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ABSTRACT

This is the fourth volume in a series of monographs from the Comprehensive Community Mental Health Service for Children and Their Families Program, which currently supports 41 comprehensive system of care sites to meet the needs of children with serious emotional disturbances (SED). This volume identifies the essential elements of wraparound services, provides a meta-analysis of the research previously done on the topic, and examines how three sites are turning wraparound into promising practices in their system of care. Chapters address: (1) the history of the wraparound process, including significant legal cases, programmatic roots of the wraparound process, community involvement concepts, and the rapid growth of wraparound; (2) the conceptual framework for wraparound, including the 10 essential elements and 10 requirements for implementation of wraparound at the practice level (requirements for a referral mechanism, resource coordinators, formation of the child and family teams, and an interactive team process and formation of partnerships to develop individualized plans); (3) 3 wraparound model sites; (4) the findings of the state/territory wraparound survey (n=55) that indicate 88 percent are providing wraparound services; (5) training and quality monitoring; and (6) case studies of wraparound services. Appendices include values and principles for the system of care, wraparound survey of state child mental health directors, and potential elements essential to the wraparound process. (Contains approximately 50 references.) (CR)

Systems of Care
Promising Practices in Children's Mental Health
1998 Series

VOLUME IV
PROMISING PRACTICES IN WRAPAROUND FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE AND THEIR FAMILIES

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Foreword

It is with great pleasure that we present the first collection of monographs from the *Promising Practices Initiative* of the Comprehensive Community Mental Health Services for Children and Their Families Program. The Comprehensive Community Mental Health Services for Children and Their Families Program is a multi-million dollar grant program that currently supports 41 comprehensive systems of care throughout America, helping to meet the needs of many of the 3.5 to 4 million children with a serious emotional disturbance living in this country. Each one of the seven monographs explores a successful practice in providing effective, coordinated care to children with a serious emotional disturbance and their families.

The 1998 Series marks a turning point in this five-year-old federal effort, which is administered by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services. The first generation of five-year grants is about to come to an end, and with that "graduation" comes a responsibility to add to the national knowledge base on how best to support and service the mental health needs of children with serious emotional disturbance. Until the very recent past, these young people have been systematically denied the opportunity to share in the home, community and educational life that their peers often take for granted. Instead, these children have lived lives fraught with separation from family and community, being placed in residential treatment centers or in-patient psychiatric centers, hundreds and even thousands of miles away from their home. For many of these young people, a lack of understanding of their psychopathology, underdeveloped or non-existing community resources, and a sense of frustration of what to do have led to their eventual placement away from home.

The *Promising Practices Initiative* is one small step to ensure that all Americans can have the latest available information about how best to help serve and support these children at home and in their community. Children with serious emotional disturbance utilize many publicly funded systems, including child welfare, juvenile justice, special education, and mental health, and they and their families often face many obstacles to gaining the care they need due to the difficulties and gaps in navigating multiple service systems. Systems of care provide a promising solution for these children and their families by coordinating or integrating the services and supports they need across all of these public service systems.

The information contained within these monographs by and large has been garnered within the original 31 grants of the Comprehensive Community Mental Health Services for Children and Their Families Program. The research was conducted in a manner that mirrored the guiding principles of the systems of care involved so that it was family-driven, community-based, culturally relevant, and inclusive. Methods for information collection included: site visits and focus groups; accessing data gathered by the national program evaluation of all grantees; and numerous interviews of professionals and parents. Family members were included in the research and evaluation processes for all of the monographs. Two of the papers directly address family involvement, and all of the papers dedicate a section to the family's impact on the topic at hand. The research was drawn from the community-based systems of care and much of the research comes from systems of care with *culturally diverse populations.*

The 1998 *Promising Practices* series includes the following volumes:

Volume I - *New Roles for Families in Systems of Care* explores ways in which family members are becoming equal members with service providers and administrators, focusing specifically on two emerging roles: family members as "system of care facilitators" and "family as faculty."

