

Department of Mental Health
TRANSMITTAL LETTER

SUBJECT High Fidelity Wraparound Care Planning Process		
POLICY NUMBER DMH Policy 340.10	DATE AUG 0 1 2011	TL# 153

Purpose. To outline the high fidelity wraparound process for children and youth and their families.

Applicability. Department of Mental Health (DMH) Mental Health Authority, DMH-certified Core Services Agencies (CSAs), Community Based Intervention (CBI) providers, and DMH contracted wraparound providers who serve children or youth and their families.

Policy Clearance. Reviewed by affected responsible staff and cleared through appropriate MHA offices.

Implementation Plans. A plan of action to implement or adhere to this policy must be developed by designated responsible staff. If materials and/or training are required to implement this policy, these requirements must be part of the action plan. Specific staff should be designated to carry out the implementation and program managers are responsible for following through to ensure compliance. Action plans and completion dates should be sent to the appropriate authority. Contracting Officer Technical Representatives (COTRs) must also ensure that contractors are informed of this policy if it is applicable or pertinent to their scope of work. *Implementation of all DMH policies shall begin as soon as possible. Full implementation of this policy shall be completed within sixty (60) days after the date of this policy.*

Policy Dissemination and Filing Instructions. Managers/supervisors of DMH and DMH contractors must ensure that staff are informed of this policy. Each staff person who maintains policy manuals must ensure that this policy is filed in the **DMH** Policy and Procedures Manual, and contractors must ensure that this policy is maintained in accordance with their internal procedures.

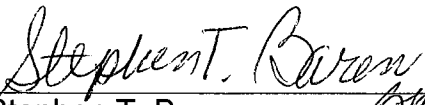

ACTION


REMOVE AND DESTROY

None

INSERT

DMH Policy 340.10


Stephen T. Baron
Director, DMH 

<p style="text-align: center;">GOVERNMENT OF THE DISTRICT OF COLUMBIA</p>  <p style="text-align: center;">DEPARTMENT OF MENTAL HEALTH</p>	<p>Policy No. 340.10</p>	<p>Date AUG 0 1 2011</p>	<p>Page 1</p>
	<p>Supersedes None</p>		

Subject: High Fidelity Wraparound Care Planning Process

1. **Purpose.** To outline the high fidelity wraparound process for children and youth and their families.
2. **Applicability.** Department of Mental Health (DMH) Mental Health Authority, DMH-certified Core Services Agencies (CSAs), Community Based Intervention (CBI) providers, and DMH contracted wraparound providers who serve children or youth and their families.
3. **Authority.** Department of Mental Health Establishment Amendment Act of 2001.
4. **Background.** High Fidelity Wraparound is a process, not a treatment *per se*. (see Section 6a below). The wraparound process aims to achieve positive outcomes by providing a structured, creative and individualized team planning process that results in plans that are more holistic than traditional care plans in that they are designed to meet the identified needs of caregivers and siblings and to address a range of life areas. Through the team-based planning and implementation process, wraparound also aims to develop the problem-solving skills, coping skills, and self-efficacy of the young people and family members. Finally, there is an emphasis on integrating the youth into the community and building the family's social support network.
5. **Policy.** DMH shall utilize contracted wraparound providers to provide high fidelity wraparound care coordination services to children and youth with the most complex needs. Wraparound providers must abide by specific requirements and timelines as outlined in their contracts, and based on the National Wraparound Initiatives (NWI) phases and activities of the wraparound process.
6. **Definitions.** For the purposes of this policy:
 - 6a. High Fidelity Wraparound Process (Wrap) - *Although wrap is often referred to as a treatment within the District of Columbia, high fidelity wraparound is a care coordination service, and is defined as:* A collaborative team-based care planning process where the family and the team implement, track, and adapt an individualized Plan of Care (POC), working toward the youth and family's long term vision for the purpose of achieving positive outcomes in the home, school, and community. The process is coordinated and facilitated by a team leader (Wraparound Care Coordinator) who is trained in the child and family team (CFT) process. The CFT works to engage the youth and family in a needs-based care planning and service delivery process. The CFT also understands the youth and family's strengths, needs, and culture, and leverages community based and natural supports/resources.
 - 6b. Wraparound Care Coordinator - The Wraparound Care Coordinator is responsible for developing and organizing the Child and Family Team (CFT) process that focuses on the development of an individualized POC for children/youth with complex emotional and/or

behavioral health needs and their families. The Wraparound Care Coordinator serves as the team leader and coordinates and facilitates the wraparound CFT process.

6c. Child and Family Team (CFT) - A group of individuals who the family believes can help them develop and implement a plan that will assist the child and family in realizing and achieving their vision of the future. At a minimum it includes the child and his/her family, a mental health representative, court involved partners, and any individuals important in the child's life and who are identified and invited to participate by the child and family. This may include, for example, teachers, extended family members, friends, family support partners, healthcare providers, relevant experts, coaches, representatives from churches, synagogues or mosques, and representatives from other child-serving systems like Child and Family Services Agency (CFSA), Department of Youth Rehabilitation Services (DYRS), DC Public Schools (DCPS), and Court Social Services (CSS). The size, scope and intensity of involvement of the team members is determined by level and complexity of need.

6d. Family Support Partner (FSP) – A team member who is a formal member of the CFT whose personal experience/journey is critical to earning the respect of the family and establishing a trusting relationship that the family values. The FSP's role is to empower the child and the family, help them engage and actively participate in the CFT process, and make informed decisions that drive the process. FSPs have a strong connection to the community and are very knowledgeable about resources, services, supports, and policies for families.

