Wayside Youth & Family Support Network
Community Service Agency -- Framingham Area

SYSTEM OF CARE COMMITTEE (Framingham CSA, 88 Lincoln Street)

19 January 2009 -- Meeting Notes

I. Welcome and Introductions
Present: Beth Chin (Wayside CSA Program Director), Gail Carey (SMOC), Laura Bleakney (FCP), Alanna Sieck (Wayside), Jean Thraen (Value Options), Jessica Justice (DCF), Kelly McNulty (DCF), Dodi Hardsog (Wayside), Joyce Nardine (DCF), Bill Fagley (Network Health), John Badenhausen (Westboro Youth Services), Chip Wilder (Employment Options)

II. Introductions and Welcome (Beth Chin)
Participant introductions followed by thanking Wayside for hosting the meeting and welcoming willing members to host meetings in the future. John Badenhausen has already offered to host in February.

III. Wraparound (Chip Wilder)
Recap on the first 5 wraparound principles. Chip had an in depth discussion about goals/outcomes and the final 5 principles of wraparound. (Postponed to later in meeting.)

IV. Feedback (All)
Discussion of participants' experience with Wayside and other CSAs. Providers reported positive feedback and success stories. Providers also stated that they have been experiencing strong partnership and team work from Intensive Care Coordinators.

V. DATA (Beth Chin)
Framingham CSA is averaging 5 referrals per week. There are currently 103 active referrals and no wait list. Two new staff members have been hired to help the team, and currently looking to increase family partners. Also, New Life Counseling has begun to serve families, as a subcontractor to Wayside.

VI. Announcements
All are welcome to bring and share information about programs, resources etc. Information about support groups will be attached electronically. Framingham CSA is hiring, send resume or call Beth Chin.

Next meeting: February 25, 2010, from 2-3:30 PM, in the Forbes Municipal Building, Room 21, Westborough.

Accessing Home-Based Services Through the Community Service Agency

When a child and family apply, or are referred, to a Community Service Agency (CSA) for home-based services, the CSA will conduct a preliminary assessment and determine if the child meets the eligibility (medical necessity) criteria for intensive care coordination (ICC). If the child satisfies these criteria, the child is enrolled in ICC; if not, the child is referred for other services, including other home-based services. A risk management or crisis safety plan is developed for every child within two days of enrollment.

A care manager then is assigned, who conducts a comprehensive home-based assessment within three weeks of enrollment. The assessment is strength-based and culturally competent, and considers family dynamics as they impact the child. Any immediate service needs are addressed promptly. The comprehensive home-based assessment includes a meeting with the child and family in their home, interviews with other providers, school officials, or key persons with the child's life, a review of relevant records, and, when needed, additional formal clinical assessments. Through this comprehensive assessment process, the care manager collects all relevant information that will be used by the integrated child and family team to develop a single, unified service plan.

The care manager also identifies the initial members of the team, which meets and develops a care plan within twenty-eight days of enrollment. A decision is made with the family whether a Family Partner would be helpful and should be included on the team. The team collaborative establishes goals, determines needed services and supports, and identifies specific providers. Some services may have to be approved by the relevant managed care organization.[1]

The care manager assists the family in accessing home-based and other services, coordinates with multiple providers or state agencies, and maximizes natural supports. Once the service plan and the amount and duration of services contained in the plan are approved and initiated, the care manager meets regularly with the child and family to coordinate and monitor these services.

All aspects of this process for accessing and obtaining services, including initial evaluation, home-based assessment, identification of the team, convening of the team, and determination of appropriate services and supports is done in close collaboration with the child and family and only with their consent.

Prepared by the Center for Public Representation
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[1] Subsequent Features will discuss the role and responsibilities of the care manager, the membership and responsibilities of the child and family team, the benefits of a family partner, the principles of the wraparound planning process, and the approval process by the managed care organizations.

The New Mental Health Assessment Process

Beginning on November 30, 2008, all mental health assessments of Medicaid-eligible children must use the Child and Adolescent Needs and Strength (CANS) process. The process will be critical in identifying children who would benefit from Intensive Care Coordination (ICC) and the other new remedial services.

The CANS is a widely used instrument to assess the strengths and needs of a child, as well as of the child‘s family or caretaker. It includes a number of domains in which the child's and family's functioning is assessed. The CANS asks the decisionmaker to respond to a number of issues under six general categories: problem presentation, risk behaviors, functioning, care intensity, caregiver capacity, and strengths. The reviewer assigns one of four numbers to the issue: 0 for no problem; 1 for preventive intervention; 2 for action needed; and 3 for immediate/urgent action needed. Although there is a general template for the CANS, different States use somewhat different versions of the template, depending of their goals, the specific purpose of the process, and other local factors.

The CANS can be used by mental health professionals, school and child care staffpersons, child care and juvenile justice workers, and even family members/advocates to make decisions concerning treatment or support. Reviewers must be trained and certified in the use of the CANS, in order to ensure reliability and consistency in ratings. The University of Massachusetts is offering free training to all interest clinicians, both through in person and a web-based training program. To date, almost five thousand mental health clinicians have been trained, and almost 4,000 have been certified.

Massachusetts has two CANS: one for children under the age of five years old; another for children five and above. In the context of the Children's Behavioral Health Initiative and the implementation of the *Rosie D.* Judgment, the CANS will be used to assess all children who are screened by a primary care clinician as having a behavioral health condition; all children who are referred by child-care staff, such as early intervention programs, pre-school and school programs, state agencies, health professionals, and medical facilities, to a mental health provider; and all children whose families seek mental health care from a Medicaid provider. The CANS assessment will determine what supports, intervention, or other treatment the child needs, and should result in a referral to appropriate mental health services, and particularly the remedial services ordered by the Court.

The CANS may also be used to evaluate the outcome of interventions, by evaluating their impact on the child and family. Finally, in some circumstances it has been employed as an evaluation instrument for an entire system of care. Massachusetts intends to use the CANS as an evaluation instrument as well as a tool to guide service and treatment decisions. It is developing an electronic information management capacity that will allow providers to share CANS reports, and for the Commonwealth to use CANS

findings, recorded both before and after services are provided, to evaluate child nad system outcomes.

The CANS was developed by Dr. John Lyons to provide a structure and guide for evaluating both the strengths and needs of children with behavioral health conditions. It has been repeatedly tested and validated, and is now being used by several States. General information on the CANS can be found at http://www.buddinpraed.org/cans/. Information on the Massachusetts CANS, including the instrument for children ages 1-4, the instrument for children ages 5 and above, the schedule and process for Massachusetts Medicaid providers, as well as Frequently Asked Questions (FAQs)can be found at http://www.mass.gov/?pageID=eohhs2terminal&L=5&L0=Home&L1=Government&L2=Special+Commissions+and+Initiatives&L3=Children's+Behavioral+Health+Initiative&L4=Training+for+Providers&sid=Eeohhs2&b=terminalcontent&f=masshealth_provider_prov_child-bh-hlth-intiative-cans&csid=Eeohhs2.