Volume II - *Promising Practices in Family-Provider Collaboration* examines the fundamental challenges and key aspects of success in building collaboration between families and service providers.

Volume III - *The Role of Education in a System of Care: Effectively Serving Children with Emotional or Behavioral Disorders* explores sites that are overcoming obstacles to educating children with a serious emotional disturbance and establishing successful school-based systems of care.

Volume IV - *Promising Practices in Wraparound* identifies the essential elements of wraparound, provides a meta-analysis of the research previously done on the topic, and examines how three sites are turning wraparound into promising practices in their system of care.

Volume V- *Promising Practices: Training Strategies for Serving Children with Serious Emotional Disturbance and Their Families in a System of Care* examines theories of adult learning, core values, and four key areas (cultural competence, family-professional relationships, systems thinking, and inter-professional education and training), and looks at promising practices that are combining these concepts into a successful sustainable training program.

Volume VI- *Promising Practices: Building Collaboration in Systems of Care* explores the importance of collaboration in a system of care focusing on three specific issues: the foundations of collaboration, strategies for implementing the collaborative process, and the results of collaboration

Volume VII - In *A Compilation of Lessons Learned from the 22 Grantees of the 1997 Comprehensive Community Mental Health Services for Children and their Families Program*, the grantees themselves share their experiences in five main areas: family involvement/empowerment, cultural competency, systems of care, evaluation, and managed care.

These seven documents are just the beginning of this process. As you read through each paper, you may be left with a sense that some topics you would like to read about are not to be found in this series. We would expect that to happen simply because so many issues need to be addressed. We fully expect this series of documents to become part of the culture of this critical program. If a specific topic isn't here today, look for it tomorrow. In fact, let us know your thoughts on what would be most helpful to you as you go about ensuring that all children have a chance to have their mental health needs met within their home and community.

So, the 1998 *Promising Practices* series is now yours to read, share, discuss, debate, analyze, and utilize. Our hope is that the information contained throughout this Series stretches your thinking and results in your being better able to realize our collective dream that all children, no matter how difficult their disability, can be served in a quality manner within the context of their home and community. COMMUNITIES CAN!

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Acknowledgments

This *Promising Practices* series is the culmination of the efforts of many individuals and organizations who committed endless hours participating in the many interviews, meetings, phone calls, and drafting of the documents that are represented here. Special appreciation goes to all of the people involved in the grants of the Comprehensive Community Mental Health Services for Children and Their Families Program for going beyond the call of duty to make this effort successful. This activity was not in the grant announcement when they applied! Also a big thank you to all of the writing teams that have had to meet deadline after deadline in order to put this together in a timely fashion. The staff of the Child, Adolescent, and Family Branch deserve a big thank you for their support of the grantees in keeping this effort moving forward under the crunch of so many other activities that seems to make days blend into months. Thanks to David Osher and his staff at the Center for Effective Collaboration and Practice for overseeing the production of this first *Promising Practices* series, specifically: Lalaine Tate for word processing and layout design; Lenore Webb for carefully editing all the manuscripts during the final production phases; Cecily Darden for assisting in editing and proofreading; and Allison Gruner for coordinating the production. Finally, a special thank you goes to Dorothy Webman, who had the dubious pleasure of trying to coordinate this huge effort from the onset. While at times it may have felt like trying to move jelly up a hill, Dorothy was able to put a smile on a difficult challenge and rise to the occasion. Many people have commented that her commitment to the task helped them keep moving forward to a successful completion.

The sharing and learning that occurred during the course of developing this monograph have been stimulating and encouraging. The editors (Barbara Burns, Ph.D., and Sybil Goldman, M.S.W.) wish to acknowledge the significant contribution of ideas, sharing of successes/challenges, and time given freely by multiple partners in this endeavor. For a listing of all these individuals, see Appendix A.

