Safe at Home
West Virginia

Safe at Home West Virginia Timeframes

Service Delivery and Development Work Group

Safe at Home West Virginia Program Manual Table of Contents

INTRODUCTION

Safe at Home WV is a wraparound model program, designed as a strength based service delivery system, that is child and family driven and founded on an ongoing, outcome focused planning process. It is a multi-agency collaboration intended to offer flexible assistance through a coordinating agency that ensures accountability. The following core components are utilized to allow a family's needs to truly be met, by building skills and capacity within the family and the family's community to empower the family with the tools they need to sustain change.

CORE COMPONENTS:

Family Teams that think creatively are developed to drive the process.

Creative Methods are utilized to develop services that fit needs identified by the family, allowing the process to be **Needs Driven**.

Interagency Collaboration is relied upon to guide the family to develop a path toward **Natural Community Supports** composed of community resources that are identified or developed in the family's community.

Family Driven Strengths Based Planning and **Facilitation** assist the family to create a plan to meet the needs they identify for themselves.

The Wraparound process is:

- ✓ built on Family Strengths
- ✓ guided by Interagency Collaboration
- ✓ rooted in the family's community
- ✓ created by the family, for the family
- ✓ a path to natural community supports

WRAPAROUND BASICS

TEN PRINCIPLES of WRAPAROUND

Strength Based: The Wraparound process and the wraparound plan identify, build on and enhance the capabilities, knowledge, skills and assets of the child and family, their community, and other team members. This principle recognizes that all team members come to the process with skills, knowledge, and insights to meet challenges they have faced in life. The result is a process that validates existing strengths and builds on them to solve problems, resulting in the family developing the tools they need to resolve future problems.

Family Centered (voice, choice, and preference): Family and youth/child perspectives 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 such that the plan reflects family values and preferences. This principle recognizes that the likelihood of successful outcomes increases when the youth and family have ownership of the wraparound plan, and the process reflects the youth and family's priorities and perspectives. Wraparound is a collaborative process, however, within the collaboration, family members' perspectives must be the most influential.

Team Based: The wraparound team consists of individuals agreed upon by the family and committed to them through informal, formal, and community support and service relationships. In accordance with the principle of a family centered process, the family's perspective about potential team members should be the driving force in selecting team members. At times, due to conflict, practical or legal issues, family members may be reluctant to invite potential team members that could have a positive impact on the process. In such situations, family members should be provided with support to make the best, informed decision possible, and to manage any conflicts that could arise related to negative emotions attached to certain individuals. All along the way, the family should be provided with as much choice as possible.

Community Based: The wraparound team implements service and support strategies that take place in the most inclusive, most responsive, most accessible, and least restrictive settings possible; and that safely promote child and family integration into home and community life. This principle recognizes that youth thrive when they have the opportunity to participate fully in their families and communities. Teams should work together to ensure all needed services are easily accessible to the family and located within the community that the family chooses as their own.

Culturally Competent: The wraparound process demonstrates respect for and builds on the values, preferences, beliefs, culture, and identity of the child/youth and family, and their community. This principle recognizes that a family's traditions, values, and heritage are sources of great strength that must be respected. The perspectives that people express and the manner in which they express them are shaped by their culture and identity. For successful collaboration to occur, youth and families must be afforded respect for diversity in expression, opinion, and preference.

Outcomes Based: The team ties the goals and strategies of the wraparound plan to observable or measurable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly. This principle recognizes that the wraparound team must be accountable to the family and all team members, as well as any participating organizations and agencies, for achieving the goals laid out in the plan.

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. This principle recognizes that the family is more likely to reach its goals when team members approach decision making in an open-minded manner, prepared to listen and be influenced by other team members' perspectives. In addition, central to this principle is a commitment from each team member to voice his or her own perspectives and ideas.

Individualized: To achieve the goals laid out in the wraparound plan, the team develops and implements a customized set of strategies, supports, and services. This principle recognizes that when the wraparound process occurs in accordance with all of the principles of wraparound, the plan that results will be uniquely tailored to fit the needs and desires of the family, in consideration of their strengths and culture.

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. This principle recognizes that natural sources of support, i.e., those that occur in the community outside of the formal service system, are sustainable long after formal supports have left the family's life. It is thus, critical that as many natural supports as possible be identified, and included in the process. Generally, the primary source of natural support is the family's existing network of interpersonal relationships, including, family, neighbors, co-workers, church members, etc. This also may include individuals the family is connected to through community institutions, clubs and other entities the family meets through daily life.

Persistent: Despite challenges, the team persists in working toward the goals included in the wraparound plan until the team reaches agreement that a formal wraparound process is no longer required. This principle recognizes that at times, setbacks will be part of the process, and should serve as an indication that the wraparound plan needs revision, not an excuse to blame the family, or label them as a "failure".

(Miles et al, 2006)

CHILD and FAMILY TEAMS

Child and family teams are groups of people, chosen with the family and connected to them through natural, community and formal support relationships. Child and family teams develop and implement the family's plan, address unmet needs, and work toward the family's vision by monitoring the family's progress on the wraparound plan, revising and refining it as needed. The child and family teams are the forum through which the family's goals are identified and decisions on how to achieve the goals are made.

CHILD and FAMILY TEAM MEMBERS

Child and family team members can be chosen from informal, formal or community groups. Some possible team members from each of the groups are as follows:

Informal:
Family
Friends
Family's Co-workers
Neighbors
Child's Friends
Relatives

Formal:
Wraparound Staff
Mental Health Therapist
Occupational Therapist
ABA therapist
Behavioral Support Professional
Social Worker
Probation Officer
Agency Staff
Police

Community:
Parks and Recreation Staff
Regional Youth Service Centers
School Staff
Library Staff
Local Merchants
Church Members
Social Club Members
Community Organization Staff and Volunteers

STAGES of CHILD and FAMILY TEAM DEVELOPMENT

Child and family teams go through four stages of development during which the family's reliance on formal supports decreases while their reliance on natural supports in the community increases. Our role in the child and family team development, as service professionals, is to assist the family in finding informal community supports to replace us.

Phase 1: The child and family team is developed as one of the first tasks of the wraparound process. Initially the team is composed mostly of family and wraparound staff. The Wraparound Facilitator assists the family in identifying potential child and family team members by eliciting information from the family about individuals who have been important in the child and family's life.

Phase 2: Members of the community that are identified by the family with the support of other team members join the team.

Phase 3: As the process moves into the implementation phase, the composition of the child and family team transitions to more family members and friends and less professionals.

Phase 4: The family relies on the community for support as the family transitions from the wraparound program into aftercare.

(Bruns et al, 2008b)

CHILD and FAMILY TEAM MEETINGS

The initial Child and Family Team meeting, also known as the Family Joining Meeting, will occur during the first phase of the wraparound process. This initial Child and Family Team Meeting will focus on engaging the family, building genuine rapport, identifying strengths and needs and engaging additional team members. After this initial meeting, Team Meetings will occur at a minimum of every 30 days throughout the wraparound process and follow a predictable format.

Accomplishments: Child and Family Team Meetings will begin with team members sharing any accomplishments since the last meeting. This allows the focus of the wraparound process to remain positive.

Assess: After celebrating accomplishments, team members will assess whether the plan is working. This process involves reviewing each individual's assigned tasks to determine the level of follow through, identifying whether each action step worked to accomplish the strategy it was designed for and reviewing outcomes identified by the family.

Adjustments: After reviewing the plan, the facilitator will lead the team in identifying any needed changes to the plan. Adjustments may be made to any current action steps, or new ones might be added. Brainstorming will be utilized to decide on any new strategies for needs that have not been successfully met, as well as for newly identified needs.

Assign: After the team has decided on actions to be taken, team members will assign and take responsibility for specific actions.

Initially, Child and Family Team Meetings will happen more frequently. Eventually, the team will be able to identify that fewer and fewer adjustments to the plan are needed, and Child and Family Team Meetings may begin to occur less frequently, but at least the minimum of every thirty days.

(Miles et al, 2006)

WRAPAROUND FACILITATOR

The Wraparound Facilitator has a critical role with regard to fidelity to the wraparound model. This role has many important aspects. The Wraparound d Facilitator is responsible for coordinating seamless multi-agency service provision. This decreases frustration on the part of the family by making the system easier to navigate. Rather than the family feeling as if they are spinning their wheels trying to elicit the services they need from the community, the Wraparound Facilitator engages community partners in the process and facilitates creative services delivery to fit the family's unique needs.

An additional responsibility of the Wraparound Facilitator is to facilitate family joining. The wraparound process is designed to be family driven. This model of service delivery is often foreign to families who are used to encountering numerous barriers to getting the help they need for their youth. It is important that the Wraparound Facilitator create an environment that focuses on the youth and family's strengths so that they feel comfortable enough to truly be engaged in the process and take an active role in the collaboration. The family may initially have difficulty trusting that the professionals involved intend to interact with them in a different manner. It is critical that the Wraparound Facilitator set the tone of the family being the expert.

Throughout the process, the Wraparound Facilitator will be responsible for facilitating all Child and Family Team Meetings. Although each team member will have responsibility in adhering to the model, the Wraparound Facilitator will guide this process from the very beginning. The Wraparound Facilitator will be responsible for teaching the family team important skills such as brainstorming, conflict resolution and other skills designed to elicit full team collaboration. The Wraparound Facilitator will listen closely to the family to assist them in identifying strengths, needs, natural supports and other important components that are essential to the process. The Wraparound Facilitator will also guide the family in developing a crisis plan. The Wraparound Facilitator will act as a liaison, coach and support to the family team throughout the process.

LOCAL COORDINATING AGENCY

The Local Coordinating Agency will be a licensed behavioral health care provider, a licensed child placing agency or a licensed residential program. The Local Coordinating Agency will have staff members that are certified in the Child and Adolescent Needs and Strengths tool (CANS), and supervisory staff licensed as Masters prepared Social Workers, Counselors or Psychologists with at least two years of experience providing direct services to children and families. In addition, the Local Coordinating Agency will also have Wraparound Facilitators and Supervisors who have completed Wraparound certification. Memorandums of Understanding developed between the Local Coordinating Agency and community services providers to provide the needed services within the families' communities. The Local Coordinating Agency will be identified as having proven experience working with high-risk youth who are at risk of out of home placement, or who are returning from out of home placements.

WRAPAROUND FRAMEWORK

ELIGIBILITY

Youth, ages 12 to 17 (up to the youth's 17th birthday) with a diagnosis of a severe emotional or behavioral disturbance, according to standardized diagnostic criteria, that impedes his or her daily functioning currently in out-of-state residential placement and cannot return successfully without extra support, linkage and services provided by wraparound;

Youth, ages 12 to 17 (up to the youth's 17th birthday) with a diagnosis of a severe emotional or behavioral disturbance, according to standardized diagnostic criteria, that impedes his or her daily functioning currently in in-state residential placement and cannot be reunified successfully without extra support, linkage and services provided by wraparound;

Youth, ages 12 to 17 (up to the youth's 17th birthday) with a possible diagnosis of a severe emotional or behavioral disturbance, according to standardized diagnostic criteria, that impedes his or her daily functioning at risk of out-of-state residential placement, and utilization of wraparound can safely prevent the placement;

Youth, ages 12 to 17 (up to the youth's 17th birthday) with a possible diagnosis of a severe emotional or behavioral disturbance, according to standardized diagnostic criteria, that impedes his or her daily functioning at risk of in-state or PRTF residential placement and they can be safely served at home by utilizing wraparound.

REFERRAL PROCESS

To be referred to the Safe at Home WV Wraparound Program, the West Virginia Department of Health and Human Resources, Regional Program Manager (RPM), must first approve the youth. The Child Welfare worker or the MDT may recommend a referral for a specific youth. Once the RPM has approved the youth for Safe at Home WV Wraparound the RPM notifies the WV System of Care staff who will determine which Local Coordinating Agency will receive the referral. The Local Coordinating Agency then obtains the initial information needed to proceed. The Wraparound Facilitator assigned will then schedule and convene the first family team meeting.

WRAPAROUND MODEL COMPONENTS

Approval of Referral: *DHHR Regional Program Manager or designee*
Coordinating Agency Designation: *WV System of Care Staff*
Family Joining: *Wraparound Facilitator and DHHR worker*
Assessment and Discovery: *Wraparound Facilitator and Child and Family Team*
Child and Family Team Meeting and Planning: *Wraparound Facilitator and Child and Family Team*
- Weekly Team Staffing
- Monthly Family Team Meetings

Wraparound Facilitation/Service Implementation: *Wraparound Facilitator and Child and Family Team*
Mobile Urgent Response/Stabilization: *Wraparound Facilitator*
Transition: *Child and Family Team*

PHASES OF THE WRAPAROUND PROCESS

Phase 1: Engagement and Team Preparation

During this phase, the groundwork for trust and shared vision among the family and wraparound team members is established, so people are prepared to come to meetings and collaborate. During this phase, the tone is set for teamwork and team interactions that are consistent with the wraparound principles, particularly through the initial conversations and about strengths, needs, and culture. In addition, this phase provides an opportunity to begin to shift the family's orientation to one in which they understand they are an integral part of the process and their preferences are prioritized. The activities of this phase should be completed relatively quickly (within 1-2 weeks if possible), so that the team can begin meeting and establish ownership of the process as quickly as possible

Goal One: Orientation to the wraparound process

The first major goal of the Engagement and Team Preparation phase is to orient the family and youth to the wraparound process. Achieving this goal involves the wraparound facilitator having several face-to-face conversations with the family to explain the philosophy behind wraparound, build trust and rapport, describe the individuals who will be involved in the process, supports available to the family during the wraparound process, and alternatives to the wraparound process, should the family choose not to participate. It is important that the process be clearly explained in language that is easily understood by the family. Since family participation is essential to the process working, it is crucial that the family be given as much information as possible so that they can truly make an informed choice about participating. If the family chooses to participate in the wraparound process, all needed consents are obtained and the family and youth's rights and responsibilities are clearly outlined.

Additional points to consider:

Client Rights and Responsibilities:

Client Rights: It is important for all clients and their families to recognize they have the following rights:

- The right to refuse treatment
- The right to receive services, which do not discriminate, based on race, religion, color, sex, sexual orientation, disability, age, National origin, or marital status
- The right to a humane treatment environment that promotes personal dignity and self-esteem and affords reasonable protection from harm, appropriate privacy, and freedom from verbal, sexual, psychological or physical abuse or punishment
- The right to treatment and services under conditions that support personal liberty and result in positive outcomes in the maximum extent possible
- The right to confidentiality of records and information; records may only be released with written consent of the client's parents or guardians
- The right to an individual, written service plan to be developed after admission in order to gain the most benefit from services provided
- The right to assert a grievance, orally or in writing, including the right to have such grievance considered in a fair, timely, and impartial procedure, and with respect

Grievance Policy:
Safe at Home West Virginia is committed to providing quality services to children and families. Feedback from referral agencies, parents and youth is used to improve and upgrade programming. In addition, a grievance procedure is in place for addressing concerns, disagreements, and complaints. If a referral agency, parent, or youth desires to file a grievance, please contact your DHHR caseworker's supervisor.

