topics shall include, at minimum:

Treatment staff with active licensure shall comply with all required Continuing Education (CEU) requirements set forth by the Arizona Board of Behavioral Health Examiners...

- Strengths-based relationship and trust building
- Family-centered and family-engagement practice
- Motivational interviewing
- Fostering self-sufficiency in clients
- Including family vision and voice in behavioral health service planning and implementation
- Participating as a member of the applicable family team for assigned cases
- DCS safety assessment policies and procedures, including caregiver protective capacities and the protective factors framework
- Substance use and employment
- Arizona's Behavioral Health System policies and procedures in the 9 Guiding Principles for Recovery Oriented Adult Behavioral Health Services;
- Arizona's Behavioral Health System policies and procedures in the Arizona Vision and 12 Principles in the children's system;
- Child assessment and screening tools, including: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and Child and Adolescent Service Intensity Instrument (CASII)
- The ASAM Continuum
- Understanding trauma, including the impact of Adverse Childhood Experiences (ACES) and resiliency
- Culturally relevant services and culturally competent practice
- Gender specific substance use disorder treatment
- Dynamics of substance abuse and its effect on families, including diminished caregiver protective capacities and effects on employment
- Working with individuals with co-occurring disorders
- Evidence-based and evidence-informed therapeutic modalities and interventions to treat substance use disorder, including medication assisted treatment
- Relapse prevention
- Intimate partner violence, domestic violence, and family violence
- Self-harm and suicide risk assessment
- Ethics and boundaries
- The Americans with Disabilities Act (ADA)
- The Substance Abuse Block Grant (SABG)

- Confidentiality, including the Health Insurance Portability and Accountability Act (HIPAA)
- An in-depth review and understanding of this AFF Program Manual
- Arizona mandated reporter law

In addition, within 30 days of hire, the initial training for Case Coordinators and Recovery Coaches of all AFF Contractors and subcontractors shall include the following topics:

- How to access and enroll in Title XIX or XXI services including all RBHA-funded behavioral health-covered services
- Knowledge of, and the ability to connect clients with, community resources
- Assisting clients with negotiating the child welfare and behavioral health systems to maximize the desired outcome
- Helping clients successfully link to, and effectively use, resources in the community while receiving treatment for substance use
- Helping clients increase their skills and resources to manage their recovery and, subsequently, their lives
- National Center on Substance Abuse and Child Welfare (NCSACW) online trainings on substance use disorders and child welfare;
- Substance Abuse and Mental Health Services Administration (SAMHSA) Core Competencies for Peer Workers in Behavioral Health Services, with focus on competencies: recovery-oriented, person-centered, voluntary, relationship-focused and trauma-informed

The Contractor and any subcontractors shall document in the employees' personnel file the date, subject, and length of each training attended by the employee.

The Contractor shall confirm that all Contractor or Subcontractor direct care staff are invited and participate in training provided by the Collaborative Partnership related to child welfare, the AFF Model, and substance abuse issues.

Annual training shall include, but not be limited to, the following components and/or topics: Arizona mandated reporter law; therapeutic intervention techniques; evidenced-based or informed practices or programs; behavioral health conditions; substance use; child welfare policies and programs; domestic violence and intimate partner violence; and DCS safety assessment policies and procedures, including caregiver protective capacities and the protective factors framework.

PROGRAM MONITORING, EVALUATION, AND CONTINUOUS IMPROVEMENT

PROVIDER MEETINGS

DCS will host provider meetings at least quarterly to discuss program fidelity and outcome data, best practices, and barriers to service delivery, and provide the opportunity for all parties to problem solve and collaborate.

- The Contractor shall participate in provider meetings scheduled by DCS to review programmatic data and discuss program trends toward an objective of improving program fidelity and outcomes.
- The Contractor's program and data managers shall attend each provider meeting to participate in discussions about web portal issues, receive technical assistance to ensure accurate data, and identify opportunities for improving the data collection process.

SITE VISITS

The Contractor shall participate in the quality improvement process and collaboratively work with DCS to continuously improve practice fidelity and client outcomes, utilizing the Active Contract Management (ACM) framework and through participation in the site visit process.

- Quality Assurance site visits will be conducted by the AFF Statewide Coordinator and/or the AHCCCS AFF Liaison at least twice per year to monitor the quality of service

delivery within the context of the AFF model. Site visits may include a mix of the following components:

  * case file reviews;
  * personnel file reviews;
  * observations of intake, outreach, assessment, service planning, testing, and therapeutic interventions;
  * interviews of staff and/or clients;
  * invoice reviews;
  * review of curriculum and agency policy and procedures related to the AFF program;
  * review of the internal quality assurance processes in place at the agency that ensure accuracy in billing and use of proper funding sources, monitoring quality among staff, providing clinical supervision, and accurate collection of data for the program evaluation; and
  * other quality assurance processes as may be deemed appropriate by DCS.

- The Contractor's data managers involved with AFF data, and all program staff responsible for ensuring data cleaning is completed, shall attend data-focused site visits, that will be scheduled by the AFF Statewide Coordinator to discuss issues with the data portal, changes to error reports, status of data cleaning, barriers that prevent the Contractor from providing timely data, and any related issues.
- The Contractor shall cooperate with site visits from the program evaluators, as well as the Fidelity & Compliance Services (FCS) Unit, and participate in evaluation activities beyond collection of data for the web portal. Potential activities include:
  * distribution of staff and/or participant satisfaction surveys,
  * administration of pre/post testing to clients and sharing results as directed,
  * providing input into program evaluation design, and
  * development of action plans to assure timely and accurate data is available for the program evaluation.
- Technical assistance will be provided to sites in response to strengths and challenges identified during the site visit and through other interactions with the agency.
- The Contractor shall cooperate in program improvement activities identified as a result of quality assurance activities, including the development and implementation of corrective action plans as required by DCS.

DCS SATISFACTION SURVEY

The Contractor shall cooperate with the Department to develop and deliver an annual satisfaction survey of DCS Specialists and DES/Jobs Case Managers who were involved with service cases provided by the Contractor during the annual data period.

DCS will approve the final satisfaction survey content and delivery method, will compile the results of the completed surveys, and will share the results with the Contractor and the DCS Program Development Specialist.

DATA PORTAL, DATA CORRECTION, AND ANNUAL EVALUATION

A.R.S.§ 8-884 requires a method to evaluate the AFF substance abuse prevention and treatment program. A designated data portal is used to receive and store the data to be used for the statutorily-required annual evaluation, three quarterly reports, and DCS's Active Contract Management (ACM) process.

Contractors shall upload their AFF client data into this portal monthly, and correct all missing/incorrect information, following the process below:

- DCS, in collaboration with the independent evaluator, shall identify the data elements that the Contractor shall submit to the AFF data portal, and provide definitions for all data elements and values. DCS may revise the list of required data elements to meet program monitoring and evaluation needs.

- The Contractor shall submit all required data to the designated data portal by the 15th day of the month following each service month, for every AFF service request/referral and for all services provided. The data shall be complete, accurately, timely, and according to established procedures.
- Within one business day of the required upload date, DCS or an evaluation agency contracted by the agency will provide error reports that identify data errors, missing data, and other data quality issues.
- The Contractor shall monitor error reports at least monthly and correct all errors identified in the report(s) within 14 calendar days of publication of the reports.
- The Contractor's data manager shall develop procedures for monitoring accuracy of data entered/uploaded into the web portal.
- Significant issues that arise around Contractor data shall be communicated to DCS, along with a plan for correcting the errors in a timely manner.
- DCS will monitor data quality through routine quality assurance reviews of data in the designated portal, the results of which will be reported to, and addressed with, the Contractor as part of the monitoring process.
- DCS or an evaluation agency will provide a subsequent report that shows the status of the error reports after the 14-day data-cleaning period. If errors are not resolved by that time, DCS will communicate with the provider to obtain a plan to resolve the errors.

COLLABORATIVE PARTNERSHIPS

The Contractor shall develop Collaborative Partnerships through written agreements with stakeholders. Existing Collaborative Partnerships may be used if they are composed of appropriate community representatives, as defined in A.R.S. 8-882.3 and 8-883.1. The Contractor shall conduct Collaborative Partnership meetings a minimum of once per quarter. The Contractor shall submit to the DCS or DES designated staff, the meeting minutes of the Collaborative Partnerships within ten working day of each collaborative meeting.

PERFORMANCE MEASURE	BASELINE STATISTICS (AFF Annual FY2019)	PERFORMANCE GOAL
5.1 The first contact with the client occurs in-person within one working day of receipt of the referral, or concerted efforts were made.	Not Available	95%
5.2 Individuals referred to the Program accept program services within three working days of the referral, as documented by a signed AFF Release of Information.	58%	60%
5.3 Assessments are conducted on all individuals accepting services	98%	98%
5.4 Clients who successfully complete treatment accept Recovery Maintenance services as indicated by signing a Recovery Maintenance plan.	4%	25%
5.5 Individuals who have accepted services receive drug testing per the requirements in the Scope of Work.	Not available	95%

ADDENDUM A

Questions to Consider When Implementing a Trauma-Informed Approach*

Governance and Leadership	• How does agency leadership communicate its support and guidance for implementing a trauma-informed approach? • How do the agency's mission statement and/or written policies and procedures include a commitment to providing trauma-informed services and supports? • How do leadership and governance structures demonstrate support for the voice and participation of people using their services who have trauma histories?

Policy	• How do the agency's written policies and procedures include a focus on trauma and issues of safety and confidentiality? • How do the agency's written policies and procedures recognize the pervasiveness of trauma in the lives of people using services, and express a commitment to reducing re-traumatization and promoting well-being and recovery? • How do the agency's staffing policies demonstrate a commitment to staff training on providing services and supports that are culturally relevant and trauma-informed as part of staff orientation and in-service training? • How do human resources policies attend to the impact of working with people who have experienced trauma? • What policies and procedures are in place for including trauma survivors/people receiving services and peer supports in meaningful and significant roles in agency planning, governance, policy-making, services, and evaluation?
Physical Environment	• How does the physical environment promote a sense of safety, calming, and de-escalation for clients and staff? • In what ways do staff members recognize and address aspects of the physical environment that may be re-traumatizing, and work with people on developing strategies to deal with this? • How has the agency provided space that both staff and people receiving services can use to practice self-care? • How has the agency developed mechanisms to address gender-related physical and emotional safety concerns (e.g., gender-specific spaces and activities)?
Engagement and Involvement	• How do people with lived experience have the opportunity to provide feedback to the organization on quality improvement processes for better engagement and services? • How do staff members keep people fully informed of rules, procedures, activities, and schedules, while being mindful that people who are frightened or overwhelmed may have a difficulty processing information? • How is transparency and trust among staff and clients promoted? • What strategies are used to reduce the sense of power differentials among staff and clients? • How do staff members help people to identify strategies that contribute to feeling comforted and empowered?
Cross Sector Collaboration	• Is there a system of communication in place with other partner agencies working with the individual receiving services for making trauma-informed decisions? • Are collaborative partners trauma-informed? • How does the organization identify community providers and referral agencies that have experience delivering evidence-based trauma services? • What mechanisms are in place to promote cross-sector training on trauma and trauma-informed approaches?

Screening, Assessment, Treatment Services	• Is an individual's own definition of emotional safety included in treatment plans? • Is timely trauma-informed screening and assessment available and accessible to individuals receiving services? • Does the organization have the capacity to provide trauma-specific treatment or refer to appropriate trauma-specific services? • How are peer supports integrated into the service delivery approach? • How does the agency address gender-based needs in the context of trauma screening, assessment, and treatment? For instance, are gender-specific trauma services and supports available for both men and women? • Do staff members talk with people about the range of trauma reactions and work to minimize feelings of fear or shame and to increase self-understanding? • How are these trauma-specific practices incorporated into the organization's ongoing operations?
Training and Workforce Development	• How does the agency address the emotional stress that can arise when working with individuals who have had traumatic experiences? • How does the agency support training and workforce development for staff to understand and increase their trauma knowledge and interventions? • How does the organization ensure that all staff (direct care, supervisors, front desk and reception, support staff, housekeeping and maintenance) receive basic training on trauma, its impact, and strategies for trauma-informed approaches across the agency and across personnel functions? • How does workforce development/staff training address the ways identity, culture, community, and oppression can affect a person's experience of trauma, access to supports and resources, and opportunities for safety? • How does on-going workforce development/staff training provide staff supports in developing the knowledge and skills to work sensitively and effectively with trauma survivors? • What types of training and resources are provided to staff and supervisors on incorporating trauma-informed practice and supervision in their work? • What workforce development strategies are in place to assist staff in working with peer supports and recognizing the value of peer support as integral to the organization's workforce?
Progress Monitoring and Quality Assurance	• Is there a system in place that monitors the agency's progress in being trauma-informed? • Does the agency solicit feedback from both staff and individuals receiving services? • What strategies and processes does the agency use to evaluate whether staff members feel safe and valued at the agency? • How does the agency incorporate attention to culture and trauma in agency operations and quality improvement processes? • What mechanisms are in place for information collected to be incorporated into the agency's quality assurance processes and how well do those mechanisms address creating accessible, culturally relevant, trauma-informed services and supports?
Financing	• How does the agency's budget include funding support for ongoing training on trauma and trauma-informed approaches for leadership and staff development? • What funding exists for cross-sector training on trauma and trauma-informed approaches? • What funding exists for peer specialists? • How does the budget support provision of a safe physical environment?

Evaluation	• How does the agency conduct a trauma-informed organizational assessment or have measures or indicators that show their level of trauma-informed approach? • How does the perspective of people who have experienced trauma inform the agency performance beyond consumer satisfaction survey? • What processes are in place to solicit feedback from people who use services and ensure anonymity and confidentiality? • What measures or indicators are used to assess the organizational progress in becoming trauma-informed?

* Concept of Trauma and Guidance for a Trauma-Informed Approach. Published by the Substance Abuse and Mental Health Services Administration (SAMHSA). HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

ADDENDUM B

The National Child Traumatic Stress Network "What is a Trauma-Informed Child and Family Service System?"

https://www.nctsn.org/sites/default/files/resources//what_is_a_trauma_informed_child_family_service_system.pdf

ADDENDUM C

Bibliography

Daley, D. C., & Marlatt, G. A. (2006). Overcoming your alcohol or drug problem: Effective recovery strategies. Oxford University Press.

National Institute on Drug Abuse (NIDA); National Institutes of Health; U.S. Department of Health and Human Services. Principles of Drug Addiction: A Research-Based Guide. (January 2018), Found at: https://www.drugabuse.gov