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The Role and Responsibilities of the Care Manager

The Care Manager is the leader of the Care Planning Team (CPT) and the key contact for children and families seeking home-based services from the new children's mental health system. Once a child applies to the Community Service Agency and is determined to be eligible for Intensive Care Coordination (ICC), the Care Manager arranges, leads, and completes the comprehensive home-based assessment of the child's strengths and needs, which includes collecting background information and plans from other child-serving agencies,. *See* February Feature Story: "Accessing Home-Based Services Through the Community Service Agency." Based upon information gathered through this assessment process and in conjunction with the family and child, the Care Manager identifies the individuals who will be members of the Team and leads, facilitates, and oversees the CPT.[1]

The Care Manager then convenes the CPT and ensures that it identifies the strengths of the child and family, as well as any community resources that may be available to support the child. In concert with the CPT, the Care Manager develops and prepares the Individual Care Plan (the Plan), which describes the home-based services that the child will receive. Once the Plan is in place, the Care Manager assists the child and family to access all needed services, and coordinates the actual delivery of home-based and other services, including medical, educational, social, therapeutic, or related services. This is the core function of the Care Manager.

Once all needed services are in place, the Care Manager monitors the Plan, and convenes periodic reviews (at least quarterly, usually monthly, and if needed, more frequently) by the CPT to determine if services are being provided in accordance with the Plan and whether these services are adequate to meet the child's needs. If these needs change or if services must be changed, the Care Manager reconvenes the CPT and modifies the Plan as needed.

The Care Manager is also the designated person on the team responsible for collaborating with other caregivers on the child and family's behalf, such as behavioral health providers, DCF, DMH, DYS, and DDS workers, probation officers, guardians, attorneys and advocates, teachers, special education administrators, primary care physicians, natural supports (i.e. church and community agencies), and others. The Care Manager frequently contacts these other agencies or individuals, invites them to CPT meetings, provides them with copies of the completed ICP, and attends meetings of these other caregivers and child-serving agencies. The Care Manager has the primary responsibility to ensure that all plans and services are consistent, integrated, and coordinated.

The Care Manager also works directly with the child and family, meeting as often as necessary (at least monthly and, if needed several times weekly) to provide support and to ensure services are offered in a timely and responsive manner. Finally, when the

[1] The next Feature will discuss the membership, role and responsibilities of the ICT.

CPT determines that the child no longer needs and would benefit from ICC, the Care Manager facilitates transition planning, including planning for aftercare or alternative supports.

The Care Manager will either be a bachelor or master's level professional. All Care Managers will be trained in the WrapAround planning process and System of Care values. The Wraparound process refers to a four step planning process that builds upon the strengths of the child and family, that involves and responds to the preferences of the child and family, and that results in a unique set of community services and natural supports individualized for that child to achieve a positive set of outcomes. The System of Care is a cross-system coordinated network of services and supports organized to address the complex and changing needs of the child. This process will be consistent with the principles and values of the Child-Adolescent Services System Program (CASSP) which encourages care provision to be strength based, individualized, child centered, family focused, community based, multi-system, and culturally competent.

Care Managers will have caseloads that allow them to provide the level of care management that the child and family need. A Care Manager serving children with intensive needs generally will have caseloads of no more than 8-10 children; those serving children with less intensive needs will have caseloads that do not exceed 18 children. Care Managers may serve a mix of children and generally will have average caseloads of no more than 14 children.

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The Role, Responsibilities, and Membership of The Care Planning Team

Every youth enrolled in Intensive Care Coordination (ICC) will have an individualized Care Planning Team (the Team) that guides all aspects of his or her care. The Team engages and supports the family, and builds upon the family and youth's strengths to develop a mutually respectful and useful partnership to promote improved health outcomes. The Team's specific responsibility is to develop and oversee a single treatment plan that delineates specific home-based services and other supports to effectively meet the youth's needs.

The family and youth are the core members of the Team. They are both the focus of the Team's efforts and the primary members of the Team. Their culture, preferences, schedule, and communication style must be reflected in the composition and operation of the Team. They not only "drive" the Team's activities but also reasonably expect to be empowered by the Team.

As outlined in previous Features[1], once the local Community Service Agency determines that a youth is eligible for ICC, he or she is assigned a care manager. The care manager, who is the leader of the Team, meets with the youth and family in the home, and conducts a comprehensive assessment of the youth's and family's strengths and needs. The care manager also gathers information for this assessment from schools, providers and other agencies involved with the youth. In collaboration with the youth and family, the care manager identifies and selects members of the Team. They should include any involved mental health professionals, representatives of state or local agencies, school staff, or other so-called "natural" supports, such as neighbors, friends or extended family members. In addition, the Team may include a Family Partner (now called a Family Support and Training Worker) who can help parents and guardians navigate state agencies, offer supportive guidance, and model effective parenting skills.

Within 28 days of the youth's enrollment in ICC, the Team develops a single treatment plan that focuses on the strengths of the youth and family. This Individual Care Plan (the Plan) identifies the youth's treatment goals, specifies the timetables to meet those goals, and describes the type, frequency, and intensity of services to enable her to meet those goals. The Plan also lists the specific providers who will deliver each service. Even if a youth is involved in multiple agencies, he or she will have a single treatment plan that integrates all other agency plans to ensure that all services are coherent and coordinated. Moreover, every Plan must incorporate the youth's crisis plan or risk management plan.

Once the Plan is developed, the care manager, who is the key contact and support for the child and family, will monitor the Plan, and convene the Team at least quarterly, usually monthly, and even more frequently if warranted, in order to ensure that services are integrated, timely, coordinated and appropriate. The Team shares responsibility with the care manager to arrange for the provision and coordination of the services identified in the Plan that will enable the child to achieve positive outcomes. As the youth's needs change, the Team will modify the Plan and reconfigure his or her services. If the Team determines that a youth no longer requires or is benefiting from ICC, the Team will develop a transitional plan for alternative supports.

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[1] *See* "Accessing Home-Based Services Through the Community Service Agency," February 2009, and "The Role and Responsibility of the Care Manager," March 2009.

Thus, under the new children's mental health system, every youth enrolled in ICC will have one planning team that includes all relevant persons, agencies, and community members, and a single plan that integrates all services, in order to enhance coordination among providers and ensure more coherent delivery of services and supports. Treatment planning will be based upon a wraparound process for home-based services that builds on children's strengths, empowers their families, appreciates their cultures, and "wraps" services around their needs. Wraparound will be the subject of next month's Feature.

