



## Core Values

- Participant-centered approach
- Participant involvement throughout the process
- Building resources on natural and community supports
- Strength-based approach
- Providing unconditional care
- Collaborating across systems
- Using a team approach across agencies
- Ensuring Safety
- Being gender/age/and culturally responsive
- Promoting self-sufficiency
- Focus on education and employment where appropriate
- A belief in growth, learning and recovery
- Being oriented to meaningful outcomes

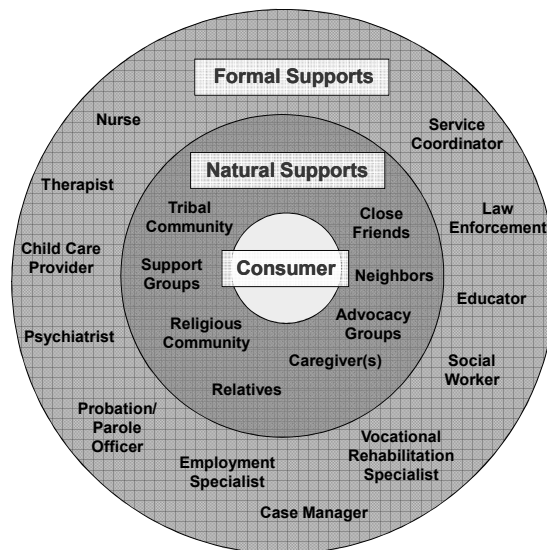
## Practicing by the Principles

- Participant Involvement
  - Participant is involved in the planning at all times
  - Participant has voice, access and ownership
- Collaborative/Team Practice
  - Participant and community supports, and service providers working together to establish one plan
  - Unconditional care in all systems involvement
- Individualized Plans
  - Plans that are strength based, needs driven, individualized, culturally competent and community based

## Target Group

- Involvement in two or more direct services
- Other interventions have not been successful over time; persistent obstacles to service access exist; and/or there is a need for service coordination
- Placement in or at risk of a restrictive living placement
- Willingness to be involved in the wraparound process

## Wraparound Team



## Levels of Team Involvement

- **Assessment, Planning, and Crisis Response Planning**
  - Teams meet every 1 – 2 weeks for 45 minutes to 1 hour
  - Phase may last approximately 2 – 3 months
- **Plan Implementation & Monitoring**
  - Teams meet as often as necessary, typically every 3 – 5 weeks
  - Phase may last approximately 6 – 12 months
- **Transition & Closure**
  - Teams may meet every 2 – 3 months while transitioning out of the formal team process

## Role of a Service Coordinator

### ROLE:

- “Expert” on the Collaborative Team Process
- Assure Team Completes the Assessment and Plan of Care
- Ensure the Plan of Care is Monitored
- Ensure Reassessment and Plan of Care Updates
- Share Outcomes

### NOT ROLE:

- Sole decision-maker
- Person who does all the work
- The only person team members call
- To dictate what should be done, to infringe on, or be a substitute or the policies and procedures of other agencies

## Balanced Approach to Juvenile Justice

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Community Protection  
Accountability  
Competency Development

*Family Involvement*

## Community Protection

Tasks of the collaborative team:

- What are our options for protecting the community from further delinquent acts?
- Who do we need on our team to provide the options we choose?
- How will we involve the youth in our planning?
- How will we coordinate our efforts?

## Accountability for Delinquent Acts

### Team tasks:

- What do the parents want to see happen?
- What are the strengths/needs and preferences of the youth?
- What does court/supervision require?
- What are the options for accountability?
- Coordination of efforts?

## Research on Youth who Offend and Institutional Placements

According to research that began in 2000:

- Youth involved in serious crimes are not a particular “type” of youth – they differ from one another, much like their peers who have not offended
- Longer stays in juvenile facilities do not reduce offending
- Continued supervision and community-based services provided after a youth is released make a difference
- Treating substance abuse can reduce subsequent offending

“Research on Pathways to Desistance: Research Update Created for the Fourth Annual Models for Change National Working Conference”, 12/9/09, Mac Arthur Foundation

## Individualized Assessment and Competency Development

Characteristics of youth in the juvenile justice system (national):

- 70% suffer from mental health disorder, 29% of these suffer from more than one disorder (Center for Mental Health and Juvenile Justice 2006)
- 33% of youth are learning disabled (US DOJ 1986)
- More than ½ of youth who are arrested tested positive for at least one drug (Watson 2004)
- 80% of youth treated for AODA have a mental health disorder (CWLA 2006)

## Individualized Assessment and Competency Development

Characteristics of youth in the juvenile justice system (Wisconsin):

- 128 CST teams served youth involved with juvenile justice; 52% met SED criteria (CST initiative, 2009)
- 453 JCI youth were screened for AODA; 56.6 were diagnosed with dependence or abuse (WI Div. of Juv. Corrections, 2008)
- At admission to Lincoln Hills, about half of males are 4 grades below classmates in reading and math testing scores (WI Div. of Juv. Corrections, 2007)

## Individualized Assessment and Competency Development

### Team tasks:

- Organize and review assessment material
- Individualize planning considering assessment
- Review all the options
- Coordinate, prioritize, sequence

## Family Involvement

Family involvement has been linked with:

- Increased empowerment and self-efficacy
- Higher satisfaction with services
- Shorter stays in residential treatment
- Higher rates of stability in after care
- Higher grades and test scores
- Regular attendance
- Improved school behavior and social skills

WI Family Ties presentation 2010

## Family Involvement

### Team tasks:

- Consider family and youth wishes
- Blend family/youth wishes with legal conditions
- Recognize parents as caregivers and provide support

## Blending a Collaborative System of Care with Court Functions

- Protection of individual liberties
- Insuring accuracy and fairness in proceedings
- Insuring equal voice of all participants
- Promoting conflict management
- Facilitate creative planning process
- Support for resource development and access
- Formal monitoring of process and meaningful outcomes
- Acknowledge and support progress

Therapeutic Jurisprudence, the Juvenile Court as the Integrative Form a Community's System of Care, The WisKids Journal, John Franz

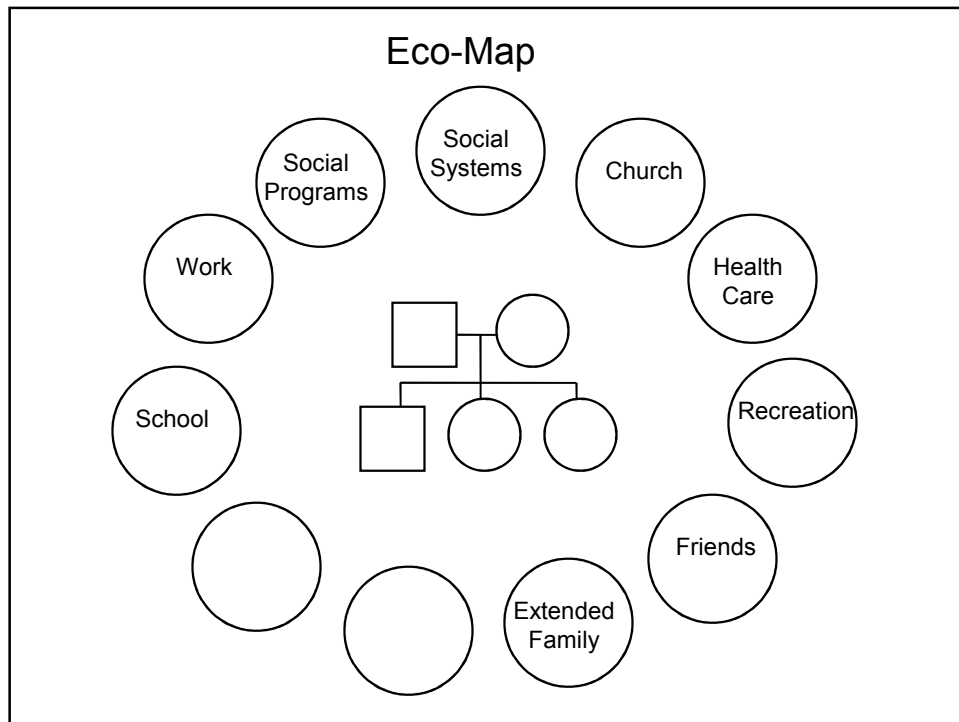
## Moving Forward Together: Working with the Local System

