

# Children's Behavioral Health Highlights

Supporting Staff and Families Through the Transition Phase of Wraparound

Issue #3

## Introduction

Since the inception of Intensive Care Coordination (ICC) services in June 2009, care coordinators and family partners have experienced difficulty moving youth and families through the fourth phase of Wraparound: Transition. The purpose of this phase is to ensure that families have the tools and supports to successfully manage the complex behavioral and mental health needs of their youth, once they are no longer enrolled in formal Wraparound services.

Since 2010, scores for the Transition Phase, on the Wraparound Fidelity Index (WFI), have been consistently lower than the other three phases: Engagement, Planning and Implementation. Although, WFI scores for Transition increased from 64% (2010) to 71% (2014), scores in this area continue to lag behind the other three: Engagement (90%), Planning (86%), and Implementation (83%).

A successful transition in the Wraparound process is crucial to prepare families for maintaining positive outcomes. Although Transition is the final phase in Wraparound, planning for Transition should begin at Phase One: Engagement. If families are not adequately prepared for transition, then the risk of remaining in ICC services for longer than needed and/or requiring other intensive behavioral and mental health services in their future increases.

Feedback from care coordinators and family partners about challenges associated with successfully transitioning families out of Wraparound include: lack of training and information for staff members about how to help families with transition and why it is important; difficulty explaining the purpose of transition planning to youth, families, and Care Plan Team (CPT) members; issues with linkage to natural and community supports; and challenges with helping youth and families to develop the skills necessary for post-transition success.

## Innovation in care

As part of a learning community convened by the statewide Wraparound coaches in September 2014, leaders from seven Community Service Agencies (CSAs) from across the Commonwealth created youth and caregiver Transition Indicator assessment tools (see attached). The assessment tools include a series of questions in which caregivers and youth evaluate their skills in several key areas thought to indicate their readiness for transition from Wraparound. Caregiver skill areas included:

- knowledge of community resources;
- connections to natural supports;
- ability to advocate for the child's needs;
- ability to manage challenging behaviors; and
- identification of self-care strategies.

Skill areas for youth included:

- connection to community activities;
- connection to peers or social groups;
- ability to advocate; and
- use of self-control strategies.

As the care coordinators and family partners began utilizing the tools with youth and families, they found that using the Transition Indicator tools was most beneficial during the assessment phase and prior to each CPT meeting. Using the tools in this way helped keep youth, families and team members focused on progress and what skills still needed addressing to support a successful transition out of Wraparound.

The tools were also used with families who were identified as being “stuck” in the Wraparound process and were not moving towards Transition. Using the tool helped to clarify those areas the team needed to focus on to help the family move more quickly toward a successful transition out of Wraparound.

## Results

At first, CSAs used the tools with only a small number of families; collecting feedback about their use from families and staff members. CSA staff members reported many benefits from incorporating the Transition Indicator tools into their work with youth and caregivers. First, the tools provided a structured training opportunity for staff members to better understand the Transition Phase. All the CSAs involved in the learning community developed a training focused on how to use the transition indicator tools with youth and families. Each of the CSAs



The Children's Behavioral Health Knowledge Center, located at the Massachusetts Department of Mental Health, was established in Chapter 321 of the Acts of 2008: An Act Relative to Children's Mental Health. The Center's mission is to ensure that: the workforce of clinicians and direct care staff providing children's behavioral health services are highly skilled and well trained; the services provided to children in the Commonwealth are cost-effective and evidence-based; and the Commonwealth continues to develop and evaluate new models of service delivery. The Knowledge Center fills a gap in the children's behavioral health system by serving as an information hub, through its Annual Symposium, [website](#), workshops, and webinars.

eventually incorporated the training into their new hire orientation processes.

Second, the tools helped care plan teams focus on those skills necessary for successful transition from the beginning of the Wraparound process rather than waiting until the end. By “starting with the end in mind” the youth, caregiver(s), and other CPT members could identify specific skills necessary for successful transition during the assessment phase and then incorporate them into the youth's Individualized Care Plan (ICP).

Furthermore, staff members reported that the tools helped them understand their role and functions more clearly. Family partners reported that the tools helped them focus on key tasks such as helping the caregiver to: develop his/her knowledge of local resources, build natural supports, enhance advocacy skills, and take time to focus on his/her own needs. Similarly, care coordinators reported that the tools offered them an opportunity to engage with youth differently by providing a mechanism to explore what skills the youth was most interested in developing.

Care coordinators and family partners were not the only ones who provided positive feedback about the tools. Caregivers reported the tools helped them focus on areas they needed the most help with. Several youth reported feeling like they had real input in developing the goals on their plan. With feedback increasingly positive, the CSAs began using them with more and more families.

### Future planning

Going forward several CSAs have plans to create age-specific youth indicators, such as ones for transition aged youth and ones for youth under nine years of age. Other future plans mentioned by the participating CSAs included: creating transition specific goals on the ICP; incorporating the rating scale from the Transition Indicator tools as an objective measure on the ICP; developing a specific process for sharing the status of the indicators during CPT meetings; and

revamping the Strength Needs and Culture Discovery document (typically used by family partners during the assessment and CPT preparation process) to mirror the Transition Indicators.

