

Building the Capacity for Family-Centered Practice in Michigan’s Changing Mental Health System

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This is a summary of two planning days that gathered people interested in promoting family-centered practice in Michigan.

The first day, 19 September 2002, was a day of reflection and exploration. People represented different perspectives and did not necessarily agree with each other on every point. The organizers asked me –as an outsider to Michigan’s system who is familiar with efforts to create family-centered practice in some other places– to identify the themes I heard in the discussion. The “we” in the summary is for convenience in writing, it refers to people in Michigan who promote family-centered practice but it does not imply unanimity among them. All of the points in the first day summary are taken from the graphic record of the meeting, but I have organized them. Though I checked my understanding at several points, my summary will have missed or misunderstood some important points in the discussion.

The second day, 18 February, focused on sketching options for action. Participants grouped themselves by their interest in taking action on a particular issue. Not all participants would agree with either the selection of issues for action or the action options sketched by other working groups. The record of this day reproduces the charts the groups used to record their work.

– John O’Brien
30 October 2002

Moving from margin to center by becoming sticky

As big structural changes in the way services are financed and planned continue to influence the Mental Health System, there are opportunities to build that system's capacity to practice in a family-centered way.

We have been successful in developing knowledge and skills about family-centered practice and demonstrating its benefits. This success has grown over the years through pilot projects and programs designed and funded as innovations. From the point of view of the people involved in these projects, family-centered practice is central to an effective mental health system. However, the way family-centered practice has grown makes it marginal to many of those who manage the system's reform, especially as the reform rolls out in local systems. It is vulnerable to being defined as one approach to addressing mental health needs, one treatment option among several, rather than as the foundation for the way the whole mental health system sees and approaches its work with children and young people. It is vulnerable to being seen as something "they do in those projects" rather than as a set of values and attitudes that the whole system embodies in its relationships with children and young people and their families. It has even been perceived by some influential advocates in the system's change process as a threat to individual self-determination.

Working together, we have created much family-centered practice "know-how" and "know-why". Our task is to assure that family-centered practice strongly informs the changes the Mental Health system is going through. This means overcoming the pressures that could encapsulate family-centered practice at the edges of the system and finding ways to make family-centered practice "sticky".* In this context, sticky means

* For more on the idea of stickiness, see Malcolm Gladwell (2000). *The tipping point: How little things can make a big difference*. New York: Little Brown & Co.

forging hard-to-shake connections between family-centered practice and as many aspects of the system's change as possible. The idea is not just to keep hold of smaller spaces for family-centered practice to continue to grow, but also to influence as much of the whole, changing Mental Health system as we can.

Though we have learned a lot and involved a growing number of families, advocates, and practitioners, there is much more to learn about family-centered practice. It is not so much a finished solution ready for sale as a way of discovering the many, many different ways that families can be resilient in their particular difficult circumstances. While there are procedures and techniques and tools that we can recommend with confidence, the effectiveness of any tool depends on the ways practitioners use themselves to communicate an attitude of respect for the (potential) strengths and gifts of the families and family members they encounter and high expectations that the mental health system will be able to support families to mobilize those gifts.

Practitioners who are just following orders will not establish the kinds of relationships that allow families to figure out how to grow stronger, no matter how detailed the orders may be or how authoritatively they are issued. This means that getting stuck to family-centered practice means getting stuck to a way of building productive relationships and facilitating creative problem solving, often in uncertain, conflicted, and challenging situations. For many experienced mental health professionals, this kind of getting stuck is a developmental process. As one participant in our discussion noted, "When I first heard about this, I thought it was total BS. As I got the chance to work with it, I began to see the positive difference it can make. Now I believe it's the right way to approach people."

For at least some of us, family-centered practice holds a further challenge: that of seeing children and young people with disabilities as

positive resources to family and community life and seeing ordinary community settings, associations, and citizens as essential resources to family resiliency. This reaches beyond even the ambitious and often elusive goal of coordinating the efforts of a community's formal service systems: education, health, child welfare, juvenile justice. It defines what a family's community offers its most valued citizens as the context for planning and providing assistance. The vision can be expressed in this planning question, "What in your community engages and supports your family now and what could engage your family if disability were not an issue?"

