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High Fidelity Wraparound 101 (Introduction)

Curriculum prepared by
Oklahoma Systems of Care
Children, Youth and Family Services



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Training Development

During 2004 and 2005, significant progress was made in defining quality Wraparound. This progress was accelerated by the work of the U.S. [National Wraparound Initiative](#)¹ (NWI) (Walker, J.S., 2004), which standardized the Wraparound process into principles and phases and activities.

This training was originally developed by the [Vroon VanDenBerg](#)² team. The adaptation of this training was completed by the Oklahoma Systems of Care State Staff, most recently with this 2010 version.

Commonly-Referenced Acronyms

Throughout this training, you will learn acronyms associated with Systems of Care. The following list will serve as a good reference as you participate in training, work with Systems of Care providers and assist families.

BHA.....	Behavioral Health Aide
CC	Care Coordinator
CT	Community Team
DRS	Department of Rehabilitation Services
FSP	Family Support Provider
IEP	Individualized Education Plan
NAMI	National Alliance for the Mentally Ill-OK
NWI	National Wraparound Initiative
OCCY.....	Oklahoma Commission on Children and Youth
ODMHSAS.....	Oklahoma Department of Mental Health & Substance Abuse Services
OFF	Oklahoma Federation of Families
OHCA.....	Oklahoma Health Care Authority
OJA	Office of Juvenile Affairs
OKDHS.....	Oklahoma Department of Human Services
OSOC	Oklahoma Systems of Care
PCBH.....	Partnership for Children’s Behavioral Health
SAMHSA	Substance Abuse and Mental Health Services Administration
SNCD.....	Strengths, Needs and Culture Discovery
SOC.....	System(s) of Care

¹ National Wraparound Initiative website: <http://www.rtc.pdx.edu/nwi/>

² Vroon VanDenBerg website: www.vroonVDB.com

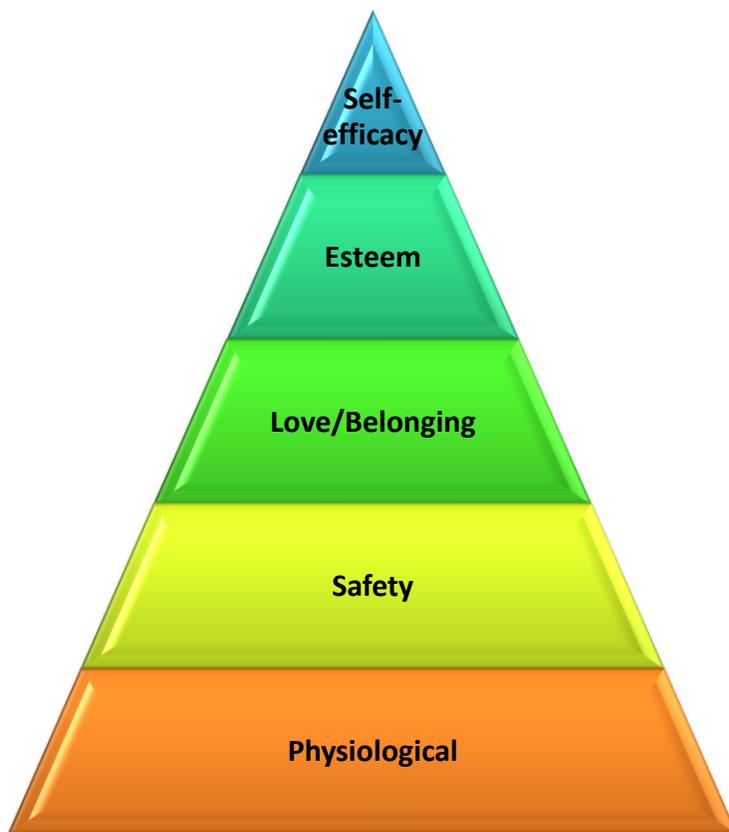
Theory of Change

A theory of change describes why something is expected to work. It begins by clearly stating what is being done and then why this impacts results. The theory of change for Wraparound tells us why Wraparound works and why it is different from other services and processes. It sets expectations for what we accomplish with families.

The theory of change is not just an academic exercise but should guide decision making by the CC/FSP/BHA as they implement the Wraparound process. The CC/FSP/BHA should continually ask:

- Have we identified and are we working on the needs that are most important to the family?
- How do my actions impact the ability of the family to get their own needs met?
- How do my actions support strengthening the natural support system for the youth and family?
- Are the plans for the family reasonable for them to implement?
- Is the process individualized for the family?

By continually asking these questions and individualizing the process, we will be more likely to have successful Wraparound.



Maslow's Hierarchy of Needs

The formal theoretical foundation of the Wraparound process builds from Maslow's (1970) hierarchy of needs, Bandura's (1977) theory of self-efficacy and Bronfenbrenner's (1979) theory of human ecology, and integration of plans, services and supports across the family. Simply put the theory of change is:

- meeting the basic needs and strengthening the social networks of children with severe mental health challenges and their families, and;
- enhancing their belief they can create a successful future or at least improved lives.

This will be further enhanced by integrating their services and supports into a single plan of action.

The first component of this theory is identifying the **needs** that are the most important to the youth and family. The second component is helping them to develop and strengthen the natural support networks that can help them meet their own needs. The third component is helping them to develop the skills and sustain them in the future. Families with complex needs often have multiple and competing plans and dozens of service providers and supports. Bringing these together into a single and simplified plan will greatly improve their prognosis of success.

The first component builds on Maslow's hierarchy of needs which is often depicted as a pyramid consisting of five levels. The four lower levels are grouped together as deficiency needs, while the top level is termed growth needs. The basic concept is that the higher needs in this hierarchy only come into focus once all the needs that are lower down in the pyramid are mainly or entirely satisfied. Once an individual has moved past a level, those needs will no longer be prioritized. However, if a lower set of needs is continually unmet for an extended period of time, the individual will temporarily re-prioritize those needs – dropping down to that level until those lower needs are reasonably satisfied again. The deficiency needs include:

Physiological needs (breathing, food, water, sex, sleep, homeostasis, excretion): are the basic needs of the organism to maintain life and consist mainly of food, shelter, and sleep. These physiological needs take the highest priority in motivation and when they are not met it will impact the person's ability to control thoughts and behaviors, and can cause people to feel sickness, pain, and discomfort.

Safety needs (security of: body, employment, resources, morality, the family, health, property): are the second level and describe issues of physical safety and security.

Love/Belonging/Social needs (friendship, family, sexual intimacy): After physiological and safety-needs are fulfilled, the third layer of human needs is social. This involves emotionally-based relationships in general, such as: friendship, sexual intimacy, having a supportive and communicative family.

Esteem needs (self-esteem, confidence, achievement, respect of others, respect by others): according to Maslow, all humans have a need to be respected, to have self-respect, and to respect others. People need to engage themselves in order to gain recognition and have an activity or activities that give the person a sense of contribution, to feel accepted and self-value, be it in a profession or hobby.

Self-efficacy/actualization (morality, creativity, spontaneity, problem solving, lack of prejudice, acceptance of facts): is the belief in one's capabilities to organize and execute the courses of action required to produce given attainments – in other words, a person's perception of their ability to reach a goal. People will be more inclined to take on a task if they believe they can succeed. People with high self-efficacy in a task are more likely to expend more effort, and persist longer, than those with low efficacy. Low self-efficacy can lead people to believe tasks are harder than they actually are. This often results in poor task planning, as well as increased stress. Observational evidence shows that people become erratic and unpredictable when engaging in a task in which they have low efficacy. On the other hand, people with high self efficacy often take a wider picture of a task in order to take the best route of action.

Self-Efficacy and Its Impact on Our Work with Families

The theory of Human Ecology (Bronfenbrenner, 1979), has had widespread influence on the way psychologists and other social scientists approach the study and treatment for human beings and their environments. The theory emphasizes the importance of social influences on human development and functioning. Children are influenced by their parents and the people who play important roles in their lives and in turn these people are influenced by the interrelations of their families, social networks, neighborhoods, communities and cultures. To the extent that parents have networks of family members and friends who share a commitment to the child, for example, parents' efforts to care for the child are enhanced. One of the central aspects of the theory is that the impact of the parent child relationship on outcomes for the child is directly related to the relationships the parent has had with others.

Systems of Care vs. Wraparound – What's the Difference?

Systems of Care (SOC) is a comprehensive spectrum of mental health and other support services that are organized into coordinated networks to meet the multiple and changing needs of children, youth and families. SOC's history in Oklahoma dates back to 1999. Here's a brief history:

1999	A group of upper & mid level administrators came together to plan for the 2000 application process. These agencies included: Oklahoma Commission on Children and Youth (OCCY), Department of Human Services (DHS), Oklahoma Health Care Authority (OHCA), Oklahoma Juvenile Authority (OJA), Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), National Alliance for the Mentally Ill-OK (NAMI-OK), and Department of Rehabilitation Services (DRS).
January 2000	Families, advocates, OCCY, DHS, ODMHSAS, OHCA, OJA, NAMI-OK, & DRS came together to form the Oklahoma Systems of Care (OSOC) State Team and fund one rural pilot and one urban pilot. Locations were based on the number of confirmed abuse & neglect cases, priority counties for OJA, number of children receiving special education services because of serious emotional disturbance and number of children hospitalized.
2000	ODMHSAS contracted with NAMI-OK to recruit family participation in OSOC and to conduct family outreach
November 2000	The first families were accepted into the OSOC program.
July 2001	Oklahoma Legislature appropriated \$196,000 for OSOC
2003	Oklahoma Legislature appropriated an additional one million dollars for the expansion of OSOC
December 2003	A delegation of all child-serving state agency directors or deputy directors, two state legislators and two family representatives attended the SAMHSA Policy Academy on developing local OSOC communities.
March 2004	The Partnership for Children's Behavioral Health (PCBH) was officially formed consisting of all the Directors of the child-serving agencies, Executive Directors of two child and family mental health advocacy organizations and three parents.
Fall 2004	OICA Fall Forum again selected funding for OSOC as one of its ten agenda items and was appropriated an additional one million dollars for the expansion of OSOC
February 2005	ODMHSAS contracted with the Evolution Foundation as the mentor agency for the new Oklahoma Federation of Families (OFF) for Youth and Children's Mental Health.
2006	The first SAMHSA federal grant activities were completed with the implementation of 36 local OSOC communities providing support to 41 counties.

October 2008	Oklahoma received a second SAMHSA federal grant to expand services to all 77 counties in Oklahoma by 2015.
January 2009	Children, Youth and Family Services support team was fully staff to support the maintenance of the existing communities as well as assist OFF with the development of new communities throughout the state.

Wraparound is a facilitated team-based process involving the child, youth, his/her family, and professional and natural supports who are involved. This process results in strengths-based individualized plans that lead to achieving positive outcomes.

The terms **Systems of Care** and **Wraparound** are often used interchangeably when in fact they are different. The Community Team is the bridge between Systems of Care and Wraparound services.