6e. CALOCUS - Child and Adolescent Level of Care Utilization System (CALOCUS) instrument is a method of quantifying the clinical severity and service needs of children and adolescents with psychiatric disorders, substance use disorders, or developmental disorders, and has the ability to integrate these as overlapping clinical issues. The overall CALOCUS score guides the level of care assignment.

6f. Family - The primary care-giving unit, including a biological, adoptive or self-created unit of people who may or may not be residing together and consisting of adult(s) and children, with adult(s) performing duties of parenthood for the children. Persons within this unit share bonds, culture, practices, and significant relationships. Biological parents, siblings and others with significant attachment to the individual living outside the home are included in the definition of family.

6g. Family Vision – The family's vision should identify the long term family goals which can encompass where the child and family like to reside, educational and vocational aspirations, and the building of relationships.

6h. Natural Supports - Natural supports are people who are informal supports and know or are related to the youth/family, but do not provide a paid service (such as a grandparent or neighbor who is connected to the youth/family). Natural supports can also be found in the youth/family's community, such as the faith community, neighborhood, school, or community organizations.

6i. Individualized Plan of Care (IPC) – The individualized plan of care for children and youth, which is the result of the Diagnostic/Assessment. The IPC includes the consumer's treatment goals, strengths, challenges, objectives, and interventions. The IPC is based on the consumer's identified needs as reflected by the Diagnostic/Assessment, the consumer's expressed needs, and referral information. The IPC shall include a statement of the specific, individualized objectives of each intervention, a description of the interventions, and specify

the frequency, duration, and scope of each intervention activity. The IPC is the authorization of treatment, based on certification that the MHRS are medically necessary by the approving practitioner. *The IPC is maintained by the consumer's CSA (or CBI provider when the child or youth is receiving CBI service), and should reflect the same overall vision and goals as the mental health section of the Plan of Care (POC). Also see Section 6j below.*

6j. Plan of Care (POC) - A written document that is developed by the child, family, and other wraparound CFT members to meet the needs of both the child and family. Essential elements include: demographic information, family vision, strengths, needs, outcomes, action items, responsible parties, date of completion of action items, updates, and a crisis and safety plan (predicted behaviors, triggers, solutions, responses to the crisis, communication tree, and hospitalization plan). *The mental health section of the POC should reflect the same goals as the IPC that is maintained by the consumer's CSA/CBI provider (see Section 6i above).*

6k. Strengths, Needs, and Cultural Discovery (SNCD) – An interview and assessment process where the Wraparound Care Coordinator (sometimes in partnership with the Family Support Partner) listens to the youth and family's journey in order to identify strengths across multiple life domains, understand the family's culture, assist the family in articulating the family's vision, identify areas of need, and begin the preparation of the CFT. A SNCD document is created based on this process, sent to the team members with the family's permission, and utilized to drive the initial stages of the CFT process and development of the child/youth's POC.

6l. Mental Health Rehabilitation Services (MHRS) – mental health rehabilitative or palliative services provided by a DMH-certified community mental health provider (CSAs, subproviders and specialty providers) to consumers in accordance with the District of Columbia State Medicaid Plan, the MAA/DMH Interagency Agreement, and the MHRS Provider Certification Standards.

6m. Core Services Agency (CSA) – a DMH-certified community-based MHRS provider that has entered into a Human Care Agreement with DMH to provide specified MHRS. A CSA shall provide at least one core service directly and may provide up to three core services via contract with a sub-provider or subcontractor. A CSA may provide specialty services directly if certified by DMH as a specialty provider.

6n. CBI Provider – Agencies certified by DMH to provide CBI services, consistent with the MHRS Standards and the Department of Mental Health Establishment Amendment Act of 2001. CBI providers shall be responsible for the treatment planning process while the child or youth is receiving CBI services (including the update of the IPC as necessary).

7. Access to the High Fidelity Wraparound.

7a. An individual, agency, or CSA/CBI provider can refer a child and family who have been identified as having the most complex needs for wraparound coordination services by contacting the DMH PRTF Diversion, Technical Assistance (TA) and Coaching for Children's Mental Health department at PRTF.Diversion@dc.gov to request a referral packet. The packet will include an instruction sheet and contact information.

(1) Complex needs may include, but are not limited to: multiple system involvement, multiple risk factors across many life domains, severe functional impairments, risk of or recent return from residential placement, or hospitalization.

(2) Trigger events that could lead to a referral to wrap may include placement change, level of care transition, excessive truancy, abscondance, release from detention, risk of probation violation, or hospitalization.

7b. Upon receipt of a completed packet, a Child and Youth Services Division staff member will review the referral packet for appropriateness for high fidelity wrap and if appropriate, notify the referral source of the assigned wraparound provider.

7c. Assignment to a wraparound provider does not shift the overall responsibility of the CSA (or CBI provider if applicable) for treatment planning and maintenance of the IPC when a child or youth is receiving wraparound services. Also see sections 6i and 6j above.

8. Wraparound Provider Responsibilities.

8a. **Wraparound Providers** shall:

(1) **Follow** the National Wraparound Initiatives (NWI) Phases and Activities of the Wraparound Process as outlined in Exhibit 1.

- For the NWI 1.3.a activity, "Explore strengths, needs, culture, and vision with the child/youth and family", that is listed in Exhibit 1, the Wraparound Care Coordinator will develop a SNCD and present to the Child and Family Team (CFT) as a summarized document no later than the first CFT meeting.

(2) **Ensure** the Wraparound Care Coordinator completes the initial CALOCUS within thirty (30) days of receiving a referral from DMH, and upon discharge from wraparound services.

8b. **Wraparound Providers** shall adhere to the following timelines and teaming activities of the Wraparound CFT process:

(1) **Meet** with the youth and family within 24-72 hours of enrollment for the initial engagement, orientation to the CFT process, and to begin the Strengths, Needs, and Cultural Discovery (SNCD) assessment process.

