

Incorporating Clinical Insights and Resources in the Wraparound Process

By John Franz
Paper Boat Consulting
Madison, WI

Wraparound Family Teams use a strength-based, solution-focused process to help families address and resolve challenges that have caused or are threatening to cause long-term disruptions in family relationships and functioning. Frequently, these challenges include the medical or behavioral health concerns of one or more of the family's members. In these situations, facilitators may need to guide Family Teams in their efforts to:

- Obtain accurate information about a family member's clinical situation and needs,
- Resolve conflicting clinical opinions or diagnoses,
- Identify and explore possible underlying causes for ambiguous health or behavioral concerns,
- Find resources for assessment and treatment of rare, atypical or complex disorders,
- Better understand the meaning and implications of a family member's diagnosis,
- Find creative ways to incorporate diagnostic information and treatment, recommendations in the overall Family Plan
- Help the family understand and make difficult treatment decisions,
- Support family members who are reluctant or fearful about entering into a treatment process,
- Resolve conflicts between clinical recommendations and a family's culture, spirituality and preferences,
- Improve communication, understanding and cooperation between clinical professionals and family members,
- Coordinate timing, transportation and cross-interactions among multiple treatments and interventions and insure adequate communication among treatment providers, and
- Find, access and fund needed treatments or interventions.

Since no facilitator can be fluent in all the clinical areas that may arise in Family Team situations, two basic skills needed for helping teams address concerns like those listed above are: being able ask questions kindly but repeatedly in various forms until an answer emerges that can be readily and consistently explained to the family and other team members; and knowing how to track down the people to whom these questions should be directed.

The situations in which a need for better input and understanding on clinical issues can run a wide gamut:

The Smith family needs help because Mrs. Smith has just been diagnosed with cancer and will not be able to provide the near constant supervision that her son, who has a pervasive developmental disorder, requires.

The McCarn family is searching for a way to help their 13-year-old daughter get back on track and end an escalating pattern of school truancy and runaway from home. One psychologist says that she has reactive attachment disorder, another believes the problems are caused by fetal alcohol effect, a third suggests that they are the result of a bipolar affective disorder.

Joan Maynard's 9-year-old son is a terror at school. The school says the problem is that Joan is too lenient. Joan and her son's psychologist say that it is the school's failure to adapt their instruction to the special needs of a child who while gifted and talented also has post-traumatic stress disorder as a result of the severe abuse he suffered at the hands of his alcoholic father. The social worker for the Maynards is caught in the middle.

Ralph Vering is terrified that his 15-year-old son, Terry, is going to die. The boy has been arrested and taken into custody for breaking and entering at the house of his girlfriend, who had just broken up with him. Terry is a fragile diabetic who only follows his regimen if there is strict supervision, but Terry's probation officer and the staff at the detention center say he should learn by facing the consequences of his behavior, which in this case would include a diabetic coma.

Greg Bento and the school are at odds over the correct way to address his 10-year-old son, Anton's needs. The school insists that Anton is properly identified as having a behavioral disorder, but Greg thinks that most of his son's behavioral problems and his depression are caused by the school's failure to program for a severe learning disability.

Facilitators are challenged to incorporate clinical insights and solicit the regular participation of clinical service providers at all four phases of the Family Team process, engagement, planning, implementation and transition.

Engagement

During the engagement phase, facilitators are learning the family's story and building a initial foundation of trust to support the remaining steps in the process. From the family's story, facilitators extract a timeline of key life events, an understanding of the family's primary formal and informal social connections, an initial inventory of the family's strengths, needs, culture and sense of direction, an agreement with the family on where they would like to start in the process of making things better, and a list of who they would like to invite to join them in this process.

Medical and behavioral health issues may emerge at a variety of points in the family's story. A teenager may have had a traumatic experience earlier in her or his life that is

influencing or coloring the way she is acting in the current circumstances. A parent may have spent years searching for an explanation and treatment for her child's bizarre behaviors. Some families will have coped with a series of health challenges in one family member after another. A parent or child with a severe emotional or behavioral disorder may have already had a wide range of prior psychotherapeutic and pharmacological treatments prior to their referral to Wraparound.

