

APPENDIX B 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.

A. 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.

¹ In the following Principles of Care and Practice Model sections, the term “family” is intended to mean children, youth, birth-parents, adoptive parents, guardians, extended family, family of choice, members of the family’s support system, and current care givers.

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, measureable methods to monitor system improvements and outcomes.

B. 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.

1) 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:

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

2) 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:

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

3) 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:

- a. Families and Class Members are provided written information about choices and limitations on choices;
- b. 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;
- c. Services focus on strengths and competencies of families, not on deficiencies and problems;
- d. 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
- e. Goals and tasks with measurable outcomes are established to assess change not compliance.

4) 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:

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

5) 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 manner. Monitoring and adapting guidelines include:

- a. Services are provided regardless of the Class Member's behavior, placement setting, family circumstances or availability of services;

- b. Never giving up on Class Members and families while keeping them safe;
- c. Understanding that setbacks may reflect the changing needs of family members, not resistance; and
- d. Skills and knowledge of the family and Class Members are essential to the change process.

6) 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:

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

C. Child and Family Team Approach

All Class Members will receive care planning and service coordination through a Child and Family Team (CFT) approach. The CFT approach is a teaming process that brings together the family and individuals that the Class Member and his or her family believe can help them develop and implement a care plan that will assist them in realizing their treatment goals. These individuals may include informal community supports, such as extended family, neighbors, friends, coaches, faith-based connections, and tribal members. CFT members may also include formal supports, such as providers, Class Member and family peer support specialists, educational professionals, and representatives from other agencies providing services to the Class Member and family.

The CFT may be small or large. At a minimum, the CFT includes the mental health provider, the Class Member, and the Class Member's parent or legal guardian. The CFT may include additional participants if the Class Member and family are involved in other child-serving systems, have complex needs, have an extensive natural or informal support system, or have multiple service providers.

The size, scope, and intensity of the involvement of CFT members is driven by the needs and desires of the Class Member and family. Members of the CFT may be added or removed as the needs and strengths of the Class Member and family change over time.

Class Members eligible for Intensive Care Coordination (ICC) will have a dedicated CFT team facilitator with training in the wraparound process for care planning.

The role of the CFT includes:

- a. Collaboratively developing an Individualized Care Plan that addresses the strengths and needs of the Class Member and family and identifies the roles of all the parties involved;

- b. Identifying, recommending, and arranging for all medically necessary services and supports needed by the Class Member and family;
- c. Facilitating coordination of service delivery for Class Members involved with more than one child-serving system and/or multiple providers;
- d. Working together to resolve differences regarding service recommendations, with particular attention to the preferences of the Class Member and family;
- e. Having a process to resolve disputes and arrive at mutually agreed upon approach for moving forward with services; and
- f. Reconvening to monitor and consider the outcomes in relation to the services that have been provided to meet treatment goals and to make needed adaptations over time.

D. Services

Class Members are eligible to receive all services set forth in the Service and Supports, defined in Appendix C, that are necessary to meet their individualized mental health strengths and needs.