Children/Youth with Severe Emotional Disability (SED) Curriculum (6 Hour)

KVC Kentucky
people matter

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Welcome!

Core Competencies

- Overview of the Phases and Principals of the Wraparound Process Based on the National Wraparound Initiative
- Wraparound Phase 1: Family and Team Engagement
- Wraparound Phase 2: Care Planning and Meeting Facilitation
- Wraparound Phase 3: Plan Implementation and Monitoring
- Wraparound Phase 4: Transition

2

Set Ground Rules for Training

- When you attend trainings, what kinds of behavior do you want to see from participants?
- What participant behaviors drive you crazy at a training?
- What ground rules do we need to set in order for you to learn what you need to learn?

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Icebreaker

Everyone write on a piece of paper THREE things about yourself that may not be known to the others in the group. Two are true and one is not. Taking turns, you will read out the three 'facts' about yourself and the rest of the group votes which are true and false.

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Morning Overview…

- Overview of the Phases and Principals of the Wraparound Process Based on the National Wraparound Initiative
  - 4 Phases of Wraparound
  - 10 Principals of Wraparound
  - Definition of Severe Emotional Disability
  - 5 Behavioral Health Diagnoses
- Wraparound Phase 1: Family and Team Engagement
  - Initial Conversations
  - Need vs. Service
  - Stages of Change
  - Empowerment
  - Natural Supports

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Afternoon Overview…

- Wraparound Phase 2: Care Planning and Meeting Facilitation
  - Steps of Care Planning
  - Goals, Objectives, and Crisis Planning
  - Meeting Facilitation
- Wraparound Phase 3: Plan Implementation and Monitoring
  - Implementing and Monitoring the Care Plan
  - Modification of the Care Plan
- Wraparound Phase 4: Transition
  - Transition
  - Networking
  - Community Resources

6

Participants will learn…

- 4 Phases of Wraparound
- 10 Principals of Wraparound
- SED definition
- Diagnoses that meet SED criteria
- Definition and purpose of initial conversations
- Sample Questions
- The difference between Need vs. Service
- The stages of change
- How to empower and support families
- Strategies for effectively engaging natural supports

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Participants will learn…

- The steps of care planning
- To develop goals and objectives, crisis and discharge planning
- How to set an agenda and establish ground rules
- The concepts of reframing, redirecting, summarizing and next steps
- Key elements of implementing and monitoring the care plan
- Steps for transitioning
- Effective networking skills
- Community resources

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What is Wraparound?

Wraparound is an intensive, holistic method of engaging with children, youth, and their families so that they can live in their homes and communities and realize their hopes and dreams.

http://nwi.pdx.edu/

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What is Wraparound?

- In recent years, Wraparound has been most commonly conceived of as an ***intensive, individualized care planning and management process***.
- The Wraparound *process* aims to achieve positive outcomes by providing a structured, creative and individualized team planning process that, compared to traditional treatment planning, results in plans that are more effective and more relevant to the child and family.
- Wraparound plans are more holistic than traditional care plans in that they are designed to meet the identified needs of caregivers and siblings and to address a range of life areas.
- Through the team-based planning and implementation process - Wraparound also aims to develop the problem-solving skills, coping skills, and self-efficacy of the young people and family members.
- There is an emphasis on integrating the youth into the community and building the family's social support network.

http://ivwt.pdx.edu/

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Why Does Wraparound Work?

- An effective team-based process
- Family/Youth voice and choice increases motivation
- Social support
- Strength-based process
- Proactive change process

SC101 (2014). State of Kentucky [PowerPoint slides].

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The Wraparound Process

- Teams are made up of 4 to 10 people who know the child best.
- Best practice is that more natural supports are on the team than professionals.
- Members of the team are chosen collaboratively and approved by the family.
- Team members are defined by roles, not titles.
- Plans are driven by youth and family strengths and needs.
- No two plans should look the alike
- Plans should be built around available services.

SC101 (2014). State of Kentucky [PowerPoint slides].

