2019

Magellan in Wyoming
Doing the Work

Magellan Health Services

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Table of Contents

INTRODUCTION TO WRAPAROUND

What is Wraparound?

Wraparound is a family-driven, youth guided process that uses the family's strengths as well as their supports to create a plan to meet the family's needs and create hope.

Wraparound places families and youth in the driver's seat as they determine what is best for their family. By partnering with and truly listening to the family, Family Care Coordinators (FCC's) and Family Support Partners (FSP's) bring together the important people in a family's life to meet on a regular basis. This team will come up with ways to provide real help to the family that will last.

Purpose of this Manual

The purpose of this manual is to provide a quick reference guide to those who have completed the initial Foundations training. Many of the concepts and ideas presented in this manual follow directly from the information presented.

This manual will provide you with the necessary understanding of what drives the High Fidelity Wraparound process and how it's used when you begin working with families. Further training and ongoing coaching is needed for FCC's and FSP's to feel good in the actual running of child & family team meetings (Wraparound meetings), as well as to deepen their ability to identify unmet needs and other important pieces of the wraparound process. Your coach will work with you to put into action the things you've already learned from training, and this manual.

Welcome to High Fidelity Wraparound! We hope you join us in this important journey of learning to support families in a new and positive way.

The Values and Principles of Wraparound

Community Based

Teams look within the family and the community for resources so families aren't struggling to get the help they need. Also, one of the main goals of the Wraparound process is to assist families in staying together, allowing youth to remain in their home and community. If services are needed, we want to help the family connect to service providers located within the community who will remain available after Wraparound.

Strengths

Strengths are identified throughout the process by getting to know the family, their supports and their community. Strengths of all team members (including the other youth in the family) should be included by identifying what qualities, skills and interests (both personal and professional) can be brought to the team and used to develop effective strategies. For example, if a team member is known as being caring, the facilitator should ask the team to describe how the person shows care for others. This allows the team to take important strengths and discover ways they can be used in the plan. Community places and resources are also considered as possible strengths that can be used in a plan.

Natural Supports

This principle recognizes the central importance of the support that family members receives "naturally," i.e., from the individuals and organizations whose connection to the family is independent of the formal service system and its resources. These sources of natural support are

sustainable and thus most likely to be available for the youth/child and family after wraparound and other formal services have ended. People who represent sources of natural support often have a high degree of importance and influence within family members' lives. These relationships bring value to the wraparound process by broadening the diversity of support, knowledge, skills, perspectives, and strategies available to the team. Such individuals and organizations may be able to provide certain types of support that more formal or professional providers find hard to provide, for example; teaching someone how to drive.

Unconditional Care

Unconditional Care means never giving up. When things aren't working for a family, the team is brought together to see how the plan can be changed to meet the family's needs. The team works with the family to come up with new strategies and re-address identified needs. Providers and families take an equal share of the responsibility for engaging in the process. To practice unconditional care, a provider will need the ability to evaluate and change their own behavior, rather than labeling the family as non-compliant or unwilling to engage. They will also need to be able to look at challenges as opportunities; to solve issues; to embrace the opportunities for new and different outcomes rather than giving up or referring families to new systems or providers – while balancing this with their own self-care.

Outcome Based

Outcomes are the measurements we use to determine how the process is working for the team and family. Plans should be turned in timely and have clear statements of what outcomes are desired. Assessments are a part of checking on outcomes and can be really helpful.

Cultural Competency

Wraparound practice goes far beyond the race and ethnicity of a youth and family. All families have their own culture and unique strengths and challenges. We need to speak with families about their way of living in order to increase our understanding as much as possible. Cultural competency also means being willing to acknowledge any lack of understanding we may have of a family's culture. What unique strengths, interests, experiences, values and preferences does each family bring to the table? This will be important information to gather to create a plan that is respectful of each family's culture.