Family Responsibilities: In addition to the rights they are afforded, families who participate in the Safe at Home West Virginia program have a responsibility to not only their youth, but also to the success of the wraparound process. The following is a brief list of what is expected of families:

1. To be honest
2. To not agree if you are not willing and able to follow through
3. To keep the lines of communication open
4. To remember they are the most important part of the team.
5. Not to be afraid to tell someone if the plan is not working or would like to change something
6. To be respectful
7. To ask questions for clarification as well as understanding.
8. To meet with the team on a regular basis (dates, places and times are agreed upon by the team with preference to the family's recommendations).
9. To inform the team of all of the accomplishments of the family
10. To CELEBRATE their successes

Goal Two: Exploration of strengths, needs, culture, and vision
The second major goal of the Engagement and Team Preparation phase of the wraparound process is to hear the family's story to gather their perspective on their strengths, needs, culture, and goals for improvement. During this phase, the family also learns about natural and formal supports. By carefully listening to the family's story, the facilitator assists the family in identifying strengths of each individual, strengths of the family as a whole, as well as potential family team members to join the process. The facilitator prepares a summary of the initial conversations with the family that is strength-based and highlights important points about strengths of individual family members and the family unit, and identifies the family's perspective on needs, culture, and vision. The document is shared with and approved by the family.

Additional points to consider:

The importance of using strength based approach:
By capitalizing on the capabilities of children and adolescents, wraparound providers create a sense of hope for the future and enhance motivation for change. The rationale for focusing on strengths rather than deficits is that this shift in focus results in a number of benefits:

1. A therapeutic relationship is likely to have a stronger foundation when a family experiences the provider as recognizing and valuing positive aspects of the family members' personalities, life histories, accomplishments, and skills.
2. It will be easier for the family to develop improved coping skills for dealing with challenges in their lives if the process begins with using the family's existing competencies and characteristics as a foundation.

3. Since families who arrive at the wraparound process often lack a natural support network, focusing on strengths will make it easier to identify potential points of attachment that can grow into informal sources of friendship and support.
4. To help families with complex needs transition from service dependence to social interdependence, focusing on eliminating negative characteristics without focusing on developing existing strengths will be less likely to be successful.

(Franz, 2008).

Ways to identify strengths:

Observation/Behaviors: If families are closely observed, strengths will be revealed in the ways they interact with each other, activities that they participate in together and values that they display. An observant Wraparound staff might notice trophies, pictures, magazines, or books that identify interests and areas of talent.

Vocabulary: Strengths often reveal themselves when Wraparound staff listens for words that imply success, happiness, coping, getting ahead, and accomplishing. Usually these words are expressed with a sigh of relief, a smile or a chuckle.

Family Treasures: Strengths can be found in family photos, descriptions of regular family gatherings, best friends, descriptions of how past problems were solved, family affiliations, family belief systems, hobbies and projects.

Stories: When families are sharing stories, listen for when things went right, when obstacles were overcome, when times were happy. If the Wraparound staff listens closely and engages appropriately, the strengths that were used to accomplish each of these things, the individuals who were helpful and how the strengths were activated will all be there.

Goal Three: Stabilization of crises

The third major goal of the Engagement and Team Preparation phase of the wraparound process is to address any pressing needs and concerns related to immediate safety issues, current crises or any potential crises the family anticipates might occur in the very near future if they are not addressed immediately. It is important that the referring professional and others close to the family be given the opportunity to share safety concerns. If any immediate concerns are identified, the family works with the facilitator to develop a plan to provide immediate relief.

Goal Four: Engagement of additional team members

The fourth major goal of the Engagement and Team Preparation phase of the wraparound process is to gain a commitment to participate from additional team members who care about the child and family and can support them through the wraparound process.

Goal Five: Arrangement of meeting logistics

The final major goal of the Engagement and Team preparation phase of the wraparound process is to agree upon meeting times and locations that are easily accessible and comfortable to all team members. In additional supports needed for meetings to occur should be discussed at this time as well, (i.e. childcare arrangements for children who are too young to participate in the process, translators, etc.).

(Bruns et al, 2008a)

Phase 2: Initial Plan Development

During this phase, team trust and mutual respect are built while the team creates an initial plan of care using a high-quality planning process that reflects the wraparound principles. In particular, youth and family should feel, during this phase, that they are heard, that the needs chosen are ones they want to work on, and that the options chosen have a reasonable chance of helping them meet these needs. This phase should be completed during one or two meetings that take place within 1-2 weeks; a rapid time frame intended to promote team cohesion and shared responsibility toward achieving the team's mission or overarching goal.

Goal One: Development of an initial wraparound plan

The first major goal of the Initial Plan Development phase of the wraparound process is to develop the initial wraparound plan. The plan should be created through a collaborative team process that elicits multiple perspectives and builds trust and a shared vision among team members. The process must be consistent with the principles of the wraparound philosophy. Development of the plan involves several important tasks.

Ground Rules: the Wraparound Facilitator guides the team in developing a list of ground rules and how the rules will be followed during the team meetings. The facilitator should ensure that the ground rules address confidentiality, mandatory reporting, and creating a safe, blame-free environment for all team members. The ground rules should be recorded, and all team members should receive a copy.

Description of Strengths: the Wraparound Facilitator will present the summary of strengths developed during the initial phase, and elicit feedback and additional strengths from team members who have been added. These should include strengths of the additional team members, and the family's community.

Creation of a Team Mission Statement: the Wraparound Facilitator reviews the family's vision and leads the team in setting a team mission. The Wraparound Facilitator introduces the idea that this will be the overarching goal that will guide the team. This task is very important, as all future activities will be assessed by asking, "How does this fit with our team mission?" The Team Mission Statement is created through a process of brainstorming that is guided by the Wraparound Facilitator. From the Team Mission Statement, a "Bumper Sticker Version" is created that is easy to remember and can be written on all wraparound plans.

Description and Prioritization of needs: the Wraparound Facilitator guides the team in reviewing needs identified during the initial phase, and including any additional needs. The Wraparound Facilitator then guides the team in prioritizing the identified needs. Non-negotiables (safety and legal mandates) should be defined during this process.

Determination of Outcomes: the Wraparound Facilitator guides the team in a discussion designed to identify outcomes that will represent success in meeting each need the team has chosen to work on. The Wraparound Facilitator assists the team in determining how they will assess the outcome and including specific indicators for each need, and how often they will be measured.

Strategy Selection: the Wraparound Facilitator guides the team in a brainstorming process to assist the team in thinking of creative strategies for meeting needs and achieving outcomes. The Wraparound Facilitator then assists the team in considering how likely the strategies are to be effective in reaching the desired outcomes, the extent to which they are community based, the extent to

which they build on identified strengths, and the extent to which they are consistent with the family's culture, values and preferences.

Assignment of Action Steps: the team assigns responsibility for undertaking action steps associated with each strategy to specific individuals to be completed in specific time frames.

Additional points to consider:

Needs versus services: Traditionally, service plans for families were often based on available services, rather than identified needs. It was not uncommon for service plans for different families to have similar components, such as "parenting". Parenting is traditionally a service offered with rigid guidelines as to what may be taught. There was very little tailoring of the service to meet a given family's specific need which might be something like, "Mr. and Mrs. Jones have difficulty setting age appropriate limits for their teen aged son, Joey". They may not get what they need from a traditional parenting class that focuses on child development and parenting toddlers and young children. The Wraparound plan is different in that the plan is based on identified needs, and strategies built on existing strengths to meet those needs. Each plan should be unique to the specific family it is designed to assist.

Examples:

SERVICES	**NEEDS**
Positive Peer Socialization	"good friends for Johnny"
Parenting Classes	"help setting rules that make sense for my teen"
Support Group	"to know other people have been through this"

Conflict is normal: When developing the initial Wraparound Plan, and throughout the Wraparound process, conflict should be anticipated as normal. Often, team members will be very passionate about their opinions, and opinions will vary. It is essential for each team to develop the ability to manage conflict without it deteriorating into something that will be damaging to the Wraparound process.

Ways to manage conflict: When a conflict arises, the Wraparound Facilitator should schedule a meeting with all parties present at the same time. All parties should be asked to come prepared to address their concerns, and provide potential solutions. It is often helpful to ask team members to bring their concerns and solutions in writing. This will ensure all points are shared, and it may assist in diffusing the emotion behind the conflict.

Finding solutions the team can live with: All concerns and solutions should be addressed using a problem-solving tool such as brainstorming or storyboarding. If no potential solutions are presented, the Wraparound Facilitator should ask questions that will guide the team toward discovering their own solutions. Team members should be assisted in identifying the underlying concerns for each perspective provided. Team members should come up with a solution that addresses the underlying concerns of each perspective.

Goal Two: Development of crisis/safety plan

The second major goal of the Initial Plan Development phase of the wraparound process is to develop a crisis/safety plan. The plan should identify potential problems and crises, and prioritize them according to seriousness and likelihood of occurrence. The plan should be an effective, clearly specific crisis prevention and response plan that is

consistent with the wraparound principles. To accomplish this goal, the facilitator guides the team in a discussion of how to maintain the safety of all family members. The facilitator then guides the team in a process of prioritization. For each potential crisis, in order of priority, the team identifies any serious risks. The discussion includes potential triggers for each listed concern, strategies for preventing each potential crisis and possible responses for each. Specific roles and responsibilities are outlined, and all of the information is documented in a safety plan document that includes proactive and reactive plans.

Additional points to consider:

Creating an effective crisis plan: When creating an effective crisis plan, it is important to listen carefully as the family describes "the worst that has ever happened" as it relates to the identified family problems. The best predictor of future crisis is the past. When the family is sharing about past crises, the Wraparound staff should be listening for details of crises that have happened in the past, including what triggered the crisis, what was tried that worked to ameliorate the crisis, and what was tried that didn't work. To develop a thorough plan, all members of the team should have input into their concerns about potential crises. Crisis plans should plan for the worst-case scenario. By planning for crises to occur, and predicting that they will, the family is reassured that crisis is a normal part of the process at times, and that they can develop the tools to address them. When a crisis plan is developed, a copy should be given to each team member, and each team member should be clearly aware of what role he/she will play in a crisis.

Reactive versus Proactive Crisis Plans: Reactive crisis plans focus on how to respond when a crisis occurs. Clear goals are developed for each team member. Proactive crisis plans focus on preventing crises from occurring. It is important to develop both, as both will likely be needed.

(Bruns et al, 2008a)

Phase 3: Implementation

During this phase, the initial wraparound plan is implemented, progress and successes are continually reviewed, and changes are made to the plan and then implemented, all while maintaining or building team cohesiveness and mutual respect. The activities of this phase are repeated until the team's mission is achieved and formal wraparound is no longer needed. Several major goals should be accomplished during the implementation phase, each of which has several important tasks. This phase includes on-going family team meetings (at least every 30 days). Between family team meetings, weekly staffings will occur. Throughout the phase, the facilitator is responsible for completing necessary documentation including maintaining and updating the plan, keeping and distributing team meeting minutes, recording progress and completion of action steps.

Goal One: Implementation of the initial wraparound plan

The first major goal of the implementation phase of the wraparound process is implementation of the initial wraparound plan. This goal involves several important tasks.

Implementation of Action Steps for each Strategy: for each strategy, team members undertake the actions steps they were assigned. The facilitator aids completion of this process by checking in with team members to follow up on progress, educating providers, and other community supports, identifying, and obtaining needed resources.

Tracking Progress on Action Steps: the team monitors progress on action steps for each strategy in the plan and tracks information related to timeliness of completion of actions steps, fidelity to the plan, and completion of requirements for any particular intervention.

Evaluation of Success of Strategies: using the outcomes/indicators the team identified for each need, the facilitator guides the team in evaluating whether the chosen strategies are helping the team meet the youth and family's needs.

Celebration of Successes: the Wraparound Facilitator encourages the team to acknowledge and celebrate successes such as progress on action steps, achievement of outcomes, and other positive events or achievements, no matter how seemingly small.

Goal Two: Revisiting and updating of the initial plan

The second major goal of the implementation phase of the wraparound process is to ensure that a collaborative team approach is utilized to continually revisit and update the plan in response to success of the initial strategies. It is important that when the team determines that strategies for meeting needs are not working or when new needs are identified or prioritized, the Wraparound Facilitator guide the team in considering new strategies and action steps using the same process as before.

Goal Three: Maintenance of team cohesiveness and trust

The third major goal of the implementation phase of the wraparound process is to maintain awareness of team members' satisfaction with the wraparound process and to take steps to continue to build team cohesiveness and trust. The Wraparound Facilitator is responsible for continually assessing team members' satisfaction with the process, and sharing observations when appropriate to maintain cohesiveness and "buy in". This may involve managing conflict and assisting team members in the process of conflict resolution.

(Bruns et al, 2008a)

Phase 4: Transition:

During this phase, plans are made for purposeful transition out of formal wraparound to a mix of formal and natural supports in the community (and, if appropriate, to services and supports in the adult system). The focus on transition is continual during the wraparound process, and the preparation for transition is apparent even during the initial engagement activities. Several goals should be accomplished during this phase, which begins when the Team's mission is met, or very close to being met.

Goal One: Plan for cessation of formal wraparound

The first major goal of the Transition phase of the wraparound process is to create a plan for cessation of formal wraparound services. This phase of the process should reflect adherence to the key principles of wraparound and should result in a supporting the youth and family to be positioned to maintain positive outcomes through reliance on informal supports developed in the community. There are several tasks related to achieving this goal.

> **Creation of a Transition Plan:** the Wraparound Facilitator guides the team in reviewing strengths and needs, identifying services and supports that will continue to meet needs and persist past termination of the formal wraparound process.
>
> **Creation of a Post-transition Crisis Management Plan:** the Wraparound Facilitator guides the team in creating a plan that includes action steps, specific responsibilities, and communication protocols to address any crises that may occur after the Transition phase of the wraparound process is complete.
>
> **Modification of the Wraparound Process to reflect Transition:** new members may be added to the team to reflect identified post-transition strategies, services and supports. The team discusses responses to any potential crises and defines each team member's role with the family after transition.

Goal Two: Create a "commencement"

The second major goal of the Transition phase of the wraparound process is to plan a ritual to celebrate the successes of the wraparound process, and thus cease the formal wraparound services. To meet this goal, the Wraparound Facilitator guides the team in creating a document that describes the strengths of the youth and family as well as other team members, lessons learned about what worked well and what did not, and successes of the process. The Wraparound Facilitator also encourages the team to create a culturally appropriate "commencement" celebration that is meaningful to the youth, family and team and recognizes their accomplishments.

Goal Three: Follow up with the family

The final goal of the Transition phase of the wraparound process is to create a plan for checking in with the family once the formal wraparound process ends. This will allow the facilitator or other team members the opportunity to assess any new needs that require a formal response, and aid team members in assisting the family in accessing any needed services.

