Wraparound Practice: Chapter 4a.1

Phases and Activities of the Wraparound Process: Building Agreement About a Practice Model

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In 2004, the National Wraparound Initiative (NWI) focused its attention on building agreement about essential elements of wraparound practice.[1] To begin this work, a small core group came together to review existing wraparound manuals and training materials. This core group, which included researchers, trainer/consultants, family members and administrators, used these materials as the basis for an initial version of a practice model. This initial version saw the wraparound process as consisting of a series of activities grouped into four phases: engagement, initial plan development, plan implementation, and transition.

This initial version of the practice model was circulated by email to an additional ten NWI members, primarily administrators of well-regarded wraparound programs. These stakeholders provided feedback in written and/or verbal form. This feedback was synthesized by the NWI coordinators and incorporated into a new draft of the practice model, which was reviewed and approved by the core group. The practice model that emerged from this process did not include any activities that were completely new (i.e., all the activities had appeared in one or more of the existing manuals or materials). However, the overall model was still quite different from any single model that had been described previously.

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1 A more detailed description of the process for defining the practice model can be found in Walker, J. S., & Bruns, E. J. (2006). Building on practice-based evidence: Using expert perspectives to define the wraparound process. *Psychiatric Services, 57,* 1579-1585.

As a next step in building agreement about practice, the core group sought feedback from the entire NWI advisory group which, at the time, had grown to include 50 members. Advisors were asked to rate each activity in the model in two ways: first, to indicate whether an activity like the one described was essential, optional, or inadvisable for wraparound; and second, whether, as written, the description of the activity was fine, acceptable with minor revisions, or unacceptable. Advisors were also given the opportunity to provide open-ended feedback about each activity, about the grouping of activities into phases, and about whether or not there were essential activities missing from the practice model.

Teams may use a variety of processes or procedures for eliciting needs or goals.

Overall, the 31 advisors who provided feedback expressed a very high level of agreement with the proposed set of activities. For 23 of the 31 activities presented, there all or all but one of the advisors agreed that the activity was essential. Advisors also found proposed descriptions of the activities generally acceptable. For 20 of the 31 proposed activities, the advisors were unanimous in finding the description acceptable.

The coordinators again revised the phases and activities, incorporating the feedback from the advisors. A document was prepared that described the phases and activities in more detail, and provided notes on each activity. These notes provided additional miscellaneous information, including the purpose of the activity, documentation or other products that should emerge from the activity, and/or cautions or challenges that might arise during the course of the activity. This document was reviewed by the core group and accepted by consensus.

The practice model, together with some of the commentary that accompanied it in its origi-nal form, is reproduced in the pages that follow. The final model included 32 activities grouped into the four phases. The intention was to define the activities in a manner that is sufficiently precise to permit fidelity measurement, but also sufficiently flexible to allow for diversity in the manner in which a given activity might be accomplished. The intention is to provide a "skeleton" of essential activities that can be accomplished or "fleshed out" in ways that are appropriate for individual communities or even individual teams. For example, an important activity during the phase of initial plan development is for the team to elicit a range of needs or goals for the team to work on, and then prioritize a small number of these to work on first. The practice model specifies that both of these two steps must happen, but does not specify *how* the steps should happen. Teams may use a variety of processes or procedures for eliciting needs or goals, and priority needs or goals can be selected using any of a variety of forms of decision making, including forms of voting or consensus building.

The remainder of this chapter is reproduced from the original *Phases and Activities* document. It begins with a few points that are important to keep in mind when reading about the phases and activities. Following these notes, the document lists and defines each of the four phases of the wraparound process. For each phase, the document describes the main goals to be accomplished in the phase and the activities that are carried out to meet each goal.

Phases and Activities of the Wraparound Process[2]

> ### Some notes:
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> - *The activities that follow identify a facilitator as responsible for guiding, motivating, or undertaking the various activities. This is not meant to imply that a single person must facilitate all of the activities, and we have not tried to specify exactly who should be responsible for each activity. The various activities may be split up among a number of different people. For example, on many teams, a parent partner or advocate takes responsibility for some activities associated with family and youth engagement, while a care coordinator is responsible for other activities. On other teams, a care coordinator takes on most of the facilitation activities with specific tasks or responsibilities taken on by a parent, youth, and/or other team members. In addition, facilitation of wraparound team work may transition between individuals over time, such as from a care coordinator to a parent, family member, or other natural support person, during the course of a wraparound process.*
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> - *The families participating in wraparound, like American families more generally, are diverse in terms of their structure and composition. Families may be a single biological or adoptive parent and child or youth, or may include grandparents and other extended family members as part of the central family group. If the court has assigned custody of the child or youth to some public agency (e.g., child protective services or juvenile justice), the caregiver in the permanency setting and/or another person designated by that agency (e.g. foster parent, social worker, probation officer) takes on some or all of the roles and responsibilities of a parent for that child and shares in selecting the team and prioritizing objectives and options. As youth become more mature and independent, they begin to make more of their own decisions, including inviting members to join the team and guiding aspects of the wraparound process.*
>
> - *The use of numbering for the phases and activities described below is not meant to imply that the activities must invariably be carried out in a specific order, or that one activity or phase must be finished before another can be started. Instead, the numbering and ordering is meant to convey an overall flow of activity and attention. For example, focus on transition activities is most apparent during the latter portions of the wraparound process; however, attention to transition issues begins with the earliest activities in a wraparound process.*

Phases and Activities of the Wraparound Process: Phase 1

MAJOR GOALS	ACTIVITIES	NOTES
PHASE 1: Engagement and team preparation			
During this phase, the groundwork for trust and shared vision among the family and wraparound team members is established, so people are prepared to come to meetings and collaborate. During this phase, the tone is set for teamwork and team interactions that are consistent with the wraparound principles, particularly through the initial conversations about strengths, needs, and culture. In addition, this phase provides an opportunity to begin to shift the family's orientation to one in which they understand they are an integral part of the process and their preferences are prioritized. The activities of this phase should be completed relatively quickly (within 1-2 weeks if possible), so that the team can begin meeting and establish ownership of the process as quickly as possible.		
1.1. Orient the family and youth GOAL: To orient the family and youth to the wraparound process.	*1.1 a. Orient the family and youth to wraparound* In face-to-face conversations, the facilitator explains the wraparound philosophy and process to family members and describes who will be involved and the nature of family and youth/child participation. Facilitator answers questions and addresses concerns. Facilitator describes alternatives to wraparound and asks family and youth if they choose to participate in wraparound. Facilitator describes types of supports available to family and youth as they participate on teams (e.g., family/youth may want coaching so they can feel more comfortable and/or effective in partnering with other team members).	This orientation to wraparound should be brief and clear, and should avoid the use of jargon, so as not to overwhelm family members. At this stage, the focus is on providing enough information so that the family and youth can make an informed choice regarding participation in the wraparound process. For some families, alternatives to wraparound may be very limited and/or non-participation in wraparound may bring negative consequences (as when wraparound is court ordered); however, this does not prevent families/youth from making an informed choice to participate based on knowledge of the alternatives and/or the consequences of non-participation.
	1.1 b. Address legal and ethical issues Facilitator reviews all consent and release forms with the family and youth, answers questions, and explains options and their consequences. Facilitator discusses relevant legal and ethical issues (e.g., mandatory reporting), informs family of their rights, and obtains necessary consents and release forms before the first team meeting.	Ethical and legal considerations will also need to be reviewed with the entire team as described in phase 2.

Phases and Activities of the Wraparound Process: Phase 1 (CONTINTUED)

MAJOR GOALS	ACTIVITIES	NOTES
1.2. Stabilize crises GOAL: To address pressing needs and concerns so that the family and team can give their attention to the wraparound process.	*1.2 a. Ask family and youth about immediate crisis concerns* Facilitator elicits information from the family and youth about immediate safety issues, current crises, or crises that they anticipate might happen in the very near future. These may include crises stemming from a lack of basic needs (e.g., food, shelter, utilities such as heat or electricity).	The goal of this activity is to quickly address the most pressing concerns. The whole team engages in proactive and future-oriented crisis/safety planning during phase 2. As with other activities in this phase, the goal is to do no more than necessary prior to convening the team, so that the facilitator does not come to be viewed as the primary service provider and so that team as a whole can feel ownership for the plan and the process.
	1.2 b. Elicit information from agency representatives and potential team members about immediate crises or potential crises Facilitator elicits information from the referring source and other knowledgeable people about pressing crisis and safety concerns.	Information about previous crises and their resolution can be useful in planning a response in 1.2.c.
	1.2 c. If immediate response is necessary, formulate a response for immediate intervention and/or stabilization Facilitator and family reach agreement about whether concerns require immediate attention and, if so, work to formulate a response that will provide immediate relief while also allowing the process of team building to move ahead.	This response should describe clear, specific steps to accomplish stabilization.
1.3. Facilitate conversations with family and youth/child GOAL: To explore individual and family strengths, needs, culture, and vision and to use these to develop a document that will serve as the starting point for planning.	*1.3 a. Explore strengths, needs, culture, and vision with child/youth and family.* Facilitator meets with the youth/child and family to hear about their experiences; gather their perspective on their individual and collective strengths, needs, elements of culture, and long-term goals or vision; and learn about natural and formal supports. Facilitator helps family identify potential team members and asks family to talk about needs and preferences for meeting arrangements (location, time, supports needed such as child care, translation).	This activity is used to develop information that will be presented to and augmented by the team in phase 2. Family members should be encouraged to consider these topics broadly.

Phases and Activities of the Wraparound Process: Phase 1 (CONTINTUED)

MAJOR GOALS	ACTIVITIES	NOTES
1.3. Facilitate conversations with family and youth/child GOAL: To explore individual and family strengths, needs, culture, and vision and to use these to develop a document that will serve as the starting point for planning. *(Continued from previous page)*	*1.3 b. Facilitator prepares a summary document* Using the information from the initial conversations with family members, the facilitator prepares a strengths-based document that summarizes key information about individual family member strengths and strengths of the family unit, as well as needs, culture, and vision. The family then reviews and approves the summary.	
1.4. Engage other team members GOAL: To gain the participation of team members who care about and can aid the youth/child and family, and to set the stage for their active and collaborative participation on the team in a manner consistent with the wraparound principles	*1.4 a. Solicit participation/ orient team members* Facilitator, together with family members if they so choose, approaches potential team members identified by the youth and family. Facilitator describes the wraparound process and clarifies the potential role and responsibilities of this person on the team. Facilitator asks the potential team members if they will participate. If so, facilitator talks with them briefly to learn their perspectives on the family's strengths and needs, and to learn about their needs and preferences for meeting.	The youth and/or family may choose to invite potential team members themselves and/or to participate in this activity alongside the facilitator. It is important, however, not to burden family members by establishing (even inadvertently) the expectation that they will be primarily responsible for recruiting and orienting team members.
1.5. Make necessary meeting arrangements GOAL: To ensure that the necessary procedures are undertaken for the team is prepared to begin an effective wraparound process.	*1.5 a. Arrange meeting logistics* Facilitator integrates information gathered from all sources to arrange meeting time and location and to assure the availability of necessary supports or adaptations such as translators or child care. Meeting time and location should be accessible and comfortable, especially for the family but also for other team members. Facilitator prepares materials—including the document summarizing family members' individual and collective strengths, and their needs, culture, and vision—to be distributed to team members.	

Phases and Activities of the Wraparound Process: Phase 2

MAJOR GOALS	ACTIVITIES	NOTES
PHASE 2: Initial plan development		
During this phase, team trust and mutual respect are built while the team creates an initial plan of care using a high-quality planning process that reflects the wraparound principles. In particular, youth and family should feel, during this phase, that they are heard, that the needs chosen are ones they want to work on, and that the options chosen have a reasonable chance of helping them meet these needs. This phase should be completed during one or two meetings that take place within 1-2 weeks, a rapid time frame intended to promote team cohesion and shared responsibility toward achieving the team's mission or overarching goal.		
2.1. Develop an initial plan of care GOAL: To create an initial plan of care using a high-quality team process that elicits multiple perspectives and builds trust and shared vision among team members, while also being consistent with the wraparound principles	*2.1 a. Determine ground rules* Facilitator guides team in a discussion of basic ground rules, elicits additional ground rules important to team members, and facilitates discussion of how these will operate during team meetings. At a minimum, this discussion should address legal and ethical issues—including confidentiality, mandatory reporting, and other legal requirements—and how to create a safe and blame-free environment for youth/family and all team members. Ground rules are recorded in team documentation and distributed to members.	In this activity, the team members define their collective expectations for team interaction and collaboration. These expectations, as written into the ground rules, should reflect the principles of wraparound. For example, the principles stress that interactions should promote family and youth voice and choice and should reflect a strengths orientation. The principles also stress that important decisions are made within the team.
	2.1 b. Describe and document strengths Facilitator presents strengths from the summary document prepared during phase 1, and elicits feedback and additional strengths, including strengths of team members and community.	While strengths are highlighted during this activity, the wraparound process features a strengths orientation throughout.
	2.1 c. Create team mission Facilitator reviews youth and family's vision and leads team in setting a team mission, introducing idea that this is the overarching goal that will guide the team through phases and, ultimately, through transition from formal wraparound.	The team mission is the collaboratively set, long-term goal that provides a one or two sentence summary of what the team is working towards.

Phases and Activities of the Wraparound Process: Phase 2 (CONTINTUED)

MAJOR GOALS	ACTIVITIES	NOTES
2.1. Develop an initial plan of care GOAL: To create an initial plan of care using a high-quality team process that elicits multiple perspectives and builds trust and shared vision among team members, while also being consistent with the wraparound principles *(Continued from previous page)*	**2.1 d. Describe and prioritize needs/goals** Facilitator guides the team in reviewing needs and adding to list. The facilitator then guides the team in prioritizing a small number of needs that the youth, family, and team want to work on first, and that they feel will help the team achieve the mission.	The elicitation and prioritization of needs is often viewed as one of the most crucial and difficult activities of the wraparound process. The team must ensure that needs are considered broadly, and that the prioritization of needs reflects youth and family views about what is most important. Needs are not services but rather broader statements related to the underlying conditions that, if addressed, will lead to the accomplishment of the mission.
	2.1 e. Determine goals and associated outcomes and indicators for each goal Facilitator guides team in discussing a specific goal or outcome that will represent success in meeting each need that the team has chosen to work on. Facilitator guides the team in deciding how the outcome will be assessed, including specific indicators and how frequently they will be measured.	Depending on the need being considered, multiple goals or outcomes may be determined. Similarly, for each goal or outcome determined by the team for measurement, multiple indicators may be chosen to be tracked by the team. However, the plan should not include so many goals, outcomes, or indicators that team members become overwhelmed or tracking of progress becomes difficult.
	2.1 f. Select strategies Facilitator guides the team in a process to think in a creative and open-ended manner about strategies for meeting needs and achieving outcomes. The facilitator uses techniques for generating multiple options, which are then evaluated by considering the extent to which they are likely to be effective in helping reach the goal, outcome, or indicator associated with the need; the extent to which they are community based, the extent to which they build on/incorporate strengths; and the extent to which they are consistent with family culture and values. When evaluating more formal service and support options, facilitator aids team in acquiring information about and /or considering the evidence base for relevant options.	This activity emphasizes creative problem solving, usually through brainstorming or other techniques, with the team considering the full range of available resources as they come up with strategies to meet needs and achieve outcomes. Importantly, this includes generating strategy options that extend beyond formal services and reach families through other avenues and time frames. These are frequently brainstormed by the team, with the youth and family and people representing their interpersonal and community connections being primary nominators of such supports. Finally, in order to best consider the evidence base for potential strategies or supports, it may be useful for a wraparound team or program to have access to and gain counsel from a point person who is well-informed on the evidence base.

Phases and Activities of the Wraparound Process: Phase 2 (CONTINTUED)

MAJOR GOALS	ACTIVITIES	NOTES
2.1. Develop an initial plan of care GOAL: To create an initial plan of care using a high-quality team process that elicits multiple perspectives and builds trust and shared vision among team members, while also being consistent with the wraparound principles *(Continued from previous page)*	**2.1 g. Assign action steps** Team assigns responsibility for undertaking action steps associated with each strategy to specific individuals and within a particular time frame.	Action steps are the separate small activities that are needed to put a strategy into place, for example, making a phone call, transporting a child, working with a family member, finding out more information, attending a support meeting, arranging an appointment. While all team members will not necessarily participate at the same level, all team members should be responsible for carrying out action steps. Care should be taken to ensure that individual team members, particularly the youth and family, are not overtaxed by the number of action steps they are assigned.
2.2. Develop crisis/safety plan GOAL: To identify potential problems and crises, prioritize according to seriousness and likelihood of occurrence, and create an effective and well-specified crisis prevention and response plan that is consistent with the wraparound principles. A more proactive safety plan may also be created.	**2.2 a. Determine potential serious risks** Facilitator guides the team in a discussion of how to maintain the safety of all family members and things that could potentially go wrong, followed by a process of prioritization based on seriousness and likelihood of occurrence.	Past crises, and the outcomes of strategies used to manage them, are often an important source of information in current crisis/safety planning.
	2.2 b. Create crisis/safety plan In order of priority, the facilitator guides team in discussion of each serious risk identified. The discussion includes safety needs or concerns and potential crisis situations, including antecedents and associated strategies for preventing each potential type of crisis, as well as potential responses for each type of crisis. Specific roles and responsibilities are created for team members. This information is documented in a written crisis plan. Some teams may also undertake steps to create a separate safety plan, which specifies all the ways in which the wraparound plan addresses potential safety issues.	One potential difficulty with this activity is the identification of a large number of crises or safety issues can mean that the crisis/safety plan "takes over" from the wraparound plan. The team thus needs to balance the need to address all risks that are deemed serious with the need to maintain focus on the larger wraparound plan as well as youth, family, and team strengths.
2.3. Complete necessary documentation and logistics	**2.3 a. Complete documentation and logistics** Facilitator guides team in setting meeting schedule and determining means of contacting team members and distributing documentation to team members.	

Phases and Activities of the Wraparound Process: Phase 3

MAJOR GOALS	ACTIVITIES	NOTES
PHASE 3: Implementation		
During this phase, the initial wraparound plan is implemented, progress and successes are continually reviewed, and changes are made to the plan and then implemented, all while maintaining or building team cohesiveness and mutual respect. The activities of this phase are repeated until the team's mission is achieved and formal wraparound is no longer needed.		
3.1. Implement the wraparound plan GOAL: To implement the initial plan of care, monitoring completion of action steps and strategies and their success in meeting need and achieving outcomes in a manner consistent with the wraparound principles.	*3.1 a. Implement action steps for each strategy* For each strategy in the wraparound plan, team members undertake action steps for which they are responsible. Facilitator aids completion of action steps by checking in and following up with team members; educating providers and other system and community representatives about wraparound as needed; and identifying and obtaining necessary resources.	The level of need for educating providers and other system and community representatives about wraparound varies considerably from one community to another. Where communities are new to the type of collaboration required by wraparound, getting provider "buy in" can be very difficult and time consuming for facilitators. Agencies implementing wraparound should be aware of these demands and be prepared to devote sufficient time, resources, and support to this need.
	3.1 b. Track progress on action steps Team monitors progress on the action steps for each strategy in the plan, tracking information about the timeliness of completion of responsibilities assigned to each team member, fidelity to the plan, and the completion of the requirements of any particular intervention.	Using the timelines associated with the action steps, the team tracks progress. When steps do not occur, teams can profit from examining the reasons why not. For example, teams may find that the person responsible needs additional support or resources to carry out the action step, or, alternatively, that different actions are necessary.
	3.1 c. Evaluate success of strategies Using the outcomes/indicators associated with each need, the facilitator guides the team in evaluating whether selected strategies are helping team meet the youth and family's needs.	Evaluation should happen at regular intervals. Exactly how frequently may be determined by program policies and/or the nature of the needs/goals. The process of evaluation should also help the team maintain focus on the "big picture" defined by the team's mission: Are these strategies, by meeting needs, helping achieve the mission?
	3.1. d. Celebrate successes The facilitator encourages the team to acknowledge and celebrate successes, such as when progress has been made on action steps, when outcomes or indicators of success have been achieved, or when positive events or achievements occur.	Acknowledging success is one way of maintaining a focus on the strengths and capacity of the team and its members. Successes do not have to be "big", nor do they necessarily have to result directly from the team plan. Some teams make recognition of "what's gone right" a part of each meeting.

Phases and Activities of the Wraparound Process: Phase 3 (CONTINTUED)

MAJOR GOALS	ACTIVITIES	NOTES
3.2. Revisit and update the plan GOAL: To use a high quality team process to ensure that the wraparound plan is continually revisited and updated to respond to the successes of initial strategies and the need for new strategies.	*3.2. a. Consider new strategies as necessary* When the team determines that strategies for meeting needs are not working, or when new needs are prioritized, the facilitator guides the team in a process of considering new strategies and action steps using the process described in activities 2.1.f and 2.1.g.	Revising of the plan takes place in the context of the needs identified in 2.1.d. Since the needs are in turn connected to the mission, the mission helps to guide evaluation and plan revisions.
3.3. Maintain/build team cohesiveness and trust GOAL: To maintain awareness of team members' satisfaction with and "buy-in" to the process, and take steps to maintain or build team cohesiveness and trust.	*3.3 a. Maintain awareness of team members' satisfaction and "buy-in"* Facilitator makes use of available information (e.g., informal chats, team feedback, surveys—if available) to assess team members' satisfaction with and commitment to the team process and plan, and shares this information with the team as appropriate. Facilitator welcomes and orients new team members who may be added to the team as the process unfolds.	Many teams maintain formal or informal processes for addressing team member engagement or "buy in", e.g. periodic surveys or an end-of-meeting wrap-up activity. In addition, youth and family members should be frequently consulted about their satisfaction with the team's work and whether they believe it is achieving progress toward their long-term vision, especially after major strategizing sessions. In general, however, this focus on assessing the process of teamwork should not eclipse the overall evaluation that is keyed to meeting identified needs and achieving the team mission.
	3.3 b. Address issues of team cohesiveness and trust Making use of available information, facilitator helps team maintain cohesiveness and satisfaction (e.g., by continually educating team members—including new team members—about wraparound principles and activities, and/or by guiding team in procedures to understand and manage disagreement, conflict, or dissatisfaction).	Teams will vary in the extent to which issues of cohesiveness and trust arise. Often, difficulties in this area arise from one or more team members' perceptions that the team's work—and/or the overall mission or needs being currently addressed—is not addressing the youth and family's "real" needs. This points to the importance of careful work in deriving the needs and mission in the first place, since shared goals are essential to maintaining team cohesiveness over time.
3.4. Complete necessary documentation and logistics	*3.4 a. Complete documentation and logistics* Facilitator maintains/updates the plan and maintains and distributes meeting minutes. Team documentation should record completion of action steps, team attendance, use of formal and informal services and supports, and expenditures. Facilitator documents results of reviews of progress, successes, and changes to the team and plan. Facilitator guides team in revising meeting logistics as necessary and distributes documentation to team members.	Team documentation should be kept current and updated, and should be distributed to and/or available to all team members in a timely fashion.

Phases and Activities of the Wraparound Process: Phase 4

MAJOR GOALS	ACTIVITIES	NOTES
PHASE 4: Transition *During this phase, plans are made for a purposeful transition out of formal wraparound to a mix of formal and natural supports in the community (and, if appropriate, to services and supports in the adult system). The focus on transition is continual during the wraparound process, and the preparation for transition is apparent even during the initial engagement activities.*		
4.1. Plan for cessation of formal wraparound GOAL: To plan a purposeful transition out of formal wraparound in a way that is consistent with the wraparound principles, and that supports the youth and family in maintaining the positive outcomes achieved in the wraparound process.	*4.1 a. Create a transition plan* Facilitator guides the team in focusing on the transition from wraparound, reviewing strengths and needs and identifying services and supports to meet needs that will persist past formal wraparound.	Preparation for transition begins early in the wraparound process, but intensifies as team meets needs and moves towards achieving the mission. While formal supports and services may be needed post-transition, the team is attentive to the need for developing a sustainable system of supports that is not dependent on formal wraparound. Teams may decide to continue wraparound—or a variation of wraparound—even after it is no longer being provided as a formal service.
	4.1 b. Create a post-transition crisis management plan Facilitator guides the team in creating post-wraparound crisis management plan that includes action steps, specific responsibilities, and communication protocols. Planning may include rehearsing responses to crises and creating linkage to post-wraparound crisis resources.	At this point in transition, youth and family members, together with their continuing supports, should have acquired skills and knowledge in how to manage crises. Post-transition crisis management planning should acknowledge and capitalize on this increased knowledge and strengthened support system. This activity will likely include identification of access points and entitlements for formal services that may be used following formal wraparound.
	4.1 c. Modify wraparound process to reflect transition New members may be added to the team to reflect identified post-transition strategies, services, and supports. The team discusses responses to potential future situations, including crises, and negotiates the nature of each team member's post-wraparound participation with the team/family. Formal wraparound team meetings reduce frequency and ultimately cease.	Teams may continue to meet using a wraparound process (or other process or format) even after formal wraparound has ended. Should teamwork continue, family members and youth, or other supports, will likely take on some or all of the facilitation and coordination activities.

Phases and Activities of the Wraparound Process: Phase 4 (CONTINTUED)

MAJOR GOALS	ACTIVITIES	NOTES
4.2. Create a "commencement" GOAL: To ensure that the cessation of formal wraparound is conducted in a way that celebrates successes and frames transition proactively and positively.	**4.2 a. Document the team's work** Facilitator guides team in creating a document that describes the strengths of the youth/child, family, and team members, and lessons learned about strategies that worked well and those that did not work so well. Team participates in preparing/reviewing necessary final reports (e.g., to court or participating providers, where necessary)	This creates a package of information that can be useful in the future.
	4.2 b. Celebrate success Facilitator encourages team to create and/or participate in a culturally appropriate "commencement" celebration that is meaningful to the youth/child, family, and team, and that recognizes their accomplishments.	This activity may be considered optional. Youth/child and family should feel that they are ready to transition from formal wraparound, and it is important that "graduation" is not constructed by systems primarily as a way to get families out of services.
4.3. Follow-up with the family GOAL: To ensure that the family is continuing to experience success after wraparound and to provide support if necessary.	**4.3 a. Check in with family** Facilitator leads team in creating a procedure for checking in with the youth and family periodically after commencement. If new needs have emerged that require a formal response, facilitator and/or other team members may aid the family in accessing appropriate services, possibly including a reconvening of the wraparound team.	The check-in procedure can be done impersonally (e.g., through questionnaires) or through contact initiated at agreed-upon intervals either by the youth or family, or by another team member.

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Wraparound Practice: Chapter 4a.2

The Phases of Wraparound: Real Life & Teams

Matt Pierce, Wraparound Trainer/Administrator

Andrew is a nine-year-old boy who was referred to the behavioral health system for the third time after being removed from his mother, Ms. Smith, and placed in Child Protective Services custody. Child Protective Services removed Andrew as a result of potential abuse and multiple unsuccessful attempts, despite implementation by family preservation services, to support Ms. Smith and Andrew to live together. The referral also noted Andrew had significant behavior challenges in the home and at school including property destruction and verbal and physical aggression towards peers and adults. Finally, the referral noted that Andrew was having difficulty establishing and maintaining relationships. Andrew is currently living in a group home shelter placement.

Molly, a case manager for a small behavioral health agency in her third week of employment is excited to start directly working with families. She has spent the first two weeks on the job in training, learning about wraparound and the child and family team process (Arizona's specific term for its team-based care management process). Molly is jazzed about the opportunity to serve families utilizing approaches that view families as partners and recognize strengths within children and their families.

Andrew is Molly's first referral, and her first assignment is to determine which practice model she's going to use in serving Andrew and his family. After reviewing the referral information and a brief conversation with the Child Protective Services case worker, Angie, she finds herself confused as to what her initial steps should be in beginning a team process for Andrew and his family. Molly approached Jim, her supervisor, and asked him for guidance around where to begin, Jim's response was pretty simple: "Do you know

The Resource Guide to Wraparound

what to do? If you do, follow child and family team practice steps. If you don't know how to move ahead, use wraparound." Molly asked for more clarity. Jim continued to explain, stating "If you are clear and confident in the fit between what's needed and what you can provide then go ahead and do it. If you're undecided and unclear as to what is needed or what will work due to the complexity of the situation or limitations of the system resources, wraparound would be the proposed practice model to implement."

He then took out a piece of paper and said, "We try at our agency to practice using the wraparound principles for all 10,000 families we serve, but we also know we can't possibly follow all of the steps of the wraparound process with any reliability for all of those families. So when we're

confident about having a clue about what to do and how to do it, we move fast and work collaboratively with the family. When we're confused or pretty sure that we don't have a good grasp on the answers we follow the wraparound process."

Jim then sketched out some differences between child and family team practice and wraparound practice on a piece of paper. Table 1 displays what he identified.

Molly explained she wasn't clear about what to do in Andrew's situation, especially since counseling and other system responses hadn't worked. Since that was true, she proposed following the wraparound process with Andrew and Ms. Smith. Jim smiled and responded "You're a quick learner. Go have some fun."

Table 1. Differences in Practice

	Standard Child and Family Team Practice	Wraparound Practice
Engagement	Engagement is primarily between us and the family with secondary engagement with others involved.	Engagement is ecological: facilitator, team, family, agencies, broader community and everyone else.
Crisis Stabilization	Stabilization is a big part of what the case manager does with the family. "The team" is family and case manager with others.	We try to avoid too much in the stabilization step. We do just enough to hold on until we can get the team process started.
Strengths	We do strengths discovery, but it's more limited—strengths are seen as grounded in the family and child, and may be less explicit drivers of practice. We share information on strengths with whoever is involved on as-needed basis.	Strengths discovery is more ecological, and we identify and use strengths and capacities of the family, child, community, and potential team members. Reframing the family as people with potential solutions, the gathered information is public and shared with all of the team being present.
Team	"Teaming" is a verb—something we do with the family usually through a team of two perspectives (case manager and family), though case manager may interact with natural supports.	The team is an entity—something we are. The addition of natural supports is important and their participation is a formalized part of the process as we make decisions.
Who is Served	All enrolled youth are served through the child and family team process.	Wraparound is utilized with youth for whom formal and traditional services have proven to be ineffective and folks involved don't know what to do.

