Arizona Judges Guide to the Department Service Array

In July 2021, the Department of Child Safety (the "Department") implemented a new service array meant to better address the needs of parents and children involved with the Department. While these services were initially phased in based on case type, all case types are now subject to the new service array. It is tempting to try to associate the new service array with the Department's prior services but such an approach will likely result in confusion as to which service is appropriate. This guide is meant to help Arizona judges better understand the Department's current service array and answer commonly asked questions about those services.

New Service Array

Family Connections (FC): FC is a trauma-informed service that assesses numerous aspects of family and child well-being to assist parents in making necessary behavioral changes to meet their child(ren)'s needs. Upon initial referral, a FC consultant must meet with the family within one-day. At that initial meeting, the FC consultants will conduct a stabilization assessment to determine if any crisis or concrete support services are immediately necessary. A more formal assessment will occur by the 30 day mark to determine what other supports are necessary to assist the family, and an FC Service Plan will be developed by the 45 day mark. The FC consultant will continue to engage in formal assessments at 90-day intervals thereafter. At each assessment, the FC consultant is assessing the families' functioning, social support, family resources, parenting attitudes and behaviors, stress, and child well-being to determine what additional community resources may be appropriate. Although connecting parents with additional community resources is an important aspect of the FC service, it is not the only service they are performing. The FC consultant is also providing direct coaching to assist parents with their problem-solving abilities and using trauma-informed interview techniques to help parents develop insight and motivation for change. The FC consultant provides this service at their weekly meetings with the parents; there are some parents who will have the FC consultant meetings once-per-week, others will have the meetings twice-per-week. The meeting frequency will be determined by the parents' needs and other services the parent is engaged in. Although the formal assessments occur at the intervals above, at each meeting the FC consultant is conducting informal assessments to assist the family. Note: this service does not substitute for therapy. The FC consultant is not a therapist. Although some of the service provision is therapeutically informed, it serves a different purpose than therapy where appropriate. There are a lot of direct services the FC consultant may provide:

1. Motivational interviewing
2. Provision of concrete resources
3. Social support interventions
4. Child development remediation
5. Parent education
6. Cognitive behavioral interventions
7. Genuine and empathetic helping relationship
8. Problem-solving coaching
9. Crisis intervention
10. Grief and loss work
11. Narrative techniques to address trauma
12. Family system interventions
13. Service facilitation

The Department's description of the program is available here.

Nurturing Parenting Program (NPP): This service provides an evidence based parenting curriculum. The website (https://www.nurturingparenting.com/) describes the programs as "family-centered trauma-informed to build nurturing parenting skills as an alternative to abusive and neglecting parenting and child-rearing practices." The NPP Practitioner will meet with the parent approximately one-time per week to conduct a parenting session. Included in the parenting session is 1 hour of parenting education and activity preparation, 30 minutes of a nurturing activity for the parent and child and 30 minutes of parent-only debrief to discuss how the parent did in implementing the new skill set. More information about this service is available here.

Safety Management Services for Parenting Time[1]

- **Supervised Visitation (SVO)**: This is the same as the ongoing service. This provider is currently only used to supervise the visits to mitigate safety threats. However, the Department is currently working to modify this approach and it is likely that in the future an SVO will also provide some parent coaching during visits. An SVO is separate from a case-aide. A case-aide is a direct Department employee. An SVO is an outside contractor. More information about the SVO service is available here.

- **Clinically Supervised Parenting Time (CSPT)**: CSPT is to provide parenting time supervision and coaching by a qualified mental health clinician. This service is generally indicated in cases of severe abuse, medical child abuse, and parent-child alienation. It is important to note that this is not a therapeutic intervention but is meant to address heightened safety concerns. A longer description is available here.

- **Family Therapy**: When therapeutic intervention is necessary to rebuild or restore the relationship between a child and the parent the Department should work through the RBHA to obtain family therapy for the parent and child. Often children may be hesitant to even engage in this service in the event of severe alienation; it is generally best to defer to the child and family team to determine when and whether this service is provided and used.