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CSA & MCE CONTACTS BY REGION 1/11/10

BOSTON

Area Office	Organization Name	Operational Contact	MBHP Contact Information	Other MCE Contact Information
Park Street	Home for Little Wanderers	Nina Rosenberg (617) 585-7544 nrosenberg@thehome.org	YRNM[1]: Patrick McCabe, (617) 350-1998 Patrick.McCabe@valueoptions.com ICM[2]: Chris Yang, (617) 350-1959 Chris.Yang@valueoptions.com	Jen Almeida, NHP/Beacon (617) 204-1454 Jennifer_Almeida@nhp.org
Dimock Street	MSPCC	Monica Roizner (617) 587-1507 mroizner@mspcc.org	YRNM: Patrick McCabe, (617) 350-1998 Patrick.McCabe@valueoptions.com ICM: Chris Yang, (617) 350-1959 Chris.Yang@valueoptions.com	Lauren Falls, Network Health, (781) 393-3601 lauren.falls@network-health.org
Hyde Park	Home for Little Wanderers	Nina Rosenberg (617) 585-7544 nrosenberg@thehome.org	YRNM: Patrick McCabe, (617) 350-1998 Patrick.McCabe@valueoptions.com ICM: Chris Yang, (617) 350-1959 Chris.Yang@valueoptions.com	Jen Almeida, NHP/Beacon (617) 204-1454 Jennifer_Almeida@nhp.org
Harbor	North Suffolk Mental Health Association, Inc.	Barbara Wilson (617) 912-7946 bwilson@northsuffolk.org	YRNM: Patrick McCabe, (617) 350-1998 Patrick.McCabe@valueoptions.com ICM: Chris Yang, (617) 350-1959 Chris.Yang@valueoptions.com	Jen Almeida, NHP/Beacon (617) 204-1454 Jennifer_Almeida@nhp.org
Boston (Specialty)	Children's Services of Roxbury	Edna Laurent-Tellus (617) 989-9499, Ext. 343 elaurent-tellus@csrox.org	YRNM: Patrick McCabe, (617) 350-1998 Patrick.McCabe@valueoptions.com ICM: Chris Yang, (617) 350-1959 Chris.Yang@valueoptions.com	Briana Duffy, Fallon/Beacon (781) 994-7500 Briana.Duffy@beaconhs.com
Statewide, focus on Metropolitan Boston (Specialty)	The Learning Center for the Deaf, Walden School	Judy Vreeland (508) 879-5110 judy_vreeland@tlcdeaf.org	YRNM: Jean Thraen, (508) 890-6418 Jean.Thraen@valueoptions.com ICM: Elyse Prack, (508) 890-6402 Elyse.Prack@valueoptions.com	Briana Duffy, Fallon/Beacon (781) 994-7500 Briana.Duffy@beaconhs.com

[1] MBHP RNM/YRNM is responsible for overall provider network management.
[2] MBHP ICM is responsible for Member-specific issues/concerns.

CSA & MCE CONTACTS BY REGION 1/11/10

METRO

Area Office	Organization Name	Operational Contact	MBHP Contact Information	Other MCE Contact Information
Arlington	Riverside Community Care	Borja Alvarez de Toledo (617) 354-2275, Ext. 113 btoledo@gcinc.org	YRNM: Patrick McCabe, (617) 350-1998 Patrick.McCabe@valueoptions.com ICM: Chris Yang, (617) 350-1959 Chris.Yang@valueoptions.com	Jill Lack, NHP/Beacon (617) 772-5774 Jill_Lack@nhp.org
Cambridge	Guidance Center, Inc.	Borja Alvarez de Toledo (617) 354-2275, Ext. 113 btoledo@gcinc.org	YRNM: Patrick McCabe, (617) 350-1998 Patrick.McCabe@valueoptions.com ICM: Chris Yang, (617) 350-1959 Chris.Yang@valueoptions.com	Jill Lack, NHP/Beacon (617) 772-5774 Jill_Lack@nhp.org
Coastal	Bay State Community Services, Inc.	Kenneth Tarabelli (617) 471-8400, Ext. 131 ktarabelli@baystatecs.org	YRNM: Patrick McCabe, (617) 350-1998 Patrick.McCabe@valueoptions.com ICM: Chris Yang, (617) 350-1959 Chris.Yang@valueoptions.com	Elizabeth Ross Wong, BMCHP (617) 748-6329 elizabeth.rosswong@bmchp.org
Statewide, focus on Metropolitan Boston (Specialty)	The Learning Center for the Deaf, Walden School	Judy Vreeland (508) 879-5110 judy_vreeland@tlcdeaf.org	YRNM: Jean Thraen, (508) 890-6418 Jean.Thraen@valueoptions.com ICM: Elyse Prack, (508) 890-6402 Elyse.Prack@valueoptions.com	Briana Duffy, Fallon/Beacon (781) 994-7500 Briana.Duffy@beaconhs.com

CSA & MCE CONTACTS BY REGION 1/11/10

CENTRAL

Area Office	Organization Name	Operational Contact	MBHP Contact Information	Other MCE Contact Information
Framingham	Wayside Youth & Family Support Network	Bonny Saulnier (508) 879-9800, Ext. 231 bonny_saulnier@waysideyouth.org	YRNM: Jean Thraen, (508) 890-6418 Jean.Thraen@valueoptions.com ICM: Kevin Patterson, (508) 890-6408 Kevin.Patterson@valueoptions.com	Lauren Falls, Network Health (781) 393-3601 lauren.falls@network-health.org
North Central	Community Healthlink	Kathy Lento (978) 466-8356 klento@communityhealthlink.org	YRNM: Jean Thraen, (508) 890-6418 Jean.Thraen@valueoptions.com ICM: Elyse Prack, (508) 890-6402 Elyse.Prack@valueoptions.com	Briana Duffy, Fallon/Beacon (781) 994-7500 Briana.Duffy@beaconhs.com
South Central	Y.O.U., Inc.	Paul Carey (508) 890-6519, Ext. 11 careyp@youinc.org	YRNM: Jean Thraen, (508) 890-6418 Jean.Thraen@valueoptions.com ICM: Kevin Patterson, (508) 890-6408 Kevin.Patterson@valueoptions.com	Briana Duffy, Fallon/Beacon (781) 994-7500 Briana.Duffy@beaconhs.com
Worcester East	Community Healthlink	Rosa Hernandez (508) 373-7834 rhernandez@communityhealthlink.org	YRNM: Jean Thraen, (508) 890-6418 Jean.Thraen@valueoptions.com ICM: Elyse Prack, (508) 890-6402 Elyse.Prack@valueoptions.com	Briana Duffy, Fallon/Beacon (781) 994-7500 Briana.Duffy@beaconhs.com
Worcester West	Community Healthlink	Rosa Hernandez (508) 373-7834 rhernandez@communityhealthlink.org	YRNM: Jean Thraen, (508) 890-6418 Jean.Thraen@valueoptions.com ICM: Elyse Prack, (508) 890-6402 Elyse.Prack@valueoptions.com	Briana Duffy, Fallon/Beacon (781) 994-7500 Briana.Duffy@beaconhs.com
Statewide, focus on Metropolitan Boston (Specialty)	The Learning Center for the Deaf, Walden School	Judy Vreeland (508) 879-5110 judy_vreeland@tlcdeaf.org	YRNM: Jean Thraen, (508) 890-6418 Jean.Thraen@valueoptions.com ICM: Elyse Prack, (508) 890-6402 Elyse.Prack@valueoptions.com	Briana Duffy, Fallon/Beacon (781) 994-7500 Briana.Duffy@beaconhs.com

