Coordinated Family Services

Team Overview

The Coordinated Family Services process centers decision-making by the family team. The team supports the child, family, and each other throughout the process. Both planning and interventions rest on the combined skills and flexible resources of this diversified, committed group of individuals. The strengths and resources of the child, family, natural supports and providers are the key to selecting interventions and supports most likely to meet the identified needs.

The Team

The goal for team membership is to have a balance of natural (informal) support people such as relatives, friends and neighbors and service providers such as a therapist, teacher, and social worker. To qualify for team involvement, individuals should:

- Have a role in the lives of the child and/or family
- Be supportive of the child and family
- Be approved for membership by the parent
- Be committed to the process (includes regular attendance at meetings, participation in decisions, and involvement in the plan of care)

Service Principles for Family Teams

- Services are child/family-centered, strength-based and oriented to the least restrictive options.
- Decisions are reached by consensus whenever possible. All members have input into the plan and all members have ownership of the plan.
- Teams meet regularly not just around crises.
- Teams address a full range of life needs that could impact on the child/family.
- Teams stay focused on reaching attainable goals and regularly measure progress.
- Teams celebrate success.
- Care is unconditional - services change if something doesn't work.

Phases of Team Involvement

1. Assessment & Planning

- **Intensive team involvement** consisting of team meetings at least once every two weeks, lasting no longer than 60 minutes each (for approximately 2 months)
- **Determine strengths and needs** of the child, family, and team
- **Complete Assessment Summary**, which assesses the 12 areas (domains) of the child and family's life, including: Living Situation; Basic Needs/Financial; Family; Mental Health; Social; Community; Cultural; Spiritual; Educational; Legal; Medical; and AODA.
- **Develop Plan of Care**. The team selects the top three priorities from the Assessment Summary domains – these are then the areas of focus in the Plan of Care.
- **Develop Safety Plans** (also called Crisis Plans) for home and school. In developing safety plans, teams preplan crisis intervention with the people and/or agencies who may be involved in the crisis resolution – outlining responsibilities and communication procedures.

2. Ongoing Monitoring

- **Implementation of the Plan of Care**. When the plan is completed, it will be reviewed, approved, and signed by all team members – once this occurs, the plan will be implemented.
- Team provides **on-going support and monitoring**; meeting when necessary to review the plan, progress toward goals, and need for plan modification. Teams typically meet every 3 to 6 weeks, depending on individual team's needs (the statutory minimum is at least every 6 months). This phase typically lasts 6 – 9 months.

3. Transition & Closure

- The family has **knowledge** of and **access** to services and a **voice** in decisions that are made about their child and family.
- Team develops a **Transition Plan**, which focuses on planning around long-term services the family will continue to use or will need to access after the formal team process has ended.
- Team provides **minimum contact and monitoring**, typically meeting every 2 to 3 months (the statutory minimum is at least every 6 months).
- **Formal team participation is ended**. Once families feel they know how to plan for the future (they have ownership of their plan) and no longer need the support of the team, the formal team process should end.
- **Family utilizes community support network**. The family knows who to contact and how to get their needs met without the ongoing support of a formal team.