P-02093 (08/2022)

CHILDREN'S SYSTEM OF CARE GUIDING DOCUMENT

Wisconsin's Children's System of Care supports promoting wellness and empowers people to achieve their fullest potential.

Children and families may access support in multiple ways within each tribal nation and county. Some may be involved in a child-serving system. Some may be seeking help to prevent the involvement in a formal system. In either circumstance, children and families are afforded opportunities for support within each unique tribal nation and county as well as the robust resources within each family and each of the communities they reside.

Wisconsin's Children's System of Care blends the principles of wraparound along with key infrastructure components, resulting in a stronger, more sustainable network of quality supports for children and families. This approach allows more children to be served due to better investment of limited resources.

The Children's System of Care Self-Assessment Tool, P-02093B, assists tribal nations and counties in identifying the Wisconsin Children's System of Care principles that describe the strengths of existing services and supports that are locally available. It also identifies resources that typically exist in each tribal nation and county that can contribute to building a children's system of care. Counties and tribes are encouraged to consider the potential roles that resources could contribute toward a local children's system of care. For further information, see P-02093C, Instructions.

Principles of Wisconsin's Children's System of Care

By creating a consensus around the strength of each principle within the local community, the team completing the Children's System of Care Self-Assessment Tool develops an understanding of how the wraparound model can build a children's system of care that provides effective support.

Family voice and choice

Family voice and youth guided: Family, youth/child, and young adults' perspectives, hopes, and dreams are intentionally elicited and prioritized during all phases of the wraparound process. Planning is grounded in family members' perspectives and the team strives to provide options and choices that reflect the family's values and preferences.

Family choice and youth directed: A process that is entirely led by families for families. Family and youth-driven, with families and young people, supported in determining the types of treatment and support provided (with increasing youth/young adult self-determination based on age and development), and their involvement in decision-making roles in system-level policies, procedures, and priorities.

Rights protection and advocacy: Protect the rights of young people and families through policies and procedures and promote effective advocacy efforts in concert with advocacy and peer-led organizations.

Cultural and linguistic responsiveness

The wraparound process demonstrates respect for and builds on the values, preferences, beliefs, culture, and identity of the child, youth, family, and community to ensure that services are sensitive and responsive to all people. Culture-specific services and support are provided. Services and supports are adapted to ensure access and effectiveness for culturally diverse populations. Providers represent the cultural and linguistic characteristics of the population served. Providers are trained in cultural and linguistic responsive care. Specific strategies are used to reduce racial and ethnic disparities in access to and outcome of services.

Mental health equity: Provide equitable services and supports that include telehealth resources that are accessible to young people and families irrespective of race, religion, national origin, gender, gender expression, sexual orientation, physical disability, socioeconomic status, geography, language,

immigration status, or other characteristics; eliminate disparities in access and quality of services and ensure that services are sensitive and responsive to all people.

Community-based

Community-based, with services and supports provided in-home, school, primary care, and community settings to the greatest possible extent, and with responsibility for system management and accountability resting within a supportive, adaptive infrastructure, processes, and relationships at the community or regional level. Deliver services and supports within the least restrictive, most natural environments that are appropriate to the needs of young people and their families, including homes, schools, primary care, outpatient, and other community settings.

Natural supports

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

Team-based

The team consists of people agreed upon by the family and is committed to the family through informal, formal, and community support. Families' youth and young adults are included in all meetings regarding their planning and future. Ensure availability and access to a broad, flexible array of effective, high-quality treatment, services, and supports for young people and their families that address their emotional, social, educational, physical health, and mental health needs, including natural and informal supports.

Collaboration

Team members work cooperatively and share responsibility for developing, implementing, monitoring, and evaluating a single wraparound plan.

The plan reflects a blending of team members' perspectives, mandates, and resources. The plan guides and coordinates each team member's work towards meeting the team's goals.
One overall plan of care is created across child/youth/young adult-serving agencies and systems (there may be more detailed plans for individual systems as a part of the overall plan)
Services are coordinated at the system level, with linkages among youth-serving systems and agencies across administrative and funding boundaries (education, child welfare, youth justice, substance use, primary care) and with mechanisms for collaboration, and system-level management, and addressing cross-system barriers to coordinated care.

Individualized and developmentally informed

Individualized: Provide individualized services and supports tailored to the unique strengths, preferences, and needs of each young person and family that are guided by a strengths-based planning process and an individualized service plan developed in partnership with young people and their families. To achieve the goals laid out in the plan, the team develops and implements a customized set of strategies, supports, and services that are congruent with the developmental progress of an individual.
Developmentally informed: Understanding of the basics of brain development of mental health and substance use, developmental needs of a child and family, trauma impact, and stages of change. Individualized service plans are developed and implemented for each child, youth, young adult, and family that address multiple life domains. Developmentally appropriate services and supports, including services that promote optimal social-emotions outcomes for young children and their families. The facilitation supports youth and young adults that support their transition to adulthood and to adult service systems as needed.