CSA & MCE CONTACTS BY REGION 1/11/10

NORTHEAST

Area Office	Organization Name	Operational Contact	MBHP Contact Information	Other MCE Contact Information
Cape Ann	Health & Education Services, Inc.	Mark Libon (978) 921-1293, Ext. 301 mlibon@hes-inc.org	YRNM: Chris Mink, (617) 350-1906 Chris.Mink@valueoptions.com ICM: Marcie Carmody, (617) 350-1930 Marcie.Carmody@valueoptions.com	Jill Lack, NHP/Beacon Jill_Lack@nhp.org (617) 772-5774
Haverhill	Health & Education Services, Inc.	Mark Libon (978) 921-1293, Ext. 301 mlibon@hes-inc.org	YRNM: Chris Mink, (617) 350-1906 Chris.Mink@valueoptions.com ICM: Marcie Carmody, (617) 350-1930 Marcie.Carmody@valueoptions.com	Jill Lack, NHP/Beacon Jill_Lack@nhp.org (617) 772-5774
Lawrence	Children's Friend and Family Services	Carla Saccone (978) 744-7905, Ext. 204 csaccone@childrensfriend.net	YRNM: Chris Mink, (617) 350-1906 Chris.Mink@valueoptions.com ICM: Diane Grillo, (617) 350-1903 Diane.Grillo@valueoptions.com	Jill Lack, NHP/Beacon Jill_Lack@nhp.org (617) 772-5774
Lowell	MSPCC	Monica Roizner (617) 587-1507 mroizner@mspcc.org	YRNM: Chris Mink, (617) 350-1906 Chris.Mink@valueoptions.com ICM : Marcie Carmody, (617) 350-1930 Marcie.Carmody@valueoptions.com	Lauren Falls, Network Health (781) 393-3601 lauren.falls@network-health.org
Lynn	Children's Friend and Family Services	Carla Saccone (978) 744-7905, Ext. 204 csaccone@childrensfriend.net	YRNM: Chris Mink, (617) 350-1906 Chris.Mink@valueoptions.com ICM: Diane Grillo, (617) 350-1903 Diane.Grillo@valueoptions.com	Jill Lack, NHP/Beacon Jill_Lack@nhp.org (617) 772-5774
Malden	Eliot Community Human Services	Robert Keane (339) 223-5868 rjkeane@eliotchs.org	YRNM: Chris Mink, (617) 350-1906 Chris.Mink@valueoptions.com ICM: Marcie Carmody, (617) 350-1930 Marcie.Carmody@valueoptions.com	Jill Lack, NHP/Beacon Jill_Lack@nhp.org (617) 772-5774
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SOUTHEAST

Area Office	Organization Name	Operational Contact	MBHP Contact Information	Other MCE Contact Information
Attleboro	Community Counseling of Bristol County, Inc.	Tom Loftus (508) 977-8073 TLoftus@comcounseling.org	YRNM: Jane Morse, (617) 350-1987 Jane.Morse@valueoptions.com ICM: Scott Romiti, (617) 350-1955 Scott.Romiti@valueoptions.com	Elizabeth Ross Wong, BMCHP (617) 748-6329 elizabeth.rosswong@bmchp.org
Brockton	BAMSI	Beverly A. Williams (508) 580-8700, Ext. 158 bwilliams@bamsi.org Aisha Bonny (508) 587-2579, Ext. 46 abonny@bamsi.org	YRNM: Jane Morse, (617) 350-1987 Jane.Morse@valueoptions.com ICM: Christie Harris, (617) 350-1991 Christie.Harris@valueoptions.com	Elizabeth Ross Wong, BMCHP (617) 748-6329 elizabeth.rosswong@bmchp.org
Cape and the Islands	Justice Resource Institute	Jennifer Miguel (508) 880-2835, Ext. 210 jmiguel@jri.org	YRNM: Jane Morse, (617) 350-1987 Jane.Morse@valueoptions.com ICM : Scott Romiti, (617) 350-1955 Scott.Romiti@valueoptions.com	Elizabeth Ross Wong, BMCHP (617) 748-6329 elizabeth.rosswong@bmchp.org
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WESTERN

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The Core of the New Children's Mental Health System:
Community Service Agencies

The new children's mental health system is designed around a core concept: the Community Service Agency (CSA). The CSA will be the primary access point for children with SED who need home-based services and will be the direct provider of Intensive Care Management (ICC). The CSA will be responsible for evaluating a child's need for home-based services through a comprehensive home-based assessment, for providing the single care manager who organizes and coordinates the Child and Family Team (Care Planning Team or CPT), and for ensuring that the team operates consistent with wrap-around principles and System of Care values.

There will be twenty-nine local CSAs, each serving the specific cities and towns that are within the twenty-nine areas of the Department of Children and Families. In addition, there will be several specialty CSAs serving distinct cultural and ethnic minorities, in order to ensure cultural competency. Every CSA will be responsible for convening a local advisory committee comprised of families, local providers, school departments, and representatives of the local offices of state child-serving agencies. MassHealth, through its designated behavioral health managed care provider, the Massachusetts Behavioral Health Partnership (MBHP), will contract with each CSA. The contract will provide mechanisms for monitoring the quality of services offered by each CSA, gathering service data, and evaluating client outcomes.