Oklahoma's System of Care

The Oklahoma System of Care consists of four major components:

1. Children, Youth and Families
2. Local Community Teams
3. State Systems of Care Team
4. National Technical Assistance



OSOC Key Principles

Family Driven

The system of care should be family driven, with the needs of the child and family dictating the types and mix of services provided. “Family driven” means that families have a primary decision-making role in the care of their children as well as in the policies and procedures governing care for all children in their community, state, tribe, territory and nation. This includes:

- Choosing supports, services and providers
- Setting goals
- Designing and implementing programs
- Monitoring outcomes
- Determining the effectiveness of all efforts to promote the mental and behavioral health of children and youth.

Youth Guided

The system of care should be youth guided. “Youth guided” means that youth are engaged as equal partners in creating systems change in policies and procedures at the individual, community, state and national levels.

Community Based

Each child or adolescent served within a system of care should have an individualized care plan developed by the family team, with leadership from the child’s parents or legally responsible adult, and the child or youth. The family team includes traditional service providers and non-traditional and informal supports. The individualized care plan refers to the procedures and activities that are appropriately scheduled and used to deliver services, treatments and supports to the child and the child’s family.

Needed services and informal supports should be available within the community, be accessible and be culturally and linguistically competent. Community-based services are enhanced by building partnerships with service systems and resources in the community and ensuring that management and decision-making responsibility are from community stakeholders.

Culturally & Linguistically Competent

The system of care should be culturally and linguistically competent with agencies, programs and services that are responsive to the cultural, racial and ethnic differences of the populations it serves. Cultural competence is the integration and transformation of knowledge, behaviors, attitudes and policies that enable policy makers, professionals, caregivers, communities, consumers and families to work effectively in cross-cultural situations. Cultural competence is a developmental process that evolves over an extended period of time.

OSOC Partnership with Oklahoma Federation of Families

[Oklahoma Federation of Families](#)³ (OFF) is a statewide family organization affiliated with the Federation of Families for Youth and Children’s Mental Health, dedicated exclusively to helping children with mental and behavioral health needs and their families achieve a better quality of life. The Oklahoma Federation of Families partners with the [Oklahoma Department of Mental Health and Substance Abuse Services](#)⁴ to provide technical assistance services to the OSOC sites throughout the state.



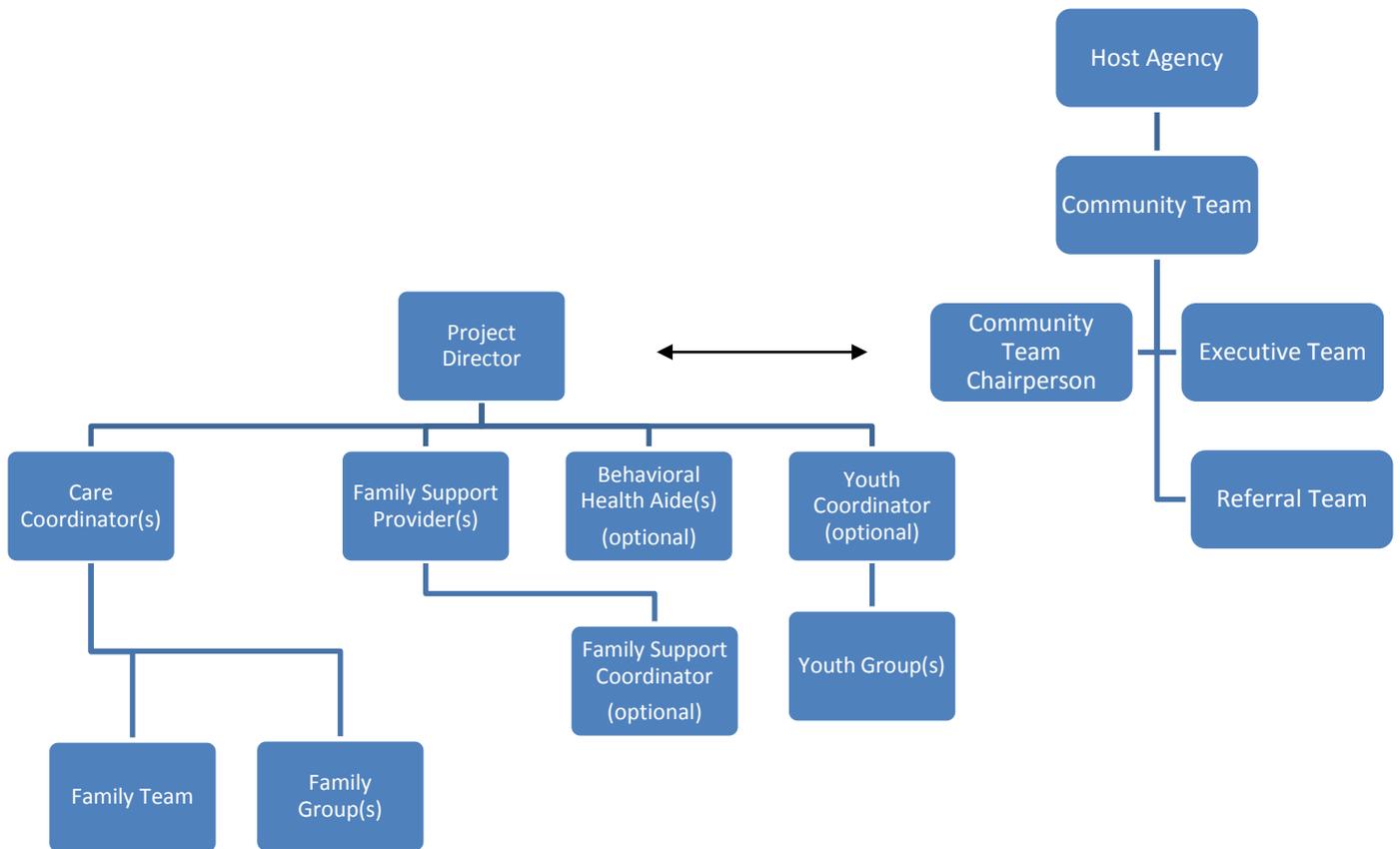
Notes

³ Oklahoma Federation of Families website: www.okfederation.org

⁴ ODMHSAS website: www.ok.gov/odmhsas

Community Team Structure and Development

OFF is a valued partner in helping communities establish local Systems of Care. An effective community team consists of key positions, each with its own set of skills and job responsibilities. A basic community team structure may look like the following:



Host Agency

This is the organization in a community that agrees to be the business partner in the arrangement. The Host Agency is often, but not always, the Community Mental Health Center serving that area. This Agency is responsible for receiving and distributing funds; providing physical support, such as office space; and administrative guidance. The Host Agency is the primary contact with ODMHSAS.

Project Director

This is the chief staff person responsible for implementing the Community Team plan on a day-to-day basis. The relationship between the Project Director and Community Team Chair is similar to that of the one between an agency executive director and an agency board president. While the Project Director may actually be on the payroll of the Host Agency, he or she takes direction from the Community Team. This can create awkward situations from time-to-time, especially if the Community Team and Host Agency are not on the same page, so the Project Director should be an expert at communication.

Community Team

This is the coalition of community agencies that drives OSOC's in a particular community. Core membership will normally be comprised of representatives from the Host Agency, OKDHS, ODMHSAS, OJA, local school system, families, mental health service providers, OSDH, etc. However, Community Teams (CT) are asked to use imagination in identifying and recruiting other parties, such as the United Way, private therapists, interested and influential business people, etc. The CT is the bridge between OSOC's and Wraparound. The CT's interest should extend beyond Wraparound. The CT's mission is to ensure that **every child** with mental illness or emotional disturbance receives the services required for success.

Community Team Chair

This is the individual elected by the CT to lead and facilitate the team. The major responsibility of this person is to ensure that the team has a plan and that the plan is followed. The CT Chair should have a close relationship with the Project Director, who will have the day-to-day responsibility of implementing the plan developed by the CT.

Executive Team

It is critical that each OSOC Community have a small group of dedicated volunteers made up of providers and family members that set the vision and overall direction for the local OSOC effort. This includes general governance and oversight of the Wraparound services as well as a sounding board for the local project director. The decision as to whether or not the Community Team is going to develop an Executive Team to address this need is optional. The Community Team may want to consider the use of an Executive Team for a variety of reasons, including:

- If the Community Team itself is a broad-based coalition with a variety of interests and a lengthy agenda, the host agency may wish to develop an Executive Team for the governance of the Wraparound Services component to address operational issues that would be of little concern to the larger coalition and to help set the direction of the larger OSOC vision. The Executive Team would then report out at the larger Community Team meeting.
- Even if the Community Team has a strong tilt toward Wraparound Services, it still might be advisable to have an Executive Team in place to advise the host agency on budgetary matters; and other sensitive issues that may arise.
- If the Community Team is small, perhaps less than dozen people, and addresses the needs described above, then it is quite possible that an Executive Team would be unnecessary.

Referral Team

This team is the subcommittee of the Community Team that has the responsibility of reviewing referrals for Wraparound Services and deciding whether or not those referrals meet selection criteria. In those cases where a referral may not meet criteria for Wraparound Services, the Referral Team has the responsibility for arranging a referral to another, more appropriate source within the local System of Care. The Referral Team's membership should be broad and include family representation. The **three levels of care** utilized by the referral team are discussed in more detail in the next section.

Care Coordinator (CC)

This staff person is assigned to a certain number of families to ensure that individual treatment plans are made and followed, that appropriate Family Teams are developed, and that the services needed are provided. While the CC works closely with the FSP, the main focus of the CC is on the Wraparound process, where the main focus of the FSP is on the families involved in that process. The CC reports to the Project Director.

Family Support Provider (FSP)

This is the staff person hired to provide intensive support to the families chosen to participate in Wraparound Services. Individuals selected for this position are often family members themselves of children with mental illness/emotional disturbance, and frequently are Wraparound graduates. The FSP reports to the Project Director and will normally serve as a member of the Family Team for each assigned family.

Behavioral Health Aide (BHA)

The Behavioral Health Aide (BHA) position is designed to work closely with existing Systems of Care staff who are providing Wraparound supports, including supervisors, CC's and FSP's. In addition, BHA may work under clinical supervision, working with behavioral health staff who are implementing treatment plans for children with behavioral needs and who are not enrolled in the Wraparound process.

Family Team

This team includes a group of agency representatives and supports — formal and informal — who come together to provide the Wraparound experience for a referred child and the child's family. Mandatory members of the Family Team include the family itself and agencies with which the child is currently involved. For example, if a child is in OKDHS custody and on probation for a law violation, both DHS and OJA would be mandatory members of the Family Team. Otherwise, the family has veto power over membership. Some Family Teams are quite large. They might include a football coach, the family minister, a Sheriff's Deputy, a family friend, a grandparent, an uncle, etc. Anyone with influence on the child should be included in the Family Team.

