The Wraparound Process: Individualized, community-based care for children and adolescents with intensive needs

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Collaborative consumer-provider teams have become an increasingly popular mechanism for creating and implementing individualized care plans for adults, children, and families with complex needs. This sort of team-based, consumer- or family-driven planning is currently used in a wide variety of human service contexts including special education, developmental disabilities, child welfare, and juvenile justice. Recently, much attention has been focused on such teams in the context of children's mental health, where an approach known as *wraparound* has become a primary strategy for planning and coordinating community-based care for children with severe emotional and behavioral disorders. One recent estimate put the number of children receiving wraparound at 200,000 (Burns & Goldman, 1999), and that number is likely increasing.

Wraparound's popularity stems from its philosophy for service delivery, which is appealing to a broad range of stakeholders, particularly the families of children and youth with severe mental health disorders. The philosophy begins from the idea that the perspectives of the family—including the child or youth—must be given primary importance during all phases and activities of wraparound. The philosophy further stresses that the wraparound planning process should be individualized, strengths based, and outcome oriented. Additionally, wraparound is intended to promote the use of community-based services and supports, thereby keeping families together while also decreasing the need for costly out-of-home placements. Finally, wraparound is intended to be a culturally competent process that is respectful of the family's values and beliefs, and that supports and builds on the strengths and assets of the family's culture, traditions, and community.

Despite widespread implementation of wraparound programs and the appeal of the philosophy, there is limited evidence for the effectiveness of the approach. This is a matter of concern among advocates of wraparound, because there is increasing pressure to allocate mental health resources to programs and interventions with demonstrated effectiveness. Accumulation of evidence for the effectiveness of wraparound has been hampered by the lack of any generally agreed-upon guidelines

for wraparound practice. Although there is agreement about the philosophy that should guide wraparound, there currently exists no widely accepted model or manual for wraparound practice. Awareness of this difficulty has led to recent efforts to build theory for wraparound, define practice parameters, and develop measures of fidelity.

Wraparound and its Roots

The wraparound philosophy, as defined by its 10 principles (Table 1), expresses a vision that has straightforward, commonsensical appeal. When a child or adolescent struggles with a severe mental health disorder, his or her family also struggles: to find adequate care and support, to stay safe, to stay together, and to maintain everyday life and functioning. The wraparound process begins by bringing a team together around the struggling child and family. Included on the team are people who have a stake in seeing the family succeed: family members, service providers, and members of the family's natural and community support networks. Guided by a wraparound facilitator, these people work to create, implement, and monitor a single, integrated plan that will maintain the child successfully in the community and help the family realize its vision for a better life. The plan typically includes formal services and interventions, together with community services and interpersonal support and assistance provided by friends, kin, and other people drawn from the family's social networks. The plan's components are measured against relevant indicators of success and are revised when outcomes are not being achieved. The planning process is family driven, culturally competent, and community and strengths based.

This vision for wraparound has evolved over the past 20 years in reaction to the typical experiences of children with severe emotional and behavioral disorders and their families. While recent years have seen some progress in transforming mental health service systems, families seeking help and support still typically encounter child-serving systems that are fragmented and uncoordinated, with a hodgepodge of providers, interventions, and payers. Community-based treatment options are often unavailable, and there is a continued over-reliance on residential treatment and other restrictive placements. Such out-of-home placements can cause irreversible damage to family and community ties as the child or adolescent spends long periods of time distant from home and/or under conditions that prohibit or greatly restrict contact with family members. Even today, the lion's share of public dollars for children's mental health continues to be spent on residential and inpatient treatment, despite a near absence of evidence of effectiveness (U. S. Department of Health and Human Services, 1999). Meanwhile, families are often blamed for their children's difficulties and discouraged from participating in or directing their children's care.

The current vision of wraparound emerged gradually from the efforts of individuals and organizations committed to providing alternatives to the experiences of children, adolescents, and families as described above. Building on program models drawn from Europe and Canada, the Kaleidoscope program in Chicago began implementing private agency-based individualized services as early as 1975. The term *wraparound* was first used in the early 1980s to describe the response to a class-action lawsuit in North Carolina that resulted in development of an array of comprehensive, community-based services for individual children and their families. In 1985, the Alaska Youth Initiative was formed with the goal of returning to Alaska youth

with complex needs who had been placed in out-of-state institutions. The Initiative was successful in returning almost all youth from out of state, and the Alaska efforts were quickly followed by replications in Washington, Vermont, and elsewhere.

