



**ACCOUNTABLE BEHAVIORAL HEALTH ALLIANCE  
INTENSIVE COMMUNITY TREATMENT SERVICES AND SUPPORTS  
WRAPAROUND MODEL  
PRACTICE GUIDELINES**

Intensive Community Treatment Services and Supports (ICTS) is a level of care within the continuum of services provided to Children receiving mental health services. Our goal is to increase the availability and quality of individualized, intensive, and culturally competent home and community based services so that children can be served in the most natural environment possible and so that the use of institutional care is minimized. The standards set forth within this policy statement are intended to represent the minimal requirements established by the state. Accountable Behavioral Health Alliance (ABHA) counties have separate policies and service standards to enhance and individualize policies set forth in this document. County specific policies are designed to make them relevant to the uniqueness of their organizations and client population.

**Philosophy and Approach**

It is the mission of ABHA to effectively and efficiently manage the behavioral health benefits for Oregon Health Plan Members. It is a natural extension of our mission to collaborate with partner agencies to provide a broad array of intensive community based and family focused services to children and their families with a goal of providing the most effective and cost efficient services to meet the individual needs of the child and their family.

ABHA recognizes the value and importance of maintaining children in their communities. We value children and their families as experts in the understanding of their needs. We promote the identification and utilization of a child and families unique strengths as critical components of an individualized plan of care. See **Attachment 1** for a plan of care template.

ICTS is included as part of a continuum of care within the ABHA Utilization Management Plan. This continuum extends from education and prevention programs and community support and outreach provided by or coordinated through county mental health programs to acute levels of service provided by hospitals. ABHA and our partner counties will use a Wraparound Model in planning for the needs of children and family clients. The children and their families will work with a Care Coordinator to identify family strengths and needs. A Child and Family Team will be convened jointly by the Care Coordinator and identified family and will develop a strength based Service Coordination Plan identifying resources, (both informal community supports and formal professional supports), to address the needs identified.

**Accountable Behavioral Health Alliance  
Intensive Community Treatment Services And Supports  
Wraparound Model  
Practice Guidelines**

ABHA will use “transition” to describe the mechanism by which a client moves within the service continuum. The word “discharge” will be used only when necessary to satisfy the state requirements as it promotes an artificial boundary reflecting poorly on the implementation of a continuum of care.

**ROLES AND RESPONSIBILITIES**

**ABHA**

- Conducts on-going UM for clients approved for admission to Psychiatric Residential and other levels of acute care by regional coordinators.
- Provides consultation and support for community care coordinator cases where child requires hospital level of care.
- Provides consultation and technical assistance to Community Care Coordinators and ICTS providers.
- Insures that training and consultation about community-based planning and ICTS are provided to Community Care Coordinators and ICTS providers
- Promotes consumer access to care and services that are family-driven, strengths-based, and culturally sensitive.
- Monitors implementation of guidelines and standards that enhance and promote quality, community-based service delivery.
- Tracks ICTS children to ensure continuous enrollment with the MHO.
- Tracks quality indicators and works with County Child Serving Agencies to determine and develop actions plans when appropriate

**Community Mental Health Program, (CMHP)**

- Conducts on-going utilization management for clients who participate in treatment within their communities, inclusive of Day Treatment.
- Responsible for providing Care Coordination to clients.
- Screens referrals and makes ICTS determination.
- Meets with family to develop a relationship and begin identifying family strengths, needs and goals.
- Works with family to establish the Child and Family Team.
- Jointly coordinates and convenes the Child and Family Team with the family as needed.
- Coordinates with DHS/Child Welfare if family is involved with DHS/Child Welfare. (DHS will facilitate Team Meetings if they are custodians).
- Maintains ICTS case file and disseminates the Service Coordination Plan.
- Maintains regular contact with the child, family, service providers and representatives of other systems in which the child is involved.
- Provides/assures case management services: assessing needs, identifying and coordinating services, monitoring service effectiveness, consultation, advocacy, crisis response, etc.
- Collaborates with Child and Family Team to adjust level of care to meet needs.

**Accountable Behavioral Health Alliance  
Intensive Community Treatment Services And Supports  
Wraparound Model  
Practice Guidelines**

- Implements a transition plan to/from services. Maintains involvement during transitions.

**ABHA/CMHP Cooperation**

- The CMHP will contact the ABHA Child and Family Manager when it is determined that a client requires a Residential or Acute level of Care.
- The CMHP and ABHA Child and Family Manager will work together to insure that involvement with the CMHP Care Coordinator and Child and Family Team continues.

Accountable Behavioral Health Alliance has consulted with Pat Miles in the development of our wraparound practice and will utilize the Wraparound Process User's Guide: A Handbook for Families, by the National Wraparound Initiative, as the basic outline for this Practice Guideline. Permission to utilize the contents of this handbook have been obtained and will accompany these guidelines (**Attachment 2**).

