Youth Empowerment Services

PRINCIPLES OF CARE PRACTICE MODEL

An active partnership with communities

Idaho Department of Juvenile Corrections

IDAHO DEPARTMENT OF HEALTH & WELFARE

DEPARTMENT OF EDUCATION STATE OF IDAHO

About the Principles of Care and Practice Model

The Principles of Care are intended to guide child-serving agencies in the delivery and management of mental health services and supports for children and youth in Idaho.

The Practice Model describes the expected experience of care in the six practice components provided to children and youth served by Idaho's children's mental health system. The Practice Model will be utilized by all agencies or individuals in the public sector who serve children and their families.

Children and their families retain the choice whether to accept or reject voluntary services. However, these Principles of Care and Practice Model do not apply to services provided to children with serious emotional disturbance on an involuntary basis, such as those services provided involuntarily to children or youth in the custody of the state or those services required by court order.

General Comment about Terms:

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- *Child* and *youth* are used interchangeably.
- *Coordinated Care Plan* is the result of the Child and Family Team (CFT) coordinating care from all providers involved in treatment and may take many forms.
- *Family* refers to biological and adoptive family as well as primary caregivers for the child.
- *Formal service and support* refers to individuals from organizations or agencies that provide a service to the family.
- *Informal service and support* refers to people who are part of the family's community and social network.

Principles of Care

The Principles of Care are eleven (11) values that are applied in all areas of mental health treatment planning, implementation and evaluation.

1.0 Family-Centered

Emphasizes each family's strengths and resources

2.0 Family and Youth Voice and Choice

Prioritizes the preferences of youth and their families in all stages of care

3.0 Strengths-Based

Identifies and builds on strengths to improve functioning

4.0 Individualized Care

Customizes care specifically for each youth and family

5.0 Team-Based

Brings families together with professionals and others to create a coordinated care plan

6.0 Community-Based Service Array

Provides local services to help families reach the goals identified in their coordinated care plan

7.0 Collaboration

Partners families, informal supports, providers, and agencies together to meet identified goals

8.0 Unconditional

Commits to achieving the goals of the coordinated care plan

9.0 Culturally Competent

Considers the family's unique cultural needs and preferences

10.0 Early Identification and Intervention

Assesses mental health and provides access to services and supports

11.0 Outcome-Based

Contains measurable goals to assess change

1.0 Family-Centered

Family-centered care emphasizes each family's strengths and resources. Families are actively engaged in the process of creating and implementing a coordinated care plan for their child. Family preferences, experiences, and perspectives are valued by all members of the Child and Family Team (CFT). Families of birth, foster, adoption, and choice are respected and included.

Essentials of Being Family-Centered:

- Family-centered care ensures that children and families are viewed as essential members of the CFT and feel supported, valued, and respected by other members of the team.
- Communication between the family, providers and other CFT members is respectful and honest.
- CFT members ensure children and their families are supported and encouraged to share their knowledge, opinions, and preferences throughout the process.
- Active engagement allows the CFT to learn about the child and family members' perspectives on their strengths (such as coping skills), needs (such as behavioral or emotional challenges), and resources (such as supportive relationships and other informal supports). The CFT uses what is learned to help the child and family develop a coordinated care plan.
- Children and family members lead the identification of short and long-term goals.
- The coordinated care plan focuses on increasing the strengths of children and their families to increase the likelihood of long-term success.
- The coordinated care plan is adapted as the needs of the family and youth change over time. These adaptations include transitions to both lower and higher levels of care as needed.
- The CFT identifies formal and informal supports needed by the child and family. As the child reaches the goals identified in the coordinated care plan, formal supports are transitioned to informal supports in the family's natural setting.

2.0 Family and Youth Voice and Choice

The preferences of the youth and family are prioritized during all phases of the process, including engagement, assessment, teaming, coordinated care planning, implementation of the plan, monitoring and adaption of the plan, and transition. All providers communicate openly and honestly with families in a way that supports the family's culture, dynamics, and personal experiences.

Essentials of Family and Youth Voice and Choice:

- The family and child decide which individuals are important on their Child and Family team (CFT).