Note: each service listed above is a *separate* service. Although they may be providing by the same contracted provider they are not one service. A JO may order the provision of one of them, two of them, or all of them, and in any combination. As always, the Court can order the services however the JO deems appropriate to manage safety threats and assess behavioral change. The Department, however, is attempting to refer them in a way that will not overwhelm the parents with unnecessary services. When ordering the various services, it is best practice to ask the Department what safety threat the service is meant to address to ensure that the Department is discussing the correct service, especially as they themselves become accustomed to the new service array.

[1] Note: visitation is both a constitutional right and can be a service. The service is the various forms of supervised or partially supervised visitation to address either (a) safety management at visitation, if necessary; (b) parenting coaching and skills training at visitation; or (c) therapeutic intervention during visitation.

Existing and Ongoing Services

Arizona Families FIRST: Families FIRST is a DCS contracted service to provide evidence-based substance abuse treatment. The program provides an initial assessment to determine what level of care, if any, a parent needs to be able to address any identified substance abuse issues. Depending on the recommended level of care, a parent may participate in services daily, three-times per week, or one time per week; in-patient or out-patient. Medically assisted treatment, recovery maintenance, and services to treat the whole family are also available. These sessions may include both individual sessions and group sessions. In Maricopa County, TERROS Behavioral Health contracts to provide this service. TERROS can provide additional services, such as psychiatric evaluations and therapeutic interventions, as appropriate. The service includes Care Coordination to keep the parent engaged in services and connect to community resources. When a parent is receiving services from AFF, a referral to FC may be redundant. More information here.

Substance Abuse Testing: The Department will submit a referral in many cases either rule-out urinalysis testing or ongoing urinalysis testing. This drug testing is usually random and scheduled two-times per-week. You can find additional details about how the Department assesses the need and frequency for drug testing here.

Behavioral Health Services through the RBHA: The Department does not provide direct referrals for behavioral health services through the RBHA, such as psychiatric evaluations, individual therapy, domestic violence therapy, or similar services. However, the Department will coordinate with the RBHA to help obtain these services if the parent has public health insurance. The Department may provide a direct referral for behavioral health services through DCS contract if a parent is denied for public health insurance or does not otherwise qualify to obtain health insurance, or the service is needed to guide permanency planning decisions rather than clinical treatment. Examples of the latter situation include bonding and best interest evaluations.

Psychological Evaluations. After consulting with a unit psychologist, or receiving a court order, the Department will submit a referral for a full-scale psychological evaluation. Depending on the provider, the psychological evaluation will provide somewhat different information. Most psychological evaluations will contain a narrative section based on a review of Department provided documentation, a summary of the psychologist's interview with the parents, a battery of tests, such as the MMPI, diagnoses, and recommendations. The recommendations are usually related to direct questions posed to the psychologist by the Department, such as a parent's prognosis to be able to safely parent the child, and if there are any interventions that may be necessary. A longer description is available here.

SENSE: The substance exposed newborn program is an intensive in-home service intended to prevent removal of a substance exposed newborn where the child can remain in the home safely with certain interventions. The SENSE team usually has a nurse, case manager, and other individuals involved to provide a parent with parenting skills and substance abuse treatment. This service partners with the Families FIRST provider to provide wrap around services. This program includes coordinated services from Family Connections, Arizona Families FIRST, and a home visiting program such as Healthy Families. More information here.

Services No Longer Applicable

The following services will no longer be available to order: BRF (family preservation team); in-home (moderate and severe); family reunification team; and parent-aide. These services had been in various states of disengagement previously but now are all be unavailable going forward.