During the late 1980s and early 1990s, wraparound's growing popularity received added momentum from the development of a broader movement to build *systems of care* for children with serious emotional and behavioral disorders (Stroul & Friedman, 1988). The impetus for systems of care came from recognition of the ongoing problems listed above: uncoordinated and ineffective services, an over-reliance on restrictive settings, and a lack of family participation and cultural competence. Proponents envision systems of care that provide a wide array of services and supports, with an emphasis on serving children and families in their home communities and in least restrictive environments. In systems of care, child- and family-serving agencies collaborate and coordinate their efforts, providing individualized, culturally competent care. Systems of care encourage the full participation of families and youth consumers in planning, evaluating, and delivering services and supports.

While the term *wraparound* came to be more and more widely used throughout the 1990s, there was still no formal agreement about exactly what wraparound was. Many wraparound programs shared features with one another, but there existed no consensus about how to define wraparound. Thus, in 1998, a group of stakeholders in wraparound gathered to clarify the essential features of wraparound. This meeting resulted in the definition of 10 elements that provide the foundation for the wraparound process (Burns & Goldman, 1999). The principles of wraparound provided in Table 1 are based on these elements.

While the 10 elements provided a clear statement of the philosophy that guides wraparound, they gave little information about the specific activities or skills necessary to implement the process in a manner that reflects the philosophy. As experience with wraparound has accumulated, challenges arising from a lack of practice standards have become clearer. Alongside documented successes, it has become apparent that many teams and programs do not operate in a manner that reflects the wraparound principles (Bruns, Burchard, Suter, Leverentz-Brady, & Force, 2004; Burchard, Bruns, & Burchard, 2002; Walker & Schutte, 2004, in press). At the most basic level, it seems that many teams have difficulty adhering to a structured planning process that includes setting specific goals and monitoring progress toward outcomes. Additionally, wraparound plans often appear to be lacking in creativity and individualization. This may stem from policies and funding arrangements (e.g., lack of flexibility for funding unique or non-traditional services and supports, system incentives to fill program beds or slots, etc.) and/or a lack of knowledge about techniques for stimulating creativity during the planning process.

More profoundly, achieving true partnership with families and youth is an ongoing challenge within wraparound, just as it is in other human service contexts, where the perspectives and priorities of professionals are likely to dominate discussion and decision making. Even when professionals desire to act in partnership with youth and families, they often lack knowledge of skills and techniques to do so. What is more, youth and family members have often never had an opportunity to explore—and thus have difficulty expressing—their own perspectives regarding needs and goals,

and the strategies that are likely to be successful in meeting them. Other challenges arise from the specification that wraparound be strengths based and culturally competent. While there seems to be little disagreement that traditional approaches within children's mental health tend to be deficit based and lacking in cultural sensitivity, much confusion remains about what exactly is meant by strengths-based and culturally competent practice.

Even when a wraparound team functions in a way that promotes family partnership, cultural competence, creativity, and a strengths orientation, other challenges often arise as the team strives to develop and implement plans are truly coordinated, comprehensive, and community based. Many communities lack a true array of services and supports, making it difficult for wraparound teams to meet child and family needs using community-based options. Policies, agency cultures and mandates, and funding requirements often work against the use of a single comprehensive plan to coordinate services and supports across agencies. Moreover, the comprehensive wraparound plan is intended to extend beyond formal services by including roles for members of the family's community and informal support networks. Providers often lack knowledge, skills, and/or resources for accomplishing this.

Research on Wraparound

Despite the challenges described in the previous section, numerous individual wraparound programs have built impressive reputations that rest upon program evaluation and more formal studies (Burchard et al., 2002; Burns & Goldman, 1999). Among these programs, the most notable example is Wraparound Milwaukee (Kamradt, 2000), which was cited by the President's New Freedom Commission on Mental Health as a model program (New Freedom Commission on Mental Health, 2003). Meanwhile, findings from a number of published pre-post studies have provided evidence that most children receiving wraparound from the study programs were able to continue living in the community for months and even years after entry into wraparound. This is in contrast to studies showing that most children with severe emotional and behavioral problems who receive traditional services are eventually placed in more restrictive settings outside their home communities (Burchard et al., 2002).