(2) **Ensure** that the CFT is assembled for the first CFT meeting within two (2) weeks of enrollment.

(3) **Ensure** that an initial Plan of Care (POC) is developed and implemented by the CFT within two (2) weeks of enrollment.

(4) **Ensure** that each family has a written SNCD document within two (2) weeks of enrollment and that it is disseminated to the CFT members for review.

(5) If a family is in crisis, the Wraparound Care Coordinator and/or the family support partner shall **work** to de-escalate the crisis situation and **assure** necessary supports are in place. Within forty-eight (48) hours, a crisis and safety plan shall be developed with the family.

(6) **Ensure** the Wraparound Care Coordinator and/or family support partner makes face-to-face contact at least once per week, and **ensure** that CFT meetings are conducted every thirty (30) days.

(7) **Ensure** that the CFT meeting is facilitated, the POC is documented and distributed to the team members, and that the CFT members adhere to the POC, thus assuring that all elements of the POC are delivered.

(8) **Ensure** that the approach to services is aligned with System of Care values (as reflected in Exhibit 2, District of Columbia Children's System of Care Guiding Principles; and the ten (10) Principles of Wraparound as outlined by the National Wraparound Initiative <http://www.rtc.pdx.edu/PDF/TenPrincWAProcess.pdf>

(9) **Ensure** that the POC includes a customized mix of services that is responsive to the family's needs using both formal and informal (natural) supports.

(10) **Submit** monthly and quarterly reports to the DMH Child and Youth Services Division as required by DMH.

9. Evaluation, Monitoring, and Training.

9a. The DMH PRTF Diversion, Technical Assistance and Coaching for Children's Mental Health department will conduct targeted observations of the CFT process for ongoing monitoring of fidelity to the wraparound model. An annual report on the fidelity to the phases and activities will be developed and provided to the Child and Youth Services Division leadership for quality improvement.

9b. Technical assistance, consultation, and training will be provided by DMH as needed to support wraparound services to ensure adherence to the high fidelity wraparound model.

10. Related References.

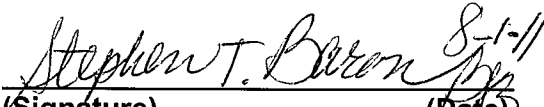
DMH Policy 340.5A, Maintaining Children and Youth in their Homes
DMH Policy 340.11, Child/Youth and Family Teaming

11. Exhibits.

Exhibit 1 – NWI Phases and Activities of the Wraparound Process
Exhibit 2 – DC Children's System of Care Guiding Principles

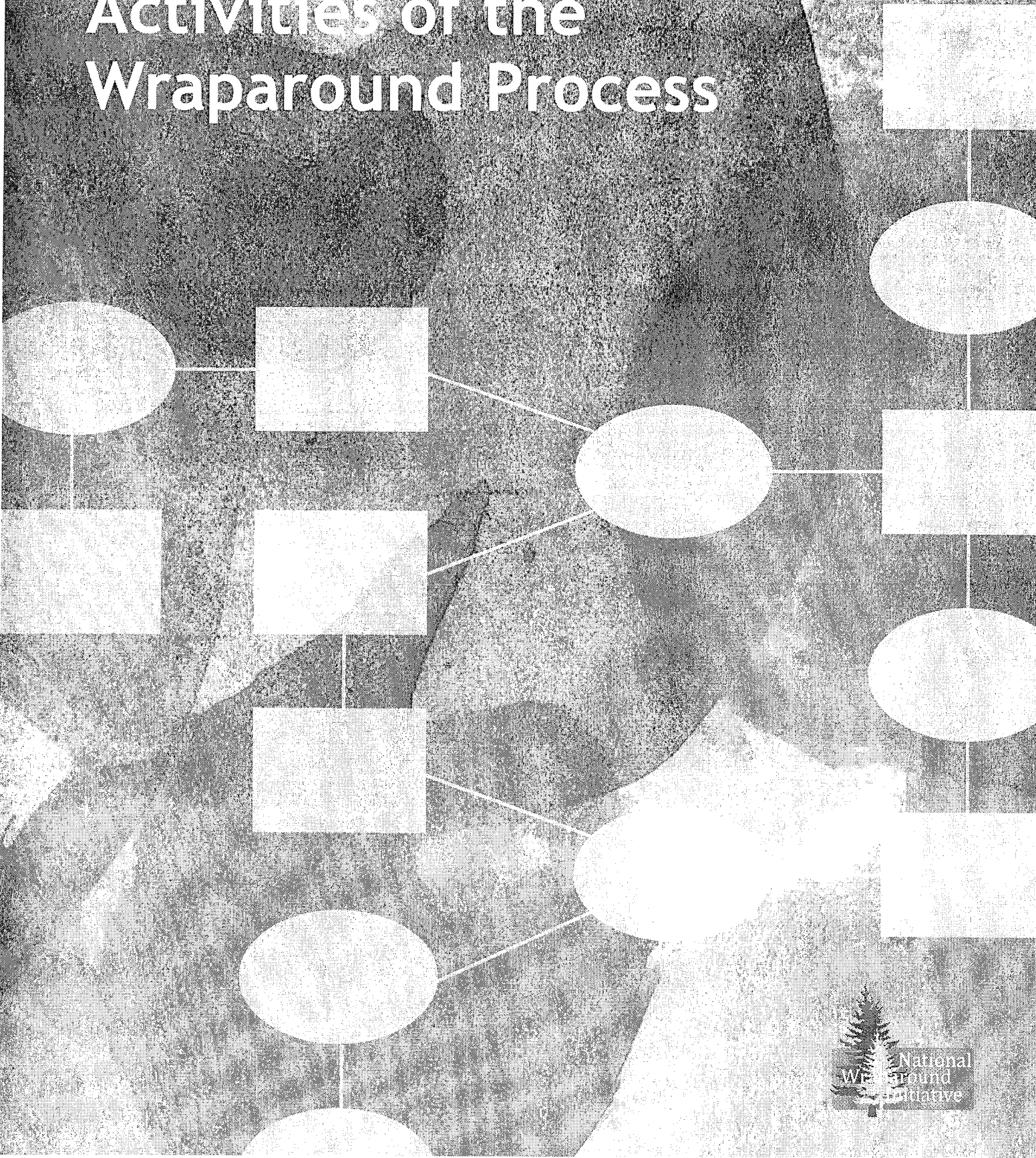
Approved By:

