Coordinating Mental Health Services in Schools, Including Wraparound and other "Tier 3" Interventions

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Washington State Association of School Psychologists
2015 Spring Lecture Series
May 29, 2015

Acknowledgments

- Jesse Suter, University of Vermont
- Elizabeth McCauley, Aaron Lyon, Clayton Cook, Doug Cheney, University of Washington
- Lucille Eber, Illinois PBIS Network
- JoAnne Malloy, University of New Hampshire

Agenda for today

- Integrating School Mental Health into Multi-Tier Systems of School Supports (MTSS)
- The Interconnected Systems Framework (ISF) for School Mental Health
- Supporting students at Tiers 2 and 3 with effective School MH supports
- "Tier 3 Wraparound"

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SMART Center Mission

- To promote quality improvement of school-based mental/behavioral health services by facilitating the transfer of evidence-based practices to educational settings.
- Overarching SMART Center Goals:
  1. Prevent and ameliorate mental health problems that interfere with academic success.
  2. Promote the well-being of youth across school, home, and community contexts.
  3. Make effective use of evidence-based intervention programs across all three tiers of support.

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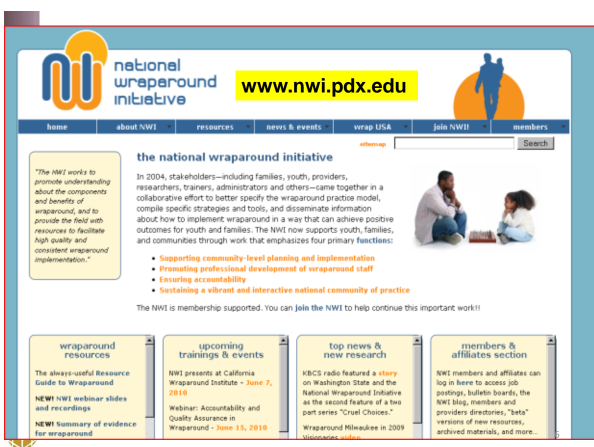
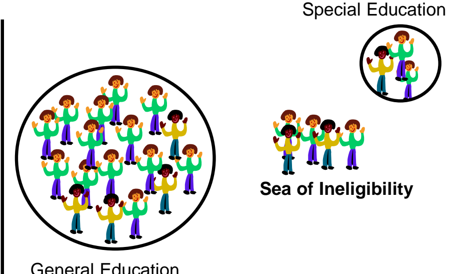
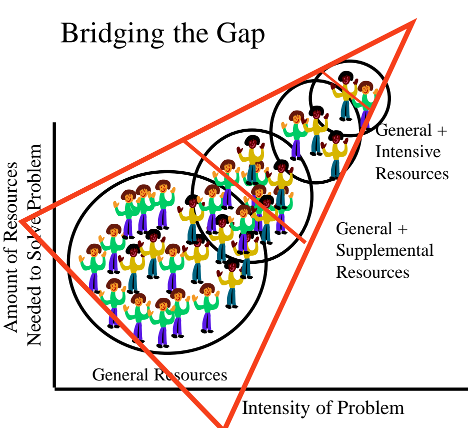


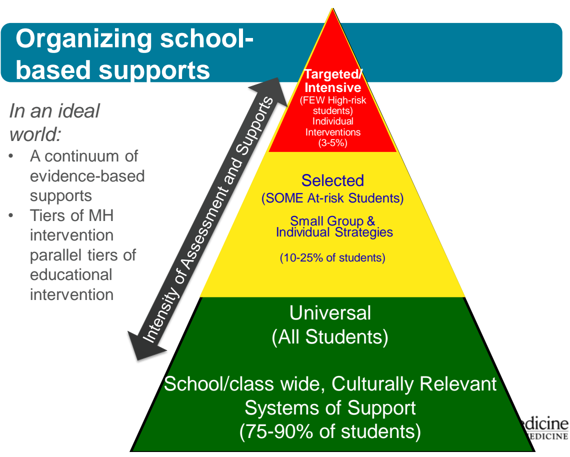
Traditional Education Policy does not adequately provide mechanisms to meet student MH needs

- An estimated 9–13 % of youth aged 9–17 have emotional and behavioral needs serious enough to impede their functioning in family, school, or community activities
- However, only 1% of students receive Special Education supports for emotional/behavioral problems
- Nonetheless, these students often end up missing school, unable to attend in class, suspended and expelled.
- Thus, many task forces and research reviews have recommended multi-tiered, *transdisciplinary* "comprehensive system of care" with universal, targeted at-risk, and intensive level services.

The Traditional "Refer" – "Test" – "Place" model is not effective

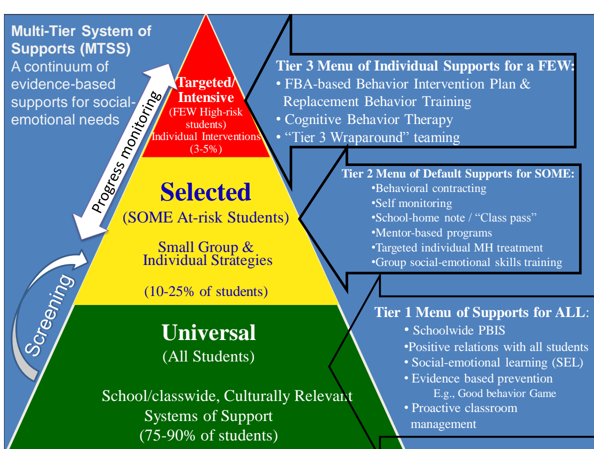






Multi-Tiered Systems of Support

- MTSS focuses on:
  - Serving **ALL** students through continuum of care
  - **Proactively** identifying students who are at-risk (i.e., universal screening)
  - **Matching** evidence-based interventions to student need
  - Frequently **monitoring student progress** to make decisions with regard to an intervention or goals
  - Monitoring and examining treatment integrity to make legally sound and **valid educational decisions**



So what's this got to do with School MH?