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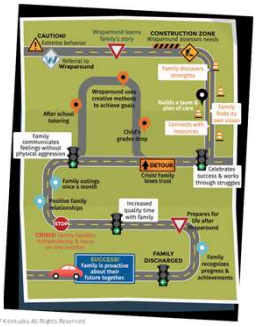

http://www.thewraparound.org/new-page-1/

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4 Phases of Wraparound

- Phase 1: Engagement and Team Preparation
- Phase 2: Initial Plan Development
- Phase 3: Implementation
- Phase 4: Transition

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4 Phases of Wraparound

- Phase 1: Engagement and Team Preparation
  - Family meets facilitator. Together they explore the family's strengths, needs and culture. They talk about what has worked in the past, and what to expect from wraparound. Facilitator engages other team members, and prepares for the first meeting.
- Phase 2: Initial Plan Development
  - Team members learn about the family's strengths, needs, and vision for the future. Team decides what to work on, how the work will be accomplished, and who is responsible for what. A plan is developed to manage crises that may occur.
- Phase 3: Implementation
  - Family and Team members meet regularly. Team reviews accomplishments and progress toward goals, and makes adjustments. Family and team members work together to implement the plan.
- Phase 4: Transition
  - As the team nears its goals, preparations are made for the family to transition out of formal wraparound. Family and team decide how family will continue to get support when needed, and how wraparound can be "re-started" if necessary.

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10 Principals of Wraparound

- Family voice and choice
- Team based
- Natural supports
- Collaboration
- Community-based
- Culturally competent
- Individualized
- Strengths based
- Persistence (Unconditional Care)
- Outcome based

http://ssel.pdx.edu/999-book/Chapters/Brunc-2.1-(10-principles-of-wrap).pdf

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10 Principals of Wraparound

- Family voice and choice
  - Family and youth/child perspectives are intentionally elicited and prioritized during all phases of the wraparound process. Planning is grounded in family members' perspective, and the team strives to provide options and choices such that the plan reflects family values and preferences.
- Team based
  - The wraparound team consists of individuals agreed upon by the family and committed to them through informal, formal, and community support and service relationships.
- Natural supports
  - The team actively seeks out and encourages the full participation of team members drawn from family members' networks of interpersonal and community relationships. The wraparound plan reflects activities and interventions that draw on sources of natural support

http://ssel.pdx.edu/999-book/Chapters/Brunc-2.1-(10-principles-of-wrap).pdf

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10 Principals of Wraparound

- Collaboration
  - Team members work cooperatively and share responsibility for developing, implementing, monitoring, and evaluating a single wraparound plan. The plan reflects a blending of team members' perspective, mandates, and resources. The plan guides and coordinates each team member's work towards meeting the team's goals.
- Community-based
  - The wraparound team implements service and support strategies that take place in the most inclusive, most responsive, most accessible, and least restrictive settings possible; and that safely promote child and family integration into home and community life.
- Culturally competent
  - The wraparound process demonstrates respect for and builds on the values, preferences, beliefs, culture, and identity of the child/youth and family, and their community.

http://ssel.pdx.edu/999-book/Chapters/Brunc-2.1-(10-principles-of-wrap).pdf

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10 Principals of Wraparound

- Individualized
  - To achieve the goals laid out in the wraparound plan, the team develops and implements a customized set of strategies, supports, and services.
- Strengths based
  - The wraparound process and the wraparound plan identify, build on, and enhance the capabilities, knowledge, skills, and assets of the child and family, their community, and other team members.
- Persistence
  - Despite challenges, the team persists in working toward the goals included in the wraparound plan until the team reaches agreement that a formal wraparound process is no longer required.
- Outcome based
  - The team ties the goals and strategies of the wraparound plan to observable of measurable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly.

http://ssel.psbs.edu/999-book/Chapters/Brans-2.1-(10-principles-of-wrap).pdf

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Severe Emotional Disability (SED) KRS 200.501 to 200.509

- "Child with a severe emotional disability" means a child with a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is listed in the current edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders and that:
- (a) Presents substantial limitations that have persisted for at least one (1) year or are judged by a mental health professional to be at high risk of continuing for one (1) year without professional intervention in at least two (2) of the following five (5) areas:

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Severe Emotional Disability (SED)

- "Self-care," defined as the ability to provide, sustain, and protect his or herself at a level appropriate to his or her age;
- "Interpersonal relationships," defined as the ability to build and maintain satisfactory relationships with peers and adults;
- "Family life," defined as the capacity to live in a family or family type environment;
- "Self-direction," defined as the child's ability to control his or her behavior and to make decisions in a manner appropriate to his or her age; and
- "Education," defined as the ability to learn social and intellectual skills from teachers in available educational settings; or
- (b) Is a Kentucky resident and is receiving residential treatment for emotional disability through the interstate compact; or
- (c) The Department for Community Based Services has removed the child from the child's home and has been unable to maintain the child in a stable setting due to behavioral or emotional disturbance; or
- (d) Is a person under twenty-one (21) years of age meeting the criteria of paragraph (a) of this subsection and who was receiving services prior to age eighteen (18) that must be continued for therapeutic benefit;

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5 Common Behavioral Diagnoses that Meet SED Criteria

- Attention Deficit Hyperactivity Disorder
- Depression
- Anxiety
- Post-Traumatic Stress Disorder
- Bi-polar

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ADHD

Symptoms

- Easily distracted
- Failure to listen to instructions properly
- Getting bored very easily
- Poor attention span
- Forgetfulness
- Hyperactive behavior
- Difficulty sitting still for long
- Fidgeting with hands or feet
- Talking too much or too often
- Restless behavior
- Getting out of seat in classroom
- General lack of self control
- Speaking inappropriately
- Aggression or agitation if upset
- Inability to get organized
- Having unfinished projects, home chores or school work

http://www.nightdiagnosis.com/a/adhd/symptoms.htm

Treatment

- Psychotherapy
  - CBT (Cognitive Behavioral Therapy)
  - Behavior Modification
  - Parent Training
- Medication Management

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Depression

Symptoms

- Feelings of sadness, emptiness or unhappiness
- Angry outbursts, irritability or frustration
- Loss of interest or pleasure in normal activities
- Sleep disturbances
- Tiredness and lack of energy
- Changes in appetite
- Anxiety, agitation or restlessness
- Feelings of worthlessness or guilt
- Trouble thinking, concentrating, making decisions and remembering things
- Frequent thoughts of death, suicidal thoughts, suicide attempts or suicide
- Unexplained physical problems

http://www.mayoclinic.org/

Treatment

- Psychotherapy
  - CBT (Cognitive Behavior Therapy)
- Medication Management
- Exercise
- Hospitalization (if suicidal)
- Residential Treatment Facilities
  - Typically hospitals/facilities are a last resort

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Anxiety

Symptoms

- Feeling nervous
- Feeling powerless
- Having a sense of impending danger, panic or doom
- Having an increased heart rate
- Breathing rapidly (hyperventilation)
- Sweating
- Trembling
- Feeling weak or tired
- Trouble concentrating or thinking about anything other than the present worry

Treatment

- Psychotherapy
  - CBT, Exposure Therapy, Nurturing Parenting
- Medication Management
- Exercise
- Avoid alcohol and other sedatives
- Use relaxation techniques
- Make sleep a priority
- Eat healthy

http://www.mayoclinic.org/

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PTSD

Symptoms

- Flashbacks—reliving the trauma over and over
- Bad dreams
- Frightening thoughts
- Staying away from places, events, or objects that are reminders of the experience
- Feeling emotionally numb
- Feeling strong guilt, depression, or worry
- Losing interest in activities that were enjoyable in the past
- Having trouble remembering the dangerous event
- Being easily startled
- Feeling tense or "on edge"
- Having difficulty sleeping, and/or having angry outbursts.