Stephen T. Baron
Director, DMH


(Signature) 8-1-11
(Date)

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Phases and Activities of the Wraparound Process



Phases and Activities of the Wraparound Process



Phases and Activities of the Wraparound Process: Phase 1

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MAJOR GOALS	ACTIVITIES	NOTES
PHASE 1: Engagement and team preparation		
<p><i>During this phase, the groundwork for trust and shared vision among the family and wraparound team members is established, so people are prepared to come to meetings and collaborate. During this phase, the tone is set for teamwork and team interactions that are consistent with the wraparound principles, particularly through the initial conversations about strengths, needs, and culture. In addition, this phase provides an opportunity to begin to shift the family's orientation to one in which they understand they are an integral part of the process and their preferences are prioritized. The activities of this phase should be completed relatively quickly (within 1-2 weeks if possible), so that the team can begin meeting and establish ownership of the process as quickly as possible.</i></p>		
<p>1.1. Orient the family and youth</p> <p>GOAL: To orient the family and youth to the wraparound process.</p>	<p>1.1 a. Orient the family and youth to wraparound</p> <p>In face-to-face conversations, the facilitator explains the wraparound philosophy and process to family members and describes who will be involved and the nature of family and youth/child participation. Facilitator answers questions and addresses concerns. Facilitator describes alternatives to wraparound and asks family and youth if they choose to participate in wraparound. Facilitator describes types of supports available to family and youth as they participate on teams (e.g., family/youth may want coaching so they can feel more comfortable and/or effective in partnering with other team members).</p>	<p>This orientation to wraparound should be brief and clear, and should avoid the use of jargon, so as not to overwhelm family members. At this stage, the focus is on providing enough information so that the family and youth can make an informed choice regarding participation in the wraparound process. For some families, alternatives to wraparound may be very limited and/or non-participation in wraparound may bring negative consequences (as when wraparound is court ordered); however, this does not prevent families/youth from making an informed choice to participate based on knowledge of the alternatives and/or the consequences of non-participation.</p>
	<p>1.1 b. Address legal and ethical issues</p> <p>Facilitator reviews all consent and release forms with the family and youth, answers questions, and explains options and their consequences. Facilitator discusses relevant legal and ethical issues (e.g., mandatory reporting), informs family of their rights, and obtains necessary consents and release forms before the first team meeting.</p>	<p>Ethical and legal considerations will also need to be reviewed with the entire team as described in phase 2.</p>



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	<p>1.1 b. Address legal and ethical issues</p> <p>Facilitator reviews all consent and release forms with the family and youth, answers questions, and explains options and their consequences. Facilitator discusses relevant legal and ethical issues (e.g., mandatory reporting), informs family of their rights, and obtains necessary consents and release forms before the first team meeting.</p>	<p>Ethical and legal considerations will also need to be reviewed with the entire team as described in phase 2.</p>

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Phases and Activities of the Wraparound Process: Phase 1 (CONTINTUED)

MAJOR GOALS	ACTIVITIES	NOTES
<p>1.2. Stabilize crises GOAL: To address pressing needs and concerns so that the family and team can give their attention to the wraparound process.</p>	<p>1.2 a. Ask family and youth about immediate crisis concerns Facilitator elicits information from the family and youth about immediate safety issues, current crises, or crises that they anticipate might happen in the very near future. These may include crises stemming from a lack of basic needs (e.g., food, shelter, utilities such as heat or electricity).</p> <p>1.2 b. Elicit information from agency representatives and potential team members about immediate crises or potential crises Facilitator elicits information from the referring source and other knowledgeable people about pressing crisis and safety concerns.</p> <p>1.2 c. If immediate response is necessary, formulate a response for immediate intervention and/or stabilization Facilitator and family reach agreement about whether concerns require immediate attention and, if so, work to formulate a response that will provide immediate relief while also allowing the process of team building to move ahead.</p>	<p>The goal of this activity is to quickly address the most pressing concerns. The whole team engages in proactive and future-oriented crisis/safety planning during phase 2. As with other activities in this phase, the goal is to do no more than necessary prior to convening the team, so that the facilitator does not come to be viewed as the primary service provider and so that team as a whole can feel ownership for the plan and the process.</p> <p>Information about previous crises and their resolution can be useful in planning a response in 1.2.c.</p> <p>This response should describe clear, specific steps to accomplish stabilization.</p>
<p>1.3. Facilitate conversations with family and youth/child GOAL: To explore individual and family strengths, needs, culture, and vision and to use these to develop a document that will serve as the starting point for planning.</p>	<p>1.3 a. Explore strengths, needs, culture, and vision with child/youth and family. Facilitator meets with the youth/child and family to hear about their experiences; gather their perspective on their individual and collective strengths, needs, elements of culture, and long-term goals or vision; and learn about natural and formal supports. Facilitator helps family identify potential team members and asks family to talk about needs and preferences for meeting arrangements (location, time, supports needed such as child care, translation).</p>	<p>This activity is used to develop information that will be presented to and augmented by the team in phase 2. Family members should be encouraged to consider these topics broadly.</p>



