We Are All We Need Inc.
Florida 501(c)3 Non-Profit Organization

"Creating & Cultivating The Village"

The Village of System Care under the We Are All We Need, community revitalization project accepts incoming referrals from 4 main sources; DJJ, DCF, LCS and LCSO Civil Citation to provide Prevention, Intervention & Diversion WRAP around services to young people and their direct caregivers & siblings who are at risk of entering or further matriculating into the Juvenile Justice and/or Child Welfare System.

**Purpose**: The purpose is to describe the process for accepting & qualifying targeted referrals and connecting these at risk young people and direct caregivers and siblings to The Village Of Care via a personal and culturally competent intake process. TVOC provides early mental health & substance use screening, care coordination, LIFE Coaching & equitable access to necessary tier based services array ranging from Community Based Programming to Behavioral & Mental Health & Substance Use Services and ongoing transition support.

**Population of Focus**

The Population of focus for The Village of Care Prevention, Intervention & Diversion Program is young people ages 17 and under living in promise zone zip codes and are at risk of increased ACE's, High Risk Behaviors, Mental Illness or Substance Abuse, or co-occuring disorders and are at risk of entering or further matriculating through Juvenile Justice and/or Child Welfare System(s).

**Eligibility Criteria**

Young people will be identified by a referral form that includes identifying information, the name and contact information of caregiver/guardian if applicable and the referral source. Young people who meet at least 2 of the criteria will be onboarded:

1. Living in a Promise Zone Zip Code
2. Truant Suspended Expelled or Extended Absence due to COVID
3. On Probation or Supervised Released or Awaiting Entry to Residential Program
4. At Risk of entering Juvenile Justice or Child Welfare due to Exhibiting High Risk Behaviors

| Applicable Primary Mental & Behavioral Health Diagnosis and Symptoms Include: | |
|---|---|
| - Anxiety Disorders<br>- Adult Attention Deficit/Hyperactivity Disorder (ADHD/ADD)<br>- Bipolar and Related Disorders<br>- Depressive Disorders<br>- Obsessive - Compulsive and Related Disorders<br>- Trauma and Stressor-Related Disorders<br>- Schizophrenia Spectrum and other Psychotic Disorders<br>- Eating Disorders<br>- Gender Dysphoria | - Disruptive, Impulse - Control and Conduct Disorders<br>- Conduct Disorder<br>- Oppositional Defiant Disorder<br>- Intermittent Explosive Disorder<br>- Attention Deficit Hyperactivity Disorder<br>- Substance Use Disorders<br>- Social and Emotional Gaps due to Adverse Childhood Experiences and Adverse Community Environments<br>- Violent or Aggressive Behavior |
| | |

We Are All We Need Inc.
Florida 501(c)3 Non-Profit Organization

"Creating & Cultivating The Village"

**Referral Procedure**

A. The Village receives A completed electronic or paper Villager Referral Application with the name of the young person referred, identifying information, name of legal guardian if applicable, name of the referral source, and check all boxes and answer all questions that apply.
   1. Completed referral includes: Attach signed consent/release of information authorization WAAWN to release information to agencies providing services.
   2. Attach updated DJJ Face sheet, comprehensive evaluation and/or PAC-T Screen, and any other previously conducted mental health or substance use screen.
   3. If no mental health or substance use prescreen has been completed Intake Specialist will be referred to The LIFE Group to receive Social Emotional Pre-Screen HSE: DESSA-HSE, DESSA-HSE-mini via phone, virtual or in person.

B. Intake Specialist will Receive & Review referral to ensure completion. All identifying information for each referral received will be tracked in a secured database.

C. Once referral is verified for eligibility, Intake Specialist will begin the Onboarding process by classifying the new villager Tier 1-3 and create a Unique Villager Profile.
   1. Tier Based Classification: Based on pre-screening information Intake Specialist will assign youth a Tier from 1 - 3 which will trigger tier based referrals. *referrals without FACE sheet or pre-screen automatically get classified as Tier 0 until screened.
      a) Tier 1: Behavioral Health: Pre-Arrest with no need for clinical mental health or substance use assessment; Referral directly to Village Community Based Network Providers Mentor Program (Male/Female)
      b) Tier 2: High Risk Behavior Intervention: Civil Citation/Suspended/Expelled or Arrested youth needing Intervention/Diversion based Behavioral Health or Substance Use Services and Support; Referral to The LIFE Group, to be assigned a LIFE Coach and develop an Individualized LIFE Plan and WRAP Around resources.
      c) Tier 3: Diagnosed Mental Illness or Co-Occuring Disorder: Need full mental health assessment and/or clinical mental health services: Refer to The LIFE Group to be assigned a Wellness Recovery Action Planning (WRAP) Coach which will have 7 days to schedule Clinical Assessments with most culturally competent Mental Health Village Network Service Provider.

