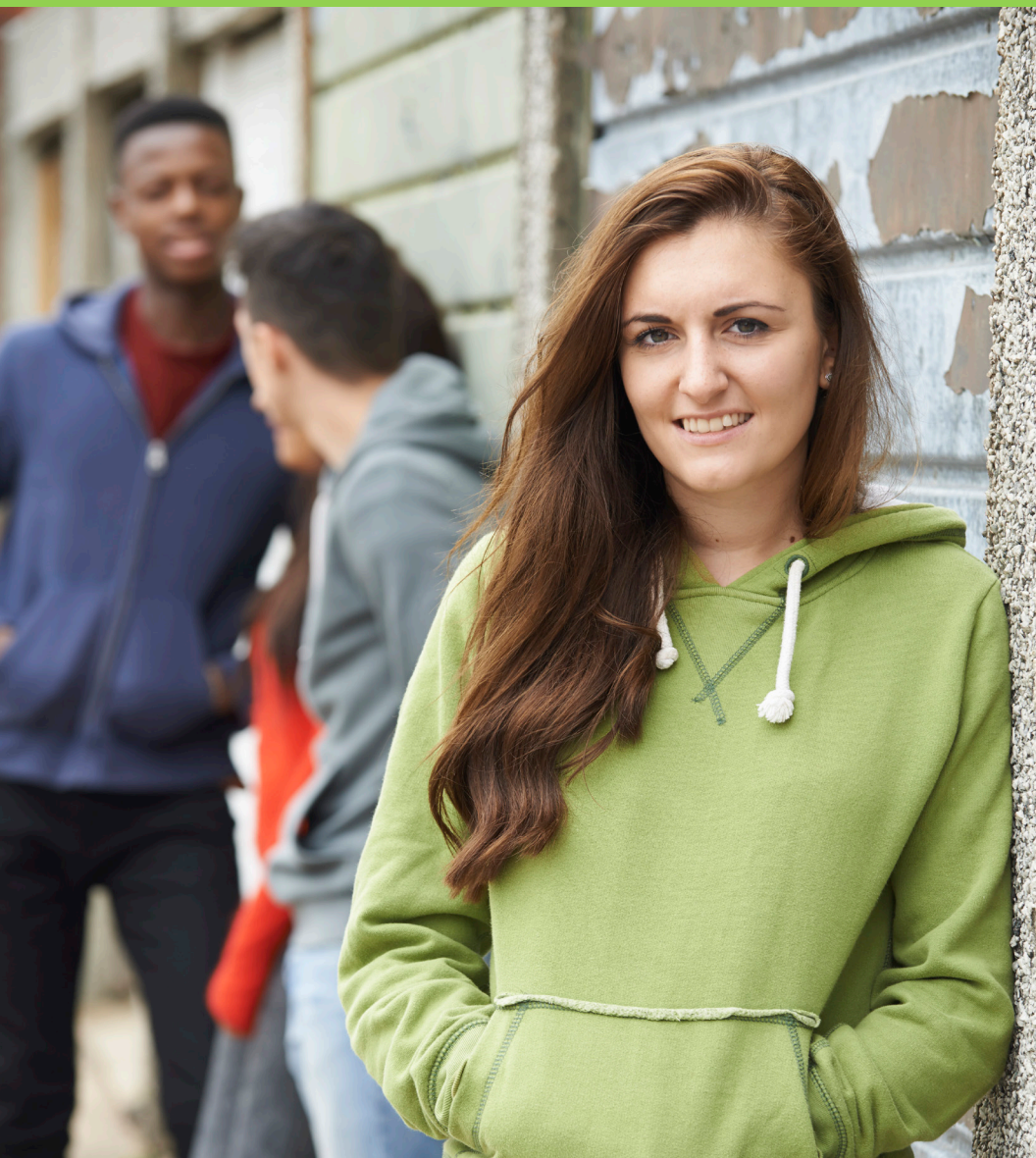
Youth Empowerment Services

YES 101

Empowering the mental wellness of children, youth and their families



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Glossary of Acronyms

CANS	Child and Adolescent Needs and Strengths
CDA	Comprehensive diagnostic assessment
CFT	Child and Family Team
FPG	Federal Poverty Guidelines (previously called FPL - Federal Poverty Level)
SED	Serious emotional disturbance
YES	Youth Empowerment Services

This booklet was developed by the Department of Health and Welfare, the State Department of Education, and the Department of Juvenile Corrections with input from parents, providers, and other partners to provide general information about the Youth Empowerment Services (YES) system of care. For more information about YES, please visit yes.idaho.gov.