Phases and Activities of the Wraparound Process: Phase 1 (CONTINTUED)

MAJOR GOALS	ACTIVITIES	NOTES
<p><i>1.3. Facilitate conversations with family and youth/child</i></p> <p>GOAL: To explore individual and family strengths, needs, culture, and vision and to use these to develop a document that will serve as the starting point for planning. <i>(Continued from previous page)</i></p>	<p><i>1.3 b. Facilitator prepares a summary document</i></p> <p>Using the information from the initial conversations with family members, the facilitator prepares a strengths-based document that summarizes key information about individual family member strengths and strengths of the family unit, as well as needs, culture, and vision. The family then reviews and approves the summary.</p>	
<p><i>1.4. Engage other team members</i></p> <p>GOAL: To gain the participation of team members who care about and can aid the youth/child and family, and to set the stage for their active and collaborative participation on the team in a manner consistent with the wraparound principles</p>	<p><i>1.4 a. Solicit participation/ orient team members</i></p> <p>Facilitator, together with family members if they so choose, approaches potential team members identified by the youth and family. Facilitator describes the wraparound process and clarifies the potential role and responsibilities of this person on the team. Facilitator asks the potential team members if they will participate. If so, facilitator talks with them briefly to learn their perspectives on the family's strengths and needs, and to learn about their needs and preferences for meeting.</p>	<p>The youth and/or family may choose to invite potential team members themselves and/or to participate in this activity alongside the facilitator. It is important, however, not to burden family members by establishing (even inadvertently) the expectation that they will be primarily responsible for recruiting and orienting team members.</p>
<p><i>1.5. Make necessary meeting arrangements</i></p> <p>GOAL: To ensure that the necessary procedures are undertaken so the team is prepared to begin an effective wraparound process.</p>	<p><i>1.5 a. Arrange meeting logistics</i></p> <p>Facilitator integrates information gathered from all sources to arrange meeting time and location and to assure the availability of necessary supports or adaptations such as translators or child care. Meeting time and location should be accessible and comfortable, especially for the family but also for other team members. Facilitator prepares materials—including the document summarizing family members' individual and collective strengths, and their needs, culture, and vision—to be distributed to team members.</p>	

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Phases and Activities of the Wraparound Process: Phase 2

MAJOR GOALS	ACTIVITIES	NOTES
PHASE 2: Initial plan development		
<p><i>During this phase, team trust and mutual respect are built while the team creates an initial plan of care using a high-quality planning process that reflects the wraparound principles. In particular, youth and family should feel, during this phase, that they are heard, that the needs chosen are ones they want to work on, and that the options chosen have a reasonable chance of helping them meet these needs. This phase should be completed during one or two meetings that take place within 1-2 weeks, a rapid time frame intended to promote team cohesion and shared responsibility toward achieving the team's mission or overarching goal.</i></p>		
<p style="text-align: center;"><i>2.1. Develop an initial plan of care</i></p> <p>GOAL: To create an initial plan of care using a high-quality team process that elicits multiple perspectives and builds trust and shared vision among team members, while also being consistent with the wraparound principles</p>	<p style="text-align: center;"><i>2.1 a. Determine ground rules</i></p> <p>Facilitator guides team in a discussion of basic ground rules, elicits additional ground rules important to team members, and facilitates discussion of how these will operate during team meetings. At a minimum, this discussion should address legal and ethical issues—including confidentiality, mandatory reporting, and other legal requirements—and how to create a safe and blame-free environment for youth/family and all team members. Ground rules are recorded in team documentation and distributed to members.</p>	<p>In this activity, the team members define their collective expectations for team interaction and collaboration. These expectations, as written into the ground rules, should reflect the principles of wraparound. For example, the principles stress that interactions should promote family and youth voice and choice and should reflect a strengths orientation. The principles also stress that important decisions are made within the team.</p>
	<p style="text-align: center;"><i>2.1 b. Describe and document strengths</i></p> <p>Facilitator presents strengths from the summary document prepared during phase 1, and elicits feedback and additional strengths, including strengths of team members and community.</p>	<p>While strengths are highlighted during this activity, the wraparound process features a strengths orientation throughout.</p>
	<p style="text-align: center;"><i>2.1 c. Create team mission</i></p> <p>Facilitator reviews youth and family's vision and leads team in setting a team mission, introducing idea that this is the overarching goal that will guide the team through phases and, ultimately, through transition from formal wraparound.</p>	<p>The team mission is the collaboratively set, long-term goal that provides a one or two sentence summary of what the team is working towards.</p>



Phases and Activities of the Wraparound Process: Phase 2 (CONTINTUED)