- *"School systems are not responsible for meeting every need of their students, but when the need directly affects learning, the school must meet the challenge"*

  – Carnegie Council Task Force, 1989

The increasing prominence of SMH

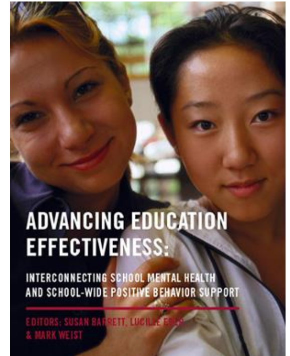
- Most youth who require mental health services do not receive them (Kataoka et al., 2002)
- SMH accounts for >70% of all MH services (Burns et al., 1995; Farmer et al., 2003)
  - 20% of all students receive SBMH services annually (Foster et al. 2005)
- Schools improve service access for underserved youth (Kataoka et al., 2007)
- SMH may facilitate improved academic performance (Walker, Kerns, Lyon, Bruns, & Cosgrove, 2010)
- Positive school climate can buffer youth from external risk factors

School Mental Health (SMH)

- Little is known about usual care school mental health services (Langley et al. 2010)
- SMH Services are unlikely to be evidence-based (Evans & Weist, 2004; Rones & Hoagwood, 2000)
- Meta-analysis of SMH programs for low-income, urban youth revealed low levels of effectiveness, some iatrogenic effects (Farahmand et al., 2011)
- EBP developers have paid insufficient attention to the school context and how it might influence effective service delivery (Ringeisen et al., 2003)

A need for better integration of MH in schools

- Youth with MH needs require multifaceted education/behavior and mental health supports
- The usual systems have not routinely provided a comprehensive, blended system of support.
- Supports need to be provided in a clustered and integrated structure,
- Academic/behavior and mental health supports need to be efficiently blended
- Sparse availability of MH providers in schools
- Labels and 'places' confused with interventions
- Separate delivery systems (Sp.Ed., Mental health, etc)



Interconnected Systems Framework

Tier I: Universal/Prevention for All

Coordinated Systems, Data, Practices for Promoting Healthy Social and Emotional Development for ALL Students

- School Improvement team gives priority to social and emotional health
- Mental Health skill development for students, staff/, families and communities
- Social Emotional Learning curricula for all
- Safe & caring learning environments
- Partnerships: school, home & community
- Decision making framework guides use of and best practices that consider unique strengths and challenges of each school community

MH/PBIS: An Expanded Tier One

- Universal screening for social, emotional, and behavioral at-risk indicators
- Universal screening for families who may request assistance for their children
- Teaching social skills with evidence-based curricula to all students
- Teaching appropriate emotional regulation and expression to all students
- Teaching behavioral expectations to all students
- Mental health professionals are part of the Tier 1 systems team, providing input and progress monitoring data
- Opportunity to review community data and expand Tier 1 intervention options based on data

Interconnected Systems Framework

Tier 2: Early Intervention for Some

Coordinated Systems for Early Detection, Identification, and Response to Mental Health Concerns

- Systems Planning Team coordinates referral process, decision rules and progress monitors
  - Array of services available
  - Communication system: staff, families and community
  - Early identification of students at risk for mental health concerns due to specific risk factors
  - Skill-building at the individual and groups level as well as support groups
- Staff and Family training to support skill development across settings

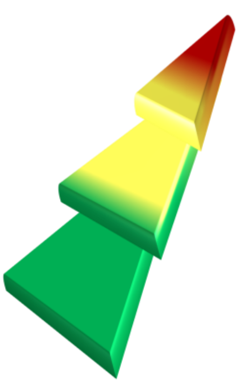
MH/PBIS: An Expanded Tier Two

- Mental health/community professionals part of secondary systems and problem solving teams
- Working smarter matrix completed to ensure key resources are both efficient and effective (i.e., initiatives are aligned and combined such as “bully prevention”, “discipline”, “character education”, “RtI behavior”, etc.)
- Groups co-facilitated by school staff and community partner (example – guidance counselor and community provider clinician)
- Opportunity to expand the continuum of interventions based on data (i.e. trauma informed interventions)
- Out-reach to families for support/interventions

Interconnected Systems Framework

Tier 3: Intensive Interventions for Few

Individual Student and Family Supports



- Systems Planning team coordinates decision rules/referrals and progress monitors
- Individual team developed to support each student
- Individual plans have array of interventions/services
- Plans can range from one to multiple life domains
- System in place for each team to monitor student progress

MH/PBIS: An Expanded Tier Three

- Mental health professional(s) part of tertiary systems team
- FBA/BIP and/or person-Centered Wraparound plans completed together with school staff and mental health provider for one concise plan, rather than each completing paperwork to be filed
- Quicker access to community-based supports for students and families

Traditional → Preferred

- Each school works out their own plan with Mental Health (MH) agency;
- District has a plan for integrating MH at all buildings (based on community data as well as school data);

Traditional → Preferred

- A MH counselor is housed in a school building 1 day a week to “see” students;
- MH person participates in teams at all 3 tiers;

Traditional → Preferred

- No data to decide on or monitor interventions;
- MH person leads group or individual interventions based on data;

SCHOOL-WIDE

1. 1. Leadership team
2. Behavior purpose statement
3. Set of positive expectations & behaviors
4. Procedures for teaching SW & classroom-wide expected behavior
5. Continuum of procedures for encouraging expected behavior
6. Continuum of procedures for discouraging rule violations
7. Procedures for on-going data-based monitoring & evaluation

EVIDENCE-BASED INTERVENTION PRACTICES

CLASSROOM

1. All school-wide
2. Maximum structure & predictability in routines & environment
3. Positively stated expectations posted, taught, reviewed, prompted, & supervised.
4. Maximum engagement through high rates of opportunities to respond, delivery of evidence-based instructional curriculum & practices
5. Continuum of strategies to acknowledge displays of appropriate behavior.
6. Continuum of strategies for responding to inappropriate behavior.

