NC High Fidelity Wraparound Overview

BACKGROUND

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) was the recipient of a four-year System of Care Expansion grant. A focus of the grant has been DMH/DD/SAS's partnership with LME-MCOs to pilot NC Wraparound, an evidenced-informed supportive service carried out by a NC Wraparound Team for youth (3-20 years old) with serious emotional disturbance or a youth with serious emotional disturbance and a co-occurring substance use disorder and/or intellectual/developmental disability.

In the first year of the pilot (April 2015 – March 2016), the target included 50 North Carolina youth transitioning from Psychiatric Residential Treatment Facilities (PRTFs) to a community-based setting such as: biological parents, kinship care, DSS foster home, therapeutic foster care, and independent living. LME-MCOs dedicated staff to manage the NC Wraparound referral process and reached out to PRTF staff to collaboratively identify youth who may be a good fit for the program.

Five pilot sites were selected and HFW teams were developed:

- Cardinal Innovations – Mecklenburg County
- Cardinal Innovations – Alamance County, Person County, Caswell County, Chatham County & Orange County
- Cardinal Innovations – Forsyth, Davie, Stokes & Rockingham County
- Eastpointe – Sampson County & Wayne County
- Smokey Mountain- Buncombe County and Henderson County

All five sites are currently working with youth and families and are expanding their teams to include a second facilitator which will allow for caseloads per team of up to twenty youth. The High Fidelity Wraparound teams are collecting outcomes in addition to completing consistent SAMHSA and Observation Measures Surveys with their families and youths to assess the effectiveness and impact of High Fidelity Wraparound.

OVERVIEW

If the family agrees to participate, the Wraparound Team from the provider agency will:

- Connect with the youth and family to build rapport.
- Conduct strengths and needs assessment with youth, family and supports.
- Participate in the Child and Family Team held at the PRTF/Out-of-Home Placement and bring community resources to the discharge planning process.
- Start developing the Child and Family Team who will support the family when the youth has returned to the home and community.
- Work with the family to increase natural supports in the transition to the community.
- Begin collecting outcome data from the youth to evaluate the pilot.

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The Child and Family Team process held at the PRTF/Out-of-Home Placement, ideally led by the family and youth, will culminate in a comprehensive treatment plan that includes supports in the youth's school, home, and community.

This comprehensive plan uses the PRTF/Out-of –Home Placement's and the family's extensive knowledge of the youth's strengths and needs to ensure a smooth and successful transition to the youth's home community.

COLLABORATION BETWEEN HIGH FIDELITY WRAPAROUND AND OTHER SERVICES

High Fidelity Wraparound strongly encourages and advocates for collaboration between themselves and any other service that is in place for a youth and his/her family. The HFW team will initiate and work to maintain communication between services to ensure strong coordination of services, support of the youth and family, and working towards positive outcomes. Examples of this coordination and collaboration would be the co-facilitation of Child and Family Meetings and the development of combined agendas. This allows for the family to reduce the amount of meetings they need to attend and ensures all involved parties have the same information regarding treatment goals, progress, and any barriers to address.

FOR OUR CHILDREN AND FAMILIES TO BE SUCCESSFUL

High Fidelity Wraparound advocates for strong coordination and communication between the PRTF and themselves prior to the youth/child discharging from the PRTF. It is recommended for the High Fidelity Wraparound team to work with the PRTF, the family, and the youth/child at least **2 weeks** but up to 30 days prior to discharge to establish and maintain engagement, smooth transition, and to encourage successful outcomes.

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