In October, MBHP issued a Request for Responses (RFR) from providers interested in serving as a CSA for one or more areas. The RFR focused only on the initial responsibilities of the CSA, and did not discuss the larger role of a CSA as the hub of the new children's mental health system. It described the CSA's roles as:

- Actively engaging youth and families seeking Intensive Care Coordination (ICC) services and Caregiver Peer to Peer Support Services, using the *Wraparound* care planning process;
- Providing infrastructure support for ICC and Family Partner services;
- Actively participating in a quality improvement process to identify the "lessons learned" from youth, families, providers, and others. These "lessons learned" will continually shape the vision and functions of the CSA; and
- Developing and supporting a local *Systems of Care Committee* that will be charged with supporting the service area's efforts to create and sustain collaborative partnerships among families, parent/family organizations, traditional and non-traditional service providers, community organizations, state agencies, faith-based groups, local schools, and other stakeholders.

As required the Court's Remedial Plan, the RFR described ICC as the core home-based service which ensures that every youth served has a family-driven, youth-guided team, facilitated by a dedicated care coordinator, that plans and ensures access to needed services and supports. ICC services include:

• A comprehensive home-based assessment of the youth's and family's strengths and needs inclusive of the Massachusetts Child and Adolescent Needs and Strengths (CANS) tool;

• Development and facilitation of a care planning team including a Family Partner if desired by the family. Family Partners assist and support families in obtaining needed services and navigating child-serving agencies;

• Creation of an individualized care plan; and

• Monitoring and follow-up activities to ensure successful implementation of the individualized care plan

CSAs will be selected in February, hire and train staff in April – June, and begin serving children by June 30, 2009. MassHealth will select a separate entity to provide training and ongoing support to ICC staff and family partners, beginning in March 2009. MassHealth, MBHP, and the Court Monitor will develop a monitoring and evaluation process for CSAs, as well as for the planning and delivery of home-based services and begin to evaluate CSAs in the fall of 2009.

Families interested in becoming family partners should contact the selected CSA in their area in March 2009.

Prepared by the Center for Public Representation
For more information, please go to www.rosied.org

Families Helping Families: the New Family Partner Program

What does it mean to truly understand the complexities and challenges of caring for a child with serious mental illness? While many professionals can empathize, few people can really identify with the personal, emotional and social toll that managing behavioral health symptoms can take on families unless they themselves have parented a child with a disability.

As families seek out services from the new Children's Behavioral Health Initiative, particularly the family-driven, wrap-around treatment planning process known as Intensive Care Coordination (ICC), they will have a new resource and a new ally in Family Partners.

On June 30, 2009, a service called **Family Support and Training** will become available to the parents and caretakers of Medicaid-eligible youth. This service is unique in that the provider's expertise stems from his or her own experience raising and caring for a child with special needs. For this reason, the Family Partner is able to offer the sense of solidarity and understanding families often need to encourage and sustain their efforts. They are a key resource in empowering families to participate and lead the wraparound process for their children.

Family Partners are specially trained and available to assist, empower and coach parents and caretakers as they access care on behalf of their child. They should speak the language, understand the culture, and be sensitive to the community values of each family.

In the context of a treatment planning process, Family Partners can support a range of therapeutic goals:

- educating parents and caretakers about the family-driven principles of wrap-around care and ensuring that their voices are heard and respected in the treatment planning process as well as helping them actively participate and make informed decisions;

- helping to address and resolve a youth's emotional or behavioral needs by supporting and enhancing the capacity of the parent to respond;

- assisting parents/caretakers as they develop additional skills and strategies to support their child's functioning;

- guiding parents/caretakers as they learn to effectively navigate child-serving systems (education, mental health, benefits, child welfare, juvenile justice) and advocate for their child's needs;

- offering linkages to peer and parent support groups and identifying formal and community based resources which the family may find helpful.

Initially, Family Partners will be provided through the local Community Service Agency (CSA), as part of the ICC program. A family member of a child who is enrolled in ICC can request a Family Partner from the CSA. As long as they meet basic **criteria** for this service, the CSA will assign a Family Partner who can work with the child and family in all aspects of the ICC process and assist in obtaining all types of services. The Family Partner will stand by and with families in all ICC meetings. As in all services, families can choose whether to seek and continue with a Family Partner.

Family Partners also will be available as a discrete service, without regard to whether the child in enrolled in ICC. Families can ask their current outpatient providers to assist them with a referral for this service. Families of children with serious emotional disturbance, who need or receive multiple services or state agency involvement should also consider a referral to Intensive Care Coordination.

Prepared by the Center for Public Representation
For more information, please go to www.rosied.org

A New Remedial Service for Youth with Challenging Behaviors

Children and youth with challenging behaviors often are at greatest risk of extended out-of-home placement, school disciplinary action and involvement in the juvenile justice system. The development of new home-based behavioral supports presents an important opportunity to preserve community connections and avoid negative outcomes for youth with serious mental health needs.

Beginning on October 1, 2009, youth and families will have access to this new, Medicaid-funded resource, known as **In-Home Behavior Management and Monitoring**. The service is designed to strengthen, promote and maintain the development of positive behaviors among children and youth. It relies upon positive behavior support strategies, rather than any form of traditional behavior modification techniques, to promote improved functioning, expanded community integration, and socially appropriate behavior. This is accomplished by identifying individually relevant strategies intended to encourage positive behavior, thereby reducing or eliminating complex, challenging problem behaviors related to the youth's mental health condition(s).

The service begins with the development of a specialized behavior assessment that leads to an individualized plan of intervention. First, a trained behavioral therapist meets with the youth and family to discuss what behaviors are interfering with the youth's successful functioning. The therapist will then propose strategies to support the youth and family's individual goals and objectives.

The resulting behavior plan should be designed to address behavioral needs in the home and community, offering solutions tailored to the unique reality of those environments. The behavior plan must be compatible with and included in the youth's overall treatment plan as well as any risk management/safety plan. Families and teachers will be trained how to employ these strategies in a consistent and effective manner, so that youth are reinforced at home, at school, and in other community settings.

A behavioral aide can also be included in the treatment plan, providing an additional resource to the youth and family. This trained paraprofessional works with, and is supervised by, the behavioral therapist. The aide may model strategies for caretakers, provide direct supports to the youth as they practice new skills in various community settings, and assist the family and teachers as they work to implement the behavior plan in their day-to-day life. Finally, the aide works with the behavioral therapist in assessing the overall effectiveness of the intervention.

If a CANs or other clinical evaluation has identified the need for intensive behavioral supports, and other behavioral interventions have not been successful in addressing the youth's needs, these new services may be appropriate. Interested families can directly contact **In-Home Behavior providers** in their

area or request referral assistance from their current outpatient providers. Families involved in Intensive Care Coordination can be referred to the In-Home Behavior service as part of the wraparound treatment planning process.