INDIVIDUAL STUDENT

1. Behavioral competence at school & district levels
2. Function-based behavior support planning
3. Team- & data-based decision making
4. Comprehensive person-centered planning & wraparound processes
5. Targeted social skills & self-management instruction
6. Individualized instructional & curricular accommodations

NONCLASSROOM

1. Positive expectations & routines taught & encouraged
2. Active supervision by all staff (Scan, move, interact)
3. Precorrections & reminders
4. Positive reinforcement

FAMILY ENGAGEMENT

1. Continuum of positive behavior support for all families
2. Frequent, regular positive contacts, communications, & acknowledgements
3. Formal & active participation & involvement as equal partner
4. Access to system of integrated school & community resources

Evidence exists for positive effects of school-based programs across tiers*

- Tier 1 SEL programs:
  - Improve social and emotional skills, attitudes, behavior
  - Meta-analysis: 11 percent increase in academic performance (Durlak et al., 2011)
- Emerging support for Tier 1 Positive Behavioral Interventions and Supports (PBIS)
- Screening and assessment likely to benefit youth with depression/anxiety
  - However, less than 2% of schools utilize systematic screening process for MEB problems
- A few (but not many) rigorous studies of intensive & individualized Tier 2 and Tier 3 SMH programs

*Bruns, Duong, Lyon, et al., in press
Farahmand et al., 2011;
Fazel, Hoagwood, Stephan, & Ford, 2014;
Hoagwood et al., 2007

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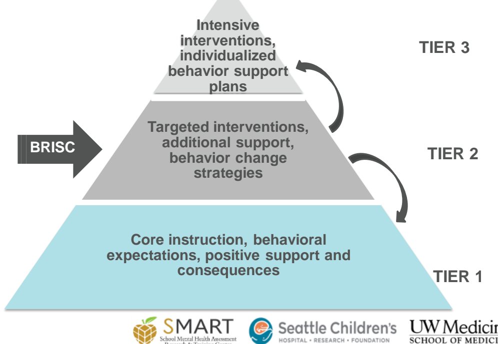
Developing a Contextually Appropriate Intervention for SMH: The Brief Intervention for School Clinicians (BRISC)

Funded by the Institute of Education Sciences (R305A120128 – McCauley & Bruns, Co-PIs; Lyon, Co-I)

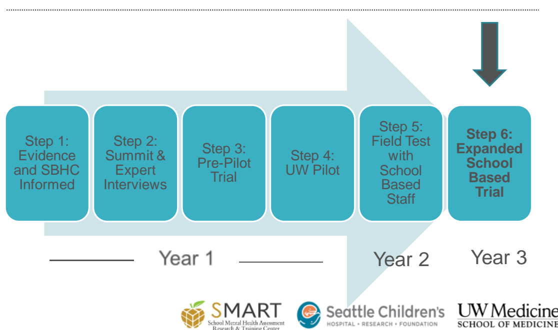
Context for BRISC

- Currently developing a <u>brief intervention model</u> (3-4 sessions) to maximize *intervention-setting fit*
  - During 2009 pilot (Lyon et al., 2011), modal number of sessions was <u>3</u>
    - Large caseloads, sole practitioner
    - Frequent disruptions
    - Engagement difficulties
  - Some clinicians struggled to determine which modules to select/prioritize
  - Many students (60%+) with subclinical presentations

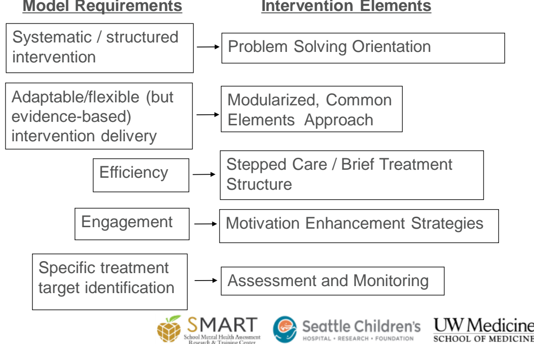
BRISC Integration with Educational Approaches



BRISC Protocol Development & Refinement
3 Year, IES Funded Goal 2



Original BRISC Components



BRISC: Summary of Findings from Year 1

- Qualitative findings from expert interviews and a *nominal group process* yielded 3 crosscutting themes (Lyon et al., 2014):
  1. Alignment with the school context (e.g., RtI framework; dev of readiness assessment)
  2. Flexible/responsive service delivery
  3. Effective data utilization (esp. integration of school/educational data)
- BRISC protocol generally feasible, acceptable, and appropriate for use with students (Lyon et al., under review)

BRISC: Summary of Findings from Year 2

- Participant recruitment procedures are feasible and effective in retaining an appropriate student sample.
- Data informed changes to improve effectiveness of BRISC training and consultation.
- Students in BRISC reported greater therapeutic alliance than TAU (small sample)
- Qualitative data from practitioners regarding feasibility and appropriateness within the school setting informed continued changes to training and treatment protocol.

Other Results from Development Stages

Four core post-BRISC pathways identified:

1. Come back if you need it
2. Supportive monitoring
3. Continue BRISC or other TAU
4. More intensive services - referral to other services (i.e. special education, psychiatry, trauma treatment, family therapy, DBT, eating disorder treatment, etc.)

