Youth Empowerment Services (YES) is the children's mental health system of care in Idaho that helps families access services and supports for their children with serious emotional disturbance (SED). This pamphlet provides information about the principles of care that are part of YES, and what families can expect from this system of care.

Serious emotional disturbance (SED) is the term used when a child under the age of 18 has the combination of a mental health diagnosis and a functional impairment, as determined by the Child and Adolescent Needs and Strengths (CANS) tool. A functional impairment impacts a child's ability to participate socially, academically, and emotionally at home, at school, or in the community.

The Child and Adolescent Needs and Strengths (CANS) tool is used in Idaho to identify a child's strengths and needs (including any functional impairment). It is used during treatment planning and service delivery.

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.

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IDAHO DEPARTMENT OF HEALTH & WELFARE

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DEPARTMENT OF EDUCATION
STATE OF IDAHO

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Youth Empowerment Services

YES

Child and Family Teams & Coordinated Care Planning

yes.idaho.gov

About the YES System of Care

Child and Family Teams

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

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.