D. Upon successful onboarding, Intake Specialist will schedule first appointment for youth in person to make a warm introduction to assigned Network Provider, LIFE Coach, and or WRAP Coach.

E. During this first meeting, if possible, the Intake Specialist will build a rapport while obtaining information regarding their interests and provide information regarding the services available via The Village of Care and ensure via observation a successful Coaching/Provider match.

F. After the initial orientation is provided to the new villager, the Intake Specialist will have the villager and/or guardian if applicable, sign The Villagers Enrollment Forms, Pre-Screen and/or Individualized LIFE plan based on necessary services. Even if the villager does not consent to ongoing services referral's (after screening) the form(s) should be signed, and appropriate box checked.

G. Within the first month or 30 days of young person referral, the intake specialist will have successfully onboarded Villager and assigned a unique villager ID and Villager profile inclusive of all screening/assessments, signed documents including an Individualized LIFE Plan and will have submitted all initial referrals.

H. The assigned LIFE coach will input and manage the Villager coaching schedule electronically via their unique Villager Profile.
   1. Ensure all Referred Program Information is collected and input
   2. Input ILP Milestones and Goal
   3. Create Evaluation schedule
   4. Track Villager attendance, participation & incidents

I. When necessary the LIFE coach will schedule Multi-Disciplinary Staffing Team (MDST) meetings which includes Villager, Village parent/guardian or whomever the villager chooses, LIFE/WRAP Coach, Intake Specialist, Clinical Staff and Program Director

J. The assigned LIFE Coach will track progress monthly by updating Villager Profile.

K. Program Director will pull monthly progress reports and will report and submit qtly program data snapshots to PSCC committee and Village Action Council to ensure fidelity.

L. Program Director will facilitate bi-weekly meetings with Intake Specialist, Behavioral Health & Mental Health key personnel to discuss status of referrals and youth enrolled in The VOC.

M. Monthly VOC project team meetings will be held to discuss the status of referrals, address concerns and discuss service plans, provider performance and any new or incoming provider applications.

N. Quarterly Village Action Council (VAC) meetings will be held with leadership and PSCC to discuss the status of the program and aid with program needs that have been identified.

O. If young person is not accepted into program, Intake specialist will forward to Program Director to identify specific reasons and contact referral source with findings. The Program director will send out a list of references to referral source within 72 hours of denial.

## II. PROGRAM PROCESS

### A. Phase 1

1. Youth exhibits high risk behaviors in the community or at school without arrest.
2. The youth is detained at school or in community and eligible for diversion program.
3. The youth is arrested, booked and released on on supervision or probation.
   a) The Youths assigned LIFE coach will make contact with youth and family to build rapport and a connection. Coach will establish rapport, set goals and milestones and provide information on available Village Services (via the Village Network Providers) to successfully complete established and desired outcomes.
   b) Based on the villager tier level, the youth and family will work together to create an Individualized LIFE Plan that includes an array of services in which will support the successful achievement of goals & milestones. Goals and Milestones include school IEP or Behavior Plans, Civil Citation or other Diversionary Conditions and/or Probation Terms. Tier 3 youth ILP will also be inclusive of a Clinical Services Schedule.
      (1) Service Array includes enrollment/access of up to 10 months of:
         (a) Clinical Mental Health Services,
         (b) Behavioral Health Services (Substance Abuse),
         (c) LIFE Coaching,
         (d) WRAP Coaching,
         (e) Athletics,
         (f) Tutoring,
         (g) Legal Aid,
         (h) SOAR Housing Aid,
         (i) Resource Connection and Volunteering.
         (j) Sample Tier Based Service Array
            **i) Tier 1 - Prevention**
               (1) Provided Screening/Assessment
               (2) Assigned LIFE Coach - Group
               (3) General LIFE Plan
               (4) Given access to The LIFE Center Events & Services
               (5) 2 Network Referrals - 1 to include mentoring
                  (a) Mentoring & Athletics or Mentoring & Tutoring
            **ii) Tier 2 - High Risk Behavior Immediate Intervention (HRBII)**
               (1) Screened/Assessed if one has not been conducted
               (2) Assigned LIFE Coach - Individual
               (3) Access to Clinical Services
               (4) Signed Individualized LIFE Treatment Plan
               (5) WRAP Planning - Group & Individual Coaching

