

Practice Improvement Protocol 8

THE ADULT CLINICAL TEAM



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

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PURPOSE

To provide guidance in establishing practice that effectively operationalizes and supports a “team” approach that is consistent with Arizona’s Principles of Person-Centered Planning for all adult behavioral health recipients.

TARGET POPULATION

All persons eighteen years or older receiving behavioral health services through the Tribal or Regional Behavioral Health Authority (T/RBHA) system including persons enrolled in the general mental health, substance abuse and seriously mentally ill programs.

INTRODUCTION

The following items are key concepts in team-based service planning:

- ❖ **Strength and Needs-Based Planning.** Based on the initial and ongoing strength-based assessment, all services should be customized to creatively reflect the person’s unique culture and individual and familial strengths in addressing the person’s behavioral health needs.
- ❖ **Consensus.** All teams strive to reach consensus regarding the needs of the person, the findings of the assessment process and the service plan.
- ❖ **Jointly Established Behavioral Health Service Plans.** When a person has criminal justice or other significant multi-system involvement, a joint assessment is developed and a jointly established behavioral health service plan is collaboratively implemented.
- ❖ **Natural and Informal Supports.** Although team membership will vary with changing needs and developing strengths, teams are encouraged to strive toward memberships that include natural and informal supports.
- ❖ **Collaboration.** Collaboration should be sought from other involved family members, agencies and the community at-large. The team should strive to promote connections with all the community has to offer rather than, for example, relying solely on paid supports.
- ❖ **Crisis Stabilization and Crisis Planning.** The team should identify and develop strategies to resolve urgent health, safety and security needs. In addition, the team should assist the person in developing a plan that includes strategies intended to prevent or mitigate crisis situations. Crisis planning seeks only to stabilize the crisis, not to change the overall plan, and incorporates family, friends, natural supports, and formal supports if necessary.

- ❖ **Single Point of Contact.** The Clinical Liaison is the single point of contact and continues to provide clinical consultation to the team throughout the assessment and service planning process. If a behavioral health representative is assigned, the behavioral health representative may assume responsibility for coordinating information exchange among team members, providers and others involved in the provision of services and supports.
- ❖ **Cultural Competency.** The adult team process, from the assessment to the facilitation of team meetings and the provision of services, should be culturally competent and linguistically appropriate, and based upon the unique values, preferences and strengths of the person, involved family members, and the community.

For more information, please see [The Child and Family Team Practice Improvement Protocol](#) and [9 A.A.C. 20](#).

BACKGROUND

The following Principles of Person-Centered Planning are required for behavioral health assessment and service planning.

- ❖ Services are developed with the understanding that the system has an unconditional commitment to its individuals.
- ❖ Services begin with empathic relationships that foster ongoing partnerships, expect equality and respect throughout the service delivery.
- ❖ Services are developed collaboratively to engage and empower individuals, include other individuals involved in the individual's life, include meaningful choice, and are accepted by the individual.
- ❖ Services are individualized, strength-based and clinically sound, and
- ❖ Services are developed with the expectation that the individual is capable of positive change, growth and leading a life of value.

Arizona has chosen to implement these assessment and service planning principles through the team approach to care. This approach is based upon a coordinated, flexible, person-driven process that supports and empowers the individual to attain an optimal level of functioning, develop healthy interpersonal relationships, experience recovery, and become a self-determined and productive member of society by:

- Managing and eliminating the debilitating symptoms of a mental illness;
- Promoting the ability to live a productive and satisfying life;

- Improving the ability to function in social, educational and vocational roles; and
- Emphasizing every individual's unique strengths, recovery process, and culture.

The team works to enhance the person's engagement in services, improve behavioral health recipient satisfaction and treatment outcomes by involving family members, peer and other natural supports, and involved allied service systems in the design, development and oversight of the individual's treatment and recovery plan.