Getting to Know YES

What is Youth Empowerment Services?

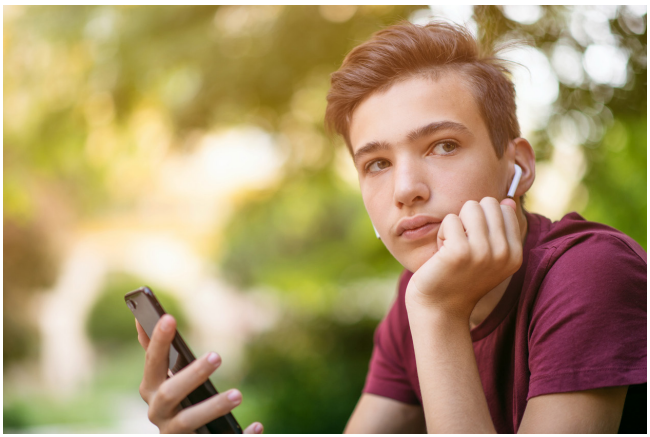
Youth Empowerment Services (YES) is Idaho's children's mental health system of care that helps families access services and supports for their children who are at risk for or have serious emotional disturbance (SED). The YES system of care also creates meaningful partnerships between families, youth, providers, and public agencies to address the youth's specific needs and help them function better at home, in school, and in the community.

What is SED?

Serious emotional disturbance (SED) is a term used when youth under the age of 18 have both a mental health diagnosis and a functional impairment as identified by the Child and Adolescent Needs and Strengths (CANS) tool.

Who can use the YES system of care?

The YES system of care is for Idaho youth under the age of 18 who are at risk for or have serious emotional disturbance (SED).



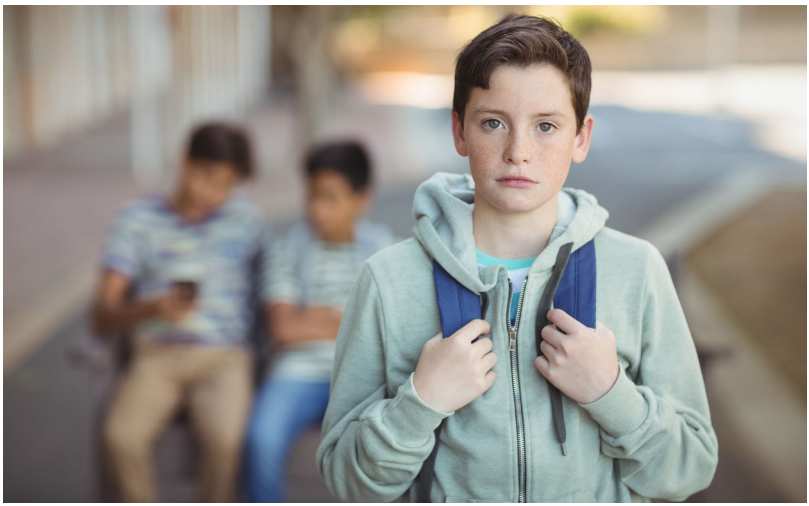
How does the YES system of care empower youth and families?

The YES system of care prioritizes the following values throughout treatment planning, implementation, and evaluation:

- Family-Centered – Emphasizes each family's strengths and resources.
- Family and Youth Voice and Choice – Prioritizes the preferences of youth and their families in all stages of care.
- Strengths-Based – Identifies and builds on strengths to improve functioning.
- Individualized Care – Customizes care specifically for each youth and family.
- Team-Based – Brings families together with professionals and others to create a coordinated care plan.
- Community-Based Service Array – Provides local services to help families reach the goals identified in their coordinated care plan.
- Collaboration – Partners families, informal supports, providers, and agencies together to meet identified goals.
- Unconditional – Commits to achieving the goals of the coordinated care plan.
- Culturally Competent – Considers the family's unique cultural needs and preferences.
- Early Identification and Intervention – Assesses mental health and provides access to services and supports.
- Outcome-Based – Contains measurable goals to assess change.

What should parents expect from the YES system of care?

- **Engagement** — Youth and families are actively involved in the creation and implementation of their coordinated care plan.
- **Assessment** — Information about the youth and family is gathered to create a meaningful coordinated care plan.
- **Care Planning & Implementation** — The coordinated care plan identifies appropriate services and supports and how families and youth access them.
- **Teaming** — Youth and families are able to collaborate with providers and community partners to create their coordinated care plan.
- **Monitoring & Adapting** — The services and supports in the coordinated care plan are evaluated and updated as needed.
- **Transition** — Type of services, frequency of use, and levels of care change as the youth and family's needs change.