- CFT members engage youth and families to learn about their strengths and needs.
- Input from the youth and family is prioritized throughout the process of developing and implementing a coordinated care plan.
- Family and youth actively participate with the CFT to determine if goals are being met and identify any needed changes to the coordinated care plan.
- Services and supports are provided in the most natural and convenient setting possible, as identified by the youth and family.
- Cultural identities, primary language, and practices of the youth and family members are recognized and valued. Cultural traditions and practices are integrated into care whenever possible. The CFT is aware that sometimes the youth and family members have different cultures they identify with, and create plans to address any cultural differences that exist among family members.

3.0 Strengths-Based

Services and supports are identified to build upon the strengths of the child and their family in order to improve the child's functioning. The coordinated care plan focuses on strengths and competencies that address needs, not on deficiencies and problems that create needs. Each service and support is delivered in a manner that enhances the capabilities, knowledge, skills, and assets of the child and their family.

Essentials of being Strengths-Based:

- Strengths and needs of the child and family are identified using the Child and Adolescent Needs and Strengths (CANS) tool.
- The Child and Family Team (CFT) members learn about individual and family strengths and use them in the coordinated care plan to address needs.
- The coordinated care plan includes plans to increase child and family strengths.

4.0 Individualized Care

Goals, services, supports, and the coordinated care plan are all customized to provide care specific to the unique strengths and needs of the youth and family. Each portion of the plan is monitored and adapted as necessary to meet the changing needs and goals of the youth and family.

Essentials of Individualized Care:

- The Child and Family Team (CFT) recognizes that every youth is unique and they and their families have specific needs, strengths, and family culture.
- The youth and family work with the CFT to identify the services and supports that best utilize their strengths and address their needs.
- The CFT develops a coordinated care plan that includes the identified services and supports and is responsive to changes in strengths and needs.

- CFT members collaborate with youth and family members to evaluate and adjust goals, services, and supports in the coordinated care plan as needed to provide the best outcomes for youth and their families.

5.0 Team-Based

Children and their families are brought together with their informal supports, professionals, and individuals from child serving organizations to create a family-driven, strengths-based coordinated care plan. This Child and Family Team (CFT) commits to supporting the child and their family throughout care.

Essentials of Being Team-Based:

- Important people in the child and family's life, such as extended family, friends, neighbors, coaches, and faith-based connections are brought together with health care providers, educational staff, and child serving agency representatives to create a CFT.
- Members on the CFT may change as the treatment goals are refined and new services and supports are identified.
- The child and their family are active and equal partners during this collaborative process.
- CFT members work together with the child and their family to develop a coordinated care plan based on a shared vision that builds on the child and family's strengths.
- CFT members use their knowledge, skills, and different perspectives to provide valuable input about strengths and needs and the services and supports that will further meaningful treatment goals.
- The CFT works together to create a coordinated care plan that is agreed on by all team members.
- The CFT works to revise and update the coordinated care plan when goals, strengths, and needs change. Changes are based on input from the child, family, other CFT members, and information from ongoing assessments and data collection.

6.0 Community-Based Service Array

A collection of formal and informal services and supports are available to help youth and families reach the goals identified in their coordinated care plan. These services and supports are intended to help youth and family use their strengths to address needs and improve their functionality. Services and supports are provided in the least restrictive setting appropriate for the youth's identified needs.

Essentials of Having a Community-Based Service Array:

- The Child and Family Team (CFT) develops a coordinated care plan that includes services and supports in the least restrictive appropriate setting possible.

- Communities, including private and public agencies, develop and support local services to help youth and their families reach the goals in their coordinated care plans.
- The youth and family members' preferences help the CFT decide when and where (e.g., home, schools, community centers, parks) services and supports are provided.
- The coordinated care plan identifies desired services and supports based on the service availability in the preferred setting.
- Successful community-based services and supports are at an appropriate intensity to meet the identified needs and strengths of the youth and their family. The intensity and duration are adjusted to match the changing needs of the youth and their family.

7.0 Collaboration

Children and their families, together with any extended family, community members, health care providers, and individuals from local or state child serving organizations and agencies work together to build the strengths and meet the needs identified in the coordinated care plan. For local and state child serving agencies, this partnership occurs at the individual treatment planning level as well as within the governance structure.