Engagement and Team Preparation

Molly visited Andrew's mother, Ms. Smith, at her apartment and Andrew at the shelter to get to know them and explain the wraparound process. During these visits Molly focused on explaining her role and responding to immediate crisis needs. She also explored strengths, needs, culture, and Andrew and his mother's vision of the future. Throughout all this, she attempted to establish trust. After a series of visits it became increasingly clear that Andrew and his mother wanted to be together.

During this time Andrew wasn't doing well at the group home. He was having trouble sleeping through the night and was fighting with some of the other kids at the group home. He also had some altercations with staff that resulted in many of his privileges being taken away from him, including phone contact with his mother. Molly started to receive requests for assistance from the group home manager, Mike, about Andrew's behavior. She met with the group home staff and the CPS caseworker, Angie, and developed a crisis plan to stabilize Andrew's placement. Molly looked forward to meeting with others to develop a crisis plan partially because she was comfortable with this type of planning thanks to her previous employment completing functional behavioral assessments for individuals with developmental disabilities. During the meeting Molly used her experience and skills and guided the team to look at reasons why some of the behavior was occurring. It was noted the fights or altercations usually occurred after dinner when Andrew was instructed to do a chore or something that he didn't want to do. Fights would also occur when he asked to call his mom and was told no. Steps in the crisis plan included getting a direct support provider from 4pm-8pm daily to help Andrew through this portion of the day. The group home staff also agreed to quit using contact with mom as a reward or consequence and allowed Andrew to contact his mom daily no matter how he behaved.

The crisis plan was developed and put into action within two weeks from the time Molly received the referral. As the crisis plan was implemented, Andrew's behavior started to improve. This allowed Molly the opportunity to focus on other activities necessary to build a team and start pro-

actively planning with the Smith family. The next step for Molly was to meet with the CPS worker to review what she had learned during her meetings with Andrew and Ms. Smith. Molly was also gathering Angie's perspective on the hopes and dreams she had for the Smith family and what would be needed for Andrew and Ms. Smith to be able to live together. Angie was apprehensive about the idea of Andrew returning home to live with his mom during these initial conversations. Angie made statements like "Mom has to prove that she's willing to change the way she's parenting," and "I have to make sure Andrew will be safe, it's my tail if something bad happens to Andrew again."

Molly's initial response was emotional and focused on "That's not right, if mom and Andrew want to live together it's up to us to figure out how we're going to make it happen." She decided to go to her supervisor, Jim, to help design some specific strategies to engage the CPS worker. Jim suggested that Molly slow down and validate Angie's concerns and work with her on achieving some common ground. Molly took this instruction and changed her approach from "I'm right and you're wrong." At this point she started having conversations with the CPS worker around developing a shared vision that included ensuring the safety of Andrew while returning to live with his mom. Molly was able to establish a relationship with the CPS worker by validating her concerns and fears and creating a mantra of "shared accountability" between systems to ensure safety. This didn't happen overnight but over the course of three weeks Molly and Angie built a trusting relationship that allowed both perspectives to be understood and respected.

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As Andrew's behavior stabilized, Molly devoted more time to exploring the family's strengths, culture and vision. She also contacted other people in the family's life, including:

- Andrew's favorite teacher, Mrs. Franklin;
- Ms. Smith's friend from work, Sandy; and
- two neighbors who provided after school care.

During the next two weeks Molly took notes on each encounter. She approached her supervisor again. "OK, I feel like I have a lot of information but I'm not sure what exactly to do with it. I know it's valuable, but how do I make it useful?" Jim's response was, "Take the information and write it into a working document that outlines the vision, strengths, needs and culture of the Smith family. Present that to team members at the first team meeting. You will update the document as you go along. This information will help the team to develop a plan of care for the family." As Jim was talking Molly was thinking to herself, "Duh, I learned that in training," but politely nodded her head and thanked Jim for his help.

After this discussion, Molly developed a document reflective of the Smith family. Molly scheduled the first team meeting which included the following individuals:

- Ms. Smith
- Andrew
- Angie - CPS case worker
- Mike – Group home manager
- Jamie- Neighbor
- Sandy- Mom's best friend
- Mrs. Franklin- Andrew's 2nd grade teacher
- Dave – Direct support worker
- Jane - Therapist
- Molly- Facilitator

Initial Plan Development

Molly contacted all of the team members shortly before the meeting to confirm their attendance. She oriented them to the overall wraparound process, the way the team meeting would proceed, and the initial purpose of the team (Andrew safely returning to live with his mother). She then developed the meeting agenda. As she was doing this, Jim stopped by and offered some words of wisdom to Molly about facilitating the first team meeting stating "Don't try to be a hero—the team was created for a reason. Rely on everybody's expertise in developing the plan. Think of yourself like a movie director. Your role in producing a successful team meeting is ensuring the stage is set so the actors can act."

The initial team meeting began with everyone introducing themselves and their relationship to the family. After introductions, Molly urged team members to be creative and generate a mission statement that would describe the team's purpose. After much discussion, Andrew spoke up and said "I belong home with my mom." Things got silent until Angie said, "How about the mission statement of Andrew belongs home." Everyone agreed. After the team mission was established, Molly led the team in developing ground rules for future meetings. The team established the following five ground rules:

- No shaming or blaming of any team member
- Stay focused on the mission
- Be on time
- Do what we say we're going to do
- There are no dumb ideas

Molly then shared her document that outlined the vision, strengths, needs, and culture of the family. She asked the team to review for accuracy and to voice any additions they would like to make. The team members verified the document's accuracy but Ms. Smith and Mike added some additional strengths for Andrew. Molly stated she would send an updated version to everyone. She then guided the team in prioritizing the needs statements listed in the document. Molly led the team in discussing the needs and made sure Ms. Smith's perspective was well represented. Ultimately, the team agreed to focus on the following needs:

- Andrew needs to know others will keep him safe when he's unable to do so

- Ms. Smith needs to feel a sense of safety within her home
- Andrew needs to see that love doesn't always have to hurt
- Ms. Smith needs to be validated for her efforts in what she's trying to do

The next step involved developing goals for each of the needs. Molly moved the discussion to brainstorming options on how the team is going to meet the targeted goals. Molly asked the team to come up with at least 10 possible strategies for each goal. She referenced the "no dumb ideas" ground rule. Everyone participated in brainstorming, including Andrew.

The team selected from their list of strategies and developed specific action steps that they were going to implement to meet the identified goals. Molly clarified who would do each action step and when it would be completed. After the team completed the initial plan, the energy in the room was extremely high. Molly nervously asked the team, "What could go wrong with this plan?' The energy instantly diffused as the room became quiet. Molly found herself becoming increasingly nervous and at a loss for words, when Ms. Smith stepped up and said "Molly, I appreciate you asking that, because we've had professionals and people involved in the past that we thought we could trust and they were famous for saying they were going to help but they never followed through and ended up causing more harm than good." The team listened intently to Ms. Smith, and decided to work on holding each other accountable. They spent the rest of the meeting developing a com-munication plan for the primary purpose of getting updates and ensuring timely follow through.

Table 2 (following page) exhibits a portion of the Andrew Belongs Home Plan that was developed during the initial meeting.

Implementation:

Molly wrote up the team meeting notes, the plan, and the updates to the strengths document and sent out copies to the team members. Molly became unsure about next steps. She wasn't clear about how to make sure team members were following through. She approached Jim for guidance. Jim stated "The team is at a crucial place, and your role right now is extremely important. In this situation you are not an implementer. As the facilitator, you need to be ensuring people are following through and that information regarding what is and isn't working is being collected. You also need to help break down any barriers that are getting in the way of the plan." Molly asked "OK, but how do I do that?" Jim replied "I would love to be able to answer that but I don't sit on this team. With each team it will look a little bit different. Your job is to work collaboratively with everyone to figure out what would work best." This was a little frustrating for Molly but she started to develop plans for implementing this approach.

Approximately a week after the initial team meeting, Molly started contacting the team members to see how it was going. She discovered a lot of things were going well. Ms. Smith and Jamie (neighbor) had attended the parent support group twice. Ms. Smith reported that she enjoyed the support meetings and had even met other parents that were in similar situations. They had exchanged phone numbers and were meeting for dinner over the weekend. Ms. Smith also stated that she met with Andrew's teacher, Ms. Franklin. She reported a positive discussion with her around ways she could change some of her responses when Andrew came home stressed out. Molly learned from Angie that everything was on schedule for Andrew's return home. In addition to noting Ms. Smith's follow through, Angie reported she was feeling more optimistic about a safe return home for Andrew.

Molly was feeling confident about the updates she was receiving from the team members until

she contacted Mike (group home manager). He reported that Andrew has been struggling lately at the group home. Andrew had received five incident reports over the last week that involved Andrew becoming physically aggressive to staff and peers. Mike felt the majority of these incidents were a result of turnover in staff at the group home. Some of the new staff didn't have a relationship with Andrew and were not following the crisis plan as designed. When Molly contacted Dave, the direct support provider, he reported that he had resigned from his position as of the following week. Hearing this information and looking at the Andrew Belongs Home Plan, Molly became increasingly concerned about how the plan could possibly work. She remembered her conversation with her supervisor about not trying to be a hero. She decided to bring the team together and discuss this new information.

Molly was able to get the team together within the week. She prepared for the team meeting by ensuring all team members had received the updates and were clear as to what the purpose of the meeting was going to be. The two agenda items that required focus were

1. How to improve Andrew's life at the group home and

2. How to ensure that the direct support activities would still occur.

Molly opened the team meeting by reviewing the ground rules and having the team members remind each other of the mission. She then led the team by reviewing progress, noting and celebrating the strengths and accomplishments that occurred from the last time the team had met. Af-

Table 2. Excerpt from "Andrew Belongs at Home" Plan

Need	Goal	Action Steps
Andrew needs to know others will keep him safe when he's unable to do so.	Ms. Smith will feel safe when Andrew returns home.	• The group home staff will continue to use the crisis plan. • Mom will spend time with the group home staff 3 times per week to learn how to interface with Andrew when he becomes stressed. • Direct support worker Dave will accompany Andrew for home visits three times per week. • Andrew will play basketball for one hour after school by himself.
Ms. Smith needs to feel a sense of safety within her home	Andrew will return home within the next two months.	• Ms. Smith will get a lock installed on her bedroom door. • Ms. Smith and Jamie will attend a support group for parents two times per week. • Angie and Ms. Smith will meet with family preservation team two times per week. • Mrs. Franklin will meet with Ms. Smith to discuss "what works for Andrew" information and to assist in home changes. • Mike, Jamie and mom will meet within the next month to develop crisis plan for when Andrew returns home.
Andrew needs to see that love doesn't always have to hurt	Andrew will form relationships with his peers	• Direct support worker Dave will take Andrew to boys and girls club two times per week. • Andrew will work with therapist Jane to work on a "person I would like to be" project once per week. • Group home manager Mike and staff will work on including Andrew in activities with other kids at group home. • Andrew will help out in Mrs. Franklin's class once per week.

ter all the updates were shared on what was going well, the team had a positive mindset about its effectiveness. The then moved into brainstorming around the items requiring action. The team generated a variety of creative options to choose from. To resolve the direct support area, it was decided Mrs. Franklin would take over those responsibilities by becoming a part-time employee for Molly's agency. The team decided to resolve the group home concerns by conducting an all staff meeting with Andrew and Mike co-facilitating to share what works and doesn't work, and to ensure all are familiar and comfortable with utilizing the crisis plan.

The team implemented the adjusted plan, and quickly Andrew became more comfortable at the group home. Mrs. Franklin was enjoying the work she was able to do with Andrew and his mom. As time went on Molly continued to receive updates on what was working and what wasn't. The team met every week to once every other week to continue to make adjustments to the plan and be proactive in discussing the question, "What could go wrong?" Molly's focused on supporting team members and ensuring all involved stayed committed to the mission of Andrew Belongs Home.

About two months from the initial team meeting, the team's work started really paying off. Andrew returned home safely with his mom and the team continued to stay focused in making the necessary accommodations to support both of them. Ms. Smith was still attending support groups and facilitating a new support group for parents that were going through similar situations. She also had developed a renewed confidence on how to

interact with Andrew under stress, and was starting to develop a social life—something she had dreamed about for years. Andrew was playing basketball on a team, receiving passing grades at school, and, though at times reluctantly, helping out around the house. Angie, the CPS worker, was very pleased with the status of the reunification process and was developing a report to send to the court that recommended CPS involvement end.

Transition

Instead of meeting at least once every two weeks, meetings were now being held once a month to every other month. Mike and Angie ended their involvement when the team went to court and presented a summary of the accomplishments. The judge was extremely impressed and agreed with the plan. The team celebrated the closure of CPS involvement by having a party at Ms. Smith's and Andrew's home and playing a variety of different games that Andrew developed.

The team continued to meet at least quarterly. Molly was still enjoying the many successes that Andrew and his mom were having. During this time Molly also became a little confused about what the purpose of her involvement was and when to introduce the concept of transition. This was the first time she had reached this place with the process. This time Molly's answer came from a phone call from Ms. Smith. Ms. Smith noted the progress made and her appreciation for the team's hard work and dedication. Molly took this opportunity and asked Ms. Smith what she saw as the future role of the team. Ms. Smith responded, "I guess to make sure that if Andrew or I are having trouble in the future that we will be able to get help right away so we don't go back to the place where we were when we first started." Ms. Smith and Molly developed steps to transition the team.

Molly set up a team meeting to discuss the concept of formal team transition. The team members present were Ms. Smith, Andrew, Jamie, Sandy, and the therapist, Jane. This meeting started their normal ritual of going over the ground rules, the team mission and vision of the family, and updates on progress and accomplishments. Molly worked with everyone to create a transition plan outlining team accomplishments while updating the crisis plan. The team decided

to have a party celebrating their work together.

Molly wrote up the meeting results and distributed the transition, crisis and re-engagement plan. Then it was time to have a little fun since the day of the team celebration had arrived. They all went to one of Andrew's basketball games and cheered as Andrew scored his first basket of the season. Afterwards everyone went to the park for a barbecue. Team members shared memories of their experience together. People expressed their happiness at the accomplishments but noted that the ending was bittersweet. Ms. Smith was last to speak. She said "Thank you all for everything. We did what we said we were going to do. We were oh so right when we developed our mission statement. Andrew indeed belongs home with me." Molly thinks of those words often as she continues this work today.

Postscript

When I agreed to complete this article or summary, I wanted to stay away from sharing an "idealized" wraparound story because I've found that it almost never happens that way. I also wanted to avoid going to a story that was so unsuccessful as to cause anyone considering Wraparound to move away from it. This story doesn't adequately capture the ups and downs of the team nor the amount of confusion experienced by Molly as she was implementing and learning this process. Rather it merely provides a snapshot of the learning process. What I tried to do is explain how things happen in our agency while recognizing that families are human and they don't always fit into our phases exactly as we wish.

Some points I wish the reader would consider include:

- We chose to follow the wraparound process in serving Andrew and Ms. Smith. This took the supervisor helping the case manager deciding what to do. From then on, Molly was coached to follow the wraparound phases as closely as possible.

- The first plan wasn't easily implemented. Unfortunately, people and their plans change. Our first ideas had to be modified and reinforced. The thing to remember and consider in the implementation of wraparound is when you get to implementation,

you need to make sure your plans were actually implemented rather than assuming they were wrong. Notice that the group home plan wasn't substantially changed. Instead the analysis of the problem is that it hadn't been implemented. So Andrew and Mike, the group home manager, found a way to get it implemented.

- People do make a difference. We use words like "celebrate" and we do have barbecues because those small rituals make a difference for youth, families and helpers. This is more than mere words. Ms. Smith continues to talk about the barbecue today. Those are often the first things that get cut when agencies are faced with budget shortfalls but we've learned that families may often value those things more than anything else that we do.

- The wraparound facilitator doesn't have to have all of the answers, but rather a commitment in getting the right people to the table. Molly learned through this process that by developing trust and creating meaning for team members, shared solutions can be brainstormed and achieved. Formal and informal supports don't like to be told what to do but appreciate being part of a team that genuinely wants to achieve positive outcomes for others.

- Quality supervision and coaching is instrumental in achieving high fidelity wraparound. This work isn't easy no matter how experienced you are. All wraparound facilitators need someone to support them, bounce ideas off of, and provide clarity and direction around next steps.

- In addition to training and supervision, there were a lot of supports necessary to achieve this success:

  » The CPS worker recognized the potential of wraparound and was supported by her supervisor and home agency to participate on the team;

  » Molly's caseload was maintained at a manageable level, allowing her to engage the family and team members, follow-up with team members, and follow-through with all the strategies in the plan;

» Molly's agency was able to do things like pay a team member with expertise (Matt's teacher), so that she could carry out her role on the team;

» Resources for things like barbeques, basketball leagues, and celebrations were readily available to the team.

Author

Matt Pierce has been working with children/families for over ten years in a variety of different capacities. Matt has had the opportunity to hold positions within the wraparound context as a facilitator, direct support provider, supervisor, trainer, and as an administrator. Matt has also developed a variety of training materials, informational guides, and practice level tools to assist facilitators, supervisors and administrators in operationalizing the wraparound philosophy.

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Wraparound Practice: Chapter 4b.1

The Application of the Ten Principles of the Wraparound Process to the Role of Family Partners on Wraparound Teams

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National Wraparound Initiative

Fidelity to the wraparound process requires effort on the part of the team and its individual members to intentionally engage in activities that are consistent with all ten principles. This document briefly describes what the family partner does on wraparound teams to put each of the ten principles of the wraparound process into practice.

The family partner who is well grounded in the principles of wraparound will confidently perform his or her role and manage the tasks and unique situations that emerge on a daily basis. Family partners must receive wraparound training as well as training specific to their role.

The family partner is a formal member of the wraparound team whose role is to serve the family and help them engage and actively participate on the team and make informed decisions that drive the process. family partners have a strong connection to the community and are very knowledgeable about resources, services, and supports for families. The family partner's personal experience is critical to earning the respect of families and establishing a trusting relationship that is valued by the family.

The family partner can be a mediator, facilitator, or bridge between families and agencies. Family partners ensure each family is heard and their individual needs are being addressed and met. The family partner should communicate and educate agency staff on wraparound principles, the importance of family voice and choice, and other key aspects of ensuring wraparound fidelity.

As the family moves through the stages of the wraparound process, it is anticipated that their sense of self-empowerment and their level of sophistication as advocates

national wraparound initiative

will increase. Self-advocacy takes many forms along a continuum from getting one's own child and family services, to being a support to other families, to influencing the policies and procedures that govern the child-serving systems. The family partner is conscious of where each family is at any point in time. The family partner coaches and encourages families to find and develop their own voices and learn how to use it effectively in their own wraparound team and beyond.

Each family should have a choice of individuals to serve as their family partner—though this is not the case in every community. As a general practice, the family partner should serve on the team only so long as the family needs their support to effectively speak for themselves. There may be some families who feel they do not need the support of a family partner once they have been introduced to the wraparound team or who may wish to facilitate their own team.

The rest of this document describes the family partner's role in supporting achievement of the ten principles of wraparound for the children, youth, and families with whom they work.

Thanks to the people on the Family Partner Task Force of the National Wraparound Initiative for their hard work and dedication in helping to establish these ten principles.

Wraparound Principle	Family Partner's Role in Implementing the Principle
1. 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' perspectives, and the team strives to provide options and choices such that the plan reflects family values and preferences	Coaching, educating, supporting and encouraging family members to use their own voices to express their views clearly and to make informed choices are the very essence of the role of the family partner. The family partner actively ensures that the family's own voice drives the wraparound process and their wraparound plan. The family partner helps to create a safe environment in which families may express their needs and views or vent frustration. The family partner can help the family discover and learn ways to describe negative experiences and express their fears and anxieties to the team in ways that promote communication.

The family partner makes a special effort to ensure the family's point of view—not the family partner's—is heard by the team. The family partner is sensitive to the fact that perspectives of individual family members may differ and that conflicts may need to be addressed by all parties to achieve the consensus necessary for the team process to move forward.

The family partner has a responsibility to educate the other team members on the significance of family voice and choice and how their own practice and behavior can create an environment where families feel safe using their voices and expressing their choices.

When a family member feels unwilling to talk about an issue, he or she may ask that the family partner (or someone else) act as a spokesperson. In such cases the family partner encourages the family member to find a way to express him- or herself before accepting responsibility of being a temporarily designated spokesperson. When acting as a spokesperson, the family partner invests as much time as is necessary to develop a complete understanding of the family's perspective. When family members specifically ask the family partner to speak on their behalf, the family partner always makes sure the family member is present and confirms what is communicated. |

Wraparound Principle	Family Partner's Role in Implementing the Principle
2. 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	The family partner coaches the family through an ongoing process of discovery and inquiry about possible team members to make sure they are connecting with individuals or agencies who can meet their needs. As a result, the family is prepared to make informed choices about team membership and understands why some team members are mandated by systems working with the family. The family partner helps the family understand how to influence the building of their team. Family partners use their knowledge of the schools, communities, services, and neighborhoods to help the family identify friends, neighbors, relatives, providers , and others from their culture and community who could serve on their team. The family partner coaches the family through the process of deciding who they want to have on their wraparound team. The family partner helps the family understand why some team members are assigned by agencies without consulting them. The family partner helps the family recognize what each of these individuals could contribute as well as the advantages and possible challenges that might arise from their participation on the team.

Wraparound Principle	Family Partner's Role in Implementing the Principle
3. 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.	The family partner helps families understand how natural supports can contribute to the overall success of their wraparound plan and helps the family identify natural supports they want to bring onto their team and incorporate into their wraparound plan. The family partner encourages the family to bring their natural supports to the wraparound process. However, they must also respect the family's choice to withhold information about natural supports if they so wish. The family partner helps the family to develop and discover natural supports already present in their lives, as well as opportunities to develop new supportive relationships in their community. The family partner describes the wealth of resources they have identified in the community (for example, sports teams, scouts, and religious groups) and helps the family see the possible benefits of involving some of these resources on the wraparound team, and the possible costs of not involving them. The family partner supports family members as a peer throughout the wraparound team process. The family partner gives them opportunities to become part of the larger circle of families where they can find support from other parents and caregivers with similar experiences who have faced similar challenges and overcome them. Family partners connect families to local family groups and organizations where, through participation in support groups, classes or other events, they have the opportunity to develop relationships with individuals who can serve as natural supports on a team or independently. Once the family has developed its own network of informal peer support they may feel they have the confidence to participate in the wraparound team without the support of a family partner. However, the family partner may remain a resource for the family because they are connected through the larger family network in the community and, at the family's request, could rejoin their team at any time.

Wraparound Principle	Family Partner's Role in Implementing the Principle
4. 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' perspectives, mandates, and resources. The plan guides and coordinates each team member's work towards meeting the team's goals.	It is the family partner's role to model, coach and encourage the process of collaboration. Having this sort of model will help families become empowered in the present and over time to work successfully with diverse individuals and providers. In addition, the family partner is a collaborative advocate, helping the family to understand the mandates and perspective of other members of the team. The family partner helps to make sure the individual family's perspective is at the forefront of all team discussions by strategizing with the family members about how they can deliver their own messages clearly and with the desired impact. Seasoned family partners report that this is the principle that tests their skills most. There are two parts to this challenge. First, it requires keeping their own views in check, respecting the family's culture, aligning themselves with the family, and using their own voice to support the family's choices. Second, the family partner must also remain engaged in strategic and mutually respectful partnerships with the wraparound facilitator and other team members. The family partner helps ensure that family voice and choice is driving the wraparound team and plan as all team members work collaboratively.

Wraparound Principle	Family Partner's Role in Implementing the Principle
5. *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	It is the family partner's role to explain why the wraparound process focuses on community-based living and services for children and youth. The family partner helps the family understand the philosophy behind this principle and consider how it could be applied to their own situation. Regardless of their own views, family partners strive to understand the reasons behind the family's placement preferences and helps the rest of the team understand what the family thinks is best for their child. The family partner informs the family about supports, services, and placements available in their community and helps them frame questions they might want to ask specific providers or agencies. The family partner helps families and their teams implement practical strategies for getting access to whatever it will take to successfully transition home or stay in the community. The family partner encourages thinking beyond the customary services and supports. The family partner helps the family clearly expresses the "why" behind their choices (including critical needs still to be addressed) to the rest of the team. The family partner also helps the family understand why others on the team might make a different recommendation and works towards blending the best from each team member's perspective and expertise into the family's plan.

Wraparound Principle	Family Partner's Role in Implementing the Principle
6. 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.	Family partners recognize and value differences among families, ethnic and cultural groups, and communities. Delivering culturally competent services begins with discovering what is important to the family. Each family has its own unique culture, as do any groups with whom the family identifies. This influences how the family approaches the tasks of daily living (for example, food, dress, work, school, spiritual beliefs and practices). This cultural context can also direct how a family faces the challenges of raising children. Families work in different ways, have different resources at their disposal and achieve differing degrees of success at meeting the needs of all their members. Family partners draw on their own experiences of raising and loving a child with emotional or behavioral issues as they work with the family and its whole team to discover the family's values, priorities, and preferences. Family partners can use their own experiences to illustrate cultural intelligence, to guide discussions about cultural needs, and to help the family and their team develop a relationship. The family partner makes sure that the culture of the family, as they define it, is respected and that the plan is grounded in the family's ethnic and cultural background in the manner the family feels it is culturally relevant for them. Implementing this principle can be facilitated by assigning a family partner who comes from the same or a similar community as the family engaged in the wraparound team. A community's wraparound initiative should recruit family partners who represent the diversity of families served through the wraparound effort, as well as individuals with varied kinds of parenting experience (such as single parents, gay or lesbian parents, grandparents, or adoptive parents).

Wraparound Principle	Family Partner's Role in Implementing the Principle
7. Individualized. To achieve the goals laid out in the wraparound plan, the team develops and implements a customized set of strategies, supports, and services	The family partner helps the family ensure the plan is customized to meet their unique needs and is related to their values, history, and traditions. The family must feel that the plan is theirs and is tailored to their daily schedule, transportation requirements, and other specific conditions. The family partner helps the family form a better vision of what it would look like to be "doing okay." The family can then identify their needs and goals to make sure the plan addresses the whole family not just a single individual. With coaching from the family partner, the family develops the skills and confidence to present these to the team and realize their vision. Family partners draw on their own experiences of negotiating services and supports for their own children to help teams understand how, regardless of system mandates, each child and family has different needs. Family partners can help the team understand how strategies used to meet one family's needs may need to be different from those effective for other families that have similar goals and needs.

Wraparound Principle	Family Partner's Role in Implementing the Principle
8. 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.	Family partners, like all members of the team, should model a strengths-based approach in all their interactions with the family. Family partners spend time with families in their homes and communities; they can observe how each family copes with simple and complex tasks in daily life. Family partners use these observations to help families get in touch with their strengths, their children's strengths, and the positive features of their communities. Family partners help families realize how their strengths (for example their resilience) may help address their needs. By sharing their own family's journeys, family partners describe the process of discovering strengths, thereby showing other families how they can acquire this strength-based skill. A family's view of itself can be compromised by systems that focus on risk factors and diagnosis or pathology. The family partner, by sharing his or her experience of discovering strengths and assets, helps the family develop new skills and competence and hope for a productive future. The family partner helps to coach other team members on always utilizing a strengths-based approach.

Wraparound Principle	Family Partner's Role in Implementing the Principle
9. 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.	Their own histories and determination in finding support and getting services for their own children and families deeply commit family partners to the principle of persistence. The family partner helps families find hope and encourages them to persist through difficulties to find solutions that work for them. The family partner works creatively with the family and their team to make sure that care does not cease when barriers and challenges are encountered. Using identified strengths, they vigilantly ensure that any undesired or unachieved outcomes are recognized by the team as a deficiency in the plan - and are not seen as the failure of the family or a particular team member. These strengths are used to promptly change in the plan when something is not working as anticipated. The family partner helps the team discover how the plan should be modified to ensure the family will get everything they need to succeed. Ideally the family partner should be committed to remaining with the family as long as (and no longer than) the family needs or desires. The family partner supports the family through self-advocacy. Phasing out the family partner should be a gradual process as families expand their role.

Wraparound Principle	Family Partner's Role in Implementing the Principle
10. Outcome based. The team ties the goals and strategies of the wraparound plan to observable or measurable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly.	The family partner ensures that indicators of success are not wholly driven by providers' or systems' goals for the family, but includes the family's expression of what success will look like from their perspective. The family partner plays an active role in ensuring that the family's vision of a positive future is the basis for indicators of success and that the team does indeed regularly and actively track progress toward these indicators and revises the wraparound plan when progress is not being achieved. In addition, a family's success often is defined by the extent to which they have become self-empowered advocates. The family partner can play a key role in documenting the degree to which—and the specific ways in which—the family has moved along this path. Where wraparound teams are conducting assessments and collecting evaluation data, the family partner understands and is able to share this information with the family so that they can assess practices and progress and modify their plan to improve outcomes.

Authors

Marlene Penn's initial experience on care planning teams was as the parent of her own child. She subsequently became an advocate for other families and trains and coaches extensively on the role of the Family Partner on wraparound teams. Marlene served as one of the faculty members on the University of South Florida Louis de la Parte Florida Mental Health Institute Course "Wraparound Interventions and the System of Care" and is co-chair of the Family Partner Task Force of the National Wraparound Initiative.

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Wraparound Practice: Chapter 4b.2

How Family Partners Contribute to the Phases and Activities of the Wraparound Process

See page 2 for proper viewing instructions

Trina W. Osher, Co-Chair, Family Partner Task Force
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Fidelity to the wraparound process requires effort on the part of the team and its individual members to intentionally engage families in all phases and activities in a manner that is consistent with the principles of wraparound. *The Application of the Ten Principles of the Wraparound Process to the Role of Family Partners on Wraparound Teams* (Penn & Osher, 2007) briefly described what the Family Partner does on wraparound teams to put each of the ten principles of the wraparound process into practice. This document explains in detail what the Family Partner does during each phase of the process to support the family's engagement in key activities. It also describes how the Family Partner's work complements that of the Wraparound Facilitator and how the Family Partner works in partnership with other members of the team. Examples given of practices are intended to be illustrative as individual family and community contexts vary and wraparound planning is unique for each child and family.

Completion and publication of this document fulfills one of the major goals of the Family Partner Task Force of the National Wraparound Initiative. The Task Force is a diverse group of more than 50 family members, youth, practitioners, advocates, administrators, policy makers and others committed to promoting high fidelity wraparound and developing resources and tools to facilitate its implementation.