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MAJOR GOALS	ACTIVITIES	NOTES
<p><i>2.1. Develop an initial plan of care</i></p> <p>GOAL: To create an initial plan of care using a high-quality team process that elicits multiple perspectives and builds trust and shared vision among team members, while also being consistent with the wrap-around principles (Continued from previous page)</p>	<p><i>2.1 d. Describe and prioritize needs/goals</i></p> <p>Facilitator guides the team in reviewing needs and adding to list. The facilitator then guides the team in prioritizing a small number of needs that the youth, family, and team want to work on first, and that they feel will help the team achieve the mission.</p>	<p>The elicitation and prioritization of needs is often viewed as one of the most crucial and difficult activities of the wraparound process. The team must ensure that needs are considered broadly, and that the prioritization of needs reflects youth and family views about what is most important. Needs are not services but rather broader statements related to the underlying conditions that, if addressed, will lead to the accomplishment of the mission.</p>
	<p><i>2.1 e. Determine goals and associated outcomes and indicators for each goal</i></p> <p>Facilitator guides team in discussing a specific goal or outcome that will represent success in meeting each need that the team has chosen to work on. Facilitator guides the team in deciding how the outcome will be assessed, including specific indicators and how frequently they will be measured.</p>	<p>Depending on the need being considered, multiple goals or outcomes may be determined. Similarly, for each goal or outcome determined by the team for measurement, multiple indicators may be chosen to be tracked by the team. However, the plan should not include so many goals, outcomes, or indicators that team members become overwhelmed or tracking of progress becomes difficult.</p>
	<p><i>2.1 f. Select strategies</i></p> <p>Facilitator guides the team in a process to think in a creative and open-ended manner about strategies for meeting needs and achieving outcomes. The facilitator uses techniques for generating multiple options, which are then evaluated by considering the extent to which they are likely to be effective in helping reach the goal, outcome, or indicator associated with the need; the extent to which they are community based, the extent to which they build on/incorporate strengths; and the extent to which they are consistent with family culture and values. When evaluating more formal service and support options, facilitator aids team in acquiring information about and /or considering the evidence base for relevant options.</p>	<p>This activity emphasizes creative problem solving, usually through brainstorming or other techniques, with the team considering the full range of available resources as they come up with strategies to meet needs and achieve outcomes. Importantly, this includes generating strategy options that extend beyond formal services and reach families through other avenues and time frames. These are frequently brainstormed by the team, with the youth and family and people representing their interpersonal and community connections being primary nominators of such supports. Finally, in order to best consider the evidence base for potential strategies or supports, it may be useful for a wraparound team or program to have access to and gain counsel from a point person who is well-informed on the evidence base.</p>

Phases and Activities of the Wraparound Process: Phase 2 (CONTINUED) AUG 0 1 2011

MAJOR GOALS	ACTIVITIES	NOTES
<p><i>2.1. Develop an initial plan of care</i></p> <p>GOAL: To create an initial plan of care using a high-quality team process that elicits multiple perspectives and builds trust and shared vision among team members, while also being consistent with the wraparound principles (Continued from previous page)</p>	<p><i>2.1 g. Assign action steps</i></p> <p>Team assigns responsibility for undertaking action steps associated with each strategy to specific individuals and within a particular time frame.</p>	<p>Action steps are the separate small activities that are needed to put a strategy into place, for example, making a phone call, transporting a child, working with a family member, finding out more information, attending a support meeting, arranging an appointment. While all team members will not necessarily participate at the same level, all team members should be responsible for carrying out action steps. Care should be taken to ensure that individual team members, particularly the youth and family, are not overtaxed by the number of action steps they are assigned.</p>
<p><i>2.2. Develop crisis/safety plan</i></p> <p>GOAL: To identify potential problems and crises, prioritize according to seriousness and likelihood of occurrence, and create an effective and well-specified crisis prevention and response plan that is consistent with the wraparound principles. A more proactive safety plan may also be created.</p>	<p><i>2.2 a. Determine potential serious risks</i></p> <p>Facilitator guides the team in a discussion of how to maintain the safety of all family members and things that could potentially go wrong, followed by a process of prioritization based on seriousness and likelihood of occurrence.</p>	<p>Past crises, and the outcomes of strategies used to manage them, are often an important source of information in current crisis/safety planning.</p>
	<p><i>2.2 b. Create crisis/safety plan</i></p> <p>In order of priority, the facilitator guides team in discussion of each serious risk identified. The discussion includes safety needs or concerns and potential crisis situations, including antecedents and associated strategies for preventing each potential type of crisis, as well as potential responses for each type of crisis. Specific roles and responsibilities are created for team members. This information is documented in a written crisis plan. Some teams may also undertake steps to create a separate safety plan, which specifies all the ways in which the wraparound plan addresses potential safety issues.</p>	<p>One potential difficulty with this activity is the identification of a large number of crises or safety issues can mean that the crisis/safety plan "takes over" from the wraparound plan. The team thus needs to balance the need to address all risks that are deemed serious with the need to maintain focus on the larger wraparound plan as well as youth, family, and team strengths.</p>
<p><i>2.3. Complete necessary documentation and logistics</i></p>	<p><i>2.3 a. Complete documentation and logistics</i></p> <p>Facilitator guides team in setting meeting schedule and determining means of contacting team members and distributing documentation to team members.</p>	