Session ONE

1. Administer and review brief standardized assessment measure(s)
2. Assess current functioning: school, peers, family
3. Identify Problems
   a) List problems
   b) Identify top 3
   c) Introduce cognitive triangle
4. Convey Helpfulness & Plan for Working Together
5. Introduce Informal Monitoring

Session TWO

1. Review informal monitoring
2. Recap problem list and identify problem to address
3. Discuss stress and obtain rating
4. Introduce problem solving
5. **Identify barriers and plan to address**
6. Create a game plan for the week

Problem Solving Skills Worksheet

1. Stop, take a breath, and identify the problem.

2. Brainstorm possible solutions (No answer is good or bad)

___ a.

___ b.

___ c.

___ d.

___ e.

___ f.

3. Evaluate possible solutions

4. Pick one to try

5. Prepare for possible obstacles

6. Try it

Problem Solving Worksheet – EXAMPLE

Step One: List identified problem

Identified Problem:	*Failing many of my classes and may not graduate*

Step Two: Identify a solution that is healthy, specific, realistic, and achievable

Solution: What do you hope to accomplish in the next few weeks	*Complete and hand in completed homework*

Step Three: Generate a list of possible steps that you could do

Possible Step	Good things about this step	Bad things about this step
Attend homework help at school	*Someone there to help if needed*	*Tired after school & don't like staying after school*
Go to the library after school	*Get to leave school. No distractions*	*Tired after school*
Go to Starbucks	*Out of the house, could get food, coffee/latte*	*I am easily distracted by people watching*
Ask questions in math class when needed	*Help me to do work/focus in class*	*People might think I'm stupid if I ask something they already know*
Do homework right after school and reward self by doing something fun	*Help get work done earlier & get to bed earlier*	*Often tired after school and want to do something right after school*
No nap after school	*More time to do HW earlier and more sleep at night – less tired*	*Tired after school*
Turn off phone while working on homework	*Less distractions*	*Might miss a text from my boyfriend; might need calculator or clock/time*

Session THREE

1. Review problem solving experiment
2. Ask for stress rating
3. **Continue problem solving:**
   a) **Individualize approach based on barriers**
   b) **Incorporate new skill as/if needed:**
      – **Stress and Mood Management Guide**
      – **Communication Skills Guide**
      – **Realistic Thinking Guide**
4. Create game plan for the coming week

Session THREE

Did student successfully implement step?

What was the BIGGEST BARRIER to moving forward?

Then:

No

Wrong Problem/ Solution → Revisit Problem List/PS Steps

Feels Nothing will Work → Motivation Guide

Can't Manage Stress/Mood → Stress and Mood Management Guide

Unable to Express Needs → Communication Guide

Stuck in Negative Thinking → Realistic Thinking Guide

Yes

More to Work on

Choose a New Problem

Done with Counseling

Session FOUR

1. Assess the outcome of the solution
2. Ask for stress rating
3. Administer and review brief standardized assessment measure
4. Review progress and continued use of problem solving skill
5. Identify and plan for next steps
   - Come back if you need it
   - Ongoing school-based counseling or other school-based services
   - Referral to outside services
   - Regular check-ins (with identified person at school)

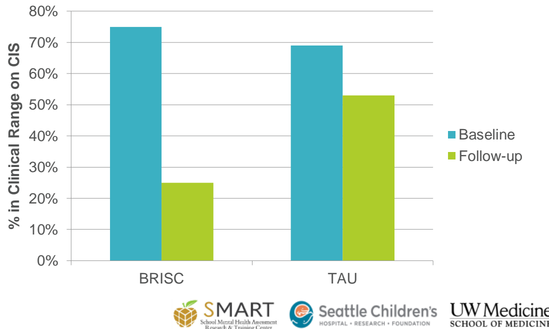
BRISC: Very Early Findings from Year 3

Study is ongoing (to the end of school year)

Very small sample size so far – but early data looks promising in the following areas:

- Meeting student needs
- Reducing impairment
- Improving interpersonal relationships
- Reducing symptoms of depression and anxiety

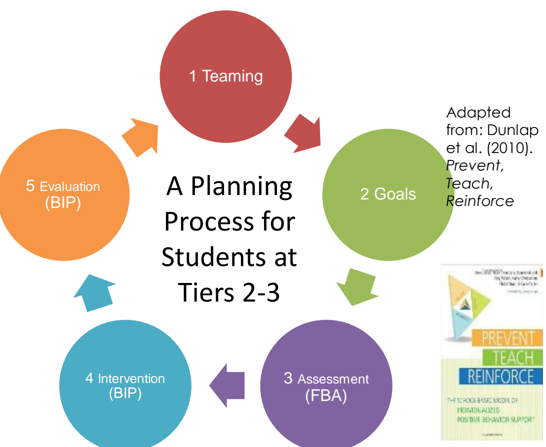
Reducing the percent of students in the clinical range – in four sessions and eight weeks



Getting to "Tier 3"

What is Tier 3 intensive?

- For students with serious and challenging behaviors that require individualized interventions
- Collection of data to determine function of behavior (FBA) and positive behavior plan to address function (BSP)
- Coordination of home, school, community interventions



Comparison Tiers 2, 3, & Wrap

Student Teams

Tier 2	Tier 3	Tier 3 Wraparound
Small behavior planning team reviewing students who need more than Tier 1 interventions	Student-specific team members (student, parent, peer, administrator, teacher, behavioral staff member, etc.)	Student and family identify team members which may include peers and professionals outside of school

Comparison Tiers 2, 3, & Wrap

Goals

Tier 2	Tier 3	Tier 3 Wraparound
Similar goals for all students: in class, on task, responding successfully to Tier 1 supports	Individualized school-based goals to address 1-2 specific problem behaviors	Student and family choose goals focused on addressing BIG needs occurring in the home, school, community

Comparison Tiers 2, 3, & Wrap

Assessment

Tier 2	Tier 3	Tier 3 Wraparound
Practical Functional Behavior Assessment (FBA) of problem behavior	FBA including observations and interviews	More comprehensive measures assessing strengths & needs in home, school and community