The Task Force uses the National Wraparound Initiative's Participatory Community of Practice model to develop tools and materials to support family partners and the organizations they work for in the field. All members of the Task-

national wraparound initiative

The Resource Guide to Wraparound

Definition of Family Partner

The Family Partner is a family member who is a formal member of the wraparound team. The family partner's role is to serve the family, help them engage and actively participate on the team, and make informed decisions that drive the process.

Family Partners have a strong connection to the community and are very knowledgeable about resources, services, and supports for families. The Family Partner's personal experience raising a child with emotional, behavioral, or mental health needs is critical to earning the respect of families and establishing a trusting relationship that is valued by the family.

The Family Partner can be a mediator, facilitator, or bridge between families and agencies. Family Partners ensure each family is heard and their individual needs are being addressed and met. The Family Partner should communicate and educate agency staff on wraparound principles, the importance of family voice and choice, and other key aspects of ensuring wraparound fidelity. The family partner works in close partnership with the wraparound facilitator.

VIEWING INSTRUCTIONS

Proper viewing of this document is essential to understanding the role of the family partner in the context of the phases and activities of the wraparound process. When viewed as intended, the reader should see a table explaining the phases of the wraparound process on the left page, and the family partner role in that phase on the right page. To achieve this view in Adobe Acrobat, choose View > Page Display > Two-Up. When viewing a printed copy, make sure the odd page is on the left and the even page is on the right (if printing on both sides, begin printing with page 2 and print page 1 separately).

Family Partner Role in the Wraparound Process: Phase 1

*PHASE 1: Engagement and team preparation***		
During this phase, the groundwork for trust and shared vision among the family and wraparound team members is established, so people are prepared to come to meetings and collaborate. During this phase, the tone is set for teamwork and team interactions that are consistent with the wraparound principles, particularly through the initial conversations about strengths, needs, and culture. In addition, this phase provides an opportunity to begin to shift the family's orientation to one in which they understand they are an integral part of the process and their preferences are prioritized. The activities of this phase should be completed relatively quickly (within 1-2 weeks if possible), so that the team can begin meeting and establish ownership of the process as quickly as possible.		
MAJOR GOALS	**ACTIVITIES**	**NOTES**
1.1. Orient the family and youth GOAL: To orient the family and youth to the wraparound process.	*1.1 a. Orient the family and youth to wraparound* In face-to-face conversations, the facilitator explains the wraparound philosophy and process to family members and describes who will be involved and the nature of family and youth/child participation. Facilitator answers questions and addresses concerns. Facilitator describes alternatives to wraparound and asks family and youth if they choose to participate in wraparound. Facilitator describes types of supports available to family and youth as they participate on teams (e.g., family/youth may want coaching so they can feel more comfortable and/or effective in partnering with other team members).	This orientation to wraparound should be brief and clear, and should avoid the use of jargon, so as not to overwhelm family members. At this stage, the focus is on providing enough information so that the family and youth can make an informed choice regarding participation in the wraparound process. For some families, alternatives to wraparound may be very limited and/or non-participation in wraparound may bring negative consequences (as when wraparound is court ordered); however, this does not prevent families/youth from making an informed choice to participate based on knowledge of the alternatives and/or the consequences of non-participation.
	1.1 b. Address legal and ethical issues Facilitator reviews all consent and release forms with the family and youth, answers questions, and explains options and their consequences. Facilitator discusses relevant legal and ethical issues (e.g., mandatory reporting), informs family of their rights, and obtains necessary consents and release forms before the first team meeting.	Ethical and legal considerations will also need to be reviewed with the entire team as described in phase 2.

** Wraparound phases defined in: Walker, J. S., Bruns, E. J., & the National Wraparound Initiative Advisory Group. (2008). Phases and activities of the wraparound process. In E. J. Bruns & J. S. Walker (Eds.), *The resource guide to wraparound*. Portland, OR: National Wraparound Initiative.

Family Partner Role in the Wraparound Process: Phase 1 (CONTINTUED)

PHASE 1: The family partner role

The family partner has a collaborative relationship with the wraparound facilitator. Together they establish mechanisms to keep each other informed, make sure the family partner knows when new families are enrolled as well as when and where team meetings will occur, and insure all newly enrolled families have the opportunity to have support from a family partner if they choose.

HOW FAMILY PARTNERS SUPPORT THE PROCESS

1.1 a. Orient the family and youth to wraparound

The family partner helps the family understand wraparound as an opportunity to get what they need and to also feel comfortable with getting engaged in the wraparound process. The family partner listens without bias, blame, or judgment in their approach. The family partner encourages and models commitment, demonstrates respect for the family's culture, builds trust with the family, and eases their fears. This is an interpersonal process. The family partner gets to know the family by meeting with family members (sometimes with the wraparound facilitator) in locations in which and at times that the family feels comfortable. The family partner explains wraparound from a family perspective, including the role of the family partner, sharing selected personal experiences as examples when relevant and appropriate. Together they explore the extent to which the family feels comfortable supporting and advocating for their child and family and how much coaching and support they will want from a family partner. The family partner gives the family helpful written materials such as family organization newsletters and brochures and materials about wraparound such as a copy of The Wraparound Process User's Guide: A Handbook for Families. The family partner reviews the guide or other informative materials with them and answers questions about what a wraparound team is and how it is created and functions. The family partner invites the family to support groups and other organized family activities in the community and encourages them to attend.

The family partner explains the limits of their own role including any time limits imposed by the program or system in which they are working. The family partner explains that they will not reveal any information the family wants to keep confidential except in cases where the safety of family members is involved.

Once the family has agreed to participate, the family partner can offer to help the family identify and organize various documents and information they will need to support and advocate for their child. This information placed in a binder, box or folder can be updated as new materials are accumulated through the wraparound process.

1.1 b. Address legal and ethical issues

The family partner explains informed consent from a family point of view. The family partner discusses system mandates with the family and helps them understand what they might expect in court proceedings.

The family partner can help them prepare for court appearances and, when invited, may attend to provide support to the family.

The family partner discusses any evaluation, data collection, or research activities associated with the wraparound initiative including how the family's participation might benefit them or others. The family partner makes sure the family understands how data will be collected and what steps will be taken to insure their personal identities are protected.

The family partner addresses the sensitive issue of mandated child abuse reporting by explaining their duty as a mandatory reporter of child abuse or neglect and what that means from a family's perspective.

Family Partner Role in the Wraparound Process: Phase 1 (CONTINTUED)

MAJOR GOALS	ACTIVITIES	NOTES
1.2. Stabilize crises GOAL: To address pressing needs and concerns so that the family and team can give their attention to the wraparound process.	*1.2 a. Ask family and youth about immediate crisis concerns* Facilitator elicits information from the family and youth about immediate safety issues, current crises, or crises that they anticipate might happen in the very near future. These may include crises stemming from a lack of basic needs (e.g., food, shelter, utilities such as heat or electricity).	The goal of this activity is to quickly address the most pressing concerns. The whole team engages in proactive and future-oriented crisis/safety planning during phase 2. As with other activities in this phase, the goal is to do no more than necessary prior to convening the team, so that the facilitator does not come to be viewed as the primary service provider and so that team as a whole can feel ownership for the plan and the process.
	1.2 b. Elicit information from agency representatives and potential team members about immediate crises or potential crises Facilitator elicits information from the referring source and other knowledgeable people about pressing crisis and safety concerns.	Information about previous crises and their resolution can be useful in planning a response in 1.2.c.
	1.2 c. If immediate response is necessary, formulate a response for immediate intervention and/or stabilization Facilitator and family reach agreement about whether concerns require immediate attention and, if so, work to formulate a response that will provide immediate relief while also allowing the process of team building to move ahead.	This response should describe clear, specific steps to accomplish stabilization.
1.3. Facilitate conversations with family and youth/child GOAL: To explore individual and family strengths, needs, culture, and vision and to use these to develop a document that will serve as the starting point for planning.	*1.3 a. Explore strengths, needs, culture, and vision with child/youth and family.* Facilitator meets with the youth/child and family to hear about their experiences; gather their perspective on their individual and collective strengths, needs, elements of culture, and long-term goals or vision; and learn about natural and formal supports. Facilitator helps family identify potential team members and asks family to talk about needs and preferences for meeting arrangements (location, time, supports needed such as child care, translation).	This activity is used to develop information that will be presented to and augmented by the team in phase 2. Family members should be encouraged to consider these topics broadly.

Family Partner Role in the Wraparound Process: Phase 1 (CONTINTUED)

HOW FAMILY PARTNERS SUPPORT THE PROCESS

1.2 a. Ask family and youth about immediate crisis concerns

The family partner participates in discussions regarding stabilization of immediate concerns to ensure that the plan is individualized and realistic for the family. The family partner is someone the family can talk with to validate how they might be feeling at the time. The family partner can help define the nature of the family's immediate concerns by listening carefully and encouraging the family to speak frankly. The family partner can ask about the signs that a crisis is likely to occur and learn what has been done by the family before so that strategies that have worked are included in the plan and those that have failed in the past are not repeated. Family partners help families identify reasonable alternatives, possible natural supports, and share what they know about resources in their communities that may give respite, food, shelter, clothing, and other necessities to help the family stabilize. Family partners offer hope and can have a calming effect and decrease the family's anxiety and fears of the unknown, when necessary, by sharing how they survived stressful experiences.

1.2 b. Elicit information from agency representatives and potential team members about immediate crises or potential crises

The family partner helps the family define crisis or safety concerns from their own experiences and clarifies for the family how other team members may view potential crisis concerns including events that could trigger a report for abuse or neglect. The family partner also helps communicate the family's perspective regarding potential crisis to the team members. The family partner encourages family members to identify both the formal and natural supports that have worked well to resolve crisis in the past and to look at what it would take to mend bridges of past natural supports.

1.2 c. If immediate response is necessary, formulate a response for immediate intervention and/or stabilization

The family partner will make sure the family feels the planned response for immediate intervention and/or stabilization can be readily implemented when it is needed. The family partner assists the family in expressing any concerns they might have about the immediate intervention and/or crisis stabilization plan.

1.3 a. Explore strengths, needs, culture, and vision with child/youth and family.

Consistent with the principle of family voice and choice, the family partner begins to prepare the family for effective self-advocacy by helping them to comfortably participate in this conversation. As a peer, in down-to-earth and heartfelt conversations, the family partner helps the family begin to think through their strengths, needs, culture, and vision so they are ready to contribute useful and valuable information that drives the process. The family partner also helps the family find ways to talk about sensitive issues, reframe negative concerns, and manage their emotions so the conversation remains respectful.

The family can plan and write their presentation and practice or "role play" with their family partner to develop their confidence and communicate clearly.

At times, the family partner may need to help the adult family members recognize when their child's behaviors and reactions are typical for their age and help the family allow their child to express their own views during the wraparound process. The family partner asks the family if they need or want support with school issues, court issues, and physical or mental health appointments. When relevant the family partner provides the family with information about their rights in the education, mental health, and other systems and connects them to expert advisers as needed.

The family partner attends to language and attitudes of all team members to promote family friendliness and avoid blaming and shaming the family or anyone else on the team.

Family Partner Role in the Wraparound Process: Phase 1 (CONTINTUED)

MAJOR GOALS	ACTIVITIES	NOTES
1.3. Facilitate conversations with family and youth/child GOAL: To explore individual and family strengths, needs, culture, and vision and to use these to develop a document that will serve as the starting point for planning. *(Continued from previous page)*	**1.3 b. Facilitator prepares a summary document** Using the information from the initial conversations with family members, the facilitator prepares a strengths-based document that summarizes key information about individual family member strengths and strengths of the family unit, as well as needs, culture, and vision. The family then reviews and approves the summary.	
1.4. Engage other team members GOAL: To gain the participation of team members who care about and can aid the youth/child and family, and to set the stage for their active and collaborative participation on the team in a manner consistent with the wraparound principles	**1.4 a. Solicit participation/ orient team members** Facilitator, together with family members if they so choose, approaches potential team members identified by the youth and family. Facilitator describes the wraparound process and clarifies the potential role and responsibilities of this person on the team. Facilitator asks the potential team members if they will participate. If so, facilitator talks with them briefly to learn their perspectives on the family's strengths and needs, and to learn about their needs and preferences for meeting.	The youth and/or family may choose to invite potential team members themselves and/or to participate in this activity alongside the facilitator. It is important, however, not to burden family members by establishing (even inadvertently) the expectation that they will be primarily responsible for recruiting and orienting team members.
1.5. Make necessary meeting arrangements GOAL: To ensure that the necessary procedures are undertaken for the team is prepared to begin an effective wraparound process.	**1.5 a. Arrange meeting logistics** Facilitator integrates information gathered from all sources to arrange meeting time and location and to assure the availability of necessary supports or adaptations such as translators or child care. Meeting time and location should be accessible and comfortable, especially for the family but also for other team members. Facilitator prepares materials—including the document summarizing family members' individual and collective strengths, and their needs, culture, and vision—to be distributed to team members.	

Family Partner Role in the Wraparound Process: Phase 1 (CONTINTUED)

HOW FAMILY PARTNERS SUPPORT THE PROCESS

1.3 b. Facilitator prepares a summary document

The family partner works with the facilitator to summarize the strengths, needs, culture and vision of the family unit and individual family members.

The family partner reviews the document with the family to make sure the family completely understands the document and that it really reflects their view of themselves, their strengths and the challenges they face.

1.4 a. Solicit participation/orient team members

The family partner, by spending time with the family and in the family's own home and community, becomes aware of individuals who could be members of the family's wraparound team including those who might provide support even though they cannot be physically present. Through frank discussions about the strengths and gifts of potential team members as well as any risks associated with their involvement, the family partner helps the family decide who they would like on their team.

The family could ask the family partner to help them invite some individuals to be on their team and explain to them what their responsibilities would be.

The family partner acts as a role model by educating system representatives on wraparound's principle of family voice and choice and helping them apply this principle to their work on the team in the context of their agency's mandates.

The family partner acts as a bridge builder encouraging understanding and collaboration between the family, and their team members.

1.5 a. Arrange meeting logistics

The family partner collaborates with the facilitator and the family to make sure that all meetings are held in places and at times comfortable and convenient for the family.

The family partner, in collaboration with the facilitator and family, may send out meeting notices and reminders, and, when necessary, identifies the need for travel, childcare, translators, or other supports for participants.

Before the meeting, the family partner works with the facilitator and family to create an agenda and consider what refreshments might be required and how to get them.

Family Partner Role in the Wraparound Process: Phase 2

PHASE 2: Initial plan development**

During this phase, team trust and mutual respect are built while the team creates an initial plan of care using a high-quality planning process that reflects the wraparound principles. In particular, youth and family should feel, during this phase, that they are heard, that the needs chosen are ones they want to work on, and that the options chosen have a reasonable chance of helping them meet these needs. This phase should be completed during one or two meetings that take place within 1-2 weeks, a rapid time frame intended to promote team cohesion and shared responsibility toward achieving the team's mission or overarching goal.

MAJOR GOALS	ACTIVITIES	NOTES
2.1. Develop an initial plan of care GOAL: To create an initial plan of care using a high-quality team process that elicits multiple perspectives and builds trust and shared vision among team members, while also being consistent with the wraparound principles	*2.1 a. Determine ground rules* Facilitator guides team in a discussion of basic ground rules, elicits additional ground rules important to team members, and facilitates discussion of how these will operate during team meetings. At a minimum, this discussion should address legal and ethical issues—including confidentiality, mandatory reporting, and other legal requirements—and how to create a safe and blame-free environment for youth/family and all team members. Ground rules are recorded in team documentation and distributed to members.	In this activity, the team members define their collective expectations for team interaction and collaboration. These expectations, as written into the ground rules, should reflect the principles of wraparound. For example, the principles stress that interactions should promote family and youth voice and choice and should reflect a strengths orientation. The principles also stress that important decisions are made within the team.
	2.1 b. Describe and document strengths Facilitator presents strengths from the summary document prepared during phase 1, and elicits feedback and additional strengths, including strengths of team members and community.	While strengths are highlighted during this activity, the wraparound process features a strengths orientation throughout.
	2.1 c. Create team mission Facilitator reviews youth and family's vision and leads team in setting a team mission, introducing idea that this is the overarching goal that will guide the team through phases and, ultimately, through transition from formal wraparound.	The team mission is the collaboratively set, long-term goal that provides a one or two sentence summary of what the team is working towards.

** Wraparound phases defined in: Walker, J. S., Bruns, E. J., & the National Wraparound Initiative Advisory Group. (2008). Phases and activities of the wraparound process. In E. J. Bruns & J. S. Walker (Eds.), *The resource guide to wraparound*. Portland, OR: National Wraparound Initiative.

Family Partner Role in the Wraparound Process: Phase 2 (CONTINTUED)

PHASE 2: The family partner role

The family partner collaborates with the wrap facilitator to establish the trust and mutual respect necessary for the team (including the family) to function.

HOW FAMILY PARTNERS SUPPORT THE PROCESS

2.1 a. Determine ground rules

With permission from the family, the family partner attends the initial care planning meeting. Before the meeting, the family partner should have a discussion with the family about where they would like the family partner to sit (next to, across from) to offer the best means of communication and support that feels comfortable for the family.

The family partner offers support to the family by encouraging family member to:

- Participate in constructing the ground rules so that they are relevant and individualized;
- Express strengths, visions, and needs;
- Describe the family's cultural, spiritual, and moral beliefs;
- Contribute to the development of strategies they feel are realistic; and
- Speak up and say "no" when suggestions are made that they do not agree with.

The family partner makes sure the family's perspective is visible and heard by asking questions of the family to be sure they are comfortable with the plan as it evolves.

The family partner encourages the meeting facilitator to use visual tools (such as chart paper, colored markers, stickers, etc.) so that family members can see the language of the plan as it develops.

The family partner helps other team members understand and feel comfortable with the principle of family voice and choice.

The family partner agrees to take responsibility for follow up tasks that are compatible with their role description and expectations.

By sharing their own experience (relevant self-disclosure) family partners help the team gain some insight into the family's situation so they can think "outside the box" and be creative in developing a practical plan. The family partner helps the family decide if the plan is likely to be workable for them. They do this by asking them questions like:

- "Is the plan flexible enough to meet your changing needs?"
- "Does the plan incorporate the natural supports you need?"
- "Do you feel your voice has been heard?"
- "Does the plan incorporate the formal and clinical services you need?"
- "Is the financing of services and supports realistic?"

2.1 b. Describe and document strengths

The family partner explains why strengths are important and how to recognize them. The family partner may describe a personal experience to illustrate the value of being strengths-based.

Drawing on prior discussion with the family, the family partner works with the family to see how their strengths and team and community strengths can be used to help address their needs with the goal of assuring natural supports are developed and used to sustain the family goal.

2.1 c. Create team mission

The family partner helps the family express changes in their vision of the future to their team. The family partner makes sure that the team mission incorporates the family's and the youth's perspectives, abilities, and preferences.

The family partner makes sure the family understands that their wraparound team's mission may need to be revised as changes occur in their child and family.

Family Partner Role in the Wraparound Process: Phase 2 (CONTINTUED)

MAJOR GOALS	ACTIVITIES	NOTES
2.1. Develop an initial plan of care GOAL: To create an initial plan of care using a high-quality team process that elicits multiple perspectives and builds trust and shared vision among team members, while also being consistent with the wraparound principles *(Continued from previous page)*	*2.1 d. Describe and prioritize needs/goals* Facilitator guides the team in reviewing needs and adding to list. The facilitator then guides the team in prioritizing a small number of needs that the youth, family, and team want to work on first, and that they feel will help the team achieve the mission.	The elicitation and prioritization of needs is often viewed as one of the most crucial and difficult activities of the wraparound process. The team must ensure that needs are considered broadly, and that the prioritization of needs reflects youth and family views about what is most important. Needs are not services but rather broader statements related to the underlying conditions that, if addressed, will lead to the accomplishment of the mission.
	2.1 e. Determine goals and associated outcomes and indicators for each goal Facilitator guides team in discussing a specific goal or outcome that will represent success in meeting each need that the team has chosen to work on. Facilitator guides the team in deciding how the outcome will be assessed, including specific indicators and how frequently they will be measured.	Depending on the need being considered, multiple goals or outcomes may be determined. Similarly, for each goal or outcome determined by the team for measurement, multiple indicators may be chosen to be tracked by the team. However, the plan should not include so many goals, outcomes, or indicators that team members become overwhelmed or tracking of progress becomes difficult.
	2.1 f. Select strategies Facilitator guides the team in a process to think in a creative and open-ended manner about strategies for meeting needs and achieving outcomes. The facilitator uses techniques for generating multiple options, which are then evaluated by considering the extent to which they are likely to be effective in helping reach the goal, outcome, or indicator associated with the need; the extent to which they are community based, the extent to which they build on/incorporate strengths; and the extent to which they are consistent with family culture and values. When evaluating more formal service and support options, facilitator aids team in acquiring information about and /or considering the evidence base for relevant options.	This activity emphasizes creative problem solving, usually through brainstorming or other techniques, with the team considering the full range of available resources as they come up with strategies to meet needs and achieve outcomes. Importantly, this includes generating strategy options that extend beyond formal services and reach families through other avenues and time frames. These are frequently brainstormed by the team, with the youth and family and people representing their interpersonal and community connections being primary nominators of such supports. Finally, in order to best consider the evidence base for potential strategies or supports, it may be useful for a wraparound team or program to have access to and gain counsel from a point person who is well-informed on the evidence base.

Family Partner Role in the Wraparound Process: Phase 2 (CONTINTUED)

HOW FAMILY PARTNERS SUPPORT THE PROCESS

2.1 d. Describe and prioritize needs/goals

The family partner helps the family to determine their priorities and express them to the team. The family partner helps the family to understand that needs not immediately addressed will be attended to once the greatest needs are taken care of. The family partner helps the family to learn the phases of the wraparound process. Attention is paid to understanding the distinction between needs, traditional services as an attempt to meet those needs, and individualized, natural supports and resources.

2.1 e. Determine goals and associated outcomes and indicators for each goal

Family Partners help the family express their views about all the goals identified in their plan of care. They encourage the family to talk about how well the goals meet their needs and priorities. The family partner makes sure the family considers how workable and realistic the plan is for them and raises any concerns they have,

The family partner helps the family to actively participate in choosing how progress on their goals will be tracked and measured. The family partners helps the family define how its members will be involved in collecting data and working with the team to understand what it means.

2.1 f. Select strategies

The family partner encourages and coaches the family to speak about how practical each proposed strategy is in the context of the family's day to day activities. The family partner also encourages the family to talk about strategies that have and have not worked for them in the past.

The family partner can support the other team members in understanding the family's perspective.

Family Partner Role in the Wraparound Process: Phase 2 (CONTINTUED)

MAJOR GOALS	ACTIVITIES	NOTES
2.1. Develop an initial plan of care GOAL: To create an initial plan of care using a high-quality team process that elicits multiple perspectives and builds trust and shared vision among team members, while also being consistent with the wraparound principles *(Continued from previous page)*	*2.1 g. Assign action steps* Team assigns responsibility for undertaking action steps associated with each strategy to specific individuals and within a particular time frame.	Action steps are the separate small activities that are needed to put a strategy into place, for example, making a phone call, transporting a child, working with a family member, finding out more information, attending a support meeting, arranging an appointment. While all team members will not necessarily participate at the same level, all team members should be responsible for carrying out action steps. Care should be taken to ensure that individual team members, particularly the youth and family, are not overtaxed by the number of action steps they are assigned.
2.2. Develop crisis/ safety plan GOAL: To identify potential problems and crises, prioritize according to seriousness and likelihood of occurrence, and create an effective and well-specified crisis prevention and response plan that is consistent with the wraparound principles. A more proactive safety plan may also be created.	*2.2 a. Determine potential serious risks* Facilitator guides the team in a discussion of how to maintain the safety of all family members and things that could potentially go wrong, followed by a process of prioritization based on seriousness and likelihood of occurrence.	Past crises, and the outcomes of strategies used to manage them, are often an important source of information in current crisis/safety planning.
	2.2 b. Create crisis/safety plan In order of priority, the facilitator guides team in discussion of each serious risk identified. The discussion includes safety needs or concerns and potential crisis situations, including antecedents and associated strategies for preventing each potential type of crisis, as well as potential responses for each type of crisis. Specific roles and responsibilities are created for team members. This information is documented in a written crisis plan. Some teams may also undertake steps to create a separate safety plan, which specifies all the ways in which the wraparound plan addresses potential safety issues.	One potential difficulty with this activity is the identification of a large number of crises or safety issues can mean that the crisis/safety plan "takes over" from the wraparound plan. The team thus needs to balance the need to address all risks that are deemed serious with the need to maintain focus on the larger wraparound plan as well as youth, family, and team strengths.
2.3. Complete necessary documentation and logistics	*2.3 a. Complete documentation and logistics* Facilitator guides team in setting meeting schedule and determining means of contacting team members and distributing documentation to team members.	

Family Partner Role in the Wraparound Process: Phase 2 (CONTINTUED)

HOW FAMILY PARTNERS SUPPORT THE PROCESS

2.1 g. Assign action steps

The family partner encourages the team to assign tasks to natural supports and makes sure that the family and team are likely to experience success within a reasonably short period of time. The family partner helps the family to assess which tasks it can realistically work on. Tasks the family partner takes responsibility for should relate directly to providing support to help the family accomplish tasks it has agreed to do.

2.2 a. Determine potential serious risks

The family partner contributes to crisis/safety plan development by encouraging the family to draw on their past experiences and knowledge of conditions such as environments, people, health issues, or other circumstances that could trigger a crisis or safety situation. Family partners can offer suggestions based on how they or other families have used a crisis plan.

The family partner helps the team work with the family to think about the future and what may happen that would require the use of a crisis/safety plan.

2.2 b. Create crisis/safety plan

The family partner needs to explain to the family and the team the specific responsibilities of their role and limitations imposed on them with regard to responding to crisis situations.

The family partner strongly encourages the family and the team to talk with the child or youth to understand what are likely to be the most effective strategies to avoid or de-escalate a potential crisis.

The family partner actively questions proposed responses to crisis to ensure that the crisis/safety plan includes solutions the family will use (i.e., alternatives to calling the police) and is something that the family truly feels can benefit them in the midst of a crisis and that they can follow in times of high stress.

The family partner makes sure the family has a copy of the crisis/safety plan at the end of the meeting and that they have a realistic plan for where to keep it so they can find and use it when necessary.

2.3 a. Complete documentation and logistics

The family partner reviews the initial written plan with the family to make sure that the family understands the plan, that it accurately reflects what the family has said (preferably in their own words) and what they expect from those responsible for implementing it. The family partner helps the family strategize about how to work with their team to modify anything in the plan that they are not comfortable with.

The family partner completes contact notes, individual service planning reports or other documentation according to the requirements of their employer.

The family partner helps the family use tracking procedures provided by the team and develop their own method of organizing and preserving their family's important papers and plans so they are available for future use.

If the family partner develops their own system, they need to be sure it complies with all confidentiality and record keeping requirements for personally identifiable information.

Family Partner Role in the Wraparound Process: Phase 3

PHASE 3: Implementation**

During this phase, the initial wraparound plan is implemented, progress and successes are continually reviewed, and changes are made to the plan and then implemented, all while maintaining or building team cohesiveness and mutual respect. The activities of this phase are repeated until the team's mission is achieved and formal wraparound is no longer needed.

MAJOR GOALS	ACTIVITIES	NOTES
3.1. Implement the wraparound plan GOAL: To implement the initial plan of care, monitoring completion of action steps and strategies and their success in meeting need and achieving outcomes in a manner consistent with the wraparound principles.	**3.1 a. Implement action steps for each strategy** For each strategy in the wraparound plan, team members undertake action steps for which they are responsible. Facilitator aids completion of action steps by checking in and following up with team members; educating providers and other system and community representatives about wraparound as needed; and identifying and obtaining necessary resources.	The level of need for educating providers and other system and community representatives about wraparound varies considerably from one community to another. Where communities are new to the type of collaboration required by wraparound, getting provider "buy in" can be very difficult and time consuming for facilitators. Agencies implementing wraparound should be aware of these demands and be prepared to devote sufficient time, resources, and support to this need.
	3.1 b. Track progress on action steps Team monitors progress on the action steps for each strategy in the plan, tracking information about the timeliness of completion of responsibilities assigned to each team member, fidelity to the plan, and the completion of the requirements of any particular intervention.	Using the timelines associated with the action steps, the team tracks progress. When steps do not occur, teams can profit from examining the reasons why not. For example, teams may find that the person responsible needs additional support or resources to carry out the action step, or, alternatively, that different actions are necessary.
	3.1 c. Evaluate success of strategies Using the outcomes/indicators associated with each need, the facilitator guides the team in evaluating whether selected strategies are helping team meet the youth and family's needs.	Evaluation should happen at regular intervals. Exactly how frequently may be determined by program policies and/or the nature of the needs/goals. The process of evaluation should also help the team maintain focus on the "big picture" defined by the team's mission: Are these strategies, by meeting needs, helping achieve the mission?
	3.1. d. Celebrate successes The facilitator encourages the team to acknowledge and celebrate successes, such as when progress has been made on action steps, when outcomes or indicators of success have been achieved, or when positive events or achievements occur.	Acknowledging success is one way of maintaining a focus on the strengths and capacity of the team and its members. Successes do not have to be "big", nor do they necessarily have to result directly from the team plan. Some teams make recognition of "what's gone right" a part of each meeting.

** Wraparound phases defined in: Walker, J. S., Bruns, E. J., & the National Wraparound Initiative Advisory Group. (2008). Phases and activities of the wraparound process. In E. J. Bruns & J. S. Walker (Eds.), *The resource guide to wraparound.* Portland, OR: National Wraparound Initiative.

Family Partner Role in the Wraparound Process: Phase 3 (CONTINTUED)

PHASE 3: The family partner role

The family partner maintains a strategic partnership with the facilitator. Together they ensure everyone on the team is comfortable with the process and their responsibilities, encouraging team decision making in an open atmosphere where everyone, especially the family, has all the information needed to participate and make decisions.

Roles and responsibilities for all team members to implement wraparound plans should be clearly defined according to local policy. These policies and procedures should include what to do when someone fails to fulfill their responsibilities.

HOW FAMILY PARTNERS SUPPORT THE PROCESS

3.1 a. Implement action steps for each strategy

The family partner supports plan implementation by carrying through on the action steps they have agreed to take on.