(Bruns et al, 2008a)

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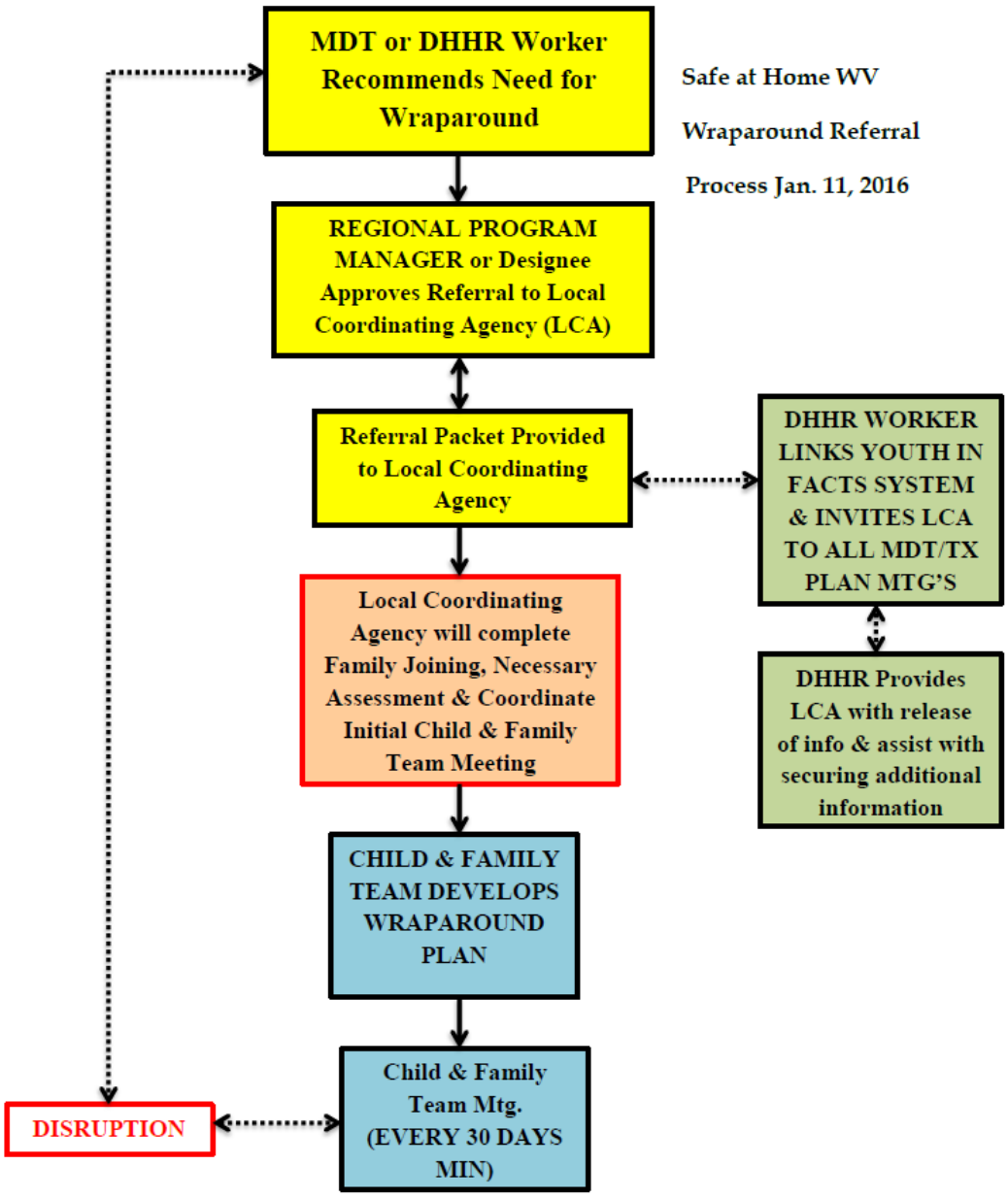
Appendix A: Wraparound Process Flow Chart

Safe at Home WV Process

Subject:	Safe at Home WV Wraparound Detail Flowchart
Date:	Updated 1/25/16



Talking with the MDT

Safe at Home West Virginia is a philosophical shift in the way we deliver support to our families, and the Wraparound model is one way we deliver this support. Because Safe at Home WV and Wraparound are not about buying a service but providing individualized support how and where families need it, it can be difficult to communicate the effectiveness of the process. When a family becomes involved in the court system, whether through abuse and neglect or juvenile justice, the Department provides the court with a detailed plan of rehabilitation for the youth and/or family that addresses the underlying safety/legal issues. These plans present to the MDT and court as tangible plans that they can hold, see, and agree to before they are implemented. The problem with this model of support is that for families in which safety issues are present to the level of judicial involvement, the family is often in need of much more than a plan that stipulates to them what they are going to do to correct the problem. Thus, the plan becomes a temporary plan that is often unsustainable, unreasonable, or unsuitable to the family's needs.

The Wraparound model of planning is quite the opposite. The Wraparound model is agreed to before the plan is implemented. When a Child Welfare Worker recognizes the need for a family to participate in wraparound planning, it may be difficult to find agreement with the MDT or Court because they will be required to agree to a plan that has not yet been created. It should be understood that the Department of Health and Human Resources has made every effort to effectively present Safe at Home WV and the Wraparound model to Circuit Judges and probation officers in your regions. However, based on situations such as presenting this model to attorneys, the turnover of Probation Officers, or the swearing of new Judges, the education of the wraparound process will be an on-going responsibility of the worker. This document's intent is to provide the Child Welfare Worker with facts and "tips" on how to effectively communicate and educate the MDT and Courts on the wraparound process.

WRAPAROUND IS ABOUT FLEXIBLE FUNDING FOR FORMAL SERVICE DELIVERY

Historically, the Department of Health and Human Resources has provided services in a rigid manner; for example, transportation services. Transportation services as provided through ASO services had limitations on how, where, and who could utilize these services and in what manner. These services, while beneficial for children in foster care, did not provide assistance for families when and where they needed it most…in their communities. It is not about making the family fit the service but making the service fit the family. Safe at Home has allowed the Department of Health and Human Resources to collaborate with child serving agencies, communities, and our families to provide flexible funding to give families what they need now, not after the trauma of a child removal has occurred.

WRAPAROUND'S PRIMARY FOCUS IS ON THE DEVELOPMENT AND TRANSITION TO INFORMAL PROVIDERS (NATURAL SUPPORTS)

The Wraparound plan will often begin with formal (paid) service providers, but will develop and implement natural supports that allow the family to sustain support after the DHHR and court system have left their lives. The focus of the plan's success will be driven by the idea of "what will the situation look like after we are gone". An introspective look into our own lives will often reveal an intricate support system that is comprised of family, friends, neighbors, and other community members. Often times the families we serve do not know how to access these supports, or they have

family members that want to help but do not know how to help. Wraparound will surface and enhance the family's ability to discover and utilize the supports we so often take-for-granted.

THE WRAPAROUND PLAN WILL ALWAYS INCLUDE "NON-NEGOTIABLES"

"Non-negotiables" are those items that must be included in the plan to account for safety and legal requirements. For example, a youth who is involved in a wraparound plan because they are habitually truant from school would be required to attend school regularly as part of the wraparound plan. This allows the court to ensure that the reasons they were brought to the court's attention in the first place are addressed. However, the "non-negotiables" should focus on the "what" and not the "how", meaning that instructing the wraparound facilitator in how they will address the matter of truancy is counterproductive to the wraparound process and should be avoided.

THE WRAPAROUND PLAN ALLOWS THE DEPARTMENT TO MAKE REASONABLE EFFORTS

WV state code requires the Department to make reasonable efforts to prevent the removal of a child from their home and to make reasonable efforts to reunify children with their families. State Statute 49-4-105 requires the court to make a finding of reasonable efforts. Wraparound is one more process that has been a proven effective tool in preventing the removal of children from their homes. It is the least restrictive alternative to residential placement and keeps children in their communities.

WRAPAROUND IS A FAMILY-CENTERED APPROACH

The Department has long believed in a child-centered, family-focused approach to case planning, but it seems to have become a common practice that when a youth becomes involved in the juvenile justice system the majority of services and attention are centered on the juvenile, with little to no focus on the family. What is often overlooked is the extent to which the juvenile's involvement with the justice system impacts the family as a whole, and that family dynamics may have created the juvenile's problem to begin with so rehabilitation cannot truly occur until those dynamics are addressed. The Wraparound process requires the participation of the entire (age appropriate) nuclear family. All family members' needs and strengths will be addressed and planned for.

THE WRAPAROUND PLAN IS ALWAYS EVOLVING

The Wraparound Plan is designed to immediately address the safety needs of the family, but also to continually change as the family's needs change. It is fool-hearty to assume that one plan will consistently address the needs of any given family. Instead, it should be expected that family needs will change through the process and that an effective plan will need to consistently be re-evaluated for needed changes to be implemented.

WRAPAROUND PLANS FOR CRISIS

When a family is identified in need of a wraparound plan, it should be expected that this is a family who will experience episodic crisis. The Wraparound facilitator will develop with the family a crisis plan, intended to provide and control for safety when these episodes occur. For example, it is understood in planning for drug addicts that the average addict will relapse seven times before experiencing sobriety. Instead of recognizing this unfortunate truth and planning for it, those involved in the rehabilitation planning often implement plans that are unrealistic to a drug user and penalize the family for relapses. The wraparound plan would identify drug use as a problem and effectively plan for the safety of the children when the parent experiences relapse. This crisis planning is not permission for the parent to "use" but instead an understanding that it is likely to occur and a plan to reduce or eliminate the child from experiencing the trauma that is associated with child removals.

Phase	Worker Actions	Time Frame	Documentation Required
1. Team Preparation and Engagement	1.Contact APS Healthcare and request roll back of services if other providers have been working with family 2.Contact providers and inform authorized units have been rolled back 3.Contact family and notify of service disruption 4.Discussion with family about their involvement in Wrap should have been made prior to referral, however, additional information should be provided to educate family on next steps 5.If child is in group residential placement and does not have an identified family to return to, the worker must help the facilitator identify and appropriate foster family, kinship/relative provider, and continuously conduct diligent searches to establish permanency 6.Add Wraparound to services, non ASO	Within ***24 Hours*** of Referral Acceptance Within ***24 Hours*** of Referral Acceptance Within ***24 Hours*** of Referral Acceptance	Appropriate documentation in contacts web screens to document notifications to APS, Providers, and Family required ASO service screens need to have appropriate wraparound service type entered and all active ASO services must be end dated and rolled back Document any and all potential kinship/relative providers and/or diligent searches that occur to aid in the development of a family for children who are in group residential and do not have an identified family

	service screens in FACTS		
	7. Work with facilitator to schedule initial child and family team meeting 8. Provide Wraparound facilitator with necessary and appropriate information ***(required assessments, visitation plan, safety plan, discharge summaries, treatment plans, court orders, permanency plans, aftercare/transition plans, progress reports, court summaries, completed and attached information for SAH wraparound referral form, terms and conditions if applicable, etc.)*** on child and family. Provided information should be deliberate. Faxing the entire case file should not be considered appropriate 9. Notify wraparound facilitator of any scheduled court hearings and MDT's, if applicable	Within ***72 Hours*** of Referral Acceptance	Document in contacts web screen time, date, and place the initial meeting will occur (within 14 days) Document in contact web screens summary of information provided to facilitator Ensure wraparound facilitator is provided MDT notifications as necessary (on-going)

	10. Facilitate/lead first Family Joining meeting with family and wraparound facilitator 11. Define Non-Negotiables with family and wraparound facilitator 12. Help wraparound facilitator and family identify potential team members and informal supports 13. Provide wraparound facilitator and family with known community resources and providers or areas in need of exploration 14. Encourage family to share with wraparound facilitator providers that have been helpful, any current planning that has worked to provide safety, or any other information the family may want to share 15. Help family to identify strengths and protective capacities	Within ***5 business days of*** referral acceptance	Document Face-to-Face meeting with family and wraparound facilitator in contact web screen Document Non-Negotiables identified in contacts web screens Document any family team members determined and informal supports that have been identified in contact web screens Document identified community resources, providers that may be utilized in contact web screens Document any providers that the family identifies they would like to use in contact web screens Document the strengths the family identified, which includes those the worker helped the family identify
2. **Initial Plan Development**	1. Participate in first Child and Family Team Meeting(s) and help to identify ground rules for meetings 2. Collaborate with family, team members, and facilitator to develop	Within ***14 Days*** of Referral Acceptance Completion of plan must occur within ***30 days***	Document the results of Face-to-Face Child and Family Team Meeting(s) and identify participants in contact web screens Document identified crisis plan summary in web screens, upload to file cabinet when document is received, add to

	crisis plan (existing safety plan elements may be included) 3. Collaborate with family, team members, and wraparound facilitators to develop wraparound plan (may take more than one meeting) 4. Collaborate with child, family, team members, and wraparound facilitator to resolve any conflicts as needed		document tracking screens Document identified wraparound plan summary in web screens, upload to file cabinet when document is received, add to document tracking screens Document conflicts and resolutions in contact web screens
3. Implementation	1. Work collaboratively with wraparound facilitator and family to implement wraparound plan 2. Work with child and family team to identify progress and review plan monthly, or as needed 3. Work with wraparound facilitator and child and family team to identify changes needed to plan as needed 4. Celebrate success with the family 5. Ensure family and wraparound facilitator continue to be made aware of court hearings and MDTs, if applicable	Within ***30 days*** of referral acceptance and ***On-Going*** until discharge	Document any and all face-to-face meetings with child and family team (minimum monthly) and identify participants and outcomes Upload Monthly progress review documents and add to document tracking Document any changes to wrap plan in contact web screens, upload new document and add to document tracking Document any Crisis that occur and results, upload to filing cabinet any associated documents and add to document tracking Documentation for court hearings and MDTs as already established by standard policies and procedures Document efforts to identify informal providers and diligent search efforts in contact web screens as required and if applicable

	6. Continue to work to identify any needed unidentified informal supports and diligent searches for relatives, if applicable and as required by policy 7. Collaborate with team and wraparound facilitator to ensure continued cohesiveness and trust building 8. Begin discussing transition planning needs		Document identified transition planning needs in contact web screens
4. **Transition**	9. Work collaboratively with child and family team and wrap facilitator to develop after-care crisis plan 10. Work with family and wraparound facilitator to begin transitioning to the use of community supports and informal providers 11. Work collaboratively with wraparound facilitator and family to monitor actual transition out of care, and make changes as needed 12. Work collaboratively	This phase does not have specified timelines but should be ***on going*** from service beginning Transition should always be the goal and steps should always be taken with this phase in mind	Document after-care crisis plan summary in contacts web screens, upload document when it is received Document community resources and informal supports identified as necessary and any resources or supports that are still needed for successful transition in contact web screens Document any changes made to transitioning plan and/or crisis plan, upload documents to filing cabinet, add to document tracking Document after-care plan summary in contact web screens, upload document to filing cabinet, add to

	with child and family team and wraparound facilitator to develop after-care plan 13. Formal discharge		document tracking Document in contact web screens the family's final discharge when transition to informal provider and community supports has been successful and sustaining

PHASE	GOAL	TASK	TIMELINE
Phase 1- Engagement and Team Preparation (30days)		Receive referral; schedule initial Family Joining meeting with the family that will include the DHHR worker.	*72 hours*
	I. Orientation to the Wraparound Process	Family orientation to the wraparound process (this will involve several face-to-face conversations with the family to explain the philosophy behind wraparound, build trust and rapport, describe the role of the wraparound facilitator, supports available to the family during the wraparound process, and alternatives to the wraparound process, should the family decide not to participate. (These meetings should occur at a time and place comfortable for the family.)	Orientation and engagement should begin during the very first contact and engagement should continue and be a primary focus during the wraparound process. The first Family Joining meeting should be ***scheduled within 72 hours of referral and occur within 5 business days of referral acceptance.***
		• ***DHHR worker will introduce Wraparound Facilitator (WF) to 1st Family Joining meeting within 5 business days of referral acceptance.*** • WF initiates Family Joining • WF Reviews and provides the family a copy of the Family Guide to Wraparound • WF Explains & Reviews Client Rights and Responsibilities • WF Explains & Reviews Grievance Policy • WF Explains & Reviews Family Responsibilities • WF reviews and obtains signatures for consent forms. • WF explains confidentiality.	Begins at the first contact with the family and orientation will involve several face-to-face conversations with ***the family during the first 14 days after referral acceptance leading*** up to the first Child & Family Team Meeting.
	II. Exploration of strengths, needs, culture and vision.	• Family story- family perspective on their strengths needs, culture and goals for improvement. • Strengths Discovery	Ongoing ***during first 14 days of referral.***