Factors like these underscore the importance of producing an accurate timeline that not only includes key events, but also the treatments received and the impact of those interventions. This is an opportunity to learn more about what worked, what helped a little bit, what had minimal effect and what produced negative results, as well as names and contact numbers for possible team members or team consultants, and resources for additional assessments or services.

In looking at prior experiences in the clinical domain, the facilitator should not only be inquiring about prior difficulties, treatments and results, but also about the family's responses to both the problems they were facing and the assistance that they received. The family's responses will provide important examples of their coping skills and strategies. Does the family deal with challenges with an attitude of optimism, stoicism or pessimism? Are they effective self-advocates? Did they feel heard and understood by prior service providers? Was there a conflict between the culture of the family and the culture of the clinicians with whom they were involved?¹

As the family and others involved in assisting the family describe their concerns about the well-being of various family members during the engagement phase, the issue of additional needed assessments may arise. For example, a youth might say, "I'd give anything to know what's really going on inside my head. Everybody tells me something different." Or a social worker for a family might state, "There's no question the children aren't getting adequate care, but I don't think the problem is that their mother is lazy. I think she's clinically depressed. I just can't get her to trust me enough to get a decent evaluation.

Getting additional evaluations or assessments to fill in missing pieces of the puzzle can be an important part of the Family Team's action plan. To obtain maximum benefit from these investigations, however, the family, and especially the family members who are receiving the evaluations, need to concur that they are needed, buy into using them as part of the team's strategy, and know why the information from the assessment might help them accomplish their goals.

¹ A well-known book that should be required reading for anyone in cross-cultural care situations is Anne Fadiman's *The Spirit Catches you and You Fall Down* (New York, Farrar, Straus and Giroux, 1997) which tells of the tragic results when American doctors acting in what they believed were the best interests of a Hmong child with severe epilepsy failed to understand and take into account her family's culture and worldview.

In some ways Family Teams are conducting an experiment. As they enter the Wraparound process, families are experiencing various kinds of difficulties. During the engagement and planning phases of the process, teams form tentative hypotheses about the unmet needs that are contributing to those problems. In general each hypothesis states that if we meet these particular needs through this type of action, the life of this family should be measurably improved. Getting an assessment or diagnosis in itself doesn't make anyone's life better, except to the degree that some comfort comes from having a name and a cause for what has been making you feel badly. But if a better understanding of the clinical issues underlying a person's problems can lead to an improved strategy for helping that person resolve those problems, then a good evaluation can be invaluable.

For example. Marjan Collier has had repeated referrals to social services for neglecting her two young children. A child welfare worker suggests that it might be because Marjan is depressed so Marjan sees a doctor and goes on an antidepressant. Neither her energy level nor the care she provides her children improves. As a last step before removing the children, the worker refers Marjan and her family for Wraparound services. When the family team facilitator listens carefully to Marjan's story, he learns that she has been severely abused three separate times in her life: when she was an infant, by an uncle; when she was in junior high school by her mother's boy friend; and as a young adult by the father of her two children. A key element of the subsequent action plan is a thorough evaluation that confirms severe post traumatic stress disorder and a far different design for clinical intervention and social support. It turns out that Marjan's ability to hold things together just enough despite all that had been done to her (a big strength) also led people to make the wrong assumptions about her motivation and needs.

When family team facilitators are in the engagement phase with a family that appears to have complex needs that cross over a number of different clinical disciplines, they may find that applying a multi-system screen to the information in the family's story to be helpful in sorting things out.

An example of a strengths-based multi-system screening tool is the ABLE review. The purpose of this review is to sort out information from the story about a family member with complex needs in terms of assets and challenges in four areas: Attachments, Behaviors, Learning and Experiences. *Attachments* includes relationships with family members and other primary caregivers, friendships, sources of social support and intimate connections. *Behaviors* includes successful coping strategies as well as patterns of self-defeating, harmful or illegal activities. *Learning* includes formal and informal skill acquisition, academic achievement and barriers to success in school or in work. *Experiences* include prior successes or traumas, as well as physical and emotional attributes and illnesses.

Some aspects of any person or family's attachments, behavior, learning and experiences contribute to their safety and well-being, and other aspects inhibit or interfere. Comparing the net impact of these positive and negative influences produces a functional

differential that the family and team can use to pinpoint areas of high clinical concern for further action.

The following chart summarizes the key elements of an ABLE review for a child. Variations can be used to look at the circumstances of a parent, or at the overall situation of a family.

Table One: Elements of an ABLE Review

	Attachment	Behavior	Learning	Experiences
Supportive Factors	Attachment and relationship patterns that have supported the child’s positive growth and well-being and provided a sense of being loved and cared for	Adaptive behaviors that demonstrate the child’s strengths and ability to address his or her needs in an effective and prosocial manner	Cognitive neurological, and attitudinal attributes of the child that help him or her adjust to and overcome any challenges that he or she may confront	Events, interactions and physical or medical aspects of the child’s life that have supported increased resiliency, safety, permanency and well-being
Impeding Factors	Attachment and relationship patterns that place or have placed the child at risk or caused emotional and physical harm and generated a negative and distorted sense of self and others	Maladaptive behaviors that cause harm to or create risk for the child or others, interfere with the formation of positive and supportive relationships, and/or prevent care givers from helping the child effectively address his or her needs	Cognitive neurological, and attitudinal attributes of the child that interfere with his or her ability to adjust to and overcome any challenges that he or she may confront	Events and interactions that have caused harm or created risk for the child, including accidents, abuse, neglect, self-injury, loss and other forms of trauma
Functional differential	What are the net unmet needs of the child and those who care for her/him in the area of attachment?	What are the net unmet needs of the child and those who care for her/him in the area of behavior?	What are the net unmet needs of the child and those who care for her/him in the area of learning?	What are the net unmet needs of the child and those who care for her/him in the area of experiences and health?

Based on a comparison of the supportive and impeding factors in each area, a functional differential for that area can be prepared that identifies the critical unmet needs that must be addressed for the Family Team’s action plan to be effective. For example, in the area of attachment, a child may have been abandoned by her mother but have an older sister who is willing to commit to being the child’s long-term primary caregiver. The functional differential is that the child has a difficult time consistently bonding with the sister because of the impact of the mother’s abandonment and because the child is not comfortable with the role in the family that the sister expects the child to assume.

In the area of behavior, while the child from the example might be generally quiet and compliant in school and at home, on occasion she can rapidly fall into a difficult mode characterized by violent tantrums that have included property damage and hitting and biting the people around her. The functional differential is the need to find and address the triggers for her tantrums, develop effective cues for interrupting them, and devise alternative behaviors so that she can express her feelings without violence.

Looking at the child's situation from a learning perspective, she reads above grade level and loves to lose herself in novels and stories. On the other hand, she has little enthusiasm for schoolwork and performs poorly in most of her classes. The functional differential is to discover the driving force behind her academic apathy. The sister speculates that it may simply be laziness, but the school counselor wonders whether it might be a combination of a preprocessing learning disability that makes it difficult for her to follow classes presented in a large group format along with a lack of motivation because she is so unsure about what her future will be like.

Finally, from the perspective of experiences and health, the supportive factors include the child's achievements while in a group home prior to going to live with her sister: she picked up a year and a half's worth of school credits in 11 months, made several friends and came out of her shell enough to participate on a recreational soccer team in the community. Impeding factors include the impact of a major trauma she suffered when she was sexually assaulted by a neighbor while in a foster home placement prior to her move to the group home, and an ongoing problem managing her asthma. The differential is to identify the best strategy for helping her integrate the effects of the assault, her respiratory problems and the earlier abandonment by her mother in a way that helps her continue to develop her ability to form positive connections with peers, adults, her sister and her sister's family.

A qualitative baseline measure for each of the four elements of the ABLE analysis can be set by asking a fundamental needs question in each context. For example on a scale of 1-10, how well do this girl's attachment and relationships with her primary care givers help her achieve safety, well-being and permanency? She can express her perspective, as can her sister, her sister's husband and the child welfare worker assigned to supervise the case. It is the job of the Family Team to develop a response that raises this measure to an acceptable level. Similar measures can be set for the other ABLE elements. Within this framework, the need for and the ways of using clinical services become more clearly defined.

Planning

In the planning phase, the facilitator assembles an initial team and guides them through the process of enhancing the initial strengths inventories for the family and its members, clarifying the team mission, identifying and prioritizing the critical unmet needs, brainstorming options for building on strengths to meet needs, and selecting the best options to include in an initial plan that states the specific actions to be undertaken, a timeline for accomplishing them, the persons responsible for carrying them out, and

measures for keeping track of whether the actions have occurred and the degree to which they have helped improve the family's situation.

The purpose of the team is not only to help come up with a plan, but also to help put it into effect. In addition, the team also functions as an important source of social support for the family as it goes through the process of change and growth generated by the plan.

Facilitators often find it difficult to include medical or behavioral health service providers as active members of Family Teams. Psychologists, mental health and substance abuse counselors, pediatricians, psychiatrists, nurse practitioners, and nurses, physician's assistants, physical, speech and occupational therapists, often work tight schedules controlled by the clinics that employ them and rarely have the flexibility to attend 60 to 90 minute Family Team meetings.

Therefore the tendency is to relate to them as auxiliary services and delegate responsibility to a member of the family or other team member to confer with them and bring information back to the team. Sometimes this is unavoidable, but where possible, strategies for obtaining more involvement by key clinical service providers should be considered. Otherwise, the danger is that the service provider will generate their own plan of care that may or may not be well synchronized with the Family Team plan.²

This participation can be supported in several ways. First, consider having a meeting at the person's office or clinic with a specialized agenda that relates only to their plans for assessment and treatment. Prior to such a meeting, it is important to obtain all necessary releases to allow the person to participate in the meeting, but the facilitator should also prepare both the clinician and the team for the meeting so that everyone is clear about its format and purpose. A good time to ask for a meeting like this is after a clinician has completed a formal assessment, or prior to beginning a complex service intervention, or after a course of treatment to assess its impact. Sometimes as long as the child or other family member who the clinician is treating is present at the meeting, the clinician can bill insurance or medical assistance for the time spent in consultation.

A second option is to have the clinician participate by teleconference or videoconference. As the technology for videoconferencing becomes simpler and more offices and agencies have broadband Internet access, more and more specialized providers such as child

² The American Academy of Pediatrics has developed their own system for good communication, family-centered planning, and careful coordination among all those involved in assisting a family with a child who has complex needs. Called "Medical Home" this system uses a pediatrician or pediatric nurse practitioner as a Family Team facilitator making sure that family voice and culture are heard, and that the family understands what the specialists involved with the child's care are recommending and doing. Cf. Nickel, R.E. & Desch, L.W. eds. (2000) *The Physician's Guide to Caring for Children with Disabilities and Chronic Conditions*. Baltimore: Paul H. Brookes. To learn more about the AAP's Medical Home model, visit <http://www.medicalhomeinfo.org>.

psychiatrists are offering what is coming to be called telemedicine services. As with meetings at the clinician's offices, the facilitator should take the time to prepare the team for video and teleconferences, not only by making sure that the technology is working properly, but also that people know the purpose and agenda for the meeting.

The third option is to form a clinical subcommittee of the Family Team to confer with a clinical services provider. This option would be used when the provider's schedule and that of the team members just won't jibe. Besides being clear about purpose and agenda, the facilitator should also make sure that the subcommittee (perhaps a parent, child, the facilitator and a family support person) are bringing along as many of the team's questions as possible, and that a good record of the meeting is being prepared to take back to the rest of the team.

Clinical input to the planning phase can help the team select a more precise and workable hypothesis about which needs are the critical driving forces behind the concerns that brought the family into Wraparound, and what options are out there for addressing those needs.

Implementation

During the implementation phase the facilitator helps the team put the action plan into action. Meetings that occur during this phase keep track of changes in the family's situation, newly acquired strengths and skills, deeper understanding and new priorities for needs, and further clarification of the team mission. Most importantly the team looks at whether they are doing what they said they would do in the plan, whether it is helping and whether there are ways of doing things differently that might be more effective.

Clinical involvement during the implementation phase can vary from occasional consultation, to updated evaluations for tracking progress, to ongoing treatment or intervention. The facilitator's task is to help keep the clinical services and the Family Team process on the same track. Sometimes all that's needed is to keep channels of communication open. Sometimes it's a good idea to have an occasional meeting just focusing on the clinical components. For example, if the action plan is for a youth to use a day treatment program as a setting to pick up needed social skills for returning to regular school at the start of the next semester, it makes sense to get the Family Team and some of the day treatment staff together from time to time to track progress toward this goal, and find out what the team can do to help with the upcoming change in educational placement.

One of the ways the Family Team can be helpful to the clinical provider is by expanding the impact of the clinician's work to other environments and times of the day. With good communication everyone can be on the same page with encouragement, expectations, interventions and assistance.

There are limitations on linkages between the Family Team and clinical providers. Everyone has the right to privacy in clinical consultation and treatment. Just because a

facilitator is trying to improve the connection and communication between the team and a clinical provider doesn't mean that a child or parent's therapist or psychiatrist or physician should be asked to divulge confidential information. Sometimes the information flow is one way, or only with regard to a few aspects of what is going on – perhaps only transportation, or satisfaction or a shared sense of progress. Even when a family is in therapy together, they have the right to keep that information to themselves if they want to. When facilitators are bringing Family Teams on line for the first time one of their tasks is helping the team establish its rules of operation. Where clinical input is likely to be an important part of the team process, the facilitator should make sure the family and team talk through how they want to handle this information so that clear ground rules are in place. The family also needs to know that they can change those ground rules at any time.

During the implementation phase it is important to track progress toward accomplishing the family and team mission. Most often this is done qualitatively. For example, if a parent's critical need is to feel that her child with a history of past self-harm can be safe if left alone or in the care of another person, at the outset the parent can indicate on a scale of 1-10 the level of her current sense that her daughter would be safe without her direct supervision. Then the team with the help of its clinical consultant can develop action plans for making things better; and from time to time the parent can indicate changes on this scale. At the same time the daughter can reflect on her own sense of progress.

It is likely that the team will have implemented a variety of formal and informal strategies to help the family accomplish their goals, some of which will include clinical services. By bringing together information from both the mother and daughter on their perceived sense of progress and combining it with input from the team members and clinicians who are providing the informal and formal assistance the team can generate a comprehensive and integrated sense of what is working and what should be adjusted.

As the family continues to make progress, the team will shift into the final phase, transition.

Transition

In the transition phase the facilitator assists the family in the process of separating from the Family Team and forging any needed linkages for ongoing formal and informal support. The time for transition is usually indicated when the primary indicators of progress have begun to level in the “doing all right” range and gross indicators of concerns (running away, family disruptions, violent outbursts, school truancy, legal violations, etc) have subsided.

Clinical input during the transition phase should include the provider's perspective on the progress being made by the child or family member or family as a group, suggestions for after care activities and supports, and possible arrangements for ongoing services.

In many instances, children and families continue to need clinical services following their involvement in Wraparound. On the medical side, this could include such things as the need for a youth with fragile diabetes to work closely with his pediatric endocrinology clinic case manager. On the behavioral health side, it might be helping a youth who is in recovery from abuse of cocaine and opiates to come up with strategies for maintaining her links with her substance abuse counselor and her teen NA support group.

As the facilitator helps the Family Team prepare a transition portfolio with the aftercare plan, information and references the family will need following their involvement with Wraparound, it will be important to include not only contact numbers and procedures for accessing clinical services that might be needed, but also reports or report summaries to help new care providers quickly pick up on prior services the family has received and what has worked, options that probably should be avoided and connections for obtaining additional background material.

Conclusion

Facilitators do not need to be clinicians in order to include clinical insights in the Family Team process. They do need to have a solid understanding of the family team process and the ability to form a bridge for communication and cooperation between teams and clinical providers. Once this bridge is in place, teams, clinicians and especially families will benefit from the shared perspectives that are created.

This article is copyrighted ©2006 by John Franz. However, permission is given to share it with groups of 50 or less provided that its content is unchanged, no fee is charged, and the author's attribution and this copyright notice are included. Comments and suggestions are welcome. The author can be reached via the email portal at www.paperboat.com. Please contact the author for permission if this article is to be included in a larger publication, or disseminated to more than 50 people to make sure it is the most current version, and just to let him know what's happening to it.