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For more information, please go to www.rosied.org

In-Home Therapy Services

An important part of serving youth with behavioral health needs is offering in-home treatment and supports tailored to the everyday situations that they and their families face. These services must be youth and family-centered, culturally-competent, strength-based, and able to address each family's personal goals, unique strengths and specific needs in their local communities.

Beginning on November 1, 2009, youth and families will have access to a new Medicaid-funded program designed with these principles in mind. In-Home Therapy Services are intended to treat children and adolescents in the context of their families. They work to strengthen caregivers' ability to effectively support their child's healthy functioning. In-Home Therapy providers accomplish this goal by developing an understanding of how the family functions, and then teaching skills and strategies to address challenging situations as they arise.

In-Home Therapy Services are different from traditional outpatient therapy. They offer 24/7 urgent response capacity, flexible scheduling, and much more intensive interventions over a longer period of time. Most importantly, they are provided where the youth and families live, rather than in an office. The services should be particularly valuable to families who want to learn new strategies to relate to one another or to manage a youth's behavior more effectively in the home and community.

In-Home Therapy Services can include a combination of therapy provided by a qualified clinician, as well as training and support, delivered by a qualified paraprofessional. Together with the family and youth, the clinician will identify strengths and needs, set goals, and develop and implement a treatment plan. This plan may help the youth and family improve communication and problem-solving in difficult situations, set effective limits, establish helpful routines for the youth, and manage risks and safety concerns. In-Home Therapists can also identify and refer families to additional services, including other new *Rosie D.* remedial services, assist with basic care coordination, and locate other community resources and natural supports for the family. Therapeutic Training and Support paraprofessionals work under the supervision of a clinician, teach the youth to understand, interpret, and manage their emotional responses, and assist the family in working towards treatment plan goals.

In-Home Therapy may be provided in any setting where the youth is naturally located including natural and foster homes, schools, child care centers, respite programs and other community settings. Most providers which currently offer Family Stabilization Teams (FST) will begin offering In-Home Therapy Services. Unlike FST, the new services have no specific limits on either the intensity or duration of these services. In-Home Therapy is available to youth regardless of their MassHealth coverage type.

Additional information regarding In-Home Therapy Services, including a list of network providers by region, is available on this website.

Prepared by the Center for Public Representation
For more information, please go to <u>www.rosied.org</u>

A New Approach to Crisis Services: The Advantages of Mobile Response

The Court's decision in *Rosie D.* and the resulting creation of **Mobile Crisis Intervention Services** represents a revolutionary change in the delivery of crisis services in Massachusetts. Starting on June 30, 2009, Medicaid-eligible children and families who experience behavioral health crises will have a new, alternative resource to support them in the community.

In the past, parents and caretakers had few choices when a behavioral health crisis arose. They could call 911 for ambulance or police response, or try to safely transport their child to a local emergency department or crisis center. These options often escalated the situation and created additional trauma for the youth and family. They experienced lengthy stays in emergency departments, often ending in admission to restrictive treatment settings.

MassHealth's new Mobile Crisis Intervention Service represents a distinctly different approach to supporting youth and families in crisis.

First, the service can be delivered <u>wherever</u> the crisis is occurring, including at home, school or other community setting. A mobile team consisting of a master's level clinician and trained paraprofessional will provide a face-to-face therapeutic response to identify, assess and stabilize a situation while trying to reduce immediate risk of harm to the youth or others.

Second, Mobile Crisis is available <u>whenever</u> the crisis is taking place. Crisis assessment and stabilization services are provided 24 hours a day, 7 days a week. While intended to be a short term response, these supports can be available for up to 72 hours. This allows mobile teams to offer continuing support, take detailed histories, provide appropriate resources and service referrals, and either develop or aid in implementation of a risk management and safety plan.

Third, the service is designed to <u>reduce</u> the likelihood of unnecessary psychiatric hospitalization and promote resolution of crises in the least restrictive setting. In this way, Mobile Crisis offers youth and families an opportunity to de-escalate a situation or problem while also developing strategies to address any future safety concerns.

For youth and families receiving Intensive Care Coordination (ICC), Mobile Crisis can be accessed through their CSA provider and its 24 hour response service. This will ensure immediate coordination between the Care Planning Team and the Mobile Crisis provider. Other families or caretakers can reach their Mobile Crisis team by contacting the local **Emergency Service Provider**.

Requests for Mobile Crisis Services will be directed through a phone triage system where a live person will take basic information. The Mobile Crisis team is required to be at the requested location within one hour. The team will conduct a mental status exam, help to implement any existing crisis plans, access emergency medication consultation if needed,

seek consent to facilitate a variety of service referrals, and follow-up to ensure appropriate resources have been identified. Finally, the Mobile Team can conduct a crisis assessment to see if a higher level of care is needed. If necessary, the team can obtain authorization for and arrange transfer and admission to an appropriate treatment facility.

As part of developing the *Rosie D*. remedial service network, the Commonwealth has re-procured its entire Emergency Service Provider (ESP) system. There are 21 ESP providers across the state, four of whom will remain operated by the Department of Mental Health. The Massachusetts Behavioral Health Partnership (MBHP) is supporting the readiness of Mobile Crisis providers, undertaking statewide trainings as well as individual program consultation with a national mobile crisis expert. A list of **ESPs** by region is available in this website's library.

Prepared by the Center for Public Representation
For more information, please go to www.rosied.org

Achieving the Promise of A Single Plan and Single Team: Interagency Coordination In the New Children's Behavioral Health System

As required by the Court's Judgment in *Rosie D .v Patrick* and in order to achieve the promise of its own Children’s Behavioral Health Initiative, the Secretary of Health and Human Services has developed a set of interagency protocols between MassHealth and each of its other state agencies, including the Departments of Mental Health, Children and Families, Youth Services, Public Health, Developmental Services, and various commissions and offices. These protocols are designed to ensure agency collaboration with the new behavioral health service system and to inform efforts to better coordinate the delivery of care for youth involved in multiple child-serving agencies. For families, these protocols set forth the requirements for agency staff to participate in a single treatment team and to develop a single treatment plan. The protocols are the key tools for families, advocates, providers, state agency staff, and the Court to ensure that youth served by various state agencies are provided comprehensive, coordinated care.

Each agency's protocol document references the goals of the new home and community-based services and the corresponding mission of the respective state agency (DMH, DCF, DYS, DSS, DPH). They describe the range of new remedial services now available to Medicaid-eligible children and families, and describe who can benefit from these services. For each agency, the protocols specify how referrals to the new service system can be made and staffs’ responsibilities to facilitate access to care. Medical necessity criteria and a list of provider contacts are appended to the protocols to support these activities.

