CHILD AND FAMILY TEAMS UNIFY SUPPORTS, PROVIDERS TO MEET YOUTH NEEDS

What is a Child and Family Team (CFT)?

Child and Family Teams bring youth and their families together with their providers and natural supports to develop a unified plan to meet their treatment needs. In addition to the family and mental health provider, a CFT can consist of any number of caring and invested people (friends, teachers, counselors) that the family would like to help them address the youth's treatment.

A major strength of the CFT is its team-based approach that brings the people together to help the youth be successful and achieve their goals.

How will the CFT work?

This teaming process that can occur at any level of treatment, ensuring those services meet a youth's individualized needs. The CFT process describes the collaboration that drives the planning for care and achieving the youth's goals.

Teams meet to create the care plan with treatment goals that are measurable, addressing what is expected to change for the child/youth and family, and encouraging youth and their family to work toward wellness and self-sufficiency.

Care plans created by CFTs always include a crisis and safety plan and may include a person-centered service plan or Wraparound plan of care, as described on the back of this page.

As treatment progresses, the CFT should update the plan as the needs of the youth and family change and at minimum, once a year. Members of the team may change as needs change.

CFT meetings are commonly held monthly, though meeting frequency and length is driven by the family. As long as the family is enrolled in services, a team will meet for as long and as often as they feel it is needed.

Child and Family Teams cannot exist without the engagement of the youth and family. They lead the team in identifying goals for their plan and are supported and empowered to achieve those goals by the team members.

How long can a CFT be used?

A CFT will meet and exist for as long as the family and youth feel it needs to. As long as youth and family are engaged in mental health services, they are empowered to have a CFT.

How does a CFT end?

Transitions between types of care – such as between community-based services and inpatient treatment – are planned for by CFTs as they occur. Transitions out of care, including a CFT, are also planned when the family feels they have met their treatment goals. It is suggested that families celebrate milestones like the end of the CFT process.

How are CFTs created?

To create a Child and Family Team to help achieve your treatment goals, start by contacting your provider. Then with your child, think of a couple more people you'd like to add to your team. You can find more information about eligibility and how to get started on the Youth Empowerment Services CFT page.

Learn More

Visit YES.idaho.gov or call Magellan Healthcare, 1-855-202-0973, to learn more about YES, Child and Family Teams, and how you can find help for your family. Specific information on the topics in this document can be found:

Child and Family Teams: YES.idaho.gov/youth-empowerment-services/tools/understanding-yes/child-and-family-teams/

Wraparound: YES.idaho.gov/youth-empowerment-services/tools/understanding-yes/wraparound-intensive-services/

CHILD AND FAMILY TEAMS UNIFY SUPPORTS, PROVIDERS TO MEET YOUTH NEEDS

Where does a CFT fit with my child's services?

Youth may be involved in services like Wraparound, where they may have developed a comprehensive plan of care, or Intensive Care Coordination, where they have a person-centered service plan. A Child and Family Team provides a process for both of these services, and other treatment services to bring together the youth's providers and key supports to meet their needs.

Wraparound

Wraparound is a formal, fidelity-based, principles driven planning process for Idaho youth and their families exhibiting the highest need. Youth and their families in need of an intensive coordinated planning process to meet their individualized needs are able to participate voluntarily in Wraparound.

Youth participating in Wraparound are involved in multiple youth-serving systems (either Child Protection, Juvenile Justice, Educational, Developmental Disabilities, or Medical), or are at risk of removal from their home or community.

A Wraparound coordinator assists the youth and family in identifying their strengths and needs, choosing and orienting prospective teammembers for the Child and Family Team, and creating a vision for the youth and family to meet the identified, prioritized needs.

The coordinator facilitates a planning process that pulls together formal, informal, and natural supports to develop a Wraparound Plan of Care, a crisis and safety plan, and a transition plan, and also monitors identified outcomes during an average of 12-14 months.

- To learn more about Wraparound, contact Magellan Healthcare, 1-855-202-0973 or visit YES.idaho.gov/youth-empowerment-services/tools/understanding-yes/wraparound-intensive-services/
- You can also use the forms on this page to electronically submit a question: YES.idaho.gov/youth-empowerment-services/about-yes/contact-us/comments-and-questions

Intensive Care Coordination

Intensive Care Coordination is a service that helps families access services and coordinate care through formal and informal supports, as well as track a youth's progress.

It is available to any Medicaid member under 18 years of age, including youth with expanded income eligibility.

To learn more, contact Magellan Healthcare, 1-855-202-0973, or visit magellanofidaho.com.

You can also e-mail WraparoundCoE@dhw.idaho.gov for more information.

A designated, targeted care coordinator serves as a care guide for the family and is responsible for integrating services between providers, systems and programs, linking families to what they need.

The coordinator is also responsible for setting up and facilitating Child and Family Team (CFT) meetings that help families, their providers and natural supports, setting treatment goals and identifying and navigating access to services to help meet those goals.

Goals and services are based on family voice and choice and are documented in a person-centered service plan, which includes both formal and informal services and supports.