Comparison Tiers 2, 3, & Wrap

Interventions

Tier 2	Tier 3	Tier 3 Wraparound
Tiers 1 and 2 interventions with individualized components to Tier 2 interventions if needed	Tiers 1 and 2 interventions and Behavior Support Plan (BSP) including Safety Plan	Same as Tiers 1, 2 and 3; Crisis/safety plan; Community services, as needed

Comparison Tiers 2, 3, & Wrap

Evaluation

Tier 2	Tier 3	Tier 3 Wraparound
Office discipline referrals, Check-in/Check out data attendance, nurse visits, other	Same as Tier 2, and SWIS Student Support Information System (ISIS)	Same as Tier 3,and other data tools

Tier 2/3 Process Builds Across Tiers

Tier 2
Teams
Goals
Assessment
Intervention
Evaluation

Tier 3
Teams
Goals
Assessment
Intervention
Evaluation

Tier 3 Wraparound
Teams
Goals
Assessment
Intervention
Evaluation

T3 Wraparound: Main Messages

- School-wide PBS (with all three tiers) is proving to be both practical and effective at building the positive social cultures that support educational gains.
- Addressing the behavior support needs of those students with the most intensive needs is part of school-wide PBS.
  - Commonly referred to as "Tier 3" or intensive individualized supports
- School-based wraparound can be a key "Tier 3" strategy within PBS that emphasizes a collaborative, team based approach to solving behavior problems
  - However, system collaboration and workforce support is critical to success
- Wraparound is about to "go to scale" in Washington State

Quick Exercise

If you were to do **everything you could** to **sabotage** the effectiveness of your work with the students with the top 3-5% of emotional and behavioral needs in the school, what would you do?

What is the Wraparound Process?

- Wraparound is a family-driven, team-based process for planning and implementing services and supports.
- Through the Wraparound process, teams create plans that are geared toward meeting the unique and holistic needs of these youth and their caregivers and families.
- The Wraparound team members meet regularly to implement and monitor the plan to ensure its success.
  - Team members include individuals relevant to the success of the identified youth, including his or her parents/caregivers, other family members and community members, mental health professionals, educators, system representatives, and others

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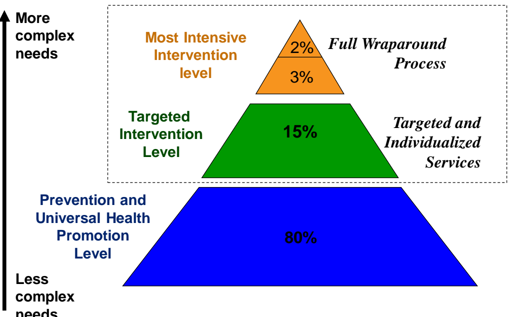
Who is wraparound for?
Youths with most complex needs



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Why do we need Wraparound?

- Working with youths with complex needs and multiple system involvement is challenging and outcomes are poor
  - Child and family needs are complex
    - Youths with serious EBD typically have multiple and overlapping problem areas that need attention
    - Families often have unmet basic needs
  - Families are rarely fully engaged in services
    - They don't feel that the system is working for them
    - Leads to treatment dropouts and missed opportunities

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Why Wraparound? (continued)

- Systems are in "siloes"
  - Special education, mental health, primary health care, juvenile justice, child welfare each are intended to support youth with special needs
  - However, the systems also have different philosophies, structures, funding streams, eligibility criteria, and mandates
- These systems don't work together well for individual families unless there is a way to bring them together
  - Youth get passed from one system to another as problems get worse
  - Families relinquish custody to get help
  - Children are placed out of home

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The Evans Family

- Crystal, 34
- Tyler, 36
- David, 14
- Kyle, 12
- Kaia, 12

Major Problems:

- Crystal has depression and suicide ideation
- Tyler is an alcoholic and can not keep a job
- David has been arrested multiple times for increasing levels of theft, vandalism, drug and alcohol use and assault
- David is in juvenile detention and due to lack of progress may be moving to higher level of care
- David is two years behind in school and does not seem to care
- The twins were abused by their dad and are in specialized foster case
- The twins have been diagnosed with bipolar disorders and are often very aggressive
- The twins are very disruptive at school and are not working to grade level

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26 Helpers and 13 Plans

Helpers:
- School (5)
- Technical School (2)
- Bailey Center (2)
- Child Welfare (1)
- Specialized Foster Care (2)
- Juvenile Justice (1)
- Children’s Mental Health (6)
- Adult Mental Health (3)
- Employment Services (2)
- AA (1)
- Housing Department (1)

Plans:
- 2 IEPs (Kyle and Kaia)
- Tech Center Plan
- Bailey Center Plan
- Permanency Plan
- Specialized Foster Care Plan
- Probation Plan
- 3 Children’s MH Tx Plans
- 2 Adult MH Tx Plans
- Employment Services

- **35 Treatment Goals or Objectives**

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Monthly Appointments for the Evans Family

Child Welfare Worker	1
Probation Officer	2
Crystal’s Psychologist	2
Crystal’s Psychiatrist	1
Dave’s therapist	4
Dave’s restitution services	4
Appointments with Probation and School	2
Family Based	4
Twins’ Therapists	4
Group Rehabilitation	8
Tyler’s anger management	4
Children’s Psychiatrist	1
Other misc. meetings:, Housing, Medical	5
TOTAL	42

Also: 16 AA meetings Tyler goes to each month to preserve his sobriety, daily schedule (School, tech center, and vocational training) and the dozen or more calls from the schools and other providers each month.