It is worth acknowledging that much more of the current language of systems change in Michigan speaks of "person-centered planning" and "self-determination" than of "family-centered practice". Some people may see conflicts between family-centered practice and self-determination/person-centered planning. These perceived conflicts are occasions to discover stickiness by exploring exactly where the points of difference may lie. Whatever substantive conflicts there may be (and as someone with a claim to know something about both person-centered work and self-determination I do not see any*), there is overwhelming commonality in that all three themes for reform call for similarly deep cultural changes in local Mental Health services.

*Obviously others –to whom I have not had the opportunity to listen- do see important differences, otherwise they would not oppose including explicit reference to family-centered practice in law. I speculate that their differences from my understanding of person-centered planning and self-determination turn on their seeing the "self" in self-determination as an individual with a right to exercise sole power and my seeing that "self" in terms of relationships which can become conflicted and difficult but which are essential to human thriving and denied only at great cost. This deep difference in views actually has few practical consequences as long as those who hold an individualistic view are willing to acknowledge the legitimacy of the perspective that individuals who mobilizing social support for their goals will have more practical power than those who go it alone.

A challenging environment

From the point of view of families who rely on the Mental Health system for assistance, the meaning of family-centered practice is straightforward: "They listen respectfully to what my family sees that we need to keep my son or daughter secure and thriving and then they respond with what we need. If they have too little money to do everything they could, they offer to help us figure out other ways to get what we need and the assistance they do offer us fits our requirements as close to exactly as humanly possible." When a family's contact with the Mental Health system begins in a time of crisis, the system's immediate response to the emergency lays the foundation for a longer term positive relationship. When a family's initial request of the Mental Health system is limited and straightforward –for example, a need for help arranging regular respite, the system's answer communicates a respect and responsiveness that encourages the family to see system staff as potential allies in their further search for ways that they can live good lives with disability. Planning itself should offer support that adjusts to family differences rather than experienced as intrusive: families for whom planning happens on the calendar on the fridge shouldn't feel obligated to create full color posters of their long- term, all-life-domains desirable futures; families who find value in articulating a more expansive and longer-term vision and checking-in regularly to make revisions should have the support to do so.

Current reality makes it difficult for the system to consistently deliver on this straightforward understanding of family-centered practice. This is frustrating for families, some of whom can honestly say, "They aren't doing it. Instead of respectful listening and responsive assistance we get a fight to be heard and programs that don't take account of what we know is most important."

This family frustration is an important comment on the depth of change that family-centered practice requires. More than a change in the structure of financing services, more than a change in organizational structure and staff job descriptions, more than a change in assessment and planning procedures, family-centered practice calls for a deep change in the culture of local Mental Health services.

Each of the following complexities defines a facet of the work of cultural change. Family-centered practice has important contributions to working through each of them. These are, therefore, occasions to look for stickiness, occasions to challenge people to consider the lessons from family-centered practice.

- The Mental Health system is implementing two comprehensive changes at once across client groups with different reasons to seek service, different responses to available service technologies, and different histories. Services are financed through a managed care approach and services are to respect recipient's choices about the services they use as identified through person-centered planning. Though it's possible to make a logical argument that these two changes will work together and increase the Mental Health system's efficiency and effectiveness, the practical test of this argument lies ahead. The ways the system invents to balance recipient choice with the demands of a capitated system will determine a limit of the Mental Health system's effectiveness in responding to individual choice. Hard economic times will make this test more challenging. It is reasonable to expect that courts will intervene in some of the conflicts between recipient choice and rationing scarce funds. It is also reasonable to expect attempts to narrow the definition of "medically necessity".
- Family-centered planning (or person-centered planning) delivers far more when there are capable service providers interested in increasing the variety of responses they can make to different family needs than

when available service providers offer standardized responses with the expectation that recipients will take what they provide. For example, in some communities, people who use home-health services find that existing providers find the idea of taking direction from the users of their services alien and unacceptable.