Strengths-based

The wraparound process and the plan identify, build on and enhance the capabilities, knowledge, skills, and assets of the child and family, their community, and other team members.
Individual services and supports are tailored to the unique strengths, preferences, and needs of each young person and family that are guided by a strengths-based planning process.

Unconditional

The system of care, including the team, does not give up on, blame, or reject children, youth, and their families. When faced with challenges or setbacks, the team continues to work toward meeting the needs of youth and families.

Outcome-based

The team ties the goals and strategies of the plan to observable or measurable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly. Require that all data contribute to understanding the strengths and challenges that contribute to the quality of support and services that children, youth, and families receive. Other sources of data that contribute to assessing the quality of services and supports include large data pools already collected by behavioral health, child welfare, school districts, youth justice agencies, etc.
Data-driven accountability: Incorporate mechanisms to ensure that systems and services are data-driven, with continuous accountability and quality improvement mechanisms to track, monitor, and manage the achievement of goals; fidelity to System of Care principles; the utilization and quality of clinical services and supports; equity and disparities in service delivery; and outcomes and costs at the child and family and system levels.
Quality improvement and evaluation: Measurements include both process data and outcome data that are typically important to families and reflect the principles of wraparound (child and family assets and strengths, caregiver well-being, youth, and family empowerment).
Outcomes are collected and drive program improvement: There is centralized monitoring of relevant outcomes for youth and families receiving programs and services. This information is used as the basis for funding, policy discussions, and strategic planning.

Resource areas to consider in system of care development when blending Coordinated Services Teams Initiatives, Comprehensive Community Services, and the wraparound model

By identifying the unique array of resources and strengths available locally, the assessment team can create a consensus regarding opportunities to build upon strengths and minimize barriers to enhancing the children's system of care.

Readiness

The creation of a children's system of care is a complex process that requires support from a wide range of people. Fortunately, it can be done by focusing on strengths and a few areas at a time. Foundations for a successful children's system of care include understanding where there is support for change, recognizing which wraparound principles are already strong in the community, and setting goals accordingly. Foundations for ongoing success can be laid.

Youth-serving system interagency collaboration*:* Ensure that services are coordinated at the system level, with linkages among youth-serving systems and agencies across administrative and funding boundaries (education, child welfare, juvenile justice, substance use, primary care) and with mechanisms for collaboration, system-level management, and addressing cross-system barriers to coordinated care.

Local leadership**:** Local leadership including family and community members, supports and promotes the principles of practice. Leadership has adapted structures, policies, and practices to integrate programs into one service to best serve children. System of care principles are promoted internally and through partnerships with other community members or organizations.

Internal partnerships**:** A continuum to serve children has been created that includes prevention, early intervention, treatment, and after-care, with all staff working collaboratively.

Fiscal policies and sustainability: Fiscal policies are in place that supports a sustainability plan.

Public health approach: Incorporate a public health approach including mental health promotion, prevention, early identification, and early intervention in addition to treatment to improve long-term outcomes, including mechanisms in schools and other settings to identify problems as early as possible and implement mental health promotion and prevention activities directed at all children, youth, and young adults and their families.

Practice change

There is evidence that practices support the creation and development of effective systems of care. Recognizing these practices and focusing on them early in the change process will not only result in positive outcomes for individual children, youth, and families. They can also be the starting point for more complex interagency collaboration that is required for optimal support to families. Early efforts should include identifying where these practices already exist.

Single point of access: There is a single point of access to needed supports and services, including for underserved populations. Outreach occurs throughout community resources, including underserved populations. There is a centralized, single point of access to obtain support and services.

Screening and assessment at intake: There is a clear process to determine eligibility. A thorough assessment is completed using developmentally appropriate tools, utilizing existing assessment and treatment information, and meeting any and all requirements.

Family-driven, youth-guided, and strengths-based treatment plan and services: Youth and family are provided with support and skill-building so they can participate fully and comfortably in their treatment and written plan development, including leading meetings, developing their own goals, advocating for themselves, and influencing their team and other decision-making entities. Respite care is a resource available to parents and other primary caregivers to utilize during planned and emergency short-term care to facilitate children, young adults, and families being supported in staying together.

Health-mental health integration*:* Incorporate mechanisms to integrate services provided by primary health care and mental health service providers to increase the ability of primary care practitioners and behavioral health providers to better respond to both mental health and physical health problem.

Education and skill-building offered: The youth and family are empowered at various levels of involvement, such as family teams, school advocates, coordinating committee members, quality improvement committees, and presenting their stories to others.