Questions

These are the questions that I have either struggled with the most or what I have heard from other JOs and what I believe are the answers:

1. **What is the difference between a parent-aide and FC/NPP/SVO?** A parent-aide was a singular service that provided parenting skills classes (the "skill sessions") and supervised visitation services. The FC program is an entirely new concept and there is really no direct analogy to prior services offered. In addition, the curriculum that the parent-aide was previously offered varied between the various contract providers. NPP will provide a universal curriculum that is evidence based and trauma-informed to each parent with an Arizona DCS case. FC and NPP do not supervise parenting time.

2. **What is the difference between a FC and BRF or FRT?** An FC will remain with the parent as long as the service is necessary and is not based on a certain amount of time. FC is also available before and after a dependency case has initiated/closed. In other words, if a case starts out as an in-home, transitions to an out-of-home, and then moves back to an in-home, the same FC will remain throughout all of those transitions. In the past, if that occurred, the BRF or FRT would have immediately closed and then we would have needed to wait for a parent-aide. FC, among the other items described above, will connect the family to appropriate resources, if they are needed. Instead of providing the same presumptive set of services for every family as BRF or FRT or may have, FC conducts more individualized assessments to connect the appropriate services that help remedy an identified safety threat, or impact child well-being.

3. **Should I order FC, NPP, and SVO at the same time?** The Department will assess each family individually to determine which of the services are most appropriate. Whereas the Department essentially always reflexively offered a parent-aide (and we generally ordered one), the new services are more specifically tied to behavior change outcomes. Before knowing which service is appropriate, we need to be clear on what the necessary behavior change is. The services are indicated in the following situations:

    a. FC: Families with a behavior change goal related to family connections and roles, social supports, family resources, parenting attitudes and skills, parenting stress and coping skills, and general child well-being. Some examples:

        i. Home is hazardous;
        ii. Parent lacks connection to community resources for food, shelter, medical care, etc.
        iii. Child has unique or special needs and parent needs help accessing community resources to address those needs;
        iv. Parent needs assistance to connect to social supports;
        v. Parent is experiencing high-stress from the parenting role.

b. NPP: If FCC is offered/ordered, the Department's preference is that we do not order NPP at the PPH/IDH. Instead, they would like to have DCS coordinate with the FC consultant to make that assessment and determine whether NPP would be of benefit or if there are other, more applicable, community resources (e.g., if the barrier is stable housing as assessed, NPP is not going to be helpful for that.) If the Department is not offering (and we are not ordering FC) at the PPH/IDH they may then immediately offer the NPP program. NPP is appropriate for families that have a behavior change goal related to parent empathy, age-appropriate expectations of the child, non-violent discipline, family roles, and age-appropriate child power and independence. Some examples:

   i. Parent provided inadequate supervision due to lack of age-appropriate expectations or child independence;
   ii. Parent injured the child during discipline;
   iii. Parent has unrealistic expectations about child behavior;
   iv. Child's behavior is a safety threat;
   v. Parent has negative perceptions of child or lacks empathy;
   vi. Parent puts own emotional needs above self.

c. SVO: this is the same, essentially, as it was previously. We should continue to push the Department on whether supervised visitation is actually necessary instead of being a reflexive 2x/2hr or 1x/2hr per week. The progressive parenting guides (parts 1 and 2) remain helpful in determining the appropriateness of this service and the Department should be following it.

4. **How do NPP and FC relate to Families FIRST?** Neither the NPP nor FC consultant will provide direct substance abuse treatment. There may be portions of the NPP curriculum that highlight the risk that substance abuse poses to children, and the FC may provide additional support services either directly or indirectly through the resources described above, but Families FIRST remains the primary provider of substance abuse treatment. It may be the case that due to a parent's chronic substance abuse that neither NPP nor FC is indicated. In cases where a parent is disconnected from reality it will be necessary for a parent to first meaningfully participate in Families FIRST. As a practical matter, if a parent is in-patient or in detox, whether through Families First or another provider, it will likely make sense to wait for a parent to finish that program before ordering FC or NPP, as appropriate. In addition, Families FIRST has a case coordination service that occasionally operates in a similar manner to the FC consultant.