Three quasi-experimental studies and two randomized clinical trials provide further encouraging support for the wraparound process. Among the five studies, four reported positive outcomes for children and youth receiving wraparound, in areas such as improved community adjustment, improved behavior, decreased functional impairment, fewer social problems, fewer placement changes, fewer days absent from school, and lower rates of delinquency (these results are summarized in Burchard, Bruns & Burchard, 2002). On the basis of results such as these, the Surgeon General's report on mental health characterized the available research as providing "emerging evidence" for the effectiveness of the approach (U. S. Department of Health and Human Services, 1999). The fifth study, published more recently, found no differences in outcomes for youth enrolled in wraparound versus a quasi-experimental comparison group; however, the study did not measure implementation and the author cautioned that there was little evidence youth in the two groups received services that differed meaningfully (Bickman, Smith, Lambert, & Andrade, 2003).

While these results are encouraging overall, they do not go very far in terms of building an evidence base for wraparound. The primary difficulty rests in the fact that none of the studies measured implementation or fidelity, making it impossible to determine how groups within a study differed, and the extent to which the wraparound that was delivered across the different studies was actually the same intervention. As is the case in communities overall, the wraparound that was implemented likely varied significantly from study site to study site.

Recognition of these difficulties provided a stimulus for the development of measures of wraparound fidelity during the late 1990s. Fidelity measures are intended to assess the extent to which a program *as implemented* is faithful to its prescribed protocol, standards, or model. Within wraparound, two approaches to the measurement of fidelity have been explored, one focusing on direct observation of fidelity to key elements of the wraparound process and the other focusing on reported perceptions of fidelity to the wraparound principles. The best-developed measure of process fidelity within wraparound is the Wraparound Observation Form (WOF, Nordness & Epstein, 2003), a structured observation form completed by an observer during a team meeting. The observer rates whether or not meeting participants engaged in certain types of activities that are presumed to reflect the principles of wraparound. In contrast, the Wraparound Fidelity Index (WFI, Bruns et al., 2004) uses structured interviews with family, youth, and care coordinators to assess perceptions of whether wraparound has been delivered in a way that reflects the philosophy expressed in the principles.

Current Work and Future Directions

As things stand now, there is widespread enthusiasm for wraparound, support from ongoing funding initiatives, and evidence from program evaluation that the wraparound process has the potential to be effective. Most importantly, people who have participated on wraparound teams and implemented wraparound programs have accumulated a vast amount of practical knowledge about what makes wraparound successful. Yet there is also a growing realization that, given the current emphasis on evidence-based practices, it is unlikely that this positive momentum can continue unless wraparound practice can be more clearly defined. Such clarification will pave the way for replication and for accumulation of the research that is essential for establishing evidence of effectiveness.

One possible solution to this difficulty is that one well-regarded wraparound program or model will be replicated at several sites with a high degree of fidelity, and the replications will be studied sufficiently to produce the beginnings of an evidence base. The practices and elements of this program could evolve from there to become the *de facto* standard for wraparound. While this might be an expedient route to achieving a clear definition of wraparound, it also presents several drawbacks. First, by drawing exclusively from one program, there is the potential to lose much of the collective wisdom that has accumulated among practitioners, particularly knowledge that has grown out of efforts to implement wraparound within diverse communities and diverse policy and funding contexts. This presents a risk of sacrificing part of what has made wraparound successful, particularly in terms of being culturally competent, individualized, and community based. Picking one program as *the* model for

wraparound would also seem to undercut the collaborative ethos that has been a central feature of wraparound's development, with wraparound developers freely sharing ideas and building their own practice models through incorporating tools and techniques used by others. More practically, it is quite possible that several programs would begin this evolution. If this happens, the stage is set for the development of rival wraparound models competing for legitimacy and for the resources that are required for the work of documenting effectiveness.

In response to such concerns, stakeholders from across the country came together in 2003 to work out a strategy for collaboratively defining wraparound and developing evidence for effectiveness. The idea that emerged from this meeting was to work as a group to refine the principles of wraparound and to specify the basic activities that are essential for wraparound. The activities would be defined in a manner that was sufficiently precise to permit measurement of process fidelity, but also sufficiently flexible to allow for diversity in the manner in which a given activity might be accomplished. The group also agreed that it was important to remedy the lack of a theory base for wraparound. While wraparound has always had implicit associations with various psychosocial theories (Burns, Schoenwald, Burchard, Faw, & Santos, 2000), a clear rationale has not been developed to explain why practice undertaken in accordance with wraparound's principles should produce the desired outcomes. This lack of theory has exacerbated difficulties in defining wraparound practice and conducting research. While recent work has begun the theory-building effort (Walker & Schutte, 2004), members of the group prioritized this for future work.