Getting Started

How does a family access the YES system of care?

If a family wants to access the Youth Empowerment Services (YES) system of care for mental health services and supports, there are multiple ways to get started.

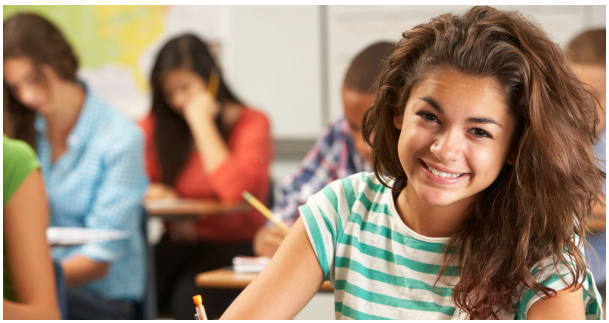
Meet with an independent assessor

The independent assessor helps identify youth who have serious emotional disturbance (SED).

Not every child needs to meet with the independent assessor, but it may be useful in the following situations:

- If you previously applied for Medicaid and were not eligible, call the Independent Assessor to schedule an assessment for SED.
- The youth already has Medicaid, but would like to access respite services for the youth covered by Medicaid.

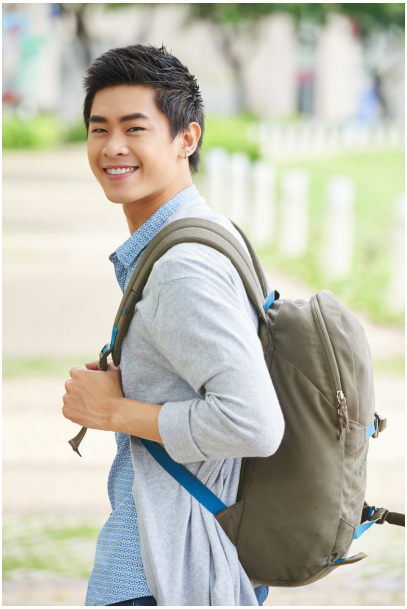
Please Note: If a youth is eligible for Medicaid coverage after visiting the independent assessor, annual independent assessments and eligibility determinations are required to maintain eligibility. Contact information for the Independent Assessor is on the yes.idaho.gov website.



Contact the Idaho Behavioral Health Plan Managed Care Organization

If the youth does not have Medicaid, and the household has an income over 300% of the federal poverty guideline (FPG), Magellan Healthcare can help families find mental health providers who are part of the YES system of care.

Contact the Idaho Behavioral Health Plan Managed Care Organization, Magellan Healthcare, at 1-855-202-0973 or visit MagellanofIdaho.com.



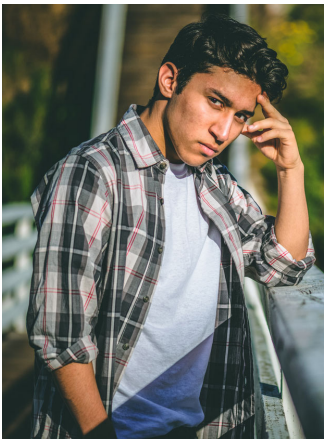
Call a mental health provider to schedule an assessment

If the youth already has Medicaid, the family may contact a Medicaid behavioral health provider directly and ask for a mental health evaluation to be completed using the CANS tool. For assistance in finding a Medicaid behavioral health provider, the family may contact the Idaho Behavioral Health Plan managed care provider. Contact information for the Idaho Behavioral Health Plan managed care provider is on the yes.idaho.gov website.

Is YES only a program for children with Medicaid?

Access to the YES system of care is available to all Idaho youth under the age of 18 who have a mental health diagnosis and a functional impairment, known as serious emotional disturbance (SED), or youth at risk of an SED. For Medicaid eligible youth, Medicaid covers many of the services that are part of the YES system of care. For youth who do not qualify for Medicaid, services may be accessed for a fee through Magellan Healthcare, MagellanofIdaho.com.

Understanding the CANS



What is the CANS?

The Child and Adolescent Needs and Strengths (CANS) tool is used in Idaho to identify a youth's strengths and needs, including a functional impairment. The CANS uses the youth and family's story to recognize strengths that can help during treatment, as well as needs that may require intervention. The results of the CANS are used to help identify appropriate services and then help monitor progress towards goals.