Family Team Facilitator

The Family Team Facilitator is the person designated to lead Family Team. This person may be a member of the family or someone designated by the family. This person has the responsibility for working with the CC and FSP in facilitating the Family Team meeting.

Family Group

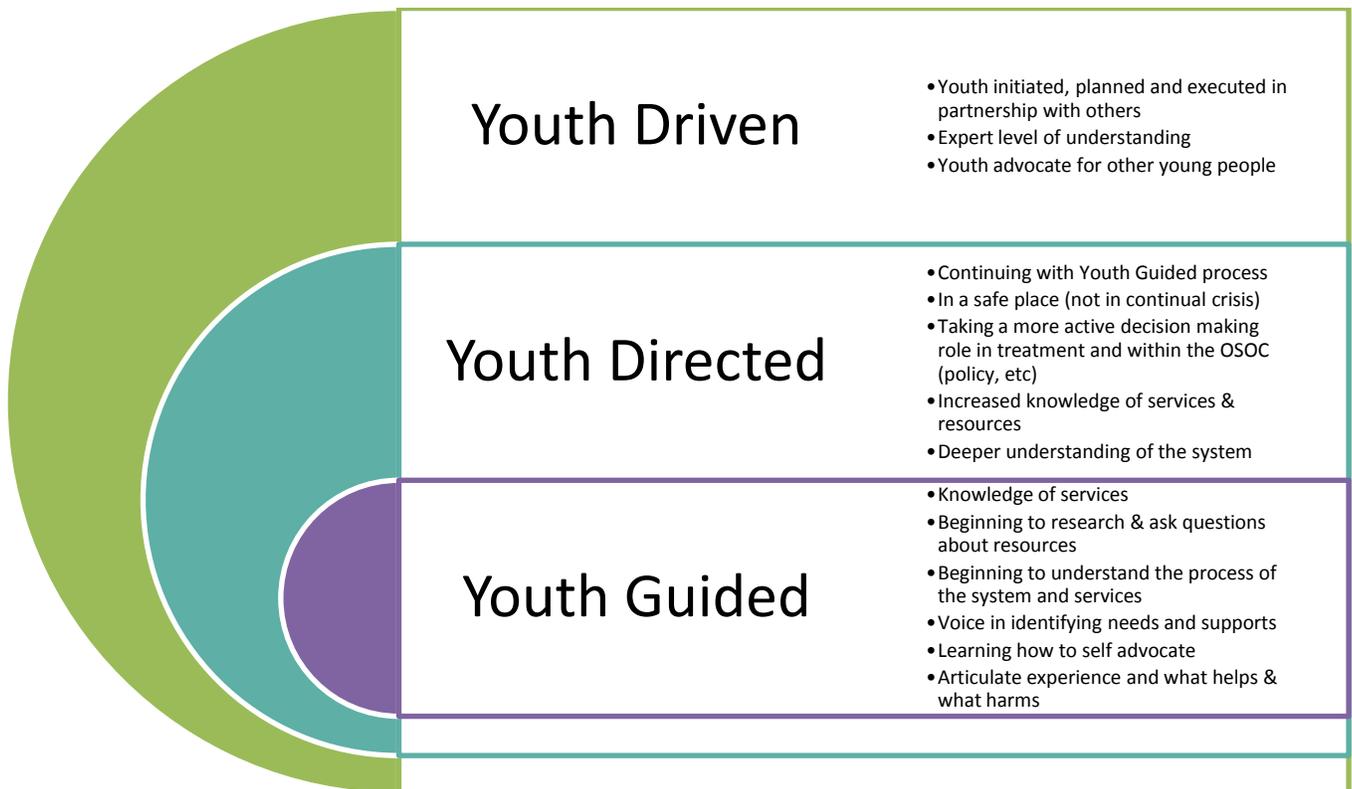
The purpose of a family group is to provide an independent family voice and insure the full involvement of the family during planning, implementation, management, delivery, and evaluation of the local system of care. The two keys to success are:

1. The group includes families whose children would be eligible to enroll in the OSOC.
2. The group must have the capacity to speak with an independent voice when it is representing families in grant communities and when making decisions.

Family groups have another very important purpose – to provide peer support. These groups are made up of people who have a common focus, meet on a regular basis, share feelings and concerns and work toward healthy solutions to problems.

Youth Group

The purpose of a youth group is to provide a safe environment for young people to come together, support each other and learn how to advocate for themselves. A successful youth group puts emphasis on youth guided, youth directed and youth driven with regards to the youth themselves, their community and policy making. Another level of the youth group is addressing the various needs of the children and youth receiving mental health services. One OSOC community may have 3-4 different groups serving various age groups. For example, child care for 7 and under age group, a group for the 8 to 12 year olds, a group for the 13 to 16 year olds and a group for transitional aged youth (ages 18-24) and young adults.



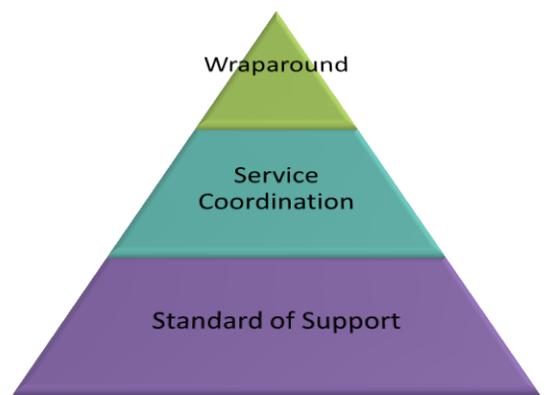
Three Levels of Care

The Referral Team is a subcommittee of the Community Team that has the responsibility of reviewing referrals for Wraparound services and deciding which level of care the family would benefit most from: 1) standard of support, 2) service coordination, and 3) Wraparound. In cases where a referral does not meet the criteria for Wraparound services, the Referral Team has the responsibility for arranging a referral to another, more appropriate source within the local community. The Referral Team's membership should be broad and include family representation.

Standard of Support

This level of care is available to any family in the community and as a resource for service providers. The Standard of Support is upheld by the community's Referral Team. It is their responsibility to brainstorm potential options for the family. Those options are then relayed back to the family. The Referral Team makes the appropriate referrals.

Family Example - Bruce's OJA worker has been unsuccessful in finding community resources to help him with his battle against addiction. His OJA worker notifies the family and his mother attends the referral team along with the worker. The entire referral team brainstorms potential options to help Bruce get the supports that he needs. They identified several additional support groups. A few of the support groups were even led by teens. They talked about some potential therapists that have been successful helping teens that suffer from addiction. The therapist from the CMHC offers to meet with Bruce's family and OJA worker in order to make the appropriate referrals.



Service Coordination

This next level of care is like "short term Wraparound". It is designed for families who have support and know how to utilize it. These families need help putting crisis plans in place and accessing resources. It is an intense process similar to Wraparound in the beginning. The short term is due to the family being capable of the implementation process.

Family Example - Bruce is currently in OJA custody and still having legal trouble. His parents need help accessing services for medication and additional intense therapy for his substance abuse. They would like a crisis plan put into place and need a reminder of their

families strengths by utilizing the Strengths, Needs and Cultural Discovery (SNCD). They feel fully capable of implementing the plan and accessing the resources (both community and natural) after the initial referrals are made.

Wraparound

Traditional Wraparound process is a way to help families with complex needs stay connected as a family and remain in the community. It is all about empowering the family to learn how to utilize natural supports and community resources to help them be successful. A few of the guiding principles include: family voice and choice, team based, individualized, and strengths based. The Wraparound process is driven completely by the family and their team of natural supports. They chose the goals they want to work on and how to move forward. Wraparound utilizes SNCD. This identifies the family's strengths and what they do well. It helps the Wraparound team understand the family's culture and embrace the culture to meet the needs of the family.

Family Example - Bruce has been hospitalized 30 days in the past year due to his serious emotional disturbance. He has recently been released back into the community but he is still in OJA custody due to prior legal trouble he encountered. His OJA worker requires him to complete anger management, individual counseling, and family counseling. He is in school and on an IEP. His IEP requires that he attend after school tutoring at least 3X per week to help him stay caught up in school. The family feels that they have burned all of their bridges and have no support. Wraparound will get all the professionals (OJA worker, therapist, anger management teacher, and school personnel) around the same table and prioritize the family's needs as the family sees fit. We will start to rebuild the bridges that have been burned and teach the family how to access support.

The Guiding Principles from the National Wraparound Initiative

Overview of the Wraparound Process, Principles and Steps

The Wraparound process is how we implement the system of care at the child and family level. It is based on common personal, community, and system values. It is a process that provides integration of all services and supports around a child, youth and family.

The Wraparound process is a way to improve the lives of children with complex needs and their families. It is not a program or a type of service. The process is used by communities to support children with complex needs and their families by developing individualized plans of care. The key characteristics of the process are that the plan is developed by a family centered team, is individualized based on the strengths and culture of the child and their family, and is driven by needs rather than services.

Oklahoma follows these guiding principles:

Family Driven: Family members are integral parts of the team and must have ownership of the plan. No planning sessions occur without the presence of the family.

Youth Guided: Youth are engaged as equal partners in creating systems change in policies and procedures at the individual, community, state and national levels.

Team Based: The actual individualized plan is developed by a Wraparound team that consists of the family, natural supports and formal supports that care about and know the child and family best. The team is selected by the family and typically has no more one-half of the membership consisting of professionals.

Natural Supports: The individualized plan is family-focused with maximum family involvement, with variation depending on the needs of the child and family. The process focuses on strengthening the supports for the family, extended family and social supports through involving them in the planning and implementation process.

Collaboration: All parties work as a team with the family. They design and implement one plan.

Community Based: When residential treatment or hospitalization is accessed, these service modalities are used as stabilization resources (and not as placements that operate outside of the plan).

Culturally & Linguistically Competent: Services and supports must be tailored to the unique culture of the child and family. Family culture refers to individual family race and ethnicity as well as family habits, preferences, beliefs, language, rituals, and dress. A culturally competent Wraparound staff identifies the family's culture and ensures that this principle is embedded in the Wraparound plan.

Individualized: Each child, youth, and family has an individualized plan. The plan may include services (such as therapy or day treatment) that other plans have included but when they do include these more typical services, the team always evaluates and understands why the service is a precise match for the unique needs of the child, youth, and/or family.

Strengths Based: The plan is based on the unique strengths, needs, values, norms, preferences, culture and vision of the child, family and community. By building on these strengths, the plan supports who the child is and how the child will positively progress in life. The plan is focused on typical needs in life domain areas that all persons (of like age, sex, culture) have. These life domains are: family, living situation, financial, educational, social, spiritual, recreational, behavioral, emotional, health, legal, cultural, safety, and others.

Unconditional Care: When things do not go well, the child and family are not "kicked out", but rather, the individualized services and supports are changed. Planning, services, and supports cut across traditional agency boundaries through multi-agency involvement and funding.