- Experienced professionals have invested in developing their ability to provide particular types of clinical services. These services can offer real value under some circumstances, but families may require something different than professionals are accustomed to offering. Indeed, some of us feel that effectively facilitating family-centered plans calls for a different skill set than clinical work does. There are two dangers: 1) that necessary clinical services are neglected, and 2) that what professionals prefer to do drives the definition of needs or service responses to needs ("Your family needs what we are comfortable doing.")
- Experienced professionals have developed relationships with service providers that create well-worn pathways. This makes for smooth referrals, but it can also be a barrier to learning new ways to respond to individual situations. This is especially true when a referral pattern results in children or young people being placed in expensive facilities that separate them from their families –sometimes for extended periods of time. While the costs of such placements are high and their long-term effectiveness may be limited, they are known and predictable: one can place a child or young person with confidence in what they will get. More family-centered alternatives may be more uncertain and more demanding.
- The change process has mostly been driven from the top-down. While there have been opportunities for participation in defining requirements, local managers and service workers are called to meet new standards under new fiscal conditions on a time-table that is set from above.

- Services have historically exercised very high levels of control over the people who rely on them. For people with mild and transient impairments, this control takes the form of unilaterally defining what service workers will do and not do. For people with long-term needs for substantial assistance, this control has been more directly life-defining and sometimes is has upheld low-expectations or even been harsh. Historically, services have felt legitimate in dictating to those they serve and often this has been justified by highlighting the deficiencies of recipients. The rising voice of people who use services represents a real, if usually un-discussed emotional threat because it shakes a worldview that has shaped most service programs and many careers.

Given the high degree of uncertainty, the top-down comprehensive change process, and the level of change required, it is a testament to the commitment of local CMH and service provider managers and staff that there are positive examples of family-centered practice to learn from. Resistance to family-centered practice is an understandable response. When it seems like one more in a list of externally imposed requirements, some local managers and staff will...

- Assert that they already practice in family-centered way and that no real change in their own ways of working are necessary. Say that improvements depend on changes in “the other guy”: more funds and staff; greater community support for service programs, etc.
- Appeal to large caseload size and pressure of work as a reason that it isn’t possible to find time to build relationships with families or meet at times and places convenient to families.
- Demand linear, step-by-step instructions for engaging families and for resolving any potential conflicts or difficulties that they can imagine. Expect that these instructions can be delivered to them and

implemented in a minimum time and in a way that makes minimal demands on them.

- Raise concerns about liability and the risks that they imagine that family-centered practice will introduce and treat those concerns as reasons to say “no” rather than as potential problems to be investigated.
- Define family-centered practice as a specialty very different from what they do and ask for places to refer those who demand family-centered practice. Define themselves as unprepared to practice in a family-centered way.
- Talk about unreasonable demands that families have or might make. Talk as if there were a necessary division between family-centered practice and good clinical practice. Talk about family demands that they believe would not make taxpayers angry. Talk as if engaging family members must necessarily conflict with a person’s development or self-determination. Talk about situations in which families have been or might be neglectful, exploitive, or even abusive of their family members. Assume that these concerns are typical of families and represent good reasons to disengage oneself from family-centered practice.

These responses are signals of the extent of the cultural change necessary. Such deep changes call for more than management . They call for leadership committed to the values underlying family-centered practice.

Leverage points

We each identified leverage points that we would allow to percolate through our thoughts and conversations between our two meetings. These include...