Phases and Activities of the Wraparound Process: Phase 3

MAJOR GOALS	ACTIVITIES	NOTES
PHASE 3: Implementation		
<p><i>During this phase, the initial wraparound plan is implemented, progress and successes are continually reviewed, and changes are made to the plan and then implemented, all while maintaining or building team cohesiveness and mutual respect. The activities of this phase are repeated until the team's mission is achieved and formal wraparound is no longer needed.</i></p>		
<p>3.1. Implement the wraparound plan</p> <p>GOAL: To implement the initial plan of care, monitoring completion of action steps and strategies and their success in meeting need and achieving outcomes in a manner consistent with the wrap-around principles.</p>	<p>3.1 a. Implement action steps for each strategy</p> <p>For each strategy in the wraparound plan, team members undertake action steps for which they are responsible. Facilitator aids completion of action steps by checking in and following up with team members; educating providers and other system and community representatives about wraparound as needed; and identifying and obtaining necessary resources.</p>	<p>The level of need for educating providers and other system and community representatives about wraparound varies considerably from one community to another. Where communities are new to the type of collaboration required by wraparound, getting provider "buy in" can be very difficult and time consuming for facilitators. Agencies implementing wraparound should be aware of these demands and be prepared to devote sufficient time, resources, and support to this need.</p>
	<p>3.1 b. Track progress on action steps</p> <p>Team monitors progress on the action steps for each strategy in the plan, tracking information about the timeliness of completion of responsibilities assigned to each team member, fidelity to the plan, and the completion of the requirements of any particular intervention.</p>	<p>Using the timelines associated with the action steps, the team tracks progress. When steps do not occur, teams can profit from examining the reasons why not. For example, teams may find that the person responsible needs additional support or resources to carry out the action step, or, alternatively, that different actions are necessary.</p>
	<p>3.1 c. Evaluate success of strategies</p> <p>Using the outcomes/indicators associated with each need, the facilitator guides the team in evaluating whether selected strategies are helping team meet the youth and family's needs.</p>	<p>Evaluation should happen at regular intervals. Exactly how frequently may be determined by program policies and/or the nature of the needs/goals. The process of evaluation should also help the team maintain focus on the "big picture" defined by the team's mission: Are these strategies, by meeting needs, helping achieve the mission?</p>
	<p>3.1 d. Celebrate successes</p> <p>The facilitator encourages the team to acknowledge and celebrate successes, such as when progress has been made on action steps, when outcomes or indicators of success have been achieved, or when positive events or achievements occur.</p>	<p>Acknowledging success is one way of maintaining a focus on the strengths and capacity of the team and its members. Successes do not have to be "big", nor do they necessarily have to result directly from the team plan. Some teams make recognition of "what's gone right" a part of each meeting.</p>

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Phases and Activities of the Wraparound Process: Phase 3 (CONTINUED)

MAJOR GOALS	ACTIVITIES	NOTES
<p><i>3.2. Revisit and update the plan</i></p> <p>GOAL: To use a high quality team process to ensure that the wraparound plan is continually revisited and updated to respond to the successes of initial strategies and the need for new strategies.</p>	<p><i>3.2. a. Consider new strategies as necessary</i></p> <p>When the team determines that strategies for meeting needs are not working, or when new needs are prioritized, the facilitator guides the team in a process of considering new strategies and action steps using the process described in activities 2.1.f and 2.1.g.</p>	<p>Revising of the plan takes place in the context of the needs identified in 2.1.d. Since the needs are in turn connected to the mission, the mission helps to guide evaluation and plan revisions.</p>
<p><i>3.3. Maintain/build team cohesiveness and trust</i></p> <p>GOAL: To maintain awareness of team members' satisfaction with and "buy-in" to the process, and take steps to maintain or build team cohesiveness and trust.</p>	<p><i>3.3 a. Maintain awareness of team members' satisfaction and "buy-in"</i></p> <p>Facilitator makes use of available information (e.g., informal chats, team feedback, surveys—if available) to assess team members' satisfaction with and commitment to the team process and plan, and shares this information with the team as appropriate. Facilitator welcomes and orients new team members who may be added to the team as the process unfolds.</p>	<p>Many teams maintain formal or informal processes for addressing team member engagement or "buy in", e.g. periodic surveys or an end-of-meeting wrap-up activity. In addition, youth and family members should be frequently consulted about their satisfaction with the team's work and whether they believe it is achieving progress toward their long-term vision, especially after major strategizing sessions. In general, however, this focus on assessing the process of teamwork should not eclipse the overall evaluation that is keyed to meeting identified needs and achieving the team mission.</p>
	<p><i>3.3 b. Address issues of team cohesiveness and trust</i></p> <p>Making use of available information, facilitator helps team maintain cohesiveness and satisfaction (e.g., by continually educating team members—including new team members—about wraparound principles and activities, and/or by guiding team in procedures to understand and manage disagreement, conflict, or dissatisfaction).</p>	<p>Teams will vary in the extent to which issues of cohesiveness and trust arise. Often, difficulties in this area arise from one or more team members' perceptions that the team's work—and/or the overall mission or needs being currently addressed—is not addressing the youth and family's "real" needs. This points to the importance of careful work in deriving the needs and mission in the first place, since shared goals are essential to maintaining team cohesiveness over time.</p>
<p><i>3.4. Complete necessary documentation and logistics</i></p>	<p><i>3.4 a. Complete documentation and logistics</i></p> <p>Facilitator maintains/updates the plan and maintains and distributes meeting minutes. Team documentation should record completion of action steps, team attendance, use of formal and informal services and supports, and expenditures. Facilitator documents results of reviews of progress, successes, and changes to the team and plan. Facilitator guides team in revising meeting logistics as necessary and distributes documentation to team members.</p>	<p>Team documentation should be kept current and updated, and should be distributed to and/or available to all team members in a timely fashion.</p>



