



High Fidelity Wraparound Training

Advance Reading and Pre-Tests

Instructions: You have been selected to go through the 101 Level High Fidelity Wraparound Training. Prior to the training, all participants are expected to complete two assignments prior to the training date. First, read the following nine page article which is titled The Wraparound Process, then take a ten question pre-test on the article. Next, read the Family Example (This family is the subject of the new DVD and is to be used throughout the training) and then take the pre-test on the family. Give the pre-tests to your supervisor.

The Wraparound Process

Rationale. Over the last 25 years, the world-wide human services community has been faced with growing complexity of human services needs, especially for children, youth, and their families. This has been caused by many factors, not the least of which are poverty, societal stress, war, increasing focus on technology over human interaction, loss of family, and others. Recent studies have indicated that loss of connection to large numbers of “caring people” has been one of the most commonly cited factors that has led to increasingly negative outcomes for our children and youth. Caring people are those who look out for the child and youth on a daily basis, providing nurturing, guidance, and an example of strong adult behavior in the parenting areas.

One of the ways that our societies historically coped with the increasing complexity of the emotional needs of children, youth, and their families, was to “professionalize” the helping response. A huge human services industry of professional helpers has been created over the last 50 years. This movement proved beneficial in some ways, but in other ways created a dependence on professional advice and decision making, and a decrease of family voice and choice in decision making. It is important to stress that the historical roots of many human service agencies began with a greater focus on family voice and choice than now exists. For example, Hull House in Chicago, which is widely acknowledged as being the birthplace of social work in North America, began with a motto of “People Helping People” and a creed of family voice and decision making over family needs.

In addition, one of the factors that has influenced outcomes at the family level was the “silo effect”, caused by development of separate child welfare, juvenile justice, education, mental health, developmental disability, public health, addiction, housing, welfare, medical, vocational, legal, and other services models. Even though families did not come in neat packages that fit the silos, these systems often did not interact at the policy, agency, and practice model levels. Families with complex needs would often have multiple and sometimes competing plans, and would be overwhelmed with professional demands.

In response to problems with the above separately developed silos, the notion of a “system of care” was conceptualized by Beth Stroul and Robert Friedman in 1986. The concept of the system of care has evolved over the last 20 years, which stresses the need for the silos to human services agencies are turning to their roots and indeed the roots of human kind, the use of small teams of helpers to assist our most vulnerable citizens.

A key addition to the system of care movement has been the national development of family organizations for children and youth with serious emotional disturbance and their families. This development has been led by the Federation of Families for Children’s Mental Health, which now has chapters in almost every state in the U.S. Associations for Retarded Citizens, Mental Health Associations, Alliance for the Mentally Ill Child and Adolescent Services, autism-focused family organizations, and many others have been established nationwide, with similar organizations in Canada. Family organizations participate in the system of care in many different ways, including policy development, program design and evaluation, and delivery of services and supports. For example, the system of care efforts in Tulsa, Oklahoma include use of family member graduates of the programs as mentors and supports to new families coming into services.

In 1982, Jane Knitzer in her book, *Unclaimed Children*, found that two-thirds of all children with severe emotional disturbances were not receiving appropriate services. These children were "unclaimed" by the public agencies responsible to serve them, and there was little coordination among the various child-serving systems. To address this need, Congress appropriated funds in 1984 for the Child and Adolescent Service System Program (CASSP) led by Ira Lourie, M.D., and envisioned as a comprehensive mental health system of care for children, adolescents and their families. Federal grants supported the development of wraparound practice and systems of care across the country. Subsequently, national technical assistance centers at Georgetown University, Portland State University, and the University of South Florida were established to support best practice development, research and evaluation of wraparound and systems of care.

Collaboration and Integration. In the last 25 years, virtually every system has begun to use some version of team based planning. Some of these models are single system focused, some are collaborative, and some are integrated. In single system team based planning, schools, juvenile justice, or other systems will convene a team to focus on one aspect of a youth and families life. For example, a restorative justice team may focus on a juvenile justice goal of helping a young offender do restitution to his or her victims. Collaborative teams may be convened to attempt to obtain a broad based view of a family, and a single system team may invite other systems to a meeting to discuss the entire family and the entire family needs. There are a number of collaborative planning models, including person centered planning, balanced approach teams, multi-systemic therapy teams, family group decision making, positive behavioral support teams, and others.

At times, even though these collaborative teams are convened by a single system, all relevant systems are invited, and the family is very much involved. An example of this is the child welfare Family Unity Model, created by Jim Nice and colleagues, in the state of Oregon.

