

**FAMILY-CENTERED PRACTICE
INTERPRETIVE AND CONSULTATIVE ADVISORY
May 16, 2006**

I. PURPOSE

As a result of the Department's review of Pre-paid Inpatient Health Plans (PIHPs), Community Mental Health Services Programs (CMHSPs), and their provider networks, and implementation of family-centered practice with parents and their minor children, several issues have arisen that need clarification. These include:

- The need to develop a clear definition of family-centered practice.
- How to apply person centered planning when working with children, youth and families.
- How to achieve family-centered practice within the CMHSP and its provider networks.
- How documentation should be completed in the Individual Plan of Service when services and supports are provided to the whole family.
- How the Department will review the CMHSP's performance regarding compliance on these issues.

The purpose of this advisory is to provide CMHSPs with the Department's interpretation and consultation on these issues.

II. BACKGROUND

The Person-Centered Planning Policy Practice Guideline states: "The Michigan Department of Community Health (MDCH) has advocated and supported a family approach to service delivery for children and their families. A family-centered approach recognizes the importance of the family and the fact that supports and services impact the entire family. In the case of minors, the child/family is the focus of service planning, and family members are integral to the planning process and its success. The wants and needs of the child and his/her family are considered in the development of the Individual Plan of Service." As the child matures toward transition age, services and supports should become more youth-directed.

The Mental Health Commission Final Report, (Part II), October 15, 2004, p.36, identifies that there is a "lack of consistent standards of care for children's mental health services, e.g., lack of a clear definition of 'family-centered practice', which makes it difficult to require all public and private providers to include the child and family in all decisions about their care." The Commission's Final Report goes on to say that the proposed strategy to resolve this problem is to "develop a clear, consensus-based definition of, and guidelines for, 'family-centered practice', outlining implications and action items and revise MDCH policies on person-centered planning to specify family-centered practice

when children are the identified consumer so that the child and family are included in any/all decisions about their care. Include children in treatment planning by offering them direct information in developmentally appropriate ways about service options” (p. 38).

The 1999 report of The Surgeon General of the United States states, “‘children are not little adults.’ Even more than is true for adults, children must be seen in the context of their social environments, e.g., their family, peer group and larger physical and cultural surroundings. Childhood mental health is expressed in this context, as children proceed through development.”

The article entitled, “The Ecology of the Family” highlights the importance of the principle of interdependence. “One part of the family system cannot be understood in isolation from the other parts. Children cannot be understood outside the context of their families. Any description of a child has to consider the two-way patterns of interaction within that child’s family and between the family and its social environment. Describing individual family members does not describe the family system. A family is more than the sum of its parts.” (Connard and Novick, 1996)

III. DEFINITION OF FAMILY-CENTERED PRACTICE

For the purposes of this advisory, a child is defined as a minor, birth to age 12. A youth is defined as a minor, age 13 to 18. For the purpose of family-centered practice planning, a family defines whom their family is and whom they would like to participate in planning.

Family-centered practice is a planning and service delivery process that:

- A. Recognizes that parents play a unique and essential role in the lives of their minor children and have the greatest influence on the child’s health, growth and development;
- B. Recognizes that enhancing parenting competence and confidence is the best avenue to achieving better outcomes for children;
- C. Is family-specific, individualized by the culture, strengths, concerns, and resources of each family;
- D. Seeks to build a self-empowerment within parents, children and youth;
- E. Promotes resiliency by developing interventions that build competence and skills in children, youth and families, reduces risk and enhances protective factors;
- F. Promotes a child/youth’s ability to assume more choice and leadership as he/she matures and develops in preparation for adulthood.

