

Practice Improvement Protocol 9

The Child and Family Team



**Developed by the
Arizona Department of Health Services
Division of Behavioral Health Services**

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ADHS PRACTICE IMPROVEMENT PROTOCOL: THE CHILD AND FAMILY TEAM

ISSUE: The assurance that all TXIX and TXXI eligible members under the age of 21 receive behavioral health services in keeping with the 12 Arizona Principles.

PURPOSE: To establish protocols that effectively operationalize the Child and Family Team approach in Arizona.

TARGET POPULATION: All TXIX and TXXI eligible members under the age of 21 receiving behavioral health services through the T/RBHA system.

BACKGROUND: ADHS is committed to the provision of behavioral health services to children through family-centered practice. Such practice is based upon a coordinated, flexible, family-driven process that:

- Explores and documents the strengths and needs of a child and family;
- Establishes and prioritizes service goals;
- Identifies the supports necessary to meet those goals;
- Describes a course of action encompassed in a written plan developed by team members;
- Monitors accomplishments; and
- Determines the responsibilities of all team members in these efforts.

DEFINITIONS:

- **Child and Family Team:** The Child and Family Team is a group of people that includes, at a minimum, the child and his/her family, any foster parents, a behavioral health representative, and any individuals important in the child's life and who are identified and invited to participate by the child and family¹. This may include, for example, teachers, extended family members, friends and other natural supports, family support partners, healthcare providers, coaches, community resource providers, representatives from churches, synagogues or mosques, agents from other service systems like Child Protective Services or the Division of Developmental Disabilities, etc. The size, scope and intensity of involvement of the team members are determined by the objectives established for the child, and by which individuals are needed to develop and coordinate an effective service plan, and can therefore expand and contract as necessary to be successful on behalf of the child.
- **Clinical Liaison:** As the concept applies to the Child and Family Team, a Clinical Liaison is a Behavioral Health Technician or Behavioral Health Professional who has met ADHS credentialing and privileging standards and whose responsibilities are to support the family in the development of the Child and Family Team, to provide clinical oversight and consultation to the Child and Family Team process and to advise the team on services, natural supports and

¹ In the case of children who may be legally dependent or delinquent, the custodial agency participates in the selection of team membership with the child and family.

providers whose involvement may benefit the team. Clinical liaisons are the individuals also responsible for performing the initial core assessment when additionally privileged to do so. A Clinical Liaison will be involved with every Child and Family Team.

- **Family:** The primary care-giving unit, inclusive of the wide diversity of primary care-giving units in our culture. Family therefore is a biological, adoptive or self-created unit of people residing together and consisting of adult(s) and children, with adult(s) performing duties of parenthood for the children. Persons within this unit share bonds, culture, practices and significant relationships. Biological parents, siblings and others with significant attachment to the individual living outside the home are included in the definition of family.

PROCEDURES:

1. WHICH CHILDREN SHOULD HAVE CHILD AND FAMILY TEAMS?

While the original development of the Child and Family Team process has focused on children and families with the most complex needs, the intent of ADHS is to universally apply the Twelve Arizona Principles, and to use the Child and Family Team process with every child. The character of the team will vary based on the goals, needs and strengths of each child and family. As such, each team will be structured and will function in a unique and flexible manner that will require varying levels of involvement from the Behavioral Health system, other child-serving agencies, and other natural supports.

A further goal is to educate, support and empower families to eventually facilitate their own teams. Until the system has matured to this point, many situations (particularly those serving multi-system involved families, children in out-of-home placements, children transitioning into the adult system, children whose placements are at risk, or children whose service plans have been unsuccessful) will likely require teams with greater complexity, and even designated facilitators. A designated facilitator should be provided to any team requesting one.