Community Based

The wraparound team should be composed of people who have a strong commitment to the family's well-being. In accordance with principle of Voice & Choice, choices about who is invited to join the team should be driven by family members' perspectives. Family members should be provided with support for making informed decisions about who they invite to join the team, as

well as support for dealing with any conflicts or negative emotions that may arise from working with team members that they find difficult. When a state agency has legal custody of a child or youth, the caregiver in the permanency setting and/or another person designated by that agency may have a great deal of influence over who should be on the team; however, in accordance with the wraparound principles it's important to support the family.

Individualized

Capturing the unique qualities and strengths that make up individuals, families and teams is critical to the success of wraparound. The wraparound process is driven by needs identified by the family and team which are then re-stated as positive goals. These goals will guide the team's work towards getting the family the support for which they have asked. Needs are not a specific service, behavior or diagnosis. What will it look like when that need is taken care of? Answering this will help you write it in as a strength based goal.

Family Voice and Choice / Family Centered / Family Driven

An individualized plan has the youth and their family front and center. The youth and family are able to clearly identify a plan as theirs. They are listened to by their team in determining a plan and are given full information and choice in setting objectives, strategies, providers and supports to assist them. The providers are there as sounding boards and when asked, provide guidance, advice, information and resources. This is a major practice shift for some professionals, as many are used to an expert model where they offer advice based on their expertise, writing up a plan for families, perhaps without them being present, and informing them of what they think they need, as well what actions should take place.

Collaboration & Integration

Working together as a unified team is at the core of the Wraparound process, both at the system and the child and family team level. At the child and family team level, collaboration means the FCC takes an active role in getting everyone to work together and help assign responsibilities so each team member is a part of helping the family reach their vision. Decisions are made together as a team, with a decision making process that is decided by the family. Collaboration also means making sure all needed system representatives, such as DFS, probation, mental health, education and primary care physicians, are at the table to ensure the family has one plan and all parties are on the same page.

Families deserve to have one plan in which systems have integrated their tasks and mandates to meet the family's needs.

Child & Family Teams (CFT's or Wraparound Teams)

What is a Child & Family Team?

A Child & Family Team is a group of people identified by both the youth and the family who will work with them throughout the wraparound process. A CFT is composed of formal, natural and informal members. CFT's meet on a regular basis, more often at the beginning and then as they move towards "purposeful transition". They meet in a way that families will continue after wraparound. The meetings generally start in the family's home or at a place in the community that is most convenient and comfortable for the family.

Team Members

Formal Supports

Formal supports generally represent the systems who employ them. Possible formal supports include therapists/mental health providers, DFS workers, probation or parole officers and school representatives.

Natural & Community Supports

This is generally someone who has an enduring relationship with the family. They could be extended family members, close neighbors or friends. These "go to" people are those the family trusts.

Community supports may include spiritual leaders, landlords, sponsors, support group leaders or someone in the neighborhood who could be brought to the team for support.

Identifying Formal Supports

Ask the family to discuss who is currently involved with their family and youth. Remember, system representatives can be teachers, school guidance counselors, therapists, Department of Family Service (DFS), probation or parole workers or anyone else who is paid to provide a service to the family.

Formal supports are strongly encouraged to come to the first team meeting to be a part of the Child & Family Team and to assist in the creation of a single plan of care and then to come as it makes sense. If a youth is in DFS custody, the DFS social worker has to be a part of the team. If a family chooses to exclude a formal team member, the Family Care Coordinator (FCC) should explain the risk of excluding someone who may have the power to derail their plan through independent actions outside the team.

Identifying Potential Natural & Community Supports

Listen to the family's story.
Listen for past supports and resources, paying close attention to what has worked for the family in previous situations. Who has been there for them during past hard times or crises? Who would they call in the middle of the night if they had to?

Analyze the family story to identify team members.
When the family talks about their past and what brought them to HFWA, pay close attention for the names of people who they speak about as having an important role in their past or present life. Once the family story is written up (in what we call a Strenths, Needs & Cultural Discovery), go back over it with the family to make sure it is accurate, as well as to ask for further information about whom they have found helpful to them in the past.

Get to know the family.
Who do they identify as family? How do they describe themselves?

Be observant.
Look for family pictures, pets, artwork, hobbies, trophies or certificates on display, etc., around the house. Ask the family to tell you about what you see.