http://www.ninds.nih.gov/

Treatment

- Psychotherapy
  - TFCBT (Trauma Focused Cognitive Behavior Therapy)
- Cognitive therapy
- Exposure therapy
- Medication Management

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Bi-polar

Symptoms

- Feelings of euphoria *or* extreme irritability
- Unrealistic, grandiose beliefs
- Decreased need for sleep
- Increased energy
- Rapid speech and racing thoughts
- Impaired judgment and impulsivity
- Hyperactivity
- Anger or rage

(Ibid)

Treatment

- Psychotherapy
  - DBT - best used with adolescents
- Medication Management
- Electroconvulsive Therapy (ECT) - usually used as a last resort

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Phase 1: Family and Team Engagement

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Initial Conversations with family, youth, and team members

- Why are initial conversations important?
  - Initial conversations begin to build the foundations of the working relationship between the case manager, family and team members.
  - Initial conversations begin the BUY IN process. BUY IN is essential
  - Initial conversations initiate the family, youth, and team members to the wraparound process.

SCISS (2014). State of Kentucky [PowerPoint slides].

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"Nobody cares how much you know, until they know how much you care."

~Theodore Roosevelt

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Value Card Sort

- Select your top twenty values
- Narrow it down to ten
- Narrow it down to top three
- Share you top three
- Process as a team

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Value Card Website Information Website

Values Card exercise can be found and printed at the following website free of charge:

http://www.motivationalinterviewing.org/sites/default/files/valuescardsort_0.pdf

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Initial Conversation Analogy

If you went to lunch with someone you didn't know very well – Would you start the conversation by asking "what's your diagnosis?" or "what medication are you on?"

SCTDT (2014). State of Kentucky (PowerPoint slides).

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Initial Conversations with Parents

- Who do you call on when your world falls apart?
- What would you like your family's life to look like one or two years from now?
- What do people *not* get to see about your child that you wish they could?
- What is your child good at?
- What is a family tradition that you want your child to remember?
- Who is your child's hero and why do you think that is?
- What would you grab besides pictures and people if your home was on fire and you could?
- Who was the person who most influenced you as a child and who has that kind of influence over your child?

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Initial Conversations with Youth

- What is your mom/dad good at?
- Who do you call when your world falls apart?
- What is the best thing that has happened to you in the past week?
- Who do you look up to?
- What are you good at?
- What do you like to do when you aren't at school?
- Who is your hero and why?
- Tell about a time when you made someone proud?
- What song always puts you in a good mood and why?

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Initial Conversations with Team Members

- What characteristic do you like the most about the youth?
- Tell a time when the youth made you proud.
- What do you know about the Wraparound process?
- Tell a time when the youth was helpful to others.
- Tell a time when the youth was successful.

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https://www.youtube.com/watch?v=iQUWI5pmiUg

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Tips for Home Visits

- Be glad to be in the family's home.
- Listen well and use appropriate language.
- Be on time or call if you are going to be late.
- Be flexible.
- Dress comfortably, but respectfully.
- Be yourself and confident.
- Find the strengths.
- Include any family members in the house.
- Don't expect perfection for you or them.
- Do no remain in any uncomfortable or dangerous situation.
- Respect the family's culture.

SC101 (2014). State of Kentucky [PowerPoint slides].

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What is a Needs and Strength Based Assessment?

- Required by Medicaid
- Lays the groundwork and foundations for a successful plan
- Learn the good news and identify existing strengths
- Get a truly balanced picture
- Youth and family strengths pull them through life's crisis moments, not their pathology and diagnoses.
- Build on existing and strengths increases successes.

SC101 (2014). State of Kentucky [PowerPoint slides].

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Tips for Strength/Needs Assessments

Gives team members a chance to know the whole child, not their service history.

Listen for other possible team members and natural supports.

Strengths are gathered in a conversational manner with the youth, family and team members

Immediately identify and reflect back strengths you hear.