Outcome Based & Cost Responsible: Governments at regional and local levels work together with providers to improve services. Both system of care issues and issues of individual plans are considered. Outcome measures are identified and individual Wraparound plans are frequently evaluated. The collaborative funders of services agree to focus funding on efforts like Wraparound which have solid evidence for effectiveness.

Phases and Activities of Wraparound Practice

The **U.S. National Wraparound Initiative** has developed the concept of phases and activities of Wraparound practice to describe the overall tasks of the process.

Phase One: 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. This phase, particularly through the initial conversations about strengths, needs, culture, and vision, sets the tone for teamwork and team interactions that are consistent with the Wraparound principles. The activities of this phase should be completed relatively quickly so that the team can begin meeting and establish ownership of the process as quickly as possible. Key activities include:

- Orient the family to Wraparound
- Stabilize crises
- Facilitate conversations about strengths, needs, culture and vision of the family
- Engage other potential team members
- Make needed meeting arrangements

Phase Two: Initial Plan Development

During this phase, team trust and mutual respect are built while creating an initial plan of care using a high quality planning process that reflects the Wraparound principles. In particular, youth and family should feel: 1) that they are heard, 2) that the needs chosen are ones they want to work on, and 3) 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. Key activities include:

- Develop a plan of care
- Develop a detailed crisis/safety plan

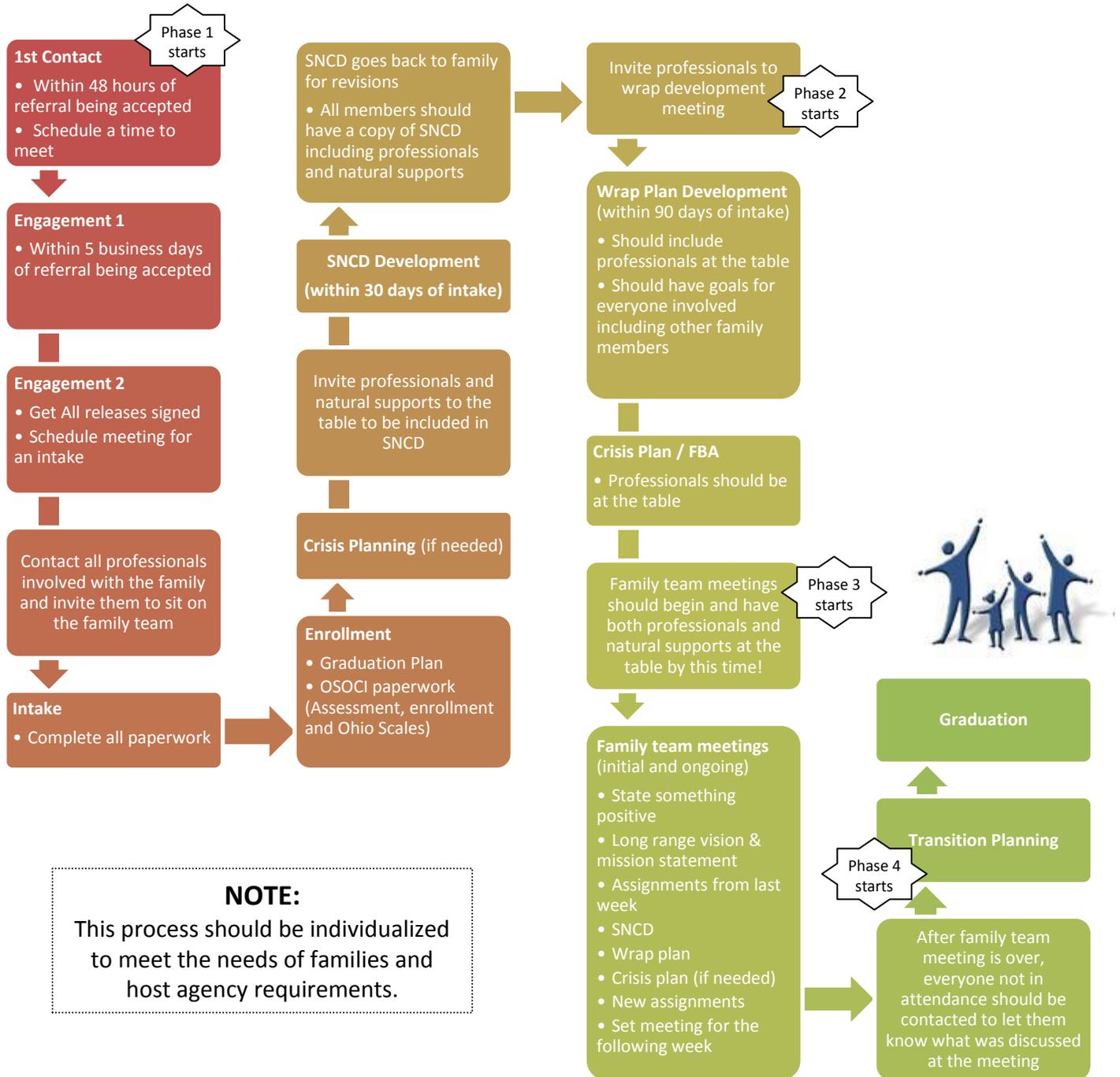
Phase Three: Implementation

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. Key activities include:

- Implement the plan
- Revisit and update the plan
- Maintain team cohesiveness and trust
- Complete documentation and handle logistics

Oklahoma's Wraparound Phases and Key Activities

Based on experiences with OSOC in Oklahoma since 2002, the following timeline describes in more detail the key activities that occur during these four phases.



What is a Care Coordinator?

A Care Coordinator (CC) is a person who ensures that the values and steps of the process are delivered with the highest possible fidelity to national best practices, while still allowing for local individualization of the process.

The CC is not just a neutral coordinator of services but someone who brings added value to the process by:

- Helping the family to develop a positive view of the future, through doing a strengths, needs and culture discovery.
- Teaching and supporting the family to learn and use skills to develop their own plans, access their own resources, and to be as independent as possible.
- Working with the family to build and strengthen their natural support network.
- Developing a partnership relationship with the family that helps them to address and work through challenges to make changes in their lives. This may include understanding developmental readiness and using “teachable moments” to surface issues that are important to helping the family reach their long range vision.

Characteristics of Effective CC's

- Outgoing personality that leads to engagement with others and trust
- Able to understand from another’s point of view and possess a diverse view of what families need to have better lives
- Effective communicator who utilizes appropriate skills (sense of humor, common sense, empathy, etc)
- Detail management and follow through
- Broad base of life experience just as important as academic learning or degrees
- Self-awareness (of potential “blind spots”)
- Understanding and experience with different systems, including schools, mental health, child welfare, juvenile justice, health, etc
- Knowledge of local community resources and able to engage resources when appropriate
- Ability to suspend our personal culture and judgment
- A keen interest in understanding others
- Willingness to share appropriate self-disclosure, when appropriate
- Know when to seek supervision and/or clinical input
- Mobilizes team to implement plan – doesn’t take on too much

What is a Family Support Provider?

A Family Support Provider (FSP) is designed to provide intense levels of direct support for families. FSP's are a distinctly different job than the CC's, but work closely with the CC to support positive outcomes for the family. In general, but not always, the FSP is a graduate of Wraparound, or is a family member of a person with complex emotional or medical needs.

Characteristics of Effective FSP's

- Often is a graduate of Wraparound or a family member of someone with complex needs.
- Provides direct support to families, especially to those without their own support networks while encouraging and coaching families to develop their own support system.
- Helps carry out significant aspects of plans, in the beginning stages.
- Familiar with CC roles and is comfortable performing CC-related skills, when needed.
- Acts as a role model, teacher and/or coach that the child and family team members can identify with (FSP should be listed as a service provider on the family's wrap plan).
- Able to share personal history when relevant to the situation.
- Able to accept constructive feedback and willing to work on personal development in order to improve effectiveness in position.
- Effective communicator who utilizes appropriate skills (sense of humor, common sense, empathy, etc).

What is a Behavioral Health Aide?

The BHA position is designed to work closely with existing Systems of Care staff who are providing Wraparound supports, including supervisors, CC's and FSP's.

Characteristics of Effective BHA's

- Interest in working with children
- Practical skills, including being able to work without continuous supervision
- Good professional boundaries
- Be able to understand and assess the culture of both agencies and families
- Diplomatic when helping families see the need for change
- Utilize basic conflict resolution skills
- Able to work with a team that is family driven
- Able to see that parents can be the experts with their own children
- Patient when change is slow at the family level
- Able to work a varied work schedule tailored to the needs of the family
- Able to keep confidential information private
- Has a strong belief that youth and families can change
- Able to look for strengths and needs in behavioral situations

What's the Difference: CC, FSP and BHA?

The following table represents the major differences and similarities between the roles of CC' and FSP:

Care Coordinator (CC)	Family Support Provider (FSP)	Behavioral Health Aide (BHA)
<ul style="list-style-type: none"> • Responsible to ensure all Phases and Activities of the Wraparound Process are done to high fidelity • Engagement through education • Crisis Stabilization Planning • Functional Assessment • Doing and writing Strengths Needs and Culture Discovery • Creating Team • Managing Planning • Writing Plan • Crisis and Safety Planning • Link to other systems and clinical support, including Behavioral Aides • Link to community resources • Link to other Wraparound CC's and line staff from other systems • Team maintenance over time • Transition Coordination • Track Graduates over time • Public contacts and education about Wraparound 	<ul style="list-style-type: none"> • Engagement through education and direct support • Helping carry out crisis stabilization • Modeling Strengths-based approaches and sharing experiences • Being team member as needed; temporary surrogate supports • Carrying out Plan Strategies • Link to natural supports and community resources • Direct support to Youth and Parents • Liaisons to School and others • Directly encouraging Family Voice • Participate in parent support groups • Support and encourage Graduates over time • Help Families with paperwork • Provide support in court • Model parenting skills • Public contacts and education about Wraparound 	<ul style="list-style-type: none"> • Overall engagement has already been done, the BHA focuses on their own engagement with the family. • May focus on behaviors behind the crisis – parental, child, and/or youth. • Is often a resource to the team rather than a team member. • Carries out plan strategies as they relate to problem behaviors • Works in-school in behavioral role only • Must be competent in functional assessment because they will be directly involved with creating and coaching the replacement behaviors. The result of the functional assessment will dictate the focus of their relationship with the family and youth.