### Lessons learned

While the participating CSAs learned about the importance of focusing on transition, equally important is what they learned about implementing a change process in their CSA. CSA leaders cited the importance of regular staff meetings (weekly if possible) to keep focused on implementing a change process; engaging staff using a “bottom-up” process to optimize buy-in; measuring progress using data the CSA already collects to increase efficiency; starting small and allowing staff to test the change and make necessary adjustments; and lastly, changes in practice must be a process that requires continuous commitment from directors, supervisors, and all staff.

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**Indicators for Families Enrolled in Wraparound**

Youth's Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Date Completed: \_\_\_\_\_

<p align="center"><b>Able to manage child's challenging behavior</b></p> <p><b>What is your child's challenging behavior?</b></p> <p>_____</p>	<table border="0"> <tr> <td align="center">Not sure what to do</td> <td align="center">Respond but unable to improve behavior</td> <td align="center">Able to prevent or manage behavior</td> </tr> <tr> <td align="center">1.....</td> <td align="center">2.....</td> <td align="center">3.....</td> </tr> <tr> <td align="center">4.....</td> <td align="center">5.....</td> <td></td> </tr> </table>	Not sure what to do	Respond but unable to improve behavior	Able to prevent or manage behavior	1.....	2.....	3.....	4.....	5.....													
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<p><b>Talking with Service Providers:</b></p>  <p align="center"><b>School:</b> <b>Therapists:</b> <b>Others:</b></p>	<table border="0"> <tr> <td align="center">Difficult</td> <td align="center">I can with help</td> <td align="center">I am able to on my own</td> </tr> <tr> <td align="center">1.....</td> <td align="center">2.....</td> <td align="center">3.....</td> </tr> <tr> <td align="center">4.....</td> <td align="center">5.....</td> <td></td> </tr> <tr> <td align="center">1.....</td> <td align="center">2.....</td> <td align="center">3.....</td> </tr> <tr> <td align="center">4.....</td> <td align="center">5.....</td> <td></td> </tr> <tr> <td align="center">1.....</td> <td align="center">2.....</td> <td align="center">3.....</td> </tr> <tr> <td align="center">4.....</td> <td align="center">5.....</td> <td></td> </tr> </table>	Difficult	I can with help	I am able to on my own	1.....	2.....	3.....	4.....	5.....		1.....	2.....	3.....	4.....	5.....		1.....	2.....	3.....	4.....	5.....	
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<p><b>Able to understand the many "systems" that can assist my child</b></p>	<table border="0"> <tr> <td align="center">Unfamiliar with "systems"</td> <td align="center">Use the "systems" with help</td> <td align="center">Can use "systems" without help</td> </tr> <tr> <td align="center">1.....</td> <td align="center">2.....</td> <td align="center">3.....</td> </tr> <tr> <td align="center">4.....</td> <td align="center">5.....</td> <td></td> </tr> </table>	Unfamiliar with "systems"	Use the "systems" with help	Can use "systems" without help	1.....	2.....	3.....	4.....	5.....													
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4.....	5.....																					

<p><b>Able to identify and access community resources</b></p>	<p>Depend on others      Access some Resources      Able to find new resources</p> <p>1.....2.....3.....4.....5</p>
<p><b>Able to develop or maintain supports through friends and family</b></p>	<p>No supports      Maintain Some Supports      Actively Maintain and Develop Supports</p> <p>1.....2.....3.....4.....5</p>
<p><b>Follow through with plans, tasks, appointments, etc.</b></p>	<p>When I remember/have time      Can follow through with Support      Able to follow through independently</p> <p>1.....2.....3.....4.....5</p>
<p><b>Self Care (Taking a break, time to relax)</b></p>	<p>No Time      Sometimes with Encouragement      Good Self Care</p> <p>1.....2.....3.....4.....5</p>
<p><b>Other</b></p> <p><b>Child and family strengths, support/training ideas for Family Partner</b></p>	



<p>Do you feel comfortable expressing how you feel?</p> <p>At Home</p> <p>In School</p> <p>With Providers/Others</p>	<p><b>Never</b>      <b>Rarely</b>      <b>Sometimes</b>      <b>Often</b>      <b>Always</b></p> <p>1 ----- 2 ----- 3 ----- 4 ----- 5</p> <p><b>Never</b>      <b>Rarely</b>      <b>Sometimes</b>      <b>Often</b>      <b>Always</b></p> <p>1 ----- 2 ----- 3 ----- 4 ----- 5</p> <p><b>Never</b>      <b>Rarely</b>      <b>Sometimes</b>      <b>Often</b>      <b>Always</b></p> <p>1 ----- 2 ----- 3 ----- 4 ----- 5</p> <p>Comments:</p>
<p>Do you have friends that you hang out with regularly?</p>	<p><b>Never</b>      <b>Rarely</b>      <b>Sometimes</b>      <b>Often</b>      <b>Always</b></p> <p>1 ----- 2 ----- 3 ----- 4 ----- 5</p> <p>Comments:</p>
<p>Other</p>	<p><b>Never</b>      <b>Rarely</b>      <b>Sometimes</b>      <b>Often</b>      <b>Always</b></p> <p>1 ----- 2 ----- 3 ----- 4 ----- 5</p> <p>Comments:</p>

**1. Is there something you would like to learn or discover about yourself?**

**2. What would you like to see yourself doing in 6 months from now?**