DEFINITIONS

Adult Clinical Team

Child and Family Team (CFT)

Clinical Liaison

Empowerment

Engagement

Family

Family Member

Guardian

Interim and Ongoing Individual Service Plans

Natural and Community Supports

Behavioral Health Representative

Recovery

Recovery Goal

Stigma

PROCEDURES

1. WHICH INDIVIDUALS SHOULD HAVE TEAMS?

ADHS intends to apply the Principles of Person-Centered Planning to every enrolled adult person. Every enrolled adult should be served through an Adult Clinical Team.

While the composition of the team will vary based on the goals, needs, strengths and preferences of each person and involved family members, the process used by the team should conform to the Principles of Person-Centered Planning. As such, each team should be structured to function in a unique and flexible manner that involves various participants from the behavioral health system, natural supports and other involved agencies.

A behavioral health representative will facilitate the work of the team, however the eventual goal is to educate, support and empower willing individuals and/or involved family members to eventually facilitate their own teams.

Assistance with facilitation in particularly challenging situations should be available to any team requesting it. The T/RBHA should have a mechanism for teams to request additional consultation and assistance. This may include utilizing internal or external individuals from the behavioral health system with expertise in mediation, facilitation, person-centered planning and/or other skills that would be beneficial to the team process.

2. WHAT ARE THE RESPONSIBILITIES OF THE TEAM?

The team's primary function is to develop a comprehensive and unified service plan with the enrolled person that is responsive to his/her identified needs. The team uses a person-centered approach that:

- Explores and documents the strengths and needs of the person;
- Establishes and prioritizes service goals;
- Identifies the supports necessary to meet those goals;
- Describes a course of action encompassed in a written plan within 90 days of the intake developed by team members;
- Monitors and recognizes accomplishments;
- Determines the responsibilities of all team members in these efforts;
- Continually updates assessment; and
- Reviews and revises the service plan as needed

3. WHO SHOULD PARTICIPATE IN THE TEAM?

At a minimum, the team consists of the person and a qualified behavioral health representative. In general, the size, scope and/or intensity of involvement of the team members are determined by the acuity and intensity of the service needs, objectives established by the person, and the individuals that are needed to develop and coordinate an effective service plan. Therefore, the team's composition will expand and contract as necessary to be successful on behalf of the person. For example, based on the individual's need, the team for a person determined to have a serious mental illness might include a psychiatrist, case manager, vocational specialist, nurse, and other professionals or paraprofessionals such as service providers (e.g., counselors, residential staff, peer support workers) or a health plan representative. While the Clinical Liaison or behavioral health representative should be a consistent participant, other team members may only attend planning sessions as needed.

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

When a person enters the behavioral health system, the individual completing the initial core assessment assumes the role of Clinical Liaison. In most cases, the behavioral health representative on the person's team will be the Clinical Liaison. If not, the Clinical Liaison will be responsible for ensuring that a behavioral health representative is assigned to the team to work with the enrolled individual. During the initial assessment, the Clinical Liaison begins to work with the person and any involved family members to develop and support the team and provides clinical oversight and consultation as an active team member. The Clinical Liaison completes any remaining addenda as applicable. After the Interim Service plan has been developed at the initial core assessment, the Clinical Liaison continues to participate as long as services are provided. If the identified needs of the person so require, the Clinical Liaison may transfer those responsibilities to a different Clinical Liaison who may be a better fit and/or more available to work with the team on a long-term basis.

5. WHAT ARE THE BENEFITS OF INVOLVING FAMILY MEMBERS?

Involving and engaging family members is an important part of the assessment, treatment, support and recovery of all enrolled adults. Behavioral health representatives (e.g., Clinical Liaisons, case managers, service providers) should continuously work to involve and engage both the person and his/her family members. Family members bring accumulated knowledge about the individual to these processes and can also serve as a source of significant support. Family members have information and perspectives that can help the team provide optimal support and services. The Adult Clinical Team should consider, and utilize as appropriate, information received from family members, friends or other providers who have knowledge of the person. As active members of the team, the person, family members, Clinician Liaison and other participants will make decisions together about goals, needs, supports and treatment services.