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Comments from the Files:

- Parents don’t respond to school’s calls
- Family is dysfunctional
- Parents are resistant to treatment
- Home is chaotic
- David does not respect authority
- Twins are at risk due to parental attitude
- Mother is non-compliant with her psychiatrist
- She does not take her meds
- Father is unemployable due to attitude
- Numerous missed therapy sessions
- Attendance at family therapy not consistent
- Recommend court ordered group therapy for parents

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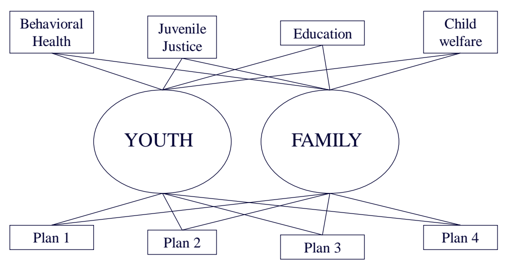
Traditional services rely on professionals and can result in multiple plans



Laura Burger Lucas, ohana coaching, 2009

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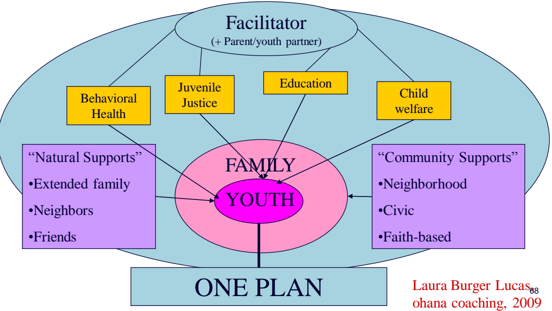
In wraparound, a facilitator coordinates the work of system partners and other natural helpers so there is one coordinated plan



Laura Burger Lucas, ohana coaching, 2009

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What's Different in Wraparound?

- An integrated plan is designed by a team of people important to the family
- The plan is driven by and "owned" by the family and youth
- The plan focuses on the priority needs as identified by the family
- Strategies in the plan include supports and interventions across multiple life domains and settings (i.e., behavior support plans, school interventions, basic living supports, family supports, help from friends and relatives, etc)
- Strategies include supports for adults, siblings, and family members as well as the "identified youth"

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Wraparound and Schools

- Wraparound can be integrated into school-based planning for students with special needs, regardless of special education label or agency involvement.
- The wraparound approach is a critical part of the SW-PBS system as it offers a means for schools to succeed with the 1–2% of students whose needs have become so complex that starting with an FBA/BIP process for one selected problem behavior is not enough

Wraparound and Schools

- Full implementation of SW-PBS at the universal level provides a solid base of lower-level interventions (e.g., primary and secondary)
  - To build a more effective and supportive environments in which to implement wraparound plans.
- Within a three-tier system of behavioral support, students who need tertiary-level supports also have access to and can benefit from universal and secondary supports.
  - Each level of support in SW-PBS is "in addition to" the previous level. In other words, no student only needs wraparound.

Wraparound and Schools

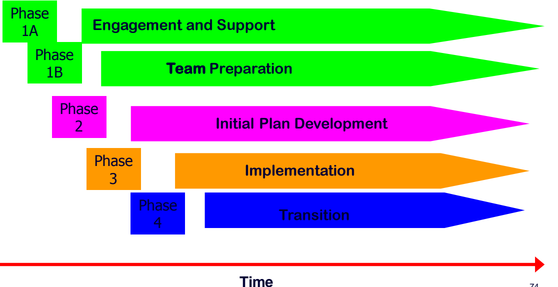
- Wraparound can be seen as similar to special education or mental health treatment planning
- However, it dedicates more effort to building constructive relationships and support networks among the youth and his or her family
- This is accomplished by establishing a unique team with each student and the student's family that
  - Is invested in achieving agreed-on quality-of-life indicators.
  - Follows a response to intervention (RTI) model
  - Uses more intensive techniques for engagement and team development
  - Ensures that a cohesive wraparound team and plan are formed.

Why move to Phase I wraparound instead of an FBA around one problem behavior?

- Discussing problem behaviors would not have motivated family to participate on team.
- Probably not the first time schools have approached family in this manner (“let’s talk about behavior”)
- Bigger needs to work on to improve quality of life for youth and family
- Open-ended conversation and use of wrap data tools helped engage family
- Full involvement of other formal helpers and “natural supports” will probably be needed to develop and implement a holistic response

A practice model:

The Four Phases of Wraparound



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Phase 1 A and B

Phase 1 : Engagement and Team Preparation

- Care Coordinator & Family Support Partner meets with the family to discuss the wraparound process and listen to the family’s story.
- Assess for safety and make a support plan if needed
- Discuss concerns, needs, hopes, dreams, and strengths.
- Listen to the family’s vision for the future.
- Identify people who care about the family as well as people the family have found helpful for each family member.
- Reach agreement about who will come to a meeting to develop a plan and where we should have that meeting.

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Phase 1: Creating an alliance

- From emphasizing *problems* to emphasizing *competence*
- • From the role of *expert* to the role of *accountable ally*
- • From working on *professional* turf to working on *family* turf
- • From *teaching to* to *learning with*

Laura Burger Lucas, ohana coaching, 2009; From William Madsen, PhD, "Collaborative Therapies for Multi-Stressed Families"

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Phase 1: Bringing the relevant expertise to the cause of meeting needs

- Wraparound facilitator
- Parent and/or youth partner
- Elder
- Teacher
- Parents and grandparents
- Therapist
- Youth
- Friend
- Mentor

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Phase 2

Phase 2: Initial Plan Development

- Conduct first Child & Family Team (CFT) meeting with people who are providing services to the family as well as people who are connected to the family in a supportive role.
- The team will:
  - Review the family vision
  - Develop a Mission Statement about what the team will be working on together
  - Review and collectively prioritize the family's needs
  - Come up with several different ways to meet those needs that match up with the family's strengths
- Different team members will take on different tasks that have been agreed to.