		• Identify Potential Team Members • Community Resource Bank • WV CANS (complete or check in on within 30 days) • Initial Psycho-Social	
	III. Stabilization of crisis	• ***Address any immediate safety issues***, current crisis or potential crisis in the immediate future. • Obtain safety concerns from referring professionals. • Develop Initial Crisis Plan	****At first Family Joining meeting and ongoing during first 14 days.**
	IV. Engagement of additional team members	• Gain commitment to participate from additional team members.	***Ongoing during first 14 days of referral acceptance***.
	V. Arrangement of meeting logistics	• Agree upon meeting times and locations that are accessible and comfortable to all team members. • Discuss and arrange for supports such as child care, transportation, translators, etc.). • Plan for snacks	***Ongoing during first 14 days of referral.***
Phase 2- Initial Plan Development		During this phase, team trust and mutual respect are built while the team creates an initial plan of care. During this phase the youth and family should feel they are heard, their chosen needs are prioritized.	This phase ***should begin within 14 days of referral acceptance and be completed in one to two Child and Family Team meetings***. All initial plans must *be complete within 30 days of initial referral. Monthly summaries are due by the 5th business day of the month following the month of service provision.*
	I. Development of Initial Wraparound Plan	• **Ground Rules** -Brainstorm list of ground rules and how they will be followed during team meetings. WF assures they include confidentiality, mandatory reporting, and creating a **safe, blame-free environment** for all team members.	***Should begin within 14 days of referral and be completed in one to two Child and Family Team meetings within one to two weeks of beginning.*** The wraparound plan

		• **Description of Strengths-** WF will introduce the youth and family using the summary of strengths developed during the engagement and orientation phase. All team members should be introduced by the strengths they bring to the team. Additional feedback on all team member strengths should be elicited. • **Creation of Team Mission Statement-** The WF reviews the family's vision and leads the team in setting a team mission. **All future activities and funding will be assessed by asking "How does this fit with our team mission"?** From the team mission a "Bumper Sticker Version" is created that is easy to remember and can be written on all wraparound forms. • **Description and Prioritization of Needs-** WF guides the team in reviewing, identifying and prioritizing needs. Non-negotiables (safety and legal mandates) are defined. • **Determination of Outcomes-** WF guides the team in identifying outcomes that will represent success of each identified need. • **Strategy Selection-** WF guides the team in brainstorming to think of creative strategies to meet the identified needs and outcomes. • **Assignment of Action Steps-** The team assigns responsibility for undertaking actions steps for each strategy.	should be typed and all members receive a copy within ***5 business days*** of finalization from the Wraparound Facilitator.
	II. Development of Crisis/Safety Plan	The crisis plan should identify potential problems and crisis. The WF should guide the team in a discussion of how to maintain the safety of all family members.	Completed at first Child and Family Team Meeting ***(within 14 days of referral).***

		For each potential crisis, in order of priority, the team identifies any serious risks. This discussion should include potential triggers for each listed concern, strategies for preventing and possible responses for each. Specific roles and responsibilities are outlines, and all of the information is documented in ***a safety plan document that includes proactive and reactive plans.***	
Phase 3- Implementation		During this phase, the initial wraparound plan is implemented, progress and successes are continually reviewed, and changes are made to the plan and then implemented, all while maintaining or building team cohesiveness and mutual respect.	The activities of implementation phase are repeated until the team's mission is achieved and formal wraparound is no longer needed. This phase ***includes ongoing family team meetings (at least every 30 days).*** Between family team meetings *weekly staffing s will occur.*
	I. Implementation of the Wraparound Plan	• Implementation of Action Steps for each Strategy • Tracking Progress on Action Steps • Evaluation of Success of Strategies • Celebration of Success	Ongoing
	II. Revisiting and Updating of the Initial Plan	WF assures that a collaborative approach is utilized to continually revisit and update the plan in response to success of the initial strategies. It is important that the WF guide the team in reconsidering new strategies and action steps using the same process as before.	***Every 30 days or sooner as needed.***
	III. Maintenance of Team Cohesiveness and Trust	The WF maintains awareness of team member's satisfaction with the wraparound process and takes steps to continue to build team cohesiveness and trust. This may involve managing conflict and assisting team	Ongoing

		members in the process of conflict resolution.	
Phase 4- Transition		During this phase, plans are made for purposeful transition out of formal wraparound to a mix of formal and natural supports in the community. Several goals should be accomplished during this phase.	*Begins when team mission is met or close to being met.*
	I. Plan for Cessation of Formal Wraparound	• Creation of a Transition Plan • Creation of a Post-Transition Crisis Management Plan • Modification of the Wraparound Process to Reflect Transition	
	II. Create a Commencement	Plan a ritual to celebrate the successes of the wraparound process, and thus cease the formal wraparound services.	
	III. Follow up With the Family	The team creates a plan for checking in with the family once wraparound ends. This provides opportunity to assess any new needs that require a formal response in assisting the family in accessing any needed services.	

Safe at Home West Virginia

Facilitator Responsibilities and Timeframe Matrix

PHASE	COORDINATION/FACILITATION	DIRECT	OTHER
Engagement & Team Preparation	WRAPAROUND Enrollment Contact Family ***72 hours/Schedule*** Schedule Family Joining-***72 hours*** First Family Joining Meeting – ***5 business days from referral*** Open Case file/Secure Info. Schedule appointments Schedule first Child & Family Team Meeting-***Must occur within 14 days*** Arrange location, snacks, and logistics of Family Team Mtg. Define Non-Negotiables with DHHR/Court Community Analysis Linkage-Advocacy	Participate in Family Joining Initial Psycho-Social Assessments: CANS (within 30 days), Strengths Community Resource Bank Wraparound Orientation w/family-Forms Family Vision Identify Potential Family Team Members Consents/Authorizations Initial Crisis Plan-***Must occur within 5 days*** Family Team Meeting- ***Must occur within 14 days of initial referral.*** Participate in case specific weekly staffing	Case Note Documentation, Review, and Logging. Case Notes Service Tracking
Initial Plan Development	Develop Wraparound Plan-***Begin within 14 days of referral*** Finalize Wraparound Plan -***30 days*** Develop Pro-Active & Reactive Crisis Plan Creative Fund Request Community Building-Analysis Identify Team assignments DHHR communication Monthly Summary ***– By the 5th business day of the month following the month of service provision*** Discharge planning	Wraparound Orientation w/child Participate in case specific weekly staffing Coordinate, Facilitate, Plan Family Team Meeting Continue to identify team strengths, Potential team members and add to community resource bank. DHHR/Court meetings as required Mobile Crisis response as needed	Case Notes Monitor Creative Funds Service Tracking CQI & Evaluation activities Service Utilization Report to Wraparound Model/Plan Integrity

Implementation	Review/update/monitor Wraparound Plan Coordinate Team services Finalize Community Entries DHHR communication Monthly Summary	Participate in case specific weekly staffing Family Team Meeting DHHR/Court meetings as required Mobile Crisis response as needed Monthly Family Team Meeting Facilitation, Coordination, and Planning	Case Notes Monitor any Basic Need Funds Service Tracking CQI & Evaluation activities Service Utilization Report to Wraparound Model/Plan Integrity
Transition	Review/update/monitor Wraparound Plan Coordinate Team services Community Linkage/ Transitions DHHR communication Transition Planning Monthly Progress Report Transition to Natural Supports Disenrollment	Participate in case specific weekly staffing Family Team Meeting DHHR/Court meetings as required Mobile Crisis response as needed Assessment: CANS, Strengths Inventory	Case Notes Monitor Creative Funds Service Tracking Model/Plan Integrity CQI & Evaluation activities Service Utilization Report to Wraparound

Safe at Home West Virginia
Wraparound Document Provision Guide

Document	Timeframe for Provision	Recipients
Initial Crisis Plan If an immediate crisis concern exists, an initial crisis plan should be developed, in conjunction with the Family Joining Meeting, and provided to Child & Family Team Members and the DHHR Worker & Supervisor	Must be developed within 5 days of referral. Provided to recipients within 2 additional business days.	Child & Family Team Members DHHR Worker & Supervisor
Initial Wraparound Plan The Crisis/Safety Plan is developed within the Initial Wraparound Plan, and is updated as needed The utilization of informal supports begins with the development of the Initial Wraparound Plan. These efforts increase during the transition planning phase, and are reflected in Updated Wraparound Plans	Must be developed within 30 days of referral. Provided to recipients within 5 additional business days.	Child & Family Team Members DHHR Worker & Supervisor
Updated Wraparound Plans	Must be provided to recipients within 5 additional business days of the Child and Family Team Meeting where plan adjustments occurred.	Child & Family Team Members DHHR Worker & Supervisor

Monthly Summaries	Due by the 5th business day of the month following the month of service provision. Example: If the service month ends on October 31st, the Monthly Summary is due within 5 business days in November.	Child & Family Team Members DHHR Worker & Supervisor
Court Reports	Must be submitted no less than 10 calendar days prior to a scheduled hearing.	Child & Family Team Members DHHR Worker & Supervisor Court Counsel Prosecutor
Discharge Summary	Must be provided to recipients within 14 calendar days of discharge from Safe at Home West Virginia.	Child & Family Team Members DHHR Worker & Supervisor

Safe at Home WV
Wraparound
Referral Form

Safe at Home WV Eligibility:	
☐	Youth, ages 12 to 17 (up to the youth's 17th birthday) with a diagnosis of a severe emotional or behavioral disturbance that impedes his or her daily functioning (according to standard diagnostic criteria) currently in out-of-state residential placement and cannot return successfully without extra support, linkage and services provided by wraparound;
☐	Youth, ages 12 to 17 (up to the youth's 17th birthday) with a diagnosis of a severe emotional or behavioral disturbance that impedes his or her daily functioning (according to standard diagnostic criteria) currently in in-state residential placement and cannot be reunified successfully without extra support, linkage and services provided by wraparound;
☐	Youth, ages 12 to 17 (up to the youth's 17th birthday) with a diagnosis of a severe emotional or behavioral disturbance that impedes his or her daily functioning (according to standard diagnostic criteria) at risk of out-of-state residential placement and utilization of wraparound can safely prevent the placement;
☐	Youth, ages 12 to 17 (up to the youth's 17th birthday) with a diagnosis of a severe emotional or behavioral disturbance that impedes his or her daily functioning (according to standard diagnostic criteria) at risk of in-state residential or PRTF residential placement and they can be safely served at home by utilizing wraparound;

Client Details:			
Name:			
Client ID#:			Facts Case #:
Worker:	Phone #: - -		Worker email:
D.O.B.:			Home County:
Race:	Gender: ☐ Male ☐ Female		SSN:
Medicaid ☐ Yes ☐ No		Medicaid ID#:	
Private Insurance Carrier* ☐ Yes ☐ No		Judge:	
Permanent Address:		Phone #: - -	
Address 1:			
Address 2:			
City:		State:	Zip:
Current Address:		Phone #: - -	

Address 1:		
Address 2:		
City:	State:	Zip:

Custody:

Custody Status:	Temporary: ☐ Permanent: ☐
Legal Guardian (DHHR/DJS):	Phone #: - - ext:
Attorney:	Phone #: - - ext:
G.A.L.:	Phone #: - - ext:
J.P.O.:	Phone #: - - ext:

1: Education Status:

Grade:	
Is there a current IEP? (*Please attach)	☐ Yes* ☐ No
Is the client currently expelled from educational institution?	☐ Yes* ☐ No
*If yes, date effective:	Name of School:
High School Diploma: ☐ Yes* ☐ No	GED: ☐ Yes* ☐ No

2: Permanency Plan/Step-down Plan:

(Please continue at end if necessary. Addendum #2)

Step-down Caretaker:	Phone #: - - ext:
Step-down Caretaker relationship to Client:	

3: Clinical Review Date (If applicable):

Recommendations for Safe at Home WV Referral:

(Please continue at end if necessary. Addendum #3)

Was Clinical Review less than 30 days ago? ☐ Yes* ☐ No	*** IF YES ENCLOSE SECTIONS 1, 2 & 3 THEN SKIP TO SECTION 10.**

4: Presenting Problems:

(Please continue at end if necessary. Addendum #4)

5: Placement History:

(Please continue at end if necessary. Addendum #5)

6: Abuse/Neglect History:

(Please continue at end if necessary. Addendum #6)

7: Youth Services History: Yes*: ☐ No: ☐ *Please give details

Delinquency: Yes: ☐ No: ☐

Status of Offense:

If on probation, please list the charges:

(Please continue at end if necessary. Addendum #7)

8: Diagnosis and Full Scale IQ:

(Please continue at end if necessary. Addendum #8)

9: Medical Conditions:

Current Medications:

(Please continue at end if necessary. Addendum #9)

10: Reason for Safe at Home WV Request:

a: Why have placements/home disrupted or why is child at risk of placement?

(Please continue at end if necessary. Addendum #9)

b: What services have been exhausted by youth & family or provider?

(Please continue at end if necessary. Addendum #10

c: What formal or informal support services are needed to facilitate the youth's successful return to their designated community?

(Please continue at end if necessary. Addendum #11)

d: What formal or informal support services are available in the returning youth's designated community?

(Please continue at end if necessary. Addendum #12)

11: Required Documents:

Attachment	Submitted & Attached	Not Applicable	Safe at Home WV Received (Safe at Home WV use only)
IEP	☐ Yes ☐ No	☐	☐
Service Log for Child	☐ Yes ☐ No	☐	☐
Service Log for Caretaker	☐ Yes ☐ No	☐	☐
Treatment Plan	☐ Yes ☐ No	☐	☐
Discharge Plan from Facility/Provider	☐ Yes ☐ No	☐	☐
Safety Plan	☐ Yes ☐ No	☐	☐
Clinical Reviews from Last 6 Months	☐ Yes ☐ No	☐	☐

12: Referral Source:

Worker Signature:	
Print Name:	**Date:**
Supervisor Signature:	**Date:**
Print Name:	
Child's Name:	**Client ID:**
Was Safe at Home WV referral discussed with parent/guardian:	☐ Yes ☐ No
Did Parent/Guardian agree to Safe at Home WV referral	☐ Yes ☐ No

13: Safe at Home WV Referral Outcome:	
Child's Name:	**Client ID:**
Safe at Home WV Approved	☐ Yes ☐ No
Regional Program Manager Signature:	
Print Name:	**Date:**
Recommendations: (Please continue at end if necessary. Addendum #13)	

Addendum #2-Permanency Plan/Step-down Plan. Continued:

Addendum #3-Clinical Review Recommendations for WV Safe at Home Continued:

Addendum #4-Presenting Problems. Continued:

Addendum #5-Placement History. Continued:

Addendum #6-Abuse/Neglect History. Continued:

Addendum #7-Youth Services History. Continued:

Addendum #8-Diagnosis. Continued:

Addendum #9-Medical Conditions. Continued:

Addendum #10a-Why have placements/home disrupted or why is child at risk of placement? Continued:

Addendum #10b-What services have been exhausted by youth & family? Continued:

Addendum #10c-What formal or informal support services are needed to facilitate the youth's successful return to their designated community? Continued:

Addendum #10d-What formal or informal support services are available in the returning youth's designated community? Continued:

Addendum #13-Safe at Home WV Outcome Recommendations. Continued:

Acceptance Letter

[Your Name]
[Street Address]
[City, ST ZIP Code]
[Date]

[Recipient Name]
[Title]
[Company Name]
[Street Address]
[City, ST ZIP Code]

Dear [Recipient Name]:

We have reviewed a referral submitted by West Virginia Department of Health and Human Resources recommending your participation in the wraparound process, and I am pleased to inform you that a Wraparound Facilitator has been assigned to your family.

Please read carefully the enclosed information with your family. This enclosed information will walk you through the concepts and principles of the wraparound process and help your family understand what to expect as a result of their involvement.