The family partner mentors and coaches the family in their journey towards self-empowerment and independence. The family partner provides support as needed, to follow through on action steps without taking over. Some examples are:

- Accompanying family members to meetings with the school, court appearances, and other meetings as requested;
- Inviting family members to support groups, training and other group family activities;
- Encouraging family members to contact their care coordinator, teacher, physician, or other provider as questions or concerns emerge;
- Cheering the family on as they complete each significant stage of activity;
- Helping the family monitor implementation of their plan.

The family partner can practice communication techniques with family if necessary, and help work any concerns or barriers of the family about conversations with any team members or providers.

In some communities when specified in the wraparound crisis plan, family partners can be called upon to help avert a crisis by supporting the family's efforts to intervene before troubling behaviors escalate into a full crisis.

3.1 b. Track progress on action steps

Between meetings, the family partner checks with the family to see if they are following through on tasks and keeping track of other's actions they agreed to monitor. The family partner may provide additional support to family members and their informal supports if needed.

If the family feels things are not going well, the family partner encourages them to bring this to the attention of the team so any issues can be resolved quickly.

3.1 c. Evaluate success of strategies

The family partner encourages the team to present data in ways that make it easy for the family to understand what is being measured and what it means. The family partner also encourages the family to ask questions and provide their own views on progress in order to be an active participant with the team.

3.1. d. Celebrate successes

The family partner encourages the team to honor the family's efforts in a manner that is culturally relevant and meaningful to the family. The family partner also highlights the family's accomplishments and acknowledges what team members have done to facilitate achieving goals.

The family partner remembers to acknowledge small steps along the way as well.

Family Partner Role in the Wraparound Process: Phase 3 (CONTINTUED)

MAJOR GOALS	ACTIVITIES	NOTES
3.2. Revisit and update the plan GOAL: To use a high quality team process to ensure that the wraparound plan is continually revisited and updated to respond to the successes of initial strategies and the need for new strategies.	*3.2. a. Consider new strategies as necessary* When the team determines that strategies for meeting needs are not working, or when new needs are prioritized, the facilitator guides the team in a process of considering new strategies and action steps using the process described in activities 2.1.f and 2.1.g.	Revising of the plan takes place in the context of the needs identified in 2.1.d. Since the needs are in turn connected to the mission, the mission helps to guide evaluation and plan revisions.
3.3. Maintain/build team cohesiveness and trust GOAL: To maintain awareness of team members' satisfaction with and "buy-in" to the process, and take steps to maintain or build team cohesiveness and trust.	*3.3 a. Maintain awareness of team members' satisfaction and "buy-in"* Facilitator makes use of available information (e.g., informal chats, team feedback, surveys—if available) to assess team members' satisfaction with and commitment to the team process and plan, and shares this information with the team as appropriate. Facilitator welcomes and orients new team members who may be added to the team as the process unfolds.	Many teams maintain formal or informal processes for addressing team member engagement or "buy in", e.g. periodic surveys or an end-of-meeting wrap-up activity. In addition, youth and family members should be frequently consulted about their satisfaction with the team's work and whether they believe it is achieving progress toward their long-term vision, especially after major strategizing sessions. In general, however, this focus on assessing the process of teamwork should not eclipse the overall evaluation that is keyed to meeting identified needs and achieving the team mission.
	3.3 b. Address issues of team cohesiveness and trust Making use of available information, facilitator helps team maintain cohesiveness and satisfaction (e.g., by continually educating team members—including new team members—about wraparound principles and activities, and/or by guiding team in procedures to understand and manage disagreement, conflict, or dissatisfaction).	Teams will vary in the extent to which issues of cohesiveness and trust arise. Often, difficulties in this area arise from one or more team members' perceptions that the team's work—and/or the overall mission or needs being currently addressed—is not addressing the youth and family's "real" needs. This points to the importance of careful work in deriving the needs and mission in the first place, since shared goals are essential to maintaining team cohesiveness over time.
3.4. Complete necessary documentation and logistics	*3.4 a. Complete documentation and logistics* Facilitator maintains/updates the plan and maintains and distributes meeting minutes. Team documentation should record completion of action steps, team attendance, use of formal and informal services and supports, and expenditures. Facilitator documents results of reviews of progress, successes, and changes to the team and plan. Facilitator guides team in revising meeting logistics as necessary and distributes documentation to team members.	Team documentation should be kept current and updated, and should be distributed to and/or available to all team members in a timely fashion.

Family Partner Role in the Wraparound Process: Phase 3 (CONTINTUED)

HOW FAMILY PARTNERS SUPPORT THE PROCESS

3.2. a. Consider new strategies as necessary

The family partner goes over the plan each time they visit or speak by phone with the family. They discuss what is working and what may not be working. The family partner encourages the family to request a team meeting whenever they feel the need to make adjustments to the plan - such as when there are frequent crises.

The family partner assists and supports the family in bringing updates back to their team to identify barriers and select strategies that may work better. The family partner encourages the family to discuss their feelings and commitment to the evolving plan and to tell their team what they are experiencing and thinking.

3.3 a. Maintain awareness of team members' satisfaction and "buy-in"

The family partner acts as a collaborative advocate by being non-adversarial and coaching the family to find ways of keeping the conversation and approaches honest and respectful even in difficult moments. Because they are peers with similar experience, family partners can ease family members' fears, listening (without passing judgment) to what they are saying, and assuring them that they have a voice on their team.

The family partner may need to help the family bring their concerns, dissatisfactions, or conflicts to the surface. In such cases, the family partner explores ways to communicate with the team that the family feels are safe and can lead to resolution with other team members.

The family partner collaborates with team members to maintain their confidence with the process and help them stay engaged, use the plan, adapt it when needed, and continue to develop better ways to communicate with the family, understand and meet their needs.

3.3 b. Address issues of team cohesiveness and trust

The family partner's own behavior can help maintain the team's cohesiveness and trust. Family partners can model how to frame and reframe an issue to facilitate collaboration, being patient, and being strengths-based all through the wraparound process.

By reminding the team of the meaning of the Principles of Wraparound the family partner can help the team examine how their actions are building trust, cohesiveness, and collaboration to achieve shared goals.

The family partner encourages the family or team members to bring issues into the open where they can get supports to resolve conflicts quickly.

3.4 a. Complete documentation and logistics

The family partner reviews updates to the written plan with the family to make sure that the family understands the plan, that it accurately reflects what the family has said (preferably in their own words) and what they expect from those responsible for implementing it. The family partner helps the family strategize about how to work with their team to modify anything in the plan that they are not comfortable with.

The family partner completes contact notes, individual service planning reports or other documentation according to the requirements of their employer.

The family partner helps the family to use tracking procedures provided by the team or to develop their own method (such as a binder or folder or storage box) of organizing and preserving their family's important papers and plans. The family partner participates in evaluating the implementation of wraparound such as collecting data, interviewing families, participating in data analysis and reporting results to the team, community, families, and funding sources.

Family Partner Role in the Wraparound Process: Phase 4

PHASE 4: Transition**

During this phase, plans are made for a purposeful transition out of formal wraparound to a mix of formal and natural supports in the community (and, if appropriate, to services and supports in the adult system). The focus on transition is continual during the wraparound process, and the preparation for transition is apparent even during the initial engagement activities.

MAJOR GOALS	ACTIVITIES	NOTES
4.1. Plan for cessation of formal wraparound GOAL: To plan a purposeful transition out of formal wraparound in a way that is consistent with the wraparound principles, and that supports the youth and family in maintaining the positive outcomes achieved in the wraparound process.	*4.1 a. Create a transition plan* Facilitator guides the team in focusing on the transition from wraparound, reviewing strengths and needs and identifying services and supports to meet needs that will persist past formal wraparound.	Preparation for transition begins early in the wraparound process, but intensifies as team meets needs and moves towards achieving the mission. While formal supports and services may be needed post-transition, the team is attentive to the need for developing a sustainable system of supports that is not dependent on formal wraparound. Teams may decide to continue wraparound—or a variation of wraparound—even after it is no longer being provided as a formal service.
	4.1 b. Create a post-transition crisis management plan Facilitator guides the team in creating post-wraparound crisis management plan that includes action steps, specific responsibilities, and communication protocols. Planning may include rehearsing responses to crises and creating linkage to post-wraparound crisis resources.	At this point in transition, youth and family members, together with their continuing supports, should have acquired skills and knowledge in how to manage crises. Post-transition crisis management planning should acknowledge and capitalize on this increased knowledge and strengthened support system. This activity will likely include identification of access points and entitlements for formal services that may be used following formal wraparound.
	4.1 c. Modify wraparound process to reflect transition New members may be added to the team to reflect identified post-transition strategies, services, and supports. The team discusses responses to potential future situations, including crises, and negotiates the nature of each team member's post-wraparound participation with the team/family. Formal wraparound team meetings reduce frequency and ultimately cease.	Teams may continue to meet using a wraparound process (or other process or format) even after formal wraparound has ended. Should teamwork continue, family members and youth, or other supports, will likely take on some or all of the facilitation and coordination activities.

** Wraparound phases defined in: Walker, J. S., Bruns, E. J., & the National Wraparound Initiative Advisory Group. (2008). Phases and activities of the wraparound process. In E. J. Bruns & J. S. Walker (Eds.), *The resource guide to wraparound*. Portland, OR: National Wraparound Initiative.

Family Partner Role in the Wraparound Process: Phase 4 (CONTINTUED)

PHASE 4: The family partner role

The family partner focuses on making sure the family is well prepared for transition, is connected to necessary supports, and has the skills and knowledge they need to feel comfortable and capable of getting help without the formal support of the wraparound team in the future.

HOW FAMILY PARTNERS SUPPORT THE PROCESS

4.1 a. Create a transition plan

The family partner helps the family to look back on their wraparound experience, identify what they have learned, review their plan, and determine if the outcomes they hoped for were achieved.

The family partner checks the family's comfort level with the cessation of formal wraparound and the time frame in which it will occur. The family partner supports the family in self-advocacy if time frames do not work for them.

The family partner talks with the family about what graduating from wraparound will mean for them and how they can manage to maintain whatever gains were made. The family partner helps the family acknowledge their own level of self empowerment and identify the specific strategies the family is able to use to advocate for their child, use natural supports and services, or get help in a crisis.

The family partner supports the creation of a post transition or after care plan in format family will be able to use. The family partner can give the family a file or binder of community and state resources and places they could in the future. . use

Some family partners are able to provide supportive contact via phone, consistent with employer policy, after formal wraparound has ended.

The family partner encourages the family to join a family-run organization and participate in family activities in the community where they can receive ongoing peer support as well as provide support to others if they are ready.

4.1 b. Create a post-transition crisis management plan

Family partners can encourage the family to call a team meeting when they need it, create their own agendas, and to facilitate their own team meetings.

The family partner makes sure the family has a crisis plan they can implement. The family partner makes sure family members know who to contact and how to get in touch with people quickly if a crisis occurs.

4.1 c. Modify wraparound process to reflect transition

At the time of transition, the family assumes responsibility for advocating for themselves. Family partner may help the family assume the facilitation of their own team post formal wraparound. The family may call on the family partner to help them refresh their skills when difficulties arise.

Family Partner Role in the Wraparound Process: Phase 4 (CONTINTUED)

MAJOR GOALS	ACTIVITIES	NOTES
4.2. Create a "commencement" GOAL: To ensure that the cessation of formal wraparound is conducted in a way that celebrates successes and frames transition proactively and positively.	**4.2 a. Document the team's work** Facilitator guides team in creating a document that describes the strengths of the youth/child, family, and team members, and lessons learned about strategies that worked well and those that did not work so well. Team participates in preparing/reviewing necessary final reports (e.g., to court or participating providers, where necessary)	This creates a package of information that can be useful in the future.
	4.2 b. Celebrate success Facilitator encourages team to create and/or participate in a culturally appropriate "commencement" celebration that is meaningful to the youth/child, family, and team, and that recognizes their accomplishments.	This activity may be considered optional. Youth/child and family should feel that they are ready to transition from formal wraparound, and it is important that "graduation" is not constructed by systems primarily as a way to get families out of services.
4.3. Follow-up with the family GOAL: To ensure that the family is continuing to experience success after wraparound and to provide support if necessary.	**4.3 a. Check in with family** Facilitator leads team in creating a procedure for checking in with the youth and family periodically after commencement. If new needs have emerged that require a formal response, facilitator and/or other team members may aid the family in accessing appropriate services, possibly including a reconvening of the wraparound team.	The check-in procedure can be done impersonally (e.g., through questionnaires) or through contact initiated at agreed-upon intervals either by the youth or family, or by another team member.

Phases and Activities of the Wraparound Process: Phase 4 (CONTINTUED)

HOW FAMILY PARTNERS SUPPORT THE PROCESS

4.2 a. Document the team's work

Family partners, as part of the team, ask the family what kind of commencement they would like and how they want to celebrate.

Family partners participate in planning this event to make sure this is the family's time in the sun.

The family partner makes sure the family has collected all its important plans and papers in an organized way so they have ready access to them in the future.

4.2 b. Celebrate success

The family partner encourages the family to participate in the commencement celebration. If the family does not participate, the family partner finds a way to acknowledge the family success and bring closure to their relationship.

4.3 a. Check in with family

Depending on the community policies and resources that are available to support family partner work, the family partner and family may create a plan to stay connected by phone or face-to-face meetings on an individual basis. In most communities the family partner calls the family three to four weeks after transition to see how they are doing. In some communities family partners support families long after all other formal wraparound services are finished.

The family partner's connection with family organizations in the community can give rise to opportunities for them to see and connect with wraparound graduates through newsletters, support group meetings, invitations to special events, conferences, volunteering or employment in the family movement or system of care, or joining workgroups, taskforces, advisory groups, and governing bodies.

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Family Partners and the Wraparound Process

Patricia Miles, Consultant

As communities and organizations begin to develop capacity to implement the wraparound process, issues of staffing will arise. It is generally accepted that wraparound projects will need some type of process/team facilitator, who may also be referred to as a "care coordinator," "resource coordinator," or "wraparound facilitator." Depending on the funding stream and generally acceptable wraparound practice within the state or local municipality, other staff roles may also be a part of creating infrastructure to implement a quality process. One such staff role is that of a family partner, who may be referred to as a parent partner, family support partner, peer support or family advocate. Family partners employed in wraparound are individuals who have experienced the child/family service system from the "other side of the counter," as caregivers or loved ones of recipients of service.

History of Family Partners in Wraparound

Early wraparound efforts typically began with a target population of young people who had spent a great deal of time in restrictive environments in order to access treatment. Initial projects focused on returning these young people to their families and communities by redirecting funds, creating new interventions and arranging for people to serve and support one child at a time. Since these early efforts typically began with a need to redirect dollars that were already being spent, they started with a minimum of staff to keep overhead low. This minimal staffing usually involved someone to take on a facilitation role to bring people together and to follow though on managing bureaucra-

cy, funding issues and assuring that services were provided. In the early 1990s, many system of care projects began to experiment with hiring family members, including parents, in addition to funding free-standing family organizations. For those family members who were hired within service delivery organizations, a number of challenges arose.

To start off, several things quickly became clear about the organizational environments that employed these parents/family members. The first was that it had to be everyone's responsibility to interrupt bias, blame, and judgment as it impacted families and caregivers accessing services. Those sites that expected the hired family member to take on sole responsibility of correcting institutional bias soon found that those family members felt isolated and burdened by this responsibility.

The second lesson was that it wasn't enough to just hire a family member. In order to achieve results, family members' efforts were more effective when paired with a practice change strategy. It wasn't helpful if the "host environment" employing these parents and family members wasn't prepared to change the way it interacted with families receiving services. If the model of service remained expert-driven, there wasn't enough room to allow the designated experts to continue in their role while also integrating the expertise brought to the table by the family support partner. In effect, without changing the way of doing business, there seemed to be room for only one "expert" at the table.

In contrast, some agencies engaged in hiring parents and family members were also implementing wraparound efforts in order to move from an expert-driven model to a collaborative model. This was an attempt to align direct service with system of care values. It was not unusual for the parents and family members hired at these agencies to find a sense of coherence, belonging and purpose within the wraparound process. Indeed, parents hired at these service provider agencies often found themselves as the primary advocates for implementation of a quality wraparound process.

Models for Integrating Family Partners in the Wraparound Process

As wraparound expanded, second- and third-generation projects began to hire parents and family members as part of initial program design. Some early wraparound projects had designed and funded structures to support family involvement, but later projects were more likely to pair family members with wraparound facilitation staff to facilitate high-quality wraparound delivery as well build family involvement into the overall system.

As projects began to experiment with the roles of family members in wraparound projects, regional variances and opportunities presented themselves. These regional variations were sometimes driven by funding streams, as in the case of projects that were heavily dependent on federal entitlements. Other variations came from community or system context. Communities that had a strong, free-standing family organization might approach it one way while other communities that were experiencing broad-scale system change through lawsuit or legislative action might choose to implement differently. Regardless of the particular design, the vast majority of these projects involved in employing family members found that they could see direct benefits from the peer-to-peer support and activities of family members sharing with other family members.

The tables that follow describe and define various roles for family members hired within wraparound projects. The first model that a project selects may not prove to be the model they ultimately implement. Additionally, there are many more roles for family members within an overall system than those typically attached to a wraparound project. Regardless of the model chosen, if you are an administrator who is planning or implementing a wraparound project, it is important to keep in mind several principles about family partners:

1. *The wraparound family partner has to be someone who has experienced the service system from the consumer perspective.* This unique perspective allows these indi-

viduals to relate to families in unique ways and also helps professionals see their activities from a different perspective.

2. *Wraparound family partners bring a wealth of formal training in addition to their personal experiences*. Many wraparound projects who have employed family partners have found that they come to the table with a variety of formal education in addition to their personal experiences. Journalists, marketers, website designers, party planners and social workers are some of

the professional roles that family partners have brought to the table, in addition to their personal experience of caring about someone who has received services.

3. *It* is *personal to the family partners*. We hire family partners because of their personal experience. It doesn't make sense to turn around and ask them to "not take things personally" when their first condition of employment is their personal experience.

Possible Models for Implementing Family Partners in Wraparound Projects:
1. Paired Facilitator + Family Partner Team

Option	Defined	Advantages	Disadvantages
1. **Paired Facilitator + Family Partner Team**	This model consists of a wraparound facilitator and family partner paired to implement the wraparound process. The first responsibility of the family partner is to assure that the parent/caregiver's voice and perspective is understood by other wraparound staff and the child and family team. When the Family Partner is sure that the parent's perspective is understood, they will also ensure that wraparound implementation is done with quality and adherence to practice steps. Typically, this model involves increasing caseload size somewhat since both parties are working directly with the same families. The family partner will also perform support activities with families as they go through the wraparound process.	1. Wraparound is a complex process: having two people see it through together can increase reliability of wraparound practice. 2. Having a shared caseload increases continuity in the event of turnover. 3. The paired approach models a true parent/professional partnership when implemented well. 4. Multiple perspectives blended in a team may associate with a broader and more inclusive view of the family.	1. Both parties can end up "stepping" on each other's roles. 2. Issues of caseload size and cost have not been resolved. If a facilitator can manage a caseload of a certain amount, how should that increase when the project also hires one or more family partners? 3. This model runs the risk of these two people being so tightly connected that the family or other team members can feel on the "outside." 4. Creating the sense of both parties on the same team can be challenging.

Possible Models for Implementing Family Partners in Wraparound Projects: 2. Peer Parent Support

Option	Defined	Advantages	Disadvantages
2. Peer Parent Support	This model is more interdependent than the paired model in that family partners are hired to provide peer support to families experiencing the wraparound process. In this model, the family partner meets the family either with or around the same time as the wraparound Facilitator. The family partner uses a method to identify whether the family will need contact that is intensive, moderate or supportive. This range includes at least weekly face-to-face contact and attendance at most child and family team meetings (intensive) to regular phone contact and attendance at child and family team meetings. In this model, family partners provide accurate and reliable information to families they can use in decision making as well as connecting to families to others who have a shared experience.	1. Allows the wraparound facilitator and family partner to be connected when they need to be and independent when they need to be. 2. Allows the family partner to tailor their response to each family's unique needs. 3. Direct support can be delivered at the family's pace rather than in pace with wraparound.	1. Both parties (family partner and wraparound facilitator) have to work at keeping communication open and accurate. 2. Either party (facilitator and family partner) can end up at cross purposes. 3. Wraparound administration must make sure that support activities performed by family partners aren't seen as somehow "less important." 4. More challenging to build accountability for family partners, because much of their direct work with families may be "unseen." Thus, a project using this model needs to develop means to recognize and document good work.

Possible Models for Implementing Family Partners in Wraparound Projects: 3. Parents as Peer Interveners

Option	Defined	Advantages	Disadvantages
3. Parents as Peer Interveners	This model creates a capacity for family partners to deliver direct services, supports and interventions to parents and caregivers. This model starts with an expectation that some parents/caregivers will benefit from direct interventions that are provided using a peer-to-peer model. In this model, the child and family team will work collaboratively with the family and other team members to identify needs, goals and strategies. If the team reaches agreement about a need, the parent intervener will be called in to accomplish that need. These individuals will spend minimal time in team meetings and much more time working directly with families, in particular parents and caregivers. Examples of activities these peer interveners will work on include helping a parent locate and access community resources, coaching skills that will help the parent/caregiver cope successfully, assisting the parent/caregiver with building a social network and other imaginative responses that are identified by the child and family team. These peer parent interveners are typically time limited and goal oriented.	1. Creates capacity to get work done outside of team meetings. 2. Opens up a possibility of peer-to-peer work with parents who are struggling with building new skills or resources. 3. Creates more options for parents to be hired within the system outside of a wraparound process. This role doesn't need wraparound to happen for the work to occur. 4. Can bill federal entitlements for this work as long as the peer-to-peer work with parents is tied to the identified child's diagnostic needs.	1. This model may lend itself to a "fix-it" mentality with parents or caregivers. Projects must guard against this. 2. The time-limited, goal-oriented nature of this arrangement can cause parents to feel let down if they counted on support provided by the peer parent Intervener. 3. If using federal Medicaid funding to support this role, the program has to demonstrate how these peer services to the caregiver relate to the identified child's diagnosis.

Possible Models for Implementing Family Partners in Wraparound Projects: 4. Parents as System Developers or Family Involvement Coordinators

Option	Defined	Advantages	Disadvantages
4. Parents as System Developers or Family Involvement Coordinators	This design is especially well suited in those projects that don't have full funding to hire as many family partners as they would prefer, or in sites that are struggling to locate and hire parents/caregivers who are willing to work in the wraparound project. In this model, the project hires a relatively small number of parents or caregivers to assist with start-up activities. In this model, the role of the family involvement coordinator is to develop the hospitality of the wraparound project specifically as it welcomes parents and caregivers into the project. Typically, in this role, the family involvement coordinator will meet with parents/caregivers as they enter the project to provide an overview of the wraparound process as well as inviting the parent/caregiver to call any time with concerns or questions. The family involvement coordinator may not have contact again with that parent as they go through wraparound. If problems occur, either through identification by the parent or program staff, the family involvement coordinator or parent system developer can troubleshoot the situation to ensure that it is resolved and that the parent's perspective is understood.	1. This role is effective when the parent system developer or family involvement coordinator has influence and access to the project's administration. It assures family perspective in wraparound management. 2. Creates a capacity for parents to connect even when the project can't hire enough parents to be available on every team. 3. The family involvement coordinator can develop some community activities such as support groups so that families can connect outside of wraparound.	1. Staff can "over-rely" on the family involvement coordinator to "fix" conflicts with caregivers rather than resolving differences themselves. 2. The family involvement coordinator/parent system developer who gets called in as the troubleshooter may never get a chance to really connect with teams that are working. This can lead to discouragement. 3. Other wraparound staff can experience the family involvement coordinator/parent system developer as "policing" their practice as families are invited to call them with concerns. Projects have to guard against a backlash around this role.

Possible Models for Implementing Family Partners in Wraparound Projects: 5. Families as Wraparound Facilitators

Option	Defined	Advantages	Disadvantages
5. Families as Wraparound Facilitators	Parents and family members are effective advocates for high-quality wraparound implementation. As a result, some wraparound projects have hired parents and caregivers as wraparound facilitators. In this role, the parent or caregiver will take on the responsibilities of any wraparound facilitator. Those sites that have elected to hire wraparound alumni as facilitators expect that the person in the facilitator role will share information about their personal wraparound experience as part of implementing the process, as a way to fully engage family members.	1. Personal experience allows for strong connections between the family and the wraparound facilitator (who is also a parent). 2. Many parents can bring their personal experience of navigating systems and communities to the wraparound planning table. 3. This model enables efficient use of staff roles, especially for projects that don't have a great deal of funding available for staffing. 4. There is some thought that family members "get" wraparound quicker because of their personal experience.	1. Wraparound family partner and wraparound facilitator are two different, full-time roles. Placing these roles together may result in neither getting done well. 2. Projects have to guard against creating a dual workforce of those "professionally" trained and those "personally" trained. 3. Regardless of which "type" of training the facilitators received, all facilitators require consistent support and supervision.

Summary

There are many roles for hired family members within the wraparound process. These descriptions are not intended to be exhaustive but rather should be seen as starting concepts. Wraparound managers who are interested in hiring family members as part of their wraparound delivery should start by creating a model with clear assumptions, and then monitor that model to assure that the initial assumptions are being realized and make informed adjustments based on results. Key ingredients for building an effective family partner capacity include building a strong training component so family partners can continue to develop and refine their skill sets, developing an adequate career ladder so family partners can continue to grow and improve, and developing an adequate feedback loop so family partners can modify their role as the project matures.

A word about youth partners: Many wraparound projects are beginning to experiment with hiring youth partners, peers or "near peers" who have experienced wraparound or system intervention. This is a relatively new development in wraparound implementation and should be treated with the same careful consideration of other innovations in wraparound. As with the family partner, the youth partner requires model development, ongoing training and support as well as creating opportunities for individuals in these roles to grow, advance and develop.

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Patricia Miles is a consultant who lives in Oregon and helps communities, agencies, schools and others work to improve outcomes with people who are receiving public services.

Wraparound Practice: Chapter 4b.4

Building a Quality Family Partner Foundation: Tips for Implementers

Patricia Miles, Consultant

Many wraparound projects have enhanced their delivery of wraparound planning by hiring family partners. Family partners in wraparound serve many purposes, including providing direct peer-to-peer support for family members, providing consultation to wraparound staff members about the perspective of the parent/caregiver, developing resources and supports on behalf of families, and participating in oversight efforts of wraparound. Figure 1 (next page) defines a cycle for employing family partners in wraparound projects. This summary will review each of these stages and identify typical mistakes as well as tips to build a strong foundation integrating family partners within wraparound projects.

The first opportunity for wraparound projects involves *recruiting* potential family partners. Family partners are individuals who have experienced the system from the "other side of the counter." Typically, in wraparound, these individuals are parents or caregivers of children who have received direct services although in some cases, other family members are hired. Projects that want to enhance wraparound through the use of family partners must make arrangements to recruit people who have had direct experience within the system rather than simply using the title of family partner for people who haven't had that direct experience.

When the recruitment process is underway, wraparound projects should move to *hiring* family partners. A project interested in hiring should be prepared to make accommodations to facilitate hiring. Administrators and managers should be prepared to accommodate both the personal and professional experience of family partners when making job

Figure 1. Stages in Building a Strong Family Partner Capacity
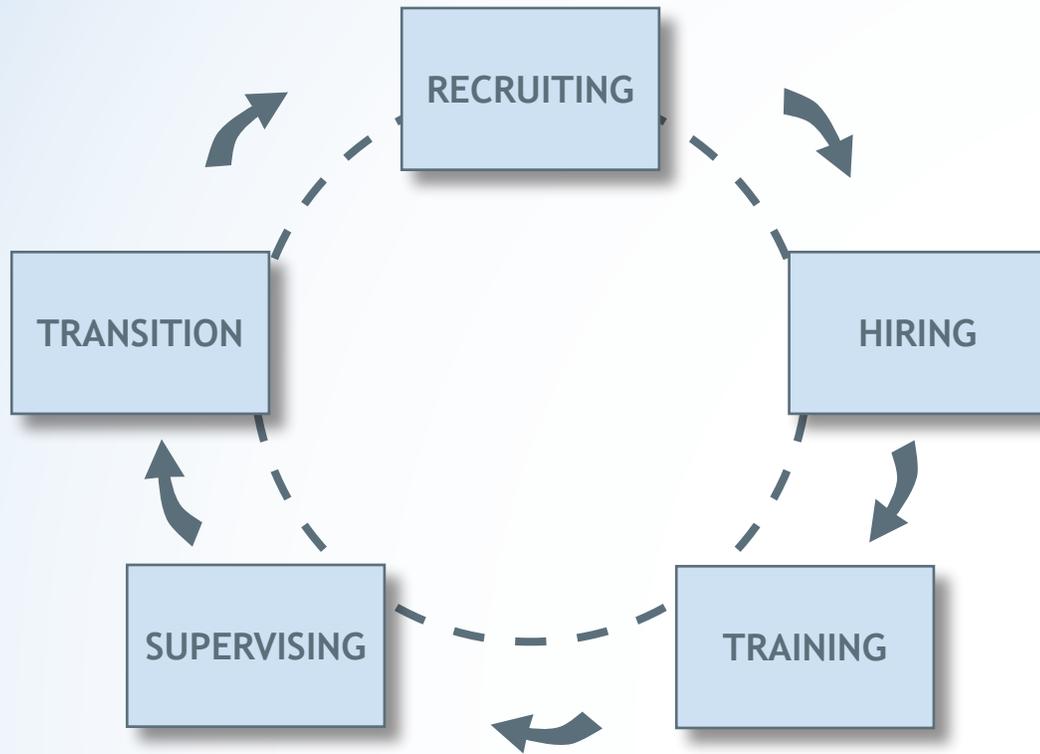
assignments and outlining pay. Family partners are hired because of their personal experience. Recognition of this personal experience can be accommodated by working with the human resource department. When building this recognition for personal experience, the project should also develop ways to recognize this through salary levels.

When a hire has been made, wraparound leadership should begin a *training* initiative to assure that the family partners have adequate access to the resources, tools and information they may need. Not all parents or family members who have experienced the system turn into family partners. Many individuals who apply for family partner positions have reached a place in their own life that causes them to want to share their experiences in a way that helps other families. In fact, many family partners reflect that their journey to becoming a family partner has often followed this path:

- First, parents/caregivers reflect that they have been "brought to their knees" by their child's diagnosis. This is often described as a sense of disequilibrium and feeling of powerlessness.

- Second, the parent/caregiver recognizes that they and their family have become part of a system whether they like it or not.

