The workgroup meet to discuss issues related to delivering effective wraparound to families in which the parents or caregivers have significant mental health of substance use issue. At the 2008 Training Institute, the work group was formed based on the experience of some wraparound practitioners, family members, and program administrators who recognized that some significant and consistent phenomena occurred that required enhancements or modifications of phase related activities. These phenomena were related to range of factors. The notes below represent the content of the discussion at this workgroup meeting.

1. **Funding structures** – The source and mandate of funding available influences the capacity of child and family team to identify and respond to needs of family members. For example wraparound funded by children’s behavioral health insurance is influenced to focus on functional outcome for the child and bring to bear, on the formal resource side, child focused services such as in home behavioral plans and implementation supports. Adult functional outcomes while relevant to wraparound are not necessarily supported by child mental health behavioral funding. Therefore there is less leverage and sanction, as well as support to operate within and engage the adults formal supports that address the parent/caregivers needs.

2. **Mandates of agencies** - can also impact the capacity of wraparound teams and their facilitators to adequately include adult and caregiver needs as central to wraparound plans. For example state funded programs are often driven by department mandates. Juvenile justice originated wraparound programming mandates reducing repeat offending, public safety and increase in youth functional outcomes such as school attendance and employment but is not weighed to outcomes that improve or enhance parental/care giver functioning.

3. **Unique barriers to engagement** – parents and care givers experience complex barriers to engagement in the wraparound process which require more extensive and differently focused phase activity. It was a common experience that while parents and care givers with MH and SUD had great difficulty participating in teams and forming working relationships with Family Partners and Team Leaders and often were not able to articulate or define real, personal goals, until much later in the process when some real trusting relationships had been built and they had time to really understand the process. Some of the issue influence engagement were reported as:
   a. Executive functioning issues – decision making, organizing, language and cognitive areas of need require interfere with engagement and genuine parent or care giver participation.
   b. Social capacity – social anxiety, skills, and experience are frequently barriers that impact parent/caregivers capacity to operate in wraparound phase process.
c. Self regulator skills – often impacted by mental health and substance use issue are further barrier to engagement in team based planned development and implementation of actions steps from team plan
d. TRIPLE STIGMA – parents and caregivers with mental health and substance use issue within their community and cultures simultaneously experience three type of stigma which makes participation on teams, in actions steps and partnerships with providers complex and which require special acknowledgement, sensitivity and flexibility in implementing the phase process.
   i. Stigma One – have a child with an emotional or behavioral disorder.
   ii. Stigma two – being an adult with mental health or substance use disorder
   iii. Stigma three – being a parent with a mental health or substance abuse disorder.

4. Lack of training of child and family team facilitators – in assessing, understanding, engaging, and working with adults with mental health and substance use disorder is a major work force barrier in implementing effective teams.

5. Social risk – Its not just stigma but there is risk in revealing your condition which prevents adequate needs assessment and planning in wraparound, (as well as all other formal service interventions)

6. Program Examples
   a. Project Connect – is a program of Henderson Mental Health Center in Fort Lauderdale, Fla. [www.hendersonmhc.org](http://www.hendersonmhc.org) which uses wraparound to support reintegration of children to their home who have been placed by the local child welfare agencies. Project Connect has been successful utilizing wraparound for this population but has need to be very flexible within the phase process activities in order to successfully engage the parents and care givers most of whom have MH or SUD.
   b. Family Options – is a program of Employment Options in Marlborough Massachusetts [www.employmentoptions.org](http://www.employmentoptions.org) which uses wraparound for parents identified with severe mental illness whose children also have major emotional or behavioral difficulties. Family Options has enhance its implementation of the phase process using best practices from psychiatric rehabilitation and adult recovery practice.

7. Family partner role - also needs to be specifically informed by the experiences of the parents/care giver with MH and/or SUDs. A family partners ideally should have lived experience by which they can relate to these parents. This experience should help them to: fully hear and understand the parent’s experience, coach them with the skills they need to support them to the outcomes to which they are inclined, and help them safely navigate the system to the benefit of their children and themselves.
8. “Customized to strengths” - Parents’/caregivers’ strengths and needs exploration – the work group participants discussed the need for more useful, functional understanding of the strengths and needs of parents and caregivers so that a plan can include outcomes that are customized to the strengths of the parents and can engage parents around those strengths. Current barriers to being able to customize to strengths with adults with MH and SUD disorder include the need for: more training and comfort with exploring these issues; trust, stigma, and social risk; and the generality of the life domain areas of needs exploration which does not, by itself, support such an exploration. There was general interest in the need to have a tool or more targeted protocol which could be used successfully by a wide range of family partners and team leaders with varying levels of experience in wraparound that would help produce needs and strengths process for parents with MH and SUD that is truly customized to strengths.

9. **Next Steps:**
   a. Send out the work group notes to existing work group.
   b. Work group feedback on notes for meeting is requested.
   c. Specific feedback regarding their experience applying wraparound to families in which parents and caregivers have MH and/or SUD.
   d. Specific feedback from work group on protocol or potential tools to effectively conduct strengths and needs assessment that address parents needs and are “customized to strengths”
   e. Work group members are encouraged to share any success, writing, new programs with each other that could help inform and support practice.