Practical questions.
Who helps with childcare? What is the daily schedule like? Who can they depend on at work or school? What does the family do on the weekends and who do they do it with?

Feeling questions.
Who can they really laugh with? Who are they comfortable crying with? Who do they look up to?

Miracle question.
If you could wake up tomorrow and things were better, what would that look like for you and your family? Who is involved in the miracle? Who was most helpful?

Get to know the family's community & neighborhood.
Familiarize yourself with the family's surroundings. Find out who the neighbors are and who the family depends on.

Get to know the family's culture.
Who shares the family's ideas, values, interests, activities and beliefs?

Recognize team resources.
Recognize personal, as well as professional strengths. Each team member is an expert and may have different resources. Use strengths and interests as a way to help members change roles.

Child and Family Team Functions

When incorporating team members, it is important to remember to:

- Recognize and respect the family culture and preferences.
- Normalize the process – how have all of us depended on others in times of need? Provide examples.
- Explain the benefits.
- Share success stories with the family and team of other families who have utilized a team for help.

Team Invitations

Once the team members are determined, the facilitator should ask the family who they would like to invite to the first team meeting. Collaborate on who will do the inviting, as well as explain what the team process looks like and the purpose of the meetings. This may include empowering the family to mend past relationships. It's important to provide an agenda so team members can decide whether they need to attend or not. For example: a teacher may choose not to come to a meeting where the priority is to look at budgets.

Well functioning teams…

- Remain strength based, family driven and outcome focused.
- Have a diverse membership.
- Communicate within the team.
- Know how to ask for help.
- Listen to each other.
- Embrace conflict.
- Everyone works.

The Four Phases of Wraparound

All four phases happen continually. Transition starts with engagement and engagement happens throughout the process. Discovering new needs, skills, strengths, strategies and resources for meeting a family's need is almost a constant activity. Team preparation, engagement and welcoming, can also happen throughout the process.

PHASE 1: Engagement or Relationship Building

Team Preparation/Engagement & Welcoming

Technically speaking, think of the engagement process as all about getting to know people and relationship building while getting people ready to be a team. By having discussions about child and family strengths and needs, the tone is set for collaborative teamwork; trust is built.

Goals and Tasks of Phase 1:

- Orient the family to the Wraparound process.
- Band Aide Crisis Plans *(see Appendix D).*
- Explore strengths, needs, culture and vision with the child and family.
- Do assessments with the family: Children's Dashboard, ACES, CANS, explain WFi-EZ
- Identify and engage team members and orient them to the process.
- Develop an initial family vision to guide needs discussions *(see Appendix B).*
- Identify and prioritize youth and family needs *(see Appendix C).*
- Develop an initial Strengths, Needs and Culture Discovery (SNCD) with the family *(see Appendix A).*
- Arrange the first Child & Family Team Meeting (CFT)
- Create an agenda for the first meeting

Getting Started

When getting started with families, FCC's should be prepared to listen to concerns, stabilize the situation and meet immediate needs through a Band-Aid crisis plan. This is the time to begin building trust. FCC's must own the responsibility for engagement by asking themselves what it is they must do to engage the family rather than expecting the family to engage with them. It may take several initial meetings with a family, to begin to have rapport with them. Explaining the process in ways they can understand and relate to, following through, and being open, honest, and clear about your role, is essential to establishing the kind of trust it takes for families to begin feeling safe enough to discover or even reveal underlying needs.

Key Assumptions for Positive Engagement:

- All people have strengths and each person's strengths are unique.
- Change happens by building on strengths.
- People generally know their own strengths and needs but may need assistance bringing them out.

- Exploring strengths identifies things you have in common.
- All environments have strengths to be built upon.

PHASE 2: **Planning**
Initial Plan Development

Phase two involves holding a larger crisis planning meeting and an initial Child and Family Team meeting. During these meetings, a team is developed where all members are heard and valued for their contributions.

Goals and Tasks of Phase 2:

Crisis Planning

- Work with a team to develop a crisis plan to help families navigate the crisis they identify
- Make sure the family and their crisis team have a copy of the crisis plan for future reference

Develop an initial plan of care.

- Determine ground rules. Distribute the agenda.
- Discuss and document strengths of all team members and the family's community.
- Brainstorm and select strategies to meet prioritized needs.
- Review and finalize the initial crisis/safety plan for the family and youth *(see Appendix D).*
- Assign roles and responsibilities to all team members.
- Schedule the next two to three team meetings.
- Document the initial objectives, outcomes, and actions steps, for the whole plan of care *(see Appendix E).*

Distribute the initial plan of care to **all team members as soon as possible**. By doing so, all team members are left with a sense of urgency to progress. It also helps everyone to stay on task.

PHASE 3: Implementation or **Doing**
Plan Implementation & Refinement

Phase three involves continuous review of team progress and success. Team meetings are held on a regular basis; at least monthly is recommended and moving towards purposeful transition means morphing meetings towards something a family will continue after wraparound. Changes are made to each piece of the plan of care as needed.

Goals and Tasks of Phase 3:

- The initial plan is implemented.
- Progress is tracked by the FCC and reviewed and discussed in team meetings.
- Success is evaluated and celebrated.
- Continue to use Transition Readiness Tool to track progress, CANS to inform POC and explain the fidelity monitoring tool (WFi-EZ) to family and complete
- New goals, objectives and strategies are determined when necessary.

- The team builds cohesiveness; communication and trust *(see Appendix F).*
- The facilitator maintains awareness, as well as addresses issues of team member buy-in and family satisfaction.
- Updates are documented and any team meeting logistics are addressed ***(cont. Appendix D & E).***

PHASE 4: Transition or **Moving On**

Plan Completion & Transition

In phase four the family defines "good enough" towards having their needs met. At this point the family is "unwrapped" (to a degree) as plans are made for a purposeful transition out of formal Wraparound and into a mix of formal and natural supports that are determined by the family to keep them going towards their vision.

Goals and Tasks of Phase 4:

- Plans are made for a transition out of formal Wraparound services to a mix of informal/natural and formal supports in the community.
- The process and plan is modified to reflect transition planning *(see Appendix D & E).*
- The team celebrate successes and the team's work is documented.
- A transition portfolio is compiled which contains important contacts, past records and a follow-up plan for the family.

Appendix A

A Strengths, Needs, and Culture Discovery

A strengths, needs, and culture discovery is conducted while getting to know each family member, team member and the family's community. Strengths and culture are used when brainstorming objectives and strategies to meet the needs of the family.

Strengths and needs discussions are also ongoing, as they change over time and more can be added as the process continues. This also allows a family to re-write their own story as needs and circumstances change. Continuing to discover new skills, strengths and needs gives families and teams a way to continue to move forward and not get stuck.

Key Elements of a Strengths Needs and Culture Discovery:

- Attitudes and values.
- Skills and abilities.
- Attributes and history.
- Preferences.
- Needs at the time.
- Ways their family functions, how they celebrate, who they think they are and what traditions, values, ideas, lifestyles, and other things are most important to them.

This is the Family's Story and discusses:

- A strength's and culture of the whole family
- A family vision.
- Needs statements
- Discussion of strengths, needs and culture in at least four different life domains

The Family Story

The family story is obtained by sitting down with the family in a setting that's comfortable to them; allowing the family to tell you what brought them to this point in life. It is best done by having conversations in which the facilitator prepares themselves to be open and active listeners while just letting the family talk. This conversation should be an on-going activity throughout the wraparound process.

"'Seek first to understand' involves a very deep shift in paradigm. We typically seek first to be understood. Most people do not listen with the intent to understand; they listen with the intent to reply. They are either speaking or preparing to speak." - Stephen Covey

When the facilitator asks questions, it should be done in a gentle and inquisitive way, finding out such things as what has and hasn't worked in the past and what the family would like to see for

their future. The facilitator should strive to learn the family's culture by finding out their values, likes, dislikes and ways of doing things. When done well, the facilitator often has a very good start to identifying the family's strengths and needs, as well as who could potentially be team members for this family.

Appendix B

A Family Vision

Asking the youth and family about their family vision may involve having them imagine what they'd like to see for their family in the next six months to a year. Or by asking the question, "If life was better for your family what would it look like?" Often the vision may come out as a needs statement or a list of concerns. In this case, it is important to ask the questions, "If those needs were met or your family's concerns were addressed, what would life look like?" What would the family have achieved? What would you like to change to achieve this vision? The FCC or FSP encourages the family to look at what a normal life might look like for them, which assists in keeping the plan focused on what is really getting in the way of the family achieving their goals and not what the professionals on the team may think they should achieve or work on.

A Family Vision should be…

- Concise
- In the family's own words
- Strength based
- What they want to move towards

You may also find times when teens do not agree with their parent or guardian's vision for the future. This is where you will need to assist the family in negotiating what the vision will be.

Appendix C

Needs Statements

Always keep in mind: What does the family need or want to achieve to reach their vision? and "Bad behavior comes from unmet needs." (Pat Miles)

Needs statements are…

Individualized: Each member of the team will have different ideas of what the family and/or youth needs. It is important that each need statement clearly identifies who has the need.

Not a service: Avoid labeling services as needs. They are part of a strategy that can be used to meet a need of the family or youth. Saying a child "needs counseling" is identifying a service while the need might be a desire to learn better parenting skills.

Not a diagnosis, label or deficit: Needs represent the underlying causes for behaviors or defines what is getting in the way of a person being successful. Labels and diagnosis may describe a list of conditions that may or may not be applicable to an individual, but they do not tell us what is impacting a person's ability to reach their vision.

Enduring: Good need statements require a decent amount of work; they are not needs that can be met by the first or second Child & Family Team Meeting.

Clear & Respectful: Every team member should be able to understand all needs statements. Families should feel respected in the process by team members who are listening and sensitive to addressing their needs.

The family's top two to three needs should be prioritized. Like all of us, trying to work on too much at once is overwhelming and a set up for failure.

Needs Become Goals

Needs statements are then reworded into goals. If this need is taken care of, what would their life look like?

Appendix D

Crisis Planning

Crisis: An unstable or crucial time or state of affairs whose outcome can change everything. (Possibly de-rail the wraparound process)

Safety Plan: A method of achieving security from threat of danger, harm or loss (possibly preventing a crisis).

Band Aide Plans - Meeting Immediate Crisis Needs

When meeting with the family for the first time or during visits prior to the first team meeting, there may be times where there is a need for immediate stabilization of a situation. The following is a brief synopsis of how the four phases of the Wraparound process would be implemented.

Engagement: Engage and actively listen; listen with an ear for functional strengths and supports.

Planning: Describe clear, specific steps to meet immediate needs (stabilize the situation); utilize functional strengths of family members and support system.

Implementation: Assign tasks. Be prepared to become involved as needed. Do something!

Transition: Turn the plan over as quickly as possible; is there enough support in place, preferably friends and family, to avoid crises in the future?

Two key areas should be considered in band aide planning: safety and relief.

Safety supersedes any other immediate needs. *Safety issues* may include the need for shelter or issues with the current physical environment such as access to weapons or sharp objects.

Needs for relief may appear less critical than safety needs but are equally important in preparing the family to engage in a process towards a better life. Relief may include making sure families have access to the necessary communication devices, adequate heat or electricity or getting a small break from each other to maintain a safe household.

Band Aide plans call for an immediate response, are action oriented and are limited in duration. They are put in place until the first `child and family team meeting occurs. When the child and family team convenes, the plan should be reviewed to assure the immediate needs have been met and to assist with the more comprehensive crisis/safety planning.

Band Aide Planning Checklist:

- Has the family been heard in identifying their immediate needs?
- Does the plan clearly focus on the needs for safety and relief?
- Has the plan taken into account existing skills, strengths and support?
- Is the plan specific and action oriented?
- Have the physical environment and all practical needs been accounted for?
- Has a clear time frame been established as to when a more comprehensive plan will be put in place?

Crisis Plans

Crisis Plans:

- Tells people responding to the crisis how to react immediately and responsively to the events.
- Are practical and realistic.
- Build on strengths of the team and community. Include as many natural and informal supports as possible.
- Are defined by the family.

- Lists relevant medical information.
- Identify and describe triggers or risk factors that may lead up to or cause the crisis.
- Describes what helps the caregiver cope during times of crisis.
- List family and community supports that could be utilized including names, addresses and phone numbers.
- Identify what resources (places or things) could be used or put in place.
- Lists specific strategies in order of suggested use to resolve crisis.
- Consider what different people need to take care of themselves after the crisis is resolved.

Prevention:

- Aim is to prevent crisis.
- Focus on *what to do* instead of what not to do.
- Work towards uncovering underlying needs; reasons why a crises may occur.
- Utilize strengths and skills to help a family stay at a "normal" spot.
- Contain needs based on what the family and team identify.

Early Intervention

- Aim is to prevent crisis by de-escalating the situation
- Focus on *what to do* instead of what not to do.
- Work towards uncovering underlying needs; reasons why an escalation is occurring.
- Utilize strengths and skills to help with de-escalation.
- Meet the needs

Intervention

- Aim is to keep everyone safe and de-escalate the situation
- Focus on *what to do* instead of what not to do
- Utilize functional strengths and skills to meet safety needs.

Follow Through

- Give everyone space to breathe
- Make sure the situation doesn't escalate again
- Focus on *what to do* instead of what not to do
- Utilize strengths and skills to meet safety needs.

Things to Remember in Crisis Planning

- Safety plans change over time and address all settings.
- Strategies should address risk factors, as well as the family definition of a crisis.
- Strategies should be written in order of suggested use.
- Keep in mind least intrusive and least restrictive to most in listing the strategies. Be as specific as possible.
- Have all team members sign off on plan indicating their approval and commitment to the plan.

Appendix E

Plan of Care Components

Developing an Individualized Plan

- Getting to know the family and hearing their story.
- Identifying the family vision.
- Identifies needs.
- Family and team prioritize needs.
- Action planning.
- Commitments.
- Assessments – CANS, Children's Dashboard, WFi-EZ
- Documentation (update, discovery and plans).
- Crisis/safety planning that utilizes steps 1-9.

A Wraparound Plan of Care Includes:

- Plan of Care (POC)
- Objectives and strategies to meet needs-goals
- Measurable objectives and strategies
- Who is responsible for what and when

Life Domain Areas for Care Planning:

- Mental/emotional health, medical
- Safety
- Education/work
- Family
- Living
- Culture/spiritual
- Legal/restoration
- Social/recreational
- Other

Domains are used to look at what areas of a person's or family's life and celebrate their strengths and the unique components that make up each family. It helps you understand their family culture and how they go about doing things. It promotes a holistic view of life in the planning process rather than just focusing on the narrow scope of mental and behavioral health.

Objectives to Meet Needs-Goals

- Build on strengths.
- Are designed to meet underlying needs.
- Utilize as many natural/informal supports as possible.
- Engages the whole team and defines team member's roles and responsibilities.
- Are specific: who, what, when, how.
- Are modified in response to changes or progress.
- Reflect why a service is being used.
- Take into consideration normalization.

Objectives are formed by the team by brainstorming all the possible ways a need-goal can be met. Then the family decides which ideas will help them get there. The FCC and team will assist by breaking down the objectives into strategies that outline who will do what and when. The team will set benchmarks as to how they will know the objectives are getting them closer to meeting the family's needs. The FCC will end the meeting by checking on how it went, summarizing what has been accomplished, answering any final questions and scheduling the next two to three team meetings to check on progress and refine the plan as needed.

Appendix F

Team Meetings

Running Meetings

This skill set will be explored more fully with your coach in on-going training.
The basics include:

- Make sure you have fully prepared each team member for what to expect at the team meeting.
- With the family, prepare an agenda ahead of time and send it to the team.
- At the first meeting set ground rules with the team. Ground rules may contain things like reminders for letting each person speak without interruption, respecting differences of opinion and agreeing to work through conflict.
- Be prepared ahead of time to run the meeting, keeping in mind materials needed as well as making it comfortable.
- Have a way to record the meeting to keep all members focused. You might use the big post-it pads or a white board. You may want to ask a family or team member to do the writing while you are facilitating.

- Stick to the time frame out of respect for all team members' schedules. A member of the team can act as a time keeper, if need be.
- With the family, decide who will do introductions and how. Introductions should contain not only names but also the person's strengths and their role.
- Share what you have learned about the family including strengths, a review of the family vision and potential needs. The family may choose to do this themselves so be sure to ask ahead of time.
- Have the team add to the family's list of strengths; revise the vision as needed and review; review the needs-goals and let team members comment on them, then the family decides if they want to revise, then prioritize the needs.
- Create an open atmosphere where team members are encouraged to brainstorm multiple solutions to meet needs.
- Remind the team to keep their discussion regarding the family at the team meetings and not outside. Remember "nothing about them without them" (Naomi Tannen).
- End the meeting by checking how it went and thanking the team, as well as a brief summary of accomplishments; letting the team know when to expect a copy of the Plan of Care.
- Establish the place and time for the next meeting and ask the team to schedule the next two to three meetings to assist the them in getting on a regular schedule.

Steps for Managing Ongoing Plan of Care Meetings

Step One: Reviewing Accomplishments

The FCC and FSP keep the strength based perspective and start the meeting on a positive note by reviewing the accomplishments since the last team meeting. This is done by checking with the family first and then the team members – there shouldn't be any surprises as the FSP and FCC have been in contact with team members in between meetings. Use applause or other methods of celebrating success to keep the team energized and enthusiastic. The accomplishments should be recorded visually for all team members to see.

Step Two: Evaluate Progress

When evaluating progress the facilitator and team should look at three aspects:

- Follow through.
- Impact.
- Forward movement.

In checking for follow through the FCC holds all team members accountable for their assigned tasks.

When looking for impact, look to see if the objectives and strategies actually helped. Are the identified needs-goals closer to being met? Have the identified benchmarks been reached? Ask the family if what was done actually helped, not just whether or not a service was provided to them. When checking for forward movement, look to see if the intervention assisted the family in moving closer to their vision of a better future, as well as has it helped the family to improve their support network?

Step Three: Adjust the Plan

The plan may need to be adjusted due to needs-goals being met or new needs arising or to stop things that are not working. When adjusting the plan don't forget to refer to the strengths list for ideas for new and effective strategies. The team should review all objectives and make a determination of whether to keep, drop or change each one.

Step Four: Make New Commitments

When reviewing tasks, the FCC should acknowledge and reinforce the spirit of volunteerism. Team members should be encouraged to make new commitments and perhaps change roles. For example, there will be times when a formal member such as a school teacher becomes a coach of a summer sport and agrees to become an informal team member for a family to mentor a young person in that sport. The facilitator should recognize each team member's strengths and interests to assist them in making new commitments to the family and team. Once the revised plan with new commitments is developed, a time line should be established for the tasks and the newly documented plan should be distributed.

Step Five: Update Progress Regularly

Document activities in progress notes and on the Plan of Care that reflect with increasing involvement, how the family is taking over their own process. Each time they do something themselves, rather than the FCC, FSP or other team member doing for them, document it. Keep track along the way whether you are doing for, doing with, or cheering on the family. Document exactly how this is being done. What actions are taking place regularly? What positive changes have come about since wraparound began? How is the family working toward their vision and staying involved with the team process?

Step Six: Evaluate for Transition

One of the main goals for wraparound, is to have the family involved and driving their team, helping them move towards purposeful transition. The sooner families can take over the process and can maintain relationships with their team members, actively develop plans, implement and evaluate those plans, the better. We want to be supportive and helpful in empowering families to get their needs met.

- What skills have been learned?

- How are their strengths being used to help build confidence?
- What new ways can the family do for themselves?
- Are they ready to do more?

Using the Transition Readiness Tool will help answer these questions regularly and can help the team and the family understand that you are always working towards transition out of formal wraparound. Knowing and practicing well ahead of time, builds confidence and offers reassurance that support will still be available, even after the formal process is over.

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