SCSU (2014). State of Kentucky [PowerPoint slides].

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https://www.youtube.com/watch?v=AZEIcuNEVdY

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Need vs. Service

- **A need is why a service is required**
- **A service is how we meet the need**
- Example: Client needs to have healthy teeth and gums
  - Service – Client will attend a dental appointment within the next 4 weeks and follow dentist recommendations.
- Example: Client needs to feel good about self
  - Service – Client will participate in individual therapy once per week for 2 hours for the next 8 weeks to learn coping skills to eliminate substance use.
- Example: Client needs to feel safe and secure at school
  - Service – Client will check in with favorite teacher 2 times per day for the next 8 weeks.

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Common Unmet Needs for Families

- Relationships that support family goals
- Sense of safety and well being
- Relevant skills and knowledge
- Power and control
- Sense of value and self worth
- Joy and dreams = HOPE

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Identifying Needs

- Behavior has a purpose: to get something or to avoid something
- Difficult behaviors result from unmet needs.
- Difficult behaviors tell us important things about a person's life.
- Allow the family and youth to voice their needs rather than focusing only the behaviors or symptoms.

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Common Challenging Behaviors

- Physically aggressive
- Refuses to complete homework or go to school
- Parent doesn't provide clear limits/boundaries
- Verbally aggressive
- Digs at skin until it bleeds
- Disrespectful
- My teacher picks on me
- My parents don't trust me
- I'm not allowed to make my own decisions

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Moving from Behavior to Needs

- Physically aggressive
- Refuses to do homework or go to school
- Parent doesn't provide clear limits/boundaries
- Needs to be allowed to express anger about his mother dying in a way that he will not hurt himself or others
- Needs to be reassured she can complete the work
- Mother needs to feel supported by father when she sets limits/boundaries

SCSSI (2014). State of Kentucky [PowerPoint slides].

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Moving from Behavior to Needs

- Verbally aggressive
- Digs at skin until it bleeds
- My teacher picks on me
- I'm not allowed to make my own decisions
- Needs to feel protected when at school.
- Needs to feel like parents can take care of "grown up" issues without her help or worry.
- Teacher needs to feel supported in the classroom
- Parents and youth need to negotiate clear boundaries around friendships.

SCSSI (2014). State of Kentucky [PowerPoint slides].

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Group Activity

- Read the scenario at your table.
- As a group, make a list of strengths for your table's scenario.
- Based on your scenario, identify the top 3 needs.

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Strengths and Case Planning

- Identify strengths and build upon those
  - Example: Susie wants to gain employment and she loves animals. A pet store, humane society, animal shelter or groomer may be a place of employment client would enjoy.
- Develop goals around strengths
- Its not fixing the deficits, its enhancing the strengths.
- Agency case plans will differ.

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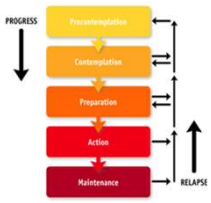
Stages of Change by Prochaska and DiClemente

- Pre-Contemplation
- Contemplation
- Preparation
- Action
- Maintenance
- Relapse



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Stages of Change

- Pre-Contemplation
  - Not currently considering change:
    - "Ignorance is bliss"

- Validate lack of readiness
- Clarify: decision is theirs
- Encourage re-evaluation of current behavior
- Encourage self-exploration, not action
- Explain and personalize the risk

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Stages of Change

- Contemplation
  - Ambivalent about change:
    - "Sitting on the fence"

- Validate lack of readiness
- Clarify: decision is theirs
- Encourage evaluation of pros and cons of behavior change
- Identify and promote new, positive outcome expectations

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Stages of Change

- Preparation
  - Some experience with change and are trying to change:
    - "Testing the waters"
- Identify and assist in problem solving re: obstacles
- Help patient identify social support
- Verify that patient has underlying skills for behavior change
- Encourage small initial steps

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Stages of Change

- Action
  - Practicing new behavior
- Focus on restructuring cues and social support
- Bolster self-efficacy for dealing with obstacles
- Combat feelings of loss and reiterate long-term benefits

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Stages of Change

- Maintenance
  - Continued commitment to sustaining new behavior
- Plan for follow-up support
- Reinforce internal rewards
- Discuss coping with relapse

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Stages of Change

- Relapse
  - Resumption of old behaviors:
    - "Fall from grace"
- Evaluate trigger for relapse
- Reassess motivation and barriers
- Plan stronger coping strategies

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What is Empowerment?