The Wraparound model has been developed as a treatment planning process and has been adopted by the Oregon Addictions and Mental Health (AMH) Division as an approved Evidence-Based Practice (EBP) (<http://www.oregon.gov/DHS/mentalhealth/ebp/ap/wraparound.pdf>).

The basic tenants of a Wraparound model are that services are strengths-based, family driven and decisions are by team consensus. The Wraparound process is an open model, with treatment planning meetings that are open to all members of the team, including the client and family, with an equal voice to all participants.

As outlined in the User's Guide, the Wraparound process has four distinct phases:

**The engagement and preparation of the team** – This phase involves completing initial conversations with the family as well as other stakeholders. The focus of these initial conversations is to listen for individual perspectives on strengths and needs as well as identifying potential team members. Responsibility for finding strengths and crafting needs statements and for listening for potential team members rests with the Facilitator. In addition to completing initial interviews, the Facilitator is also responsible for explaining the process and soliciting input from various team members. Products developed during this phase include a family strengths summary as well as an inventory of the strengths of the individual family members and their key formal and informal supports.

**Accountable Behavioral Health Alliance  
Intensive Community Treatment Services And Supports  
Wraparound Model  
Practice Guidelines**

**The initial plan development-** This phase requires that the Facilitator present summaries of strengths and needs as discovered during the team preparation phase and then ask the gathered group of team members to create a team mission statement, add to the needs list and choose the most important needs that must be addressed in order to accomplish the mission and craft interventions which will meet the chosen needs by building on the identified strengths. A Plan of Care is developed, documented by the Facilitator and distributed to all team members. Products developed during this phase include the initial Plan of Care, the team’s mission statement and a list of the roles and goals of the team members.

**Implementation of the plan –** This phase takes as long as it takes for the family and all team members to agree that needs have been met and that the mission has been accomplished. The goal of the team is to meet needs enough and accomplish the mission statement sufficiently to insure the well being of the children involved and to allow a family to live a life that is “good enough”. The initial actions should be modified or discard as the team meets together over time to determine whether the actions had an impact on the need and whether the meeting for those needs is helping the team realize the mission. Products developed during this phase include documentation of actions taken, progress made, plan modifications, and changes in the needs and situation of the child and family. ABHA Counties will use the Plan of Care as documentation as to progress and changes.

Transition to the next level or phase of treatment – This phase involves helping the team to recognize when they have achieved the right mix of interventions to meet needs and begin assisting the family as it phases out of formal support through the team process. This does not mean that all the interventions must cease or that all sources of services and support will no longer be involved. The team brainstorms follow-up options that will help and support the family succeed outside of the formal wraparound structure and team members will identify what type of follow-up supports they can provide to the family. The Team facilitator takes this information and puts it into a transition plan, which is made available to the team for review. A celebration of the team’s accomplishments occurs and the facilitator completes a formal discharge letter identifying the family strengths as well as accomplishments of the team.

These steps are more formally outlined in the User’s Guide. ABHA will adopt the steps as outlined in the guide as the process component of this practice guideline.

As outlined in the User’s Guide, the basic principles of a Wraparound process include the elements of:

- **Family voice and choice**
- **Team based**
- **Natural supports**
- **Collaboration**
- **Community-based**
- **Culturally competent**
- **Individualized**
- **Strengths based**
- **Persistence**
- **Outcome based**



**Accountable Behavioral Health Alliance  
Intensive Community Treatment Services And Supports  
Wraparound Model  
Practice Guidelines**

The details of these principles are fully outlined in the User's Guide and will be referenced as an important component of these guidelines.

ABHA will encourage each provider engaged in the ICTS delivery of services to utilize these guidelines during the Wraparound process with the understanding that each child and treatment process is unique and not without its' challenges. There will be ongoing efforts to monitor adherence to the spirit of fidelity when implementing any EBP. ABHA has implemented an outcome measurement tool and will continue to work with provider agencies to monitor outcome measurement and utilize an outcome informed process to assist the family and team toward a successful treatment experience.

## Individualized & Tailored Care Plan & Budget

Family Name:	Date: Plan Start Date: Plan End Date:
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Team Mission Statement

Life Domain	Need	Action	Strength (matches action)	Total Projected Cost	Outcomes
Family					
Living Situation					
Social / Fun					

Name \_\_\_\_\_

Client # \_\_\_\_\_ DOB \_\_\_\_\_

Psych / Emotional					
School / Work					
Spiritual / Cultural					
Safety / Crisis					

Name _____
Client # _____ DOB _____

Legal					
Health / Medical					
Must be completed quarterly:			Identify barriers which were met in implementing the plan:		
Plan review date:			<input type="checkbox"/> Funding <input type="checkbox"/> Policy / Rules <input type="checkbox"/> Eligibility <input type="checkbox"/> Behavior <input type="checkbox"/> Regulations <input type="checkbox"/> Attitudes <input type="checkbox"/> Resources <input type="checkbox"/> Other ( please list)		
Notes from review:					

Name _____
Client # _____ DOB _____