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Phase 2: From listing strengths to identifying and leveraging functional strengths

- "David likes football"
- "David likes to watch football with his uncle on Sundays"
- "David enjoys hanging out with his uncle; David does well in social situations in which he feels like he can contribute to the conversations; Watching football is one activity in which David doesn't feel anxious or worry."

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Phase 3

Phase 3: Plan Implementation and Refinement

- Based on the CFT meetings, the team has created a written plan of care.
- Action steps have been created, team members are committed to do the work, and our team comes together regularly.
- When the team meets, it:
  - Reviews Accomplishments (what has been done and what's been going well);
  - Assesses whether the plan has been working to achieve the family's goals;
  - Adjusts things that aren't working within the plan;
  - Assigns new tasks to team members.

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Phase 3: Implementation

- Includes a focus on systematic tracking of progress toward meeting the priority needs/achieving goals
  - Stop and replace action steps that *aren't* working
  - Continue action steps that *are* working
  - Celebrate success!
  - Adjust type, frequency and intensity in response to feedback

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Phase 4

Phase 4: Transition

- There is a point when the team will no longer need to meet regularly.
- Transition out of Wraparound may involve a final meeting of the whole team, a small celebration, or simply the family deciding they are ready to move on.
- The family we will get a record of what work was completed as well as list of what was accomplished.
- The team will also make a plan for the future, including who the family can call on if they need help or if they need to re-convene their team.
- Sometimes transition steps include the family and their supports practicing responses to crises or problems that may arise

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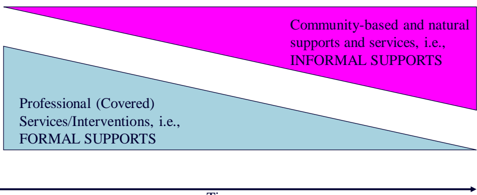
Phase 4: From professional services to informal/community supports



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Outcomes of Wraparound

Does wraparound work?
For whom?
What leads to positive outcomes?

84

Does wraparound work?

Evidence from Nine Published Controlled Studies is Positive

Study	Target population	Control Group Design	N
1. Hyde et al. (1996)*	Mental health	Non-equivalent comparison	69
2. Clark et al. (1998)*	Child welfare	Randomized control	132
3. Evans et al. (1998)*	Mental health	Randomized control	42
4. Bickman et al. (2003)*	Mental health	Non-equivalent comparison	111
5. Carney et al. (2003)*	Juvenile justice	Randomized control	141
6. Pullman et al. (2006)*	Juvenile justice	Historical comparison	204
7. Rast et al. (2007)*	Child welfare	Matched comparison	67
8. Rauso et al. (2009)	Child welfare	Matched comparison	210
9. Mears et al. (2009)	MH/Child welfare	Matched comparison	121

*Included in 2009 meta-analysis (Suter & Bruns, 2009)

Outcomes of wraparound (9 controlled, published studies to date; Bruns & Suter, 2010)

- Better functioning and mental health outcomes
- Reduced recidivism and better juvenile justice outcomes
- Increased rate of case closure for child welfare involved youths
- Reduction in costs associated with residential placements

Meta analysis finds significant effects

- Recent meta-analysis found significant, medium-sized effects in favor of wraparound for Living Situation outcomes (placement stability and restrictiveness)
- A significant, small to medium sized effect found for:
  - Mental health (behaviors and functioning)
  - School (attendance/GPA), and
  - Community (e.g., JJ, re-offending) outcomes
- The overall effect size of all outcomes in the 7 studies is about the same (.35) as for “evidence-based” treatments, when compared to services as usual (Weisz et al., 2005)

Suter & Bruns (2009)

Wraparound is increasingly considered "evidence based"

- Under review by SAMHSA National Registry of Effective Practices and Programs (NREPP)
- State of Oregon Inventory of EBPs
- California Clearinghouse for Effective Child Welfare Practices
- Washington Institute for Public Policy: "Full fidelity wraparound" is a research-based practice

UNDER WHAT CONDITIONS

Does wraparound actually work well?

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Outcomes depend on implementation.

Studies indicate that Wraparound teams often fail to:

- Incorporate full complement of key individuals on the Wraparound team;
- Engage youth in community activities, things they do well, or activities to help develop friendships;
- Use family/community strengths to plan/implement services;
- Engage natural supports, such as extended family members and community members;
- Use flexible funds to help implement strategies
- Consistently assess outcomes and satisfaction.

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What is the connection between fidelity and outcomes with wraparound?

- Provider staff whose families experience better outcomes were found to score higher on fidelity tools (Bruns, Rast et al., 2006)
- Wraparound initiatives with positive fidelity assessments demonstrate more positive outcomes (Bruns, Leverentz-Brady, & Suter, 2008)

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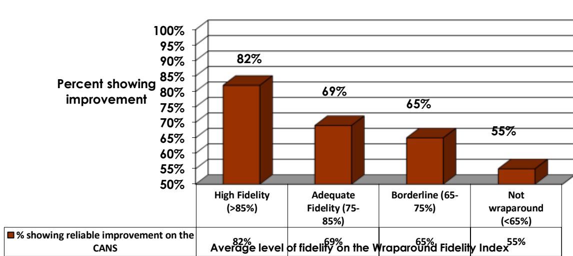
Higher fidelity is associated with better child and youth outcomes



Effland, McIntyre, & Walton, 2010

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What does it take to get high fidelity scores?

- Training and coaching found to be associated with gains in fidelity and higher fidelity
- Communities with better developed supports for wraparound show higher fidelity scores

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Necessary Community and System Supports for Wraparound

Types of program and system support for Wraparound

1. Community partnership *Do we have collaboration across our key systems and stakeholders?*
2. Collaborative action *Do the stakeholders take concrete steps to translate the wraparound philosophy into concrete policies, practices and achievements?*
3. Fiscal policies *Do we have the funding and fiscal strategies to meet the needs of children participating in wraparound?*
4. Service array *Do teams have access to the services and supports they need to meet families' needs?*
5. Human resource development *Do we have the right jobs, caseloads, and working conditions? Are people supported with coaching, training, and supervision?*
6. Accountability *Do we use tools that help us make sure we're doing a good job?*

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Summary: What Leads To Outcomes?