iii) **Tier 3 - Last Opportunity Support Team (LOST)**

(1) Diagnosed Mental Illness, Substance Abuse or Co-Occuring Disorder

(2) Assigned LIFE Coach - Individual

(3) Qtrly MDST Meetings

(4) Behavioral Health Plan

(5) Mental Health Plan

(6) Individualized LIFE Plan

c) Upon agreement to the ILP, the youth will actively participate in their ILP's service schedule and provided access to LIFE coach for 10 months in which they will meet regularly both in person and virtually with their LIFE coach to influence and track progress.

d) According to Villagers Schedule, high school villagers will conduct quarterly self assessments electronically to track Social Emotional Development.

e) During the Villagers 10 months, family members including siblings will have access to general village support such as group parent coaching, grief workshops and social emotional skill building opportunities. All youth and families will be encouraged to work with WRAP coach to establish a Wellness Recovery Action Plan for themselves and/or families.

**B. Phase 2**

1. The Villager is 30 Days prior to ILP term/completion.

a) The LIFE Coach meets with Villager and parents to review ILP and begin development of Villager Transition Plan. This plan includes a review of goal and milestone achievement, final post screens/assessments and a transition support plan which allows Villager ongoing access to The LIFE Center for up to 12 months.

b) The LIFE Coach will work with Tier 2 and Tier 3 youth to ensure ongoing access and provision for clinical & behavioral services as needed during transition period not to exceed 12 months.

c) Villager 14 - 17 will be referred to a WRAP Groups which meets as scheduled on weekends to develop Certified WRAP plans for Teens and Families.

d) Tier 1 youth will be engaged by LIFE coach to reduce any gaps of support services by conducing a transition meeting to discuss ongoing support needs.

e) LIFE coach will complete a Villager Transition plan and update Villager profile

**C. Phase 3**

1. Villager Completes ILP Term/Goals & Milestones.
2. Villager has already completed and agreed to Villager Transition Plan

a) Youth in high school will continue working with LIFE Coach weekly or bi-weekly and required to communicate at least 1 non-F2F communication weekly.
b) Youth not in High School will be assigned LIFE Groups and encouraged to attend at least 1 group monthly.
c) All Villages will have access to WRAP coaches and support groups and encouraged to continue development of WRAP plan.
d) The LIFE Coach will continue to work with family to ensure sibling support and family support structures are in place.
e) Support structures and services are but not limited to:
   (1) SOAR Housing Support
   (2) Financial Support & Aid Connection
   (3) SNAP Benefit Enrollment
   (4) Parent Support Groups
   (5) LIFE Support Group - Youth
   (6) WRAP Groups
   (7) Wrap Around Services
   (8) Therapies & Clinical Support
   (9) Faith Connection
   (10) Recovery Support Groups

**D. Phase 4**

1. Villager is Discharged from active villager status after 12 month transition period.
   a) Villager profile and records are securely maintained for up to 24 months in an inactive stage.
   b) Youth All established ongoing clinical and/or behavioral health treatment services will continue, or linkage with providers of the youth and families choosing will be facilitated by their LIFE Coach, WRAP Coach or Intake Specialist within 30 days of discharge.

III. Monthly VOC project team meetings will be held to discuss the status of referrals, address concerns and discuss service plans, provider performance and any new or incoming provider applications.
IV. Quarterly Village Action Council (VAC) meetings will be held with leadership and PSCC to discuss the status of the program and aid with program needs that have been identified.
V. WAAWN will ensure that all villagers are connected to ongoing support needs and services by completing bi-annual village check in communications.

**References:**

**National Wrap Around Implementation Center: https://www.nwic.org/**
**SAMHSA System of Care: http:..www.tapartnership.org/soc/socintro.php**