- The process of enhancing the capacity of individuals or groups to make choices and to transform those choices into desired actions and outcomes.

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Empower and Support in the Care Planning Process

- Family is able to name and invite team members of their choosing
- Family is able to prioritize needs and goals
- Empowering families to complete objectives independently with support of team.

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How do we empower our clients?

- Do for, Do With, Cheer On!
- Client is in need of academic success
  - CM will call the school and ask to speak with the staff member responsible for scheduling ARC meetings. CM will model a conversation with the facilitator while mother listens.
  - CM will have mother call the facilitator later in the week to follow up on progress of scheduling ARC meeting. CM will sit with mother while the call is made and be ready for any needed assistance.
  - Mother will continue to call on her own to follow up with the status of the ARC meeting.
  - CM will provide praise and encouragement to mother for advocating for her child's needs.

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How do we empower our clients?

- Father needs to feel he is supporting his family financially.
  - CM researches job openings in the area and shows father how to search for jobs.
  - CM goes with father to obtain and submit job applications while providing support.
  - Father obtains applications and completes applications on this own, resulting in employment.

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How do we empower our clients?

- 8 year old needs to feel safe at school
  - CM will model coping skills for client to use when client feels unsafe (skills client is learning in IT)
  - CM will practice learned coping skills with client.
  - CM will praise client when he uses his coping skills independently.

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What is a Natural Support?

- "Natural Supports" means personal associations and relationships typically developed in the community that enhance the quality and security of life for people, including, but not limited to, family relationships; friendships reflecting the diversity of the neighborhood and the community; association with fellow students or employees in regular classrooms and work places; and associations developed though participation in clubs, organizations, and other civic activities

Lanterman Developmental Disabilities Services Act, Section 4512 of the Welfare and Institutions Code, Part (m)

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What is a Personal Support?

- Support provided by individuals who know or are related to the individual or family, but do not provide a paid service.

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What is a Community Support?

- Supports that are part of the individual and/or family's community, such as faith community, neighborhood, or community organizations.

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Personal vs. Community Support

Personal

- Family
- Friends
- Relatives
- Neighbors
- Children's Friends
- School Classmates
- Work Colleagues

Community

- School
- Parks and Recreation
- Library
- Local Merchants
- Faith Based Organizations/Church
- Social Clubs
- Interest Groups

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Why Do Families Need Natural Supports?

- Families trust those whom they know care about them.
- Natural supports will be with the family for the long haul.
- Builds family resiliency.
- Shared commitment to success.
- Builds community connection.
- Builds new reputation.
- Natural supports can provide history, give reality checks, unlimited support, and know the family best.
- Add new ideas, abilities, and strengths to create new interventions.
- Improve access to community resources.
- Families can see more effective results and quicker outcomes.

(End)

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Group Activity

- As a group, discuss effective ways to engage natural supports in the care planning process.
  - Strategies to engage family members
  - Strategies to engage team members
  - Strategies to link supports to the team (think outside of the box)
  - Examples:
    - Ask the family: "Who do you want as part of your team?"
    - Be prepared to answer the questions: "What's in it for me? Why would I help?"
    - Transport family to Natural Support if family does not have transportation and Natural Support is within reasonable distance.