In a collaborative model of care, child serving agencies and schools learn about each other's systems, "staff" families together, and attempt to establish cross-system values and standards. The movement to collaboration has been in reaction to the lack of cross-system training and education about each categorical system's mission and structures. However, there are limits to a collaborative model, even though collaboration is an important developmental step for many communities, provinces, and states. In a collaborative model, each system communicates, but at the end of the day, each system makes their own decision about the intervention for the family. This results in multiple service plans for the one family, which may potentially be in disagreement and result in one

family having been ordered to go to literally dozens of appointments over a month. When these well-intentioned plans fail, the family is often blamed. In collaborative teams, at the end of the meeting, all professionals attending will still go back to their respective agencies or schools and make their own decision about how to proceed with the youth or family. Ideally, their choices are informed by family voice and choice, but in reality, each agency is often most driven by their own mandates.

An integrated planning team convenes around a neutral table, not pre-designated to any one system, but rather a table that recognizes that the youth and family may have complex needs that cut across system boundaries. Currently, wraparound is the only commonly used method of integration of system needs and family needs that produces one overall approach to a youth and family needs. The team members include all relevant systems, the family, and their own natural supports. Ideally, the team commits to having only one piece of paper – a common plan, but realistically, systems may have different forms tied to their own agency or system’s requirements. Regardless of whether or not there are multiple forms, what is on the forms is consistent in every system, and is driven by the same values and principles.

History of Wraparound. The basic hypothesis of this process is that if the needs of a youth and family are met, it is likely that the youth and family will have a good or at least an improved life. This hypothesis has been central to life on the planet for thousands of years, and is certainly not a new concept. However, as the basis for formal efforts to de-categorize services and improve outcomes, the field has been in development for approximately 35 years.

The earliest form of wraparound (the term wraparound was not yet used to describe the process) came out of efforts by John Brown and his colleagues in Canada who operated the Brownsdale programs. These programs centered on the concepts of needs-based, individualized services that were unconditional. John Brown had based these concepts on efforts in Belgium and the principles of the Larch Movement, focused on normalization. These concepts were utilized in designing the Kaleidoscope program in Chicago that began implementing private agency-based individualized services in 1975 under director Karl Dennis. The term “wraparound” was conceived by Dr. Lenore Behar in her work on individualized services in North Carolina. In 1985, officials of the State of Alaska social services, mental health, and education departments sought consultation from Kaleidoscope, and formed the Alaska Youth Initiative, and both Kaleidoscope and the Alaska effort labeled their work as “Wraparound”. This effort was successful in returning to Alaska almost all youth with complex needs who were placed in out-of-state institutions. The Alaska efforts were quickly

followed by replication attempts in Washington, Vermont, and in more than 30 other states, and in Canada.

The Wraparound Process: Guiding Principles from the U.S. National Wraparound Initiative

Overview of the High Fidelity Wraparound Process, Principles and Steps: The wraparound process is a way to improve the lives of children with complex needs and their families. It is not a program or a type of service. The integration process of wraparound is used by communities to support children with complex needs and their families by developing individualized plans of care. The key characteristics of the process are that the plan is developed by a family centered team, is individualized based on the strengths and culture of the child and their family, and is needs rather than services driven. The wraparound process was innovated from the grass roots of America and Canada. Consequently, the process and outcomes of the process varied widely state to state, province to province. In 2002, a group of wraparound innovators began discussions about development of US national standardized principles, phases, and activities for wraparound, which have been completed. Wraparound that is done according to these principles and the phases and activities of the process is referred to as High Fidelity Wraparound. (See National Wraparound Initiative in Google for a comprehensive overview of these standards) Canadian wraparound innovators are currently developing similar standards for Canada.

The U.S. National Wraparound Initiative, led by Eric Bruns, Ph.D., Janet Walker, Ph.D., Trina Osher, Jim Rast, Ph.D., John VanDenBerg, Ph.D., and others, has standardized ten guiding principles:

1. Family Voice and Choice
2. Team Based
3. Natural Supports
4. Collaboration
5. Community Based
6. Culturally Competent
7. Individualized
8. Strengths Based
9. Persistence
10. Outcome Based

The family are integral parts of the team and must have ownership of the plan. No planning sessions occur without the presence of the family. This principle is referred to as Family Voice and Choice. The actual individualized plan is developed by a wraparound team, who consist of the family and the three to

seven people who care and know the child and family best. The team is selected by the family and typically has no more than half professionals. The team represents the principle of Team Based. The individualized plan is child-centered and family-focused with maximum family involvement, with variation depending on the needs of the child and family. The process focuses on strengthening the natural family, extended family and social supports for the child by involving them in the planning and implementation process. These social supports represent the principle of Natural Supports.

Many families who are served through the wraparound process have needs which have traditionally been met by more than one services system or schools. These services systems and schools agree to the principle of Collaboration, working together and moving to Integration where all parties work in a team with the family and design and implement one plan. Services and supports are based on the principle of being Community-based. When residential treatment or hospitalization is accessed, these service modalities are to be used as stabilization resources and not as placements that operate outside of the plan produced by the child and family team. All services and supports must be based on the principle of being Culturally Competent. That is to say, services and supports must be tailored to the unique culture of the child and family. Family culture refers to family race and ethnicity as well as family habits, preferences, beliefs, language, rituals, and dress, based on “one family at a time”.

The principle of true Individualization is at the heart of the wraparound process. Each child, youth, and family has an individualized plan. The plan may include services (such as therapy or day treatment) that other plans have included but when they do include these more typical services, the team always evaluates and understands why the service is a precise match for the unique needs of the child, youth, and/or family. The plan is structured around the principle of Strengths Based, where the plan is based on the unique strengths, needs, values, norms, preferences, and culture, and vision of the child, family, and community. No interventions are allowed in the plan unless they have matching child, family, and community strengths. By building on these strengths, the plan supports who the child is and how the child will positively progress in life. The plan is focused on typical needs in life domain areas that all persons (of like age, sex, culture) have. These life domains are: independence, family, living situation, financial, educational, social, recreational, behavioral, emotional, health, legal, cultural, safety, and others.

The child and family team and agency staff who provide services and supports must make a commitment to the principle of Persistence in delivery of services and supports. When things do not go well, the child and family are not “kicked out”, but rather, the individualized services and supports are changed. Planning,

services, and supports cut across traditional agency boundaries through multi-agency involvement and funding. Governments at regional and local levels work together with providers to improve services, and commit to the final principle of being Outcome Based. Both system of care issues and issues of individual plans are considered. Outcome measures are identified and individual wraparound plans are frequently evaluated. The collaborative funders of services agree to focus funding on efforts like wraparound which have solid evidence for effectiveness.

Phases of Wraparound Practice From the National Wraparound Initiative

Phase One: Engagement and Team Preparation. During this phase, the groundwork for trust and shared vision among the family and wraparound team members is established, so people are prepared to come to meetings and collaborate. This phase, particularly through the initial conversations about Strengths, needs, culture, and vision, sets the tone for teamwork and team interactions that are consistent with the wraparound principles. The activities of this phase should be completed relatively quickly (within 1-2 weeks if possible), so that the team can begin meeting and establish ownership of the process as quickly as possible.

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

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

Phase Four: Transition. During this phase, plans are made for a purposeful transition out of formal wraparound to a mix of formal and natural supports in the community (and, if appropriate, to services and supports in the adult system). The focus on transition is continual during the wraparound process, and the

preparation for transition is apparent even during the initial engagement activities.

Phases and Activities of the Wraparound Process

<p>Engagement and Team Preparation</p> <ul style="list-style-type: none">• Orient the family to Wraparound• Stabilize crises• Facilitate conversations about strengths, needs, culture, and vision of the family• Engage other potential team members• Make needed meeting arrangements <p>Initial Plan Development</p> <ul style="list-style-type: none">• Develop a plan of care• Develop a detailed crisis/safety plan	<p>Implementation</p> <ul style="list-style-type: none">• Implement the plan• Revisit and update the plan• Maintain team cohesiveness and trust• Complete documentation and handle logistics <p>Transition</p> <ul style="list-style-type: none">• Plan for cessation of wrap• Conduct commencement ceremonies• Follow-up with the family after graduation
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12

Systemic Changes Needed to Support Wraparound

The national movement toward wraparound within services to children, youth, and families is based on the fact that many children and youth, and their family members, have complex needs which do not fit neatly into our pre-conceived service models and silos. Over the last few decades, increasing realization about structural changes to the system of care has led to major innovations in how states and provinces design their overall systems. Sheila Pires, a leading system of care expert, in her monograph, Building Systems of Care: A Primer (2002), says:

The structures that are created send a message about values, either undermining or reinforcing the values and principles that have been adopted. For example, individualized, flexible service provision is a key principle of systems of care. However, if the financing structure attaches dollars only to programs, the principle of individualizing care will be undermined – not that it is impossible to incorporate individualized service provision within this structure, but it is more difficult. The structure in this instance sends a message about how much the system truly values an individualized, wraparound approach.

States have been pushed to develop systems of care in part due to a series of lawsuits, beginning with Willie M. vs. The State of North Carolina in the 1980's. These lawsuits have reinforced the right of children with complex needs to be served in the least restrictive and most therapeutic environment. Family members have brought these class action lawsuits in more than 20 states. An example of a recent lawsuit is the Jason K. settlement in Arizona. This lawsuit settlement establish "Child and Family Teams" in a wraparound model as the primary decision making body for design and delivery of behavioral health services for children and youth, and their families. Arizona state level behavioral health has been establishing structure that puts these family centered teams in the middle of the system, and is using the teams to establish medical necessity for Medicaid reimbursement purposes.

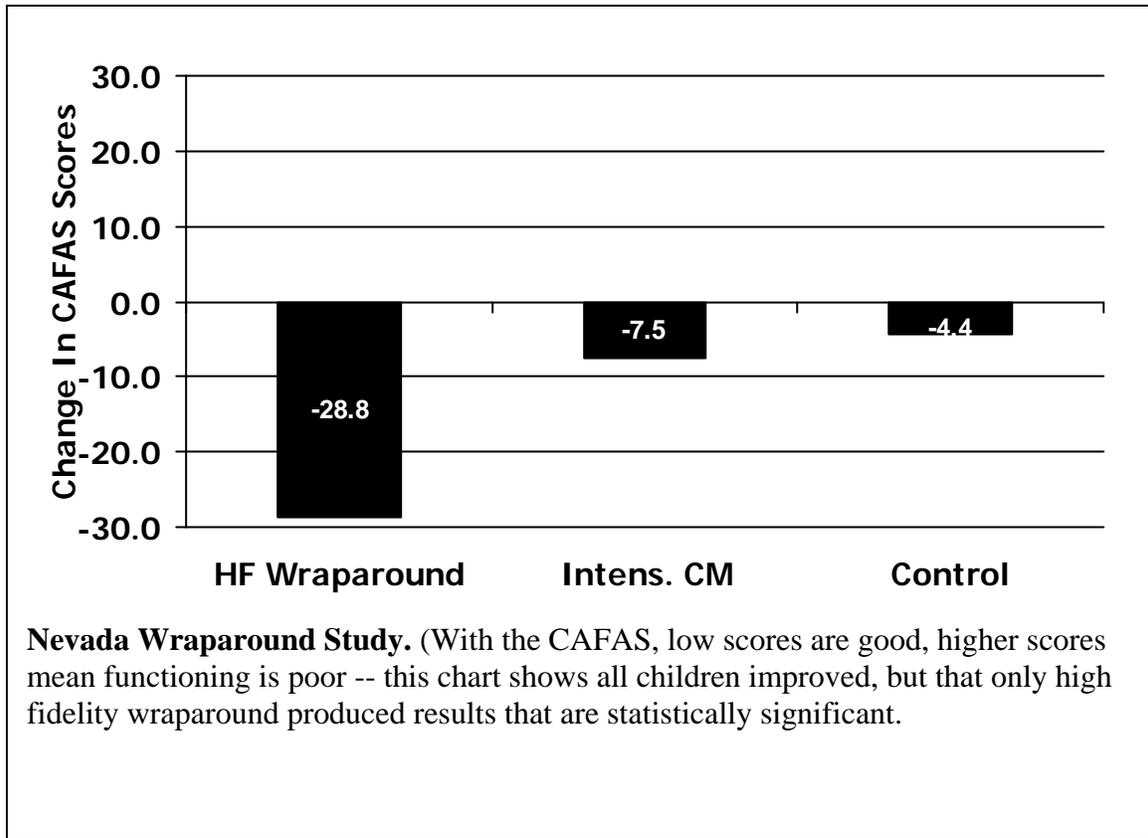
Research Outcomes

Recent research on High Fidelity Wraparound has demonstrated that the process can produce significantly better outcomes for children and families with significant needs than traditional approaches, including: 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; and increased family resources to support their own children

Over the last several years, important controlled research on wraparound has been carried out. In a recent study in Nevada, child welfare referrals to wraparound were assigned to a "standard treatment control group", getting typical services such as therapy, case management, and day treatment. Another group was assigned to an "Intensive case management" group, with a case manager with low case loads and access to flexible funding. The third group in the study was a High Fidelity Wraparound Group, based on the phases and activities of the National Wraparound Initiative. These children and their families received highly individualized services and supports, an integrated plan, and a team where the parents were in charge to the maximum extent possible, given the safety issues for the children. All children were given a standardized test of functioning called the Child and Adolescent Functional Assessment Scale, or CAFAS. This is the most commonly used measure of functioning for children with emotional problems.

In this study, the first two groups made no statistically different progress over a year, and yet the wraparound group did make statistically different progress. This progress meant that this group dropped out of clinical range based on the definition of clinical need that is built into the CAFAS. Recent studies have produced very similar outcomes to the Nevada study, and new research has been coming out over the last two years. Wraparound is well on its path to being considered evidence-based practice.

Please see the chart that summarizes this research on the next page.



Summary

The High Fidelity Wraparound Process for children, youth, and their families is growing rapidly in North America. Each major child-serving system is currently involved integrated wraparound planning. A strong national network of family organizations and new federal funding is helping drive and support this movement. The wraparound process is ensuring that children and youth can be appropriately served within their communities, in their family homes, and in a manner that respects the dignity and importance of the family.