Your Wraparound Facilitator will be in touch with you to schedule a visit to your home.

Thank you for allowing us to serve your family.

Sincerely,

Enclosure

CC: DHHR
[Street Address]
[City, ST ZIP Code]

Statement of Confidentiality

Wraparound is a grouping of services delivered by multi-agency teams designed to provide community based integrated services for youth in out of state/region placements or to prevent out of state/region placements that are youth driven, strength-based, and family focused. Eligible youth must be assessed as safe and appropriate for return to/remain in the community and must be pre-approved by the DHHR Regional Program Manager or designee. The Wraparound Team will provide intensive multi-agency support through collaboration to facilitate successful community reunification/preservation.

I, _____ (Print Name), understand in my capacity as a member of the Wraparound team with access to confidential client information, that I am required to conduct myself in strict conformance to applicable federal and state privacy laws such as HIPAA and WV Law governing confidential information.

I understand that all information, which may identify a patient/client or which relates to a patient/clients health, must be maintained in the strictest confidence. I agree to protect the confidentiality and privacy of all confidential client information and records during and after my participation in the WRAPAROUND services. I also understand that I must not access, use or disclose any client information in any way other than what is needed to perform my identified and legitimate duties as a participant of the WRAPAROUND.

I will take all reasonable precautions to safeguard *confidential* information. These precautions include using lockable file cabinets, locking office doors, securing data disks, tapes or CDs, using a password protected screen saver, etc. I agree to store my electronic media in recommended containers and store back up media in approved locations.

Upon the completion of my role in the Wraparound Team, I will ensure that I return all client data, forms and copies to the designated WRAPAROUND representative. If I have made my own personal notes, I must ensure that such information is destroyed in a manner that renders it unreadable and unusable by anyone.

Disclosures Required by Law: I understand that I am required by law to report suspected child or elder abuse to the appropriate authority. I agree to cooperate with any investigation by the Department of Health and Human Services or any oversight agency as required. I understand that nothing in this acknowledgement prevents me from making a disclosure of confidential patient information if I am required by law to make such a disclosure.

I acknowledge that I have read and understand the guidelines regarding information disclosure, HIPAA's federal privacy regulations and WV law. I understand that certain federal and state rules and regulations may apply to the confidential information. *My signature acknowledges that I have read the terms and conditions of this acknowledgement. This signature page will be maintained by a designated WRAPAROUND representative.*

By my signature below, I acknowledge that I have read the terms and conditions of this confidential acknowledgement.

Signature: _____

Printed Name: _____

Date: _____

Work Phone: _____

Agency: _____

SAFE AT HOME WV WRAPAROUND
Consent for Services

I, (youth), do hereby give permission to the Wraparound Team (Agency Name) to provide Pre-Community Integration, Intensive Family Preservation, Reunification, Mentoring, Care Coordination, Wraparound Facilitation, Crisis Response, Parenting, Assessment, Respite, Youth Coaching, Aftercare and any other services/interventions defined on the wraparound plan. I do hereby agree to participate in my Individual/Family Assessment and Wraparound Plan. I understand that participation in this program is voluntary.

It is the responsibility of the parent/legal guardian to notify the worker if an appointment needs to be cancelled and rescheduled.

I have received and have had explained to me a copy of my rights as a client within this program.

Client (age 12 and above)	Date
Parent/Guardian	Date
Wraparound Facilitator	Date

Agency Name

SAFE AT HOME WV INDIVIDUAL WRAPAROUND PLAN

REFERRAL INFORMATION:

Date of Referral	Source/County	Person & Contact Information
Date of Wraparound Start	Case Type	Date of Current Plan:

YOUTH DEMOGRAPHICS:

YOUTH NAME:

Date of Birth:	Gender:	Race:

CURRENT LIVING SITUATION/SETTING WITH ADDRESS:

ACADEMIC SETTING:

GRADE LEVEL:

IEP: ☐

GPA:

OTHER/MISC:

FAMILY DEMOGRAPHICS:

NAME/RELATIONSHIP	INVOLVEMENT STATUS (FULLY ACTIVE; SEMI-ACTIVE; OTHER)	CONACT ROUTE

Child & Family Team Meeting – PLANNING FORM

Youth/Family Name: _____ Date: _____

Meeting Site: _____

INTRODUCTIONS & SRENGTH DISCOVERY

SUPPORT KEY	NAME: (Relationship or Position)	STRENGTHS

Support Key: NS = Natural/Informal Support, F = Immediate Family, FS = Formal Support

OTHER POTENIAL TEAM MEMBERS

How do we engage other members that would strengthen the team?

WHO (relationship or position)	WHAT WOULD THEY ADD?	WHO CONACT ENGAGES?

GROUND RULES

Identify the Ground Rules & Team Process, including how decisions are made. It is important to create a safe, respectful environment where all ideas can be heard.

DISCOVERING COMMUNITY RESOURCES

Quickly brainstorm natural & formal supports in the Family's Neighborhood.

MISSION STATEMENT

Please summarize the Mission Statement that has been developed by the Family Team:

MISSION "BUMPER STICKER" STATEMENT

FAMILY'S CONCERNS AND POSSIBLE ROADBLOCKS

CONCERNS & NEEDS

The following 5 needs were chosen as the most important to help meet the Mission Statement: prioritize the needs 1-5 with 1 representing immediate, etc.

1.

2.

3.

4.

5.

PUTTING IT ALL TOGETHER

Goal 1 (Should address the above need #1 by stating what needs to change) :

OUTCOME MEASUREMENT: (How will we know it has changed? CANS scores can be used.)

STRENGTH-BASED STRATEGIES (include who is responsible for completing the action)	**TIMELINE** (include start date and completion date)	**BARRIERS & CHALLENGES**	**PROGRESS**

Goal 2 (Should address the above need #2 by stating what needs to change) :

OUTCOME MEASUREMENT: (How will we know it has changed? CANS scores can be used.)

STRENGTH-BASED STRATEGIES (include who is responsible for completing the action)	**TIMELINE** (include start date and completion date)	**BARRIERS & CHALLENGES**	**PROGRESS**

Goal 3 (Should address the above need #3 by stating what needs to change) :			
OUTCOME MEASUREMENT; (How will we know it has changed? CANS scores can be used.)			
STRENGTH-BASED STRATEGIES (include who is responsible for completing the action)	**TIMELINE** (include start date and completion date)	**BARRIERS & CHALLENGES**	**PROGRESS**

Goal 4 (Should address the above need #4 by stating what needs to change) :
OUTCOME MEASUREMENT; (How will we know it has changed? CANS scores can be used.)

STRENGTH-BASED STRATEGIES (include who is responsible for completing the action)	**TIMELINE** (include start date and completion date)	**BARRIERS & CHALLENGES**	**PROGRESS**

Goal 5 (Should address the above need #5 by stating what needs to change) :
OUTCOME MEASUREMENT; (How will we know it has changed? CANS scores can be used.)

STRENGTH-BASED STRATEGIES (include who is responsible for completing the action)	**TIMELINE** (include start date and completion date)	**BARRIERS & CHALLENGES**	**PROGRESS**

DEVELOPING THE INITIAL SAFETY/CRISIS PLAN

Identify the System (CPS, DHHR, Probation, Mental Health, etc.) Non-Negotiables for the Youth and/or Family Members:

1. _____
2. _____
3. _____
4. _____
5. _____

Identify the Family Non-Negotiables:

1. _____
2. _____
3. _____
4. _____
5. _____

OTHER CONCERNS/NEEDS THAT MERIT "WATCH/PREVENT"

CRISIS PLANNING – Pro-Active Reactive

Remember, "Crisis is when adults do not know what to do"

Youth/Family Name: _____ Date of Plan: _____

Wraparound Facilitator: _____

Agency: _____

POTENTIAL CRISIS:	
ACTION STEPS (What works best?)	**PERSON(S) RESPONSIBLE**
PLAN "B" (What if the above does not work?)	**PERSON(S) RESPONSIBLE**

POTENTIAL CRISIS:	
ACTION STEPS (What works best?)	**PERSON(S) RESPONSIBLE**
PLAN "B" (What if the above does not work?)	**PERSON(S) RESPONSIBLE**

Make Additional Copies as Necessary

Crisis Plan: FAMILY PHONE TREE
Important People, Services & Contact Numbers

FAMILY NETWORK

NAME	RELATIONSHIP	CONTACT NUMBERS

FRIENDS & NATURAL SUPPORTS

NAME	RELATIONSHIP	CONTACT NUMBERS

SERVICE PROVIDERS

NAME	RELATIONSHIP	CONTACT NUMBERS

POST CRISIS FOLLOW-UP TASKS:

TASK	TIME-FRAME	RESPONSIBLE PERSON

OVERALL PROGRESS

ASSIGNMENTS AND FOLLOW-UP TASKS:

TASK	TIME-FRAME	RESPONSIBLE PERSON

SIGNATURES:

NAME	RELATIONSHIP OR POSITION	AGREE or DISAGREE	DATE

Safe at Home West Virginia
Monthly Summary Guidance

Monthly summaries are one of the methods of communication used to summarize service delivery and progress toward goal achievement. Monthly summaries shall be completed for each family participating in Safe at Home West Virginia. Summaries should include services directly provided, or coordinated, by the Wraparound Facilitator. Wraparound Facilitators are responsible for understanding, and adhering to, the documentation requirements for Safe at Home West Virginia. Monthly summaries are to be provided within five business days of the month following the month services were provided. For example: if the service month ends on October 31, the monthly summary is due within five business days in November. Summaries are to be provided to the DHHR worker and their supervisor, as well as all Family Team members.

Monthly summaries should include all case activity that has occurred within the month of service. Documentation should reflect how the case activity relates back to the family's identified goals. Monthly summaries should include the family's movement toward achieving the desired outcomes documented in the wraparound plan. Any barriers to progress, and how these barriers will be addressed, should also be included. The level of family participation, and their response to services delivered should be documented. Home visits, family and child contact, coordinated meetings with Departmental staff, court and school liaison services should be included in the summary. Referrals and linkage to community supports and/or services that occur within the month of service should be documented within the summary. While some of the information included may be similar month to month, the bulk of information provided should be new, and specific to the month of service. Any safety concerns that occur should be noted in the summary, and reported immediately to the assigned DHHR worker.

SAFE AT HOME WV WRAPAROUND MONTHLY SUMMARY

Admission Date: Review Date:

Local Coordinating Agency: Wraparound Facilitator:

Family Demographics

Family Name:	FACTS Case ID:	County of Service:
Address:		
City, State, Zip Code:		Phone:
At-Risk Youth:	FACTS Client ID:	
Placement Residence:		Phone:
Address:		
City, State, Zip Code:		

Educational Information (please identify the education information for the identified at-risk youth)

Current School:	Phone:
Address:	
City, State, Zip	Academic Standing:
Grade Level:	IEP:

Does the current IEP meet the youth's educational needs (briefly explain):

Date of last IEP Review:

Family Household (Provide name and relationship of each member of the household of primary residence)

Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:

Absent Parent Information (Please list any absent parent identified with contact information):

Family Team Members

Name: Email:	Relationship: Phone:
Name: Email:	Relationship: Phone:
Name: Email:	Relationship: Phone:
Name: Email:	Relationship: Phone:
Name: Email:	Relationship: Phone:
Name: Email:	Relationship: Phone:
Name: Email:	Relationship: Phone:
Name: Email:	Relationship: Phone:

Judicial Information Case Number(s):

Judge: Phone:	County: Email:
Juvenile Probation Officer: Email:	Phone:
Prosecuting Attorney: Email:	Phone:
Youth's Attorney: Email:	Phone:
CASA: Email:	Phone:

WRAPAROUND Plan Goals (identify top 4 active goals)

Goal 1:
Goal 2:
Goal 3:
Goal 4:

WRAPAROUND Summary of Progress (include information related to service provision, progress, barriers and methods to address barriers, family participation, meetings, linkage and safety concerns occurring within the month of service)

Goal 1

Related Case Activity:

Progress:

Barriers & Methods to Address Barriers:

Goal 2

Related Case Activity:

Progress:

Barriers & Methods to Address Barriers:

Goal 3

Related Case Activity:

Progress:

Barriers & Methods to Address Barriers:

Goal 4:

Related Case Activity:

Progress:

Barriers & Methods to Address Barriers:

Summary of Home Visits & Contacts with Family Members, Including Dates:

Summary of Family Participation:

Referrals and Linkage to Community Supports or Services:

Safety Concerns:

Additional Comments:

Medication Changes

Change in Medication	Medication Purpose	Reason for Medication Change	Date of Change

Services (Identify formal and Informal services provided to youth and family)

Identified Need	Identified Service (Identify whether formal or informal)	Dates of Service Contact	Missed Appointments By Family, Facilitator or Provider (Provide Explanation)

CANS (Include the date of the most recent completed CANS. If the CANS was updated during the month of service, include a summary of the updated CANS)

Date of Most Recent CANS: _____

Summary of updated CANS during the month of service:

_____ _____

(Wraparound Facilitator's signature) (Credentials) (Date)

WV SAFE AT HOME

A FAMILY'S GUIDE TO WRAPAROUND

Rhonda Hayes

WELCOME TO THE SAFE AT HOME WV WRAPAROUND

This User Handbook was developed to serve as a "road map" for family members engaged in Safe At Home West Virginia's wraparound process; an approach to planning and implementing services and supports for their child, youth and family. Wraparound is based on the belief that youth make the most progress when family and community are collaboratively involved in the case planning process and that the plan includes ways to assure that children/youth and their families can experience success in their communities, homes and schools.

In the following pages, you will find a brief description of the Wraparound process including a list of common terms and guiding principles. Later in this handbook, you will see a more detailed description of the process along with some checklists you can use to ensure your family is on the right path and that the process is closely following the guiding principles and phases of the wraparound model.

WHO MAY BENEFIT FROM WRAPAROUND?

Wraparound is designed to help groups of people involved in a family's life, work together to support the family and their child/youth who are returning from, or at risk of being sent to, an out-of-home placement. To participate in the wraparound process, a family must be referred by their WV Department of Health and Human Resources (WV DHHR) case worker, have approval from the multi-disciplinary team (if applicable), and the at-risk youth/child must be between the ages of 12 and 17, in jeopardy of being removed from their home or in need of extra support to return home, and have a diagnosis of severe mental or behavioral disturbance according to a standardized diagnostic manual.

GETTING STARTED WITH WRAPAROUND

Before your child/youth has even returned/left home, a Wraparound Facilitator assigned to assist your family will contact you to introduce his/her self, meet the family, and explain what the family can expect from involvement in the wraparound process. Your Wraparound Facilitator should explain the wraparound process and how it progresses through four phases. The phases are:

- **Engagement and Team Preparation:** One of the first people your family will meet is a Wraparound Facilitator. The Wraparound Facilitator will inform you about Wraparound and determine if the process can meet the needs of your child and family. A critical part of the wraparound process is the Child and Adolescent Needs and Strengths assessment (CANS). The Wraparound Facilitator will meet with your family to begin the assessment and planning process. The purpose of the CANS assessment is to help determine the various needs that your at-risk youth may have that will need to be addressed in the planning process. This assessment will be revisited several times throughout the wraparound process and will help guide the team in understanding progress and new needs that may arise during treatment. During this process, you should discuss your

concerns, needs, hopes, dreams and strengths with your Wraparound Facilitator. You should then describe your vision for the future and identify people who care about you and your family. You, your family and your Wraparound Facilitator will discuss who should come to your Family Team Meeting to develop a plan and when and where the Child and Family Team Meeting should occur.