Program and System Supports →

Training, Coaching, and Quality Assurance →

Adherence to a clear theory- and research based **wraparound service model** →

Positive Outcomes!

Opportunities for Schools Psychs to Get Involved in School-Based Mental Health

- System change agent – influencing adoption of MTSS framework
- Consultation on Tier 1 implementation
- Case manage or consult on Tier 2 implementation
- Implementation scientist
  - Creating infrastructure to support effective adoption and use of evidence-based practices

Opportunities for Schools Psychs to Get Involved in School-Based Mental Health

- Direct therapy with child
  - Cognitive Behavior Therapy / BRISC
- Conduct FBA and develop individualized BIPs
- Parent training
  - Quarterly parent training offerings
- Data-based decision making
  - Screening
  - Progress monitoring
- Facilitating effective wraparound

Why a Lawsuit?

Washington **needs to build a better system** that is designed to meet youth's needs.

What is WISe?

"Wraparound with Intensive Services" delivered through **Child and Family Teams (CFT's)** that:

- **Plan** and **implement** services
- **Assess** whether plan is working
- **Make changes** to plan as needed

See the WISe Program Model described in **Appendix B**

What is WISe?

Uses **Array of Intensive Services** that includes:

- Intensive **Care coordination**
- **Direct services**
- **24 hour mobile crisis** planning and intervention services

What is WISe?

Uses **Array of Intensive Services** that includes:

- Intensive **Care coordination**
- **Direct services**
- **24 hour mobile crisis** planning and intervention services

Direct Services

Family education

In-home functional behavioral assessment

Positive behavioral support aids

Individual, Family, and Evidence Based Therapeutic services

See the service descriptions listed in **Appendix A**.

How would I participate in WISe?

Thousands of kids are likely to be eligible for WISe.

You **might be eligible** if you:

- Can use a **Medicaid** Coupon
- Are between **ages of 0 to 21**
- **Need intensive services** to treat a **mental illness or mental health condition** that is **interfering** with your school, family, or community life

See WISe Proxy Characteristics listed in **Appendix D**

How would I participate in WISe?

Youth will receive a **WISe Screen** to determine eligibility

- **Professionals will be trained to look for signs** to refer a youth for a WISe Screen.
- **Any youth or family will be able to ask** for and get a WISe Screen. *No referral is necessary.*
- **Community Mental Health Agencies** will provide WISe Screens and Services

See WISe Access Protocol and Model in **Appendix C**

How would I participate in WISe?

Youth will receive a **WISe Screen** to determine eligibility

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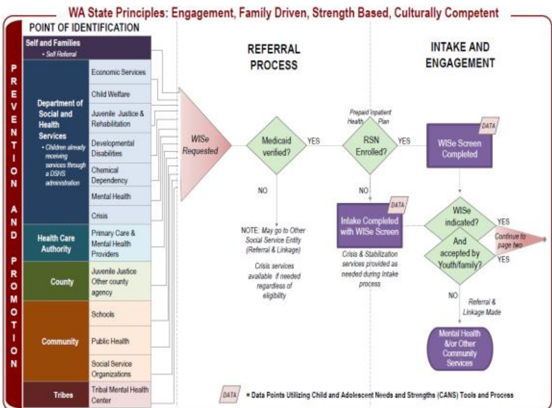
- **Any youth or family will be able to ask** for and get a WISe Screen. *No referral is necessary.*
- **Community Mental Health Agencies** will provide WISe Screens and Services

Who do I ask for help?

Contact your:

Regional Support Network (RSN), or Community Mental Health Agency (CMHA)

See WISe Access Protocol and Model in **Appendix C**



County	Contact(s) for WISe Referrals	Telephone
Benton	• Greater Columbia RSN office • Lutheran Community Services	509-735-8681 or 800-795-9296 509-735-6446 or 800-678-4876
Clark	• Southwest Washington Behavioral Health	360-397-8222
Franklin	• Greater Columbia RSN office • Lutheran Community Services	509-735-8681 or 800-795-9296 509-735-6446 or 800-678-4876
Kittitas	• Central Washington Comprehensive Mental Health • Greater Columbia RSN office	509-925-9861 509-735-8681 or 800-795-9296
Klickitat	• Central Washington Comprehensive Mental Health ○ Goldendale ○ While Salmon • Greater Columbia RSN office	 509-773-5801 509-493-3400 509-735-8681 or 800-795-9296
Mason	• Family Alliance for Mental Health	360-790-7505
Pierce	• Catholic Community Services • Optum Pierce RSN ○ Ask for a Children's Care Manager	253-208-1016 253-292-4200
Skagit	• Volunteers of America Note: For youth already enrolled and receiving Medicaid mental health services, contact the youth's assigned clinician	888-693-7200
Snohomish	• Volunteers of America Note: For youth already enrolled and receiving Medicaid mental health services, contact the youth's assigned clinician	888-693-7200
Thurston	• Family Alliance for Mental Health	360-790-7505
Walla Walla	• Central Washington Comprehensive Mental Health • Greater Columbia RSN office	509-524-2920 509-735-8681 or 800-795-9296
Whatcom	• Volunteers of America Note: For youth already enrolled and receiving Medicaid mental health services, contact the youth's assigned clinician	888-693-7200
Yakima	• Central Washington Comprehensive Mental Health • Greater Columbia RSN office • Yakima Valley Farmworkers	509-575-4084 509-735-8681 or 800-795-9296 509-453-1344

Other Contact Information

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YOUNG MINDS ADVOCACY PROJECT
115 Haight Street
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Department of Social and Health Services

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