Leverage points around family-centered practice:

- Identify those CMH's that produce good family-centered practice and generate good practice examples at each organizational level: direct practice, program, and overall administration. These examples would serve to describe what it takes from staff, program managers, and system administrators to practice in a family-centered way.
- Explore the demands placed on system management by cultural change necessary to learn how to implement systems changes. Focus in particular on how to manage a system that delivers a much wider variety of kinds of assistance, matched to different family and individual demands. Figure out ways for administrators to learn how to manage a system with less uniformity and more variety.
- Systematically inquire in local system's to discover what people say when asked, "If our local system could relate to families as you most want it to, what would be happening?" Include people with disabilities, family members, community members, staff, and administrators. Conduct the inquiry with an assumption of competence and good will.
- Find out what lessons efforts to deliver family-centered health care have for family-centered practice.
- Investigate the connections between family-centered practice and "evidence-based treatment." In what ways does research on clinical effectiveness support family-centered practice? In what, if any, ways does research on clinical effectiveness challenge family-centered practice? In what ways might a system-wide focus on evidence-based treatment threaten or limit family-centered practices? Are there any lessons from the effort to change practice to base treatment on evidence that might inform our efforts to increase adoption of family-centered practice?
- Strengthen those who are currently involved in family-centered practice. Focus in particular on people who plan with families and create opportunities for them, and the families they support, and facilitate their reflection on what they have learned and what they want to do to improve their practice. Broadcast this learning throughout the system.
- Identify positive roles that family members, children and young people can play in shaping local change. Support them to move beyond focus on themselves to become influential in their local system. This may be through well supported memberships on boards and committees in local services or in community associations.
- Increase the legitimacy of family-centered practice by insuring that state wide conferences related to changes in the system include children and young people and their families and those who assist them as featured speakers.

Leverage points specific to the relationship between family-centered practice and person-centered planning:

- Increase the number of external facilitators who are competent to assist children and young people and their families to produce person-centered plans. Carefully monitor possible certification requirements for facilitators to assure that no one committed to family-centered practice would be excluded, especially capable family members who may lack professional credentials or people who may learn best through local apprenticeship and mentoring. Explore how young people might be active in facilitation roles.
- Clearly state the values, attitudes, knowledge, and skills necessary to competently plan with families.
- Compile examples of effective planning. Identify the web of questions and actions that can lead to better planning.

- Create ways to supplement or even to replace existing training methods. For many people workshops or short training courses are not enough. Explore mentoring arrangements, facilitator support groups, etc.
- Increase people's access to different ways to facilitate plans.

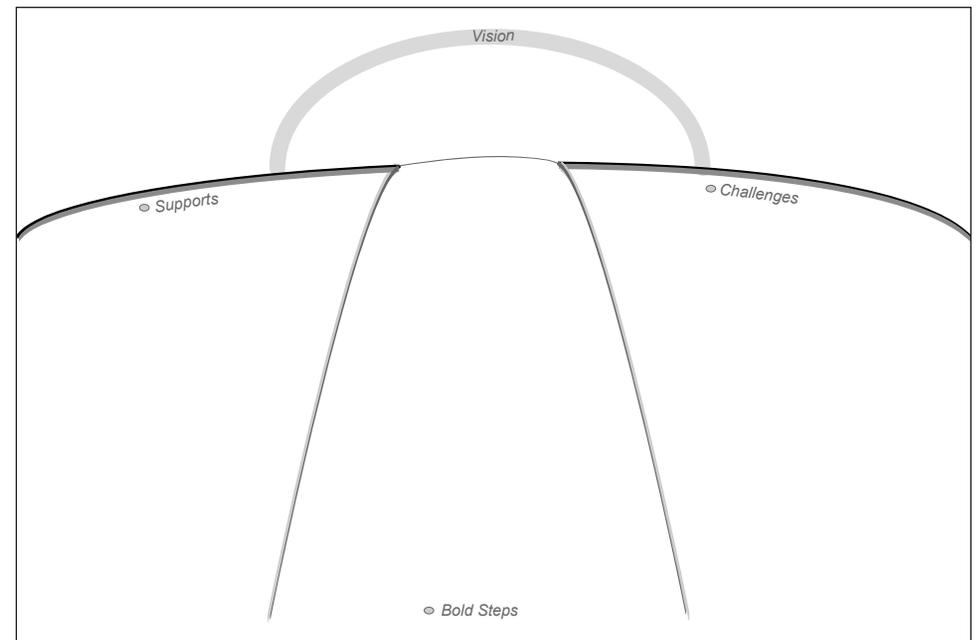
Options for Action

In its second meeting, the group organized into smaller groups around potential leverage points on the basis of personal interest in taking action on an issue. The first round of small group work organized around some of the leverage points identified in the first meeting and listed above. After these groups reported to the whole group, the whole group identified a new set of actions based on discussion of themes for action that connect the options identified in the first round of work. The group reorganized around these themes and outlined further options for action. As a final step, group members signed up to accept responsibility for moving action forward.

Because every leverage point calls for the involvement of people and groups not present in the planning process at the planning stage, working groups produced an outline to use as an initial proposal to recruit others to join in more detailed planning and action. Most groups used the simple template in the figure on the right side of this page to guide their discussion and record their findings. (This is based on David Sibbet's "Five Bold Steps Vision Template", see www.grove.org).

Connie Conklin volunteered to check-in with people connected to each option to encourage action.

The following pages summarize the set of actions the group explored and reproduce the posters the groups made to outline the results of their work.



Network of Actions to Strengthen Family-Centered Practice

Communities come together around FCP values & beliefs

FCP is embedded in the whole system

There is a clear, widely accepted statement of what FCP is / is not

The system delivers services within a system of care, utilizing evidence-based practices, in the context of FCP

Competent facilitators are available statewide

Knowledge about FCP is gathered in a usable form

A variety of FCP learning opportunities are regularly available

Good practice examples are collected and diffused throughout the system in a way that affects outcomes for families

Children's Diagnostic & Treatment Rules support FCP

Independent FCP facilitation is recognized by funding sources

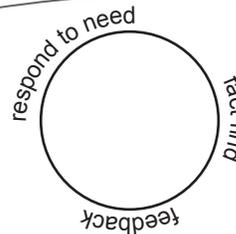
Communities Come Together Around Family-Centered Practice

Vision

Common understanding about family-centered practice
Coming together as a community around values and beliefs

● *Supports*

- Explain the benefits of family-centered practice for each partner:
 - agencies: increase cost-effectiveness
 - families: increase capacity
- Building on what's there - Chamber of Commerce; infrastructure
- Infuse principles in all partners (strategic plan)



The who in each community (leaders) (visionaries)

- Asking each community to hold community forums (town talks) & focus groups
- Holding group for information & inquiry to move system strengths & barriers up to regional & state levels for:
 - best practice models
 - system changes



Theresa, Kathleen

● *Bold Steps*

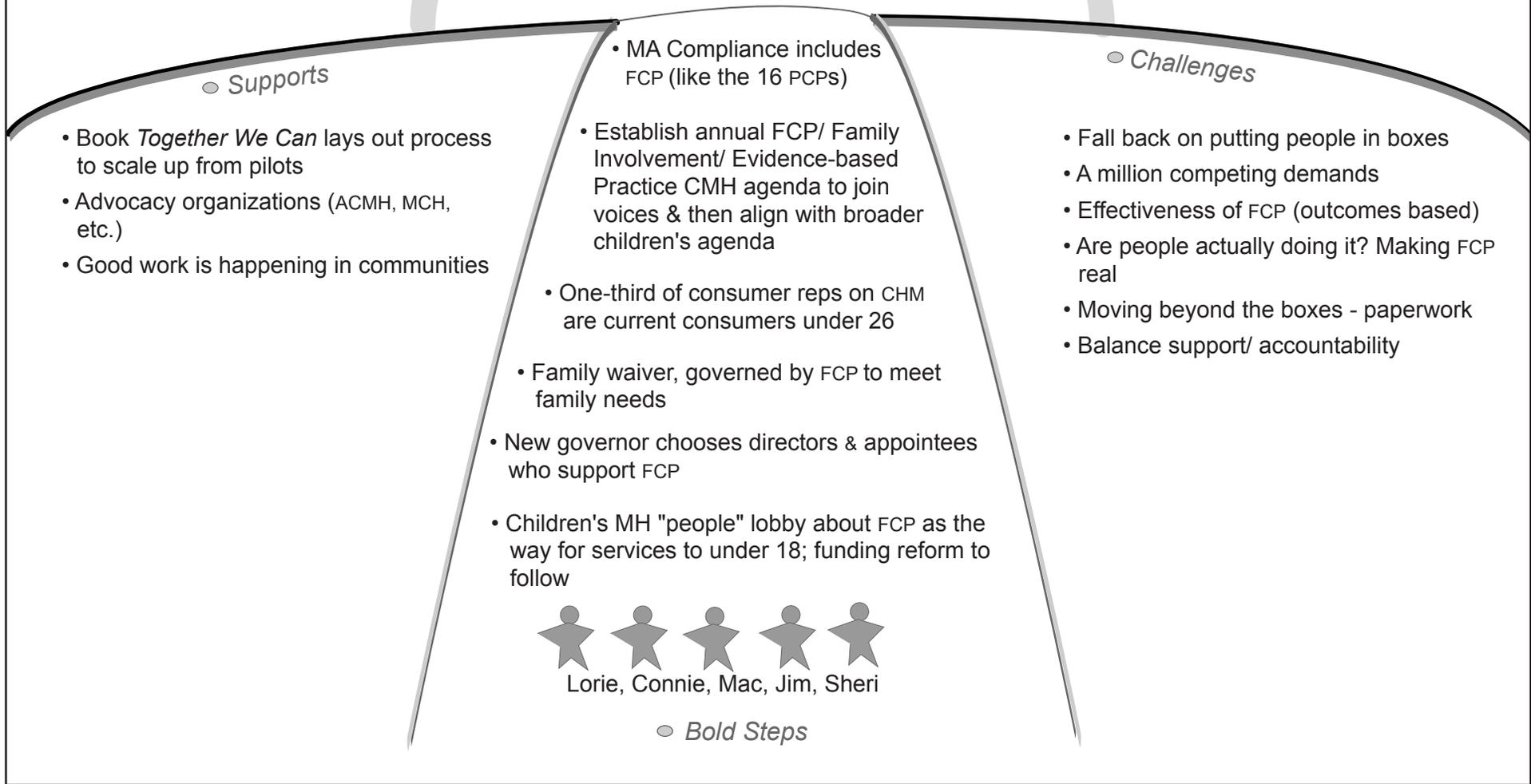
● *Challenges*

- Time issues up front
- Turf
- Trust in partners
- Flexible funding
- Finding circles on influence to make it happen
- Finding & communicating with each partner (how to get unheard voices)
- Responding to cultural & ethnic needs

Family-Centered Practice Is Embedded in the Whole System

FCP projects "go to scale" (embedded in compliance regulations)
 Strong commitment to funding, policies, & procedures that follows & supports family-centered practice
 CMH Certification depends on FCP Certification for staff
 People with influence & authority require FCP in public agencies
 FCP has same imperative as PCP (policy, compliance, quality)
 Mission based indicators on FCP for CMH • Advocates express political support for FCP

Vision



● *Supports*

- Book *Together We Can* lays out process to scale up from pilots
- Advocacy organizations (ACMH, MCH, etc.)
- Good work is happening in communities

• MA Compliance includes FCP (like the 16 PCPS)

- Establish annual FCP/ Family Involvement/ Evidence-based Practice CMH agenda to join voices & then align with broader children's agenda
- One-third of consumer reps on CHM are current consumers under 26
- Family waiver, governed by FCP to meet family needs
- New governor chooses directors & appointees who support FCP
- Children's MH "people" lobby about FCP as the way for services to under 18; funding reform to follow



● *Bold Steps*

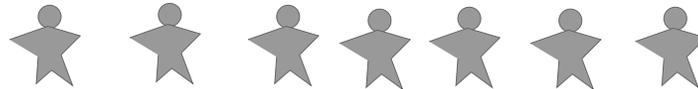
● *Challenges*

- Fall back on putting people in boxes
- A million competing demands
- Effectiveness of FCP (outcomes based)
- Are people actually doing it? Making FCP real
- Moving beyond the boxes - paperwork
- Balance support/ accountability