Participants adhere to the following principles in implementing family-centered practice,

Family-Centered Principles	Principles in Action
Partnerships are developed with parents, children and youth	<ul style="list-style-type: none"> - Families have unbiased access to the same information that providers have including but not limited to MDCH Person Centered Planning Best Practice Guidelines - Families are included in all communication about the family - Families are the primary decision makers about what will work best for their child and family - Families' opinions/recommendations are encouraged, respected and utilized during the planning process and throughout service provision. - Families are supported and encouraged to include children in the planning process - The partnership with youth is enhanced as they are taught the skills to direct their own treatment outcomes
Mutual respect and honesty exist between all partners	<ul style="list-style-type: none"> - Families are treated as valued customers by every staff they encounter - Families are valued and included in every step of the assessment and planning process - Parents and providers receive supportive feedback from each other to help them be effective - Families and providers work together to define responsibilities and roles for carrying out the family-centered plan - No decisions are made without the inclusion of the child and the family - Youth are given information and supported to make choices

Family-Centered Principles	Principles in Action
Planning and services are individualized	<ul style="list-style-type: none"> - Each family's plan is unique and includes the services and supports they choose as best suited to their family - The individualized plan incorporates the child's, youth's and family's strengths and culture into the services and supports delivered - Interventions and outcomes are consistent among mental health agencies, schools, and other organizations that serve the child, youth and family. - Plans (FCP, IEPC, etc.) should be more integrated with schools and other agencies serving the child, youth and family.
Family strengths and individual strengths are recognized and built upon	<ul style="list-style-type: none"> - Families are told from first contacts that the purpose of mental health services is to build on existing strengths and competencies - Help parents and providers focus most on the child's, youth's and family's strengths rather than on their diagnosis or disability - Help parents to recognize the strengths of other family members - Providers identify existing strengths and competencies of the child, youth and family
Family culture is acknowledged and respected	<ul style="list-style-type: none"> - Actively seek information directly from the family about the family culture - Family culture greatly influences the selection of interventions - All written materials are available in the native language or preferred mode of communication with the parents, child and youth. - Follow all Department policies with regard to providing language assistance

Family-Centered Principles	Principles in Action
Parenting competence and confidence are strengthened	<ul style="list-style-type: none"> - Parents receive supportive feedback regarding their current parenting strategies - Parents engage with providers to develop strategies to increase parenting effectiveness - The needs of children and youth are assessed with parents, then parenting strategies are individualized based on the strengths, interests and culture of the child, youth and parent - Assist family members in networking with other family members, agencies and organizations

These family-centered principles are: “belief and value statements about how families ought to be treated, how families ought to be involved in decisions concerning their children, and how services, resources, and supports ought to be made available to families.” (Dunst, 1995)

IV. COMPELLING RESEARCH

Research on family-centered practice is now in its third decade. The focus of the recent research has been on what constitutes effective family-centered practice. Research by Dunst and Trivette (1996) has shown that there are three components of effective intervention: relational practices, participatory practices, and technical quality.

Relational practices include behaviors typically associated with effective clinical interventions such as active listening, compassion, empathy, etc., as well as the positive beliefs that the staff holds about the family. These kinds of practices are typically described in terms of behaviors that strengthen program participant/staff interpersonal relationships increasing mutual trust, developing honesty, forming partnerships and supporting collaboration, etc. (Dunst, 2003)

Participatory practices include behaviors that support family choice and decision making, and which meaningfully involve families in actively procuring or obtaining desired resources or supports or achieving desired life goals. These kinds of practices strengthen existing family competencies and provide opportunities for learning new capabilities. (Dunst, 2003)

Technical Quality includes the sum of the knowledge, experiences and skills that a staff has about effective assessment, planning, services and supports.

While each component is needed to provide effective intervention, participatory practices have been shown to be of particular importance. Research has shown that participatory practices increase the parent, child/youth's belief in their own self-empowerment. A strong feeling of self-empowerment is a predictor of increased motivation (to change), performance (active engagement) and success.

Traditionally, the approach to family-centered practice has emphasized the importance of its relational aspects. It is clear that we now have new knowledge that requires a much stronger emphasis on the active engagement of families in acquiring the skills, knowledge and support they need to improve their own life circumstances.