Phases and Activities of the Wraparound Process: Phase 4

MAJOR GOALS	ACTIVITIES	NOTES
PHASE 4: Transition		
<p><i>During this phase, plans are made for a purposeful transition out of formal wraparound to a mix of formal and natural supports in the community (and, if appropriate, to services and supports in the adult system). The focus on transition is continual during the wraparound process, and the preparation for transition is apparent even during the initial engagement activities.</i></p>		
<p>4.1. Plan for cessation of formal wraparound GOAL: To plan a purposeful transition out of formal wraparound in a way that is consistent with the wraparound principles, and that supports the youth and family in maintaining the positive outcomes achieved in the wraparound process.</p>	<p>4.1 a. Create a transition plan Facilitator guides the team in focusing on the transition from wraparound, reviewing strengths and needs and identifying services and supports to meet needs that will persist past formal wraparound.</p>	<p>Preparation for transition begins early in the wraparound process, but intensifies as team meets needs and moves towards achieving the mission. While formal supports and services may be needed post-transition, the team is attentive to the need for developing a sustainable system of supports that is not dependent on formal wraparound. Teams may decide to continue wraparound—or a variation of wraparound—even after it is no longer being provided as a formal service.</p>
	<p>4.1 b. Create a post-transition crisis management plan Facilitator guides the team in creating post-wraparound crisis management plan that includes action steps, specific responsibilities, and communication protocols. Planning may include rehearsing responses to crises and creating linkage to post-wraparound crisis resources.</p>	<p>At this point in transition, youth and family members, together with their continuing supports, should have acquired skills and knowledge in how to manage crises. Post-transition crisis management planning should acknowledge and capitalize on this increased knowledge and strengthened support system. This activity will likely include identification of access points and entitlements for formal services that may be used following formal wraparound.</p>
	<p>4.1 c. Modify wraparound process to reflect transition New members may be added to the team to reflect identified post-transition strategies, services, and supports. The team discusses responses to potential future situations, including crises, and negotiates the nature of each team member's post-wraparound participation with the team/family. Formal wraparound team meetings reduce frequency and ultimately cease.</p>	<p>Teams may continue to meet using a wraparound process (or other process or format) even after formal wraparound has ended. Should teamwork continue, family members and youth, or other supports, will likely take on some or all of the facilitation and coordination activities.</p>

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Phases and Activities of the Wraparound Process: Phase 4 (CONTINTUED)

MAJOR GOALS	ACTIVITIES	NOTES
<p>4.2. Create a "commencement"</p> <p>GOAL: To ensure that the cessation of formal wrap-around is conducted in a way that celebrates successes and frames transition proactively and positively.</p>	<p>4.2 a. Document the team's work</p> <p>Facilitator guides team in creating a document that describes the strengths of the youth/child, family, and team members, and lessons learned about strategies that worked well and those that did not work so well. Team participates in preparing/reviewing necessary final reports (e.g., to court or participating providers, where necessary)</p>	<p>This creates a package of information that can be useful in the future.</p>
	<p>4.2 b. Celebrate success</p> <p>Facilitator encourages team to create and/or participate in a culturally appropriate "commencement" celebration that is meaningful to the youth/child, family, and team, and that recognizes their accomplishments.</p>	<p>This activity may be considered optional. Youth/child and family should feel that they are ready to transition from formal wraparound, and it is important that "graduation" is not constructed by systems primarily as a way to get families out of services.</p>
<p>4.3. Follow-up with the family</p> <p>GOAL: To ensure that the family is continuing to experience success after wraparound and to provide support if necessary.</p>	<p>4.3 a. Check in with family</p> <p>Facilitator leads team in creating a procedure for checking in with the youth and family periodically after commencement. If new needs have emerged that require a formal response, facilitator and/or other team members may aid the family in accessing appropriate services, possibly including a reconvening of the wraparound team.</p>	<p>The check-in procedure can be done impersonally (e.g., through questionnaires) or through contact initiated at agreed-upon intervals either by the youth or family, or by another team member.</p>



District of Columbia Children's System of Care

Guiding Principles

DMH Policy 340.10
Exhibit 2 - 8b(8)

- 1. Family Driven & Youth Guided:** A holistic approach that supports and recognizes all family members involved in a youth's care and upbringing, with the end goal of providing services that are successful and meaningful to the youth. Families have a primary decision-making role in the care of their own children as well as the policies and procedures governing care for all children. Youth and families have the right to be empowered, educated, and given a decision-making role. Youth and families are full participants in service planning, service delivery as well as the program procedures and policy development governing their care.
- 2. Individualized & Needs-Based:** Services and activities are customized, tailored, and guided by an individualized service plan that is comprehensive and based on the unique needs and strengths of the youth and their family.
- 3. Array of Services & Supports:** A comprehensive network of services and supports are readily accessible to youth and families to address the physical, emotional, social, developmental, and educational needs of youth. Clinically appropriate services exist along a continuum of care from early identification and early intervention through transition to adulthood.
- 4. High Quality:** Service delivery incorporates evidence-based, promising, and best practices in meeting the complex needs of youth and families. The rights of youth and families are protected and effective advocacy efforts are promoted.
- 5. Community-Based:** Community-based service options are fully explored so that services and supports take place in the most inclusive, normative, and least restrictive setting possible. The DC System of Care will continuously develop the capacity of the community to care for its youth and families, maximizing traditional and natural community resources.
- 6. Cultural Competence:** Policies and service delivery will demonstrate respect for the unique and diverse roles, values, beliefs, race, ethnicity, culture and gender of the youth, family, and their community.
- 7. Early Identification & Intervention:** Early identification and intervention is promoted to identify and address social, emotional, physical, and educational needs, enhance the likelihood of improved outcomes, and lessen the need for more intensive and restrictive services as adolescents and young adults.
- 8. Integrated Care:** Child-serving agencies will systematically coordinate efforts and blend resources to enhance the availability of traditional services, natural supports, and community resources and to avoid duplication of services and gaps in care. Agencies collaborate to ensure appropriate and clear transitions between levels of care and between youth and adult systems of care.
- 9. Strengths-Based:** Assessments comprehensively identify and services build on the capabilities, knowledge, skills, and assets of the youth and family, their community, and other team members.
- 10. Outcomes-Based:** Goals and objectives identified in the individualized service plan are clearly understood and measurable, with supports and services helping youth to live with their families, achieve success in school, and avoid delinquency. Outcomes are used to drive decisions to further improve services for youth at the system and practice level.
- 11. Least Restrictive:** Services and supports are provided in the most inclusive, normative and least restrictive setting possible, to increase the likelihood of successful integration into family, home and community life.