Perhaps most importantly, the protocols describe the roles state agency staff and contracted providers must play for the individuals whom they serve. The protocols set forth new requirements concerning agency participation in, and coordination with, the team-based wraparound process facilitated by Intensive Care Coordination. Specifically, they generally require that state agency staff, such as DCF social workers or DYS probation officers, participate on the Individual Care Planning team. The protocols mandate that the agency's own service plan or conditions of probation are incorporated and integrated into the Individual Care Plan.

Where disagreements arise within the Individual Care Planning Team, the protocols create an informal dispute resolution process as well as a new formal process for resolving interagency issues, consistent with new regulations soon to be issued under Chapter 321 of the Children’s Mental Health law. Families can invoke these procedures to ensure that state agency staff participate in the planning process and that agency services are integrated into a single plan, are acceptable to the family, and are fully implemented.

Finally, the protocols describe training expectations within the various state agencies and their representation in the Community Service Agencies (CSA’s) regional System of Care Committees.

Protocols have been finalized and trainings delivered for the Department of Mental Health, the Department of Children and Families, the Department of Youth Services, the Department of Developmental Services, and the Department of Public Health's Bureau of Substance Abuse and School Based Health Centers and its Early Intervention Program. Protocols are being developed for the Massachusetts Rehabilitation Commission, the Department of Transitional Assistance, the Office for Refugees and Immigrants and the Commissions for the Blind and the Deaf and Hard of Hearing.

Upcoming features will focus on specific interagency protocols and their potential impact on eligible class members. Youth and families who are involved in other state agencies and who seek new remedial services and the wraparound treatment planning process are encouraged to contact the Center or one of its statewide legal network providers. Designated programs and network attorneys can be found under "How to Get Help" on the *Rosie D*. home page. Final interagency protocols for **DMH, DCF, DYS, DPH, and DDS** can be found in the *Rosie D.* Document Library.

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For more information, please go to www.rosied.org

The Critical Importance of Screening

When Congress enacted the Medicaid Act, and its Early Periodic Screening Diagnostic and Treatment (EPSDT) provisions, it recognized that the key to improving the health of America's children was early detection and preventive care. A core provision of the program was the requirement that all Medicaid-eligible children must be "screened" at designated intervals and, whenever else needed. With advice from local chapters of the American Academy of Pediatricians, each State established its own periodic screening schedule, and rules for additional screening whenever a child visits a pediatrician or other health care professional (inter-periodic screening). Congress also mandated that there be separate screening for vision, hearing, developmental issues, dental needs, and immunizations. States are required to report annually on the number of children screened at each age bracket between birth to 21.

A review of States' annual reports indicates that compliance with these Congressional mandates varies considerably. Moreover, since the reports do not reflect each type of required screening, it is impossible to determine the compliance level on developmental screening for behavioral conditions. Because of the critical importance of developmental screening in the prevention, early identification, and treatment of mental health conditions, the Court in *Rosie D.* ordered the Commonwealth to make significant improvements in its screening system. Specifically, it required that: (1) MassHealth adopt a standard set of behavioral health screening instruments; (2) MassHealth train pediatricians and other health care professionals on the new instruments and its screening regulations; (3) primary care professionals who conduct screenings report their findings as a condion for reimbursement; (4) primary care clinicians refer children to mental health professionals if a behavioral health problem is identified, as a result of the screening; and (5) MassHealth collect detailed data on the new screening system. In addition, MassHealth revised its education and outreach materials for families to emphasize the importance of behavioral health screening.

These reforms can make a significant difference for children's mental health in the Commonwealth. If problems are identified early, they are much easier to ameliorate. Early intervention programs are available for the youngest children, between birth and three years of age. Treatment of young children can prevent more intractable conditions, more functional impairments, and more expensive interventions. Most importantly, early identification and treatment is generally more effective. Families with concerns about their children's behavior or other mental health conditions are encouraged to request a special behavioral health screening from their treating doctor or other health care professional.

The early data reports of the new behavioral health screening initiative indicate significant gaps remain in the Commonwealth. Although all children who visit their pediatrician or health care professional for a periodic EPSDT visit must now receive a behavioral health screening, only 25% did in the first six months since the new program was initiated on January 1, 2008. Of those who were properly screened, only 7% were identified as having a behavior health condition, even though national data indicates this

figure is well over 10% and often approaching 20%. Finally, of those identified as having a behavior health condition, there was no data on the percentage who were referred for a mental health assessment, even though this figure should be approach 100%. Thus, despite the critical importance of behavioral health screening, as mandated by the Congress and ordered by the federal court, much remains to be done to ensure compliance with these mandates in Massachusetts.

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For more information, please go to www.rosied.org

Therapeutic Mentoring: A Chance for Youth to Learn New Skills

Key to the success of any child or adolescent is their ability to effectively navigate the world around them. This is especially true for youth with serious behavioral health needs, who may require specialized supports, coaching and training in order to develop the skills to relate well to their peers and to participate fully in their communities.

Beginning on October 1, 2009, MassHealth will offer a new service designed to teach these skills through a structured one-to-one relationship with a Therapeutic Mentor. This strength-based service looks to support youth as they work to master activities of daily living, develop age-appropriate behaviors and improve communication, problem-solving and social skills with peers and adults. The Mentor is a guide, a model, and a teacher for the youth, accompanying him/her during various community events and assisting the youth to learn skills that will enable him/her to fully and skillfully engage in these activities.

Like other new home-based supports, Therapeutic Mentoring offers a flexible approach to service delivery, working with youth across various life domains and promoting improved functioning at home, in school and through participation in a range of social, recreational or vocational activities in the community. However, Therapeutic Mentors do not directly fund social or recreational activities, nor are they intended to act as a teacher's aide or a respite provider for parents/caretakers.

Therapeutic Mentoring must be necessary to achieve a goal(s) in an established behavioral health treatment plan. Therefore, youth seeking referrals must either be receiving outpatient services, the new In-Home Therapy (available after November 1, 2009) or Intensive Care Coordination (ICC). For youth in ICC, the Therapeutic Mentor becomes an important part of the Care Planning Team, directly supporting the youth's functional progress and assisting them in communicating their goals and needs to the Team.

Therapeutic mentors must be over 21 years of age, meet educational qualifications and undergo specialized training in a variety of areas including Wrap Around treatment planning, cultural competence, family-centered practice, behavior management coaching, social skills training, crisis management and first aid/CPR. Mentors receive clinical supervision and consultation from their provider organization and are expected to work closely with the family, care planning team or other referring outpatient providers to coordinate care.

Therapeutic mentoring is designed for youth who require this kind of support, coaching and guidance to succeed in their homes and communities. It can also be an important resource for youth who may be at risk for out-of-home placement or require support in transitioning back to the community from a congregate care setting.

