Developing Wraparound Levels of Care for 10 Clusters of Youth with Behavioral Health Issues

Presented At

NACM ANNUAL CONFERENCE
October 24-26, 2017, Omaha, NE

Presenters

- **Region V Systems--Professional Partners Program**
  - Renee' Dozier, MPA
  - Malcom Miles, BS
  - Annie Glenn, BS
  - Ashley McCracken, BA
  - LaShawnda Nimox, AAS
  - Jordan Holmes, BSW
- **Synthesis, Inc.**
  - Bill Rubin, MA

Background & Assumptions

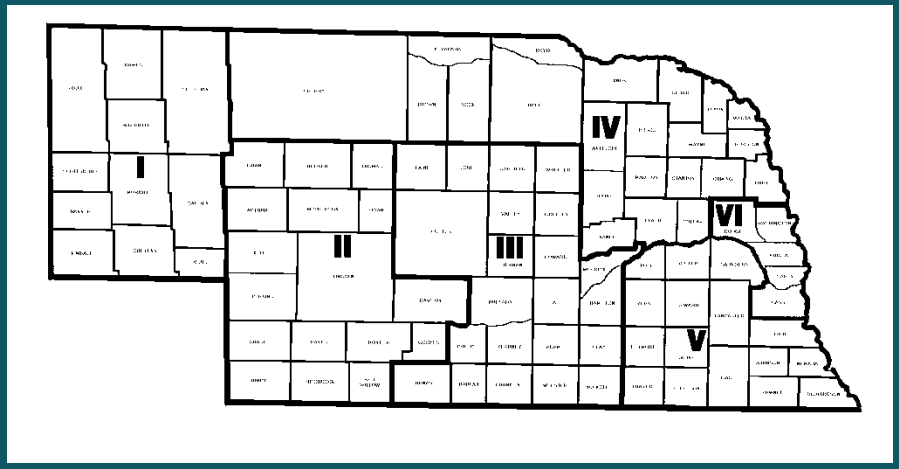
- Wraparound Services Are Key To Systems Of Care
- There Is Systematic Diversity Within The Larger SOC Population
- 10 Clusters of Youth with Behavioral Health Issues Have Been Identified
- Cluster Descriptions Can Be Used To Develop Targeted Wraparound Goals, Services, and Levels of Care

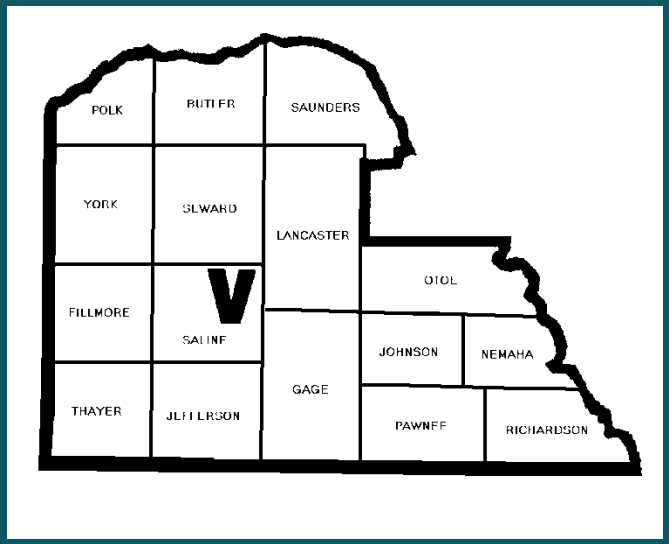
OUR PRESENTATION WILL

- Describe The Region V Professional Partners Program
- Provide An Overview of Cluster-Based Planning™ for Youth
- Describe The Steps in Identifying Goals, Services and Levels of Care for the 10 Youth Clusters
- Give Examples of the Cluster-based Level of Care Guidelines and Materials
- Describe the Plan for Staff Training and Implementation

AN OVERVIEW OF THE REGION V PROFESSIONAL PARTNERS PROGRAM

Region V Systems' Geographic Area





PROFESSIONAL PARTNER PROGRAM

- Family & Youth Investment Professional Partner Program utilizes a Wraparound approach to work with families with children who have a serious emotional disturbance (SED) and young adults diagnosed with a serious mental illness (SMI)

- FYI provides intensive *team facilitation* and *service coordination* to participants who are involved in multiple youth systems and young adults transitioning from the children's system of care.

- Wraparound teams are developed for the purpose of planning and support, with a balance of formal and informal supports.

- In the majority of cases, children/young adults can be effectively served in their communities and can often remain at home/live independently while receiving services.

WRAPAROUND PRINCIPLES

1. Individualized
2. Family Voice & Choice
3. Strengths Based
4. Culturally Competent
5. Team Based

WRAPAROUND PRINCIPLES

6. Outcome based
7. Natural Supports
8. Unconditional Care
9. Collaboration
10. Community Based

GOALS OF CLUSTER-BASED LEVEL OF CARE DEVELOPMENT PROCESS

TO BUILD A LEVEL OF CARE SYSTEM TO ADDRESS THE NEEDS OF YOUTH AND FAMILIES WITH DIFFERENT SHARED LIVED EXPERIENCES/CLUSTER HISTORIES

AN OVERVIEW OF CLUSTER-BASED PLANNING™ FOR YOUTH

DISCLOSURE STATEMENT

- Cluster Based Planning™ is a proprietary system developed by Synthesis, Inc., Columbus, Ohio.
- Cluster-based Planning™ is a registered trademark of Synthesis, Inc.
- William V. Rubin, MA is the founder and Owner of Synthesis.
- The Cluster-based Planning™ system and all associated materials are owned by Synthesis, Inc.
- Region V Systems has the right to use the system and materials developed with Synthesis within their organization and with their contract agencies.

THE BEHAVIORAL HEALTH LANDSCAPE
(The Policy Makers & Planners Current View)

AS PROVIDERS WE OFTEN ARE STANDING SO CLOSE THAT WE CANNOT SEE THE FOREST FOR THE TREES

WE NEED TO FIND A PLACE BETWEEN THE MOUNTAINTOP AND THE EDGE OF THE FOREST

WHAT IS A CLUSTER?

A Cluster Is A Subgroup Of A Larger Population In Need That Shares Common Problems, Strengths, Treatment Histories (or lack of service histories), Social or Environmental Contexts, and/or Life Situations.

HOW WERE CLUSTERS & OUTCOMES IDENTIFIED?

Step 1: Identifying Clusters

"Expert Knowledge Elicitation" Process Was Employed.

A Multi-agency Work Group Was Established.

Work Group Members Described Youth And Families That Were Similar and Who They Saw Relatively Frequently.

Draft Prose Cluster Descriptions Were Prepared.

Step 2: Validating and Enhancing the Drafts

- Work Group Reviewed Cluster Drafts for Validation and Enhancement
- **A Final Cluster Description Was Prepared.**
- The First Two Steps Were Repeated Until At Least 90% Of The Youth Seen Were Described.
- The Cluster Descriptions Incorporate The Language And Knowledge Of The Community's Experts.
- **Similar Clusters Were Found Across Several Replication Sites (Both Rural And Urban Settings).**

Step 3: Goals/Outcomes For Each Cluster

"Intention Analysis" (Taynor, Daugherty, Nelson 1990) Was Used.

The Members Of The Work Group Were Asked: *What Would You Like To Have Happen In The Lives Of Cluster Members? How Would You Know When It Happened*?

Behaviorally Anchored Outcome Measures Were Thus Developed.

The Goals Differed Consistently Across Sites By Cluster.

Clusters Of Youth In Need Of Systems of Care

Cluster 1

Youth Who Have ADHD Or Other Neuro-Behavioral Conditions

Cluster 2

Vulnerable Youth Who Are Depressed and/or Suicidal

Cluster 3

Youth With Serious Behavior Problems

Cluster 4

Youth Who Have Been Sexually, Physically Or Emotionally Abused

Cluster 5

Youth Affected By Traumatic Events

Cluster 6

Youth With Substance Abuse Issues

Cluster 7

Very Anxious Youth

Cluster 8

Youth Not Adjusting To Stressful Life Events Or Crises

Cluster 9

Youth Involved In Sexual Offenses

Cluster 10

Youth With Both Cognitive Limitations And Behavioral Problems

CLUSTER 1: Youth Who Have ADHD Or Other Neuro-behavioral Conditions

Members of this cluster often have Attention Deficit Disorder (ADD), ADHD, Tourette Syndrome and/or other neuro-behavioral conditions. Some also have other specific learning problems. These conditions may not have been accurately diagnosed or appropriately addressed. Cluster members are easily distracted and typically have difficulty concentrating or following instructions. Some may also have poor motor skills and poor eye-hand coordination, and may appear clumsy. Many have very poor handwriting. Cluster members often have trouble sitting still or being quiet. In many cases, behaviors such as tapping pencils on the desk, humming, or constantly moving their legs or feet may be misinterpreted by teachers and others as purposeful and deliberately annoying. Some have difficulty making eye contact which may be interpreted as their not paying attention. At times, cluster members may appear to be daydreaming or just lost in thought. However, it is more likely that their mind is racing and they are trying to attend to many thoughts at once.

Some members of this cluster are unusually active, impulsive, and/or persistent. They can't seem to accept no for an answer and may have difficulty playing games by the rules, accepting responsibilities or limits in general. They may punch or poke at their parents, siblings, or others. They grab or touch things and are continually into something. Many have poor sleeping habits and some do not sleep much at all. Most are easily frustrated and sometimes this results in anger, destructiveness, and/or temper outbursts.

The neurological systems of many cluster members are quite sensitive. Some are unusually sensitive to sounds and/or light. Specific foods and additives also may affect their behavior. Some are sensitive to touch. They may misinterpret an unexpected touch as someone hitting them and respond as if they were being attacked. For others, touch can be soothing, and used to help them focus on a specific task. Some may be overwhelmed by moderate noise and become very agitated. Many are sensitive to how specific articles of clothing fit or feel and may either want to wear them all the time or not at all.

School presents a host of challenges for members of this cluster. While they often have average to above average intellectual abilities, many are labeled early as having behavior and performance problems and some may be placed in special classes. Many learn by doing and often like to take things apart to understand how they work. Most cluster members function best when tasks are more structured; the environment is consistent; and they encounter few distractions. **One of the most consistent things about cluster members is their inconsistency in both school performance and behavior in general.** Some who can entertain themselves for hours will, at other times, be unable to stay still and/or require constant attention from parents. They are sporadic in completing academic work or returning completed homework, and typically need a consistent schedule or routine, and monitoring, at both home and school.

Members of this cluster typically lack social skills and have few friends. They are impulsive and demanding. They may always need to be first. They often do not recognize how their actions affect others and have difficulty understanding why others may respond negatively to them. In order to resolve conflicts, some may use verbal threats or become physically aggressive. Because of their low self-esteem, some cluster members can be easily manipulated. Over time, other children may begin to avoid cluster members, leaving them isolated and without support.

Over time, children in this cluster may have adopted alternative behaviors in order to compensate for the effects of their condition(s) and the negative responses they have received from others. Unfortunately, many of these patterns of behavior have put them in conflict with others in school, with peers, with other family members, and with the community. Their problems in school, for example, may result in their being temporarily removed or placed in special programs. Their disruptive and aggressive behavior may bring them into contact with the courts. Initially, the children in this group are seen as unruly; however, this may escalate into more serious problems such as substance abuse and/or criminal behavior. Depression may also become a direct consequence of their experiences.

Medications and issues about them play a major role in the lives of many cluster members. Their complex medical situations may have been misdiagnosed and they may have been prescribed inappropriate or inadequate medications. The stigma of having to take medications on a regular basis, often at school, also reinforces their low self-esteem. Some parents may have failed to insure that they get their medications consistently and some cluster members or their parents have resisted the use of medication because of negative effects such as lost appetite, lost sleep, and anxiety.

The members of this cluster come from all types of families. Generally, however, there is considerable confusion and chaos in the household. The house may be a mess and there is little structure provided for any of the children. The parents may seem under constant stress and on an emotional roller-coaster. Some parents lack knowledge of good parenting skills. Others have been successful with other children but lack the skills to parent children with these complex problems. Many feel the problems are their fault and are frustrated by their inability to supervise and control their children. Some parents are also struggling with problems of their own such as substance abuse, mental health issues, limited education, and/or undiagnosed ADHD. Family support is often inconsistent. Because of their embarrassment, many of these parents may not reach out for support at all.

CLUSTER 4: Youth Who Have Been Sexually, Physically Or Emotionally Abused

Members of this cluster have experienced sexual, physical, and/or severe emotional abuse. These children have suffered severe trauma, but many seem blocked from feeling physical or emotional pain. They have low self-esteem and they may believe the abuse or violence was their fault. Their physical and emotional boundaries have been violated and often significant people in their lives have abused them or failed to protect them. Thus, they have difficulty trusting anyone or themselves. Members of this cluster may have witnessed abuse or feared that their siblings and/or parents were being victimized. With all that has happened to them, members of this cluster tend to be secretive and guarded about the abuse. They don't tell others that it is happening and may even deny it when confronted about it by those trying to help them.

It is not uncommon for younger members of this cluster to have irrational fears or nightmares. Many are easily startled and/or may be fearful of loud noises. In addition, they may have symptoms of anxiety, phobias or engage in ritualistic behaviors. Some may attempt to gain a sense of control by acting out against others. Some may try to hurt, or physically or sexually abuse other children. In extreme cases, they may set fires or harm animals. While younger children may show these responses more immediately after their abuse, the behaviors can also emerge at a later date and developmental stage, including adulthood.

When the abuse starts during adolescence, some cluster members show obvious changes in their personal relationships and behavior. They may withdraw from their usual peer group or their grades may drop. They may begin to associate with teens that are more oppositional and have more severe behavior problems. They may engage in self-injurious behavior, become suicidal, or develop eating disorders.

Cluster members who have been sexually abused may have difficulty with normal sexual development. They may continually talk about the abuse, masturbate compulsively, or play out the abusive events. Their personal hygiene may deteriorate, or conversely, they may establish cleansing rituals such as needing to take frequent showers. Many have difficulty understanding sexuality, appropriate sexual behavior, and/or their sexual identity. They may dress in highly seductive clothes, act out sexually, and be seen as promiscuous. Younger children may be sexually precocious, often being preoccupied with information typically above their developmental level. Teenagers of both genders may develop pseudo-relationships based solely on sex. Some find protection by making themselves unattractive—not wearing makeup, wearing shapeless clothing or even becoming overweight. Others may avoid age appropriate situations or relationships that may result in sexual behavior or intimacy. Children in this cluster are often exposed to adult environments that tend to be over-sexualized. For instance, pornographic materials may be left out at home, and adults may wear provocative clothing and tell dirty jokes in front of the kids.

Parents of cluster members may devote a good deal of energy presenting the family as normal. The perpetrators frequently use intimidation, threats, guilt, and rewards to control others. Members of this cluster may feel guilt as well as fear, and may be discouraged from involving themselves outside the home. Without trusting relations with family members or peers, children in this cluster are isolated. Some won't tell others about the abuse because they don't want to be removed from their home. At other times, when children do tell about the abuse, they are not believed or protected.

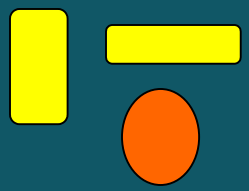
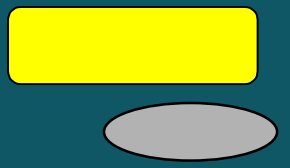
Cluster members, even in the same family, may react differently to their experiences of violence and/or abuse:

- **Some act out and can be seen as having behavior problems**. They may misbehave at the end of the school day in order to incur a detention so they can avoid having to go back home where it is not safe. Some attempt to control others through the use of verbal threats or violence.
- **Others become withdrawn, depressed, and occasionally suicidal**. They are anxious and fearful but keep their hurt inside. They may take on the victim role and may set themselves up for further abuse. For instance, they may date individuals who verbally, sexually, or physically abuse them.
- **A third subgroup acts older than their chronological age**. They become the adult in the family, very responsible at home and high achievers at school. They may assume the care of siblings and replace the parent in other roles.
- **In contrast, a fourth subgroup acts younger than they are**. Adolescents may throw temper tantrums or run away from home. Younger children may revert to baby talk, thumb-sucking, soiling, or tantrums.

Members of this cluster often live in families where parents show little respect for each other or their children. Many of the parents are themselves victims of abuse and often lack good parenting skills. They yell at their children and may physically or sexually abuse them. They don't respect their children's personal privacy, personal boundaries, or property. They don't listen to what they say and don't seem to care what goes on in their lives. They may treat other's children much better than they do their own. Parents who are the perpetrators of abuse often use anger and power to control the other family members.

Despite the violence and/or abuse they have suffered, some cluster members have developed ways to cope. They appear to be tough, strong, and resilient. Some have been able to compartmentalize the abusive situation and seem better adjusted. Some cluster members are able to survive the abuse and lead healthy lives. However, at different times later in their lives, they may have difficulties or stressful periods during which these issues may re-emerge.

CLUSTER-BASED PLANNING OVERVIEW

	Youth with ADHD and/or Other Neuro-Behavioral Conditions	Youth with Serious Behavior Problems	Youth Who Have Been Sexually, Physically or Emotionally Abused
CLUSTERS			
SERVICES			
SAMPLE TREATMENT GOALS OR OUTCOMES	Caregivers develop a greater understanding of the nature of the Neuro-behavioral condition Success in school Youth gets along with other kids Parents are able to manage medication issues Youth can better manage his/her behavior. Caregivers support the youth's positive mental & physical health Caregiver participates in implementing IEP Reduction in need for disciplinary actions	Reduce high risk & severe problem behaviors The youth responds appropriately to rules and those in authority The youth engages in age-appropriate constructive activities The youth can connect feelings to actions The youth accepts responsibility for actions and experiences remorse Caregiver provides positive support & guidance The youth improves social skills and peer relationships School attendance is improved School behavior is improved The youth solving problems & making better choices	The youth can attribute responsibility to the perpetrator The youth has enhanced ability to trust others The youth has developed skills to prevent victimization The youth is leading an active life The youth can identify and express feelings The youth can maintain personal, social, and sexual boundaries The youth can manage anger The youth has a positive feeling about his/her body The youth can deal more effectively with their family
RESOURCES & COSTS	•Programs •Services •Trained Staff •Facilities •Dollars	•Programs •Services •Trained Staff •Facilities •Dollars	•Programs •Services •Trained Staff •Facilities •Dollars

WHAT HAS BEEN ACCOMPLISHED IN REGION V TO PLAN AND IMPLEMENT A CLUSTER-BASED LOC SYSTEM FOR PROFESSIONAL PARTNER WRAPAROUND SERVICES?

LEVEL OF CARE DEVELOPMENT STEPS

1. Clarified The 4 Phases Of Wraparound:
   1) Engagement & Orientation
   2) Plan Development
   3) Plan Implementation
   4) Transition
2. Identified Characteristics and Life Situations Of The Youth/Family At Admission
3. Identified Goals/Objectives That Would Result In The Youth/Family Moving Thru the Phases to Discharge

LEVEL OF CARE DEVELOPMENT STEPS
(Continued)

4. Identified What PP Should Be Doing To Help Youth & Family Move Thru the Phases (A Job Description For Each Cluster)
5. Identified The Types And Frequencies Of Professional Partner Contacts That Would Be Needed At Each Level Of Care

Step 1: Clarifying the Phases Of Wraparound

- Combined Phases 1 & 2 Which Cover The First 30-35 Days Of Service
- Split Phase 3 (Plan Implementation) Into Two Levels Suggesting The Need For Different Types And/Or Amount Of Services

Phases 1 & 2	Phase 3A	Phase 3B	Phase 4
Engagement, Persuasion, Orientation, Plan Development	The Youth And Family Are Actively Engaged In Making Changes In Their Lives	The Youth And Family Are Trying To Solidify Their Gains So That They Can Move Toward Transition (Phase 4) And Discharge	Transition to Discharge

Step 2: Identified Characteristics and Life Situations Of The Youth/Family At Admission

- One Cluster At A Time
- Talked About Several Youth/Families That Share The Cluster History
- Described What Their Situation Was Like; What They Were Experiencing, Feeling And/Or Were Challenged By At The Time Of Their Admission

Cluster 1: Youth with ADHD and Other Neuro-Behavioral Conditions At Admission

Youth Typically Has Been Diagnosed With Condition Such As ADHD, ADD, Tourette Syndrome, Or A Learning Disability.

Youth Is Currently Experiencing Significant Difficulties In School (May Have Been Suspended Or Expelled).

Youth May Have An IEP; However It May Not Be Adequate.

Parents Are Often At A Loss When They Meet With School Personnel, Don't Know Their Rights, Or What To Suggest.

Youth Is Typically In Conflict With Other Family Members And Peers.

They Are Impulsive And Impatient And Need To Do Or Have Things Now.

There Is Often Little Organization Or Structure In The Family Life.

Other Agencies Such As Child Welfare Or Juvenile Court (For Minor Offenses) May Be Involved.

The Youth Becomes Easily Frustrated. In Response Has Learned Behaviors Which Put Them In Conflict With Others.

The Youth May Or May Not Want To Take Meds And Parents May Not Insure That The Child Takes The Meds As Prescribed.

Parents Often Appear Desperate To Have Help With Their Child But Also May Not Follow Through On Recommendations.

Cluster 4: Youth Who Have Been Sexually / Physically Abused

At Admission

Youth has been sexually or physically abused by parent, relative, family friend, etc.

The youth's physical and emotional boundaries have been violated and significant people in their lives have failed to protect them.

Youth has difficulty trusting anyone including themselves. They feel they were responsible for the abuse.

The Youth, Parents, and Others may be guarded, secretive, and not forthcoming about the events.

The youth may not want to come forward for fear that they will be guilty of "destroying the family".

Youth may have been aggressive (even sexually inappropriate) toward other youth or may be depressed and may have made a suicidal gesture or serious attempt.

Some perpetrators may still be in the household while others may have been removed (e.g. in jail or prison)

Caregivers, parents and others may focus on youth's behavior rather than the underlying emotions resulting from the abuse.

Court involvement is still possible. Youth may still need to testify against the perpetrator.

Non-abusing parent may deny abuse and continue to be emotionally and/or financially dependent upon the perpetrator.

Non-abusing parents don't really engage in treatment process.

Step 3: Identified Goals/Objectives That Would Result In The Youth/Family Moving Thru the Phases of Wraparound to Discharge

- Cluster By Cluster
- Reviewed Cluster Description
- Reviewed Characteristics Of Cluster Members At Admission
- Identified Core Goals For Phases 1 & 2 (First 30-35 Days)
- Discussed Cluster Members Who Had Moved Part-way Or All The Way Through The Phases
- Identified Challenges Overcome And/Or Changes Made Over Time That Supported Their Progress
- Formalized Desired Changes As Goals/Outcomes
- Ranked The Goals In Terms Of Their Importance In Progressing Through The Phases Of The Program

Goals for Youth in Cluster 1
Youth with ADHD or Other Neuro-behavioral Conditions

How Frequently Or To What Extent Does Each Statement Currently Describe The Youth And His/Her Parents?

A	*A Wraparound Team Has Been Identified And Is Meeting Regularly.*	***3***
B	*The Youth And Parent(S) Are Regularly Attending Wraparound Team Meetings And/Or Appointments With Professional Partners.*	***3***
C	*The Youth And Family Have Developed A "Safety Plan" Which Includes What To Do If The Youth Engages In Aggressive And/Or Destructive Behavior.*	***4***
D	*The Youth And Family Can Identify Individual And Family Strengths*	***4***
E	*A Service Plan Has Been Developed With The Wraparound Team, The Youth And His/Her Parent(s).*	***4***
F	*A Full Physical, Psychological, Social, And Educational Assessment Has Been Completed On The Youth. If Requested And Scheduled But Not Completed = "3".* ***P1***	
G	*The Parents, (Youth If Possible), School And Others Involved Have A Clear And Common Understanding Of The Youth's Neuro-Behavioral Condition(S), Problems, Strengths, Needs For Treatment, Accommodation, And/Or Supports.* ***P1***	
H	*Parents Have Sought Out And Are Finding Useful Information From Knowledgeable Professionals As Well As Advocacy And Family Support Groups.* ***P2***	
I	*Parents Know Their Child's Rights To Education And Other Services.* ***P3***	

J	*Parents Have Found Others (Including The Professional Partner) Who Can Advocate For Their Child And Family With The Schools And Other Service Agencies.* ***P2***	
K	*Parents Have Learned Skills To Be Able To Advocate For The Rights Of Their Child And Family (For Example, They Request Specific Accommodations In IEP Meetings).* ***P3***	
L	*Parents Are Able To Help Their Child Understand The Meaning And Implications Of His/Her Neuro-Behavioral Condition.* ***P2***	
M	*Parents, With Help From Others, Have Been Able To Reduce Conflicts, Provide Structure And Stability, And Promote Daily Living And Self-Management Skills For Their Child* ***P2***	
N	*The Parents/Caregivers Are Skilled At Helping The Youth Manage His/Her Behavior. They Work Together With Teachers To Create A Consistent And Structured Home And School Environment* ***P2***	
O	*The Youth Is Taking More Responsibility For Doing Things That Reduce The Negative Impact Of His Condition On His Life.* ***P3***	
P	*The Youth Is Included In Decision Making And In Setting Expectations And Limits.* ***P3***	
Q	*The Youth Is Engaged In Recreational Activities With Peers From His School And/Or Neighborhood.* ***P3***	

Goals for Youth in Cluster 4
Youth Who Have Been Sexually Or Physically Abused

How Frequently Or To What Extent Does Each Statement Currently Describe The Youth And His/Her Parents?

A	*A Wraparound Team Has Been Identified And Is Meeting Regularly.*	**2**
B	*The Youth And Parent(S) Are Regularly Attending Wraparound Team Meetings and/or Appointments With Professional Partners.*	**2**
C	*The Youth And Family Have Developed A "Safety Plan" Which Includes Ways To Protect The Youth From Further Abuse.*	**4**
D	*The Youth And Family Can Identify Individual And Family Strengths.*	**3**
E	*A Service Plan Has Been Developed With The Wraparound Team, The Youth And His/Her Parent(s).*	**3**
F	*Appropriate Authorities (E.G. Police, Child Protective Services, Etc) Have Been Notified And Are Actively Dealing With The Issues Of Abuse Or Trauma.* **P1**	
G	*There Have Been Few Or No Incidents Of Physical/Sexual Abuse In The Past 30 Days.* **P3**	
H	*The Youth's Contact With The Perpetrator Of The Abuse Has Been Significantly Reduced Or Terminated.* **P1**	
I	*The Youth Has Had A Complete Physical Exam.* (If One Has Been Scheduled But Not Complete Score A 3) **P1**	

J	*The Youth Is Engaged And Benefitting From Trauma Focused Counseling.* **P2**	
K	*The Non-Abusing Parent Or Other Caregivers Acknowledge The Abuse And Are Focusing On Helping The Youth Deal With The Trauma.* **P2**	
L	*The Non-Abusing Parent Has Made The Youth The Priority And Is Willing To Give Up Financial Or Emotional Security To Make Sure The Youth Is Safe From The Perpetrator.* **P2**	
M	*The Youth Is In A Stable And/or Permanent, Safe Living Environment.* **P2**	
N	*The Youth Is Leading A More Active Life, Interacting With Peers, And Not Letting Trauma-Based Responses (e.g. Panic, Anxiety, Flash Backs, Depression, Flooding) Interfere With Her/his Activities.* **P4**	
O	*The Youth Is Able To Establish Appropriate Relationships Including Being Able To Establish Physical And Emotional Boundaries* **P4**	
P	*The Youth Is Comfortable With His/Her Body, Gender, and/or Sexual Identity.* **P4**	
Q	*The Non-Abusing Parent Is Dealing With Their Own Personal Issues In Counseling And Recognizing Their Likely Role In The Abuse Of Their Child.* **P3**	

Step 4: Identified What PP Should Be Doing To Help Youth & Family Move Thru the Levels of Care

(A Job Description Customized For Each Cluster)

- Cluster By Cluster
- Reviewed Cluster Description
- Reviewed Characteristics At Admission
- Reviewed Cluster-specific Goals
- Described Cluster Members Who Had Done Well And Those Who Had Not Made As Much Progress
- Identified What PP Had Done That Had Worked
- Identified What PP Would Want To Do To Address The Cluster-based Goals
- Described the Areas of Focus For PPs In Working With Youth And Families In Each Cluster.

PROFESSIONAL PARTNER AREAS OF FOCUS FOR MEMBERS OF CLUSTER 1

Getting family accurate information about the child's neuro-behavioral condition. Referring parents to medical and other professionals, searching the web for information, reviewing information with the family.

Help parents learn about IEP meetings and the active role they should be playing in them. PP will likely need special training on these issues. Or the PP could refer families to local educational advocacy organizations (e.g. Disability Rights Nebraska) or parent groups that provide specific training and support.

PP should help the parent(s) prepare for IEP meetings so that they can present ideas for their child's educational plan. The PP may accompany the parent to the meeting and should play the role of a facilitator.

Help the youth and parents become their own advocates. Goal is to help them learn to do for themselves. This may involve a **"Do For", "Do With", "Provide Verbal Guidance/Reminders" And "They Do On Their Own"** sequence of steps.

Connect them with family/peer support groups. PP may want to go at first with the youth and/or family since they may be ambivalent about sharing with others.

Help the family find community-based recreational activities in which the youth and/or family can participate. In order to help "normalize" social activities, the PP should help the family identify things the youth may like to do independently. PP program may need to provide some funds to cover these activities (e.g. For A "Y" membership, for a team uniform, or to help with transportation costs).

Identify and access resources and materials that support coping with or maximizing functioning while living with physical health conditions.

Help family make decisions about use of medications. Help them maintain medication regimens if prescribed.

PROFESSIONAL PARTNER AREAS OF FOCUS FOR MEMBERS OF CLUSTER 4

Focus should be on insuring the safety of the youth. If sexual or physical abuse is suspected but has yet to be confirmed, PP needs to try to assess the situation.

If abuse is suspected but not acknowledged, PP must follow internal and legal reporting requirements.

It is important for the PP to regularly spend some time separately with the youth. Even if they are younger this may give the child a sense of safety and a time when they might share information or feelings about traumatic events while playing.

Identify a "safe person" in the family's network to whom the youth can turn in emergencies.

Help the parents understand that "non-abused" siblings may show problem behaviors resulting from the family trauma.

Educate the non-abusing parent(s) and other caregivers about abuse and trauma. Remember that the caregivers may themselves have been abused and may need validation for their feelings and support or counseling if this triggers memories and feelings.

Educate non-abusing caregivers about the long term affects of trauma. Their apparent "unwillingness" may really be a lack of knowledge and skills to support the youth.

Make A "Warm Handoff" for trauma counseling for youth and also non-abusing parent or caregivers. Eventually only funding for transportation may be needed to make appointments.

PP should also discuss the issue of peer support groups with youth and/or non-abusing parent and make referrals as needed.

Work to hold parents accountable. For example, that they keep perpetrator away from the youth; that the youth gets to therapy sessions; or that they get to their own counseling sessions.

Work to insure the family's public benefits are maintained (if appropriate).

Connect youth and family to social and educational activities in the community. Funding for these activities may be needed.

PP may want to develop reinforcement plans with incentives to help the youth and family members become more firmly engaged in the treatment and activities needed for their recovery. Funding for incentives may be needed.

Step 5: Identified The Types And Frequencies Of Professional Partner Contacts That Would Be Needed At Each Level Of Care

- Reviewed The Activities For PPs In Working With Youth And Families In Each Cluster.
- Identified Contact Frequencies Separately for Phase 1 & 2; Phase 3A; And Phase 3B For The Following Key Professional Partner Contacts :
  - Family Contacts
  - Participant Contacts
  - Collateral Contacts
  - Wraparound Team Meetings

Types And Frequencies Of Professional Partner Contacts That Would Be Needed At Each Level Of Care

CLUSTER 1	WRAPAROUND PHASE 1 (Engagement/Orient/Team Prep) WRAPAROUND PHASE 2 (Initial Plan Development)	WRAPAROUND PHASE 3A (Plan Implementation—Hard Work and Making Changes)	WRAPAROUND PHASE 3B (Consolidating Gains and Step Down to Transition)	WRAPAROUND PHASE 4 (Transition & Discharge)
LOC	Family Contact = 3-4 x/mo Participant Contact = 1-2 x/mo Collateral Contact = 3-4x/mo Team Meeting = 1-2x/mo Contacts with Therapist and Schools	Family Contact= 100% need 3-4 / mo Participant Contact= 40% need 1-2/mo Collateral Contact= 80% need 3-4/mo Team Meeting = 100% need 1-2/mo Contacts with Probation, CFS-DHHS, Skill Builder, Therapist, School, Educational Advocacy Groups/Parent Support Groups, Other Community Orgs (YMCA, YWCA, Churches, Camps, City Recreation)	Family Contact = 100% need 1x/mo Participant Contact=20% need 1-2x/mo Collateral Contact = 50% need 3-4x/mo Team Meeting = 100% need 1-2x/mo Contacts with Probation, CFS-DHHS, Skill Builder, Therapist, School, Educational Advocacy Groups/Parent Support Groups, Other Community Orgs (YMCA, YWCA, Churches, Camps, City Recreation)	

Types And Frequencies Of Professional Partner Contacts That Would Be Needed At Each Level Of Care

CLUSTER 4	WRAPAROUND PHASE 1 (Engagement/Orient/Team Prep) WRAPAROUND PHASE 2 (Initial Plan Development)	WRAPAROUND PHASE 3A (Plan Implementation—Hard Work and Making Changes)	WRAPAROUND PHASE 3B (Consolidating Gains and Step Down to Transition)	WRAPAROUND PHASE 4 (Transition & Discharge)
LOC	Family Contact = 3-4 x/mo Participant Contact = 1-2 x/mo Collateral Contact => 5x /mo Team Meeting = 1-2x/mo Contacts with Probation, CFS-DHHS, Skill Builder, Therapist, School	Family Contact= 100% need 3-4 / mo Participant Contact= 100% need 1-2/mo Collateral Contact= 100% need 3-4/mo Team Meeting = 100% need 1-2/mo Contacts with Probation, CFS-DHHS, Clinical Consult, Supervisor, Skill Builder, Therapist, School, Support Groups, Other Community Orgs (YMCA, YWCA, Churches, Camps, City Recreation)	Family Contact = 100% need 1x/mo Participant Contact=100% need 1-2x/mo Collateral Contact = 80% need 1-2x/mo Team Meeting = 100% need 1x/mo Contacts with Probation, CFS-DHHS, Skill Builder, Therapist, School, Support Groups, Other Community Orgs (same as 3A)	

LEVEL OF CARE IMPLEMENTATION STATUS

- Staff Will Be Trained In November 2017
- All Current Clients Will Then Be Assessed On Cluster-based Goals And A Current Level Of Care Will Be Determined
- Level Of Care Tracking And Periodic Goal Rating Procedures Will Be Implemented
- Staff Will Continue To Document PP Contacts And Use Of Flex Funds Using Revised Definitions
- Evaluation Design Will Have Been Finalized
- Monthly PP LOC Meetings Scheduled (PP Staff, CQI Staff And Synthesis)
- Periodic Data Analyses And Feedback To Staff Being Planned

For More Information Contact

Renee' Dozier, MPA
Director of Youth and Family Programs
Director Professional Partners Program
Region V Systems
1645 N St.
Lincoln, NE 68508

Phone: (402) 441-4343
E-mail: rdozier@region5systems.net

Bill Rubin, MA, CEO
Synthesis, Inc.
3049 Olive St.
Columbus, OH 43204

(614) 365-9444 or (800) 322-944
E-mail: synthesis@synthesisincohio.com

SYNTHESIS, INC.

3049 Olive St., Columbus, Ohio, 43204 Telephone (614) 365-9444 Toll-Free (800) 322-9441
Fax (614) 365-9016 e-mail: synthesis@synthesisincohio.com
On the Web at: www.synthesisincohio.com