- Team members may include community or family members who care about you as a family and want to see you succeed, such as friends, neighbors, relatives, pastor, etc. Other members will include people who are providing services such as Service Providers, DHHR Worker, Probation Officer or teachers.
- The time and place for each meeting will be determined by what is convenient for you and your family, and practical for the other team members involved. Together you may choose to have a meeting at your home and avoid having to find baby sitters or driving long distances. On the other hand, you may choose a location away from home to help focus efforts on the task of developing your plan. Possible locations may include a service provider's office, community building, church, library or a local park.
- Family members are treated as peers and are the experts about their own family throughout the wraparound process.

- **Initial Plan Development:** During this phase, you will attend your first Child and Family Team Meeting with your selected team members. During the initial meeting the team will:
  - Look at your family's needs and strengths;
  - Determine if Wraparound can provide the assistance and support you need;
  - Determine several different ways to meet those needs, including using your identified strengths to meet your needs;
  - Determine expected measurable outcomes;
  - Determine what your family's mission statement will be;
  - Begin assigning team members specific tasks, and;
  - Finalize a "Service Plan" (also called the Wraparound plan).

Planning is grounded in family members' perspectives, and the team strives to provide options and choices such that the plan reflects family values and preferences.

Within the planning process, you and your family will help create a crisis plan. Crises are common for children with many needs. The Child and Family Team will create a Crisis Plan so that all members of the Team will know how to respond when there is a crisis. The following are some things to consider when developing a Crisis Plan:

- Input from the child/youth about how a crisis looks and feels to them, what supports are most helpful, and what is important for others NOT to do;
- Clearly defined roles for team members during a crisis;
- Identify potential crisis situations/triggers/precursors based on past history and family input;

- Identify action steps to avoid crisis;
- Identify action steps to resolve crisis including who to call for assistance;
- Address the needs of the whole family (i.e., providing for care of siblings) as well as the needs of the involved systems and community;
- Include action steps for Post Crisis Follow up; and
- Be open to changing the crisis plan, as it may be needed to meet the continuing needs of your family.

- **Plan Implementation:** Every month, during the Child and Family Team Meeting, you and your team will review the "Service Plan", or "Wraparound Plan", to monitor progress and make changes if necessary. This monthly review will include the following steps:
  - Review and celebrate your accomplishments (what has been working well);
  - Determine whether the plan is working to achieve your goals;
  - Adjust the areas of the plan that are not working; and
  - Assign additional tasks (if necessary) to team members.

Encourage input from family and service providers on setting goals, reviewing progress and planning. These areas will be included in Monthly Progress Reports that will be submitted to the Department of Health and Human Resources, the multidisciplinary team and the Court (if applicable). The family will also receive a copy of their report.

- **Transition:** Eventually, as the Child and Family Team develop the right mix of strategies, interventions and supports, the team will see goals being accomplished. When these goals are met and the team determines your family no longer needs the supports of the wraparound program, your family will be formally discharged from the program. With this in mind, the team will begin discharge planning during the initial meetings. Through brainstorming and discussion, the team will identify options that will help and support the family following discharge.

  During this transition phase, you will also begin discussing with your team after-care planning. After-care is a time to practice what has been discussed in your Child and Family Team Meetings and to continue the accomplishments and goals of the Individual Service Plan. Some of the wraparound supports will continue to be available, but the Wraparound Facilitator will gradually reduce their weekly contact, until they are no longer meeting with you. Once your family has begun the after-care portion of your wraparound plan, the Wraparound Facilitator will set up a schedule of a short series of calls to check in with the family, conduct brief surveys and follow-up on the child's/youth's progress.

PRINCIPALS OF WRAPAROUND

1. **Family voice and choice**. The family's point of view is heard by the team intentionally and prioritized during all phases of the process. Planning is grounded in family members' perspectives, and the team strives to provide options and choices such that the plan reflects family values and preferences.
2. **Team based**. The Wraparound Team consists of individuals agreed upon by the family and committed to them through informal, formal, and community support and service provider relationships.
3. **Natural supports**. The team actively seeks out and encourages the full participation of team members drawn from family members' choices and community relationships. The plan reflects activities and interventions that draw on sources for natural support.
4. **Collaboration**. Team members work cooperatively and share responsibility for developing, implementing, monitoring and evaluating a single Wraparound service plan. The plan reflects a blending of team members' perspectives, mandates and resources. The plan guides and coordinates each team members' work towards meeting the team's goals.
5. **Community-based.** Wraparound implements service and support strategies that take place in the most inclusive, most responsive, most accessible, and least restrictive settings possible; and that safely promote child and family integration into home and community life.
6. **Culturally competent.** Wraparound demonstrates respect for and builds on the values, preferences, beliefs, culture and identity of the child/youth and family, and their community.
7. **Individualized.** To achieve the goals laid out in the wraparound plan, the team develops and implements a customized set of strategies, supports and services.
8. **Strengths based.** The wraparound plan will identify, build on and enhance the capabilities, knowledge, skills and assets of the child and family, their community, and other team members.
9. **Persistence.** Despite challenges, the team will keep working toward the goals included in the wraparound plan until the team reaches agreement that a formal wraparound plan is no longer needed.
10. **Outcome based.** The team ties the goals and strategies of the wraparound plan to observable or measurable indicators of success, monitors progress in terms of these indicators and revises the plan accordingly.

COMMON TERMS

The following is a list of common terms and their meaning as used in Wraparound. You may see these terms included in forms or documents used in the process or hear them while participating with other team members in developing and monitoring the wraparound plan.

- **Action steps** – Statements that describe specific activities that will be undertaken, including who will do them and within what time frame.
- **Wraparound Facilitator** – A person trained to facilitate the Wraparound process for an individual family. This person also has the responsibility to educate the other team members on the significance of family voice and choice and how their own practice and behavior can create an environment where families feel safe using their voices and expressing their choices.
- **Formal supports** – Services and supports provided by professionals (or other individuals) who are "paid to care" under a structure of requirements for which there is oversight by state or federal agencies, national professional associations, or the general public arena.
- **Life domains** – Areas of daily activity critical to healthy growth and development of a child or successful functioning of a family. Life domains include such areas as safety, school/work, health, social/fun, a place to live, legal issues, culture, behaviors, emotions, transportation and finances.
- **Mission Statement** – A statement developed by the team that provides a one or two sentence summary of what the team is working toward with the youth and family.
- **Natural supports** – Individuals or organizations in the family's own community, kinship, social or spiritual networks, such as friends, extended family members, ministers, neighbors and so forth.
- **Outcomes** – Child, family or team goals stated in a way that can be observed and measured.
- **Wraparound Service Plan, WRAP plan or Plan of Care** – A document that describes the family, the team, and the work to be undertaken to meet the family's needs and achieve the family's long-term vision.
- **Strengths** – The assets, skills, capacities, actions, talents, potential and gifts in each family member, each team member, the family as a whole, and the community. In the Wraparound process, strengths help family members and others to handle life situations; thus, a goal for Wraparound is to promote these strengths and to use them to accomplish the goals in the team's service plan.
- **Vision** – A statement constructed by the youth and family (with help from their service coordinator or team) that describes how they wish things to be in the future, individually and as a family. "What are our family's goals? What do you want our future to look like?"

- **Wraparound Principles** – A set of 10 statements that defines the Wraparound philosophy and guides the activities of the process.
- **Wraparound** – A group of people – chosen with and by the family- connected to them through natural, community, and formal support relationships – who assist in developing and implementing the family's plan, address unmet needs, and work toward the family's vision.

CONFIDENTIALITY

It is important to understand the boundaries of confidentiality during the wraparound process. In general, information that is shared in team meetings will stay within the confines of the team. However, there are some exceptions to this confidentiality. If your family is involved in judicial proceedings, monthly summaries are required to be provided to the court to be made part of the permanent record. Monthly summaries will be provided to you and your family showing overviews of progress and continuing goals and plan objectives. Concern for the safety of children and requirements of State Law, requires two additional exceptions to the release of confidential information. First, as Mandated Reporters, professional providers are obligated to report any suspicion or knowledge that a child has been hurt, is in danger or is being hurt. Lastly, professional providers are obligated to report, under the Duty to Warn law, any specific plan to harm another person. Confidentiality is a valued and important part of the process and unless the information is required to be shared, it will not be.

CLIENT (CONSUMER) RIGHTS

As a consumer, you have the following rights:

- The right to refuse treatment.
- The right to receive services that do not discriminate based on race, religion, color, sex, sexual orientation, disability, age, national origin or marital status.
- The right to a humane treatment environment that promotes personal dignity and self-esteem and affords reasonable protection from harm, appropriate privacy, and freedom from verbal, sexual, psychological or physical abuse or punishment.
- The right to treatment and services under conditions that support your personal liberty and result in positive outcomes in the maximum extent possible.
- The right to confidentiality of records and information. Records may only be released with written consent of the client's guardian or parents.
- The right to an individual, written service plan to be developed after acceptance in order to gain the most benefit from services provided.
- The right to a grievance, orally or in writing, including the right to have such grievance considered in a fair, timely and impartial procedure and with respect.

PARENT AND/OR CAREGIVER RESPONSIBILITIES

Wraparound welcomes you to become involved in all parts of the Program. During or after your enrollment in Wraparound, you are encouraged to join in on different groups, meetings or activities. Some of the ways families can participate is to provide your feedback in surveys, focus groups and mutual help support groups. All of these give Wraparound very important information on improving our services to families and youth in West Virginia. Your input is highly valued and very important!

Here are a few tips that will make Wraparound successful for your family:

- Be open.
- Be honest with the team as well as with your child.
- If you do not understand, ask for clarification.
- Ask questions….lots of questions.
- Be respectful.
- Tell the team what has been tried in the past.
- Tell the team what you like and do not like.
- Keep the lines of communication open.
- Feel free to call the staff about good things that happen.
- Trust the team that has come together for you and your family.
- Ask about discharge plans.
- Tell the team how you resolve conflict. How do you resolve disagreements? How does your family discipline the youth?

YOUTH'S RESPONSIBLITIES

The purpose of the Wraparound process is to help the youth make positive life choices. Wraparound provides this support through a team created for you and by you. Some team members will be people who provide you and your family support, such as counselors and therapists. Others will be people you choose because you care about one another—for example, family members, a good friend or a favorite teacher. Team members support you as you figure out what is working in your life and what is not.

Together, you and your team create a plan based on your challenges, your dreams and your life. Your wraparound plan is unique to you and your situation. While no two plans look alike, youth seem to want the same thing: to feel loved and safe in their families, friendships and communities. They want to find ways to express themselves to others. Wraparound can help with that.

There is no getting around the age thing: if you are under 18, adults have legal responsibility for your decisions. With that said, the point of Wraparound is to involve you as much as possible in choices that affect your life. For example, in Wraparound you will:

- Help pick your support team.

- Create your plan with input from all team members—not just the therapists, doctors, teachers and other professionals.
- Includes things you like to do, what activities and interests you have and to include those in your plan.

If you want to strengthen a relationship with someone in your family, your team will help you do that. If you have done something illegal or unsafe for you or others, you will have fewer choices. As your actions become safer, you will likely get more choices and make more decisions for yourself.

In order for the Wraparound to be successful, here are a few things you may want to keep in mind:

- Be open.
- Be honest with the team as well as your family.
- If you do not understand, ask for clarification.
- Ask questions….lots of questions.
- Tell the team what has been tried in the past.
- Tell the team what you like and do not like.
- Keep the lines of communication open.
- Feel free to call the staff about good things that happen.
- Trust the team that has come together for you and your family.
- Ask about discharge plans.
- You are the most important part of the team.
- Do be afraid to tell someone if the plan is not working or you would like to change something.
- Be respectful.

FAMILIES RESPONSIBILITIES

Families also have a responsibility to their child, but also play a vital role in the success Wraparound.

The following is a brief list of what the Wraparound expects from the families:

- Be honest.
- Do not agree if you are not willing and able to follow through.
- Keep the communication lines open.
- Do not be afraid to tell someone if the plan is not working or you would like to change something.
- Be respectful.
- Ask questions for clarification as well as for understanding.
- Meet with the team on a regular basis (dates, places and times are agreed upon by the team with preference to the family's recommendations).

- Inform the team of all the accomplishments of the family.
- CELEBRATE the successes.

DOCUMENTS AND FORMS

As a family involved in the wraparound process, you can expect to see some of the following documents and forms as they proceed through the process.

Engagement and Team Preparation:

- Strength list or inventory
- List of potential family team members
- Form providing initial permission to provide services
- Release form(s) allowing the Wraparound Facilitator to speak with other team members

Initial Plan Development

- Plan of Care that includes Team Mission, most important needs, actions that detail who is responsible to follow through and when
- Written crisis plan that includes who will do what when things go wrong and who should be called in what order
- Schedule of future team meetings
- Permission and release form(s) if new service providers are called
- Monthly Plan Reviews/Child and Family Team Meetings
- Team minutes that detail accomplishments, changes to plan and schedules of meetings
- Regular progress reports that reflect progress made from the original plan
- Updated release forms for team members especially if new ones are added
- Discharge Planning
- Transition plan that describes how ongoing services will be accessed if necessary
- Crisis plan that includes who will be contacted in the event of an emergency
- Follow-up phone numbers for all team members who might be contacted
- Formal discharge plan that describes strengths of the family, the interventions that were successful and those that were not
- The Discharge Summary
- After-Care and Tracking
- Schedule for short series of calls to check in with family
- Family Satisfaction Survey

SPECIAL REQUESTS

1. If you or a family member needs an interpreter, please ask Wraparound Facilitator to provide one for you.

2. If you or a family member has a specific disability, the Wraparound Facilitator will help you find the right person to help.

GRIEVANCE POLICY

Wraparound is committed to providing quality services to WV children and families. Feedback from referral agencies, parents and youth is used to improve and upgrade our programs. In addition, a grievance procedure is in place for addressing concerns, disagreements and complaints. Should a parent, youth, wraparound facilitator or other professional wish to file a grievance, they may contact their DHHR caseworker's supervisor.

ACKNOWLEDGEMENT

Information provided in this Handbook was adapted from The Wraparound Process User's Guide: a Handbook for Families, Portland, OR: National Wraparound Initiative, Research and Training Center on Family Support and Children's Mental Health, Portland State University (2006).

SAFE AT HOME WV WRAPAROUND
CHILD AND FAMILY TEAM MEETING AGENDA [SAMPLE]

I. Introductions
   a. Team Introductions
   b. Child and Family Team Meeting Facilitator highlight client and family strengths/introduce Team members by their strengths.

II. Facilitator explains purpose of the Child and Family Team Meeting and explains the general process

III. Facilitator reviews policies:
   a. Confidentiality Statement
   b. Authorizations
   c. Mandated reporting
   d. Ground rules agreed upon

IV. Strengths List and Community Resource Bank

V. Team Mission

VI. Story Boarding
   a. Introduce non-negotiable;
   b. Chart non-negotiable;
   c. List concerns;
   d. Transform concerns into Needs Statements;
   e. Develop Reactive and Proactive Crises Plans;
   f. Select strengths-based strategies for each targeted need. Ensure strengths are used to build upon in developing strategies;
   g. Each strategy should have a targeted outcome.

VII. Summarize Accomplishments-Evaluate Child and Family Team Meeting

VIII. Schedule next 3-4 Child and Family Team Meetings/Share contact information as needed.

Follow-up Child and Family Team Meetings

I. Introductions
II. What is going well? What is working? (youth, family, DHHR/PO, Wraparound Facilitator, Youth Coach, School)
III. Review strategy/outcome status-New identified needs/strengths?
IV. New/revised strategies, as needed
V. Asset Development Plan Reports-Wraparound Facilitator/Youth Coach
VI. Wraparound Facilitator update
VII. Evaluation of Team Meeting
VIII. Logistics- meeting times/day/location/snacks

Possible Team Decision Making Process

The following is an example of a possible team decision-making process. Any process you select needs to be taken to the team. The team needs to spend time discussing the process. They should adapt it to fit their needs. They should put the process in their own words.
This handout can be taken to the team to consider. It can be given out or mailed out prior to a meeting. Members should consider the following and bring their answers to the next meeting.