2. HOW DO CLINICAL LIAISONS AND OTHER BEHAVIORAL HEALTH REPRESENTATIVES SUPPORT THE WORK OF THE CHILD AND FAMILY TEAM?

When a child and family enter the behavioral health system, the individual completing the initial core assessment assumes the role of Clinical Liaison. During the initial assessment, the Clinical Liaison begins to work with the child and family to develop and support the Child and Family Team, and provides clinical oversight and consultation for the Child and Family Team as an active team member. The Clinical Liaison completes any remaining unfinished necessary assessment processes, modules or addenda. After the next steps for initial services have been decided at the initial core assessment, the Clinical Liaison continues to participate in a consultative role for as long as services are provided. If the identified needs of the child and family so require, the Clinical Liaison may transfer those responsibilities to a different Clinical Liaison who may be better fitted and available to work with them on a long-term basis. In cases

where therapy is being provided, the Clinical Liaison will most likely be the therapist providing services to the child and family.

Each Child and Family Team shall have an assigned behavioral health representative as an active member. This representative may be a Behavioral Health Professional, a Behavioral Health Technician or a Para-Professional, and is responsible for assisting the Child and Family Team in treatment planning, securing behavioral health services, and any other processes requiring involvement or facilitation from the behavioral health system. In most cases, the behavioral health representative will be the Clinical Liaison for that Child and Family Team. With the assistance of the behavioral health representative, the Child and Family Team completes the Strengths and Culture Discovery and assumes responsibility for overseeing and facilitating decision-making regarding the child's behavioral health services and other identified areas of need.

Families have a powerful role in the Child and Family Team process, actively participating in the process of assessing needs, identifying team members, developing and implementing the plan. A key element of enlisting the family's participation is engaging the family with warmth, empathy, genuineness and respect.

The Child and Family Team is responsible for the supportive aspects of service provision and determines which of its members will oversee:

- Ongoing revisions as necessary to the assessment and treatment plan;
- Collaboration with other child-serving agencies or individuals identified as supports to the treatment process;
- Communication within the Child and Family Team;
- Ensuring the maintenance of continuity of care between behavioral health care providers and primary care providers and out-patient and in-patient behavioral health care providers; and
- Ensuring that appropriate covered services and supports are provided.

If the behavioral health representative is not also the Clinical Liaison for the Child and Family Team, their respective responsibilities will be coordinated.

3. WHAT AUTHORITY DOES THE CHILD AND FAMILY TEAM HAVE IN SECURING SERVICES?

The Child and Family Team, with the assistance of the behavioral health representative, is responsible for overseeing and facilitating decision-making regarding the child's behavioral health services. Based upon the recommendations and decisions of the Child and Family Team, the behavioral health representative will formally secure any and all covered services (barring the exceptions listed below) that will address the needs of the child and family. The Child and Family Team is expected to carefully consider and give substantial weight to family preferences in formulating its views on the developing service plan, acknowledging the family's expert knowledge of their child.

In determining how to successfully meet its objectives, the Child and Family

Team should not begin by identifying specific interventions, placements or services, but rather on the underlying needs of the child (and of the family in providing for the child) and on the type, intensity, and frequency of supports needed. As long as decisions are based on comprehensive reviews of the strengths and needs of the eligible child, are in accordance with the Twelve Principles of the Arizona Vision, and have objective and measurable outcomes, the RBHA should provide all covered services decided upon by the Child and Family Team with the following exceptions:

- Level I services which must be prior authorized in accordance with ADHS' policy on prior authorization.
- Covered services that the ADHS/DBHS Medical Director has approved for T/RBHA prior authorization processes in accordance with ADHS' policy on prior authorization.
- Service recommendations that the Clinical Liaison believes to be inconsistent with the Twelve Principles. In such a case, the Clinical Liaison attends all Child and Family Team meetings and actively participates in the service planning process until consensus is reached on a new plan that meets the needs of the child and the family.
- Services not covered by TXIX and TXXI funds.