A Clear Statement of What Family-Centered Practice Is/Is Not

Adopt a Single Statement of What Family Centered Practice Is/ Is Not
Through Collaboration Between Families and Other Champions

- Gather existing statements that define family centered practice. Language matters, so screen out any that are obviously inadequate. Then randomly pick one.
 - Define values that support the definition
 - Cross-system stakeholder group (including educators, parents, and youth) picks definition and defines supporting values
 - Make the selection at a party, and define supporting values there too
- Create tools that measure the implementation of family-centered values in practice
- Produce documents that define what family-centered practice is/ is not for different audiences



Joan, Connie, Nancy, Lori, Sheri, Kathleen, Sherry,

Family-Centered Practice, System of Care, Evidence-Based Treatment

Vision

To create a public mental health system where services/supports are delivered within 1) a system of care, 2) utilizing evidence-based practices, with 3) a construct of family-centered practice

● *Supports*

- General acceptance that 1, 2 3 above are not mutually incompatible
- DCH/ MACMHB recognition of & effort towards need to build knowledge base and change practice in the system
- DCH & CMHSP kids staff have positive relationship with ACMH
- "Voice" of children growing stronger
- * Greater push toward cross-system's collaboration at federal/ state/ local levels

- Advocate for legislative mandate to create local systems of care via:
 - mandated family-centered practice
 - finance reform (authority & method)
 - use of evidence based treatment where applicable

- Re-do Children's Diagnostic & Treatment regs to:
 - mandate that 24 hours required training focus on 3 areas: system of care, evidence-based treatment; family-centered practice
 - eliminate "process" stuff
 - move to consumer outcome model that demonstrates family driven practice



Jim, Jim

● *Bold Steps*

● *Challenges*

- Inadequate/ inconsistent knowledge base of FCP & evidence based practice
- Need to increase examples of how 1, 2, 3 above ought to be inter-related
- Issue is broader than public mental health system
- Current funding structure
- No mandate for evidence-based practice or system of care.
- Mandate for PCP/FCP is narrow
- No (up-front) incentives to practice consistent with 1, 2, 3 above in cost-driven system
- No clear dissemination process for information
- No/inadequate formal endorsements/ recognition/ requirements for family-centered practice

Competent Facilitators Available Statewide

Vision

Facilitators are available statewide
 [-->raise awareness---offer training<--]
 defined skill set including family-centered values
 Facilitators include family members, youth, peers,
 community members

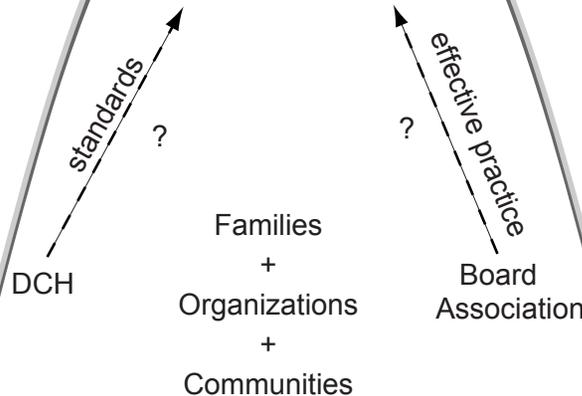
● Supports

- Expectation for independent facilitation
- Build from current monitoring standards (2) related to FCP
- Connection with CMH Board Association & Children's Sub-committee
- Upcoming B waiver renewal - focus of person-centered planning & independent facilitation

● Challenges

- Incorporate more about family-centered practice/ plans into DCH monitoring of CMH
- What we currently know isn't integrated
- Establish expectation by DCH that CMH will incorporate family-centered planning into independent facilitation expectations

Get it out to people!
 with supports to make it real



- Create a document that defines the skill set for independent facilitators that includes family-centered practice values/skills