- Third, the parent/caregiver realizes that if their family is likely to survive this experience, they will need to engage in the process of help as they never imagined.

- Finally, the parent/caregiver develops an interest in helping engage others on their own journey towards resilience and recovery.

Even the most self aware family partner deserves to be engaged in a process of skill and com-

Table 1. Stages in Building a Strong Family Partner Capacity

DO:	DON'T:
Openly recruit all family members who have participated in system services	Screen out individuals based on their compliance as a service recipient
Make accommodations to assure families can access system services in the future while having their privacy protected	Tell families if they become Family Partners they can no longer use services
Anticipate the need for career growth by building capacity for Family Partners to move into lead, supervisory or management positions within the Family Partner job cluster	Set up a hierarchy between other Wraparound staff and Family Partner staff
Encourage Family Partners to share their personal experience with professionals and other family members	Limit what the Family Partner is able to share by using one working definition of professional boundaries
Empower the Family Partner to interrupt bias, blame and prejudicial stances	Make interrupting bias the responsibility of only the Family Partner
Train Family Partners along with other Wraparound staff	Confuse Wraparound training with Family Partner training. They are two different things.
Develop specific training opportunities for Family Partners as it fits with the model your project is pursuing	Choose training activities in a vacuum. Family Partners should have access to the same training opportunities as all other Wraparound staff. On the other hand, Family Partners deserve to have some specialized areas of training that are unique to the role of peer support provider.
Prepare the rest of the workforce to develop alliances with Family Partners	Assume that alliances will form without attention. Family Partners are recruited and hired because of their unique vantage point about the way the system operates. Other differences may include age of Family Partners as well as formal training. Alliances will not form easily and will require administrators to nurture similarities and normalize differences in perspective.
Hold Family Partners accountable to produce results and activities	Over-accommodate Family Partners
Create meaningful roles for Family Partners in the operations of your Wraparound project	Use Family Partners as window dressing or a symbol of your commitment to families
Involve families in the Wraparound project operations	Confuse Family Partners with family involvement. Avoid over-reliance on Family Partners when seeking family voice about the functioning of the system or program.

petency development. The wraparound project that fails to create a skill development capacity is building a project based on personality rather than competency.

While training is an ongoing process, *supervision* of the family partner is another element in creating a strong foundation for the wraparound project. Family partners should have clear expectations for how they should perform within the wraparound project. This allows supervisors to manage to the skill set rather than the personality of the people in the role. Supervisory issues include developing the capacity for family partners to work cooperatively with other wraparound staff, managing supportive relationships with family members, and managing around their own situation. Family partner boundaries are different than boundaries for people who have been professionally trained for their roles. Supervisors have to join with family partners in order to establish helpful limits and structures to manage their personal stories.

Some family partners indicate they anticipate staying in the position forever. Others, however, are interested advancing and developing additional skills. Wraparound projects have to be prepared to help family partners *transition* in their jobs, either through promotion, reassignment, or termination. A common error involves failing to create a career ladder that allows the family partner to advance while remaining in the family peer job cluster. In some projects, family partners find their only mechanism to advance involves moving into a more traditional role such as facilitator or care manager. Reassignment may involve helping the family partner to move into another depart-

ment that allows for lateral growth rather than promotional growth. Many wraparound projects managed by nonprofit, multi-purpose agencies find that after experimenting with family partners in wraparound, they would like to see family partners in other departments. Creating capacity for wraparound family partners to move into other departments can keep family partners sharp, invested and interested. Finally, the last step in transition involves terminating a family partner when they can't demonstrate the necessary skills in enough time to help the families the project serves. If the person can't develop the ability to deliver peer-to-peer support, the wraparound manager has to be prepared to hold the person accountable and help them transition out of the project. When the transition phase is complete, the project should being with recruitment again.

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Wraparound Practice: Chapter 4b.5

A Dozen Mistakes in Using Family Partners in Wraparound

Patricia Miles, Consultant

Mistake 1

Making Family Support a Specialty Service: Wraparound was designed to be a supportive process. Supporting families, including parents/caregivers, is the responsibility of all wraparound staff. Some projects make the mistake of using family partners as the sole supporters or providers of family perspectives.

Mistake 2

Creating an Assistant Class: family partners are hired because of their personal experience. This personal experience should be recognized and equated to traditional sources of expertise, including professional and/or educational experience. If this personal experience is not recognized, family partners can wind up being seen as assistant facilitators or as assistants to other wraparound staff. While everyone can use more help, if the project evolves in this direction, the potential of family partners in creating conditions for family voice is not likely to be realized.

Mistake 3

Failing to Hire Family Members in this Role: The power of family partners is that they have direct experience from another perspective. Family partners who have "been there" help families who are experiencing loneliness by creating capacity to see themselves in others who have had similar experiences. While everyone can be supportive to families, not everyone can relate on this personal level.

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Mistake 4

Confusing Agreement and Understanding: Family partners are intended to increase the capacity of project staff to understand the perspective of the family, especially as it is experienced by the parent or caregiver. Some family partners, however, find themselves in the position of advocating for team members to agree with the parent's perspective rather than ensuring that team members understand that perspective. This puts the family partner in an advocacy role and can lead to team members "taking sides" instead of participating in a collaborative process.

Mistake 5

Family Partners as Parent Correctors: A strength of family partners is that they can engage parents and caregivers in candid and realistic conversations through use of their personal stories and experiences. This engagement process seems to lead to greater engagement with the wraparound project. Some projects, however, will use this connection to put family partners in the role of correcting parents. This undermines the power of the position to build supportive peer-to-peer relationships.

Mistake 6

Family Partner as Ultimate Role Model: Family partners are hired because of their personal experience. At the time of hire, the family partner's life may be going well and their loved one's diagnosis or symptoms may be well managed. It is tempting to use that scenario as a example of what the family should expect to happen to them. This is a problem for two reasons. The first is that if the family partner has a child who is living with a mental illness, things can go out of balance quickly. Putting the family partner on a pedestal just means they are likely to fall when the mental illness requires intervention. Second, putting a family partner on a pedestal undermines the power of peer-to-peer support. Instead, projects should ensure that staff are realistic and accepting about what family partners are likely to go through in their role. Projects that do an effective job of supporting family partners will make accommodations for family partners who are going

through their own struggles, and ensure that the family partner doesn't feel like a "failure" when their loved one's challenge requires attention.

Mistake 7

Turning family partners into youth workers: Most Wraparound projects rest in the child and youth service world. This focus on young people typically encourages development of various staff roles that are effective in working with children and youth. Family partners, especially those first hired, can find themselves functioning as an "ex-

tra pair of hands" in working with young people rather than holding the perspective of other family members. This is a problem when the opportunity to understand the parent's perspective is lost as family partners stay too busy working with youth, too.

Mistake 8

Family Partners as the Values Police: Making wraparound principles and system of care values real is the responsibility of all wraparound staff. Values statements are often very personal to family partners. Some projects will find that family partners are often the first ones to comment on situations that don't fit with the values. Putting the family partners in the policing role can result in organizational isolation as well as creating dependence within the rest of the project.

Mistake 9

Family Partner as Decoration: Family partners seem to make wraparound work better. Family partners can also take on symbolic importance by reflecting the project's commitment to involving and listening to families. Projects must strive to create meaningful roles for family partners rather than using this role solely as a symbol of family involvement.

Mistake 10

Confusing Personalities and Skills: The first family partners hired are usually true pioneers who are in a position to extend their personal lives to help others. These strong personalities with a sense of vision are usually successful because of who they are rather than anything the project does. As the project matures it is important for projects to move from simply hiring strong personalities to assuring that family partners have the right skill set to perform the job.

Mistake 11

Confusing Peer-to-Peer Support and the Wraparound Process: There are many roles for parents within the service system. Being a family partner within wraparound is just one among many possible peer-to-peer support roles. Many quality projects can use peer-to-peer support to enhance the family's experience of service and to increase the capacity of the system to provide customer centered care. Wraparound is not the only vehicle for peer-to-peer support to occur. Indeed, the entire service system including outpatient mental health clinics, in-home counseling programs, family re-source centers and school based interventions, can realize benefits from hiring family members in peer support roles.

Mistake 12

Stopping at One: Family partners represent a very real enhancement to the way the wraparound process is implemented. Depending on the project's capacity, stopping at the first family partner may keep the project from building real capacity for peer-to-peer support. Projects should be strategic and take a long view in building their capacity for peer-to-peer support. Projects that think they have built this capacity when they have hired only one family partner—even as the project continues to grow—are failing to realize the potential and power of peer-to-peer support and its potential impact on the efficacy of the wraparound process.

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Family Stories about Family Partners in Wraparound

Marlene Penn, Co-Chair, Family Partner Task Force
National Wraparound Initiative
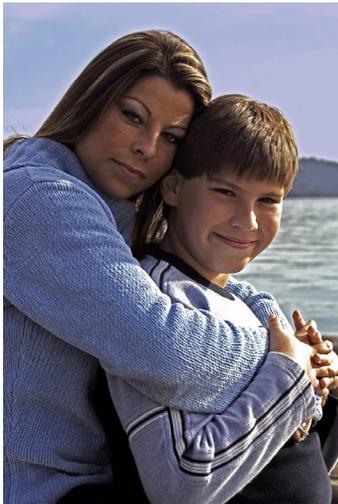
Marlene Penn shares three stories of families who benefited from having a family partner involved in their wraparound process.

Family Involvement Center, Phoenix, Arizona

In this story, Dawn, the mother of a 13-year-old son with mental health concerns, shares her story about the critical role her Family Support Partner from the Family Involvement Center played in her family's experience with wraparound and in her own journey toward self-empowerment.

Having a family support partner [FSP] at first was a little scary for us. We had a lot of complex situations and needs in our family, and we had some bad experiences in the past with individuals who claimed to offer us support and help, so I was really skeptical. The FSP asked me to coffee and I thought, "OK what is this all about?" The last time I was asked to coffee by a behavioral health professional, it was to try and coax me to leave my husband because they thought he was not good for our family.

Well, this person gave me a totally different perspective. She was genuinely concerned and shared her personal experiences, which made me feel she was there to help me and not just my child. She began attending my child and family team meetings and was able to help get across what I was either wanting or trying to say. She also helped others to hear what our family needs were. In the child and family team meetings, she often stopped conversations, which were going full speed, to ensure people were really hearing us. She supported our

goals and desire to stay together as a family in a way that was strengths based. She understood the love in our family and how we needed to be there for each other. She was also very supportive when we had juvenile justice involved regarding our son, and attended court hearings with us often. That was not expected but greatly appreciated.

She was not the case manager, but was great at keeping us all on target, to move my family towards outcomes. She's truly seen us through the thick and thin of our lives, and let me tell you, we have been through a lot—trying to find community resources, and so forth. Just the time to get away and talk to someone without feeling like you are being judged was so important to us. Without our family support partner, I would have felt like I was wavering in deep waters without so much as a raft in sight. She was my anchor many times, and taught me how to advocate for my family in a way that was strengths-based and solution-focused for everyone involved in our team, but especially our family. My husband began to feel acceptance and support, rather than a harsh, judgmental atmosphere.

She continues to be a resource and a creative problem solver for us, and for other families. I call her and get her advice for others. I now work in the system to help families, and it was the excellent model that she set for me that allowed me to become a family leader. She did not encourage me to go in this direction, but she definitely inspired me greatly by her example alone.

Family Support Organization of Burlington County, New Jersey

Marie Vandergrift of Southampton New Jersey was actually the first to enter the wraparound process in her county, and she describes her experience of having a family partner as well as the overall impact of wraparound in her life.

They told me that a family support partner [FSP] would be coming with my care manager to meet me and my family. I didn't have to go anywhere! They came right to my trailer in a very heavy snowstorm. The care manager and her supervisor came in with the FSP for our first "face to face." Within about five minutes, my son said of the FSP, "finally, someone who understands." My

family partner really did understand because she had been through so many of the same problems with her family and child welfare. Our care management organization really tried to help my son and they did a lot. My family support partner and her whole organization were always there for me. They gave me so much courage. I was very timid. I would not speak up and I was very much afraid of child welfare. I learned so much from having my family partner there with me always.

She had invited me to come and speak at a legislative event. While we were in the car, I got a call from the residential facility telling me that my son would be discharged the following week. There was no transition plan to speak of. I was very upset and just kind of accepted it. My family partner coached me to discuss this with my care manager and to request a child and family team meeting, if I wanted to. My FSP dialed the number and asked me to take the phone. I felt timid but I wanted to do it. When the care manager wasn't there, she suggested that we call back and ask to speak to the supervisor. I was willing to try. The supervisor wasn't there either. "Let's try the clinical coordinator," my family partner said. So I did and I reached her. I did all of the talking with my cheerleader sitting right next to me. A child and family team meeting was called together promptly and I feel like I changed forever.

That day, I spoke with confidence before the legislature. My FSP never pushed me to do anything I didn't want to do, but she encouraged me to try things to empower myself. Today, I serve on the board of directors of the care management organization, Partners for Kids and Families. From my family partner and the whole family organization, I learned not to blame myself; I learned to empower myself and my family. I am a partner to the system, not a victim of the system. I didn't understand in the beginning why only my son was referred for wraparound. My other son needed more. The wraparound team supported my whole family.

Today, my daughter is on the planning board of the family support organization's Youth Partnership. Both of my sons are doing well and living independently. They are about to become fathers, and I am about to become a grandmother.

The Montgomery County Federation of Families for Children's Mental Health, Maryland

Celia Serkin, Executive Director, describes how important wraparound and having a family support partner was to Valerie Oliver and Sheila Ward before they both became family support partners themselves.

Valerie Oliver became engaged in the wraparound process when she felt that her life was spinning out of control and going downhill. She felt isolated and alone. She had no outside or natural supports to help her address her child's mental health challenges. Wraparound came into her life, and Valerie began to embark on a journey toward self-advocacy and self-efficacy.

Valerie had a care coordinator and a family support partner who jointly facilitated her child and family team. Her team members extended a helping hand and opened many doors that had previously been closed to her. Valerie's family support partner encouraged her to acquire survival tools that helped her to work towards achieving self-sufficiency. Her family support partner stressed the importance of Valerie maintaining her dignity and respect and having a choice about what she wanted and needed for her family. She guided Valerie and supported her in her decision to select the right path for her family. She acknowledged Valerie's strengths and needs.

Valerie began leading her own child and family team and creating a viable support system for her family. With the help of her family support partner and the care coordinator, Valerie and her team members implemented a clearly defined plan of care that had individually tailored goals. Her son got back on his feet and was able to be maintained in the community. Valerie restored her faith and had hope for a better future.

Sheila Ward felt that she was desperately in need of assistance when she began participating in wraparound. She had a child with mental health challenges, who had psychiatric hospitalizations and was having many difficulties. When Sheila became involved in wraparound, she was assigned to a partnership dyad consisting of a family support partner and a care coordinator. They came to Sheila's home when she felt that she was at her lowest point and in need of many services and supports to uplift and empower her. They were caring and compassionate and helped Sheila build her own child and family team. Sheila related to her family support partner because they had similar experiences. Her family support partner explained the value of the wraparound process. Sheila felt hopeful because she saw that her family support partner was "in a good place." Sheila witnessed her family support partner co-facilitating her team and realized that she could learn to run her own child and family team meeting. Sheila is now a family support partner who provides support to families involved in wraparound in Montgomery County through Maryland Choices.

> *From my family partner and the whole family organization, I learned not to blame myself; I learned to empower myself and my family.*

Author

Marlene Penn's initial experience on care planning teams was as the parent of her own child. She subsequently became an advocate for other families and trains and coaches extensively on the role of the Family Partner on wraparound teams. Marlene served as one of the faculty members on the University of South Florida Louis de la Parte Florida Mental Health Institute Course "Wraparound Interventions and the System of Care" and is co-chair of the Family Partner Task Force of the National Wraparound Initiative.

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Community Stories About Family Partners in Wraparound

Marlene Penn, Co-Chair of the Family Partner Task Force
National Wraparound Initiative

Marlene Penn shares three stories about engaging family partners in wraparound efforts—and how it benefited the community.

Coordinated Family Focused Care (CFFC), Massachusetts

In this essay, Linda Roy, Senior Family Partner, Behavioral Health Network in Springfield Massachusetts describes how the family partners in one of the Coordinated Family Focused Care (CFFC) projects in Massachusetts found that, by reaching out to the community, they could achieve tremendous success in providing a way for families to connect to other families during the wraparound process, and stay connected after formal wraparound ends.

There are five CFFC projects administered through the Massachusetts Behavioral Health Partnership throughout Massachusetts. Each agency employs five wraparound family partners.

The (CFFC) family partners initiated and hosted an event they called the "Family Support Summit." All organizations that offered children's services in their community were invited to answer the question, "What is available in our community for ongoing family support?" One clearly identified need was for a weekly support group for parents that offered childcare. Two local organizations committed to working with the CFFC Family Partners to develop a weekly support group for all parents in their community. They decided to call it Family Fun Night.

They tackled a series of challenges along the way. They

had to find a central location and set up adequate transportation for families to attend. They had to get child care workers and work with them to structure and provide age-appropriate activities for children over a wide age range. They needed to find local speakers for family-driven topics, and they hoped to find sources for donations of food to serve both the adults and the children. Finally, they had to publicize the initial event throughout the community. A further challenge was to negotiate responsibilities among the collaborating organizations.

Families who are current recipients of wraparound are emerging as the next generation of family leaders.

Their diligence and collaboration efforts paid off. A local elementary school offered them space for weekly meetings. They received many other donations from the community as well, including food, children's games, art supplies and materials for a "May Is Mental Health Month" children's art show. A local college donated exhibit space for the art show, which has since become an annual event. They found area professionals willing to donate their time and expertise presenting to families on several key topics. Two other local colleges committed college students to execute service projects with the children's group. Together, the three organizations comprising the collaborative publicized the group and the first planned event.

Today, Family Fun Night meets weekly and is completing its second year. The Family Support Summit continues to meet every other month and has published a booklet of direct-access supports for area families.

The Montgomery County Federation of Families for Children's Mental Health, Maryland

Celia Serkin presents this essay entitled "Passing the Baton: Building Generations of Family Leaders through the Wraparound Process."

The Montgomery County Federation of Families for Children's Mental Health (the Federation) is a family organization in Maryland that serves families of children with emotional, behavioral, and mental health challenges. The Federation underwent a revitalization to sustain the family component of Montgomery County's Substance Abuse and Mental Health Services Administration (SAMHSA) funded system of care grant, which utilized wraparound and family support to help children and youth with serious emotional disorders and their families. The Federation is building generations of family leaders and developing an organically grown peer support network that is integrated into the County's wraparound project. This network strengthens both the individual family members linked to it and the community at large.

Families who were engaged in wraparound for their own children and families are now Federation staff who are delivering family support to other families currently receiving wraparound. Families who are current recipients of wraparound are emerging as the next generation of family leaders. They are giving testimony before legislators, offering peer support to other families involved in wraparound, and organizing family support events. They are part of a grassroots peer support network, which is intricately tied to the national family movement. Building a family-to-family support network not only empowers individual members of that network, but it also strengthens a community. Increasing family-to-family support on a grassroots level improves community well being.

As one example of this process, consider Valerie Oliver, whose individual story was presented earlier in the section in the "Family Stories" chapter. Valerie emerged as a natural born leader. Currently, Valerie is working with the Federation as a family support partner. She serves on the child and family teams and helps families to engage in wraparound, which is provided through Maryland Choices. Valerie runs two support groups for family members. Families can participate in these groups even if they are not involved in wraparound. The community can refer families to

these groups, which are free of charge. Valerie is empowering and educating other family members, and building leaders from within the population she is serving. She has recruited families to organize family support events, to do system advocacy, and to provide one-on-one support to other family members.

Karina Funes, a Latina family support partner at the Federation, works with both English speaking and non-English speaking families. She is the family liaison on the Local Coordinating Council (LCC), an interagency group with representatives from public agencies serving children and youth. It is through the LCC that families begin to access wraparound. Karina serves as a cultural broker who advocates for family voice and choice, and for culturally sensitive treatment of family members. She goes with families to IEP meetings, discharge planning meetings at hospitals, court hearings, and meetings with social services agencies. She works to ensure that community agencies treat family members who do not speak English with dignity and respect, and as partners in decision-making.

The community has elicited the support of family support partners to connect and engage families in wraparound. Community members have asked family support partners for help in identifying natural supports and showing family members how to use specific advocacy strategies to access needed services. They have asked family support partners to help families feel less isolated by connecting them to the Federation's family support activities. The community has asked family support partners to give presentations and conduct trainings.

The family support partners sometimes face challenges from the community. They are asked at times to perform tasks that do not promote family members' independence or empowerment; for example, asking a family support partner to do tasks that the family members are capable of doing for themselves. Another challenge is how a community representative may misinterpret "family-driven" as it relates to the wraparound process and the role of both the family member and the family support partner. A community representative may feel frustrated when the family support partner will not tell the family member what to do. The community representative may want the family support partner to dictate to family members what action needs to be taken. The family support partner wants the family members to acquire knowledge and skills that will help them make their own decisions.

As a result of the work of family support partners, families who were once disenfranchised are testifying before the County Executive, writing to the County Council, and meeting with their legislators. They are speaking up in meetings and encouraging other family members to participate in family support events and leadership opportunities.

Family Involvement Center, Phoenix, Arizona

Lynette Tolliver, Systems Transformation Manager of the Family Involvement Center (FIC), describes the many roles family support partners play in Arizona's system of care and on individual families' child and family teams.

Family support partners (FSP) in Arizona are engaged in the community primarily through the Behavioral Health system. As families in wraparound are generally served by multiple child-serving agencies, the FSP tends to serve as a bridge-builder. The FSP assists in building communication and relationships between the parent, child, school faculty and other wraparound team members to explore whether there are appropriate supports in place at school. FSPs, having "walked the walk" with their own children, are often the best prepared team member to provide assistance in getting an IEP or 504 plan in place and then ensuring it is adhered to. Through this type of bridge-building and on-going

support, the FSP helps ensure the child and family are consistently supported across both the behavioral health and education systems. This helps ensure the wraparound team can move towards positive outcomes in both arenas.

The FSP provides support to parents on issues or challenges that may have contributed to the family becoming involved with child protective services. The FSP can often more easily engage the parents and get them involved with formal services and informal supports that are geared towards helping the parent achieve reunification goals. This, in turn, often leads to positively impacting the perspective of the professionals involved with the family's plan.

The family support partners in Arizona have also helped address larger community issues through their support to individual families. For example, there was a major void in one family's life due to losing their faith-based support system due to the struggles they regularly encountered related to their child's behavioral health needs. Their house of worship was not equipped to support the family due to their child's challenges, and thus discouraged the family from coming back again. For the family this was a major loss and their trust was shaken because their faith community had been an important part of their culture and values.

Because the FSP was able to help the family feel comfortable talking about this issue, the team was better able to understand how this loss affected the family, and the importance of addressing this need. With this new understanding, the FSP served as a bridge builder and assisted the family in rebuilding this part of their community support system. They also assisted the faith community in better understanding and supporting the needs of families raising children with behavioral health needs.

The major challenge for FSPs is for other professionals to respect the uniqueness of their role and to understand that, in the clinical arena, there are certain ethical boundaries that simply do not apply to the role of the FSP. They go "in deep" and share their own experiences in order to provide support and hope to other families in their journey. They also assist families in finding their voices as opposed to becoming the voice for families. Finally, they assist professionals in seeing the family perspective, the families with whom they work.

Author

Marlene Penn's initial experience on care planning teams was as the parent of her own child. She subsequently became an advocate for other families and trains and coaches extensively on the role of the Family Partner on wraparound teams. Marlene served as one of the faculty members on the University of South Florida Louis de la Parte Florida Mental Health Institute Course "Wraparound Interventions and the System of Care" and is co-chair of the Family Partner Task Force of the National Wraparound Initiative.

Youth Engagement, Empowerment, and Participation in Wraparound

Marvin Alexander, Vice-Chair
Youth MOVE National

Everyone benefits when young people are actively engaged in the decisions that directly affect their lives! Youth, families, adults, organizations, policymakers, and communities as a whole benefit when young people have a voice that is listened to, respected, and utilized.

Engaging youth in decision making is essential to their overall development. This is true for all youth, even youth with behavioral and emotional issues. All youth are developing; all youth have strengths; all youth have needs; all youth can contribute to their communities; all youth are valued. Youth are agents of their own development (Pittman, 1998). They should be involved in every decision that will have an effect on their lives. This does not mean that young people shouldn't have caring and positive adults standing in roles of support available to them at all times.

Involving youth in service planning and decision making would seem to be a no-brainer for practitioners that serve children and adolescents. However, many struggle with understanding that the right to self-determination should be afforded to all families and to youth based on their level of maturity.

It is important to remember that children and youth grow into adults and that, as they mature, the foundation for adulthood is being built. Youth must be allowed opportunities to develop. For young people with severe behavioral and emotional challenges that foundation is built while he or she is also experiencing ongoing crisis, feelings of mistrust, wanting to be "normal," and the typical stressors of most all youth experience during transition from childhood to adulthood. It is important to leave a positive impression

and to be supportive of youth. Efforts to do so will be remembered and have a direct affect on a human life.

Treatment Planning

Being the only young person in a wraparound team meeting may be intimidating. It is the responsibility of the adults involved to remain youth-guided, remembering that the young person is ultimately responsible for obtaining his/her goals. Team members must remain strengths-based throughout the entire engagement process. Meetings could be counterproductive if the youth feel as if everyone is against them. Remember to focus on the positive behaviors and address negative behaviors in a functional, non-degrading way.

Authentic involvement in treatment planning helps youth take personal responsibility for their treatment. Because young people are actively engaged and "own" their plans, the chances of successful outcomes in treatment are significantly improved.

Youth as Leaders

With strong adult and system support, a young person is able to develop new skills and knowledge that will allow him or her to participate in system building and to be of support to peers. In this manner, young people are able to reframe their personal identities from an "SED/ problem kid" to a leader contributes positively in the community. Youth develop confidence and their involvement strengthens their sense of pride, identity, and self-esteem.

Adults who work with youth often have to work hard to overcome ingrained habits of adultism. Adultism is the assumption that adults are better (or more competent) than youth and should therefore act on behalf of young people without their agreement because youth lack life experience and are inferior. Adults should listen to and partner with young people by supporting them, not controlling them. Comments such as "You're all kids to me," and referring to youth projects or

activities in ways that make them seem inferior to those of adults fosters the undervaluing of youth.

Case in Point:

While in a regional governance board meeting a project director was asked about upcoming youth group activities. The project director responded, very happy that the person had asked, and said: "Well, they're having a little retreat this weekend." The youth coordinator took this as an offense--he and the youth group had worked extremely hard on planning the retreat and the project director chopped all of their efforts down to a "little retreat." Not only did the project director not acknowledge their hard work but she separated the youth group from the rest of the team by saying "..*they*'re having...." Youth should be engaged as equal partners. Their contributions should be valued.

A Win-Win

When youth are engaged, involved, and actively participating in wraparound, there are benefits for the young people and for the community. What is more, the philosophy of wraparound states the importance of youth voice. There should be no question in anyone's mind about the importance of making this ideal of youth empowerment come to life.

Author

Marvin Alexander is the Vice-Chair of YouthMOVE National, a national youth-run organization devoted to uniting the voices and causes of youth and young adults who have serious emotional disorders and are involved in multiple systems. Marvin is a national leader who has provided technical assistance, consultation and training to groups and organizations across the country. He is an advocate of youth rights and voice, not only in their own treatment but also in the development of policies, research, program evaluation, and the overall transformation of systems that directly touch the lives of American youth.

Youth Advocates: What They Do and Why Your Wraparound Program Should Hire One

Brian Lombrowski, Wraparound Facilitator
    SAMHSA System of Care

Gloria Fields, Youth Advocate
Antoine Griffin-Van Dorn, Youth Advocate
Melissa Castillo, Youth Advocate
    Mental Health Association of New York

Our perspectives on youth advocacy have been shaped by our personal experiences as recipients of mental health and child welfare services, as well as our experiences as a Care Coordinator and as Youth Advocates within New York City's system of care. We know first-hand how hard it is for youth to feel supported and heard as they make their way through the educational and service systems. We have also seen what a difference youth advocates can make in engaging youth and empowering them to be full partners in their own care. As an integral part of a wraparound team, youth advocates keep it real for their team members and serve as a continuous reminder of the importance of staying strength based and youth guided. For the youth who participate in wraparound, the presence of youth advocates provides concrete evidence that their care teams just might really mean what we say—that the youth's voice matters.

Potential Roles of the Youth Advocate Within the System of Care

Engagement. Too often a youth's strengths, voice and preferences remain unrecognized and unheard by their service providers. The past disappointments that youth have experienced with service providers, peers and family members can also leave youth feeling mistrustful, without hope and reluctant to engage in relationship-building with people on their care team. The opportunity to speak with another youth who has undergone similar experiences and who is a part of their wraparound team is often the first step in building trust and reducing the isolation that is typical for youth

who struggle with mental health challenges.

Support. Perhaps the most important role for the youth advocate is providing peer support to the youth whom they work with. For a youth, just knowing that there is somebody there for them who understands, and who has got their back, can be the basis for creating a new sense of hope and possibility.

Voice. Through the time that the youth advocate spends with the youth there is an opportunity to learn the youth's strengths, interests, and needs from the youth's perspective, and to coach and support the youth to voice their concerns and wants with their service providers and families. When youth have difficulty in making their voices heard or wishes known in meetings, youth advocates can, by agreement with the youth, advocate on the youth's behalf.

> *For a youth, just knowing that there is somebody there for them who understands, and who has got their back, can be the basis for creating a new sense of hope and possibility.*

Mentor. Like a traditional Big Brother or Big Sister, the youth advocate is a role model for the youth that they work with. Youth advocates are able to share their experiences about what has helped and hurt them in their process of recovery, and to offer suggestions about alternative ways of handling situations that may arise with peers, parents, providers and others within the community. Youth advocates also have the flexibility to meet youth where they feel comfortable, and to participate in activities ranging from meeting for lunch or going shopping to meeting at family court or at the youth's school.

Bridge/Culture Broker. The gulf between the youth and service providers can be large, both culturally and in terms of control. The youth advocate can act as a bridge between the two. Ideally, the youth advocate will be fluent in both the language of the youth culture as well as the language of the provider culture, and prevent the breakdown of communication between the two. This role is particularly important in settings such as hospitals and residential treatment facilities where the power differential between youth and adults is greatest. A young person who is trusted by both youth and adults in such a setting can help to ameliorate the effects of the power differential.