Essentials of Collaboration:

- When a child is involved with several systems (e.g. medical care, education, corrections, and child welfare) these systems work together with the Child and Family Team (CFT) to build on strengths and meet the identified needs of the child.
- Children and families may choose who is on their CFT and may choose not to include specific providers, supports, and members of involved agencies.
- Exclusion from the CFT does not relieve local and state agencies of the responsibility to work together to further the treatment goals identified in the coordinated care plan, although excluded agencies may also have additional goals that need to be accomplished (e.g. IEP goals, probation requirements, child and family case plans).
- Local and state agencies work together to develop rules, policies, procedures, and monitoring systems to ensure services are seamless for the child and family regardless of where access starts (e.g. primary care doctor, school, state agency) or how their needs change over time.

8.0 Unconditional

The Child and Family Team (CFT) is committed to achieving the goals of the coordinated care plan regardless of the youth's behavior, placement, family circumstances, or availability of community-based services. The youth and their family indicate when the CFT process is complete.

Essentials of Being Unconditional:

- Members of the CFT work with youth and family to achieve the goals of the care plan.

- The priority of the CFT is to build the youth and family's strengths while addressing the identified needs.
- The CFT works to find appropriate services and supports for the youth and family regardless of availability of formal community-based services.
- If there is a lack of progress, the CFT attempts to identify changing needs rather than assuming that lack of progress is due to resistance or noncompliance with treatment.
- The CFT remains committed to assisting and supporting the youth and family members regardless of any challenges or difficult conditions the youth, family, or providers experience in their efforts to meet goals.
- All team members are committed to working towards youth and family-driven goals until the family agrees the identified needs have been addressed.

9.0 Culturally Competency

Services and supports are provided in a manner that is understandable and relatable to the child and family. Services and supports are also provided in a manner that is considerate of child and family's unique cultural needs and preferences. Services also respect the individuality of each member of the family.

Essentials of Having Cultural Competency:

- In all phases of the Child and Family Team's work, cultural identities, primary language, and practices of the child and family members are recognized and valued.
- Cultural traditions and practices are integrated into care whenever possible.
- The CFT is aware that the child and family members may identify with different cultures, and includes plans to address any cultural differences that exist among family members.
- Cultural competency includes respect for and openness to learning about cultural identities and practices of youth and their family.
    - Cultural identity and practices include race, nationality, locality (where they are from), disability, language, ethnicity, religion, political beliefs, ability to adapt to new cultures, sexual orientation, gender identity, and socioeconomic status as well as other aspects of diversity.
    - The CFT learns about the importance and role of cultural practices for individual children and their family members, and integrates this understanding into the coordinated care plan and associated services and supports.
    - If the culture of the child and the family are different, both need to be accommodated in the coordinated care plan.

10.0 Early Identification and Intervention

Youth are given opportunities to assess their mental health and access appropriate services and supports when needs are first identified.

Essentials of Early Identification and Intervention:

- Personal use screenings are available if youth, parents, teachers, faith based connections, recreational staff, or others notice a possible mental health need.
- Family doctors complete a screening if they observe any potential mental health needs during routine appointments.
- Both types of screenings provide the youth and their family with more information to help them decide if a full mental health assessment may be beneficial.
- Once a full mental health assessment is completed, strengths and needs of both the youth and their family are identified.
- The strengths and needs of the youth and their family are considered by the Child and Family Team (CFT) when creating a coordinated care plan.
- Needed services and supports are included in the coordinated care plan at the appropriate level and intensity identified in the assessment, recognizing that early intervention provides the most positive outcome.

11.0 Outcome-Based

Coordinated care plans contain observable and measurable goals that are used to assess change rather than child and family compliance. State agencies develop meaningful, measurable methods to monitor system improvements and outcomes.

Essentials of Being Outcome-Based:

- The Child and Family Team (CFT) creates a coordinated care plan with services and supports based on measurable goals.
- The CFT revises goals, services, and supports to address a lack of progress or changing needs.
- The CFT monitors the success of specific services and supports. Changes are made to the coordinated care plan when goals are reached or adjustments to the services and supports are needed to improve effectiveness.
- Progress towards meeting the goals of the coordinated care plan are identified with improvement in any functional impairment as noted by the family and the Child and Adolescent Needs and Strengths (CANS) tool.
- State agencies monitor outcomes from all children and families receiving services and supports to ensure they are providing effective and efficient services. State agencies make changes to address any systematic barriers to effective and efficient services and supports.