5. **How do NPP and FC relate to behavioral/mental health?** NPP is unlikely to have much, if any, overlap with the various behavioral/mental health services through the RBHA. Some of the services by the FC will have an effect of improving mental health, such as cognitive behavioral interviews, narrative techniques to address trauma, and grief and loss work. In addition, the FC consultant may be a helpful addition to identify and locate services that will meet the parents' behavioral/mental health needs.

6. **Are there times when NPP or FC is indicated but the Department won't recommend it?** Yes. Among the more obvious situations (no contact order, parent incarcerated, etc.) the Department does not recommend these services when "mental or physical health

impairment require stabilization before parent could benefit from FC (i.e., active psychosis, physical illness requiring hospitalization or residential care, pervasive substance use impacting reality orientation)…" In those cases, mental health services through the RBHA, substance abuse through Families FIRST, or physical care may be appropriate to see some preliminary behavioral changes. This is a case-by-care determination.

7. **Can I order all three programs?** Yes, just as we order services over the Department's objection on a regular basis, there is nothing that would prevent us from doing so now. Of course, the Department will object if we are not following the process outlined above, but there is nothing new that prevents us from ordering these services as appropriate. I assume that most parent's attorneys are going to reflexively ask for all three services in every case due to the continuing service checklist mindset instead of a behavioral change mindset. The services are meant to effect a behavioral change, not check boxes. All that said, we can order any combination of the services that we deem appropriate. We should continue to push the Department to identify what the identified safety threats are and how each service is meant to address that threat, as opposed to what services are available as a stand-alone question. If we are ordering a service for a parent that does not address an identified behavioral change we may just be setting them up for failure by requiring them to engage in yet another service.

8. **Will FC or NPP continue even after a case is dismissed?** Yes. The Department can offer FC and NPP to parents without a dependency. Part of the new federal legislation in fact has helped spur some of this change because it provides more funding for these types of programs to avoid the removal of children and the provision of more services to prevent removal. I would expect us to start seeing more cases where the parents might already be set up with FC and NPP coming in to the PPH/IDH because the Department was working with the parents more prior to removal. Similarly, because the Department can provide these services without Court intervention (as they have always been able to do with BRF, SENSE, and substance abuse treatment these services can (and I would assume often will) continue after a case is dismissed. Dismissal is based on whether there continue to exist any safety concerns that present an unreasonable risk of harm to the child(ren), not whether parents have completed services. This is the position the Department has been transitioning to, so there should not be arguments that a case needs to remain open to "complete FC" or "finish NPP."

9. **Is there a set timeframe for FC?** Yes, and no. Compared to FRT/FPT and parent-aide services that had somewhat strict timeframes (i.e., FRTs were essentially always 4-months unless an extension was necessary) an FC is more fluid. However, there are pretty strict timelines for the assessments and what will occur at those assessments. Given those timelines, it is very unlikely that we would see an FC close out within the first 90-days of intervention since the first "big" assessment occurs at that time. Technically, the contract specifies that the default length of an FC consultants assignment is for 150 days.

10. **How does the FC assessment relate to a psychological or psychiatric evaluation?** They are entirely different from each other and should not be conflated. We should continue our practice of ordering psych evals as necessary. The formal assessments that an FC conducts at 30-days and then every 90-days thereafter is completely different than a psychological evaluation. The use of an FC or a psychological evaluation does not obviate the need for the other service. Similarly, it continues to be unnecessary to need both types of

assessments in every case. In addition, the FC is assessing different information. Frankly, I am hopeful that the assessments done by an FC will actually be more useful to the parents because the FC will have regular, ongoing contact. Psychiatric evaluations will need to continue through the RBHA as before; certainly the FC will not have authority to make any diagnoses, prescribe medication, or engage in medication management.