Group Facilitator. Youth advocates can also play an important role in building and maintaining opportunities for youth to meet and socialize in a non-stigmatizing environment. In New York City, youth advocates facilitate several peer support, skill building and socialization groups for youth involved in the system of care.

Systems Transformation. Youth advocacy positions provide important opportunities for youth leadership development, creating a pool of well-informed youth who can provide a youth perspective on governance boards and planning and advisory bodies. In New York City, youth advocates also serve as part of the training team that delivers training on system of care principles and values and the family network (wraparound) process. Youth advocates are also called upon to provide presentations on issues of concern to youth, families and providers such as gang involvement and youth engagement. Making a place for youth at all of these tables and involving youth at all levels of decision making is an important part of realizing our effort to create a youth guided system of care.

Who Are Youth Advocates?

Youth advocates are generally young adults from the ages of 18-25 who have had personal experience within child- and family-serving systems (mental health, special education, child welfare, juvenile justice), and who are interested in ensuring that their peers receive high quality services that are responsive to their needs. More often than not, youth advocates are motivated by their desire to create more positive experiences for youth within the system of care than the ones that

they had. The opportunity to make a difference to other youth facing emotional and behavioral challenges can also make a positive difference in the youth advocate's own recovery.

What to Look for When Hiring a Youth Advocate

In addition to the credibility that youth advocates have by virtue of their age and experience within the system of care, successful youth advocates are far enough along in their own recovery process that they can handle the stress of the job and serve as a positive role model for the youth they work with.

The ideal candidate will be young yet mature, and will have had experience within the child- and family-serving systems. Although as an organization we have employed youth advocates as young as 16, older youth more typically have the maturity it takes to balance the demands of the job with their personal life and self-care.

Past experience working with children (working for the YMCA, as a camp counselor, etc.) or an interest in working in the helping professions can be a plus. However, for many youth advocates, it is important to remember that this may be their first job. Far more important than work experience or educational credentials is a willingness to learn, the ability to relate well to other youth from diverse backgrounds, the capacity to follow through and a willingness to share their own experiences with child-and family-serving systems. Stigma is a factor that may influence a candidate's willingness to speak openly about his or her men-

tal health challenges in an interview situation. Remember, this is a process and the youth doesn't really know how safe disclosure is. The presence of other youth advocates in the interview or a separate meeting with another youth advocate can create a safer environment in which to assess whether the youth will be comfortable enough acknowledging their own challenges to other youth when appropriate.

How to Find the Ideal Candidate

Using the same search practices as you would to find a qualified social worker is likely to yield few applicants. Personal referrals have led to some of our most productive hires. Another strategy is to meet the young people where the young people are. Find community organizations within systems of care where youth are likely to be, and post flyers in those locations. Use the Internet. Go onto Myspace and post job announcements in public forums that are mental health related. Contact organizations of independent self-described youth advocates like the National Youth Rights Association (NYRA), Youth Advocates for Community-Based Treatment (Youth ACT), the National Youth Leadership Council (NYLC) or local chapters of the Federation of Families for Children's Mental Health. Individuals who, with no profit to themselves, have already decided to organize to fight for youth rights are likely to be good candidates for the job.

Training and Supervision of Youth Advocates

Experience as a recipient of services from mental health, special education, juvenile justice and/or the child welfare system is a necessary but not sufficient condition to being successful as a youth advocate. Organizations that hire youth advocates have a great responsibility to provide training and supervision that will help youth advocates to feel valued and supported, and to develop skills, set appropriate boundaries and engage in self-care.

Good training of youth advocates involves fostering the development of listening, engagement, collaboration, boundary setting and, last but not least, public speaking skills. Excellent listening

skills play a major factor in the work of youth advocates. Because so many youth have not been included in planning for their own care and are turned off to services, the development of good engagement and listening skills is critically important. Listening and engagement skills form the basis for discovering the youth's needs and preferences and a starting place for giving voice to the youth's concerns.

Specific skill training about system of care principles and values, community resources and collaboration across systems is also needed. Other important areas for skill development include wraparound principles and processes, and group facilitation. Information about the cultures and language used by the various child and youth service systems is also needed to help youth advocates function effectively as culture brokers for the youth. The availability of coaching and help with public speaking is also important for youth advocates, who are often called on to present a youth perspective in public forums and to make presentations about youth-related topics to other youth or providers within the community.

The work that we do is hard work and the challenges of many of the youth and families that we work with can be overwhelming for even the most seasoned professional. Close relationships between youth advocates and the youth they work with often develop. Individual supervision, opportunities to meet with other youth advocates and group supervision are important vehicles for providing the support needed so that advocates can safeguard their own well being and maintain appropriate limits and boundaries with the youth they serve.

Accountability and Evaluation

Since many organizations have never had youth advocates as staff members, it is especially important for the hiring organization to be very clear about the expectations for youth advocates and to revisit these expectations frequently as the organization and staff gain clarity about the role of youth advocates within their organization. These expectations should be clearly communicated in job descriptions and as part of performance appraisals.

Team meetings where all team members discuss how their work with youth is progressing provide a more informal means of ensuring that youth advocates are delivering quality services. Work with individual youth can be discussed and contact notes reviewed in the context of individual supervision meetings with all team members including youth advocates.

Final Thoughts

Youth advocacy, as defined in this article, is still in its infancy. There is still much that remains to be defined about the role and the proper place of youth advocates. As with any new frontier in social service practice, there is worry about using an unknown variable in the treatment process.

While there is a great deal of upside as we have described in involving peers within the wraparound team, there is also the concern that negative outcomes can occur when vulnerable youth are put in contact with someone whose perspective has been formed through negative experiences in child-and-family serving systems.

We hope that by providing this primer on how to find youth advocates, how to utilize youth advocates, and how to train and develop youth advocates, we can put these concerns to rest, and increase the numbers of young people in the systems of care who are getting paid to help motivate others through their voices of experience.

Authors

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At the time this article was written, Melissa Castillo was a youth advocate with the Mental Health Association of New York.

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Youth Participation in Wraparound Team Planning: Why and How

Janet Walker, Co-Director, National Wraparound Initiative, and Research Associate Professor, Portland State University School of Social Work

Human service and educational agencies and systems often convene teams to work collaboratively on plans for serving children or youth. This is particularly true for children and youth who are involved with multiple systems or who are felt to be in need of intensive intervention. Here, we focus on wraparound planning teams, but similar planning goes on in IEP (Individualized Education Plan) teams, foster care independent living program teams, transition planning teams, youth/family decision teams, and other teams that create service or treatment plans. Unfortunately, it is often true that these plans are created *for* youth, with little input or buy-in from the young people themselves.

In previous research on wraparound, we found that many adults who participated on teams were eager to involve youth in planning in a more meaningful way, but were unsure how to feasibly accomplish this goal. One difficulty they cited was that some of their colleagues were not really committed to the idea that youth should have an important role in making decisions for their care, service, education and treatment plans. These colleagues were seen as raising a range of objections, such as:

- Involving youth is not worth the time it would take;
- We know what's best for youth and we should make the decisions;
- We already do give youth the opportunity to participate in planning, but they just aren't interested;
- Our youth have emotional and behavioral difficulties—they don't know what's good for them and any-

way they can't work productively in meetings;

- Our youth have attentional problems—they really don't want to sit through long meetings;

- Our youth have cognitive delays—they don't have the skills to contribute to plans;

- Our youth have difficult lives—their feelings will be hurt if they come to meetings and we discuss what's going on, and so on.

In response, we began work on AMP. AMP—*Achieve My Plan*—is a five-year project that is developing and testing ways to increase the meaningful participation of youth in collaborative team planning meetings. The work of the AMP project is undertaken with the guidance and active partici-

pation of an advisory group that includes youth, caregivers and providers who have extensive personal experience with multiple service systems and interdisciplinary planning. Advisors have worked together with research staff to design and evaluate the products from the AMP project.

Early on in our work together, we came to the realization that changing practices related to youth participation in team planning would require developing materials that could answer two big sets of questions and doubts that people raise when thinking about youth participation. First, *Why?* Why is it worthwhile for organizations and agencies that participate in team planning for youth to change what they do, to adopt new practices that increase young people's role in team discussions and decisions? And second, *How?* What

do these organizations and agencies need to do—and what do the people who participate on teams need to do—to ensure that planning with youth is collaborative and productive rather than confrontational or (as youth fear) one more opportunity for adults to lecture young people all about the bad things they did in the past and tell the young people what they are going to have to do now.

To respond to the *Why* question, we put together a document called *Youth Participation in Collaborative Team Planning: Research Tells us we Should be Doing Better*. In the next part of this chapter, we will summarize some of what is written in that document. The document reviews published research, and presents empirical evidence that supports the idea that meaningful youth participation in team planning is practical, feasible, and worthwhile. The entire document is included as an appendix for this *Resource Guide*. We also created a video called *Youth Participation in Collaborative Team Planning: Why it Matters*. To make the video, AMP advisors interviewed one another about their experiences with team planning and youth (non)participation. The video uses clips from these interviews to show in a very immediate way how a lack of participation contributes to youth powerlessness, hopelessness, and plan failure; and how collaboration with youth has the potential for opposite outcomes. This video can be accessed at http://www.rtc.pdx.edu/AMP/pgVideo_AMP_ImportanceOfYPP.shtml.

To respond to the *How* question, we created another document called *Best Practices for Increasing Meaningful Youth Participation in Collaborative Team Planning*. This document combines insights gained from published sources with insights from our advisors and from other youth, caregivers, and providers who have provided feedback to the AMP project. (Again, the full document is included as an appendix to this *Resource Guide*.) In the later sections of this chapter, we outline these best practices that, together, describe a vision of what it takes to create plans *with* youth, so that youth will see the plans as a means to help them move towards important life goals. Some of these practices require time and resources, and many require that teams organize their work in ways that are different from usual. But this is to be expected—getting a higher level of youth participation will require an investment.

Organizations and teams that implement practices to ensure meaningful youth participation in wraparound will of course need some way of gathering data that can tell them how they are doing. The last section of this chapter focuses on strategies for evaluating youth participation and related outcomes.

Finally, the AMP project has developed an intervention that includes the best practices outlined in this chapter. Currently, we are conducting a formal evaluation to document the impact that the AMP intervention has on youth participation in planning, the quality of plans, team member satisfaction with planning, organizational attitudes about the feasibility and usefulness of youth participation in planning, and youth empowerment with respect to mental healthcare. In the near future, we will know the outcomes from that evaluation. We will also have the full range of materials available to help organizations and communities implement the AMP intervention.

The *Why* of Meaningful Youth Participation

Youth Participation in Collaborative Team Planning: Research Tells us we Should be Doing Better reviews published research as a means to providing answers to a series of questions or doubts that people may have regarding the usefulness and feasibility of youth participation. Here, we review the main questions and answers. Please see the full document for more detailed answers and research citations.

Aren't young people already involved in their education, care, and treatment planning? The best available research indicates that few students participate meaningfully in creating their Individualized Education Plans (IEPs). It also appears that youth with emotional or behavioral disorders do not usually participate meaningfully in creating their own care, treatment, or service plans. Professionals who participate in this kind of planning are also dissatisfied with the level of youth participation.

Participating meaningfully in planning means that young people have to take part in making decisions and setting and monitoring goals. Can youth who have significant mental health, learning, and/or cognitive difficulties really be expect- ed *to master the skills needed to do this?* Children and youth of all ages and with a variety of disabilities and challenges have successfully learned the necessary skills and participated in planning.

Why is it so important to include young people in planning for their education, treatment or care? What's to be gained? There are a lot of potential benefits to increasing youth participation in planning. First of all, when people feel they are doing something because they want to, they tend to be happier and more engaged, and do a better job, than when they don't feel they have a choice. Second, learning to make plans and achieve goals is an important part of growing up for any young person. People who are confident that they can solve problems in their lives and reach the goals they set for themselves experience many positive outcomes—including positive emotional and behavioral outcomes. Developing these feelings of "self-efficacy" would seem particularly important for youth who face high levels of challenge in life. However, it appears that children with disabilities and children who are involved with the child welfare or mental health systems have far fewer opportunities than their peers to experience self-efficacy. In addition to all these reasons, perhaps the most important reason for including youth meaningfully in planning is because it's the right thing to do.

The *How* of Meaningful Youth Participation

The *how* of promoting meaningful youth participation in wraparound team planning has several distinct aspects. First, the organization(s) that take the lead in convening wraparound teams need to build an organizational culture that prioritizes and values youth voice in team discussions and decisions. Additionally, the organization needs to define and build capacity for new ways of working directly with youth. These include practices for preparing youth for participation, running meetings that encourage youth participation, and holding teams accountable for carrying out collaborative decisions.

Organizational Culture

Agency staff are more likely to support youth participation if they see that it is a priority within

the agency, and if the agency provides resources—like time and training—so that staff can gain the skills they need to carry out activities that encourage youth participation. Staff, families, and youth themselves will be more open to youth participation if they are exposed to information—like the AMP video and other publications—that demonstrates that increasing youth participation is both desirable and possible. The agency should be clear about its commitment to youth participation in decision making by affirming that:

- once decisions are made (with youth participation), the decisions should not be changed later without further youth participation;
- youth should be invited to participate in their entire wraparound meetings; and
- important information should not be shared when youth are absent.

Preparation for the Meeting

One of the things that our youth advisors were clearest about that a team meeting should not have surprises. Many of the youth had had bad experiences with meetings when they felt blindsided by topics that were to be discussed. Or they were told they would have input into a decisions and then (surprise!), the actual decision was made without consideration of their what they thought or what they wanted. Because of experiences such as these—and also because of a natural anxiety about sitting in a room with a group of adults who have power over their lives—youth are likely to anticipate a meeting with distrust, anxiety, or even anger. If, however, a young person knows what will happen in the meeting, he or she can feel more of a sense of security that there will be no unpleasant surprises. Additionally, knowing what is going to happen at the meeting means that the young person can prepare his or her thoughts and ideas in advance. Thus, an organization that promotes meaningful youth participation helps make sure that a young person knows what is going to happen during a meeting, and further ensures that the young person has adequate support to prepare for the meeting. Specifically, such an organization ensures that...

- *In consultation with the youth, an agenda is formulated before the meeting.*
- *Adequate preparation is provided so that a young person has an opportunity to be supported through a process of thinking about what and how he or she wants to contribute to the topics on the agenda.*
- *Preparation includes an opportunity for the youth to formulate goals that will be part of the plan.*
- *Preparation also includes helping the youth plan to contribute to the meeting in whatever manner feels comfortable to him or her.*
- *The youth is supported in planning specific strategies he or she might use during the meeting to help stay calm and/or focused.*
- *Someone helps the youth figure out who can support him or her during the meeting and prepare that "support person" for this role.*

Running a Meeting that Feels Safe for Participation

Young people report that, during team meetings, they are often ignored, lectured at, and/or harshly criticized. To help the meeting feel safe, the team should agree to a set of ground rules, and the facilitator should be able to control the meeting in a way that ensures that people follow the rules. Ground rules should include the following:

- *All team members treat each other respectfully, the youth no less than others.*
- *Remain strengths-based and solution-focused.*
- *During the meeting, stick to the agenda that the youth has helped create.*
- *Make sure that everyone can understand what is going on.*
- *Speak in ways that don't alienate or hurt the youth.*
- *Be clear about exactly who is doing what to follow up on decisions made in the meeting.*

During the meeting, team members must act and interact in ways that ensure that the youth will have real influence in discussion and decision making. Thus, the tem should purposefully structure discussion in ways that provide multiple opportunities for the youth to express his or hers ideas or offer comments, even if he/she doesn't want to say a lot at any one time.

Beyond this, it is also important for the team to structure decision making in ways that support collaboration. Collaboration (with youth or with anyone else) is supported when people are able to keep an open mind and explore different perspectives and different options fully before making decisions about what to do. Thus, collaborative teams do not make decisions about solutions until they have had a chance to think carefully about what the goal, problem, or need really is. Furthermore, a collaborative and creative team will consider several different strategies to solve a problem or meet a need before selecting an option to pursue.

Holding Each Other Accountable

Finally, team members earn each other's trust—and accomplish their work—by following through on the action steps they commit to during planning. Seeing people follow through on their commitments to the plan is particularly important for young people who have been heavily involved with service systems. Often, these young people have experience with being let down by providers. Youth who have had input into decisions for a plan may be particularly skeptical, thinking it entirely possible that providers will be unmotivated to follow through on decisions that reflect a young person's priorities rather than their own.

Thus it is important for team members to hold each other accountable for carrying out the action steps that they commit to during planning. In order for this to happen, these commitments must be made clear during planning and they must be recorded. The team must also have a process for checking in later on to see whether or not team members have actually followed through.

How Are We Doing?

While a philosophical commitment to increasing youth participation in team planning is a first step, organizations and teams will not really know how well they are putting this philosophy into practice unless they gather some data. One straightforward way of doing this is through basic checklists that assess whether or not the steps, strategies, or structures that are intended to support youth participation were actually employed. Suppose, for example, an organization has agreed that a staff member will work through a series of activities with a youth before his or her first team meeting to prepare him or her for participation.

When these activities have been completed, the young person and the staff member can fill out a checklist together, affirming that each step in the preparation has been completed. When this basic fidelity checklist is completed, the staff member and the young person sign it, and the organization retains the checklist for its records. Similar checklists can be used to assess whether appropriate steps and structures to support participation have occurred during the meeting itself, and whether appropriate steps are taken to ensure accountability.

In addition to these kinds of process checklists, it is helpful for organizations to measure whether or not the processes and steps they are implementing are actually increasing youths' perceptions of participation and empowerment in their mental healthcare. There are various strategies for doing so. One is to collect simple post-meeting surveys that ask team members to rate the planning process in terms of its success in achieving youth participation. Organizations can also benefit by using valid, reliable measures for assessing par-

ticipation and empowerment. The Research and Training Center on Family Support and Children's Mental Health has created and tested measures designed precisely for this purpose.

- The *Youth Participation in Planning scale* (YPP) assesses youth perceptions of whether interdisciplinary teams that create service, care, or treatment plans support meaningful youth participation in the planning process. The YPP has 16 items on three subscales: preparation for planning, plan and process, and accountability.

- The *Youth Empowerment Scale—Mental Health* (YES/MH). Is designed to assess young people's perceptions of capacity and confidence with respect to managing their own mental health conditions, working with providers to optimize services and supports, and using their experience and knowledge to help peers and improve service systems.

More information about these measures can be found at www.rtc.pdx.edu, or by contacting rtcpubs@pdx.edu.

Conclusion

Agencies, organizations, or teams that are serious and ethical about promoting youth participation in planning must start with a systematic and intentional plan about the specific organizational strategies and practices that they will adopt. As they undertake this work, they should do so with the full participation of youth who are representative of those who will be participating on teams. In this way, the organization can select specific strategies that are appropriate for supporting the youth that are served.

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Wraparound Practice: Chapter 4c.4

Youth Involvement in Wraparound at the Organization and System Levels

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As Marvin Alexander points out in Chapter 4c.1 of the *Resource Guide*, ensuring youth participation in treatment planning is only part of what it means for wraparound to promote youth voice. Youth voice is also needed as part of leadership and decision making at the program, agency, and system level. The Technical Assistance Partnership has produced a valuable guide to help youth and adults understand how to cultivate youth voice at these "higher" levels of wraparound. *Youth Involvement in Systems of Care: A Guide to Empowerment* is included in its entirety as an appendix to this *Resource Guide* (see Appendix 6e.3).

The Guide is organized into ten sections:

I. Youth Involvement: Moving From a Good Idea to a Necessary Solution

Youth involvement is a necessary solution to meet the needs of youth and families in systems of care. This chapter will provide you with the rationale for involving youth, including literature on the positive youth development approach and additional information providing support for youth involvement. Readers will understand how the power of youth participation helps to rebuild the community, fosters resiliency, and combats stigma around mental illness.

II. Who Benefits From Youth Involvement?

Everyone does. This chapter informs readers of the key

national wraparound initiative

benefits from authentically involving youth in systems of care. It addresses benefits for youth, families, programs, organizations, planners, policymakers, and the community as a whole.

III. History of the System of Care Youth Movement

The history of youth involvement has followed a path similar to that of the Family Movement. This chapter highlights critical milestones of the Youth Movement.

IV. Advancing the Youth Movement: Establishing the Value Base

Advancing the movement requires an understanding and commitment to the values around youth involvement. This chapter will inform readers about these values and how to utilize them in climbing the ladder towards authentic youth involvement.

V. Getting Started: Hiring the Coordinator and Forming the Group

This chapter provides the blueprint for the steps necessary to develop a youth-directed group in systems of care. It will guide readers through the steps of hiring a youth coordinator and developing the youth group.

VI. Cultivating the Environment for Growing Leaders

Leadership development requires an environment of support and training. Youth and adults need to build partnership and understanding in order to foster a youth-guided system. This chapter will enhance the readers' understanding of what it takes to cultivate this type of environment and build partnership.

VII. Youth Involvement in Systems of Care: Making It Happen

How do you make it happen? Readers will be guided through examples of involving youth in every level of system of care development from developing a communitywide event to meaningful engagement on boards, to evaluation and social marketing, and working towards sustainability.

VIII. On the Horizon

Youth involvement is continuously evolving within systems of care. On the Horizon informs readers about upcoming developments, including the development of the National Youth Development Board as well as focus group studies conducted by ORC Macro on youth involvement in system of care communities.

IX. Resources for Youth Involvement

This final chapter provides readers with a resource list that focuses on various components of youth involvement.

X. References

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Wraparound Practice: Chapter 4d.1

Direct Support Services in Wraparound

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Direct Support services are the flexible, creative, community-based services that help put an effective wraparound plan into action. Broadly defined, they are individualized support services provided in the home or community by anyone, whether paid or unpaid, that cares about the family. For example, just as a paid support worker may help a child learn to purchase groceries and cook a meal, that same support could be provided by the child's uncle, a volunteer from the community, or anyone else that plays an important role in the family's life. However, for the purposes of this paper, the focus is primarily on paid direct support employees that help carry out the work outlined in a wraparound plan.

Wraparound as a Service or Process?

Debates often occur regarding whether wraparound is a team-based planning process guided by an underlying set of principles, or whether it is a set of services provided to a family. For example, some agencies advertise that they offer "wraparound services," yet those services may not be provided in the context of effective and creative team-based planning, or they may not be family-driven, strengths-based, or flexible. Other agencies may offer "wraparound facilitation" or care coordination, but do not have the flexible, community-based workforce to help implement the creative plans designed by wraparound teams. In order to provide helpful and meaningful support for a family, all of the following elements are important: a) creative, team-based planning, b) adherence to the ten principles of wraparound (as developed by the National Wraparound Initia-

tive), and c) a flexible workforce to help provide the support designed by the team.

Direct support services are needed in a system to support individualized, community-based practice. However, equally important to the success of community-based care is the tie to the values and process elements of wraparound. Families consistently report that home-based services alone, without grounding in the principles of wraparound, are of little use. Similarly, creative planning and quality needs identification may be less than fruitful without a flexible, community-based workforce to help implement the plans. For this reason, it is essential that direct support services are tied intimately with the wraparound process and that wraparound initiatives in a community include a strong component of direct support workforce development.

Overview of Direct Support Services

Direct support services (also known in some communities as direct services, home-based services, or community-based services) may be organized in a variety of formats, but those that are most effective share a set of important values, regardless of program configuration. The following are the six core values of direct support services:

1. *Direct support services occur in the home and community, not in the office.*

   Less Effective Example of this Value: A direct support provider agency operates by default out of its clinic office, providing a variety of classes and groups for children to attend. They do not have employees that work in the community due to concerns about liability, insurance, scheduling inefficiency and transportation costs.

   Effective Example of this Value: A direct support provider agency works entirely in the homes, schools and neighborhoods of the children and families with which it works. The agency has made the adjustments needed to provide services in this context because it believes this is where services are most needed and helpful.

2. *Direct support services are commissioned by a family-driven collaborative team, such as a wraparound team, which helps define the needs to be addressed through the direct*

support services as well as the frequency, duration and time of delivery.

Less Effective Example of this Value: A case manager, without the involvement of the wraparound team, requests services from a direct support provider. That provider, independent of the team, meets with the family to develop a service plan. The provider never works with the wraparound team to identify the needs that should be addressed through direct support.

Effective Example of this Value: A wraparound team identifies that it would like a direct support provider to help a young man explore his career interests. The team commissions a provider to accompany the young man to a variety of places in the community, where he can gain experience learning what is involved with various professions in which he thinks he may have an interest. These include places such as a blacksmith shop, an attorney's office, a dairy farm and an accountant's office. The team asks the provider to report back after doing these activities.

3. *Direct support services are individualized to the strengths and culture of the child and family rather than delivered as a scripted or pre-packaged set of services.*

Less Effective Example of this Value: Despite the wraparound team's request to work with a youth on career exploration, a direct support provider tells the team that they cannot do this because they do not have a career exploration program. (There has not been enough interest in the community to develop one.) Instead, they want to

include the youth in their social skills and public transportation curriculum.

Effective Example of this Value: Rather than having a pre-set program, the direct support provider listens to what the team needs and develops the services based on those needs. The direct support provider arranges visits to each of the career exploration places in which the youth is interested and helps the young man come up with the types of questions he would like to ask at each place. Arrangements are made to allow the youth to help with some activities on site at each place to get a feel for each type of career.

4. *Direct support services are geared toward helping children live in the community rather than in institutions or congregate care settings.*

Less Effective Example of this Value: Upon receiving a referral to help a youth transition home from a treatment center, the direct support provider learns of his challenging behavior and declines the referral, saying he needs to spend more time in the treatment center becoming stable before they can help him.

Effective Example of this Value: A direct support provider works with a young man who, without intensive support, would not be ready to leave the treatment center at which he resides and live again with his family. The young man has some very challenging behavior, such as running away, punching people when he is angry, and making threats of violence using weapons. The provider works closely with the team to develop a comprehensive safety plan and does what it takes to put the plan into action and help the child return home, knowing there will be difficult challenges ahead behaviorally.

5. *Direct support services are provided when the family needs them most and in the frequency and duration needed by the family, rather than having pre-determined, program-driven time slots, frequencies or durations.*

Less Effective Example of this Value: A direct support provider tells a team that it cannot meet its request for services because the request is for three hours on a Saturday. The provider explains that the agency only works Monday through Friday from 8 am to 7 pm, and that the services must be ordered in four-hour segments, so as to not interfere with the agency's scheduling pattern. Additionally, the agency's program calls for visits twice per week for a duration three months.

Effective Example of this Value: A direct support provider has no arbitrary structure that limits the frequency, duration, time of day, day of the week, or length of participation in support services. Services can be configured in any manner needed by the wraparound team.

> *Direct support services are provided when the family needs them most and in the frequency and duration needed by the family, rather than having pre-determined, program-driven time slots, frequencies or durations.*

6. *Direct support services are based on positive actions and opportunities. They are provided using an approach that builds on capacities and strengths, opportunities to participate in activities that are important to the child and family, chances to make choices and learn from mistakes without criticism, activities that promote dignity and respect for the individual and family, and opportunities that help an individual practice (rather than just talk about) living a life full of dignity and respect in the community. Direct support services avoid punishment, behavior level systems, ultimatums, coercion, removal of opportunities to participate in the community, and criticism.*

Less Effective Example of this Value: A direct

support provider is working with a child who says something disrespectful to a peer. In front of the peer, the support worker corrects the child by saying, "Stop speaking disrespectfully to your friend (a verbal punishment)." When they get back to the house, the support worker relates the experience to the child's mother and recommends that he not be permitted to attend his sister's graduation the next week because of the behavior.

Effective Example of this Value: A direct support provider is working with a child who says something disrespectful to a peer. Rather than embarrassing the child by directly correcting him in front of friends, the support worker ignores the disrespectful comments and models a positive comment to the peer. The worker then searches for the next possible opportunity to notice something respectful that the child says, and when he does, the worker immediately provides a wealth of attention and positive feedback regarding the respectful comment. The provider engages the help of the entire wraparound team to systemically provide positive feedback every time anyone notices the child acting respectfully.

Which Services Are Direct Support Services?

Questions sometimes arise as to whether a particular type of traditional service, such as counseling, is a direct support service, if it adheres to the six values of direct support, or whether direct support only includes certain services such as peer mentoring, respite and skills training. The answer depends on the degree to which the service in question is congruent with the core values of direct support. For an example, consider the examination of the service, family counseling, in Table 1.

This same analysis may be conducted regarding services that are often, without second thought, classified as direct support services, such as a peer mentoring. However, if the service does not adhere to the core values underlying direct support, it may be that the third example of family counseling cited above is more of a true direct support service than the peer mentoring, despite the service titles. Consider the examples in Table 2.

Table 1. Family Counseling as Direct Support

Service	Context	Direct Support?
Family Counseling	Provided in the therapist's office, focused primarily on sharing feelings and talking.	Not a direct support service.
Family Counseling	Provided in the family's home, conducted seated around the living room table, focused primarily on sharing feelings and talking.	Debatable, but may not be if focused on talking rather than on actions and activities or if driven by the professional in terms of content, duration and frequency.
Family Counseling	Provided in the family's home at the time requested by the wraparound team (Friday night after dinner), focused on the needs identified by the team (relationships in action) as the family does yard work together. The counselor helps two siblings weed a flower bed collaboratively and supports the mother in her role as parent by helping her direct the activity.	Most likely could be considered a direct support service.

Table 2. Peer Mentoring as Direct Support

Service	Context	Direct Support?
Peer Mentor	Provided at the clinic office with a group of other youth, focused on psychoeducational materials regarding impulse control, based on a theory of depriving youth of community-based activities as a consequence for lack of impulse control.	Probably not a direct support service.
Peer Mentor	Provided in the community at a horse stable owned by a friend of the peer mentor because "all youth could benefit from interactions with horses" and because the peer mentor likes horses.	Probably not a true direct support service because it is based on the interest of the peer mentor, is not individualized, and does not tie to a need identified by the wraparound team.
Peer Mentor	Provided in the youth's neighborhood, helping him start a pick-up game of basketball at the park, with the focus on learning to make friends (an area of need identified by the wraparound team).	Definitely a direct support service

Keeping Children in the Community

A primary focus of direct support is helping children live successfully in the community rather than in institutions or congregate care settings. Direct support services play a critical role in preventing out-of-home placements and returning children from out-of-home placements.

Because direct supports can be used in so many different configurations, it is important for the wraparound team to identify the needs of the family related to the risk of out-of-home care. While safety is often identified as a reason for seeking out-of-home placement (either safety of the individual, siblings, parents, or the community in general), it is often not the only, and sometimes not even the primary, underlying need, despite initial presentation. Consider the following examples:

Example 1: A young man was placed in a treatment center because he physically attacked his siblings and parents when angry, sometimes causing injury. However, upon closer examination, the wraparound team found that he did not have aggressiveness in any other setting, and the young man's mother explained that there were significantly strained relationships at home affecting the family's interactions. Therefore, the primary focus for support services upon return to the home was not simply physical protection of others in the home. Instead, it was upon family relationships and interactions.

Example 2: A twelve-year-old girl was hospitalized for cutting herself when sad. The hospital was reluctant to send her home without someone to monitor her situation 24 hours per day to ensure she would not cut herself. However, the wraparound team viewed the primary need of the girl to be positive attention and activities rather than simply preventing self-harm. Spending a few hours a week with a mentor from her church as well as paid direct support mentors for a few hours several times per week helped create an environment where she could safely live at home. The team reflected that simply monitoring her for cutting activity would have never addressed her primary need, and therefore may not have sufficiently addressed the safety issue.

The reasons for risk of out-of-home care may be as varied as the number of people participating in wraparound. They may include the need

for a break for a parent, employment or financial needs, impulse control, boredom, lack of friendship, need for positive attention, strained sibling relationships, or a number of other needs. Effective wraparound teams help discover the types of support that will address the underlying needs of the family rather than simply employing one-to-one monitoring services.

Once the needs are identified, direct support providers may be commissioned to help address them through community-based activities such as mentoring, modeling, living skills training, positive behavior support, respite, peer support, family support, or a variety of other activities.

What Families Have to Say About the Value of Direct Support

The following quotes regarding the value of direct support come from families who have been recipients of direct support services (some details have been changed to protect privacy).

- "My child's direct supports, which we refer to as his "coaches," are his teachers in life skills; manners, personal care, chores, taking responsibility for his actions, kindness, self-control, and even in helping him in nurturing his relationship with God!"

- "My son participated in soccer last winter through the YMCA and that was quite an accomplishment, even though there were a couple of times we had to leave in the middle of a practice or game. Because of the help of direct support services, it was the very first time he was able to participate in a group activity. He is learning to ice skate, bowl, and ride a dirt bike right now."

- "I would not even be here had we not been recipients of direct support services because we wouldn't have a story with a happy ending in sight to share."

- "He was kicked out for bad behavior of every single day care setting we placed him in and we had to remove him from the mainstream school setting because he could not function in an appropriate way to get him to behave for any length of time... I was even asked to keep him from his church Bible study and remove him from the children's choir; this also meant that I couldn't attend Bible study or church either. Our direct support services worked with him at his school, and slowly his grades and behavior started improving. Now he is in a mainstream classroom. They also attended church, Bible study and choir with my son, helping him integrate back into our regular community activities. Now, I can attend church again as well."

- "My daughter had no friends at school, church, or in the neighborhood, and even family members didn't want to be around us for long periods of time. No one would baby-sit; so I was exhausted, frustrated, and felt very isolated. Direct support services helped me get a break, find some hope, helped my daughter make and keep friends, helped us find babysitters who could work with her, and helped us reconnect with my extended family."

- "If direct support services were not involved, my children would no longer be in my home and I would have to deal with that guilt. I've been married 14 years and we've had a wonderful marriage. The children were taking up so much of our time and energy that we only saw each other in passing and under stress. It's been so much better than it had been. We all learn from each other."

- "Life is much better now. Like before, my daughter used to throw a tantrum when we went to the store and she wanted something I couldn't buy for her. Now, she doesn't throw a tantrum. Now I can take her out to public and stuff; it is much better."

Examples of Direct Support Provision

Some people ask for examples of the types of direct support that have helped children and families. Because each situation leads to a unique configuration of support that is tailored to the interests, strengths, needs and culture of the family, it is impossible to list all of the different examples

of direct support. In addition, as discussed earlier, direct support is not simply a list of service categories, such as respite or living skills training. Please consider the following examples of direct support to be illustrations of some of the possible configurations of direct support, rather than as a comprehensive listing.

- An eight-year-old boy struggling with impulse control loves trains. His direct support worker takes him to the library to learn about trains and to a train park to watch the trains in action. Together, they create a train book that shows a variety of the boy's favorite trains. The book shows how a train is slow to get started as well as to slow down. This framework is used with the boy in his response to impulses, using the language of a train slowing down or starting up.

- A direct support worker accompanies a young girl to her Girl Scout troop, which she would not otherwise be able to attend due to behavior struggles. The worker helps the girl transition into the group setting and helps others in the troop understand how to interact effectively with the girl.

- A direct support worker helps a sixteen-year-old boy research recipes that look good to him and create a shopping list of items needed to prepare the recipes. Together, they go to the local grocery store to find and purchase the items. They bring the items back to the home, cook them together, and serve the meal to the boy's family.

- A direct support worker helps a teenage girl prepare a resume that highlights her skills and attributes effectively. Together, they collect job applications and complete them, attaching a resume to each. They practice how she will introduce herself to a prospective employer, how to have a phone conversation following up on the application, and how to dress for and participate in the job interview.

- A young boy, struggling with self-image partially due to weight issues, participates in a number of physical activities with his direct support worker, such as soccer, basketball and jogging. The worker helps the young man learn to organize a pick-up game in the neighborhood, and models handling insults from peers without taking them personally.

- A direct support worker helps a young woman create an appreciation card for her mother, with whom she has a strained relationship. Together they practice what she will say to her mom as she gives her the card and how to be prepared to respond positively to a number of different responses she may receive.

Note that in the examples above, an important consideration is the needs being addressed by each activity, not simply the activity itself. For example, the same activity (such as going to a movie theatre) may be carried out to help with a number of different purposes or needs. A direct support worker may take a child to a movie to practice social skills in public, or to have a positive interaction with a distant sibling, or to learn about an important life skill being taught in a particular movie, or as a reward built into a structured incentive system, or simply to give his or her parent a break. In order to understand direct support service activities, one must know the purpose behind the activity, not just the activity itself. This concept is discussed in more detail in the section titled "Purposeful Support."

Coordinating Through the Team

As mentioned earlier, the wraparound team identifies the need for direct support services, finds a direct support provider which it commissions to do certain tasks, monitors progress and communicates with the provider on a regular basis, adjusts the plan based on the results of the service provision, and makes decisions about how to transition the child and family away from paid direct support services when goals have been met. The following section provides information about each of these roles of the wraparound team.

Identifying a Provider: The facilitator of the team considers whether direct support services would help meet one or more of the needs identified by the team. The facilitator ensures that the team has relevant information and makes an informed choice regarding the different sources of direct support available, including natural supports, community supports and paid direct supports. Some teams choose to invite prospective providers to team meetings in order to learn about the approach of the provider and determine the goodness of fit for the child and family. An essential role of the team is to determine whether the direct support provider operates according to the six principles of direct support outlined earlier. Prior to meeting with potential providers, the facilitator helps the team consider questions such as the following: "What are we asking the provider to help with?", "What availability are we seeking (days of the week, times of day, frequency, etc.)?", and "What can we ask the provider to help determine if it is a good match for our needs?"

Commissioning the Provider: Once a provider has been selected, the team commissions the provider to do certain tasks based on the needs of the family. Experience shows that when this step is missing, providers often get involved without knowing exactly what the team and family want them to be working on. This may result in inefficient use of resources. The provider must understand that it works for the team and that it needs to report regularly to the team. This means that the team may help define its role and the expectations associated with it. It also means that the team makes the decision to end the provision of support.

Monitoring and Communicating Progress: The team regularly monitors the progress of the direct support work. This may be accomplished by having the support provider attend team meetings in order to report, by submission of regular written reports or data collection, or by a combination of these methods. The section of this paper concerning outcome measurement contains additional suggestions for tracking, reporting and using information obtained by support providers.

Adjusting: The team often needs to adjust the approach to support provision. This may be indicated by the data collected from outcome measurement, or it may simply be at the request of the family or another team member. Adjustments to support are common and expected in direct support provision in a wraparound context. At a provider level, the company should be prepared to be asked to do things differently, provide alternate support workers, or otherwise make adjustments. At a team level, members may consider how to best adjust the current configuration of support, how to supplement the support with other sources, or even how to replace the support with another provider if it is not working.

> *A key responsibility of the team is to work toward independence by trying to use less paid direct support over time and more natural and community resources.*

Working Toward Transition: A key responsibility of the team is to work toward independence by trying to use less paid direct support over time and more natural and community resources. However, this does not happen automatically. It requires consistent effort by the team and should be a regular part of consideration when a team is using a direct support provider. This may be an area of fear or concern for some families. They

may have experienced services being pulled from them without warning in the past, they may worry friends or community members would be unwilling or unable to provide the type of support needed, or they may have a number of other concerns about discussions toward transition of support. However, rather than bypassing discussions about support provision, teams should listen carefully to all the concerns of the family and create a safe place for them to be expressed. It is a careful balancing trick to transition support effectively and respectfully. However, teams have an obligation to their community to use resources effectively. Because no community has unlimited resources, every hour of paid support consumed means another child or family elsewhere is doing without. Therefore, teams should seriously consider the need to transition the amount and type of support provided over time, always respecting the opinions of each of the team members, particularly the family. The trap many teams fall into is waiting to discuss transition of support until late in the process or choosing not to even consider the need to transition support for a particular child due to fears about the implications of such discussions. This is an area that requires a great deal of diplomacy, respect and honesty, and it is a significant part of creating a community where the needs of as many families as possible can be addressed.

What If There is Not a Team in Place?

Sometimes a direct support agency may receive requests to provide support when there is no wraparound team in place, or when there is a team, but it is not functioning well. In these cases, the direct support provider may play an important role in helping form or improve the group planning process, even if informally. For example, the direct support worker can help the team consider the types of activities desired from the direct support agency, helping them explore interest, strengths, needs and culture. Or, the direct support worker may help organize the people that care about the child into an informal team in order to make sure everyone is working together to help the child. Rather than refusing to participate unless there is a high-quality wraparound team in place, a strong direct support provider agency will jump in and help the team process along.

Individualizing Support

As mentioned above, direct support services are tailored to fit with family needs, strengths, interests and culture.

Sometimes, these areas have been identified by the team prior to the referral for direct support services. Other times, the direct support provider must play a more active role in helping discover and build consensus around these areas with the family and the team. A direct support provider may use tools, such as a functional behavioral assessment, to help discover these and other areas important to conducting quality positive behavior support. Such an assessment is often requested by the team of the direct support provider when particularly challenging behavior is present. The following areas are often parts of a functional behavioral assessment:

- Family story, elements of family culture
- Presenting behavioral needs or concerns
- A deconstruction of the context of the behavior:

  » Slow (setting events) triggers
  » Fast (antecedents) triggers
  » Specific descriptions of the behavior when it occurs
  » Consequences being experienced as a result of the behavior (note: consequences do not mean punishments—they are simply the "what happens next" that follows a behavior)

- Relationships
- Choices map (what choices the individual is allowed to make in various contexts)
- Behavior that develops respect and positive reputation
- Behavior that detracts from respect and positive reputation
- What works for this individual
- What is known not to work for this individual
- Recommendations for consideration in support planning

Support Planning

Once needs, strengths, culture and interests have been identified, the team begins planning the support. In some instances, the entire wraparound team is part of developing the support plan used by the direct support provider. At other times, the team simply commissions the direct support provider to develop the specific support

plan with the family based on the needs identified by the team and report back to the team regarding the plan development.

In either case, the direct support provider plays a key role in developing a plan for individual support based on all available information and materials, with special consideration to the functional behavioral assessment, if one has been conducted. The support plan may take a variety of formats, but some of the universal elements are the following:

1. Goals of support provision, as stated by the family
2. Needs of the child/family underlying the identified goals
3. Strategies/activities to be conducted by the direct support provider, answering the specific "who, what, where, when and how" questions associated with the plan
4. Measurement of progress—how the progress toward the goals will be measured

Support planning involves consideration of

both prevention and reaction. Prevention planning is similar to crisis planning in wraparound because it identifies what could go wrong and what can be done to prevent concerning behavior from occurring in the first place. Planning also needs to focus on how to react if the challenging behavior does in fact occur. Direct support providers may ask questions such as the following to help develop an effective prevention plan:

- What adjustments to the setting/context could be made in order to prevent the concerning behavior from ever occurring in the first place (without criticizing or blaming any member of the team, especially the family or child)?
- Which activities are most likely to help keep the concerning behavior from occurring, and how can we get all the members of the team working together to use these types of activities uniformly?
- How do we integrate what we have learned from the functional behavioral assessment into the prevention plan (such as what works/doesn't work)?
- What signs show us when things are starting to get concerning for the child (such as mannerisms, words, etc.).
- What can be done when things start to escalate, and in what way can we uniformly implement them as a team?

Provider-Side Individualization

We have discussed various ways a wraparound team can work with a direct support provider to individualize support services. There are also important considerations solely on the side of the direct support provider that help tailor the support to the individual and family. For example, the provider must consider which of its staff members best match the request for services and how to mobilize those individuals to meet the support needs.

While this may appear to be a simple task, in reality it is full of challenges. For example, smaller agencies may have a more difficult time finding an ideal match for a particular child. While an agency with 50 support workers may be able to

find within its ranks a male support worker from an African nation who plays basketball (an actual request that came to a support provider from one wraparound team), an agency with only five employees will be far more restricted in being able to do so. Nevertheless, finding the best match possible for each child is critical to success, so direct support providers must do whatever they can to help find the best match possible.

Prevention planning is similar to crisis planning in wraparound because it identifies what could go wrong and what can be done to prevent concerning behavior from occurring in the first place.

One option providers may use is recruiting and hiring specifically for an individual or family. Some providers have the family help interview the prospective employees who would be hired to work with their family. However, a challenge to this approach is it takes some time to go through the hiring process in order to find the right person, and there may be challenges associated with human resources laws in specifically targeting specific ages, races, genders, and so forth.

An important aspect in finding the best match for a child and family is knowing the attributes, skills and interests of the employees of the support provider organization. If a request arises for a worker who loves crocheting and softball, yet the company has no idea what the particular interests and skills are of its support workforce, the company severely limits its ability to provide the best match possible for the family.

However the right match has been identified for a particular child or family, there may still be challenges ahead in deploying that worker. For example, most agencies cannot afford to have workers sitting by idly waiting for the request to come

along for which those workers would be the perfect match. Instead, typical agencies have most of their workforce busy working in the field on a continual basis and have openings of availability only when families transition out of service or when new hiring occurs. Perhaps a request comes for a support worker from an African nation who is a young male and loves basketball and the organization has just the employee in its workforce. However, that employee is currently working to capacity with a young man with who has had tremendous success and who would likely experience difficulty if an abrupt transition were to occur to accommodate the request made by the new referral.

This is where creative management of the direct support agency becomes critical as there are often no easy answers when trying to find the best matches possible for youth. The provider may consider some of the following questions:

- Which child would benefit (or be harmed) more from working with (or not working with) this particular support worker?

- How can we meet both needs at once? For example, spending less time with the first child than the worker is currently, and less time with the new child than the request specifies, and supplementing the remaining time with additional workers for both children.

- How can we find another worker who will meet the needs equally well?

- What can be changed about the context to reduce the degree to which a particular person is needed? For example, could a relative of the child fill some of the cultural and social needs, while a paid support worker fills other needs?

Purposeful Support

Even when a team has masterfully outlined needs, strengths, culture, a functional behavioral assessment, and a detailed support plan, direct support providers face the challenge of ensuring that the support is carried out as planned, with consistent, purposeful interactions. While the team may be experiencing the vision of what the

support worker should do, sometimes the support worker, for a number of reasons, may experience challenges catching the same vision.

One reason this may occur is the support worker is the one working each day with the family. Theoretical progress and activities may be diffi-

cult to translate into daily interactions, especially across an entire visit with a child or family. For example, the worker may understand that the team would like him to take a child grocery shopping in order to gain real-life experience in independent living. However, if the worker is scheduled to be there for five hours and the shopping only takes one, the worker may wonder what to do the rest of the time. One temptation is to just "hang out" the rest of the time. Another may be to leave earlier than planned. Another may be to create forced learning opportunities falling back on tradition psychoeducational techniques so as to not "waste the time."

Again, there are no easy answers in this scenario, and quality supervision (discussed in the next section) is perhaps the best answer to this situation. What if that worker were part of a 24-hour safety network helping keep a child safe in the community and the provider agency had committed to the entire five hour period with the child? The answer of leaving early would not be acceptable (nor would it be for a number of other circumstances, some as simple as the family is counting on the support worker to be with the child until the agreed-upon time and has built its plans around that commitment). Support workers

must be prepared ahead of time to think about what to do throughout their entire time working with a child and family, even when the unexpected occurs. A constant dialogue within the worker's head should occur, processing the following question: "Why am I doing what I am doing right now?" The answer to that continual question should always be "Because it relates to the goals, needs, and plans for this child."

If direct support regresses into simple "hanging out" without a clear purpose, much of the benefit of the support may be lost. But what about if the purpose of the support is companionship and mentoring? The answer is the worker would know and constantly be considering that this is the purpose of the support that day. A breakdown occurs when everyone else on the team thinks the support worker is working on social skills in the community, while the support worker himself thinks he is simply spending time to build rapport. What could otherwise be remarkable progress toward goals may instead turn into months of stalled progress.

Consistent, purposeful support is perhaps the single biggest challenge for an effective direct support provider agency. Significant amounts of energy in the form of training, supervision and constant encouragement may be required before an agency is successful in having a support workforce that is providing support in this manner. One clinical director at a support provider agency is famous for having employees always on their toes prepared for his question: "Why are (or were) you doing what you are (were) doing?"

Supervision of Support

In many professions, direct supervision is a key factor in the quality of product or service provided by the company. In the field of direct support, this could not be more accurate. Consider the following critical roles a quality supervisor plays in a direct support provider agency:

- **Knowing where support workers are at any given time.** This helps reduce the chance of their getting hurt and reduces the chances of their doing something that will be harmful to the child or the agency. One significant concern people often have about running a direct support agency is

how they will know what all those employees are doing out there in the field. Supervisors are a key to knowing this information.

- **Instilling the culture of the company.** Despite what a company teaches in new employee orientation or claims in its mission statement, it is the day-to-day interactions with a supervisor that teach employees what is the true culture of the agency. This is the way effective direct support agencies instill the six values of direct support into their operations and their workforce. For example, a supervisor who emulates the values of positive support and strengths-based practice with a support worker, despite a variety of challenges that worker may be facing in the work, helps that employee learn to think in a positive and strengths-based manner each day, even when times get tough.

- **Clinical guidance.** While direct support may be a less traditional form of clinical service, it is clinical nonetheless, and therefore requires quality clinical guidance and support. In this context, clinical means that the services help provide assistance for challenging behavioral circumstances for a child and family. Because direct support workers are often behavior technicians and paraprofessional level employees, the amount of clinical support is often more than in a traditional outpatient clinic setting.

- **Consistency for the family and other agencies.** Especially when multiple support workers from a single agency work with a single family, a supervisor plays a critical role in providing cohesion and consistency in the support provided. The supervisor often acts as the liaison between the family and the support agency, as well as between the wraparound team including other stakeholder agencies and the support agency. Quality supervision helps provide a more consistent experience with direct support for families and other agencies.

- **Handling the complexity of flexibility.** The more an agency is flexible in its response to requests for support, the more complex running the agency becomes. Supervisors play a critical role in helping families get the amount of support they need from the best match of support workers possible, while also helping support workers get the help they need finding enough hours of work to sustain their employment and handling the inconveniences they sometimes experience by providing flexible support. For example, if an agency's best match for a child is an individual who lives two hours away, this creates challenges for that employee if the agency chooses to deploy him or her in that role. Supervisors need to maintain an awareness of the needs of the direct support workers and communicate these to other management staff. Some agencies choose to place some supervisors over direct support employees and appoint others to coordinate the support with families so that they can help assure that the needs of both get addressed.

Program Models of Direct Support

The first step in having an effective model of direct support is not to have a model at all. This may sound extreme and unorganized, but program models often interfere with a direct support provider agency's ability to be flexible and meet the needs of the family. For example, if a program pairs a master's level clinician with a bachelor's level technician as a support team for all families, this may be helpful for some families, but it also may be a hindrance for others. If the provider model is that the support workers make two one-hour visits per week to the home, but the family needs five six-hour periods of support, conflict between family need and program models occur again.

Perhaps the best program model for a direct support provider is to do whatever the wraparound team needs them to do. Whether one support worker coming to the home once per month or whether six support workers coming every day, the team knows best what a family needs and a support provider's job is to help the team meet their

needs. Of course, a team may combine the support from a variety of provider sources, including the natural and community resources of a family. However, this should not be reason for a provider to develop limiting program structures. Instead, direct support providers may be most effective when maintaining as flexible program model as possible.

> *An effective support provider develops tools and reporting mechanisms to help measure, monitor and report behavioral progress.*

Having a flexible program model does not mean the organization should lack structure. As discussed earlier, the more flexible the organization, the more complex the management of the company. Therefore, flexible providers actually require higher degrees of structure and support. Flexible program structure with inadequate supervision and protocol structure is a recipe for disaster. On the contrary, organization and quality administrative structures and processes help support the greatest degree of flexibility possible for a support provider.

While there is room in a community for support providers that specialize in the provision of a single type of support service, such as respite, or that work with a specialized population, such as children using substances, it is important that there are support providers available that use more of a "generalist" model of support. Generalist providers work with children of any age and with any type of presenting situation. They mold their support entirely around the needs of a family. It may be difficult to keep children living in the community safely without access to the services of a generalist support provider because support needs do not occur in isolation (a child who uses substances may require a variety of types of support) and it would be extremely difficult to predict and organize a community consisting exclusively of specialty providers. This concept is similar to the reason grocery stores have evolved into supermarkets. It simply did not work for families to have to make separate trips to so many different specialty stores to get what they need in the current busy lifestyle.

Although helpful for the effort to keep children in the community, operating under a generalist direct support provider approach is challenging for the support provider as it requires greater degrees of flexibility, supervision, consultation on specialty topics, and insurance protection. For example, a generalist provider could be used to work with any specialty behavior challenge such as gang involvement, sexual offenses, or eating disorders. However, the provider will need to bring in specialized consultation in the presenting subject to help orient and train the support workers in the approach to use with the particular specialty topic.

Measuring Outcomes

One of the most challenging functions of a provider organization is agreeing on and using outcome measures. However, without measurement and reporting of outcomes, progress is less likely. Therefore, an effective support provider develops tools and reporting mechanisms to help measure, monitor and report behavioral progress.

The starting place for outcome measurement is establishing a baseline. This does not have to involve complex university-level statistics. Instead, it may be as simple as plotting on a chart how often a child wets the bed or threatens his sibling for one week and using the average as the baseline. Each team should work with the direct support provider to develop agreed-upon baselines for the behavior for which the help of the support provider is sought.

A common temptation is to measure negative behavior. For example, the situation above describes measurement of the frequency of bed wetting or threatening behavior. However, that measurement could easily be reversed to measure how often the bed is kept dry or days of positive interactions.

Another pitfall of outcome measurement is stating the measurement in terms of the absence of a behavior. This is sometimes called the "dead man's rule." In other words, never describe the

behavior you are trying to monitor in terms of something a dead man can do. For example, if the goal were "Tom will stop lying," this is something a dead person could do, because it is simply the absence of a behavior. Additionally, "Justice will refrain from hitting and biting peers" is something a dead person could do. Effective measurement states goals in terms of something a living person could accomplish. For example, "Tom will tell the truth" or "Justice will keep her hands (and mouth) to herself."

A third trap of outcomes is being too general. Both examples listed in the preceding paragraph would be difficult to measure because they are not specific enough. The support provider must work with the team on making the measurement as specific as possible. One way to do this is to ask how we will know when the behavior being measured occurs. For example, "Justice will keep her hands to herself during her school class as evidenced by observation from the teacher and the support worker."

Once a specific statement relating to the behavior has been created, a system for tracking the measurement is easy to develop. For the example of Justice keeping her hands to herself, for example, a simple form could be developed for the teacher and support worker to mark each 30 minute period in which Justice does indeed keep her hands to herself.

The information tracked by team members, including the support workers, on a day to day basis will require some form of organization in order to be meaningful. Teams may organize the data into scatter plots, histograms, narrative reports, or many other formats. The critical element is that the information is compiled so that it can be considered by the team.

The team uses the complied information to consider the progress being made and to make any needed adjustments to the plan. For example, one team decided to help encourage positive playground behavior for a child by using a peer his own age as the intervention source (the paid support worker helped the peer to develop and implement strategies to help the student). Weeks later, the data showed no improvement in social behavior on the playground. The team decided to modify the approach by having the paid support worker interact directly with the child, and

weeks later the data showed significant improvement. This was not the only option available to the team. They could have stayed the course with the current plan, modified the approach with the peer, found a different peer, or any number of different options. The important point is that the team reviews the data and makes decisions about how to modify the approach.

Agency Outcomes

Effective support providers are interested in the feedback of youth and families regarding their services and provide a manner for them to comfortably provide input that helps shape the company. Whether this information is sought directly by a company employee or by a third party (such as a local family organization), keep in mind the following considerations:

1. *Families may fear they will lose their services if they report negative information about a direct support worker or agency.* Create an environment where they can share concerns openly while reducing this fear as much as possible. For example, the agency may use a third party to collect the information, allow anonymous feedback, or provide a statement that the information will only be used in the aggregate.

2. *Make changes to the agency based on the feedback.* Do not simply collect the feedback and place it on a shelf. This is not respectful to the families contributing the input.

3. *Consider using a peer or family member to collect the input from families.*

4. *Before relying extensively on electronic media to collect input from families, keep in mind they may not all have access to it, or even if they do it may not be a preferred communication method for them.* Consider at least offering alternatives to electronic submissions.

5. *Be considerate. Do not take too much of a family's time with a burdensome survey or try to collect the information too often.* The experience should be geared toward the family rather than the benefit of the

agency. Do not leave a survey for a family to complete without providing an envelope and stamp. Consider providing a small gift for families that complete surveys that is not tied to their answers.

How Are Direct Support Services Funded?

Direct support services may be funded using a number of different methods, ranging from private pay services in the community to public sector social services such as those provided by Medicaid. As evidence grows concerning the benefit of community-based direct support services, more funding methods become available.

One funding model for direct support is a fee-for-service arrangement, where services are paid on an hourly or daily basis for the work performed. These arrangements may be helpful to a direct support provider because they ensure the agency will be paid for every hour of service performed. However, a challenge with this model is it may be difficult to predict the amount of support that will be purchased over the course of a year, and cash flow is often delayed as agencies try to collect payment following the provision of service.

Another funding model is block purchase with encounter claims. In this model, a contract with the direct support provider specifies a desired amount of funding for a period of time (such as a year) and an anticipated amount of direct support that will be provided in return. The funding amount is typically divided into equal payments over the course of the contract period and paid in advance to the provider. The provider earns credit back toward the funded amount through the provision of services, but adjustments for delivery under or over the contracted amount are not made each month. Instead, the equal payments continue month to month and adjustments in service provision are made to ensure that the provider earns credit for the amount of funding that has been provided. This model provides a cash flow advantage for the direct support provider and helps the agency plan regarding utilization across the contract period. However, this approach also carries some risk. If the amount of funding is not earned by the provider, it often must be returned to the contracting agency, regardless of whether that money had been spent. In addition, when a provider accepts too many referrals and provides work above and beyond the contracted amount, the provider does not necessarily receive additional funding for those services. This is part of the tradeoff in a block funding arrangement: The provider must closely manage spending, capacity and encounter claim value.

Conclusion

Direct support is one of the most critical aspects of helping children live safely and successfully in their own communities. However, effective direct support that operates according to the six values of direct support outlined in this paper may be difficult to operationalize. Therefore, it is important that communities carefully consider the needs they have for direct support service capacity development and devote the resources required for successful creation and support of these essential services.

Author

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Wraparound Practice: Chapter 4d.2

The Role of the Clinician Employed in a Wraparound Program

Debra Manners

How does a clinician become a valuable contributor to the wraparound process? Many wraparound providers struggle with the fit between a support perspective and clinical focus. At Hathaway-Sycamores, we have defined a new role, the Wraparound Clinician, who works exclusively with child and family (wraparound) teams. For clinicians to be successful in this role, they need to transform their participation from a traditional clinical role to a community-based and family-centered practice approach. When this transformation occurs, the wraparound project can successfully integrate all perspectives effectively and efficiently.

Recruitment

Defining the role of the Wraparound Clinician begins with recruitment. The role requires that the applicant be licensed or eligible in a behavioral health field. Not all applicants will be a good fit for the job, however. For example, many clinicians seeking employment are looking for an agency that allows them to practice independently and provide an "outpatient" approach akin to a private practice. In contrast, the Wraparound Clinician is a team player that must interact, consult, and collaborate not only with youth and families but with other professionals as well. In many wraparound projects, licensed clinicians have a hard time accepting that they are one among equals on the treatment team and providing services alongside staff in the community and in family homes. Another qualification required is to have the critical thinking and communication skills that are needed in order to act as a "bridge" or translator between the strength-based, needs-driven, family-centered wraparound process and the Medicaid planning and billing processes that are built around a medical model of men-

national wraparound initiative

tal illness. When recruiting for a clinician to enhance wraparound operations, it is important to assess the applicant's values, beliefs and clinical approach to assure a fit with wraparound principles. Key attributes in the selection process are skills such as maintaining a non-judgmental attitude toward families, engaging and working with others from diverse backgrounds, appreciating the various training and life experiences of other staff, and reaching agreement without needing to prevail as the expert.

> *When recruiting for a clinician to enhance wraparound operations, it is important to assess the applicant's values, beliefs and clinical approach to assure a fit with wraparound principles.*

Conducting the initial interview in a group format and including a parent partner sets the stage for collaboration. One technique utilized is to assess the applicant's response to the question, "the worst home is better then the best placement." In the applicant's response, their values and critical thinking skills become obvious. Having a conversation about this question is an opportunity to assess the applicant's ability to provide non-judgmental, family-centered interactions and interventions. Teaching skills and coaching to wraparound practice can be fruitful only after selecting a clinician who has values consistent with wraparound.