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Phase 2: Care Planning and Meeting Facilitation

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Steps to Care Planning

- Identification of Needs
- Prioritize Needs
- Develop Goals
- Develop Objectives
- Identify Resources
- Develop Crisis Plan
- Discharge and Transition Plan
- Set Next Meeting Date

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Identification of Needs

- Review strengths and identify any additional strengths.
- Using the Strength and Needs Assessment will assist in developing the needs for the client and family.
- Identifying needs will help the team develop goals and objectives that will be most beneficial to the client and family.
- Develop a family mission/vision statement.

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Prioritizing Needs

- It is important for the family to have the ability to prioritize their needs.
- What may seem like the most important need to the Case Manager and Therapist, may not be the most important need for the client or family.
- Prioritizing needs further focuses your care plan and the direction it will be headed.
- Team should not rehash or vent about situations, but may add to the strengths or needs list.

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Develop Goals

- Develop a Team Goal
  - Introduce as the overarching goal that will guide the team through the wraparound process.
- Using your strength and needs assessment and the family's prioritized needs, goals are developed.
- Remember the difference between Need vs. Service when developing goals.
- Goals should be measurable and attainable.

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Developing Goals

- NO "Cookie Cutter" approaches
- The plan is unique and customized to each individualized client/family.

- Questions to ask during development…
  - How do we know there is an unmet need?
  - Are there undesirable or difficult behaviors?
  - How do we write a measurable and observable goal?
  - Through tying the need and the behavior together in a goal statement by using SMART.

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SMART

- **S**pecific: What is it that the team wants to achieve?
  - Ask "who, what, where, when, and how?"
- **M**easurable: You need to be able to track the progress and measure the outcome.
  - Answer how much or how many?
- **A**ction-Oriented: Say what the team will do.
  - Describe a result
- **R**ealistic: Is this goal something the youth, family or team can actually do?
- **T**imeline: Goals should include a time limit.
  - "By when?"

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SMART Goal Formula

Team will meet _____ need, as evidenced by a reduction/increase in _____ behavior from _____ amount to _____ amount, as reported by _____ person(s) within _____ timeframe.

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Sample SMART Goals

- Daniel will increase his feelings of safety and security as evidenced by a reduction in walking out of class 5 times per week to 4 times per week, to be monitored and reported by Daniel and his teacher within the next two months.
- Briley will feel more confident about her ability to make friends as evidenced by a increase of social involvement with peers on the playground from 0 times per day to 2 times per day, as reported by Briley and her teacher within the next 2 months.

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Develop Objectives

- An objective is the specific act a team member is responsible for.
- Develop objectives for each goal.
  - Strategies, activities or interventions
- You should have at least 2 objectives per goal.
  - One for the case manager and one for another team member

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Development of Crisis Plan

- Define what a crisis would look like for the client
- List effective coping skills that have worked in the past
- Identify Natural/Community Supports
- Who do you call when your world falls apart?
- List name/phone numbers for natural supports
- List name/phone numbers for current mental health providers with After Hours Crisis Line
- List name/phone numbers for community supports (DCBS, DJJ, CDW)
- List 911 if immediate danger

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Set Next Meeting Date

- If you are not discharging or transitioning, always remember to set the next meeting date.
- Everyone is there, so get it on your calendar!

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Group Activity

- As a group, develop at least 2 goals and 3 objectives for each goal for your table's scenario

Use SMART goals!

- Develop a crisis plan for your scenario

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Identify Resources

- Keeping resources community based is essential.
  - If you have a family without transportation, you cannot expect them to travel to another city/county for needed services. This will set the family up to fail.
- Know the community you work in. Build rapport with your community partners. Developing relationships with community partners will give you the ability to broaden your resource pool for your families.
- Ask team members for their ideas and knowledge of community resources.
  - Some of our families teach us about resources.

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Community Resource Group Activity

- Compile a list for each geographic area represented at your table. List 5 community resources for each area and 2 State Level resources.
- Discuss the benefit your resources provide.
- Where do you go to find update information on resources?