Why does a child need a CANS?

The Child and Adolescent Needs and Strengths (CANS) is a communication tool that helps families and providers use a common language to identify needs and strengths, identify appropriate services and supports for treatment, and monitor progress towards goals. Once a family tells their story while completing the CANS, that story is used to help providers understand the unique needs each family has and the strengths that a youth and family have to support them during treatment. The Youth Empowerment Services (YES) system of care uses the CANS as a standard throughout Idaho.

How is the CANS tool different than a comprehensive diagnostic assessment (CDA)?

A comprehensive diagnostic assessment (CDA), sometimes called a mental health assessment, is a process where a licensed clinician reviews the history of the person seeking care, conducts a clinical interview, and evaluates any available data to identify mental health issues and service needs. A completed CDA includes background information, the results of a mental status exam, and a mental health diagnosis, if appropriate.

The Child and Adolescent Needs and Strengths (CANS) tool is often used at the same time as a CDA, as it helps the family share their story with the mental health provider. While the CDA identifies a mental health diagnosis, the CANS helps to identify specific needs that may benefit from treatment.

Working with Child and Family Teams

How does a Child and Family Team Work?

A Child and Family Team (CFT) is a group of caring and invested people who are invited by the youth and family to work together to help create a coordinated care plan. Members of the CFT include the youth, the family, and the mental health provider, but may also include extended family, friends, individuals from child-serving agencies, and community members.

The youth and family are essential Child and Family Team members, and a CFT may not meet without them. Families and youth are supported, valued, and respected by other members of the team. They lead the team in identifying short and long-term goals for the coordinated care plan.

Child and Family Teams meet as needed to create the coordinated care plan and then update it as treatment progresses and the needs of the youth and family change, at least once a year. The length of time that a CFT may meet depends on the needs of the youth and family. Members of the CFT may change over time.

Developing a Coordinated Care Plan

What is a coordinated care plan?

Coordinated care plans are created by Child and Family Teams (CFT) and identify services and supports in the community that may help the youth and family reach their treatment goals. If a youth has gone to the Independent Assessor they will create a coordinated care plan that includes a person-centered service plan. Treatment goals in coordinated care plans are measurable, assess change (but not compliance) and encourage the youth and family to work towards wellness and self-sufficiency. All types of coordinated care plans also include mental health crisis and safety plans.

How is a coordinated care plan different than a treatment plan?

Coordinated care plans are created by the Child and Family Team (CFT) to coordinate the care being given by all providers. Treatment plans explain only the service or support being offered by that specific provider.

Each provider creates an individualized treatment plan to explain how they plan to help the youth reach the goals identified in the coordinated care plan. They also identify the strength being built or the need being addressed with measurable goals.

How do coordinated care plans help with transitions?

A transition is the change between levels of service, such as when a youth moves between community-based services and inpatient care. Transitions also occur when a youth moves between systems, such as when they complete a treatment plan with a mental health provider and move towards a less formal support in their community. Youth transition out of the Youth Empowerment Services (YES) system of care when they turn 18.

Expected transitions are planned for in the coordinated care plan and monitored as progress is made towards treatment goals. Members of the Child and Family Team (CFT) can revise the coordinated care plan to support the family during times of transition.

Understanding YES in the Community

Are YES services coordinated with my child's school?

Most schools do not directly provide services as part of the YES system of care, but school staff may participate on a Child and Family Team (CFT), help a family complete the CANS with the family's mental health provider, support the goals identified on the coordinated care plan, or provide in-school supports. How schools choose to get involved and the resources available vary between districts, and families are encouraged to discuss involvement with their local school staff.

Is the YES system of care available if my child is in a county detention facility or state correction center?

The Youth Empowerment Services (YES) system of care looks a little different when a youth is in the custody of a county detention facility or the Idaho Department of Juvenile Corrections. In those cases, the Child and Family Team (CFT), which may be called a treatment team, has members from county or state child-serving agencies, and the services and supports may not be community-based or voluntary. While every effort is made to include families on these teams, court orders must be followed, and that may impact the ability for the family to participate. The services identified by the treatment team reflect the services available in the facility and may include different services than are available in the community. Expected transitions are planned for in the coordinated care plan and monitored as progress is made towards treatment goals. Members of the Child and Family Team (CFT) can revise the coordinated care plan to support the family during times of transition.

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