Practice Model

1.0 Engagement

Getting youth and their families actively involved in the creation and implementation of their coordinated care plan

2.0 Assessment

Gathering and evaluating information to create a coordinated care plan

3.0 Care Planning & Implementation

Identifying and providing appropriate services and supports in a coordinated care plan

4.0 Teaming

Collaborating with children, their families, providers, and community partners to create a coordinated care plan

5.0 Monitoring & Adapting

Evaluating and updating the services and supports in the coordinated care plan

6.0 Transition

Altering levels of care and support in the coordinated care plan.

1.0 Engagement

Engagement is the process of mental health agencies, providers, and child serving organizations empowering youth and their families to take an active role in improving their own mental health. This process is designed to motivate youth and their families to recognize their own strengths, needs, and resources. Engaging families is the foundation to building trust and mutually-beneficial relationships between family members, Child and Family Team (CFT) members, and service providers.

Engagement principles include:

- providing families and their children with respect, honesty, and transparency;
- learning about the strengths and needs of the youth and their family with the intent of helping them reach their goals;
- using the family's primary language and avoiding jargon; and
- valuing and respecting cultural diversity.

Essentials of Engagement:

- Engagement is a continuous process of communication and involvement used across all services and supports to gain input from youth and their families.
- Engagement adheres to all Principles of Care.
- Communication between the family, providers and team members is respectful and honest.
- Engagement builds trusting relationships between youth, their families, providers, agencies and any other members of the CFT.
- Active engagement allows the CFT to learn about the youth and family members' perspectives on their strengths (such as coping skills), needs (such as behavioral or emotional challenges), and resources (such as supportive relationships and other informal supports). The CFT uses what is learned to help the youth and family develop a coordinated care plan.
- Input from the youth and family is prioritized throughout the process of developing and implementing a coordinated care plan.
- Members of the CFT communicate their belief in the family's ability to succeed and listen to the youth and family without judgement or defensiveness.
- Members of the CFT use language that is accessible and familiar to all team members.
- Based on the family's preferred method of communication, the family, providers, and other CFT members determine how to maintain contact with each other throughout the period of time the youth is in treatment.
- In all phases of the team's work, cultural identities, primary language, and practices of the youth and family members are recognized and valued. Cultural traditions and practices are integrated into care whenever possible. The CFT is aware that sometimes the youth and family members have different cultures they identify with, and create plans to address any cultural differences that exist among family members.

2.0 Assessment

Assessment is the practice of gathering and evaluating information about children with mental health concerns and their families in order to understand strengths and needs. This discovery process may include a self-administered mental health questionnaire or a brief screening by a medical professional. Both tools serve to identify children who may have a need for mental health services. A more comprehensive assessment by a mental health professional can provide an in-depth evaluation of available strengths, underlying needs, functional impairment, specific mental health concerns, and risk factors.

Assessment principles include:

- acknowledging families as experts on their children
- listening to families and ensuring they are heard and valued

- identifying individual and family strengths and considering them a vital part of understanding the child and their needs
- offering questionnaires and screenings created from the Child and Adolescent Needs and Strengths (CANS) tool
- making appropriate referrals.

Essentials of Assessment:

1. The screening process, whether completed by the child or family, or by a medical professional, provides the child and their family with more information to help them decide if a full mental health assessment may be beneficial.
2. A screening is not required before an assessment is completed.
3. Providers recognize that children and their families are experts on their own experiences and place significant value on their input.
4. Evaluators learn about the strengths of all family members as an important part of getting to know the family and understanding how each person's interactions contribute to the strengths and needs of the child and family.
5. Families may choose to include other individuals in the assessment process who can add important details about both strengths and needs.
6. The CANS replaces all previous functional assessment and planning tools, such as the CAFAS.
7. If a CANS assessment has already been completed, providers access that information in the ICANS system as part of their information gathering process, as they become CANS certified.
8. A child should only have one CANS in the ICANS system, with new providers updating the existing file as needed.
9. Once a CANS assessment has been completed, consideration is given to the child and family to prevent the need to repeat sensitive information unless clinically necessary.
10. The assessment process includes the identification of existing and potential informal supports for both the child and family.
11. Clinicians review and discuss initial assessment findings with the child and family members to ensure transparency in the assessment process and agreement on the results.

3.0 Care Planning & Implementation

Care planning is the practice of creating a menu of appropriate services and supports unique to the strengths and needs of each youth and their family. The care plan should incorporate informal services and supports whenever possible, and formal services and supports should be delivered in the least restrictive setting and modality. to meet the assessed needs and strengths of needs of the individual child. The care planning process engages the youth, their family, and others on the Child and Family Team (CFT) to develop a written coordinated care plan. The

coordinated care plan combines the strengths and needs identified by the Child and Adolescent Needs and Strengths (CANS) tool with all treatment plans from individual providers, if they exist, and natural supports, into one comprehensive plan that helps the youth, family, providers, and natural supporters, focus on specific identified goals. These goals are designed to help the youth achieve a better level of functioning and reduce the impact of mental illness.

The coordinated care plan describes the youth's strengths and needs, short and long-term goals, and addresses crisis, safety, and transitions to different levels of care. The coordinated care plan also specifies the strategies, resources, and timeframes for implementation of services and supports.

Care planning and implementation principles include:

- providing families written information about choices they have in their care planning and teaming process
- informing families of any limitations due to agency involvement, access to services, and availability of resources
- providing families both formal and informal services in the most appropriate and least restrictive settings, with family voice and choice being the primary factor in making decisions regarding intervention strategies
- identifying community-based services and supports that can be accessed currently or as resources expand in the youth's community
- focusing services on strengths and competencies that address needs, not on deficiencies and problems that create needs
- planning services that are available, accessible, and provided in a time, location, and manner that causes the least amount of additional strain to the youth and family
- measuring the outcomes of goals and tasks to assess change not compliance.

Essentials of Care Planning and Implementation:

1. The coordinated care plan:
    a. is the product of the Child and Family Team (CFT).
        - Family preference is the primary factor in deciding which strategies work best to meet the goals developed by the CFT.
    b. is written and developed to build upon the strengths of the youth and their family to improve the youth's functioning.
    c. includes goals that:
        - are clear to all team member
        - utilize the youth and family's identified and potential strength
        - address the youth and family's unmet needs
        - are measurable (e.g. tracking changes in the number or frequency of behaviors and improved levels of functioning)

- are used to assess change rather than assess youth and family compliance (e.g., missed appointments, incomplete tasks)
- address short-term improvements as well as long-term youth and family driven objectives to encourage the youth and family to work towards wellness and self-sufficiency.

d. includes information from all provider treatment plans and any agency specific documentation such as person-centered plans, developmental disability plans, court ordered goals, or Family and Community Services plans. Members representing each group may be invited to participate on the CFT.

e. includes information about:
   - strengths to be utilized
   - needs to be addressed
   - why specific goals are selected
   - strategies to address crises and safety
   - integration of formal and informal services and supports between all relevant child and family serving systems and community supports
   - transitions between formal and informal supports
   - the planning required to discharge from a placement or program.

2. As a part of coordinated care planning and implementation, families and youth are fully engaged in reviewing service options and limitations, and the care plan is representative of youth and family preference.
3. Services and supports are provided in the most natural and convenient time and setting possible, as identified by the youth and family.

4.0 Teaming

Teaming is the process of bringing a child and their family together with any extended family, community members, mental health providers, and individuals from child serving organizations that are committed to helping the child reach their treatment goals. These caring and invested individuals are invited by the family to work with and support their child and family through a Child and Family Team (CFT) coordinated care approach. The goal of the CFT is to include the perspectives of each member to create a more informed and collaborative care plan for the child and their family.

Children that require a higher level of treatment planning may have a wraparound coordinator to facilitate their CFT and work to coordinate and monitor service delivery.

Teaming principles include:

- ensuring families have input regarding who is on their CFT
- engaging families as full and active partners in the process

- creating a decision-making method that is a joint activity with the child and family rather than a process where decisions are made by a "majority rule" of the team.

Essentials of Teaming:

1. The child and their family are active and equal partners during the collaborative team-based planning process known as the Child and Family Team (CFT).
2. The child and family's concerns, competencies, and perspectives inform all decision-making on the CFT.
3. Team members commit to supporting the child and their family throughout care.
4. CFT members work collaboratively with the child and their family to develop a coordinated care plan based on a shared vision that builds on the child and family's strengths.
5. The family and child decide which individuals from the community are important to be included on their CFT. Examples include (but are not limited to):

    - extended family
    - friends
    - neighbors
    - coaches
    - faith-based connections
    - doctors
    - therapists
    - service providers
    - teachers or other educational staff
    - state and local agency representatives from child serving organizations

    Including CFT members with different perspectives about the child and family improves the decision making and planning process by providing valuable input about strengths and needs and the services and supports that will further meaningful treatment goals.
6. The CFT identifies both formal and informal services and supports to help the family reach identified goals.
7. Members on the CFT may change as the treatment goals are refined and new services and supports are identified.
8. The CFT remains in place for the duration of a child's treatment.

5.0 Monitoring & Adapting

Monitoring and adapting is the practice of continually evaluating the effectiveness of the coordinated care plan, assessing circumstances and resources, and reworking the plan as needed. The Child and Family Team (CFT) is responsible for reassessing the youth and family's needs, applying knowledge gained through ongoing assessments and data collection, and adapting the plan in a timely manner.

Principles of monitoring and adapting include:

- Identifying services regardless of the youth's behavior, placement, family circumstances or availability of community-based services
- never giving up on the youth and family
- modifying the coordinated care plan to keep the youth and family safe
- understanding that setbacks may reflect the changing needs of the youth or family members, not resistance
- recognizing the skills and knowledge of the family and youth are essential to the change process.

Essentials of Monitoring & Adapting:

1. The youth, family and other CFT members continuously evaluate the coordinated care plan for effectiveness.
2. The coordinated care plan is revised and updated based on input from the youth, family, other CFT members, and information from ongoing assessments and data collection.
3. The coordinated care plan is reviewed to ensure the plan is providing services regardless of the youth's behavior, placement, family circumstances, or availability of community-based services.
4. Services are monitored to ensure that providers are working towards the goals identified in the coordinated care plan and are mindful of keeping the youth and family safe.
5. The coordinated care plan is adapted as the needs of the family and youth change over time. These adaptations include transitions to both lower and higher levels of care as needed.
6. If there is a lack of progress, the CFT attempts to identify changing needs rather than assuming that lack of progress is due to resistance or noncompliance with treatment.
7. The CFT realizes that planning, monitoring and adaptation processes are essential to accomplishing change.

6.0 Transition

Transition is the process of moving between levels of care and/or formal and informal services and supports. One goal of each coordinated care plan is to identify the appropriate level of care and find the correct balance of formal and informal supports that is needed to help a child and family meet their goals. As goals are achieved, the Child and Family Team (CFT) works to reduce the level of care supplied and the amount of formal services a child receives. Formal services are then replaced with informal supports. If a child has an increase in needs, and/or a reduction in strengths that are reflected in the Child and Adolescent Needs and Strengths (CANS) tool, the CFT may choose to transition to a higher level of care and increase formal supports.

The transition away from higher levels of care occurs after the CANS tool identifies that the child has developed enough strengths to justify the change and appropriate formal and informal supports are in place for the child and family. This transition is intended to help the family ensure long-term success.

Transition principles include:

- recognizing that the family is key in identifying available resources and supports; and
- viewing the community as the preferred resource for formal and informal supports.

Essentials of Transition:

1. Transition planning is the job of the CFT and is included in the coordinated care plan.
2. When a child has met a goal, the CFT identifies any level of care that can be reduced or formal services and supports that can be replaced with informal supports. The timeline for these transitions and any indicators (such as a change in CANS results, or enacting a crisis plan), that a child may need to return to the more formal supports are included in the coordinated care plan.
3. During the transition planning process, the child and family collaborates with other individuals on the Child and Family Team (CFT) to identify and engage informal community resources to provide sustainable support. Key considerations include:
    a. determining if an informal support is committed to meeting the ongoing needs of the child and family;
    b. assessing the informal supports' ability to enhance the child and family strengths; and
    c. confirming that the informal supports are aware of the transition plans, are prepared to work with the child and family to meet the identified need, and have effectively engaged the child and family.
4. Stable informal supports for the child and family are in place before transitioning away from formal services. Transitions occur over time and are included in the coordinated care plan.
5. The CFT will be in place for the duration of a child's treatment and can increase levels of care and formal supports at any time it is needed by the child or family.