Executive Summary

INTRODUCTION

Wraparound is an approach to implementing individualized, comprehensive services within a system of care for youth with complicated multi-dimensional problems. One population for whom wraparound has proven particularly useful is those children and adolescents with severe emotional and behavioral problems. Emerging from a strong need to reduce reliance on institutional care and to eliminate the fragmented care traditionally provided to youth who are at high risk, key child leaders and the federal Center for Mental Health Services (CMHS), among others, have been engaged in significant initiatives to better understand the best provision of care for this population. Wraparound, now being disseminated across the country, is seen as a promising approach focused at the child and family level to address mental health needs more appropriately and effectively in the community. While the major initiative to develop wraparound in many states has come from the mental health system, this is an intervention for all child service sectors, with education, juvenile justice, and child welfare also taking the lead role.

This monograph was developed with the support of the Child, Adolescent, and Family Branch of the Center for Mental Health Services as part of an effort to increase understanding about the status of wraparound as a relatively new and innovative approach within a system of care. In this vein, a number of major questions were posed that have been addressed over the past year in a partnership with key developers and trainers, family members, wraparound program directors, state policy makers, and researchers. Briefly, these questions include:

- *How is wraparound defined and operationalized; and is there consensus?*
- *How is wraparound organized, and to what extent has it been disseminated across the country?*
- *As wraparound is implemented, how is competence developed and quality monitored?*
- *How strong is the evidence that wraparound is effective in achieving its aims?*
- *What further steps in the arenas of policy, training, and research are recommended to facilitate broader dissemination?*

DEVELOPMENT OF THE REPORT

To examine the preceding questions, an ambitious set of tasks was undertaken. Initially, a literature review was conducted to assess the existing evidence base for wraparound. From this review, key individuals were identified for a focus group that gathered for two days at Duke University during the Spring of 1998. Probably the most important effort behind the development of this report was this meeting, which was designed to achieve consensus around the definition, values, essential elements, and requirements for the practice of wraparound (See Appendix A for a list of participants).

The relevance of clearly defining an intervention is to ensure that it can be recognized and replicated. Clarification of the definition, values, elements, and practice requirements for the wraparound approach could help to determine whether what is being provided is truly wraparound, and to differentiate it from other interventions. Wraparound is consistent with system of care values and is a process for care delivery within a service system. At the same time, wraparound is closely tied to other key concepts of a system of care. It is individualized care, which is also true of other interventions often associated with the term "system of care." Whether wraparound is equivalent to intensive case management has been deliberated. There are multiple approaches to case management, of which wraparound may be considered the strongest one, but this awaits research comparing approaches to case management.

A survey of U.S. states and territories was conducted in order to examine in what ways and to what extent the wraparound process was being implemented across the country. Three promising programs were chosen from a number of strong candidates for site visits in order to further explore aspects of organization and implementation. This provided an opportunity for in-depth exploration of the process of implementing wraparound and identification of lessons learned from those sites that might be applicable to other communities as they engage in similar reform efforts.

The information gained over the course of this project is presented in the monograph. The origins and background of the wraparound approach are presented from the perspective of one of its founders. The definition, values, elements, and requirements for practice are outlined, as agreed upon during the focus group meeting at Duke University. These delineations represent consensus among key stakeholders, in addition to the recognition that much more work needs to be done. Three model sites—Milwaukee, Wisconsin; La Grange, Illinois; and Santa Clara County, California—are discussed, with emphases on similarities and differences in their implementation of the wraparound approach. The results of the state wraparound survey are presented, followed by a description of some of the standards and fidelity measures received in response to the survey. The monograph also describes some approaches to training and quality

monitoring, as well as some suggested steps to create and use tools that measure wraparound fidelity. Finally, results of our literature search are presented in the form of a review of wraparound studies conducted to date.

OBSERVATIONS OF BEST PRACTICES

The examination of wraparound with multiple and diverse partners (families, developers, administrators, policy makers, and researchers) communicated to the editors of this monograph the strong sense of a rapidly expanding movement to reform service delivery for children and families across the country. Enthusiasm and commitment on the part of recipients and providers are strong. There seems to be considerable consensus among these groups around definition and practice requirements, while also allowing flexibility for adaptation based on the special characteristics of communities and target populations. