PRINCIPLES OF CARE & PRACTICE MODEL

The State of Idaho is developing a new system of care for Idaho's children and youth with serious emotional disturbance (SED), called Youth Empowerment Services (YES).

Youth Empowerment Services will provide a new way for families to find the mental health help they need for their children and youth, using a strengths-based and family-centered team approach to individualized care. Through a coordinated and collaborative effort, multiple child-serving agencies will work with the family to build a treatment plan around the unique needs and strengths of each child.

This new system of care has been authorized by the Department of Health & Welfare (DHW) as part of the settlement resulting from the Jeff D. Class Action lawsuit. The descriptions of the Principles of Care and Practice Model included here are excerpted directly from the Jeff D. Settlement Agreement, Appendix B Principles of Care and Practice Model – pages B-1 through B-6. To read the Jeff D Settlement Agreement in full, visit the Project section of the YES website: yes.idaho.gov.

Providers serving Class Members* will be required to deliver services using the Principles of Care and Practice Model outlined in this document beginning with the first phase of the YES implementation effective 7/1/2018. Providers will receive further guidance and training regarding the practice of the Principles of Care and Practice Model in advance of the 7/1/2018 effective date.

**CLASS MEMBER: Idaho residents with a serious emotional disturbance who are under the age of eighteen (18), have a diagnosable mental health condition and have a substantial functional impairment; the diagnosis must be based on the Diagnostic and Statistical Manual of Mental Disorders (DSM).*

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 Class Members. These principles are consistent with the Legislative Intent language of the Children's Mental Health Services Act (Idaho Code 16-2402) and System of Care Values and Principles.

The Practice Model describes the expected experience of care in the six practice components provided to Class Members 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 Class Members and their families.[1]

Class Members 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 Class Members on an involuntary basis, such as those services provided involuntarily to Class Members in the custody of the state or those services required by court order.

[1] In the following Principles of Care and Practice Model sections, the term "family" is intended to mean children, youth, birthparents, adoptive parents, guardians, extended family, family of choice, members of the family's support system, and current care givers.

PRINCIPLES OF CARE

The delivery of public-sector children's mental health services in Idaho is guided by the following Principles of Care:

FAMILY-CENTERED

A defining characteristic of family-centered care is family engagement. Family engagement emphasizes family strengths and maximizes family resources. Family experience, expertise, and perspective are welcomed. Families are active participants in solution and outcome-focused planning and decision-making. Families of birth, foster, and adoptive parents, and families of choice are respected and valued.

FAMILY AND YOUTH VOICE AND CHOICE

Family and Class Members' voice, choice, and preferences are intentionally elicited and prioritized during all phases of the treatment process, including care planning, delivery, transition, and evaluation of services. Service is founded on the principle of communicating openly and honestly with families in a way that supports disclosure of culture, family dynamics, and personal experiences in order to meet the individual needs of the family and Class Member.

STRENGTHS BASED

Services and supports are planned and delivered in a manner that identifies, builds on, and enhances the capabilities, knowledge, skills and assets of the Class Member and family, their community, and other team members.

INDIVIDUALIZED CARE

Services, strategies, and supports are individualized to the unique strengths and needs of each Class Member and family. They are altered when necessary to meet changing needs and goals or in response to poor outcomes.

TEAM BASED

A team-based approach in partnership with the family and Class Member to bring together natural supports, professionals, and others to develop a family-driven, strengths-based, and solution-focused individualized treatment plan. The team is committed to work with the Class Member and family regardless of the Class Member's behavior, and to continue to work towards the goals of the individualized treatment plan.

COMMUNITY BASED SERVICE ARRAY

An array of community-based interventions will be available and provided according to the individualized treatment plan and in the least restrictive setting to meet the Class Member's needs.

COLLABORATION

System partners, including local and state agencies and departments, families, and Class Members, work together to meet the behavioral health needs of Class Members involved in multiple systems. This collaboration occurs at the individual treatment planning level as well as the governance structure.

UNCONDITIONAL

The team working in partnership with the family and Class Member are committed to achieving the goals of the individualized treatment plan regardless of the Class Member's behavior, placement setting, family circumstances, or availability of services in the community until the family indicates the formal process is no longer necessary.

CULTURAL COMPETENCY

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

EARLY IDENTIFICATION AND INTERVENTION

Opportunities are available to screen or assess potential Class Members and provide appropriate interventions when mental health issues are first identified.

OUTCOME BASED

Individualized Treatment Plans contain observable, measurable indicators of success that are monitored and revised to achieve the intended goals or outcomes. State agencies and departments develop meaningful, measurable methods to monitor system improvements and outcomes.