Family-Centered Practice Across the Age Range

One of the most important tasks of parenting is to prepare children to be the leaders, managers and decision-makers of their own lives. This is true for **every child, their parents and all family members**. Children with disabilities or emotional disturbances, their parents, and other family members are **more like** families where children are typically developing than they are different. While the disability or emotional disturbance certainly impacts the family, it ought not derail the crucial developmental process that needs to take place to prepare children, from birth onward, to successfully lead their own lives upon reaching the age of majority.

Parents and providers need to understand how family-centered practice fits with the child's developmental sequence. Clearly each family's culture, beliefs, and values impact exactly how the sequence will play out for any given child and his or her family, but some general comments can be made.

- When children are younger in chronological age, parents make more of the decisions about their lives. As children grow older, they are expected to make more choices for themselves and direct their plan.
- The amount of support and guidance that parents exert on decision-making is greater when children are younger and lessens as children age.
- To make "good decisions" as adults, children need opportunities to practice from early childhood onward.
- To conceive of themselves as the leader, and decision-maker, for their own lives as adults, children need opportunities to learn how to do this from early childhood onward.
- Children (and parents) have to safely experience the consequences of decisions to learn to make better decisions, e.g., decisions with fewer negative consequences.

The emphasis of family-centered practices thus needs to shift, over the child's life, from supporting parents to make decisions for and on behalf of the child to supporting the youth to make his or her own decisions, in the context of their family's values, culture and beliefs. Outcomes (results) should support the youth becoming more of a decision-maker. As the child matures, strategies to address outcomes should become more youth-directed and incorporate the youth's unique individuality. This shift in the focus of

family-centered practice as the child approaches the age of majority can provide a smooth transition through person-centered planning for the youth and his or her family. The child and family have in fact been getting ready for that transition for the child's entire life.

V. STEPS IN THE IMPLEMENTATION OF FAMILY-CENTERED PRACTICE

There are three major steps in the implementation of family-centered practice by a PIHP, CMHSP and their provider networks:

1. Formal adoption of family-centered principles by the PIHP, the CMHSP and their sub-contractors, including the development of policies and procedures that are used to guide program practices, staff job descriptions, and performance reviews.
2. Application of these family-centered principles to all programs and program staff that serve children from birth to age 18 and their parents, including the development of: standards and benchmarks against which day-to-day program decisions and practices are made and success is evaluated.
3. Evaluation by the parent, child and youth of the PIHPs and CMHSPs adherence to family-centered principles, including the extent to which these consumers judge their experiences, from first contacts onward, as being consistent with family-centered principles.

VI. APPLICATION OF FAMILY-CENTERED PRINCIPLES

<p style="text-align: center;">Essential Elements Person-Centered Planning</p>	<p style="text-align: center;">Interpretive Guidance Family-Centered Practice</p>
<p>1. Person-centered planning is a process in which the individual is provided with opportunities to reconvene any or all of the planning processes whenever he/she wants or needs.</p>	<p>The child, youth and family have an opportunity to reconvene any or all of the planning processes whenever he/she/they want or need.</p> <p>Once a plan is developed, the policy requirement is that the Individual Plan of Service is updated based on the needs of the child and family, and the frequency of review is identified in the plan. Since children develop at a much faster rate than adults, more frequent review of the plan may be warranted if requested by the child and family, or in some instances, as required by certain programs, e.g., Early On, Children’s Waiver, wraparound. These reviews can be documented in progress notes, or as otherwise required by the program.</p>
<p>2. The process encourages strengthening and developing natural supports by inviting family, friends and allies to participate in the planning meeting(s) to assist the individual with his/her dreams, goals and desires.</p>	<p>The child, youth and family determine who should be involved in the planning meeting. The child, youth and family should be asked who they want to participate. If the youth and parent disagree about who should be involved in the planning meeting, the mental health practitioner should help negotiate with them and try to make the process as inclusive as possible. We should encourage inviting system and natural supports as a way to coordinate services and supports.</p>
<p>3. The individual is provided with the options of choosing external independent facilitation of his/her meeting(s), unless the individual is receiving short-term outpatient therapy only, medication only, or is incarcerated.</p>	<p>No interpretive guidance other than this applies to child, youth and family.</p>