1. Please look over the decision making process below before the next meeting.
2. Would this process work for you?
3. How would you modify this process to better suit your needs?
4. How would you reword the process so that it reads the way you would like it to?
5. Are there elements to this process that you think are missing and that we should add?
6. Do you have another decision making process that you would rather use? If so, please bring it to the next meeting.
7. At the next meeting we will establish our process for team decision making.

Decision Making Process

1. We agree that no decisions will be made outside of the team meeting.
2. If a decision must be made before we can meet, we agree to be contacted by the Wraparound Facilitator who will bring everyone up to date on the status of the decision.
3. Any decision made, by contacting all members outside of the group, will be reviewed at the next meeting.
4. Team members will take turns expressing their thoughts, concerns, and solutions regarding any decisions to be made.
5. If the decision is regarding a systems issue, perhaps more information is required.
6. In any decision, the family opinion carries the most weight.
7. After a thorough discussion, a vote is taken regarding the decision. Extra weight will be given to the parents' vote.
8. We agree that we will attempt to create win/win solutions for our team.

Possible Conflict Resolution Process

The following is an example of a possible team issue-resolving process. Any process you select needs to be taken to the team. The team needs to spend time discussing the process. They should adapt it to fit their needs. They should put the process in their own words.
This handout can be taken to the team to consider. It can be given out or mailed out prior to a meeting. Members should consider the following and bring their answers to the next meeting.

1. Please look over the issue-resolving process below before the next meeting.
2. Would this process work for you?
3. How would you modify this process to better suit your needs?
4. How would you reword the process so that it reads the way you would like it to?
5. Are there elements to this process that you think are missing and that we should add?
6. Do you have another issue-resolving process that you would rather use? If so, please bring it to the next meeting.
7. At the next meeting we will establish our process for resolving issues.

Issue-Resolving Steps

1. We agree to say that we feel there is an issue and we would like to use the issue-resolving steps.
2. If unable to say it in a child and family team meeting, we will present the issue to the Wraparound Facilitator.
3. If not presented at the meeting, the Wraparound Facilitator will contact all team members with the issue, and set a meeting time to carry out the issue-resolving process.
4. Everyone commits to writing out what their concerns are, regarding the issue, and to come to the meeting with a list of possible solutions.
5. At the meeting, the Wraparound Facilitator will list the concerns and possible solutions on flip chart paper for all to see.
6. Team members will take turns expressing their concerns and why they think the solutions they have brought will work.
7. If it is a systems issue, perhaps more information is required.
8. If it is just a difference of opinion, the family opinion carries more weight.
9. After a thorough discussion, a vote is taken regarding the solution. Extra weight will be given to the parents' vote.
10. We will attempt to create win/win solutions for our team.

Technique	Key Features	Best Application
Story Boarding	• maximizes group ownership of the process by having members actually write ideas on note cards which the Wraparound Facilitator puts on the wall • quicker process since the Wraparound Facilitator is not the only recorder in the group, it can take less time • ease of mobility since cards are easily transported and used for transcribing notes into a written plan • maximizes child and parents' voice by asking child and parents to record their ideas on cards • life domains are used as headings, but all are easily available when cross-domain ideas are generated	• communities which are fairly specific or behavioral in terms of their objectives for child and family outcomes • teams which are already committed to normalization and implementation of community-based options (the normalization or goal setting process built into story boarding is not as structured or explicit as that in bubble planning) • environments in which time commitments of team members are a primary concern or where an interim plan must be quickly developed (this process can be completed in a single meeting by an experienced Wraparound Facilitator)
Bubble Planning	• facilitates consensus building and buy in from the team as they work through and vote on each stage • clearly identifies family needs as the central focus and goal for the team's efforts • supports a variety of adult management strategies for an experienced Wraparound Facilitator, through changes in emphasis and by structured reinforcement of multiple suggestions	• communities in which comprehensive planning efforts are new, or in which the commitment to community-based options is wavering • teams with divisiveness about what should be done and why • teams building plans for children and families with highly complex (and possibly politicized) needs where it is important that the rationale behind every step is clearly identified
Clock Planning	• focuses group on the real time and life of the family • presents a very concrete picture of activities, commitments and potential conflicts • helps in normalizing family needs by addressing them in manageable increments	• families that are currently receiving a multitude of services, with real questions as to the actual benefits derived • families with several children who have varying schedules and needs • teams seeking to understand a family that has experienced a pattern of crises or disruptions that typically occur at certain times

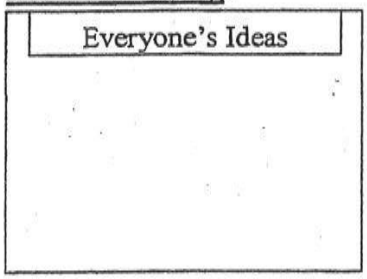
Comparison of Individualized Planning Techniques

Some Storyboarding Styles

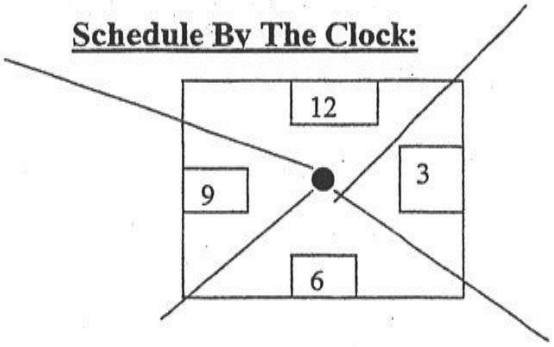
There are many ways to storyboard information. The most important thing about story boarding is that it puts everyone's thoughts out where all can see and plan together. It also takes the focus off of individuals and on to planning solutions.

Examples:

Brainstorming:



Schedule By The Clock:



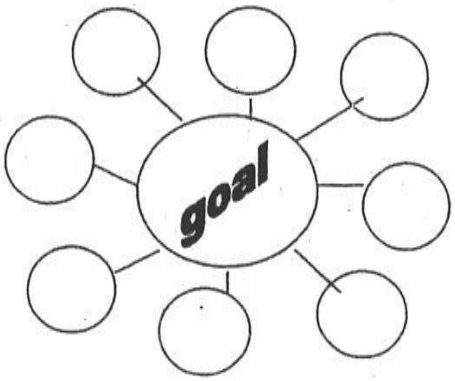
Developing A Plan:

Need	Who	What	When	Why/Strength

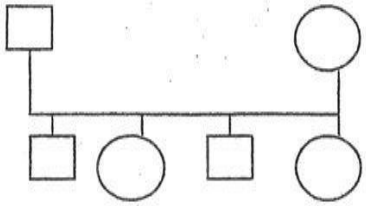
Schedule By The Calendar:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

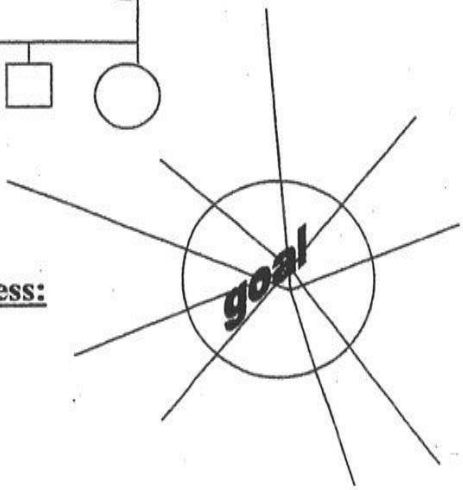
Bubble Diagram, Main Goal & Sub-Sets:



Traditional Genogram For Strengths:



Goal, With Possible Solutions or Concerns To Address:



Services versus Needs

Services are prescribed resources that can be applied to the general public, to treat the problems professionals see. In many cases services are not immediate and require a waiting period. Services are routine, they are not client specific and there is a defined way to provide them. Services help a professional to find ways for clients to complete tasks.

- Parenting
- Adult living skills
- Transportation
- Therapy
- Visitation
- Mentoring
- Assessment
- Treatment Planning
- Tutoring
- Job Coaching

Needs are client focused and individualized. These are the basic necessities that a person has to have. They are the things that have to be addressed immediately to avoid crisis and allow the client to begin working on other issues. Meeting needs is not routine work. It requires action, collaboration and willingness for out of the box thinking. Meeting needs ensures a client's physical and emotional survival.

- Food
- Water
- Shelter
- Heat
- Health
- Safety
- Security
- Connection with others

One of the most important skills to have in facilitating child and family teams is to understand the difference between *needs* and *services*.

Needs describe what it will take for the family to achieve their family vision…their long-term goal. *Needs* are also based on the life domains (family, safety, legal, mental health, educational/vocational, recreational, medical, spiritual/religious, cultural, housing, financial, transitional planning). *Services* are a type of strategy to meet a need.

One of the most common mistakes made when implementing wraparound is jumping immediately to services. It is most commonly seen in statements such as, *the child "needs" a mentor* or *the family "needs" therapy.*

There are other examples of services that are commonly identified as, "needs". Some of the other ones are medication monitoring, residential treatment, behavioral assistance, tutoring, hospitalization, partial hospitalization and psychological/psychiatric evaluations. **None of these are needs. *They are all strategies to meet needs.***

When needs are confused with services (and it will happen), keep in mind that a step has been skipped. We are already identifying strategies before the underlying need has been established. We are missing, "why" the service is, "needed".

In order to get a true need statement, take the service that has been suggested and plug it in to any or all of the following questions.

- What is it you hope to get out of _____?
- How will _____ help you?
- What type of concerns do you want _____ to address?
- What does the child/family need help with, that _____ will address?

By answering these questions, you will have a better understanding of what the underlying need is. In one of the previous examples, perhaps the, "need" for a mentor reflected an underlying need for the child to have access to safe recreational activities in the community. Now when the team is searching for strategies, it does not have to limit itself to just looking for a mentor. The team can go back to the strengths list to brainstorm a number of different natural, normalized, strategies to meet the underlying need.

Be careful with the following phrases. They do not identify specific services but also do not provide very much detail as far as what the need is.

- **The youth needs a role model**.
  The use of the phrase, "role model" is often another way of saying the youth "needs a mentor". Plug, "role model" into the questions listed on the previous page. The answers should give you a better understanding of the underlying need.
- **The child needs someone to talk to about her feelings.**
  The first concern with this statement is that it is generally code for saying the child needs therapy, and it has been previously established, therapy is not a need. The second concern with this statement is that it makes a very big assumption. The assumption is that by getting things, "off their chest" and talking about feelings, kids will naturally feel better. That may be true for some youth, but not for all of them. Though well intentioned, placing an emphasis on talking about their feelings with vulnerable children with limited coping skills may end up making them feel much worse. In fact, for many types of effective therapy with kids (for example, art therapy and play therapy) talking is not the primary focus. If the, "need" to talk to someone is brought up, the team should have a thorough discussion to ensure that this truly reflects the individualized need of the youth.

Family Needs Scale

Carl J. Dunst, Carolyn S. Cooper, Janet C. Weeldreyer, Kathy D. Snyder and Joyce H. Chase

Name_____ Date_____

This scale asks you to indicate if you have a need for any type of help or assistance listed below. Please *circle* the response that best describes how you feel about needing help in those areas

1. Having money to buy necessities and pay bills	N/A	1	2	3	4	5
2. Budgeting money	N/A	1	2	3	4	5
3. Paying for special needs of my child	N/A	1	2	3	4	5
4. Saving money for the future	N/A	1	2	3	4	5
5. Having clean water to drink	N/A	1	2	3	4	5
6. Having food for two meals a day for my family	N/A	1	2	3	4	5
7. Having time to cook healthy meals for my family	N/A	1	2	3	4	5
8. Feeding my child	N/A	1	2	3	4	5
9. Getting a place to live	N/A	1	2	3	4	5
10. Having plumbing, lighting, heat	N/A	1	2	3	4	5
11. Getting furniture, clothes, toys	N/A	1	2	3	4	5
12. Completing chores, repairs, home improvement	N/A	1	2	3	4	5
13. Adapting my house for my child	N/A	1	2	3	4	5
14. Getting a job	N/A	1	2	3	4	5
15. Having a satisfying job	N/A	1	2	3	4	5
16. Planning for future job for my child	N/A	1	2	3	4	5
17. Getting where I need to go	N/A	1	2	3	4	5
18. Getting in touch with people I need to talk to	N/A	1	2	3	4	5
19. Transporting my child	N/A	1	2	3	4	5

20. Having special travel equipment for my child	N/A	1	2	3	4	5
21. Finding someone to talk to about my child	N/A	1	2	3	4	5
22. Having someone to talk to	N/A	1	2	3	4	5
23. Having medical and dental care for my family	N/A	1	2	3	4	5
24. Having time to take care of myself	N/A	1	2	3	4	5
25. Having emergency health care	N/A	1	2	3	4	5
26. Finding dental and medical care for my child	N/A	1	2	3	4	5
27. Planning for future health needs	N/A	1	2	3	4	5
28. Managing the daily needs of my child at home	N/A	1	2	3	4	5
29. Caring for my child during work hours	N/A	1	2	3	4	5
30. Having emergency child care	N/A	1	2	3	4	5
31. Getting respite care for my child	N/A	1	2	3	4	5
32. Finding care for my child in the future	N/A	1	2	3	4	5
33. Finding a school placement for my child	N/A	1	2	3	4	5
34. Getting equipment or therapy for my child	N/A	1	2	3	4	5
35. Having time to take my child to appointments	N/A	1	2	3	4	5
36. Exploring future educational options for my child	N/A	1	2	3	4	5
37. Expanding my education, skills, and interests	N/A	1	2	3	4	5
38. Doing things that I enjoy	N/A	1	2	3	4	5

39. Doing things with my family	N/A	1	2	3	4	5
40. Participation in parent groups or clubs	N/A	1	2	3	4	5
41. Traveling/vacationing with my child	N/A	1	2	3	4	5

Family Needs Scale Scoring Sheet

A. Enter the individual item score in the space provided.
B. Sum the scores down each column to obtain the subscale scores.
C. Sum the column totals from B and put total in C Total Scale Score.

A. Scale Items	Basic Resources	Specialized Care	Growth & Support	Financial	Future Concerns
1. Having money to buy necessities and pay bills					
2. Budgeting money					
3. Paying for special needs of my child					
4. Saving money for the future					
5. Having clean water to drink					
6. Having food for two meals for my family					
7. Having time to cook healthy meals for my family					
8. Feeding my child					
9. Getting a place to live					
10. Having plumbing, lighting, heat					
11. Getting furniture, clothes, toys					
12. Completing chores, repairs, home improvement					
13. Adapting my house for my child					
14. Getting a job					
15. Having a satisfying job					
16. Planning for future job for my child					
17. Getting where I need to go					
18. Getting in touch with people I need to talk to					
19. Transporting my child					

20. Having special travel equipment for my child					
21. Finding someone to talk to about my child					
22. Having someone to talk to					
23. Having medical and dental care for my family					
24. Having time to take care of myself					
25. Having emergency health care					
26. Finding special dental and medical care for my child					
27. Planning for future health needs					
28. Managing the daily needs of my child at home					
29. Caring for my child during work hours					
30. Having emergency child care					
31. Getting respite care for my child					
32. Finding care for my child in the future					
33. Finding a school placement for my child					
34. Getting equipment or therapy for my child					
35. Having time to take my child to appointments					
36. Exploring future educational options for my child					
37. Expanding my education, skills, and interests					
38. Doing things that I enjoy					
39. Doing things with my family					
40. Participation in parent groups or clubs					
41. Traveling/vacationing with my child					
B. Subscale Scores					

C. Total Scale Score		=		+		+		+		+

Inventory of Social Support

Carol M. Trivette and Carl J. Dunst

Name_____ Date_____

This scale asks about people and groups that may provide you with help and assistance. The scale is divided into two parts. Please read the instructions that go with each part before completing each section of the scale.