Role

Typically, a wraparound clinician works with fifteen to twenty child and family teams, providing consultation, coordination, oversight, intervention, and evaluation. In doing so, a clinician hired by a wraparound project provides benefits for other staff as well as for families.

Direct Benefits to Families and Their Teams: Providing consultation is helpful to the family. Often families want clarity around specific issues. Talking to a clinician provides support and a level of understanding about their child, who may be experiencing mental health symptoms. For example, parents of a child who is experiencing specific behaviors and has the diagnosis of bi-polar may not understand the volatility of mood and rapid changes that occur from agitation to silliness. The clinician can help them understand why interventions work or may fail to work and how to support and assist the child depending on what is happening at home and at school. The clinician is also available to consult with the child's psychiatrist and assist in supporting symptom monitoring with the family. Consultation, evaluation and direct mental health services are provided as needed and defined by the child and family team. The clinician's activities are performed differently within each child and family team process. Each family that enters the wraparound process will have an opportunity to engage with the clinician from the wraparound process. It is important during the engagement phase that the clinician explains his or her role to the child, family and other formal and informal supports on the team. The clinician thus sets the stage for two types of interactions with the child and family team: consultation and/or providing intervention.

Often, youth enrolled in wraparound programs are involved in multiple formal systems and therefore they may have more than one clinician. In this case, the wraparound clinician's role is to develop strategies and interventions that complement the work of the other clinicians. Wraparound clinicians also provide risk assessments, assist with hospitalizations, educate the other team members around particular symptoms and diagnoses, and implement evidence-based practices. The clinician also completes court reports regarding client participation, frequency and progress. The clinician interventions are not "stand alones"; they build on or set the stage for the work of the other team members.

Direct Benefits to Other Employed Staff and Program Operations: At our agency, the clinician is typically only one of several staff working with a child/youth and family. A central part

of the clinician's goal is to coordinate the work provided by these staff members, and to provide oversight. This is guided through a comprehensive psychosocial assessment. In wraparound, the clinician completes the assessment that captures the facts of the child and family's history and situation, and that also includes their strengths and what has worked with interventions and services in the past. The clinical skills and knowledge provides other staff with a better understanding of behaviors and how interventions are selected or created so that they fit a family's strengths and unmet needs. For example; in developing a family safety plan it is important for the team to understand the seriousness of diagnosis, behaviors, and specific interventions. The clinician's understanding of behavior and past experience offers support and direction to those staff who do not have clinical training or extensive experience in working with children and families experiencing emotional stress and disturbance. The clinician is valuable during the safety planning process because they are able to assess for safety and risk. In addition the clinician is part of the rotating 24/7 crisis response team for all enrolled children and families and can be a consultative resource to the staff that is called to a family home during a crisis. The clinician is available to assess the situation, determine if the child's behavior or mental health condition can be met with interventions in the home or whether temporary placement in a respite group home or other emergency setting is required such as psychiatric inpatient hospitalization.

Funding & Wraparound Clinicians: In Los Angeles County, funding to support wraparound projects consists of a blend of state and federal Medicaid dollars. Thus, each child enrolled in wraparound must have a diagnosis and meet medical necessity to draw down the federal dollars. Medical necessity can only be assessed by a licensed clinician, and Medicaid requires a treatment plan that links interventions to specific mental health goals. In contrast, the wraparound plan starts with ascertaining child and family needs, and building holistic strategies to address needs and build on strengths. Thus the clinician must be able to take the wraparound plan, developed by the child and family team, and "translate" it to create a Medicaid plan

that documents mental health goals and interventions in a way that will satisfy state requirements. The clinician is responsible for creating the treatment plan to meet the state's Medicaid plan and to

meet the needs of the child and family. In keeping true to the values and practices of wraparound, the clinician documents the mental health goals and interventions for team review after the wraparound plan of care has been developed by the child and family team. The mental health goals are integrated across twelve life domains. For example; the wraparound plan may be built around meeting an unmet need such as "Juan needs to know that even when he gets upset adults will be there for him." The Medicaid plan, in contrast, would focus on the mental health goal of reducing anxiety. For both plans, the interventions then would be helping Juan's mother to respond to him when he is upset and assisting Juan in understanding his own process and escalation when he begins getting anxious. These types of interventions are agreed upon by the child and family team. Various staff can bill Medicaid for providing these services once a Medicaid treatment plan is completed. The wraparound clinician continually monitors the treatment plan to assure that it is driven by the child and family team wraparound planning process. Finally, the clinician is also responsible for collecting data for treatment planning and outcomes. Specific tools most often utilized are the Child & Adolescent Functional Assessment Scale, Child Behavior Checklist, Youth Self Report, Restrictiveness of Living Environment Scale, and the Global Assessment of Functioning.

Training of The Wraparound Clinician

Preparing clinicians to be successful in their role requires on-going training and supervision. All trainings must build on a family-centered foundation. Much of this is fairly standard clinical training. Typical courses provided are diagnosis and symptom reduction, evidence-based practices, legal and ethical issues, confidentiality, and child abuse reporting. On the other hand, wraparound clinicians find that while their knowledge base is similar to other clinically trained positions, the wraparound process changes the focus and application of that knowledge. Two examples are presented below:

Child Abuse Reporting. During the engagement phase it is important that the clinician explain to the family their obligation as a mandated reporter. Often, in the traditional clinical model, if child abuse is suspected the report is made without knowledge of it happening by the family. After the investigation, the parent/suspected individual may be angry and lose trust in the clinician and other providers. What is essential for a clinician in wraparound is to learn when child abuse is suspected, and if the child is not in immediate danger, to work with the family/suspected individual to make the report together. This process is essential to maintain the integrity of the team approach.

Confidentiality is another area of challenge for wraparound clinicians. The clinician in wraparound needs to know how to translate important issues for the team without violating any of the family's privileged information. The wraparound clinician also needs to help the different family members share with the whole team what others need to know so they can provide reliable help. Developing precision and competence in these skills is best taught in supervision.

In addition, the clinician role in wraparound requires skills in working collaboratively within the child and family team, with other professionals and families. As all team members, the clinician receives basic training in the philosophy of wraparound, the team meeting process, and an overview of each role.

Supervision of The Wraparound Clinician

Our agency uses a formal structure titled "Directive Supervision" when supervising the wraparound clinician. The clinician is supervised by another, more experienced, licensed clinician. This structure aligns practice with the agency's core organizational mission, values and principles. Data is gathered initially on the employee's self-rating and the supervisor's rating. Areas of practice needing improvement are targeted to be addressed through observation and coaching. In addition, family members are queried to assess if specific activities related to the clinician's role occurred. This data provides feedback to the clinician and his or her supervisor with a real-time dashboard of key performance and practice areas. During clinical supervision and at periodic reviews this information is used to help guide the clinician's growth and development, to determine gaps in training and supervision, and to celebrate achievements.

A clinician's role in wraparound is a radical departure from the traditional role. He or she serves as an asset to other staff, the child and family team and provides information and support for the child and family. Although recruiting for this role can be challenging, those who fill the role have found it to be very rewarding. It gives them flexibility and the opportunity to use a variety of skills and to work in a team where the responsibilities are shared. As the process of wraparound is utilized for different populations, a clinician who functions in a way that is compatible with the wraparound principles and practices can provide versatility, adaptability and enhance the family's experience of the process.

In the appendix of this *Resource Guide*, you can find:

- A job description for a wraparound clinician (Appendix X.1).

- The clinician self-rating form for use in directive supervision, as described above (Appendix X.2).

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Wraparound Practice: Chapter 4d.3

How School Sector Coordinators and Family Resource Developers Support the Wraparound Process

Elizabeth Berndt, Family Leadership Director
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One never knows why we find ourselves traveling the journeys we take. I certainly never set out to work in the human service field but once I helped my first family, and heard that their experience was very similar to mine, I was hooked. I am the parent of a young man who suffers from a mental illness. Together we found ourselves embarking on a journey familiar to many parents across our country. Our family was one of the first families in McHenry County to experience wraparound and from that process I learned how to process my feelings of anger and channel my energy in a positive direction. With the help of very patient and committed professionals, I was able to turn a negative experience into a passion to help other parents.

As a family new to the community, we struggled to identify natural supports and non-traditional resources to support our plan. Although we benefited from services like family therapy, it was not until natural helpers and informal supports were identified and applied that we began to consistently practice what we learned, and began to experience success on our own.

My personal experience led me to several positions as a paid parent/professional that paired me with a variety of mentors along the way. I was fortunate to work for the Illinois Federation of Families, a statewide family support organization, for several years. In 2005, I returned to the community where it all began. I am now the Family Leadership Director for McHenry County Family CARE, a child mental health System of Care initiative. My charge is to design a family leadership process to increase family involvement in our system of care and develop a workforce of parent professionals, all of whom have children with serious emotional disorders.

national wraparound initiative

The concept of relying on peer support is not a new idea. Various organizations have been using people to support other people in similar situations for many decades. What is relatively new, however, is the reasoning that parents (defined as primary caregivers for children with serious emotional disturbance) who have children with mental health disorders have a perspective based on personal experience that will benefit both other parents as well as professionals. Throughout the past 14 years, I have been part of a movement that validates the strengths of parents and caregivers and provides opportunities for those parents to support other parents. We have created a community of care that demonstrates collaboration with a variety of agencies infusing the parent voice across all systems.

We have had wraparound in our community for 14 years. In the past, wraparound facilitators, many times accompanied by the families, came to a single central location to present wrap plans. While this proved beneficial for some families, in our rural/suburban county of 600 sq. miles, it presented access barriers for others. It also meant that members of the panel were not as familiar with, or well connected to the families' communities and their resources. Another challenge was scheduling conflicts for school professionals who had to take time off from school to drive quite a distance to attend the meetings. McHenry County values the input we receive from our education professionals, so denying them the opportunity to provide insight into the academic portion of a child's day not only did a disservice to the child, but eliminated an opportunity for the teachers and other school staff to benefit from the resources and support wraparound can provide for them as well.

Resource Review Panels

In an effort to begin to address some of these challenges, the county has been divided into five sectors with all the county school districts assigned to a sector based on geographical location as well as number of children and families in the districts. Within each sector a Resource Review Panel is facilitated by a School Sector Coordinator. Local educators are encouraged to attend the Resource Review Panel meetings and learn about resources and strategies for students in their schools who are struggling.

Through our evaluation of the wraparound process over the last several years, we have learned that teachers, school social workers, and others are often unaware of the wealth of resources they have available to them. By having access to the Resource Review Panels, they are now linked to a much stronger network for themselves as well as their students and families. In addition to learning about the resources and networking, they become involved in seeking out solutions to many of the problems that prevent families from accessing services and supports, and they participate in collective brainstorming to figure out different ways to address these problems. As a result, they experience more ownership of the process and begin to feel like they are part of the community at large.

One of the many innovative qualities of McHenry County Family CARE is the incorporation of two new community resources: School Sector Coordinator (SSC) and Family Resource Developer (FRD). The SSC is similar in many respects to the community school coordinators used by the Coalition for Community Schools. The FRD positions are very similar to other positions filled by parents in other communities. The parent mentor, parent partner, parent resource specialists, just to name a few, are all very similar to each other but the differences may be the agency where they are assigned, or that the families are receiving services within a specific system. The unique quality of the SSC and FRD is that they are parents or caregivers

of a youth with serious emotional disorders. Once hired they build on their personal experience and professional training to engage families and community members in developing resources, to guide Wraparound Child and Family Teams, to access non-traditional supports and to help families navigate complicated youth serving systems. These two positions add to the value of our wraparound planning process by supporting the professionals as well as the families and identifying additional resources and supports. We have enhanced our ability to develop relationships with community members so that we may tailor the planning to meet individual youth and family needs by including more informal supports.

School Sector Coordinators

The School Sector Coordinators (SSCs) are employed by the McHenry County Mental Health Board which has entered into partnership agreements with various school districts. The agreements encourage collaboration between school districts and the mental health community to support a new way of providing services to youth and their families. Several school districts have provided office space for the sector coordinators, who split their time between different districts. Schools are required to develop student assistance teams, comprised of special educators, regular education teachers, administrators, support staff, and any others who have a vested interest in academic outcomes for students in that school district. These individuals meet regularly to discuss students who are not achieving academic success, or who may be experiencing difficulties because of their behavior.

With the addition of a sector coordinator, resources are identified and accessed much sooner for some of these students. The sector coordinators also provide workshops about mental health topics and link the schools to community resources that were often unknown because of a lack of time to develop the connections.

There are many ways that the School Sector Coordinators support the wraparound process. First, they facilitate the Resource Review Panel meetings. Community members such as business owners, parents, teachers, coaches, police officers and agency personnel meet each month to review wraparound plans and make suggestions to further strengthen the plan that has been developed by the child and family team. Wraparound plans are presented to the panel periodically for review and to request additional flexible funds. The panel members offer guidance to our wraparound facilitators by encouraging them to find community resources instead of relying completely on flexible funds to support the plan.

Second, in order to increase the responsiveness and the capacity of the Resource Review Panel to strengthen the natural support process for children and families, and offer a vast array of non-traditional services and supports, the sector coordinators network throughout the community and have developed relationships with business owners, parent leaders, faith-based organizations, among others within their sector and encourage them to become members of the panel. As a result, demographics of the community are much better reflected on each panel, and the panel more appropriately reflects the cultures and the values of the communities in each sector. These efforts have increased the buy-in from members of the community at large, who understand that their effort will support the children and families in their own communities. The addition of parents on the panel assures that the parent perspective is represented in all discussions. The panel then approves any request for flexible funding that is needed to support the wraparound plan. In addition, since they are community members they are more aware of who might be willing to provide non-traditional support thereby increasing the network of resources.

The unique quality of the School Sector Coordinator and Family Resource Developer is that they are parents or caregivers of a youth with serious emotional disorders.

Third, in order to better inform and involve parents in the wraparound process, we have used the SSC's to strengthen our initial engagement method for families entering wraparound. Upon receiving a wraparound referral, the SSC meets with the family who has been referred to Wraparound, explains the Wraparound process using the "Wraparound Process User's Guide – A Handbook for Families," and has them sign a consent form that we use to reinforce the importance of family participation in the process. And finally, sector coordinators are trained wraparound facilitators, facilitating child and family teams outside of their own sector.

The addition of a School Sector Coordinator to a school district has brought about changes in three major areas: educators' awareness of mental health issues has increased, accessibility to resources has improved, and there is an enhanced connection with individual family members. Administration and staff have commented about how the presence of the SSC has helped them function better in their own positions. Through expertise and experience, the SSC has proven to be a bridge between families, school, mental health child welfare, and juvenile justice.

School Sector Coordinator Paula Briedis illustrates this change with an example from a middle school in her sector. "The social worker and assistant principal contacted me about a 13 year-old student who was experiencing increasingly problematic behavior. They wanted direction as to how to engage the teen and her family in a more effective course. With the conversations that followed, I was able to provide many resources for the school professionals, and suggest many strategies including a referral to wraparound. I then met personally with the mother, hearing her concerns about her daughter. As a parent-professional, I could understand and empathize, bringing comfort and hope to her. After that home visit, the family agreed to enter wraparound and I worked with the school social worker to initiate the referral process. Following the assignment of the wraparound facilitator and the development of a child and family team, the school reports the girl's behavior has improved and they are no longer looking at alternative placement. Legal concerns have also been allayed, with improved behavior in the community. The family states that they are experiencing more stability within the home, and have enjoyed the supports placed by the wrap team."

Our county has a rapidly growing Latino community. Currently, 10% of McHenry County residents are Latino and it is anticipated that over the course of the next 20 years the proportion will increase to 40%. In order to create an environment that is culturally competent and responsive to community needs, we have placed an emphasis on hiring bilingual staff that reflects the cultural diversity of our county.

Ricardo Leon is a school sector coordinator in a sector that includes a large percentage of our Latino families. During the time he has been a sector coordinator, he has met with most of the schools staff, including nurses, social workers, special education teachers, regular education teachers, parent's liaisons, and support staff. He attends training, conferences and meetings, and shares his experiences and knowledge in order to influence members of the community. His personal belief is to be a good role model for the community. "I have helped with cases of truancy, cases of gang involvement... helping with doctor's appointments related to children with serious emotional disturbance. I helped a family with a daughter involved in gang practice, whose parents have very limited English." Riccardo goes on to say, "There are many situations in which the job of a SSC is crucial, important, and necessary. There is a great deal of literature on different topics

Following the assignment of the wraparound facilitator and the development of a child and family team, the school reports the girl's behavior has improved and they are no longer looking at alternative placement.

related to mental illnesses that are written originally in English, and need to be translated in some languages such as: Spanish, Polish, and Korean to reach some underserved populations. There are a good amount of people that for different reasons did not have access to education or simply did not finish their secondary, or even elementary education, I can certainly be influential on this specific topic."

Family Resource Developers

Many times, when families have children with serious emotional disorders, their lives become very complicated, which can lead to isolation and feelings of being overwhelmed. Over the last several years we surveyed families within our county to better gauge the supports they felt were lacking with our services. A common theme expressed repeatedly was the importance of having someone to listen to them who understood what they were going through, whom they could talk with, who could relate to what they were experiencing, and who didn't judge them as parents. They identified the need for more time to share their concerns and problem solve for answers.

Timing of meetings was also a factor as families told us job retention was often a challenge because the people they needed to meet with at school couldn't always meet with them when it was most convenient. This obstacle created the need for parents to take additional time off work, and was not always met with approval from their supervisors. Eventually many parents left their jobs. Many were fired. We addressed these concerns and others in the design of the Family Resource Developer program. Like the School Sector Coordinators, the Resource Developers go into the home, sometimes with a therapist, to meet with families when it is most convenient for the families.

The FRDs support the work of the School Sector Coordinators. Each FRD provides resources and support to parents as well as professionals, works in tandem with a CARE manager for our crisis intervention program, provides wraparound facilitation, and guides parents through the various system mazes. More important, they listen to the family's stories and help them begin to process what they are experiencing and offer guidance

and support as they learn strategies that will impact their children's futures.

Currently, the FRDs work with families that enter the system through our intensive crisis management program, establishing a connection with the family and working in tandem with a therapist. It is during this initial phase with the family that the FRD begins to build trust and brainstorm with the family to identify potential team members within that family's life that have a vested interest in continuing positive outcomes for the youth and family. In this manner, the FRDs help create a balance between informal supports and traditional services. An emphasis is also placed on helping the family develop a team that reflects the cultural beliefs of that family. As the family moves away from crisis, the FRD transitions with that family into wraparound planning and begins to encourage and empower the family to take over the team facilitation.

Aurora Flores, a resource developer with the Latino Coalition works with our Latino families. Upon referral into SASS (Screening Assessment and Support Services) our crisis management program, Zack Schmidt, a SASS therapist brought Aurora in to assist him and a family in developing an effective treatment plan and to strengthen the support to the family. The 5-year-old child had been referred because she had been crying so hard she would end up vomiting at school each day. She had been given a diagnosis of attachment disorder but no services were currently being provided at the school.

The family is originally from Mexico and the child and father had been separated for months

from the mother and older brother before being reunited. In addition to being separated from her mother, this young girl was pulled from her father's care to live with her grandmother, while the father secured a safe living arrangement for his family. Finally, after a successful reunification with his family, the father was injured on the job and as a result, lost his employment. After months of trying to find ways to pay for medical help, suffering the loss of income, and having no interpersonal support, the family was in danger of losing their home. Living in a home under such financial stress, and having endured the trauma of abandonment earlier, the little girl was falling apart, and the family was doing their best to meet the challenges. Recently, while taking in a friend's child to baby sit, the child ran away. A hotline call was made to child welfare and an investigation was opened. As if the situation could not get any more complicated, the mother learned she was pregnant with her third child and didn't know how she was going to pay the bills.

Aurora spent time with the family in their home listening to their concerns. Language was not a problem but even though the SASS worker is bilingual, he is not from Mexico and struggled to relate to some of the cultural barriers. Aurora however, who was born in Mexico herself, was able to help Zack understand the issues so that as a team they could help the family better. Aurora attended appointments with the family, and sat with them and helped them make phone calls, which was different from the supports the family was used to. They quickly learned that they had someone willing to go the distance with them rather than just hand them phone numbers and promise to call and check in.

Aurora's effort strengthens the treatment plan by securing supports within the community. The church paid the family's rent so they would not lose their home. Clothing was a problem so Aurora asked her fellow resource developers if they knew of a place where she could get clothes for the family. They referred her to a resale shop but it was quite a distance from the family's home. Aurora took the family shopping for clothes and was able to link them to other resources that helped to stabilize their home situation. In addition, the family has developed a strong support team of community members, including a Pastor who speaks Spanish, to help them maintain their success. The child has stopped crying at school and the family is feeling much more connected to and supported by their school and community. The SASS plan was closed and the family is doing well.

Hiring Parents

As a way to infuse the concept of hiring parents throughout our system, Family Resource Developers were employed by numerous youth-serving agencies that collaboratively could support them as a team. Seven McHenry County organizations—Family Services Community Mental Health Center, The Youth Service Bureau, McHenry County Mental Health Board, Options and Advocacy, the McHenry County Latino Coalition, The Family Health Partnership Clinic and the McHenry County Regional Office of Education—built upon existing relationships to develop a collaborative partnership with the local community to support the Family Resource Developers and the youth and families they serve. Together, these organizations currently support a team of eleven Family Resource Developers.

Collaboration among these organizations began with formal letters of commitment. Each organization committed time and resources to the development of the Family Resource Developer program through multiple joint planning meetings. Over a six-month period, representatives of each organization met regularly to learn about Systems of Care and Family Resource Developers. Together, they outlined a potential program structure identifying job responsibilities, key operating principles, necessary resources, and the training process. Finally, all the collaborating organizations signed formal Memoranda of Understanding outlining their commitment to sustainable funding, joint training, joint supervision and continued participation in the planning process.

Hiring parents into our system of care presented some initial challenges. One of our challenges was the struggle to place a value on life experience vs. book knowledge when it came to developing a pay scale for parents, many of whom do not have any college credits. We finally settled on providing the organizations with guidance about hourly figures based on what other family organizations paid their parent partners. The FRD's are

salaried at that base rate for having a high school diploma, and it increases accordingly if they have a degree.

We utilized our county website for recruiting. Since these were new positions, Family CARE staff wanted to screen applicants prior to the interviews with the different agencies, so they could be assured the person possessed the right qualifications for the job. Determining the qualifications of the resource developers proved to be an interesting topic of discussion in the early months of the project. After much discussion it was decided that it is not the level of education that makes the person the right candidate, but whether they possess the necessary skills needed to perform all functions of the job.

The Family CARE interview team used a checklist with statements directly related to the qualifications necessary for the position: excellent written and verbal communication skills, flexible time schedule, availability to attend professional development workshops, friendliness, and leadership potential. Other statements centered on the candidates' experience in the field of support and their ability to relate and work with a team. If the applicants met the criteria we sent their application packages to the five organizations who agreed to participate in the first round of hiring. We provided each organization with a copy of the resume and interview team checklist for each applicant. As they found the ideal person to complement their team, the partner organizations hired the FRDs. While there were certainly occasions when more than one organization was interested in a candidate, all organizations managed this challenge with grace and respect for each other and the Family Resource Developers involved.

Supervision of FRDs is also a joint effort. In addition to each organization's clinical director providing supervision to their Family Resource Developers, Family CARE's Clinical Director and the Family Leadership Director provide group supervision as it relates to the System of Care principles for promoting family driven, youth-guided, evidence-based, culturally competent, individualized and strengths-based care. Finally, on a monthly basis, the leaders from each organization meet with all Family Resource Developers to review the program, problem solve and provide additional support.

Staff Development

Training is a major focus of our effort because most of the parents being hired into the system have not had access to a formalized method of preparation for a job of this magnitude. The training that is offered is attended by both the resource developers and the sector coordinators since both positions are being filled by parents. They participate in one week of orientation and then begin an intensive training program. Training topics include Introduction to System of CARE, Wraparound Facilitation Training, Public Speaking and Presentation Skills, Special Education IDEA Updates, and Balancing Work and Home. Staff also provided training and ongoing support regarding the Illinois All Kids insurance program, Medicaid documentation, evaluation and data collection, evidence based practice strategies, and legislative information and updates. Future topics identified by the FRDs so far include cultural competency training and time management. Administrators and staff of partner organizations also participate in multiple training opportunities along with the School Sector Coordinators and Family Resource Developers.

Since the main function of both the FRD and the SSC positions is to support the wraparound process, it was imperative to give them a variety of ways to learn about wraparound. A wraparound facilitator mentoring process has been designed that allows the SSCs and the FRDs to attend child and family team meetings with skilled wraparound facilitators to observe the way they facilitate meetings. After they have observed another child and family team three to four times, the FRDs and SSCs co-facilitate three to four meetings with an

experienced facilitator and then test their own abilities with a facilitator/mentor observing them. If all goes well, at that point, they are ready to facilitate on their own. We have increased our capacity to serve at minimum an additional 65 families in the wraparound process with the addition of these two types of positions.

Once a month the FRD's and the SSC's attend a team meeting. These meetings are a chance to share information with each other regarding resources in the county, a chance to continue trainings with speakers on topics relevant to their job, and a place to express concerns and share successes.

Cost of the Program

The cost of the School Sector Coordinators and Family Resource Developers can vary depending on how they are paid. In our community, we chose to pay an average hourly figure of $12.00/hour. Each organization that hires a FRD receives a certain amount of money that is to be used for salary and fringe, and they decide how much they will pay the FRD depending on the level of education they have. The average salary for a school sector coordinator is $36,000.00. In addition to salary, there are other costs associated with the program. Each SSC and FRD has a wireless laptop and computer software that assure they can process their paperwork efficiently. Costs for computers, software, training, travel, and other miscellaneous items, such as printing can add up, but are necessary for the professional development and productivity of each parent professional.

Benefits of Hiring Parents into the System

The School Sector Coordinators are just beginning to meet regularly with their Resource Review Panels. The number of additional community members attending these panels, including consumers, who are now aware of system of care work, has more than doubled. School administrators are recognizing the benefit of having a liaison in their district to provide staff and families with extra information and support. The agency partners are beginning to see a shift in the way therapists work with families and the dialog is now

including how they can recruit parents and youth for their committees and boards. Families that have provided feedback on their experience with SSCs and FRDs have been very positive, and they advocate for more parents being hired into the system. Faith-based and other community members are embracing the philosophy of a family-driven system and volunteering to participate on workgroups, boards, committees, and child and family teams.

The integration of Family Resource Developers within and across these collaborating community organizations has already begun to directly fight the stigma associated with youth with serious emotional disorders. Providers working as colleagues with caregivers of youth with serious emotional disorders learn not only the challenges but also the multiple strengths these youth and families possess. Families and caregivers are no longer viewed as part of the problem, but as part of the solution.

Jason Keeler, one of the resource developer partners at the Youth Service Bureau (YSB) comments, "I think it has proven to be a validating experience. It has generated meaningful conversations in meetings that allow for a richness and diversity when talking about families. It has promoted alternative perspectives for everyone involved. More directly, within an open and collaborative framework, Family Resource Developers and staff have jointly been able to engage with those families who have unfortunately experienced 'system' failure and have been disheartened and disempowered. We have been able to reinstate some level of hope and empowerment in these families and restore some of their faith in themselves as capable and caring parents who, when it is all said and done, simply want to help their children be healthy and

> *Families and caregivers are no longer viewed as part of the problem, but as part of the solution.*

happy. Parents have often stated that they more readily become more comfortable with a [parent] who has been through some of the [similar] things that they are going through. Most are thankful for the extra attention that is focused on their issues, specifically in dealing with a youth with youth SED."

"For the staff here at YSB, it is a reaffirmation that in most circumstances parents do not fail their children, but more often it is inadequate or inappropriate child- and family-serving systems that fail to identify, understand or effectively meet families' needs. Services, particularly those to children and families, must be accessible at the time when they are most needed. As funding resources change at state and federal levels, more creativity and further collaboration will be needed at the local level to develop ways to respond to such changing conditions so that families have true access to a community of care that can meet their respective needs."

The support that the sector coordinators and resource developers provide to our families enhances the way mental health services are delivered to child, youth, and families experiencing the daily struggles of mental health disorders. Parents helped identify problems and service gaps, and are now in a position to inform the system and provide side by side support with service providers.

As we near the end of the first year of employment for these new positions, our partners are asking for time to brainstorm to look for ideas and strategies to increase their participation in the design and implementation of roles for parents, not just as sector coordinators and resource developers, but in other roles as well, in the hopes of expanding their outreach to families. The partnering that is occurring between our providers and families has gone from reserved and hesitant to accepting, excited and looking for more possibilities.

While the implementation of these two positions in our community is relatively new, we are always learning from the experience. We have started to reflect on the continuum of development for parents new to this work and identify potential triggers that might interfere with the way they interact with some professionals. As those moments of clarity surface, we can begin to strategize how to move through the emotions that occur during those times.

Many of the parents who work in the system share the same feelings of accomplishment and hope. The partnerships that have been developed so far include a diverse group of professionals and parents without whom this work would not be possible. It has not come without challenges, but the commitment of the partners has allowed each participant to learn and grow from the others.

Finally, as we look to the future, we are challenged not only with the idea of sustaining these positions, but how to put into practice family-driven principles throughout our community of care. We are posing questions to our partners to challenge them to think about strategies to sustain their effort. Those questions are: In four years, how do you see your agency including parents on advisory boards and committees, as well as paid support staff? If the money were gone tomorrow, would you still employ School Sector Coordinators and Family Resource Developers? How are we assuring the sector coordinators and resource developers remain healthy and avoid burnout?

After years of navigating the system as a parent I know I wouldn't trade my son for anything. I have grown as a person, and developed as a professional because of what I have learned from him, other parents, and professionals who chose to work with us. I am a completely different person than I was when I became a mom and he was placed in my arms that first day of his life.

I have developed more patience and understanding of differences, and more compassion than I would have if I had never traveled this journey with him. I know my feelings are shared by many parents working in this field. It is the perspective the parent professionals bring to this work that rounds out the continuum of care, and completes the circle of support for families.

Author

As a result of her experiences as a parent, **Beth Berndt** has learned about the special challenges and barriers to services that children with emotional and behavioral issues and their parents confront. Beth is a strong advocate for System of Care values. She is part of a team of parents and professionals working in concert to develop a system that offers hope and support to families, helping them move from feeling overwhelmed and isolated to becoming engaged in various ways as members of the behavioral healthcare workforce. Beth has been married for 32 years to David and is the mom of three young men.

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