Between June of 2003 and the end of 2004, the group of stakeholders, now called the National Wraparound Initiative (Bruns, Osher, Walker, & Rast, in press), grew to more than 80 members, including family members and advocates, youth consumers, service providers, and administrators and policy-makers from the agency level to the state and national levels. During that period, the Initiative made significant progress on several of its top priorities using a range of collaborative and consensus-building strategies. For example, to refine the principles of wraparound, the group began with the existing elements produced in 1998. The intention was to rework these elements so that each one focused on a single theme and so that, together, they expressed a complete philosophy for wraparound practice at the team level. Using individual and small group open-ended feedback, the writing team prepared a revised version of the principles that then became the starting point for a structured communication and consensus-building process based on the *Delphi* technique (Woudenberg, 1991). Participants in the initiative provided quantitative ratings and comments on the proposed versions of each of the principles. Feedback was aggregated and the principles were resubmitted to respondents for a second round of quantitative and qualitative feedback. Results from the second round showed that the revised principles were acceptable to the large majority of participating experts. The percentage of respondents finding the current wording of each principle acceptable averaged 93%, and ranged from 87% for *family voice and choice,* to 100%, for *outcome oriented*.

More importantly, the feedback highlighted substantive problematic areas that have important implications for wraparound. These problematic areas, though widely discussed among stakeholders, had not been systematically acknowledged

previously, since different interpretations of the wraparound philosophy had not been directly examined. In the area of family voice and choice, for example, the *Delphi* process illuminated difficulties that can arise around how the family's perspective should be balanced with the perspectives of other team members. Some comments expressed concern that the principle did not sufficiently emphasize the extent to which the wraparound process should prioritize the family members' perspectives over other team members' perspectives throughout collaboration. Others noted that there are times, such as when the child is in protective custody, that it is neither legal nor advisable for the family's perspective to drive the wraparound process. Taking all the feedback into account, the writing team produced a document that included a further-revised version of the principles (Table 1), each with an extended commentary providing details about the principle's intended meaning and how it might apply in particular problematic situations.

A similar process, though with only one round of structured feedback, was used to develop a description of the essential phases and activities of the wraparound process. Activities were grouped into four phases: engagement and preparation, initial plan development, implementation, and transition. Building on information from available descriptions of wraparound practice and open-ended feedback, a description of the phases and activities was submitted to Initiative members for review using a *Delphi*-type technique similar to that used for the principles. The goals were to determine whether each of the proposed activities was essential for wraparound, whether the set of activities as a whole was sufficient for wraparound, and whether the description of each activity was acceptable.

Overall, the 30 respondents expressed a very high level of agreement with the proposed set of activities. For 23 of the 31 activities, there was unanimous or near-unanimous (i.e., one dissenter) agreement that the activity was essential. Respondents also found the proposed descriptions of the activities generally acceptable; in fact, all respondents rated the description acceptable for 20 of the 31 activities. The activities (outlined in Table 2) and descriptions were revised to reflect feedback, and a document was prepared that described the phases and activities along with notes about particular challenges and other considerations that might be associated with a given activity. Many of these notes were derived from the commentaries provided by respondents and focus on how to accomplish difficult yet crucial activities, such as defining and prioritizing needs and eliciting and using strengths.

The results from these two efforts from the NWI testify to a high level of pre-existing--though not previously explicit--agreement regarding the guiding philosophy for wraparound and the overall structure of a practice model described by phases and their constituent activities. Equally important, the work highlighted areas of concern, both regarding situations that challenge the principles, and particular activities that are viewed as critical to the wraparound process. Taken together, these documents provide a sense of the structure or framework within which the actual practice of wraparound occurs. In the next phases of its work, members of the Initiative plan to flesh out this framework by providing inventories of tools, templates, and techniques that can be used as a basis for accomplishing the various activities in a manner consistent with the wraparound principles. Based on this foundation, critical supports

to implementing high-quality wraparound will be available to programs and team facilitators, who can then select from various options—or tailor an existing option—for accomplishing an activity. As noted above, the goal is to retain flexibility within wraparound, so that it can be responsive to the needs of individual teams and diverse communities.

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