More information about Therapeutic Mentoring, including **medical necessity criteria**, **program specifications** and a list of **provider agencies** by region, can be found at www.rosied.org.

Prepared by the Center for Public Representation
For more information, please go to www.rosied.org

The Wraparound Planning Process: A New Opportunity for Families

There is a new opportunity for families' voices to be heard, for their preferences to be honored, and for the culture to be respected when they seek mental health services for their children. This opportunity is process, called Wraparound, which will guide all aspects of the new children's mental health system in Massachusetts. Wraparound is a planning process that builds on children's strengths, empowers their families, appreciates their cultures, and “wraps” services around their needs. The Wraparound philosophy drives treatment planning and determines activities that can enable children with serious emotional disturbance to grow up at home and, together with their families, achieve positive outcomes.

The Wraparound process was first introduced to the children's mental health service system in Alaska in the late 1980s. Since then, Wraparound has been an integral component of service delivery networks in several states across the nation. One of the most effective models has been operating in Massachusetts since 1998, when the Robert Wood Johnson Foundation started a Mental Health Services Program for Youth (MHSPY) in Cambridge. Wraparound Milwaukee is another successful model of integrated care. Using a team-driven process, Wraparound Milwaukee emphasizes individualizing care, building on the strengths of a child, meeting the needs of children and families across life domains, and involving families as full and active partners in all treatment decisions. Clinical outcomes of enrolled youth have improved dramatically, and their school attendance has increased substantially.

The Wraparound process and the youth's treatment are individualized, family-driven, and culturally competent. This community-based model is effective for children with Serious Emotional Disturbance (SED), some of whom may be at risk of out-of-home placement, have complex needs, or be involved in multiple child-serving agencies and service systems. Wraparound combines formal supports, such as therapy, medication and in-home services with informal supports, such as YMCA memberships, scouting, guitar lessons or playing in a basketball league.

There are ten core principles that guide the Wraparound process:

- **Individualized**: To achieve the goals laid out in the in the wraparound plan, the team develops and implements a customized set of strategies, supports, and services.
- **Family voice and choice**: Family and youth perspectives are intentionally elicited and prioritized during all phases of the wraparound process. Planning is grounded in family members' perspectives, and the team strives to provide options and choices such that the plan reflects family values and preferences.
- **Community-based**: The wraparound team implements service and support strategies that take place in the most inclusive, most responsive, most accessible, and least restrictive settings possible; and that safely promote child and family integration into home and community life.

- **Collaboration**: Team members work cooperatively and share responsibility for developing, implementing, monitoring, and evaluating a single wraparound plan. The plan reflects a blending of team members' perspectives, mandates, and resources. The plan guides and coordinates each team member's work towards meeting the team's goals.
- **Culturally relevant:** The wraparound process demonstrates respect for, and builds on, the values, preferences, beliefs, culture, and identity of the youth and family, and their community

- **Team based**: The wraparound team consists of individuals agreed upon by the family and committed to the family through informal, formal, and community support and service relationships.

- **Natural Supports**: The team actively seeks out and encourages the full participation of team members drawn from family members' networks of interpersonal and community relationships. The wraparound plan reflects activities and interventions that draw on sources of natural support.

- **Strengths based**: The wraparound process and the wraparound plan identify, build on, and enhance the capabilities, knowledge, skills, and assets of the youth and family, their community, and other team members.

- **Unconditional**: A wraparound team does not give up on, blame, or reject youth and their families. When faced with challenges or setbacks, the team continues to work towards meeting the needs of the youth and family and towards achieving the goals in the wraparound plan until the team reached agreement that a formal wraparound process is no longer necessary.

- **Outcome based**: The team ties the goals and strategies of the wraparound plan to observable or measurable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly.

Care managers, discussed in the March 2009 Feature, and Individualized Care Planning Teams, the subject of the April 2009 Feature, are integral components of the Wraparound process in Massachusetts.

How Wraparound Works

There are four phases of Wraparound: (1) engagement and team preparation; (2) initial plan of development; (3) implementation; and (4) transition.

Phase One: Engagement & Team Preparation

A facilitator or program representative meets with the family and youth to discuss the wraparound process and listen to the family's story. The family and youth discuss their concerns, needs hopes, dreams, and strengths. They describe their vision for the

future. They identify people who care about them as well as people they have found helpful for each family member. The family and youth reach agreement with the facilitator about who will come to a meeting to develop a plan, and where they should have that meeting.

Phase Two: Initial Plan Development

The family and youth attend their first Wraparound Team meeting with people who are providing services to them, as well as people who are connected to them in a supportive role. The team will:

- Develop a mission statement about what they all will be working on together
- Look at the family's and youth's needs
- Come up with several different ways to meet those needs that match up with their strengths
- Different team members will take on different tasks that have been agreed upon
- When the meeting is over everyone will leave knowing what they have to do and how to contact other team members.

Phase Three: Plan Implementation

Based on the planning meetings, the team creates a written plan of care. The family and youth commit to some action steps, team members are committed to do the work, and the team comes together regularly. When the team meets they do four things:

Review accomplishments (what has been done and what's been going well);
Assess whether the plan has been working to achieve the family's goals;
Adjust things that aren't working within the plan;
Assign new tasks to team members.

Phase Four: Transition

Even though transitions happen throughout the process, there is a point when the family and youth will no longer need to meet regularly with the team. Completion may involve a final meeting of the whole team, a small celebration, or simply saying the family is ready to move on. The family receives a record of what was done as well as list of what worked. They also make a plan for the future, including who they can call on if they need help or if they need to re-convene our team.

For a wonderful and detailed guide to the Wraparound process, written just for families, see http://www.rtc.pdx.edu/PDF/pbWraparound_Family_Guide.pdf .

The Challenge of Implementing Wraparound

Wraparound is a dramatic change from the current system of planning and providing mental health services to children where professionals are in charge and families are

expected to be passive participants and accept what is offered. Wraparound turns this model on its head and puts families in charge. Wraparound is about family empowerment. But empowerment, like other structural reform, does not occur easily or immediately. Because the Wraparound planning process listens to families, values their participation, honors their preferences, and respects their culture, it is a new opportunity for families to be in control of the care provided to their children. But it is up to families to seize this opportunity.

Training and support will be necessary. Family organizations like Parent/Professional Advisory League (PAL) (www.ppal.net), Parents Helping Parents (www.parentshelpingparents.org), and the Federation for Children with Special Needs (www.fcsn.org) are key sources of support. In addition, the Center for Public Representation can provide training to family groups on the Wraparound process. More information about Wraparound is available in the Parents / Family section on the Rosie D. website.

Prepared by the Center for Public Representation
For more information, please go to www.rosied.org