Listed below are different individuals and groups that people often have contact with face to face, in a group, or by telephone or e-mail. For each source listed, please indicate how often you have been in contact with each person or group during the *past month*. Please indicate any person or group with whom you have had contact not included on the list.

How frequently have you had contact with each of the following during the *past month*:	Not At All	Once or Twice	Up to 10 Times	Up to 20 Times	Almost Everyday
1. Spouse or Partner	1	2	3	4	5
2. My Children	1	2	3	4	5
3. My Parents	1	2	3	4	5
4. Spouse or Partner's Parents	1	2	3	4	5
5. My Sister/Brother	1	2	3	4	5
6. My Spouse or Partner's Sister/Brother	1	2	3	4	5
7. Other Relatives	1	2	3	4	5
8. Friends	1	2	3	4	5
9. Neighbors	1	2	3	4	5
10. Church Members/Minister	1	2	3	4	5
11. Co-Workers	1	2	3	4	5
12. Babysitter, Day Care, or School	1	2	3	4	5
13. Private Therapist for Child	1	2	3	4	5
14. Child/Family Doctors	1	2	3	4	5
15. Early Childhood Intervention Program	1	2	3	4	5
16. Health Department	1	2	3	4	5
17. Social Service Department	1	2	3	4	5
18. Other Agencies	1	2	3	4	5
19. _____	1	2	3	4	5
20. _____	1	2	3	4	5

Listed below are 12 different types of help and assistance that people sometimes need and 19 different people and groups who sometimes are asked for help and assistance. For each of the 12 types of help and assistance listed, please indicate which persons or groups you go to when you need these types of help. Indicate who provides you each type of help or assistance by *checking* the appropriate box for the person or group you ask for help.

Which person(s) and/or groups provide you help? or assistance with each of the following:	Myself	Spouse or Partner	My Children	My Parents	Spouse or Partner's Parents	Sister/ Brother	Spouse or Partners Sister/ Brother	Other Relatives	Friends
1. Who do you go to for help or to talk with?	☐	☐	☐	☐	☐	☐	☐	☐	☐
2. Who helps take care of your child?	☐	☐	☐	☐	☐	☐	☐	☐	☐
3. Who do you talk to when you have questions? about raising your child?	☐	☐	☐	☐	☐	☐	☐	☐	☐
4. Who loans you money when you need it?	☐	☐	☐	☐	☐	☐	☐	☐	☐
5. Who encourages or keeps you going when things get hard?	☐	☐	☐	☐	☐	☐	☐	☐	☐
6. Who accepts your child regardless of how (s)he behaves or acts?	☐	☐	☐	☐	☐	☐	☐	☐	☐
7. Who helps you with household chores?	☐	☐	☐	☐	☐	☐	☐	☐	☐
8. Who do you do things with to have fun, just relax, or joke around?	☐	☐	☐	☐	☐	☐	☐	☐	☐
9. Who takes the time to do things with your child?	☐	☐	☐	☐	☐	☐	☐	☐	☐
10. Who takes you and your child places when you need transportation?	☐	☐	☐	☐	☐	☐	☐	☐	☐
11. Who hassles with agencies and individuals when you feel you can't get what you need or want?	☐	☐	☐	☐	☐	☐	☐	☐	☐
12. Who helps you learn about services for your child and family?	☐	☐	☐	☐	☐	☐	☐	☐	☐

Which person or groups provides you help or assistance with each of the following:	Neighbors	Church Members/ Minister	Co-Workers	Babysitter, Day Care, or School	Private Therapist for Child	Child/ Family Doctors	Early Childhood Intervention Program	Health Dept.	Social Services Dept.	Other Agencies
1. Who do you go to for help or to talk with?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2. Who helps take care of your child?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3. Who do you talk to when you have questions about raising your child?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4. Who loans you money when you need it?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5. Who encourages or keeps you going when things get hard?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6. Who accepts your child regardless of how (s)he behaves or acts?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7. Who helps you with household chores?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8. Who do you do things with to have fun, just relax, or joke around?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9. Who takes the time to do things with your child?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
10. Who takes you and your child places when you need transportation?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
11. Who hassles with agencies and individuals when you feel you can't get what you need or want?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
12. Who helps you learn about services for your child and family?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Effective Crisis Planning

- plans anticipate a crisis based on past knowledge
- plan for the "worst case" scenario
- research past crisis for cause, best interventions and consequent behaviors
- clearly defined plans help teams function in difficult times
- see crisis as a process with a beginning, middle and end
- change plan based on "what works"
- build plans that "triage" for differing levels of intensity and severity of crisis
- build plans early with child and family team
- begin by asking the family, "what can go wrong with our plan?" as a first step
- always build in 24-hour response
- clearly define roles for team members including family and natural support people
- schedule a time for the team to assess the management of the crisis within two weeks of the event
- decide that no major decisions will be made until at least 72 hours after the crisis event

(Indiana Behavioral Health Choices, n.d.)

SAFE AT HOME WV WRAPAROUND SERVICE AGREEMENT TEMPLATE (OPTIONAL)

Between

_____

and

_____

for

(List service) & (List service)

This AGREEMENT made and entered into on _____ _____, 20__ by _____ and between _____ (hereinafter called "_____") and _____ (hereinafter called "_____")

WHEREAS, _____ agrees to provide contracted services to youth and families targeted by the WRAPAROUND Program.

WHEREAS, _____ has acquired funding and authorization to provide coordination of the WRAPAROUND model.

NOW, THEREFORE, in consideration of these mutual covenants and understanding set forth herein, the parties agree as follows:

I AGREE:

a. To assign a qualified professional and paraprofessional as mutually contracted and agreed upon the responsibility of delivering WRAPAROUND services associated with this agreement.

b. To fully document services delivered within twenty-four (24) hours of activity in confidential files as per national best practice standards.

c. Supervise the staff as per mandatory employment practices.

d. To assign credentialed staff.

e. To not attempt to hire, contract with, or solicit any _____ employee(s) assigned to this Agreement without written prior consent by _____ during the term of this Agreement and for at least one year after the termination hereof.

II _____ AGREES:

a. To provide _____.

b. To not attempt to hire, contract with, or solicit any _____ employee(s) assigned to this Agreement without written prior consent by _____ during the term of this Agreement and for at least one year after the termination hereof.

III BOTH PARTIES AGREE:

a. This Agreement is intended to comply with all applicable rules and regulations of all governmental, regulatory and accrediting authorities.

b. Agree to renegotiate, in good faith, any terms, conditions or provisions of this Agreement or any other relationship between _____ and _____ determined to be in contravention of any regulation, policy or law of any such authority.

c. Agree to comply with all applicable provisions Federal and State laws relating to maintaining and providing documents to governmental officials.

d. That an inability of the Collaborating Agency to provide Contracted Services for a period of 14 or more consecutive business days will void this agreement.

e. Agree to sign and abide by a Business Associate Agreement per HIPAA requirements that governs the privacy of all client records.

IV COMPENSATION:

_____ will be invoiced for and agrees to make payments to _____ as outlined in the Collaboration Agreement for the following services:

a. _____ at a rate of _____ with prior approval by Wraparound Local Coordinating Agency and as specified on client Wraparound Plan.

b. _____ at a rate of ____ per hour with prior approval by Wraparound Local Coordinating Agency and as specified on client Wraparound Plan as per designated frequency.

c. _____ at a rate of ____ per mile with prior approval by Wraparound Local Coordinating Agency and as specified on client Wraparound Plan as per designated frequency.

d. Invoices must be submitted by the 13th of the following month of documented services. Invoices must be broke down by contracted service and other Wraparound Plan approved expenditures.

e. _____ will make payment by the 30th of the following month in accordance with the provisions outlined in the Wraparound memorandum of agreement.

_____

_____, Executive Director Date

_____, Inc.

_____

_____, Executive Director Date

_____, Inc.

SAFE AT HOME WV WRAPAROUND

Flexible Funding/Discretionary Funds

I. POLICY

Discretionary or "flexible" funds are intended for the purchase of a service or commodity that is needed to meet a specific client need. ***These funds are only to be accessed after all other funding sources have been explored and exhausted***. The disbursement of those funds by a Wraparound Local Coordinating Agency must be directly related to achieving a specific need in the Wraparound Plan for the child or family enrolled in Wraparound.

II. PROCEDURE

1. Requests for the disbursement of discretionary/flexible funds should be anticipated in advance, if possible. The following categories should be used to identify specifically what the discretionary request is for.

    - Incentive Money
    - Clothes / Shoes
    - Classes / Books / Workshops
    - Miscellaneous
    - Memberships
    - Recreation
    - Transportation

2. Out-of-pocket type disbursements of less than $50.00 may be made by Wraparound Facilitator's and sub-contracted agencies to meet the Wraparound enrolled child's needs for a recreational activity or other need (*see #4 below regarding Receipts).*

3. Disbursements in excess of $50.00 must be made by check and should be made payable directly to the Vendor or to the family by the Wraparound Local Coordinating Agency (*see #4 below regarding Receipts).*

4. Receipts must be on file for most categories (see exclusion regarding Incentive Monies below). If a "Miscellaneous" fund is dispersed and the Wraparound Facilitator or subcontracted agency is unable to get a receipt, this must be documented in the client file in a note attached to the applicable month's progress summary. This should be filed under the Fiscal area.

Note: The absence of a Receipt should be a rarity when requesting monies under the miscellaneous code.

When using the category "Incentive Monies", there must be mention of what the monies are specifically being used for in the Wraparound plan and approved by the Wraparound Local Coordinating Agency. Receipts must be kept on file by the Local Coordinating Agency for verification/proof of purchase.

5. Wraparound Local Coordinating Agencies should not release discretionary funds unless such funds have been approved by the family team and documented in the Wraparound Plan.
6. Wraparound does not pay for increased residential or foster care per diems.
7. Wraparound Sub-Contracting Agencies will submit an Invoice monthly on an approved invoice form with receipts attached.
8. The goal is to help families find resources within the community to obtain necessary items and support.
9. The WVDHHR (and/or its designees) reserves the right to audit any discretionary expenditure at any time.

III. Implementation

Flexible funding is always meant to move the Family Team towards the goal of child and family empowerment. It empowers families and children to have the ability to navigate within their community and society in general in such a way as to meet their needs in a cost-effective manner. Often flexible funds are needed to initially jump-start a particular goal, which can later be taken over by natural or community resources.

The goals set by the Family Team are related to the various life domain areas, which include but are not limited to educational, recreational, social, family, cultural, spiritual and others. The purpose of Wraparound is that normative needs of the child and family are addressed in such a way as to empower the child and family. The intent is to increase their competency within the community with empowerment to access whatever they need, from strengths based perspective.

Flexible funding is used to carry the plan forward. The Local Coordinating Agency is the fiscal agent and will keep track of the funds expended by the team and shares this information with the family team on a regular basis. Expenditures that are made for movement toward a goal are implemented with the idea that the expense is temporary or one-time expense.

Examples

The Family Team meets and comes up with goals for each of the identified life domain areas. A need that becomes evident for Johnny is transportation. Johnny is from a low-income family that doesn't have money for "extras". Johnny is 16 but does not have a driver's license. In fact at this time he is not contemplating getting a license. He is depressed and sits at home. In the strength based conversation with Johnny the other family team members find out that Johnny is very interested in music. He would like to learn to play the guitar. The Family Team finds a guitar class for Johnny at the local Parks and Recreation program. However, the classes are right after school and with both parents working there is

no one available to give him a ride. After other resources are checked out and eliminated, flexible funds are used to purchase a bus pass for Johnny so that he can get to class. The Wraparound Facilitator accompanies him on the bus the first few times so that he can learn the route. Johnny's self-esteem rises because of his success in navigating the bus line and his ability to play guitar. Now Johnny might want to be able to purchase his own guitar and other things such as sheet music. The family team can work together to look at job opportunities. Perhaps there is a local businessman who can offer Johnny an apprenticeship that could lead to a job. With employment Johnny might start thinking that he would like to have a car or his own guitar.

In the above example, the expenditure of flexible funds to purchase the bus pass was a means to experience success by building on the youth's interests and achievements.

Johnny's parents are much more invested in the process. They feel heard. They know that they are respected members of the family team.

When accessing flexible funding, it is always important to first establish the need rather than a categorical service. In that way the Wraparound plan and budget information kept for the family team become the paper trail needed to demonstrate how the flexible funding is being used to carry out your wraparound process.

In Wraparound we strive to stabilize the living situation of the family so that the child will be successful living in the community. This frequently means that we will be dealing with multiple issues that may be impacting the family's life. This could include, for example, a substance-abusing sibling or a grandparent with special needs that is living with the family. Sometimes, in order to stabilize the situation for the child, we may be called upon to assist the family in accessing services and resources for other family members.

Our mission in Wraparound is to model how resources and supports are accessed. In this way, the family members will learn how to access natural and community resources themselves in the future when we are no longer with them.

When a need is determined, it is important to look at natural and community resources prior to having the direct Wraparound staff carry out the required action or need and prior to accessing flexible funding. A useful tool to aid in this process is the Customized Resource Bank developed by the family team and documented on the Wraparound Plan.

SAFE AT HOME WEST VIRGINIA WRAPAROUND
FLEXIBLE FUNDING/ DISCRETIONARY FUNDS REQUEST FORM

MUST attach copy of the signed Wraparound Plan which indicates the flexible/discretionary funds you have requested for the child.

Child's Name: _____ Caregiver Name & Address: _____

Phone: _____

Has this child been in out-of-state placement within the last 90 days? Yes or No

Category	Cost Per Unit/Item	# Requested	Total $ Requested	Provider Name & Address	Service Description
Incentive Money					
Clothes/Shoes					
Classes/books/workshops					
Miscellaneous List: _____ _____ _____					
Membership					
Recreation					
Transportation					

Does this youth have a current IEP? ___ yes ____ no

Total Requested: _____ **Dates of Service:** _____ **to** _____ ☐**Initial** ☐**Re-Authorization**

_____ _____ _____

Signature **Date** **Agency**

OFFICE USE ONLY

Choose One: One Time Check or Emergency Funding **For Check Distribution Send to:** Caretaker Vendor Provider

Invoice ☐ Approved ☐ Approved, Emergency 30 days only ☐ Denied_____

_____ _____

Authorized Signature **Date**

SAFE AT HOME WEST VIRGINIA WRAPAROUND
FLEXIBLE FUNDING/ DISCRETIONARY FUNDS DECISION LETTER

___/___/___

_____
_____
_____
_____

Dear _____

The Flexible Funding Fund Request for _____ is:

- Approved for the following:_____
  _____
  _____
  Beginning ___/___/___ and ending ___/___/___
- Denied because _____
- Pending until _____

Please schedule a Child & Family Team meeting, no later than, ___/___/___ , to discuss the Wraparound plan, continued need for services, and service requests for continued flexible funding.

Please contact _____ immediately if services are not or cannot be provided. Questions and/or concerns may be directed to my attention at (304)

Sincerely,

Wraparound Facilitator

CC: