

# SPIRIT PROGRAM MANUAL

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## *A Handbook for Child and Family Team Members*

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This material is primarily adapted from *The Collaborative Toolkit: A Handbook for Child and Family Team Facilitators*, by Patricia Miles, Miles Consulting, Inc., Portland, OR, 503-618-1088. Supplemental resource materials are from *The Wraparound Process User's Guide: A Handbook for Families*, National Wraparound Institute and *Family Guide to Wraparound*, The Nashville Connection.

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**Wraparound** is a facilitated team based practice model designed to integrate natural and professional supports, with the family in the driver's seat.

High Fidelity Wraparound can produce significantly better outcomes for children and families with significant needs than traditional approaches:

- Increased permanency and stability for children
- Decreased restrictiveness of residential environments
- Improved behavior and mental health symptoms
- Improved school and early care outcomes
- Decreased family and child safety issues and risk factors
- Increased family and child protective factors
- Increased family engagement and satisfaction with services
- Increased family resources to support their own children

A wraparound team is formed to help define and refine family strengths, culture, vision and needs; prioritize needs and create the plan; and then carry out the plan one prioritized need at a time until the formal team is no longer needed because the vision of the family has been achieved.

*First Report of the Surgeon General of the United States on Children's Mental Health, 1999*

## Introduction

Children and families seek help or are referred for help through multiple systems in our community, such as child welfare, mental health, special education, public health and juvenile justice. The Mental Health Services Act (MHSA)-funded SPIRIT program deploys Child and Family Teams to identify and integrate thoughtful, responsive and creative interventions.

This handbook is designed to guide team members through the various steps required to organize and deliver comprehensive action plans that meet the needs of the children and families while complying with applicable federal and state mandates.

The approach presented here is built on a number of basic assumptions:

- ✓ Interventions based on child and family *strengths* are far more likely to produce sustainable results than approaches determined by deficits.
- ✓ A clear consensus about *needs* should be reached with those being served to ensure the effectiveness of services provided.
- ✓ Creative and responsive interventions are more likely to be developed through a group of people working together in a *team* setting.
- ✓ *Family-centered approaches* are the most potent. The family should be joined as partners in care, recognizing the importance of the parents' authority in decision-making. Families *should not* be viewed as needing to be "fixed" through professional intervention.
- ✓ People should not be blamed or judged if interventions don't work. Instead, the team should reevaluate the intervention, understanding of the need and strengths. Interventions should be adapted to meet the needs of the individual rather than attempting to make the recipient fit the intervention.
- ✓ Initial interactions with the child, family and their unique team should guide the creation of a *future-oriented plan*. This plan should identify the direction or anticipated outcome of interventions, as well as what activities will occur. Over time, the plan should change based on regular reviews that are done collaboratively with other team members.

These assumptions are shared by many individuals working in the helping professions. It is hard to argue with a standard of care that entails building on people's strengths, meeting needs and coordinating efforts. Yet these practices often do not occur, and when they do, they often seem the result of accident rather than planning.

A step-by-step method is offered here to increase the likelihood that effective strategies are put into practice. Typically implemented by a team and plan facilitator, these steps are drawn from best practices research and adapted to the specific circumstances of a particular community.

This manual focuses on four phases that will produce concrete written products to be used by SPIRIT teams to help children and families achieve their goals:

- 1. TEAM PREPARATION:** Initial conversations with the family as well as with other stakeholders are completed. Team members listen for individual perspectives on strengths and needs and identify potential team members. The Facilitator notes strengths and crafts needs statements. In addition to completing initial interviews, the Facilitator is also responsible for explaining the process and soliciting buy-ins from various team members.



**Products Developed:** a family strengths summary and an inventory of the strengths of the individual family members and their key formal and informal supports.

- 2. PLAN DEVELOPMENT:** This phase should be completed at the conclusion of two SPIRIT team meetings. The Facilitator presents summaries of strengths and needs discovered during Phase 1. The Facilitator also asks team members to create a sense of future (a team mission or vision statement), add to the needs list and prioritize needs that must be addressed to accomplish the mission.

Interventions are crafted to meet the chosen needs by building on identified strengths. This Plan of Care should be developed within two meetings, documented by the Facilitator and distributed to all team members.



**Products Developed:** the initial Plan of Care, the team's mission or vision statement, and a list of the roles and goals of the team members.

- 3. PLAN IMPLEMENTATION AND ADJUSTMENT:** This phase is concluded only when the family and all team members agree that needs have been met and that the mission has been accomplished. The goal of the team is to meet needs and accomplish the mission statement to an extent sufficient to ensure the well-being of the children involved and to allow a family to live a life that's *good enough*.

This means that the Facilitator must lead the team in defining areas that meet these standards while prohibiting team members from setting standards that are excessively high. For example, in working with a youth, it might be reasonable to expect that he/she

completes homework most of the time, but not necessarily 100% of the time.

As the SPIRIT team meets together over time to evaluate progress, initial actions will be modified or discarded.



**Products Developed:** documentation of actions taken, progress made, plan modifications, and changes in the needs and situation of the child and family. Depending on the nature and scope of the particular type of team, this documentation may occur through team meeting minutes or through a more formal series of action plans that follow from the initial Plan of Care.

- 4. PREPARING FOR TRANSITION:** The team learns to recognize when it has achieved the right mix of interventions to meet needs and to begin assisting the family to phases out of formal team support. Remember that all interventions do not necessarily cease nor do all sources of services and support necessarily become disengaged.

When developing a transition plan, it is important to help the child and family identify what has worked, develop a process for calling the team together in the event of unforeseen circumstances and ensure that the child and family don't feel abandoned. Crisis contingencies should be anticipated and planned for.

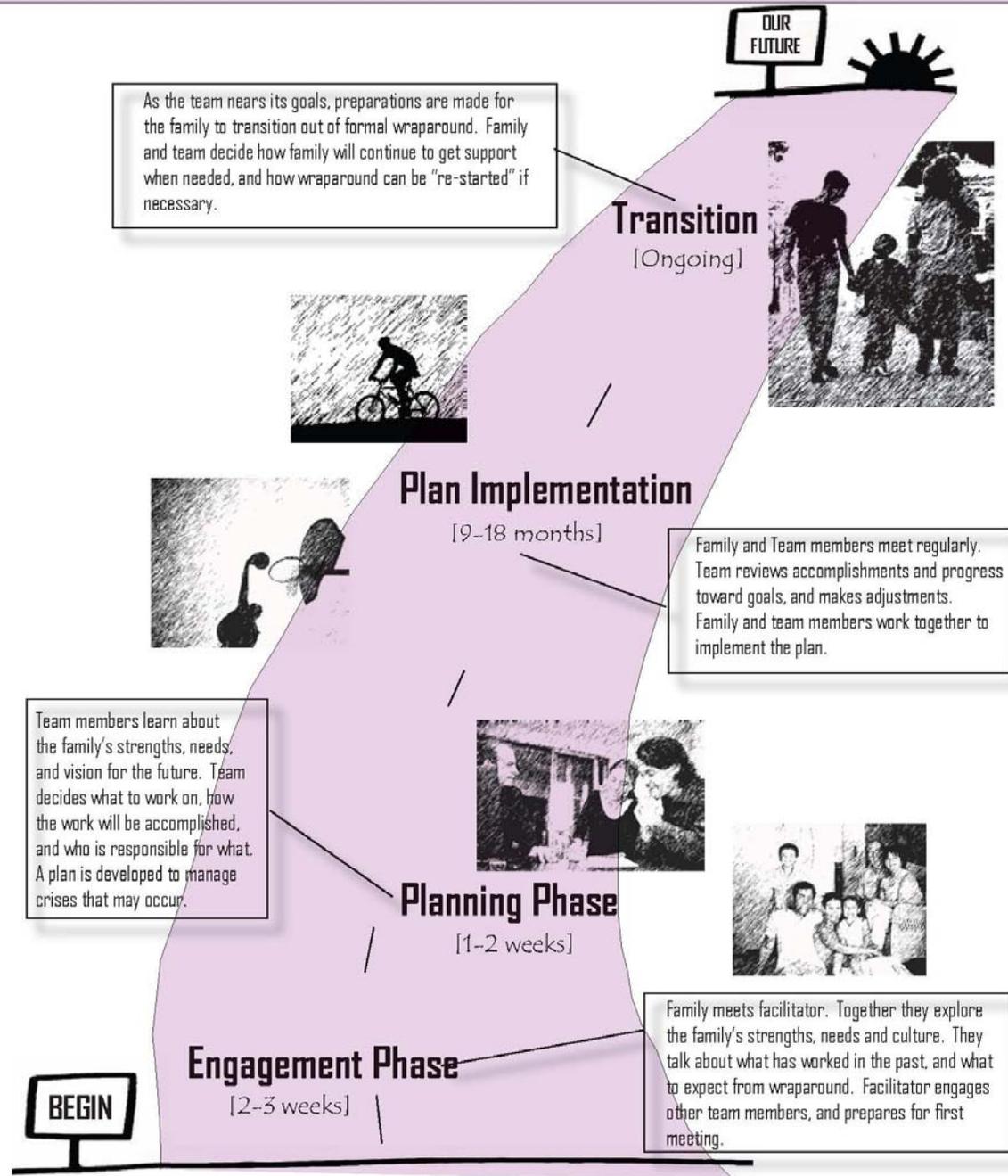


**Products Developed:** A clear protocol for accessing help should be written and distributed to all team members.

Key activities, skills, strategies and products associated with each of the four phases are presented in the pages that follow. As you read this manual, please keep in mind that it is intended to build upon, not to replace, the insights and skills that you, as a member of the SPIRIT Team, bring in serving youth and their families. This overview is intended to help all Team members become more comfortable and confident in their roles.



# The Wraparound Road Map: An Overview



(From: The Wraparound Process User's Guide: A Handbook for Families, National Wraparound Initiative, [http://www.rtc.pdx.edu/PDF/pbWraparound\\_Family\\_Guide.pdf](http://www.rtc.pdx.edu/PDF/pbWraparound_Family_Guide.pdf))

## I. Preparing the Team

### ACTIVITIES:

- ✓ Interviewing the family to hear its story and perspective on strengths and needs
- ✓ Interviewing potential team members, including other system partners, to gather their perspectives on the family's strengths and needs
- ✓ Explaining the SPIRIT Team process to potential team members
- ✓ Identifying when, where and how the first team meeting should occur
- ✓ Soliciting participation from all team members and inviting individuals to the first team meeting

**INTERVIEWING THE FAMILY:** When starting a Child and Family Team process with a new group, the Facilitator should begin with the consumer and his or her perspective. In the case of a child, it is important to first talk with the parent and obtain permission to interview the child. This reinforces the parent as an authority figure responsible for planning around the child's best interests. The goal of this initial interview is to ensure that the Facilitator understands the consumer's point of view and to identify strengths, needs and possible team members.

**TEAM TIPS:** The Facilitator should *not* take sides, "fix" situations for families or adopt a particular point of view. Instead, the Facilitator should gather information needed to strategically and quickly facilitate a quality planning process. Attempting to provide solutions this early in the process will undermine the concept of a team working together. Also, avoid returning too many times to hear the family's story. The Facilitator should limit the initial conversation to no more than two meetings.



**Products** completed during this phase include:

- A strengths summary that describes the family's story positively and highlights their good news
- A strengths inventory that lists positive skills, attributes and features of the family
- A list of potential team members, including those who will attend meetings and those who will not
- An initial needs list that captures the needs expressed by the family either verbally or behaviorally

**DOCUMENTING FAMILY STRENGTHS:** The Child and Family Team process incorporates the voice of the family into decision-making. After completing the initial interview, the Facilitator should take the time to describe the family using a narrative approach emphasizing “life domains.” These domains include fun, family, a place to live, legal, health, school, work, safety, emotions/feelings, cultural and spiritual. Other domains that are sometimes included might include finances or relationships, especially with adults.

This summary of strengths may be as short as two pages or as long as is necessary. It should be provided to the family for review prior to the first team meeting. In addition to the narrative summary, the Facilitator should also complete a strength inventory that captures brief descriptions of family member strengths. These lists should be typed and also written on poster paper for presentation at the first meeting. All team members should receive copies of the two documents at the first meeting. The Facilitator should also draft initial needs statements, ordered by life domains.

### **Creating a Needs Statement**

Here are some suggestions for compiling effective family needs statements:

- *Make it personal:* A good needs statement clearly identifies who has the needs. Avoid saying things like the “family needs fun” because each family member might have a different view of that need. The child’s need might be “to create some good memories of family time.” The parent’s need might be “to learn how to enjoy the child so they don’t have to be so tense.” Each of these has a different approach and later the team will decide which need to work on when.
- *Do not confuse needs and services:* If there’s only way to meet the need, it’s probably a service. For example, avoid saying the “child needs counseling” or the “parent needs a car.”
- *Remember that needs are not goals:* A hope, dream or destination is probably a goal rather than a need. Avoid saying that the child “needs to go to school every day,” even though that may be a goal. SPIRIT team members should determine what gets in the way of a young person attending school. The impediments will define the needs. For example, a child may need help getting to bed at night or to feel confident that he or she will be accepted at school or able to compete academically.
- *Be patient:* Quality needs statements take a while to complete; they will not be accomplished between the first and second meeting. Taking the time to craft an accurate needs statement communicates to families that the team is willing to address their most important priorities.
- *Be clear and respectful:* The needs statements should be clear understood by all team members. Facilitators should avoid jargon. Therapeutic content and language typically used by mental health professionals should either not be used or kept to a minimum. Also, articulate needs in a manner that respects the privacy of family members. For example, a needs statement might include the observation that “the grandmother needs to feel respected

as the head of her household.” The *therapeutic* perspective of this need might have to do with issues related to past difficulties with her mother. While that perspective will be considered in resolving the need, it *won't* be included in the actual needs statement.

Needs statements will be shared with the entire team, and team members will be asked to add to the list, ensuring the broadest possible feedback.

**TEAM TIPS:** Despite the emphasis on the family voice, the role of the Facilitator is *not* simply to follow the family. Instead, the Facilitator is responsible for ensuring that the family’s voice is incorporated in the process through the completion of all relevant products. This may require a certain amount of “salesmanship” on the part of the Facilitator to help the family move forward in the team process. Common errors in the preparation of documents include:



*Strengths*

- Creating strengths lists that don’t sound genuine
- Focusing first on the list rather than the story
- Failing to include all family and team members in the listing of strengths

*Needs*

- Listing goals and services as needs
- Presenting too few needs statements at the initial planning meeting

Details to be completed during this phase include:

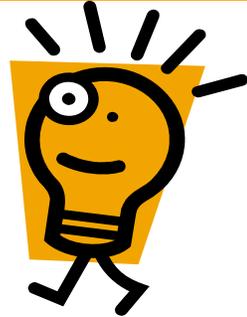
- Signed releases that allow the Facilitator to invite team members to the initial meeting
- A roster of names, phone numbers and addresses of team members
- Arrangement of any adaptive requirements for the first team meeting that might include translators, child care or any other types of assistance

**RECORD-KEEPING AND PRIVACY:** During the initial conversation with the family, the Facilitator should ensure that they have adequate record-keeping and attend to privacy details. A release that allows the Facilitator to contact team members for the purpose of convening the team should be signed by the appropriate persons. This release may be relatively narrow, allow the Facilitator to talk about the fact that a Child and Family Team process is starting for the family, and ask the team member participate.

Additionally, a roster of names, addresses and phone numbers should be developed for distribution at the first team meeting so that team members may easily contact one another. Finally, the Facilitator should resolve all issues that might contribute to the success of the

meeting. These might include arranging for translators, find an accessible meeting location, providing snacks and other considerations.

**TEAM TIPS:** Failure to have the release signed during the initial conversation with the family may result in the family being reluctant to invite other team members to the initial meeting. Obtain signatures for the releases promptly without disrupting family member input. The Facilitator's paperwork is never more important than the family, but it is necessary to complete it quickly and efficiently. However, don't make paperwork the dominant purpose of the meeting. Also, remember that if seemingly small details are neglected, a severe drop-off in team attendance may occur after the first meeting. If that happens, the Facilitator will be on his or her own trying to meet family needs, while the family feels abandoned by the team process.



## II. Developing the Plan

### ACTIVITIES:

- ✓ Holding one or two planning meetings of the entire team
- ✓ Presenting and reviewing the strengths list, including additions made by team members
- ✓ Facilitating the creation of a team-based mission statement
- ✓ Explaining the concept of needs in the SPIRIT Team process
- ✓ Presenting needs statements generated by the Facilitator as a result of initial meetings
- ✓ Having team members add their perspective on needs
- ✓ Facilitating a choice process that allows the team to select priority needs
- ✓ Brainstorming solutions, interventions and activities to meet chosen needs
- ✓ Soliciting volunteers or making assignments for follow through

**INITIAL PLANNING MEETING:** The list above details the format for the initial planning meeting. It should happen as close to this order as possible, with the beginning of the meeting always focusing on the strengths list. This allows the team to consider the good news about the family and the situation.

The creation of a Mission Statement may be a challenge as the team hasn't really begun to work together yet. However, a Mission Statement should be completed and agreed on prior to choosing needs. The Facilitator should consider a broad range of needs statements and encourage the team to do so as well. The team should choose the most important needs that will accomplish the mission using whatever process feels comfortable and ensures the family a significant voice in the selection.

Brainstorming solutions should focus on a creative process by which the team considers a range of options to a stated need, preferably at least ten potential ideas. The chosen options should be those that build on strengths and meet needs. Making assignments and soliciting volunteers allows the work to be shared by a variety of team members.

***TEAM TIPS:*** During the team meeting, the Facilitator is responsible for moving through these steps fast enough to get to actions while staying with each one long enough for it to have meaning. Some things to avoid in each of these areas include:



#### *Strengths*

- Do not spend too much time on strengths. People understandably enjoy a positive approach, but you need to move to planning.
- Avoid simply reading your prepared list. Find a way to include a meaningful story that puts some of the strengths into context
- Strengths documents should not be authored exclusively by the Facilitator. Ask other team members to contribute.

#### *Mission Statement*

- Do not let the mission be “owned” by any one team member. Start with the family, but always leave room for team members to contribute.
- Often the Facilitator will generate Mission Statements that are too long to be remembered and therefore ineffective. Create a concise Mission Statement that team members will remember.

#### *Needs Statements*

- Avoid listing services or goals as needs.
- Create room to identify as many needs as possible and sort them by life domain.

#### *Selecting Needs*

- Needs should not be selected based on any team member’s “wish list.” Instead, answer the question “What will get us closer to the mission we’ve agreed?”
- Avoid spending too much time compiling a list of needs. It is important to find an effective means of selection and then moving ahead to planning.

#### *Developing Interventions*

- Don’t stop after the first suggestion. Intervention development involves a creative process in which the team develops a range of options and then narrows it down. The Facilitator should create a team norm that encourages members to consider at least 10 options for each stated need.



**Products** completed in this phase include:

- An initial Plan of Care that details the Mission Statement, selected needs, and responses to those needs, including who will respond, when and for how long, as well as a matching of strengths to interventions.
- A written Crisis Response Plan that defines each anticipated crisis, a response to the crisis and a notification plan for all team members.

**CREATING THE PLAN:** The next phase of the SPIRIT Team process is the creation of a plan that gains the consensus of the team members. The Plan of Care is a challenge to create for several reasons. The first challenge is devising a user-friendly format; the document should be easily understood and useful to all team members. The second challenge is the dynamic nature of Child and Family Team Plan implementation. Unavoidably, the Plan of Care reflects a static point in time; the document doesn't capture the constant change and adaptation inherent to the SPIRIT Team planning process.

Nevertheless, the document is critical for capturing where the team thinks it's headed. It also serves as written framework for accountability to ensure that people who attend creative planning meetings will actually follow through on their good ideas and commitments.

In addition, the initial Plan of Care creates a basis for ongoing knowledge development by documenting the first chapter in the history of the family's involvement with the team. This saves work in the long term by not forcing the team to go over old ground.

A crisis plan should be developed and distributed to all team members. This crisis contingency plan should identify potential crises and anticipated responses from all team members. It should include a communication plan detailing who is to call whom in what sequence during a crisis.

**TEAM TIPS:** The initial Plan of Care must be completed, documented and distributed early enough in the SPIRIT Team Planning Process to ensure that team members have a collective sense momentum. Delays may result in circumstances that are long on process but short on product. Some Facilitators struggle with documenting the plan. Without a plan, the team, family and the Facilitator will tend to lose themselves in the process and never gain a sense of accomplishment.



**Details** completed in this phase include:

- Setting a schedule for ongoing meetings
- Ensuring that Plans of Care are distributed in a timely fashion to all team members

**SCHEDULING MEETINGS:** The Facilitator should identify whether completion of the initial Plan of Care will require one meeting or two. No meeting should last longer than 90 minutes. If the Facilitator determines that more than one meeting is required, they should be scheduled within one week of each other. This will help ensure that people who are present for the initial review of strengths are also able to attend the meeting that develops interventions.

Before the initial planning meeting is completed, the Facilitator should develop a schedule of ongoing meetings cooperatively with the Team. The Facilitator should distribute the Plan of Care to Team members within three days of the team meeting. Team members could be asked to provide self-addressed envelopes.

**TEAM TIPS:** Some Facilitators wait until the next team meeting to distribute the Plan of Care developed at the last team meeting. This may cause problems because in the interim, team members may have forgotten what they committed to. Also, a delay in distributing the Plan tends to reinforce the notion that all work in SPIRIT Teams occurs in the meeting, obscuring the fact that meaningful interventions and supports take place between meetings.



### III. Implementing and Adjusting the Plan

**Activities** in this phase include:

- ✓ Holding regularly scheduled team meetings to chart accomplishments, assess plans, adjust interventions and assign new responsibilities
- ✓ Providing interventions, services and supports as delineated in the plan

**ASSESSING THE PLAN:** When the initial Plan of Care is completed, the Team will have made its first, best guess at what will help achieve the goal. It is important to remember that it is only a guess; the initial Plan of Care must be regularly reviewed and modified based on information gathered from implementing the interventions.

Facilitators should start ongoing team meetings by reviewing and celebrating *accomplishments* that have occurred since the last Team meeting. In a brainstorming process, the Facilitator asks Team members to identify and present good news and positive developments since the last meeting.

Next, the team should *assess* the current plan by reviewing the component interventions, actions and strategies that were agreed to in the first meeting. The assessment focuses on two questions.

- *Follow-up*: Did each Team member actually do what was committed to at the first meeting
- *Impact*: Did the accomplished task actually help?

Deciding whether an action was helpful requires the Facilitator asking the person with action addressed the need. For example, suppose the need statement was that “the mother needs to be reassured that her daughter is safe when she was out.” An intervention might entail the therapist working with the mother to help develop strategies for managing her anxiety about her daughter’s safety and ability to make choices that keep her safe. When asked about the anxiety management plan, the mother may reply that she enjoyed the session but that she doesn’t feel more reassured about her daughter’s safety.

### **Adjusting the Plan**

This response prompts the team to *adjust* the plan. This adjustment may involve stopping an intervention, modifying an intervention by time and/or location or adding another component or continuing an intervention longer than originally planned. In the example of anxiety management, the team may decide to continue with the therapist and mother trying anxiety management techniques, but add a call from someone else to let the mother know that her daughter is doing okay. This leads the team to *assigning* responsibility for the added component. In the example of anxiety management, the team may want the daughter to call her mother regularly to reassure her that she’s okay, but the daughter may not be willing or able to do this. In a well-balanced team that is inclusive of both formal and informal supports, the daughter’s friend may volunteer for this task.

**TEAM TIPS:** If the Facilitator doesn’t begin the team meeting with accomplishments, the process may sink into negativity. Another common problem involves targeting only consumers for assignments and responsibilities. A well-balanced SPIRIT Team will share responsibilities across all team members. Finally, when adjusting interventions, avoid the dual temptations of either making no adjustments and continue doing something that isn’t working, or to stop an activity altogether rather than modifying it to make it more effective.





**Products** developed in this phase include:

- Ongoing meeting minutes that describe changes to the Plan of Care
- Quarterly reports that detail progress made in meeting needs
- Ongoing record of team member participation including who has attended team meetings and who has not

**TAKING MINUTES:** Meeting minutes are critically important for developing a collective team memory. They should be recorded at every meeting and distributed via mail or e-mail shortly after the meeting. Some Facilitators use a form that captures people’s commitments, while others take the minutes themselves. In some cases, Facilitators will ask the team to assume responsibility for minute-taking so that they are free to facilitate. At least once a quarter, the team should “take stock” to determine whether adequate progress is being made. This is usually accomplished by rating members’ perception of progress toward meeting needs. Finally, an attendance list of participating team members should be recorded.

**TEAM TIPS:** Minutes should not communicate every little detail of the conversation that occurs at the team meeting, but should document the main focus and direction of the meetings. It is important to keep the team from blaming the consumer or family for lack of progress during the quarterly review process. If the team decides that there hasn’t been adequate progress, it means it has more work to do with understanding the unmet need or creating effective responses.



**Details** completed in this phase include:

- Method for communicating schedule of team meetings
- Mechanism for orienting new team members

**SCHEDULING MEETINGS:** The Facilitator should compile a schedule of meetings and distribute it to Team members. Additionally, the Facilitator should make sure that time limits are maintained and that team meetings end on time.

As the process unfolds, it is reasonable to expect that new team members will join. This might occur when the family identifies a friend or relative who might be helpful, the child makes new friends or the child moves ahead a grade. When that occurs, the Facilitator should develop a way to orient new team members to rules and assumptions of the SPIRIT Team process and brief them on what the team has already learned and accomplished.

**TEAM TIPS:** The Facilitator should avoid canceling meetings whenever possible as this suggests that meetings are not important. The Facilitator should limit the time that team meetings are devoted to orienting new team members to ensure that adequate time is available to analyze and adjust the Plan of Care.



## IV: Preparing for Transition

**Activities** in this phase include:

- ✓ Holding team meetings to check in about continued activity and anticipated transition plans from the Child and Family Team process
- ✓ Negotiating a schedule for reducing frequency of formal Child and Family Team meetings
- ✓ Rehearsing post-team crisis response
- ✓ Conducting transition celebration rituals to help team members feel a sense of closure with the process

**PLANNING THE TRANSITION:** After a lot of creativity, collaboration and hard work, the Team will craft mix of interventions, delivered in an effective manner. This is when the team is ready to move to Phase Four. During team meetings members check in with less formality than in the previous phase. This period may last for several months.

Eventually the Team should begin to consider how to move away from the formal process. It may meet every other month or quarterly. The Team should then begin to negotiate transition out of the SPIRIT Team process altogether, creating an opportunity for team members to voice their concerns about continued success in the absence of a formal structure. Brainstorming will identify opportunities to replace the Team structure with less formal responses. One team has continued to hold an annual lunch meeting just to check in long after its formal meetings ended.

**TEAM TIPS:** The Facilitator should avoid meeting too many times or rushing the transition. An excessive number of meetings may result in unrealistically high expectations. Rushing the transition may result in people feeling abandoned by the system and not having a mechanism to access help when needed. As a result, families may return to services with a sense of failure.

Finally, the Facilitator needs to ensure that the Team or family isn't operating under the belief that no future services or supports may be needed. Families may do well with the process but still require some ongoing basic support or intervention. For example, it's not reasonable to expect a child with a learning disability to need specialized classroom instruction even after



the SPIRIT Team process has been deployed successfully. If the opportunity for arranging ongoing maintenance supports after the end of the SPIRIT Team process is not communicated, the family may be reluctant to seek help when they need it, and service providers may view the family's recovery as a failure.



**Products** developed in this phase include:

- A written transition plan that describes how ongoing services will be accessed if necessary
- A written crisis plan that includes communication protocols for those who will be contacted in the event of an emergency
- Follow-up phone numbers for all team members
- A formal discharge plan that describes strengths of the family, the interventions that were successful and those that weren't

***COMPLETING THE TRANSITION:*** In this phase, transition is negotiated among all team members. The Facilitator raises the issue and has team members voice any concerns. The Team then brainstorms follow-up options that could allow the family to function outside of the Child and Family Team structure. Finally, the team identifies what type of follow-up support they can provide to the family.

The Facilitator then creates a one- or two-page transition plan and presents it for review at the next team meeting. Once the Team has revised the Transition Plan, the entire team negotiates timeframes for transition. Finally, the Facilitator suggests a final ritual that celebrates the Team accomplishments and work well done.

After completion of the celebratory event, the Facilitator creates a formal discharge letter of no more than two pages identifying family strengths, accomplishments of the Team and interventions that were helpful. All Team Members receive a copy of the final discharge summary. The Family receives both a paper copy and an electronic copy on a CD or by e-mail. This provides the family documentation of strengths, preferences and appropriate interventions in case they need to reenter the system in the future.

**TEAM TIPS:** The Facilitator must ensure that the transition plan is written and distributed to all Team members so that no one feels abandoned by the process. The discharge summary should be realistic, concise and user-friendly for individuals who may wish to consult it in the future. This document may be the best and most long-lasting advocacy tool that a Facilitator and Team may offer a family once they leave the formal SPIRIT Team process.



**Details** completed in this phase include:

- Communicating with other service providers especially crisis teams about the best responses for the individual family
- Creating a personalized commencement ritual that recognizes the team and family's accomplishments and creates a sense of celebration

**PLANNING THE FOLLOW-UP:** As the Team negotiates and agrees on transition activities, plans for follow-up care and response should be negotiated. The Facilitator leads the Team in identifying who will introduce the family and the Team's accomplishments to follow up providers. This might include drafting a letter of introduction that the family may keep in their records or meeting with other service providers to describe activities likely to be most helpful. Sometimes this is most efficiently accomplished in Team meetings; other times it occurs outside of a Team setting.

**TEAM TIPS:** The Facilitator must set realistic expectations for the transition. It is *not* realistic to expect the family to never need help after the conclusion of formal involvement with a SPIRIT Team. Also, when they are in the midst of a crisis, it is not realistic to expect families to access crisis services while communicating what's most helpful. As a result, the Facilitator must do some work prior to the crisis and before the team stops meeting. Finally, it is important to create a ritual that doesn't foster excessively high expectations. Imagine completing high school graduation only to be told at the end of the summer that you have one more term. You would feel a sense of failure and embarrassment at returning to high school. Facilitators have to lead the team in creating "right-size" commencement rituals that allow people to feel supported and celebrated without being set up to fail.



## DEFINING TEAM ROLES: SPIRIT PRACTICE PATTERNS

### For Facilitator/Practitioner

#### 1) Welcome

- Introduce yourself, explain role in a family-friendly way
- Describe the process so family wants to participate
- Listen to the family openly and without agenda
- Assess risk and align stabilization service

#### 2) Intake/Authorization

- Solicit family story and identify strengths and unmet needs
- Review previous assessments and service history
- Help the family to identify what the outcome should be
- Help the family identify when Mental Health services will not longer be needed
- Distinguish between crisis and non-crisis situations collaboratively with the family

#### 3) Planning

- Co-facilitate planning meetings following the Wraparound process with the Parent Partner including:
  - a. Welcome and introduce Team members
  - b. Summarize the strengths of the family and reintroduce the family
  - c. Encourage team members to add to the strengths list
  - d. Generate a team mission statement by starting with the parent/family's view of what they would like to accomplish
  - e. Introduce and summarize needs
  - f. Help the team to choose needs that would be likely to accomplish the mission while assuring the parent's voice/perspective has more "weight"
  - g. Lead the team in brainstorming creative and traditional options to meet needs
  - h. Facilitate team selection of those options that build on strengths
  - i. Assign each team member at least one task from the options
  - j. Document meeting results and distributing plan to all team members
  - k. Translate meeting results into Medi-Cal billable plans

#### 4) Implementation

- Host regular Child and Family Team Meetings

- Lead the Team in:
  - a. Reviewing accomplishments
  - b. Reviewing core elements of the plan (strengths, needs, actions)
  - c. Review of action steps for accomplishment and effectiveness
  - d. Review of next steps
  - e. Assigning responsibility for next steps
  - f. Documentation and distribution of meeting results
- Function as the central receiver of all team members' information between meetings
- Encourage consistency and coherence between the Wraparound Plan of Care and individual team member actions
- Engage and involve new team members as the plan gets implemented
- Lead the team in implementing interventions using a balanced, ecological view that is inclusive of various perspectives

5) **Transition/Ending**

- Help the team to assess progress in accomplishing the mission
- Facilitate team review of the Wraparound Experience including skills learned, support systems, strengths, and new strengths
- Facilitate post-wraparound plan including crisis plan, what next
- Clarify the role of the Wraparound team during phase-out
- Facilitate celebration with Parent Partners
- Prepare formal narrative of the family's Wraparound Experience for presentation to the family

## PARENT PARTNER/FAMILY SUPPORT PARTNER

### 1. Welcome

- Go to the home
- Introduce yourself
- Explain the process and philosophy
- Sell and describe benefit to family
- Engage family in moving ahead
- Brainstorm other potential team members with parent/family
- Relate your experience to the family's situation

### 2. Intake and Authorization

- Identify parent and family strengths and potential team members
- Identify team members
- Help pull together team member perspectives on strengths and needs
- Persuade and assertively recruit and reach out to potential team members
- Provide information and orient potential team members
- Instill hope in team members that things can get better
- Coordinate attendance of team members
- Clarify parent's perspective
- Orient family regarding plan development

### 3. Planning

- Co-facilitate planning meetings following the Wraparound process with the Practitioner including:
  - a. Welcome and Introduce Team Members
  - b. Summarize the strengths of the family and reintroduce the family
  - c. Encourage team members to add to the strengths list
  - d. Generate a team mission statement by starting with parent/family's view of what they would like to accomplish
  - e. Introduce and summarize needs
  - f. Help the family to choose needs that would be likely to accomplish the mission while assuring the parent's voice/perspective has more "weight"
  - g. Lead the team in brainstorming creative and traditional options to meet needs
  - h. Facilitate team selecting those options that build on strengths
  - i. Assign each team member at least one task from the options
  - j. Document meeting results and distribute plan to all team members

#### 4. Implementation

- Bring parent's perspective to all meetings
- Provide peer oriented, direct support interventions as specified in the Plan of Care to the parent/caregiver (necessary for all SPIRIT team members)
- Communicate and check-in with the parent/caregiver between team meetings
- Provide support, friendly encouragement and reassurance to the parent between team meetings
- Communicate new information about efficacy of the Plan and Interventions to the Child and Family Team
- Remind and continually refine parent and other team members about the agree upon unmet needs
- Remind and continually reinforce the parent's perspective and targeted unmet needs to other team members
- Assist in evaluation of results or outcomes of interventions
- Keep team focused on met and unmet needs
- Keep team focused on family needs and goals

#### 5. Transition

- Affirm previous discussions about transition and its benefits to the parent
- Plan with the parent about what life will look like post-SPIRIT
- Inform team where the parent is in the transition process
- Implement the team's plan for ongoing post-wraparound support
- Link and bridge to community supports

## CHILD AND FAMILY SPECIALIST/CASEWORKER

### 1) Welcome

- Receive assignment
- Solicit feedback from referring co-worker about planned activities
- Introduce yourself and CFS/Caseworker role within each phase on the team

### 2) Intake/Authorization

- Participate in information gathering process as conjoint member of the SPIRIT team
- Complete community observations to gather information at the request of the team

### 3) Planning

- Participate in planning as conjoint member of the SPIRIT team
- Share information that is relevant to the needs and goal of the family
- Summarize information in a way that can be respected by the family and the team
- Communicate with plain language about what's going on in the child's life

### 4) Implementation

- Engage and enlist family and community partners in service implementation
- Analyze, identify and communicate needs
- Locate and develop sustainable resources for the family
- Develop skills to child, family, and community members
- Build youth capacity
  - a. Model and teach skill development for youth and family
  - b. Connect and introduce to community resources
  - c. Identify and access positive relationships for the family
- Report on progress regularly and consistently
- Apply appropriate crisis intervention response to the immediate situation
- Attend ongoing team meetings as necessary
- Share information
- Discuss and communicate role to the family

- Adapt or modify activities to fit immediate situation or family feedback
- Communicate changes to the facilitator
- Seek outside assistance and get help when necessary
- Document activity and other pertinent information
- Identify strengths and capacity of family

#### 5) Transition

- Work with the team to negotiate re-entry of this specific position
- Arrange a celebration in home and community
- Document strength-based summary
- Negotiate follow-up care, services or interventions
- Generate and communicate enthusiasm about the next steps
- Inspire confidence and introduce transition and life after this position

## GLOSSARY

**Action Steps:** Statements in a wraparound plan that describe specific activities that will be undertaken, including who will do them and within what time frame.

**Facilitator:** A person who is trained to coordinate the wraparound process for an individual family. This person may also be called the Care Coordinator, Navigator, Wraparound Specialist, Resource Facilitator or some other term. The person in the facilitator role may change over time, depending on what the family thinks is working best. For example, a parent, caregiver, or other team member may take over facilitating team meetings after a period of time.

**Formal supports:** Services and supports provided by professionals (or other individuals who are “paid to care”) under a structure of requirements for which there is oversight by state or federal agencies, national professional associations, or the general public arena.

**Life Domains:** Areas of daily activity critical to healthy growth and development of a child or successful functioning of a family. Life domains include such areas as safety, school/work, health, social/fun, a place to live, legal issues, culture, behaviors, emotions, transportations and finances.

**Mission Statement:** A statement crafted by the wraparound team that provides a one or two sentence summary of what the team is working toward with the youth and family.

**Natural Supports:** Individuals or organization’s in the family’s own community, kinship, social or spiritual networks, such as friends, extended family members, ministers, neighbors, and so forth.

**Outcomes:** Child, family or team goals stated in a way that can be observed and measured.

**Plan of Care:** (see: Wraparound Plan)

**Strengths:** Assets, skills, capacities, actions, talents, potential and gifts in each family member, each team member, the family as a whole, and the community. Strengths help family members and others to successfully navigate life situations. A goal of the wraparound process is to promote strengths and use them to accomplish the goals in the team’s plan of care.

**Vision:** A statement constructed by the youth and family (with help from their facilitator and possibly the wraparound team) that describes how they wish things to be in the future, individually and as a family.

**Wraparound:** A family centered, community-oriented, strengths-based, highly individualized planning process aimed at helping people achieve important outcomes by meeting their unmet needs both within and outside of formal human services systems while they remain in their neighborhoods and homes, whenever possible.

**Wraparound Plan:** A dynamic document that describes the family, the team, and the work to be undertaken to meet the family's needs and achieve the family's long-term vision.

**Wraparound Principles:** A set of 10 statements that defines the wraparound philosophy and guides the activities of the wraparound process.

**Wraparound Team:** A group of people – chosen with the family and connected to them through natural, community and formal support relationships – who develop and implement the family's plan, address unmet needs, and work toward the family's vision.

(From: *The Wraparound Process User's Guide: A Handbook for Families*, National Wraparound Initiative, [http://www.rtc.pdx.edu/PDF/pbWraparound\\_Family\\_Guide.pdf](http://www.rtc.pdx.edu/PDF/pbWraparound_Family_Guide.pdf))

## 10 PRINCIPLES OF WRAPAROUND

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.
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.
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.
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.
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.
6. **Culturally competent.** The wraparound process demonstrates respect for and builds on the values, preferences, beliefs, culture and identify of the child/youth and family and their community.
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.
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.
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.

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.

(From: The Wraparound Process User's Guide: A Handbook for Families, National Wraparound Initiative, [http://www.rtc.pdx.edu/PDF/pbWraparound\\_Family\\_Guide.pdf](http://www.rtc.pdx.edu/PDF/pbWraparound_Family_Guide.pdf))

## **Strengths Assessment: Sample Questions**

1. If life were better for you, how would it look?
2. What are your likes and dislikes?
3. What are you interested in?
4. What are some of the things you are good at doing?
5. What are some of the things that your family does together?
6. How do you celebrate holidays?
7. What kind of family traditions do you have?
8. Do you have a monthly budget? Are you able to stick to it?
9. Who has helped your family in the past?

From: *Family Guide to Wraparound*, the Nashville Connection, <http://www.rtc.pdx.edu/>

## TASKS CHECKLIST

### I. Preparing the Team

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Met with facilitator and explained our story<br><input type="checkbox"/> Addressed immediate needs and crises and put together an initial crisis plan | <input type="checkbox"/> Generated a strengths list<br><input type="checkbox"/> Generated a team member list<br><input type="checkbox"/> Agreed on first meeting | <input type="checkbox"/> Agreed on who will contact potential team members.<br><input type="checkbox"/> Got more information about this process. |
|--|--|--|

### II. Developing the Plan

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Participated in one or two youth/family team meetings<br><input type="checkbox"/> Our strengths were listed and reviewed<br><input type="checkbox"/> Developed a Team Mission Statement that reflects what we and other team members hope to get out of this | <input type="checkbox"/> Reviewed the needs that reflect our concerns and worries<br><input type="checkbox"/> Picked a few needs to keep us and the team from becoming overwhelmed<br><input type="checkbox"/> Brainstormed a variety of strategies to meet those needs | <input type="checkbox"/> Chose strategies that matched our strengths to meet those needs<br><input type="checkbox"/> The plan assigns activities to all team members<br><input type="checkbox"/> The plan of care has been distributed to all team members |
|---|---|--|

### III. Implementing and Adjusting the Plan

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Promised activities are being provided<br><input type="checkbox"/> Accomplishments are reviewed and recorded<br><input type="checkbox"/> Assessment of the plan is occurring | <input type="checkbox"/> Adjustment of the plan is occurring based on feedback<br><input type="checkbox"/> Assignments are made and recorded at each team meeting<br><input type="checkbox"/> Copies of minutes and updated plan of care is sent to all team | members<br><input type="checkbox"/> Regular progress reports are prepared and distributed<br><input type="checkbox"/> We practice what to do if a crisis occurs with our family and the team |
|---|--|--|

### IV. Preparing for Transition

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> We have held practice crisis drills and are confident we know what to do if things go wrong<br><input type="checkbox"/> We have a way to access services in the future<br><input type="checkbox"/> We have a way to connect with | other families who have been through the process<br><input type="checkbox"/> Our concerns have been considered<br><input type="checkbox"/> We have a list of phone numbers of team members we | may contact if needed<br><input type="checkbox"/> Leaving wraparound has been discussed with the whole team<br><input type="checkbox"/> We have written documents that describe our strengths and accomplishments. |
|---|---|--|

(From: *The Wraparound Process User's Guide: A Handbook for Families*, National Wraparound Initiative, [http://www.rtc.pdx.edu/PDF/pbWraparound\\_Family\\_Guide.pdf](http://www.rtc.pdx.edu/PDF/pbWraparound_Family_Guide.pdf))

## PRODUCTS CHECKLIST

### I. Preparing the Team

- Strength summary
- List of Potential Team Members
- Release form allowing the Facilitator to speak with other Team members
- Strength list (inventory)
- Permission to provide services form

### II. Developing the Plan

- Plan of Care including Team Mission, most important needs and actions that detail who is responsible to follow through when
- Schedule of future team meetings
- Written crisis plan that includes who will do what when things go wrong and who should be called in what order
- Permission and release forms if new service providers are called

### III. Implementing and Adjusting the Plan

- Team minutes that detail Team accomplishments, changes to the plan and schedules of meetings.
- Updated releases for Team members, especially if new ones are added.
- Regular progress reports that reflect progress made from the original plan.

### IV. Preparing for Transition

- Transition plan that describes how ongoing services will be accessed if necessary
- Follow-up phone numbers for all team members who might be contacted
- Discharge summary form
- Crisis plans that include communications protocols for those who will be contacted in the event of an emergency
- Formal discharge plan that describes strengths of the family the interventions and the interventions that were successful and those that were not

(From: *The Wraparound Process User's Guide: A Handbook for Families*, National Wraparound Initiative, [http://www.rtc.pdx.edu/PDF/pbWraparound\\_Family\\_Guide.pdf](http://www.rtc.pdx.edu/PDF/pbWraparound_Family_Guide.pdf))

## Frequently Asked Questions

### I. Preparing the Team

#### Question

**Things aren't going well for us right now. I'm afraid I can't wait three weeks for some help for my son or daughter. Does this mean we should not do wraparound?**

#### Answer

During the initial conversation with your facilitator, he or she will be prepared to help you make sure that things are safe and stable enough to move ahead with the team process. If you have concerns about safety, bring them up right away. Work on coming up with a temporary plan until you have your first team meeting.

#### Question

**Things are so bad that I've decided that my son or daughter needs to go away from home to get help. Doesn't this mean we shouldn't do wraparound?**

#### Answer

Some families will consider out-of-home placement as an option. First, remember that your son or daughter will eventually return home, so it will be helpful to consider ways to plan for that day. Second, other service providers may do a better job of helping if you identify your family's most pressing needs and start to look at ways to address them. Finally, a team approach may result in new ideas that haven't been tried before that might work.

#### Question

**What if I don't feel comfortable having our family issues discussed with family and friends?**

#### Answer

Wraparound planning brings people together to help. The wraparound process is not a forum to discuss family issues, but a way for all team members to look at your needs and decided how to meet them. Your privacy is important and should be protected. Work with your facilitator to make sure you are comfortable with the team members and what's being said during the team process.

#### Question

**How do I know that this just won't be more of the same?**

#### Answer

You can't be sure. Talk with your facilitator about what has and has not worked for your family in the past. Speak to other families who have been through the wraparound process to see how it worked for them. Consider what you need to see happen to be convinced that wraparound is working. If your family's needs and goals are not being met, the wraparound process should be changed to improve the results.

## Frequently Asked Questions (continued)

### I. Preparing the Team

#### Question

**My son or daughter has been to many meetings in which adults tell her or him what is wrong. I don't think I can get him or her to attend a wraparound meeting. What if he or she refuses to attend?**

#### Answer

Work with your facilitator to make sure that your son or daughter feels welcome and comfortable. Be sure to give her or him time on the agenda to speak up and be heard. Sometimes the focus on strengths helps reassure the young person. If your son or daughter is not comfortable attending, you and the facilitator can come up with ways to make sure his or her voice is heard.

#### Question

**The facilitator will be looking for my child and family's strengths. Does this mean that our problems will not be addressed?**

#### Answer

Your concerns will be addressed. An emphasis is placed on strengths because the most effective services and actions are built on strengths. Also, the wraparound process will remind us of assets that we often forget when confronted with challenges.

### II. Developing the Plan

#### Question

**Going over the strengths makes me embarrassed. We know what we're good at. Is it really necessary to post our strengths?**

#### Answer

Wraparound involves shared responsibility. Determining strengths can help team members become more willing to share responsibility. Although it may be a little uncomfortable for some people, many families report that posting their strengths makes them feel confident that they can reach their goals.

#### Question

**Won't wraparound result in too much process and not enough action?**

#### Answer

Any goal worth achieving takes some time. Figuring out how to resolve challenges requires identifying needs, figuring out the best way to meet those needs, and creating a good plan. However, an effective wraparound process that follows the steps outlined in this manual will not take too long.

#### Question

**What if a person behaves rudely or abusively toward me or is hard to handle at a meeting?**

#### Answer

As a member of the family, you "own" the content of the wraparound process. It's *your* story. The facilitator "owns" responsibility for the process itself. If you have concerns about how people are behaving at team meetings, discuss them with the facilitator before the meeting and tell him or her what you need to feel comfortable. If someone behaves inappropriately during the meeting, you should feel free to tell the facilitator that you're uncomfortable. Also, the team may set ground rules for meetings that all members must follow.

## Frequently Asked Questions (continued)

### III. Implementing the Plan

#### Question

I'm worried that things are not working, and we're not scheduled for another wraparound team meeting for a long time. What can I do now?

#### Answer

When the team moves to less frequent meetings because the plan of care seems to be working, a way to call an emergency meeting should be in place. This usually involves a telephone tree of all team members so that no single person is responsible for pulling everyone together. You may call the facilitator or follow your emergency team meeting protocol.

#### Question

Sometimes I don't feel comfortable talking about needs in front of certain team members. Does this mean they have to leave the team or that I can't address certain issues?

#### Answer

Throughout the process, areas may arise that families would prefer not to have discussed in the presence of all team members. In such cases, set up a meeting with the facilitator to discuss your concerns.

#### Question

We agreed to an action in our team meeting, but I know one person is not following through. What do I do now?

#### Answer

The ongoing planning process holds *all* team members accountable for follow-through. When a team member cannot follow through, the team should meet and choose a new strategy to meet the need. In addition, your facilitator may work with you and other team members to try to address issues of follow-through between meetings.

#### Question

We've been working with one service provider, but it doesn't feel right. I'm not really on the same page as this person. I would like to try another provider, but I don't want to hurt this person's feelings. How do I go about that?

#### Answer

In the wraparound process you will rate whether the outcomes for each strategy are being achieved and whether your needs are being met. If they are not, the team brainstorms other solutions. One solution could be to try a new person. If you are concerned about hurt feelings, speak with your facilitator or another team member for ideas about how to handle this.

#### Question

We had a great team but now it's the end of the school year. We're looking at a new teacher next year. I'm worried about how it will be with a new person who did not participate in the initial planning. Do we have to start the process all over again?

#### Answer

Team members will often come and go as the plan is adjusted. The facilitator is responsible for orienting new team members and assisting them to become part of the process. New team members may include new service providers or educators, friends of the family, clergy or others who have reconnected with you or connected with you for the first time.

## Frequently Asked Questions (continued)

### IV. Preparing for Transition

#### Question

Even though we completed the wraparound process, I don't feel that some issues are fully resolved. If things get worse, will we need to start the process all over again?

#### Answer

Part of transitioning is for a family to locate services and supports in the community for possible future use. Work with team members and the facilitator to make sure you feel confident about accessing services in the future and even reconvening your team, if necessary.

#### Question

Once wraparound is over, won't we return to where we started, with lots of people failing to understand us?

#### Answer

Work with your facilitator and team members to make sure you get copies of your strengths summaries, discharge summary, and other documents you can use to introduce your family to others. Look to your local family organization for help and support. Also, your transition plan should include strategies prepared by your team about how to stay connected with important team members and others who will support you in the future.

#### Question

I got used to the connections made during wraparound. I'm worried that once it is over, I will feel alone. What should I do?

#### Answer

Families often find that they want to maintain relationships with individual team members, but they don't necessarily want to continue the formal structure. Also, consider volunteering to speak to new families about the wraparound process. Your facilitator should have a way to follow-up with you, so that when you want to have another formal team meeting, it will be arranged.

#### Question

How can I keep from sinking back into old patterns?

#### Answer

Many families find elements of the wraparound ritual helpful and implement them on their own on an informal basis. For example, some families hold regular family meetings to consider strengths and accomplishments. Others from time to time discuss needs as a way of understanding behavior.

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