Share your unique resources

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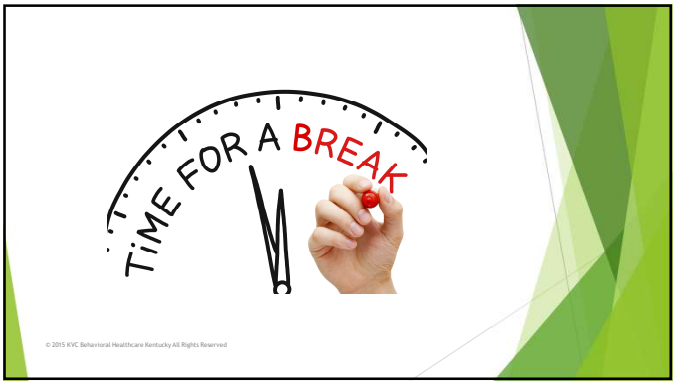
Effective Networking Skills

- **Strategically target your activities:** Not all networking events or organizations are equal; you need to determine which events will give you the best return.
- **Systematically plan networking:** Meaningful connections don't just happen—planning activities, evaluating experiences, and anticipating next moves lead to great connections.
- **Develop relationships over time:** You don't meet someone today and become their trusted advisor tomorrow. You need to learn how to build relationships and who to build them with.
- **Engage others effectively:** Sure, laughing and socializing with others is fun, but it is not how you create effective business networks. You need to learn how to engage meaningfully, remember people's names, and make sure they remember yours.
- **Showcase your expertise:** You should be able to describe your agencies programs and your role as a case manager.
- **Deliver value:** At its core, networking is an exchange of value—whether it is time, information, or your talents. You need to be able to recognize what you have to give, as well as what you want to get.

http://www.trainingmag.com/content/interpersonal-networking-skills-make-leaders-more-effective

84



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Discharge and Transition Plan

- How will the team know when the family no longer needs targeted case management services?
- Discharge planning begins at INTAKE!
- This should relate back to the team's Goals and/or Mission Statement
- Where will the youth and family go upon discharge?
- How will you help them get there?
- Have a celebration!!!!

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Group Activity

- Develop a discharge plan and celebration for the client in your scenario.

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Skills for Effective Team Meeting Facilitation

- Set an agenda
- Establish Ground Rules
- Reframe and Redirect
- Summarize the meeting at the end
- Assign Next Steps

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Phase 3: Plan Implementation and Monitoring

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Plan Implementation

- **Implement the Wraparound Plan**
  - Implement action steps for each strategy.
  - Team members are assigned and take responsibility for specific actions.
  - Track progress on action steps.
  - Assess if the plan is working.
  - Celebrate successes both large and small!
- **Revisit and update the individualized plan**
  - Consider new strategies as necessary
- **Maintain/build team cohesiveness and trust**
  - Maintain awareness of team members' satisfaction and "buy-in"
  - Address issues of team cohesiveness and trust
- **Complete necessary documentation and logistics.**

SCTDT (2016). State of Kentucky (PowerPoint slides).

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Process of Care Plan Modification

- When circumstances within the team change, a team meeting should be held to modify the care plan
  - Modify the plan by adding or changing goals and objectives

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Common Circumstances that Result in Care Plan Modification

- Client achieves the goal
- There is a change in the family system
- There is a change in the team dynamic
- Goal regression/lack of progress regarding goals
- Lack of buy-in from client, family or team members

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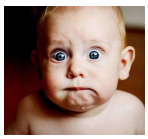
Uh-Oh! Oh No!

Circumstances have changed!
Time to modify your care plan!



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Phase 4: Transition

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Steps for Effective Transitioning

- Identification of needed treatment providers
  - It is important that the client and family knows what treatment providers they will continue to be connected to when Case Management ends.
  - Treatment providers and the family should know a specific date of transition.
- Natural Supports
  - Establishing natural supports is of the utmost importance. Who is the family going to lean on when case management services are complete? Who did the family rely on before case management services?
- Linkage/Connection to community resources
  - Ensuring your families have lists and phone numbers for community resources.

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