Evidence-based practices used: Ensure that services and supports include evidence-informed, emerging evidence-supported, and promising practices to ensure the effectiveness of services and improve outcomes for young people and their families, as well as interventions supported by practice-based evidence provided by diverse communities, professionals, families, and young people.

Trauma-informed system: The expansion beyond specific treatments involves systemwide policies and practices that address trauma. This includes identifying the signs and symptoms of trauma in staff, youth, and families served, and others involved in the system of care. Organizations and systems that are trauma-informed reflect the wraparound principles.

Services meet the mental health and/or substance use needs: All referrals are screened for both mental health and substance use. Services are available in person and telehealth is used to meet mental health, substance use, and co-occurring needs. Family members of youth receive assessment and treatment for mental health and substance use when a need is indicated. Mobile crisis response and stabilization services is provided to children and youth who are experiencing mental health emergencies and their families.

Intensive care coordination and unified treatment plan in place: Provide care coordination at the service delivery level that is tailored to the intensity of need of young people and their families to ensure that multiple services and supports are delivered in a coordinated and therapeutic manner and that they can move throughout the system of services and supports following their changing needs and preferences. A structured approach to service planning and care coordination that is built on key system of care principles. The wraparound model incorporates a dedicated care coordinator working directly with a small number of children and families. For each child served, the care coordinator creates a team comprised of the child and family, formal and informal service providers, peer support providers, and others. This team then creates, implements, and monitors an individualized, holistic service plan across all life domains.

Staff and human resources development

A commitment to multiple levels of support for ongoing learning is necessary for the successful growth of staff skills and understanding. It is also important to grow the capacity of all participants. As groups become more knowledgeable, they become better partners to support the development of a system of care.

Learning collaboratives, communities of practice, coaching, training, and supervision are available for all staff: Staff who serve children and families have supervisors who are knowledgeable about wraparound principles and receive regular clinical and reflective supervision both individually and in a group setting, along with periodic observations. Supervision is designed to support the growth and development of all staff. Care coordinators have access to clinical consultation regularly as well as when needed for complex situations. New staff receives comprehensive training, shadow experienced workers before working independently, and receive ongoing coaching to develop needed wraparound skills. Several staff are involved in a learning collaboration to share experiences and learn from others.

Consumer, community, and staff champions are identified, educated, and encouraged: A commitment to engage, equip, and empower a community and natural support network. Teams, youth, and family members regularly and effectively access these resources to implement treatment strategies. Strengths of staff champions are utilized, encouraged, and supported in the evolution of the system of care.

Overall system of care oversight is in place: An oversight committee(s) is in place that monitors systemic processes, including identifying and responding to youth and families experiencing barriers in accessing and obtaining high-quality services and support.

Coordinating committees: A single oversight committee is in place for the local system of care. A written plan is in place that assesses oversight committee(s) and identifies the benefits and challenges of working together. A clear process is in place to ensure that policies and procedures are discussed at committee meetings.

Parent and youth involvement in committees**:** There is a high level of parent and youth involvement in the committees. Youth and family members receive orientation regarding their role, are mentored by other members, and are empowered to provide input and help with decision-making. Peer support services are provided by individuals who have personal lived experience with mental health conditions and navigating service systems, whether as a consumer or as family members, or caregivers.

Family team meeting facilitation**:** Staff who provide care to children, young adults, and families have supervisors who are knowledgeable about family team meeting facilitation and have the skills to provide fidelity to the model through periodic observations. Supervision is designed to support the growth and development of all staff. New staff receives comprehensive competency-based skill-building, shadow experienced workers before working independently, and receive on-going coaching to develop needed family team meeting skills. Staff facilitate a family team meeting that is hopeful and strength-based, and teaches communication and listening skills, all while demonstrating flexibility and neutrality.

Funding

Implementation of collaborative approaches also involves cross-agency investments. One of the longstanding functions of coordinating committees has been to address funding needs and how each agency involved can contribute to meeting those needs. Holistic approaches to the needs of families eligible for a system of care require holistic approaches to funding.

Funding available: Decision-makers have access to accurate information about the types of funding streams, expenditures for services, and support for all children with complex mental health and substance use needs and are using this information to build an effective system of care. There are multiple and diverse sources of funding.

Funding can be blended across services*:* Decision-makers assume collective fiscal responsibility for children and families to meet the needs of all children with complex mental health and substance use needs.

Gaps in funding can be addressed: There is a clear and feasible plan for sustaining funding for support and services over the long term, and this plan is fully implemented. Youth who are not Medicaid funded can be served. This includes flex funds typically used to purchase non-recurring goods or services that are procured to improve a family or caregiver's ability to meet the needs of a child or youth that are not covered by other financing sources.