<p style="text-align: center;">Essential Elements Person-Centered Planning</p>	<p style="text-align: center;">Interpretive Guidance Family-Centered Practice</p>
<p>4. Before a person-centered planning meeting is initiated, a pre-planning meeting occurs. In pre-planning the individual chooses:</p> <ul style="list-style-type: none"> a. dreams, goals, desires and any topics about which he/she would like to talk about b. topics he/she does not want discussed at the meeting c. who to invite d. where and when the meeting will be held e. who will facilitate f. who will record 	<p>The family should identify the goals, dreams and desires for their child and for their family. The child and youth should also have the opportunity to express goals, dreams, and desires, and these should be discussed at age-appropriate levels for the child.</p> <p>Before a family-centered meeting is initiated, a pre-planning meeting with the family occurs. In the pre-planning meeting the child, youth and family chooses:</p> <ul style="list-style-type: none"> i. strengths, dreams, goals, desires and any topics they want to address or plan for at the meeting ii. topics they do not want discussed at the meeting iii. who to invite iv. where and when the meeting is held v. who will facilitate vi. who will record
<p>5. All potential support and/or treatment options (array of mental health services including Medicaid-covered services and alternative services and Mental Health Code-required services) to meet the expressed needs and desires of the individual are identified and discussed with the individual.</p> <ul style="list-style-type: none"> a. Health and safety needs are identified in partnership with the individual. The plan coordinates and integrates services with primary health care. b. The individual is provided with the opportunity to develop a crisis plan. c. Each Individual Plan of Service must contain the date the service is to begin, the specified scope, duration, intensity and who will provide each authorized service. 	<p>All potential support and/or treatment options (array of mental health services including Medicaid-covered services and B3 supports and services (Medicaid Policy Manual) and Mental Health Code-required services) are identified and discussed with the child and family.</p> <p>Health and safety needs are identified in partnership with the child, youth and family. The plan coordinates and integrates services/supports with primary health care and other systems working with the child and family.</p> <p>The child, youth and family are provided an opportunity to develop a crisis and safety plan. The crisis and safety plan should be a detailed plan addressing the child, youth and family and should identify on a step-by-step basis what each family member is to</p>

<p style="text-align: center;">Essential Elements Person-Centered Planning</p>	<p style="text-align: center;">Interpretive Guidance Family-Centered Practice</p>
<p>d. Alternative services are discussed.</p>	<p>do during a crisis.</p> <p>A crisis plan should be developed to address the things/events that might happen, and if a plan is not developed, it may result in an increased risk and safety concerns.</p> <p>A safety plan should be developed when there is a risk to the child, family or community safety.</p> <p>Both crisis and safety plans should have both proactive and reactive steps build in.</p> <p>Each Plan of Service must contain the date the service is to begin, the specified scope, duration, intensity and who will provide each authorized service.</p> <p>B3 supports and services are also discussed.</p>
<p>6. The individual has ongoing opportunities to express his/her needs and desires, preferences, and to make choices. This includes:</p> <p>a. Accommodations for communication with choices and options clearly explained shall be made.</p> <p>b. To the extent possible, the individual shall be given the opportunity for experiencing the options available prior to making a choice/decision. This is particularly critical for individuals who have limited life experiences in the community with respect to housing, work and other domains.</p> <p>c. Individuals who have court-appointed legal guardians shall participate in person centered planning and make decisions that are not delegated to the guardian in the Guardianship Letters of</p>	<p>No interpretive guidance other than change individual to child, youth and family and the Individual Plan of Service will include involvement of all applicable family members.</p>