Utilize or create a collaborative network of key people and organizations

- *Who is invested in outcomes for young people?*
- *Is there consensus about this?*
- *Who are the leaders?*
- *What is the local experience with teamwork?*
- *Training and education plan?*

## Evaluating Dispositional Plans

- Is it a place or a plan?
- It is outcome oriented?
- Does it address safety, accountability, and competency?
- Is there a reasonable crisis plan?
- Does the plan build on strengths?
- Does the plan respond to the needs of all participants?
- Are roles, responsibilities, timelines, and budgets clear?
- Is there a balanced use of formal & informal support?
- Is the plan participant-based?
- Will the plan increase family independence?



## Assessment

- Assess Across Criminogenic Needs
- Identifying Functional Strengths
- Identifying Needs
- Developing Needs Statements

## Family and Youth Strengths & Needs Assessment

<b>Family Functioning</b>		
	Is this an area of strength?	Level of Need 1=no need, 5=great need
Describe relationship with the family: How do members show they care/affection? Are parent/child boundaries present? How do you resolve conflict? How do you discipline/consequence? How much time do you spend together?	<input type="checkbox"/> Strength	1 2 3 4 5 Person(s) in need: _____
Strengths:	Needs:	

## Short Term Goal Plan

Name: \_\_\_\_\_

Completion Date: \_\_\_\_\_

Behaviors of Concern: \_\_\_\_\_

Need: \_\_\_\_\_

Strengths: \_\_\_\_\_

Goal: \_\_\_\_\_

**Interventions**

Intervention	Person(s) Responsible

Signatures: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Sample Team Meeting Agenda

### First Team Meeting

- Welcome & Introductions
- Review team process and core values
- Housekeeping/consensus/rules of operation
- Roles, Strengths and Goals exercise

## Sample Team Meeting Agendas

### Assessment Review

- Successes
- Review of Strength and Needs Assessment
- Begin Goal Planning

### Planning Meeting

- Successes
- Review of tasks from last meeting
- Begin goal planning: Family pick top needs
- Review of NW Day Treatment Plan of Care

# Meeting Notes

Team Meeting for: \_\_\_\_\_ Page \_\_\_ of \_\_\_  
Date: \_\_\_\_\_ Start Time: \_\_\_\_\_ End Time: \_\_\_\_\_ Location: \_\_\_\_\_  
Team Members Present: \_\_\_\_\_  
Absent: \_\_\_\_\_

Agenda:

- .
- .
- .
- .

Family Team Goals:

- 1.
- 2.
- 3.

What's working? Identify Strengths: \_\_\_\_\_

Notes:

# Meeting Notes, continued

Work Plan/Task Assigned – Who, what, by when:

- .
- .
- .
- .
- .
- .

Next Meeting Date: \_\_\_\_\_ Time: \_\_\_\_\_  
Location: \_\_\_\_\_  
Tentative Agenda Items:  
Note Taker: \_\_\_\_\_  
Team Changes/Additional Members to Contact: \_\_\_\_\_

## Summary of Process for Collaborative Team Practice

- Eco-map
- Using Natural Supports
- Preparing Families
- Use of Functional Strengths
- Individualized Planning
- Accurate Need Identification
- Meeting Facilitation: *Meeting structure, use of agendas and minutes, achieving consensus, creating effective written team plans*

[www.wicollaborative.org](http://www.wicollaborative.org)



**Wisconsin's Collaborative Systems of Care (WCSOC)  
Resource Website**

Home	Core Values	Resources	Contacts	Parents	Partners
<p style="text-align: center;"><b>Coordinated Services Team Initiative (CST)</b></p> <p style="text-align: center;">Integrated Services Projects (ISP)</p> <p style="text-align: center;">Women's AODA</p>	<p><b>Welcome</b></p> <p>This website is meant to serve as a resource...</p>	<p><b>Materials from Recent Trainings</b></p> <p><b>Wisconsin's Collaborative Systems of Care</b></p>		<p style="text-align: center;"><b>Trainings and Events</b></p> <p style="text-align: center;">WCSOC Handbooks</p> <p style="text-align: center;">Success Stories</p>	