● Bold Steps

Knowledge Gathered In Usable Form

Gathering Knowledge In a Usable Form

- Identify individuals aware of information on family centered practice, pull them together to harvest available documents & information (both in & out of state)
 - Knowledgeable people: state & local staff, parents, university staff
 - Organizations, e.g. ARC, ACMH, Family Voices, MIAMH, Headstart
 - Centers for family-centered practice around the country: e.g. Portland, Beach
- Gather good practice information though focus groups in regions - CMH Board Association & parent advocacy organizations develop & implement plans to do this
- Compile & synthesize information



Sherry

A Variety of Learning Methods

Vision

Family-centered learning opportunities will be presented over time, using a variety of methods

● Supports

- DCH requires 24 hours of training in children's issues per year
- EOT & TA system with money
- MI-AIMH (& other organizations) have experience in providing training & consultation
- DCH consultants for particular projects

- OSE DCH staff develop individualized training plans for each CMH affiliate & their providers for family-centered practice

- All training is tailored to learner's individual strengths/needs & includes methods other than lecture (e.g. hands-on, mentoring, supervision/consultation) over time

- Use existing DCH consultants more broadly in training
- Seriously explore other mentoring resources & models available



Sherry, Connie

● Bold Steps

● Challenges

- Money available for training
- Lack of knowledge of available experts
- Buy-in of administration & staff
- Confusion or disagreement about what family-centered practice is
- Lack of info about family-centered practice at the pre-service (university) level
- Financial constraints & expectations restrict non-direct service time available for staff to train or be trained, mentor or be mentored.

Good Practice Examples Are Diffused Throughout the System

Vision

The whole system knows what works and families and providers are satisfied with outcomes

● *Supports*

- Models currently exist: pilots have created guidelines, principles, values, tools
- DCH audit review process to ensure its happening
- Leadership supports efforts
- Family advocacy is alive & growing

● *FCP is mandatory*

- Develop or enhance statewide focus on FCP systematically
- Dedicated resources: people & funds
- Partner with existing leaders - moving forward together
- Use literature on diffusion
- Capture good practice examples for teaching
- Gather good practice examples at administrative, program, & direct service levels in a systematic way: focus groups, surveys, etc.

● *Challenges*

- DCH people need to talk to children people to say what they will look for in an audit
- Getting audit information to children's services about good practice
- Multi tasks required of boards without clear direction of priorities for kids
- Service delivery is categorized: SED/DD adults & kids



Sherry

● *Bold Steps*

Rules Address Family-Centered Practice

Vision

To have new Children's Diagnostic & Treatment Rules that address Systems of Care, Evidence Based Treatment, Family-Centered Practice, & Consumer Outcomes

● *Supports*

- ACMH, a variety of CMH child administrators, & the Board's Association are in support
- Staff support from the field
- Knowledge is available

- Initiate formal approval process

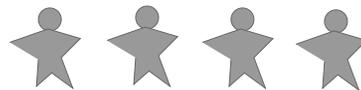
- Complete draft & circulate for feedback

- Form a committee

- Secure DCH political buy-in

● *Challenges*

- Political buy-in of everyone invested in children's mental health
- May be negative consequences to opening the issue to reconsideration



Mac, Nancy, Jim, Jim

● *Bold Steps*

Independent Facilitation is Funded

Vision

We will have a clearly defined, measurable process for FCP/PCP facilitation as a distinct service recognized by funding sources.

We will have a clear set of skills/ competencies that are used to credential/privilege practitioners of FCP/PCP facilitation.

● *Supports*

- Accrediting bodies are not too prescriptive on qualifications
- Advocacy groups & families can help with definitions

- Define skill set/competencies for FCP/PCP facilitation

- Produce & distribute to all Boards a model RFP for procurement of FCP/PCP services

- Assure that FCP/PCP is recognized as a distinct, reimbursable service within all benefit packages.

● *Challenges*

- How will FCP/PCP be paid for?
- Is FCP/PCP a distinct, defined service?
- Who "certifies"?
- Are we talking about running the meeting or creating the plan?
- How do we deal with accountability?



Connie, Nancy, Ramona, Mac, Jim

● *Bold Steps*