PRACTICE MODEL

In order to benefit from the full array of services, at whatever level appropriate and necessary to meet their needs, Class Members are best served through six key practice components that make up an overarching Practice Model. Over the course of treatment and transition, the six practice components are organized and delivered in the context of an overall Child and Family Team (CFT) approach. Many of these practice components will occur throughout a Class Member's experience in care and several will overlap or take place concurrently with other practice components. Consistent with the principle of individualized care, a Class Member's experience of care should be guided by the Practice Model and tailored according to his or her individual needs and strengths.

Child and Family Team (CFT)

Child and Family Team (CFT) is a teaming process that brings together the family and individuals that the Class Member and family believe can help them develop and implement a care plan that will assist them in realizing their treatment goals; the CFT may be small or large. For more information, please visit the YES website: yes.idaho.gov.

ENGAGEMENT

Engagement is the process of partnering with Class Members and their families to empower them to take an active role in the change process, and to motivate them to recognize their own strengths, needs, and resources. Engaging families is the foundation to building trust and mutually-beneficial relationships between family members, CFT members, and service providers.

Engagement guidelines include:

- Families and Class Members are welcomed and provided with respect, honesty, and openness;
- Providers demonstrate hope and an expectation that the family is capable of succeeding;
- Family's language is used and jargon is avoided; and
- Cultural diversity is valued and respected.

ASSESSMENT

Assessment is the practice of gathering and evaluating information about the potential Class Member and his or her family in order to assess strengths and needs. This discovery process may include a screening, which serves as a brief assessment for identifying children who may have needs for mental health services, as well as a more comprehensive assessment done by a mental health professional that provides an in-depth evaluation of underlying needs, available strengths, mental health concerns, and psychosocial risk factors. Assessment guidelines include:

- Families are acknowledged as experts on their children;
- Families are listened to, heard and valued; and
- Strengths identification of all family members and supports is central to getting to know the family.

CARE PLANNING & IMPLEMENTATION

Care planning is the practice of tailoring services and supports unique to each Class Member and family to address unmet needs. The care planning process engages the family, the Class Member, and others in CFT meetings to develop a written Individualized Treatment Plan designed to help the Class Member achieve a better level of functioning and reduce the impact of mental illness. The Individualized Treatment Plan will describe the Class Member's strengths and needs, short and long term goals, and will address crisis, safety, and transitions. The Individualized Treatment Plan should also specify the roles, strategies, resources, and timeframes for coordinated implementation of supports and services for the Class Member and family. Care planning and implementation guidelines include:

- Families and Class Members are provided written information about choices and limitations on choices;
- Services and supports, both formal and informal, will be provided in the most appropriate and least restrictive settings within the community, with family voice and choice being the primary factor in making decisions in intervention strategies;
- Services focus on strengths and competencies of families, not on deficiencies and problems;
- Planned services are available and accessible to the family and are provided in a manner that causes the least amount of additional strain to the family and Class Member; and
- Goals and tasks with measurable outcomes are established to assess change not compliance.

TEAMING

Teaming is a process that brings together the family and individuals agreed upon by the family who are committed to the Class Member through informal, formal, and community support and service relationships. These caring and invested individuals work with and support the Class Member and the family through a CFT approach. By integrating the varying perspectives of CFT members, teaming promotes better informed and more collaborative decision-making throughout the Class Member's experience in care. A Class Member who needs Intensive Care Coordination (ICC) will have a formal CFT that includes a dedicated CFT team facilitator. Teaming guidelines include:

- Families shall have input regarding who is on the CFT;
- Families are full and active partners and colleagues in the process; and
- The decision-making process is a joint process with the family and Class Member rather than a "majority rule" which decides for the family.

MONITORING AND ADAPTING

Monitoring and adapting is the practice of continually evaluating the effectiveness of the Individualized Treatment Plan, assessing circumstances and resources, and reworking the Plan as needed. The CFT is responsible for reassessing the Class Member and family's needs, applying knowledge gained through ongoing assessments, and adapting the plan in a timely matter. Monitoring and adapting guidelines include:

- Services are provided regardless of the Class Member's behavior, placement setting, family circumstances or availability of services;
- Never giving up on Class Members and families while keeping them safe;
- Understanding that setbacks may reflect the changing needs of family members, not resistance; and
- Skills and knowledge of the family and Class Members are essential to the change process.

TRANSITION

Transition is the process of moving from formal behavioral health supports and services to informal supports. The successful transition away from formal supports occurs when informal supports are in place, and the support and activities needed to ensure long-term stability are being provided. Transition guidelines include:

- Families are key in identifying resources and supports which may be utilized for solutions; and
- The community is recognized and respected as a key resource and support.