Curriculum Exercise #1: Ensuring Your Personal Safety

Instructions:

1. Consider safety issues/concerns that you might be facing in this position.
2. Think about professional boundaries that may be compromised in the CC/FSP/BHA position.
3. Write a definition for the following words or statements:
 - Confidentiality:

 - Effective communication:

 - Personal Ethics:

 - Disclosing too much:

 - Chain of Command:

 - Time Management:

 - Professionalism:

 - Personal Safety:

Things to consider about overall safety when providing home based services:

**** Always follow host agency safety guidelines; these are suggested guidelines. ****

- Let someone know where you will be and how long you plan to be there
- Always carry a charged cell phone
- Know the general area of the home
- Park near a light source
- Avoid parking where your car could be blocked
- Take only necessary items into home
- Look and listen for others in the home
- Be aware of smells associated with substance use
- Know where the exits in the home are located
- Sit in hard chair rather than upholstered furniture

Credentialing

A credentialing process has been developed and implemented for CC's and coaches that work in a local Systems of Care community (FSP credentialing coming soon). This process is designed to ensure that we are providing families with the best possible services and to help our staff continue to increase skill level. CC's are expected to complete credentialing within 9 months of starting process.

The goals for this level of credentialing are for the staff to have acquired and demonstrated a conceptual framework of the Wraparound process and have practiced and demonstrated basic skills. This is accomplished by attending the following trainings in which the individual has completed in-class behavioral rehearsals at a satisfactory level. Requirements for credentialing:

- Complete Wraparound 101 (4 day training)
- Complete 2 Wraparound 401's (per year)
- Receive 2 hours of supervision/coaching per week (by local supervisor)
- Have a professional development plan (PDP)
- Demonstrate basic skills by using a standardized documentation review and observation forms

Coaching and Supervision

During this time there is an expectation that a supervisor or coach will provide in-vivo (watching the CC do Wraparound), will review documentation outlined on the following "Documentation forms", and will provide at least 3-5 hours of supervision a month. It is expected that the supervision, coaching and any plans developed for the CC will be documented using the "[Professional Development Planning Worksheet](#)".

Professional Development Planning

The supervisor will monitor the progress of the CC closely and set measurable objectives for improvement on a frequent basis with the assistance of the coach.

The priority goal during this period is improving the performance of the CC to meet minimum expectations for fidelity. For this reason, the focus of supervision during this period is on the basic skills of facilitation and any work related skills necessary to be successful (e.g., timeliness, agency reporting requirements, etc). This requires the supervisor and coach together to develop individualized plans for each CC that are reviewed through the weekly/monthly supervision/coaching sessions and updated as needed. A sample of such a plan that can be used as the basis for external coaching is included at the end of this section.

Certificate of Credentialing

Once the CC has completed all credential requirements, he/she will receive a certificate from ODMHSAS. Credentialed CC's must keep their certificates for future site reviews and audits. Staff are required to keep all certificates of attendance from Wraparound 101 and 401's for future site reviews and audits. Both state staff and local staff will maintain a list of CC's who are in the credentialing process.

Supervisor

Supervisors will work closely with the coach as they provide coaching and assisting in the professional development process. We recommend that all supervisors attend the Strengths Based Supervision Training.

** In sites where strengths-based supervision has been used, has seen positive outcomes which include, high fidelity Wraparound, staff retention and staff satisfaction.*

Credential Maintenance

Every 2 years, a state coach will:

- Review all the documentation using the SKILL SETS or satisfactory ratings.
- Attend 401 training series at least once PER YEAR (i.e. suicide, fire setting).

If a CC does not score satisfactory ratings (not yet determined), the coach will make necessary recommendations and review charts again in 3 months.

Credentialing Tools

The skill sets are introduced through the Wraparound 101 training and are the basis for goal setting and monitoring for Wraparound certification. Priority skills have been organized into ten tools to be used to assess staff performance. These tools are included later in this section. Four of these tools require:

- initial meeting with the family
- initial Wraparound team meeting
- implementation Wraparound meeting
- crisis plan meeting

The other six tools are document reviews of the:

- strengths, needs and cultural discovery;
- Wraparound plan;
- functional assessment;
- crisis plan and safety plans;
- implementation monitoring, and;
- transition plan.

What are Skill Sets?

Skill sets are clusters of skills that are crucial in carrying out the Phases and Activities of the Wraparound Process. These skills form the basis of high fidelity Wraparound. Supervisors utilize these skills to ensure that their staff is competent in the design and implementation of Wraparound.

It is important to remember that the skills are presented in sequence as separate skills. However, experienced CC's and FSP's are able to blend a cluster of skills into one interaction. The skills are broken down into detailed actions so that a coach or a supervisor can ensure that staff has each vital skill. It is important for staff to remember that the skills must be individualized based on family needs. OSOC teaches the skills in a set sequence that matches the National Wraparound Initiative Phases and Activities, but with the understanding that the need for individualization comes first.

Credentialing Tracking Sheet

The "Credentialing Tracking Form" is used to track progress towards credentialing goals. Each time a tool is scored, the score is listed on the tracking sheet. Scores that meet certification standards (90%) are circled. Once the CC has two circles for observational items and three for documentation items this requirement is met. This sheet gives an easy avenue for seeing progress towards meeting this requirement.

* List the Date of Completion and Initials of Family Reviewed

Tool	Success One	Success Two	Success Three
Initial Meeting			
Initial Family Team			
Follow-up Family Team			
SNCD			
Wrap Plan			
Functional Assessment			
Crisis Plan			
Progress Notes			
Transition Plan			

Online Forms Library

All CC Skill Sets may be found by going to the [ODMHSAS](#) website.



Observation Form One

Initial Meeting with Child and Family

Care Coordinator: _____ Site: _____
 Reviewer: _____ Date: _____
 Child ID # _____

Code **M** **Met**
 P **Partially Met**
 U **Unmet**
 DNA **Does Not Apply**

Standard	Rating	<i>Instructions for Person Role-Playing Comments</i>
1. CC introduces self and explains role.	M P U DNA	
2. The CC actively listens to the family and youth and to determine if Wraparound is a good option.	M P U DNA	
3. Staff describes Wraparound clearly in a way that the family understands.	M P U DNA	
4. Staff answers questions about Wraparound and helps the family make an informed decision about participation.	M P U DNA	
5. Staff explains confidentiality and information sharing and gets a release of information signed.	M P U DNA	
6. Staff informs the family about his/her responsibility as a mandatory reporter.	M P U DNA	
7. Staff identifies any immediate crisis situations.	M P U DNA	
8. Staff helps family determine if these need immediate intervention.	M P U DNA	
9. Staff conducts a brief conversational functional assessment that clarifies crisis situation.	M P U DNA	
10. Staff assists family to develop a crisis stabilization plan to meet the crisis situation identified.	M P U DNA	
11. Staff ensures that the family has the resources necessary to stabilize the crisis.	M P U DNA	

Record other comments on the back of the page or attach extra sheets. If using the back or extra sheets check here _____.



Observation Form Two

Initial Wraparound Meeting

Care Coordinator: _____ Site: _____
 Reviewer: _____ Date: _____
 Child ID # _____

Code **M** **Met**
 P **Partially Met**
 U **Unmet**
 DNA **Does Not Apply**

Standard	Rating	Comments
1. CC has prepared needed documents and materials prior to the meeting.	M P U DNA	
2. CC has made every possible effort to ensure all needed professional and natural supports participate on the team.	M P U DNA	
3. The CC assists the team to develop ground rules that maximize family and youth voice and choice and prevents blame.	M P U DNA	
4. The CC assists the team to develop a decision-making procedure that maximizes family voice and choice.	M P U DNA	
5. The CC leads the team in the review, discussion and addition to the SNCD.	M P U DNA	
6. The CC leads the team to consensus on their team mission and obtains commitment from all team members to the mission.	M P U DNA	
7. The team reviews, amends, and reach consensus on positively framed youth and family needs statements, that are in language anyone can understand, and do not suggest solutions.	M P U DNA	
8. The CC assists the team to reach consensus on the prioritization of the youth and family needs statements.	M P U DNA	
9. The prioritized needs relate to the team mission and concerns that lead to the youth and family's involvement in Wraparound.	M P U DNA	
10. The CC assists the team to develop methods for evaluating progress toward addressing concerns and meeting priority needs.	M P U DNA	
11. The CC leads a robust brainstorming process to develop multiple options to meet priority needs including: formal service and support options, strength-based options, and options that mobilize natural supports.	M P U DNA	
12. The CC assists the team select the options they believe are most likely to work with the family and youth making the final selections.	M P U DNA	
13. The CC ensures that action plans define who will do what, when, and how often.	M P U DNA	
14. The CC ensures all team members contribute and are active partners in the planning process.	M P U DNA	
15. The CC assists the team to consider if other individuals are needed on the team to implement the plan.	M P U DNA	

Record other comments on the back of the page or attach extra sheets. If using the back or extra sheets check here _____.



Observation Form Three

Implementation Wraparound Meeting

Care Coordinator: _____ Site: _____
 Reviewer: _____ Date: _____
 Child ID # _____

Code **M** **Met**
 P **Partially Met**
 U **Unmet**
 DNA **Does Not Apply**

Standard	Rating	Comments
1. The CC encourages team culture by celebrating successes since the last meeting.	M P U DNA	
2. The CC reviews completion of action steps and if necessary explores why action steps were not completed.	M P U DNA	
3. The CC assists the team to determine the services and supports in the action plan are meeting the priority needs.	M P U DNA	
4. The CC leads a discussion to evaluate if progress is being made toward the team's mission and reaffirm team commitment to the mission.	M P U DNA	
5. The CC checks in with team to identify new areas of need as they emerge or as objectives are met.	M P U DNA	
6. The CC leads a robust brainstorming process to develop needed options.	M P U DNA	
7. Options include natural supports and formal services as needed options.	M P U DNA	
8. Options are strength-based and based on youth and family strengths and culture.	M P U DNA	
9. The CC assists the team to select the options they believe are most likely to work with the family and youth making the final selections.	M P U DNA	
10. The CC ensures all team members contribute and are active partners in the planning process.	M P U DNA	
11. The CC creates and maintains team safety ("no blame, no shame")	M P U DNA	
12. The CC assesses team member satisfaction with the team process.	M P U DNA	

Record other comments on the back of the page or attach extra sheets. If using the back or extra sheets check here _____.



Observation Form Four

Crisis Plan Meeting

Care Coordinator (CC): _____ Site: _____
 Reviewer: _____ Date: _____
 Child ID # _____

Code **M** **Met**
 P **Partially Met**
 U **Unmet**
 DNA **Does Not Apply**

Standard	Rating	Comments
13. The CC completes a process to prioritize crisis or safety situations based on severity and likeness of occurrence.	M P U DNA	
14. The CC engaged the people who know the child, family and crisis/behavior situation best in the functional assessment and crisis plan process.	M P U DNA	
15. The CC reviews a functional assessment that begins with a brief, clear statement of the crisis behavior or situation as a basis for crisis planning.	M P U DNA	
16. The CC leads a discussion to discuss setting events and conditions that predict a potential crisis situation.	M P U DNA	
17. The CC leads a discussion of what happens during the crisis including who is involved and if other activities going on in the environment may make the situation better or worse.	M P U DNA	
18. The CC leads a discussion of what happens after the crisis that will help to define the functions of the behavior.	M P U DNA	
19. The CC leads a discussion of what has been tried in the past, how well it was implemented and how well it worked.	M P U DNA	
20. The team develops an educated guess about what benefits or functions the youth or other family member is getting from the crisis behavior or situation.	M P U DNA	
21. The team brainstorms multiple options for preventing and responding to the crisis behavior or situation.	M P U DNA	
22. The team develops action steps designed to prevent the crisis behavior or situation from happening by modifying what occurs before the crisis.	M P U DNA	
23. The plan includes signs or behaviors that indicate the crisis is beginning and ways to de-escalate it.	M P U DNA	
24. The plan includes a detailed and sequential set of action steps to be followed by the team if the predicted crisis behavior or situation occurs.	M P U DNA	

Record other comments on the back of the page or attach extra sheets. If using the back or extra sheets check here _____.