11. **Isn't the FC basically just a more involved case manager?** No. The case manager maintains the obligation to assess safety threats, barriers, the safety and service plan, and the coordination of all services, both for the parents and the children. The FC will likely have more contact with the parents, but this has always been true of BRF/FRT/PA workers, not to mention therapists, substance abuse providers, etc. The case manager remains the central person who will collect all information and has the ongoing duty to make sure that appropriate services are in place.

12. **Will I receive reports from the FC or NPP?** We may receive these as normal disclosures, and I assume that such reports would often be marked as exhibits at trial. However, for RR/Perm Hearings, the Department's court report will remain the most important document that collects and summarizes all of the information for our review.

13. **Is this going to create a disclosure issue?** Maybe. Instead of having one provider who submitted disclosure regarding visits, skill building etc., we may have up to three different agencies who are creating different reports. We are likely to hear some complaints regarding delay but this is nothing (unfortunately) new with regards to disclosure.

14. **Does NPP replace any community parenting classes?** Maybe. If parenting skills are an identified safety concern, I would order the NPP service instead of ordering the parents to obtain parenting classes in the community. Of course, there may still be some benefit from a parent obtaining additional parenting classes if unique situations, but I think it should be generally rare to order parenting classes in the community instead of NPP.

15. **Does a case have to have FC to transition to an in-home?** No. Just as a case did not have to have an FRT to return the children, a case does not require an FC at that time of transition. Theoretically, however, unlike an FRT, we would have already had FC in place in many cases prior to being at the reunification stage since they can be referred at any time in a case's life, not just before immediate reunification. The new service array is meant to more directly address the needs of the parents and assessed safety threats, as opposed to reflecting the case status.

16. **Is there a best practice as to when an FC should be referred/ordered?** As mentioned above, the best use of an FC is when there are not other obvious safety threats that would negate the use of the FC. I think it is likely that parents' attorneys will ask for an order for an FC at the PPH/IDH because they won't want their client to have to (a) wait for the referral to be picked up and then (b) wait the 30-days for the formal assessment. However, if a parent is in-patient (and perhaps even IOP) for substance abuse, or a similar level of care for MH (or just completely unmanaged mental health), the FC will not add a lot to a case until those issues are resolved. This is where the services being separate are beneficial: we can still order NPP (if appropriate) and SVO without needing to use the FC resource. Similarly, it doesn't make much sense to order FC in substantial abuse cases that are headed towards

termination relatively quickly. In practice I think that I will order an FC in the following situations:

a. Case is an in-home and parents are not already engaged in the SENSE program (this is the one prior program that remains.) I believe that many of these cases will come to the IDH with an FC already assigned.
b. Parents are engaged in their substance abuse services and regularly testing. Even if those tests are positive, if the parents are regularly engaged I would likely order an FC.
c. There are no allegations of substance abuse/mental health/abuse, but instead the case largely revolves around domestic violence, unstable housing, or other general neglect issues.
d. Case is clearly heading towards reunification in the next 3-4 months assuming that behavioral changes continue.

17. **Is there a best practice as to when NPP should be referred/ordered?** This answer will likely evolve as we see the implementation of NPP and see how it is used in practice. NPP is useful when there are indications that a parent has diminished parenting skills, not specifically related to substance abuse or mental illness. In other words, there are cases where a parent cannot parent due to their substance use. However, when that parent is clean and sober they have appropriate parenting skills. In those situations NPP is not addressing any identified safety issue. In most cases, however, parents have both the safety issues of substance abuse/MH/DV and diminished parenting capacities. Just as with FC (and previously with parent-aide), NPP is unlikely to be very useful if a parent is still using drugs and not engaging in any services, or in the midst of mental health problems and not compliant. In those cases, I would likely hold off on ordering NPP until a parent shows engagement at least with the SA/MH services. Not necessarily sobriety, but at least behavioral changes towards addressing those issues.