When families are respectfully engaged, involved and feel empowered, their approach to the person usually changes and their support for the person's recovery increases. Education about mental illness and its treatment is essential for the person and his/her family. An ongoing educational process, intended to prepare the person and family members to participate as equals with their professional counterparts, is recommended throughout all phases of assessment, planning, service provision and recovery.¹

Involving families as partners can help ensure that a variety of supports are available to the person and helps ensure that the individual service plan addresses the identified needs of the person. Some families may choose to serve as resources for other families, staff trainers, system advocates, quality managers, resource developers and so forth.

¹ Weiden, Scheifler, McEvoy, Frances, and Ross, "Expert Consensus Treatment Guidelines for Schizophrenia," *The Journal of Clinical Psychiatry*, Volume 60, Supplement 11, 1999.

Involving families benefits behavioral health and other professionals by reinforcing their sense of doing the right thing, allowing for shared responsibility, generating excitement about possibilities, increasing options and opportunities, building worker satisfaction based on improved outcomes for behavioral health recipients, engaging families as agents of desirable system change, and adding community involvement in practice improvement challenges.

In some instances, family members may not be available to participate in the person's team. In these cases, the Clinical Liaison or behavioral health representative should work with the person to identify other individuals who are important to the person and may be willing to actively participate in the person's treatment.

6. WHAT ARE STRATEGIES THAT CAN HELP TO EFFECTIVELY ENGAGE FAMILY MEMBERS?

Family involvement represents a major shift in the "assistance" paradigm – from *doing to* to *doing with*, from *power over* to *power with*, and from *teaching the client* to *learning together*. Effective family involvement can be promoted by:

- Ensuring that family members are included at every level of the process, beginning with intake and assessment, continuing through service planning, service provision and service plan monitoring. The Clinical Liaison should, during the initial assessment, begin to ask for and encourage the participation of family members as part of the developing team. The Clinical Liaison should continue to encourage the further identification of family members and other participants by the consumer and team during the ongoing assessment process.
- Securing an effective response to any crisis or immediate need of the person/family, and then dedicating appropriate time for a more complete assessment.
- Scheduling team meetings at times (e.g., evenings, weekends) and in locations (e.g., person's home, relatives' homes, community locations of comfort and convenience) of the person's/family's preference, increasing the likelihood of their participation.
- Exercising cultural and linguistic expertise, arranging for interpreter services, providing peer and/or family support services or other aids to ensure an effective voice for the person and his/her family in the treatment process.
- Identifying and helping to address and resolve other potential barriers to active participation (e.g., transportation, child care responsibilities) of the person and his/her family members.

- Discovering, assessing and recording the person's and family's strengths, and respecting each family's unique style of coping and adjusting to stress.
- Discovering the person's and family's goals, and their descriptions of needs for behavioral health supports and/or services needed to reach those goals.
- Participating with the person and family in developing appropriate supports and service options. Joint decision-making is recommended at every stage of the assessment and treatment process. As the person recovers, he/she can take an increasingly active role in making decisions while other team members develop more supportive roles.
- Communicating with family members on a regular basis (e.g., returning phone calls from family members promptly), while recognizing that there are certain limitations governing the sharing of confidential information with family members of adult behavioral health recipients.
- Encouraging family advocacy within the team. Family members can assist in protecting the person's rights and effectively voicing support and service needs. Family members can assist in making health care decisions that are in the person's best interests.

Family involvement is an important ingredient in providing effective behavioral health support. ADHS assessment and service planning processes are sufficiently flexible to accommodate, encourage and reinforce family involvement and empowerment.

8. WHAT AUTHORITY DOES THE TEAM HAVE IN SECURING SERVICES?

Adult Clinical Team decisions should not be made without the involvement of the person (and when appropriate, the legal guardian). Meetings that result in decisions affecting the person should only occur with the person's full participation.

The team, with the assistance of the Clinical Liaison, is responsible for overseeing and facilitating decision-making regarding the person's behavioral health services. Based on the team's recommendations and decisions, the Clinical Liaison will secure covered services to address the needs of the person and involved family members. However, this excludes directly securing covered services that require prior authorization through the RBHA. The team should carefully consider and give substantial weight to the person's ideas and preferences in formulating the service plan.