Documentation Form One

Strengths, Needs and Culture Discovery

Care Coordinator (CC): _____ Site: _____
 Reviewer: _____ Date: _____
 Child ID # _____

Code **M** **Met**
 P **Partially Met**
 U **Unmet**
 DNA **Does Not Apply**

Standard	Rating	Comments
1. There is evidence that core family members and primary caretakers have been engaged in doing the strengths, needs and culture discovery (SNCD).	M P U DNA	
2. The written discovery identifies the priority concerns of the youth and family, i.e., the one or two things the youth and/or family are most worried about.	M P U DNA	
3. The discovery identifies youth and family needs across life domains, i.e., what the youth and family feel they need help with.	M P U DNA	
4. The discovery identifies the priority needs the family and youth believe they need help with first.	M P U DNA	
5. The discovery identifies professionals working with the child and lists strengths, needs and/or concerns identified by them.	M P U DNA	
6. The discovery includes detailed examples of family and youth strengths that relate to the priority needs.	M P U DNA	
7. The discovery includes specific examples of family and youth culture, that relate to the priority needs.	M P U DNA	
8. The discovery lists and discusses extended family members, friends, and others who have in the past and/or who are currently providing needed support to the family and youth.	M P U DNA	
9. The SNCD has been reviewed with the family and youth and they have revised it as needed.	M P U DNA	
10. The SNCD includes the long range vision of the youth and family.	M P U DNA	
11. The SNCD includes a list of the people that have been selected by the child and family who will be on the child and family team.	M P U DNA	

Record other comments on the back of the page or attach extra sheets. If using the back or extra sheets check here _____.



Documentation Form Two

Wrap Plan

Care Coordinator (CC): _____ Site: _____
 Reviewer: _____ Date: _____
 Child ID # _____

Code **M** **Met**
 P **Partially Met**
 U **Unmet**
 DNA **Does Not Apply**

Standard	Rating	Comments
1. The SNCD or Wraparound plan shows strengths that were added through the initial Wraparound meeting.	M P U DNA	
2. The plan specifies the team's mission.	M P U DNA	
3. The Wraparound plan includes a list of needs statements of the youth and family. Need statements are positively framed, are written in language anyone can understand, and do not suggest solutions.	M P U DNA	
4. The Wraparound plan identifies the prioritized needs for the youth and family.	M P U DNA	
5. The prioritized needs logically relate to the team mission and priority concerns.	M P U DNA	
6. The plan specifies how progress toward addressing concerns and meeting priority needs will be evaluated and measured respectively.	M P U DNA	
7. The action plan component of the plan is based on family and youth strengths and culture.	M P U DNA	
8. The action plan specifies who will do what, how often, and when action steps should be completed.	M P U DNA	
9. The plan is a mix of natural supports and formal services.	M P U DNA	
10. All team members share in plan implementation.	M P U DNA	
11. The Wraparound plan documentation describes the frequency and schedule for meetings.	M P U DNA	

Record other comments on the back of the page or attach extra sheets. If using the back or extra sheets check here _____.



Documentation Form Three

Functional Assessment

Care Coordinator (CC): _____ Site: _____
 Reviewer: _____ Date: _____
 Child ID # _____

Code **M** **Met**
 P **Partially Met**
 U **Unmet**
 DNA **Does Not Apply**

Standard	Rating	Comments
1. Begins with a brief, clear statement of the crisis behavior or situation,	M P U DNA	
2. A detailed description of the frequency, intensity, and duration of the behavior or crisis situation.	M P U DNA	
3. Includes a description of the setting events or triggers that lead to the crisis behavior or situation.	M P U DNA	
4. A statement describing when the crisis behavior or situation does not occur.	M P U DNA	
5. Includes a description of things the person does (antecedent behaviors) that signal the crisis situation or behavior may be beginning.	M P U DNA	
6. A detailed description of who is involved and if other activities going on in the environment may make the situation better or worse.	M P U DNA	
7. A detailed description of what happens after (an as a result of) the crisis or behavior including actions taken or not taken by others, emotions or responses by others, and punishments or rewards given to the youth or other family member.	M P U DNA	
8. A detailed description of what the child or family member involved in the crisis or behavior does and feels after the behavior.	M P U DNA	
9. A description of what has been tried in the past, how well it was implemented and how well it worked.	M P U DNA	
10. An educated guess about what benefits or functions the youth or other family member is getting from the crisis behavior or situation.	M P U DNA	

Record other comments on the back of the page or attach extra sheets. If using the back or extra sheets check here _____.



Documentation Form Four

Crisis Plan

Care Coordinator (CC): _____ Site: _____
 Reviewer: _____ Date: _____
 Child ID # _____

Code **M** **Met**
 P **Partially Met**
 U **Unmet**
 DNA **Does Not Apply**

Standard	Rating	Comments
1. The Crisis Plan is based on a comprehensive functional assessment and begins with a brief, clear statement of the crisis behavior or situation.	M P U DNA	
2. The crisis plan includes specific goals that are measurable. (There is a method for evaluating the progress toward desired goals/outcomes).	M P U DNA	
3. The crisis plan lists the setting events or triggers that predict the crisis or behavior.	M P U DNA	
4. The plan that defines action steps related to the setting events or triggers designed to prevent the crisis behavior or situation from happening.	M P U DNA	
5. The plan identifies signs or behaviors that indicate the crisis is beginning.	M P U DNA	
6. The plan includes responses to the signs or behaviors that indicate a crisis is beginning to deescalate the situation before it becomes severe.	M P U DNA	
7. The plan provides a detailed and sequential set of action steps to be followed by the team if the predicted crisis behavior or situation does occur.	M P U DNA	
8. The action plan specifies sequential steps of who will do what, how often, and when action steps should be completed.	M P U DNA	
9. The plan is a mix of natural supports and formal services.	M P U DNA	
10. The crisis plan options are based on family and youth strengths and culture.	M P U DNA	

Record other comments on the back of the page or attach extra sheets. If using the back or extra sheets check here _____.



Documentation Form Five

Progress Notes

Care Coordinator (CC): _____ Site: _____
 Reviewer: _____ Date: _____
 Child ID # _____

Code **M** **Met**
 P **Partially Met**
 U **Unmet**
 DNA **Does Not Apply**

Standard	Rating	Comments
1. The CC has documented: monitoring of team members completion of assigned action steps.	M P U DNA	
2. Educating providers and other system and community representatives about the Wraparound process.	M P U DNA	
3. Assisting the family and youth to access necessary resources.	M P U DNA	
4. Identifying what support team members need so they can successfully complete their assigned task(s).	M P U DNA	
5. Evaluating progress toward the team's mission and reaffirm team commitment to the mission.	M P U DNA	
6. Brainstorming new options when current options are not resulting in adequate progress toward established goals.	M P U DNA	
7. Identifying new areas of need as they emerge or as objectives are met.	M P U DNA	
8. Revising the plan so it incorporates new options and action steps.	M P U DNA	
9. Monitoring revisions to the plan to ensure they continue to align with the team's mission.	M P U DNA	
10. Orienting, preparing and welcoming new team members to the Wraparound process.	M P U DNA	

Record other comments on the back of the page or attach extra sheets. If using the back or extra sheets check here _____.



Documentation Form Six

Transition Planning

Care Coordinator (CC): _____ Site: _____
 Reviewer: _____ Date: _____
 Child ID # _____

Code **M** **Met**
 MM **Mostly Met**
 MU **Mostly Unmet**
 U **Unmet**
 DNA **Does Not Apply**

Standard	Rating	Comments
1. Transition planning documentation identifies needs, services and supports that will continue to need attention past formal Wraparound.	M P U DNA	
2. The CC has gathered additional information about family and youth and team strengths and culture for use in the development of the transition plan.	M P U DNA	
3. A specific transition plan has been developed to meet continuing needs.	M P U DNA	
4. The CC has supported the team to develop and rehearse a plan for crisis management after formal Wraparound.	M P U DNA	
5. The CC has supported the family and youth to modify the Wraparound process for continuation after the CC is gone.	M P U DNA	
6. The CC has created has updated the SNCD to document that the strengths of the family, youth and team members.	M P U DNA	
7. The lessons learned from the Wraparound process.	M P U DNA	
8. Shows the achievement of team mission.	M P U DNA	
9. The CC has developed with the team a culturally appropriate commencement celebration.	M P U DNA	
10. The CC has designed procedures for checking in on the family and youth periodically after commencement.	M P U DNA	

Record other comments on the back of the page or attach extra sheets. If using the back or extra sheets check here _____

Professional Development Worksheet for Wraparound Credentialing

Supervisor _____ Coach _____
 Care Coordinator (CC) _____ Date ___ / ___ / ___ Date of next supervision ___ / ___ / ___

Accomplishments of CC in the past month (to be completed by CC and supervisor)

	Supervisor's Pre-coaching Assessment	Coaching Summary	CC's action steps for next time frame
Goal One: Area of Skill Sets:	Past Score:	Current Score:	
	Strengths:	Strengths:	
	To improve rating:	To improve rating:	
Goal Two: Area of Skill Sets:	Past Score:	Current Score:	
	Strengths:	Strengths:	
	To improve rating:	To improve rating:	

Areas of strengths and needed improvement outside the basic skill sets can be included as additional goals.

Curriculum Exercise #2: Large Group Polarity

Instructions:

Read the following "Family Overview".

1. As you read the overview, underline or highlight any information which "makes your antenna go up" in relationship to eventually obtaining positive outcomes with this family.
2. Look for needs, strengths, family issues or cultural information.
3. Look for similarities in this youth and situation to others you have experienced.

Things to consider:

- Based on your experience, how typical is Joaquin's situation?

- With 1 being the least complex and 10 the most, what rating of complexity would you give Joaquin's situation?

- What is missing from this family's situation that would make the situation more complex?

- As a human services or education professional, what particular challenges does Joaquin and his family represent?

Family Overview

Debbie is a 33 year old mother of two children, Susanna, age 8, and Joaquin, age 15. Susanna was taken into child welfare custody and placed in foster care about nine months ago. Joaquin has been in juvenile justice custody in a local detention center for over a year. He had received an indeterminate sentence for breaking and entering and marijuana use, fighting at a very aggressive and dangerous level, and until recently has had difficulty stabilizing in the detention center. With better behavior, he is due to be released in 30 days. Debbie is divorced from Susanna and Joaquin's father, Ernesto.

Ernesto has refused to participate in the child welfare case plan for Susanna or the development of the juvenile justice plan for Joaquin. He says he does not want to be the primary parent of the children since he is now living with his girlfriend, Flavia. Flavia and Ernesto are expecting a child of their own who is due in 6 months. Ernesto has maintained visits with Susanna since he and Debbie divorced, although the visits have become sporadic since she was placed in foster care. He has never visited Joaquin at the detention center, as he felt that Joaquin had violated his trust. Previous to Joaquin's incarceration, Ernesto and Joaquin were fairly close. Ernesto blames Debbie for most of the problems with the children.

Child welfare became involved with the family three years ago after a police report of domestic violence in the home. A neighbor, who made the 911 call, believed someone was being harmed when she heard shouting, cursing and screaming coming from the home of Ernesto and Debbie. The responding police officers found Ernesto and Debbie in a physical altercation and found Debbie to be the primary aggressor. She had bloodied Ernesto's nose and was wildly out of control. Though Ernesto refused to press charges, the officers were able to restore what they feared was a temporary peace by threatening to arrest Debbie for disturbing the peace.

The police officers were concerned about the safety of Susanna and Joaquin. They observed that the children seemed numbed to the domestic violence, and looked unkempt and listless. Based on these concerns, the officers made a report to child welfare who conducted an investigation. No child abuse was substantiated but the parents were referred to domestic violence counseling. Ernesto and Debbie choose not to pursue the counseling referral.

A few months later, child welfare received a child abuse report from Susanna's school teacher after Susanna arrived for school dirty, unfed, and with bruises. Child welfare investigated and determined that the children were not receiving adequate protection, supervision, or appropriate discipline. Joaquin was out late at night with older friends, and neither parent seemed to care or be concerned. There was suspicion that Ernesto and Debbie were abusing alcohol. The abuse report was substantiated and a family preservation team was dispatched. The family preservation team was involved with the family for three months with an emphasis on parenting education.

When family preservation terminated their involvement, the preservation team recommended that Debbie and Ernesto continue in outpatient therapy and that Ernesto seek treatment for alcoholism. Ernesto and Debbie choose not to make any further therapy appointments. Ernesto was of the opinion that they had had enough therapy and he preferred to have people out of his business. He stated that he was not an alcoholic and that he did not need treatment.

Grace, the child welfare worker, warned the parents that if they continued to fail to comply with the outpatient therapy element in their case plan, the court might order the removal of the children and their placement in foster care. Fearing the removal of her children, Debbie kicked Ernesto out of the home and followed through on the referral for individual therapy for herself and the children at the local mental health center. Ernesto and Debbie divorced shortly thereafter.

During this same time period, Debbie got a job as a stocker at a local grocery store and maintained steady employment over the next year. Grace and her supervisor thought sufficient progress had been made and that the situation was stable. The family's case was closed.

About six months later, another referral was made to child protective services by the school. This time the school reported that Susanna arrived at school dirty, hadn't been fed breakfast, and was showing increasing aggression toward her teacher and peers. In addition, child welfare checked with the school social worker at Joaquin's school and found that Joaquin was often truant and frequently in trouble over thefts from other children. Susanna told her teacher that she and her mother were fighting a lot at home and that sometimes "Mom sits on me 'til I settle down and it hurts me." Another investigation was conducted. Debbie told the child welfare investigator that Susanna had frequent tantrums that she couldn't manage, and that she had given up trying to control Joaquin. About this time, Joaquin was arrested for the third time for breaking and entering and possession of marijuana. The court placed him in detention for probation violations, including not completing his restitution even with the best efforts of his experienced probation officer, Robert. Child welfare initiated a dependency action on Susanna and placed her with a single foster mother, Delta Smith. The current case has been open with child welfare for approximately nine months.

Child welfare is hoping for family reunification but has a concurrent plan for a permanent guardianship of Susanna and Joaquin by Edith, Debbie's mother, or termination and adoption if there is not rapid and sustained progress toward the goals in the family case plan.

Debbie has been diagnosed with a Bipolar Disorder. In addition to her individual therapy, she has received medication management from a psychiatrist. Debbie has become increasingly inconsistent in keeping her individual therapy appointments and taking her medication. Without medication, her mood swings are extreme, and she is more likely to be loud, obnoxious, and sometimes violent. Her therapy attendance is better when she

stays on her medication. Debbie has participated in parenting classes and received instruction on housekeeping but changes do not hold over time.

Susanna has been diagnosed with Attention Deficit Hyperactivity Disorder and Oppositional Defiant Disorder. Educational testing revealed significant learning disabilities. Susanna's individual therapist is working on helping her to learn to control her frustrations and aggressive impulses. He is teaching her anger management techniques that she uses at the foster home and at school. Hopefully she will learn to use them in the home. Susanna is taking stimulant medication to help with impulsivity and concentration. She has been placed in a special education classroom for her learning disabilities and behavior problems.

Joaquin's probation officer, Robert, and Grace, the family child welfare worker, are reluctant to see Joaquin come back to the current home situation without quick remedial action by Debbie. They feel that Joaquin should be placed in a local group home after release from detention. Debbie wants Joaquin to come home but says that he must make some changes and "Toe the line 100%" or he will be sent to live with Ernesto. Ernesto has refused to let Joaquin live with he and Flavia. Joaquin says he wants to live with his mother.

Grace is afraid there may be an impending crisis. Yesterday, she and Debbie were making arrangements during a phone conversation for Debbie to visit for two hours this Saturday at the foster home during Susanna's birthday party. Debbie said she promised Susanna that she would take her out so she could choose a new bike as her birthday present. Grace told Debbie this would not be possible since her visits with Susanna are supervised by court order and that arrangements for off-site supervision could not be made on such short notice. Grace said Debbie became agitated, threatened to show up and take Susanna anyway "because I always keep my promises so nobody better try to stop me", and then abruptly hung up the phone. Grace has tried to reconnect with Debbie both at home and at her work number but has been unsuccessful. Unless the situation is defused, Grace is very concerned there may be a serious confrontation at the foster home and fears this would be harmful to the emotional well-being of her daughter.

The court has been putting increasing pressure on juvenile justice authorities to "get tough" with repeat offender juveniles. In recent years, the courts have been especially tough on young offenders who re-offend, show up in court, and have not done previously court ordered restitution. Robert, Joaquin's probation officer has been unable to get Joaquin to understand that if he re-offends after release from detention, he could easily end up sentenced to custody until he is 19 or 20 years old. Robert has worked with Joaquin to plan to do his court ordered restitution which had gone undone prior to Joaquin being incarcerated. Robert has said that talking to Joaquin is like talking to a wall. Robert's experience tells him that Joaquin is just giving "lip service" to doing the restitution and that once released, it will be like pulling teeth to get the restitution done. Robert's experience with similar youth tells him that there is at least a 75% chance that Joaquin will re-offend, and that with no restitution completed, even a minor violation of probation will result in a long sentence.

An Overview of Strengths, Needs and Culture Discovery (SNCD)

The strengths, needs, and culture discovery is a non-negotiable part of the process and is the most important activity in the Wraparound process. This document will be the foundation in which all other activities are based. We are going to build a Wraparound plan on the strengths, needs, and culture of the family. If we do not have extensive detail and information about strengths, needs, and culture of the family, we will not end up with a strengths-based, culturally competent plan that meets the true needs of the family.

Strengths, needs, culture discovery is both an event and an ongoing process. It is an ongoing process in that the CC/FSP will continue to discover family strengths and important aspects of family culture until the CC is no longer working directly with the family. Strengths, needs, culture discovery is an event in that it is a planned meeting(s) and information gathering process with the family, and others that know the family well and who care.

SNCD Objectives

There are four overall objectives of the strengths, needs, culture discovery interview:

1. Identify strengths, assets and resources that may help meet family needs for support.
2. Learn about and understand the culture of the family, so the eventual Wraparound plan “looks like” and “feels like” the family, i.e., is culturally and linguistically competent and therefore more likely to be a plan the youth and family will buy into and participate in.
3. Record child and family needs. Identify a long range vision. Ask about and set short term goals that are steps toward the vision. Needs are immediate areas of focus that are identified by the family to address the goals and long range vision. For example “I want Victoria to be at home, but I need to be able to manage her behavior.”
4. Identify potential formal and informal supports.

A superficial strengths discovery leaves the CC/FSP and child and family team with deficits in understanding of strengths and culture to develop a truly individualized plan, and therefore, a deficit-based plan. Deficit-based plans have likely already been tried without positive outcomes. A comprehensive strengths, needs, culture discovery will permit the plan to include strength-based options for meeting the needs of the family. Such a discovery supports a plan that is highly individualized. In other words, the plan is “one of a kind” and is designed to fit the unique needs of the family. Traditional service systems offer only available categorical services with little regard for the unique needs of the family.

The SNCD is an ongoing process that has a developmental pattern which includes:

- Engaging the family in the process of the SNCD
- Identifying other people who might participate in the process
- Gathering information across life domains on the strengths and culture of the family
- Developing a long range vision
- Identifying priority needs related to the long range vision
- Developing short term goals
- Developing a draft SNCD document
- Reviewing and revising the document with the family
- Using the SNCD to drive the stages of the child and family team process and the vision, goals and needs to be addressed
- Continually updating the SNCD as new information is identified and as conditions change

The SNCD conversation(s) generally takes between one and three hours and may be split between multiple meetings depending on the needs and availability of key family members and other individuals who provide the family with support. The conversation is conducted in a safe place of the family's choosing, at a time convenient to the family.

It is useful to encourage several family members and other individuals who know the child and family well to participate in the SNCD interview. Extended family members, friends and neighbors, and other natural supports may all be potential participants in the discovery process. It is always easier to engage individuals outside the immediate family early in the Wraparound process rather than later. However, the family has the final say in determining who to include in the SNCD interview.

The findings of SNCD are recorded in a narrative format usually not less than two typewritten pages in length. The CC/FSP provides the written discovery to the family for review at the next meeting. Families often have additional strengths they thought of since the conversation and would like to be added to the discovery. Families check the document for accuracy. We recommend that the written discovery be completed within three business days as the richness of the conversation is lost if there is a longer delay.

Common Pitfalls between CC/FSP and Families during SNCD

- Making the process an interview and not a 2-way conversation.
- Omitting needs the family is experiencing.
- Not developing a long range vision.
- Not identifying potential informal or formal supports.
- Not engaging all family members in the process.

Learning more Long Range Vision and Goals



Instructions:

Fill out the answers to the following two questions about long range vision and goals.

- A long range vision for me and/or my family is: (this can be any area of personal or work life), for example, "I want to complete my Master's degree."

- A short term goal that would help me move toward the long range vision is: ,for example, "I need to research schools with the degree program I am interested in, so I know the details of their program, the cost, and the application procedures."

Introduction to Life Domains

We can conceptualize the lives of the families according to universal areas of life called *life domains*. The life domain framework is a tool with multiple uses. Life domains can be used to facilitate the identification of areas of priority need for a child and family. A CC/FSP might show the family a list of life domains followed by a brief explanation of each area. Life domains may be used by the CC/FSP as a roadmap for the strengths and culture discovery process. Inquiring about strengths and culture in each life domain helps ensure that the discovery is comprehensive, i.e., all areas of life are explored. A list of life domains follows. It can be added to or modified to fit the culture of the family or community.

Residence: Where does the family live? What is the neighborhood like? Do the current living arrangements meet the family's needs?

Family: Who is in this family by their definition? Do all family members have appropriate access to each other? What do the members of the family need to stay together or in touch with each other? Are there serious, unmet needs for any family members that impair family functioning?

Social: Do family members have friends and access to their friends? Does this family have the opportunity to socialize with each other? Do individuals socialize outside the family? Do they have any fun? Do they have any way to relax?

Behavioral Emotional: Are any problem behaviors blocking a family member's chances of having a good life? Does the referred individual have any unmet needs in these areas? Do any other family members have unmet needs in this area? Are there unresolved issues that impede normal interactions within the family or in the community?

Educational/Vocational: What will it take to ensure a viable education for the children, particularly the identified client? Do older children have access to employment opportunities? For what sort of future are they being prepared? Are their rights intact?

Safety: Is everybody in the family safe? Are there dangers to individual family members? Is anybody potentially dangerous to themselves or to the community?

Legal: Are any family members involved in the judicial system, on probation or parole? Do they have representation? Are there issues around custody?

Health: Are healthcare needs met? Does the family have access to specialized medical services they may need?

Spiritual: Are you or is your family part of a faith community? Have you or your family ever been part of a faith community?

Transportation: Leisure, Recreation.

Other Possible Areas: Crisis intervention, Pets, Hunting, Cultural, Financial.

Curriculum Exercise #4

Life Domains



Instructions:

1. Consider the life domains above and identify the domains where you and/or your family have the greatest need.

- What is the need specifically? _____

- Why is it important? _____

- What would you need to have a better life in the domain areas you identified? _____

- What are going to be the hardest domains to address and why? _____

- Any good ideas to address specific domains? _____

Definition: Needs

Needs are defined by the youth and family since they are experiencing them. Needs can be elicited by asking the youth and family: “What do you need to have a better life?” However, if a youth is in the custody of the government, a caseworker or other representative of the government may define youth and family needs. Life domains may be used as a tool to categorize and discuss areas need of the youth and family.

Once a youth and family have identified an area of need, it is crucial to find out *why the need is important*. Two families may have the same need but in exploring the need more deeply it is revealed that they have similar needs for *entirely different reasons*. Understanding the “why” of the need will permit planning that is competent to the culture of the youth and family.

Definition: Family Culture

What is family culture? Culture is defined as a particular form of civilization, especially the beliefs, customs, arts, and institutions as a society at a given time. Family culture is the unique way that a family forms itself in terms of rules, roles, habits, activities, beliefs, and other areas. You should never assume a family is strongly tied to the cultural norms of their ethnic or racial group. Every family is different, every family has its own culture.

What is cultural competence in the area of Family Culture? As professionals, we are frequently asked to assist families. Because we do not learn the unique culture of a family, our interventions effectively ignore how this family operates. We are sometimes puzzled why the family does not respond to services, or why their buy-in or cooperation is low. Culture is about differences: legitimate, important differences. Cultural competence in the area of family culture occurs when we not only discover what the individual family culture of a family is, but we appreciate the cultural differences of the family. You may find that most people are not used to thinking about culture in terms other than race or ethnicity, and that family culture is a new term for them.

Definition: Natural Supports

Identifying, Developing and Engaging Natural Supports

One of the primary values of the Wraparound process is the identification and involvement of natural supports for the youth and family’s child and family team. Natural supports of the youth and family might include: extended family, friends, neighbors, or colleagues at work.

Many families may have either lost their natural supports or never had them in the first place. Families lose natural supports for many reasons: addiction, mental illness, family violence, relocation, etc. At times, certain family cultures focus on family independence and frown on outsiders, even if they are extended family. Many times, families will not trust the CC/FSP enough to let them know who friends and extended family are. In addition, due to shame or historical feud, families may be reluctant to share names of natural supports.

Brokers of Natural Supports and Resources

An important role of the CC/FSP/BHA is development of natural supports and resources. It will be from community development efforts of this type that surrogate supports are identified for participation on child and family teams when families are bereft of such supports. Natural systems may contribute “hard goods” such as clothing or a bicycle, or emergency financial support when youth and families have needs of such support.

The faith community is an important natural partner in supporting youth and families in the Wraparound process. The faith community brokers as much as 75-80% of the natural resources in most communities. There are many other natural system partners with whom relationships may be developed.

Common brokers of natural supports in communities include:

- Faith community
- Service clubs (Kiwanis, Elks, Masonic Temples, Optimists, Daughters of the American Revolution, etc.)
- Community centers and organizations (Jewish Community Centers, YMCA, Urban League, etc.)
- Veterans clubs or groups (Veterans of Foreign Wars, etc.)
- Business groups (professional organizations, chamber of commerce)
- Ethnic clubs (Italian club)
- Senior organizations and centers
- ...and dozens of others...

Natural Supports on Child and Family Teams: Questions and Answers

What if a family has no natural resources to be on the team?

It may be that a family has no local natural supports due to having recently moved. However, the vast majority of the time that a family says they have no one to be on the child and family team, what they are really saying is that they do not trust you enough to reveal who “their people” are. In these situations, the CC/FSP should be persistent in looking for natural resources while taking the time to build a relationship with the family.

What if the family prefers not to have natural supports on the team?

Start with their preference and comfort level. There are many legitimate reasons why a family may prefer not to have natural supports on their team, including privacy preferences and family culture. However, it is vital that the Wraparound staff work to inform the family that they are risking having no one left for support once the professionals on the team go away. Frequently, we revisit this issue with the family over the first few months of participation in the Wraparound process. This may (or will) address their concerns about having natural supports on the team and encourage broader team participation.

What if most of our families in the Wraparound process have no natural team members?

We have found that this situation indicates a need for supervisory level evaluation of staff training. It is typical that 10-15% of families may prefer not to have anyone else on their team except professionals. However, if it is substantially more than that percentage, there may be a need to address how families are being asked who will be on their team. We often find that staff may see inclusion of natural team members as secondary to other treatment issues (Remember, family, faith and friends are what humans use most to get through life crises!), or that staff are worried that the team will be too big or take too much time to manage.

Sequence of SNCD

A family SNCD interview consists of three parts: the introduction, information gathering and the closing.

The Introduction

During the introduction phase of the culture discovery, the facilitator explains the process of discovery and the rationale for doing this type of interview. This is the time to engage the family in the process. Describing what will be produced (you might show them a training example) and how it will be used to drive the planning process is often helpful. It's often useful to say as part of the rationale that all families have both strengths and needs, that previous helping persons have probably concentrated too much on needs (deficits), and therefore, the facilitator's first job is to discover the family's strengths so there is a balanced understanding of the family.

Information Gathering

During the information gathering phase of the strengths, needs and culture discovery, the facilitator begins by asking spontaneous questions about the strengths, preferences, culture, habits, traditions, and family rules, etc. Ideally, the interviewer avoids using a canned list of questions. However, new interviewers may find it useful to consult a list of potential questions as they go through the process. The interviewer asks a question, and then follows up the question with other queries based on the answer given.

For those facilitators with less experience, mastery may require a dozen or more interviews before the subtle aspects of the interviewing process are acquired. For individuals with less interviewing experience, coaching by an experienced CC/FSP/BHA will be especially important as a means of providing ongoing feedback.

Many families will find it difficult at first to focus on their strengths. This may be due to the fact they have been trained by previous helping persons to focus only on their deficits. Gentle redirection is required when the family or others move into deficits. Families eventually get "in the strengths groove" and enjoy discussing aspects of their life and relationships not frequently recognized. Once in a while, despite multiple redirects back to strengths, a family will stay stuck on deficits. In these instances, it is likely that insufficient time in deep listening was spent with the family during

engagement. One might say, “You know we were planning to discuss your family’s strengths today, but it seems more important that I listen to your concerns now. We can do the strengths discovery another time.” After sufficient engagement has been established, the SNCD is rescheduled.

The Closing

During the closing part of the interview, the facilitator thanks the participants, and reminds them that they will be asked to review the written narrative of the discovery after it is compiled. Set a time with the youth and family when they can review the written discovery. Finish the interview by discussing potential child and family team members who might be invited to participate in the next step of the Wraparound process.

Important Homework Assignment

Before the two days of onsite Wraparound training, each training participant needs to conduct a SNCD interview. You must conduct the interview with a real family. ***You must disguise the family in ways that completely hide their identity to protect confidentiality.*** The information from the interview must be written up in narrative form as shown in the example included on the next several pages. It should be at least two pages long. Detail is important. Bring two copies of your SNCD narrative with you when come to the training. You will be reviewing your SNCD in pairs.

Email Amy McAlister at amcalister@odmhsas.org and request the “SNCD Word Template” to receive an electronic copy of the SNCD template (for completion electronically in Word). Amy will email this template to you upon request.

Submission of Test Completion Document

Thank you for complete this online training course. Please send a copy of your test completion document to Lauren Merrell at least 3 working days prior to attending the onsite Wraparound training.

Lauren Merrell
lmerrell@odmhsas.org
Fax: 405-522-6809

Visit the ODMHSAS website to learn more about Children, Youth and Family Services.
http://www.ok.gov/odmhsas/Consumer_Services/Children,_Youth_and_Family_Services/index.html

Template for Homework: Strengths, Needs and Cultural Discovery

Child's Name: _____

Parent/Guardian's Name: _____

Date of Interview: _____

Date(s) of Update: _____

Referral Source: _____

Reason for Referral: _____

Person(s) Providing Information:

Name	Relationship

Long Range Vision: _____

Demographics: _____

Home/Housing: _____

Family: _____

Social: _____

Behavioral-Emotional: _____

Safety: _____

Legal: _____

Health: _____

Spiritual: _____

Financial/Economic: _____

Educational/Vocational: _____

Leisure/Recreational: _____

Other (e.g. pets, traditions, etc): _____

Priority Needs or Concerns of the Youth, Family and Professionals: _____

Current Team Members and Relationship to Child:

Name	Relationship to Child or Family (Type)

Signatures:

Parent/Guardian(s)

Date

Youth

Date

Family Member

Date

Family Member

Date

Family Member

Date

Care Coordinator

Date

Family Support Provider

Date