4. WHAT ARE THE NON-NEGOTIABLES?

Other child-serving systems maintain processes that closely approximate the Child and Family Team process. Although they may use different terminology, (e.g. Person-Centered Planning Processes in developmental disabilities, or Family-Group Decision making processes in child-welfare), these processes can be embraced by the Behavioral Health System as legitimate Child and Family Team processes. What distinguishes a legitimate Child and Family Team process (by any name) is its inclusion of each of the following "non-negotiable" and distinct elements:

- **Strengths and Needs-Based Planning.** A Strengths and Culture Discovery is to be completed for each child and family. This discovery becomes part of the foundation for treatment planning. All services should be customized to creatively reflect the child and family's unique culture and individual strengths in addressing the behavioral health needs of the child.
- **Partnerships with Families.** All plans resulting from the Child and Family Team process must incorporate identified strengths and address the identified behavioral health needs of the child and family. Professional members of the team must therefore be active partners with family members, ensuring that all agreed-upon plans reflect their values, priorities, strengths and needs. An initial goal of the process may therefore be to assist the family in discovering and articulating these factors.
- **Consensus.** All Child and Family Teams strive to reach consensus on the needs of the child and family, on the findings of the assessment process and on the service plan. No decision of the Child and Family Team is to be made

without the approval of the parent or guardian, or, when appropriate, of the child or adolescent him/herself.

- **Jointly Established Behavioral Health Service Plans.** When children have multi-agency, multi-system involvement, a joint assessment is developed and a jointly established behavioral health service plan is collaboratively implemented.
- **Natural and Informal Supports.** Although Child and Family Team membership may vary with changing needs and developing strengths, teams are encouraged to strive towards memberships that are at least 50% natural and informal supports.
- **Collaboration.** Cooperation must be sought beyond the family itself and from other involved agencies, and from the community at large. The team should strive to promote positive connections with all the community has to offer rather than, for example, relying solely on paid supports. When children and families are involved with multiple child-serving systems at once, then collaboration demands the team's full respect for the societal mandates of each involved system (e.g. safety, for child welfare; learning, for education).
- **Ongoing Assessment.** The underlying needs and strengths of each family must be continually reassessed and addressed on an ongoing basis. While the *initial* assessment will always be completed within 45 days after the child and family enter the behavioral health system, the assessment process, including the Strengths and Culture Discovery, must be a continual, evolving course of action, and treatment planning an open-ended process. The Child and Family Team serves as the key point in making adjustments as may be needed to ensure successful goal attainment.
- **Child-Family Team Participation in All Decisions that Affect Them.** Providers must by necessity be able to interact, communicate and consult in the absence of a Child-Family Team. However, no meetings that result in decisions affecting the child and family should occur without the family's full participation. Decisions affecting substantive changes in service delivery should not be made without the participation of the full Child and Family Team.
- **Crisis Planning.** The Child and Family Team develops a crisis plan that predicts the most likely worst case scenario, includes strategies intended to prevent or mitigate that scenario, and a specific plan for what will happen if the crisis nevertheless occurs. Crisis planning seeks only to stabilize the crisis, not to change the overall plan; and incorporates family, friends and natural supports, as well as formal supports if necessary.
- **Flexibility that Avoids Redundant Processes.** Child and Family Teams must be flexible, and when necessary adapt their processes to accommodate parallel processes like DES Family Decision Making or permanency planning meetings, DDD Person-Centered Planning Meetings and Individualized Education Plan (IEP) meetings in special education.

- **Single Point of Contact.** One member of the Child and Family Team is assigned as the single point of contact, and assumes responsibility for coordinating information exchange among Child and Family Team members and providers regarding the provision of service.
- **Cultural Competency.** The Child and Family Team process, from the facilitation of Child and Family Team meetings to the provision of services, should be culturally competent and linguistically appropriate, building on the unique values, preferences and strengths of the child and family and of their community.

5. WHEN DOES THE CHILD AND FAMILY TEAM END?

The Child and Family Team process will be used with all children, regardless of the intensity of their needs. Although the character, frequency, and intensity of the process will vary over time and with changing family needs, the Child and Family Team does not “end” before the child is disenrolled from services or transitioned to the adult system (at which point, ideally, and according to need, the process will continue). Before any child is disenrolled, a crisis plan should be developed that outlines the specific steps that are to be taken to reconvene the Child and Family team, re-establish services and supports should it become necessary. Even at the point that behavioral health services are no longer necessary, or provided through the T/RBHA system, ADHS envisions the ongoing use of the skills, values and activities reflected in the Child and Family Team process.