<p style="text-align: center;">Essential Elements Person-Centered Planning</p>	<p style="text-align: center;">Interpretive Guidance Family-Centered Practice</p>
<p>Authority.</p> <p>d. Service delivery shall concentrate on the child as a member of a family, with the wants and needs of the child and family integral to the plan developed. Parents and family members of minors shall participate in the person-centered planning process unless:</p> <ol style="list-style-type: none"> 1. The minor is 14 years of age or older and has requested services without the knowledge or consent of parents, guardian or person in loco parentis within the restrictions stated in the Mental Health Code; 2. The minor is emancipated, or; 3. The inclusion of the parent(s) or significant family members would constitute a substantial risk of physical or emotional harm to the recipient or substantial disruption of the planning process as stated in the Mental Health Code; justification of the exclusion of parents shall be documented in the clinical record. 	
<p>7. Individuals are provided with ongoing opportunities to provide feedback on how they feel about the service, support and/or treatment they are receiving, and their progress toward attaining valued outcomes. Information is collected and changes are made in response to the individual's feedback.</p>	<p>Children, youth and families are provided with ongoing opportunities to provide feedback on the impact of their services, the support and/or treatment they are receiving, and their progress toward attaining valued outcomes. Changes in the plan are made in response to the youth and family's feedback. A dynamic process is important for children and families because of rapidly changing developmental needs.</p>
<p>8. Each individual is provided with a copy of his/her Individual Plan of Service within 15 business days after their meeting.</p>	<p>No interpretive guidance other than change individual to child, youth and family.</p>

VII. INDICATORS OF FAMILY-CENTERED PRACTICE IMPLEMENTATION

Systemic Indicators	Interpretive Guidance
1. The PIHP/CMHSP has a DCH-approved policy or practice guideline that delineates how person-centered planning will be implemented.	The PIHP/CMHSP has a DCH-approved policy or practice guideline that delineates how family-centered practice will be implemented as it pertains to children, youth and families.
2. Evidence that the PIHP/ CMHSP informs individuals of their right to person-centered planning and associated appeal mechanisms, investigates complaints in this area, and documents outcomes.	The parent of a minor child is notified of appeal rights.
3. Evidence that the PIHP/CMHSP quality improvement system actively seeks feedback from individuals receiving services, support and/or treatment regarding their satisfaction, providing opportunities to express needs and preferences and the ability to make choices. Information is collected and changes are made in response to the individual's feedback.	No interpretive guidance other than change individual to child, youth and family.
4. The PIHP/CMHSP collects information and makes changes when necessary on processes to develop natural supports. Information collected examines the development, initiation, and maintenance of community connections and friendships through the person-centered process.	No interpretive guidance other than change person-centered to family-centered.

Individual Indicators	Interpretative Guidance
1. Evidence the individual was provided with information of his/her right to person-centered planning.	The child, youth and family were provided with written information on family-centered practice and rights related to planning.
2. Evidence that the individual chose topics he/she would like to talk about in the meeting, topics he/she does not want discussed at the meeting, whether or not other persons should be involved, and those identified were involved in the planning process and in the implementation of the Individual Plan of Service.	Evidence that the child, youth and family chose topics they wanted to talk about in the meeting, and topics they did not want discussed at the meeting. They should also chose who should be involved in the planning process and in the implementation of the Plan of Service.
3. Evidence that the individual chose the places and times to meet, convenient to the individual and to the persons he/she wanted present.	Evidence that the child and family chose the places and times to meet, convenient to the child and family and to the persons they want present.
4. Evidence that the individual had choice in the selection of who will facilitate the plan, and treatment or support services provided including staff that will assist in carrying out the activities in the plan.	No interpretive guidance other than change individual to child and family.
5. Evidence that the individual's preferences and choices were considered, or a description of the dispute/appeal process and the resulting outcome.	Evidence that the child and family's cultural preferences, choices, and strengths were considered and a description of the dispute/appeal process provided. There should be a description of the family culture.
6. Evidence that the progress made toward the valued outcomes identified by the individual was reviewed and discussed for the purpose of modifying the strategies and techniques employed to achieve these outcomes.	Evidence that the progress made toward the valued outcomes identified by the child and family was reviewed and discussed formally (specific techniques, i.e. CAFAS, scaling measurement tools, family satisfaction, etc.) for the purpose of modifying the strategies and techniques employed to achieve these outcomes. It is important to discuss and tailor techniques to the child and family – address what works best within the family.

VIII. LEGAL REFERENCES

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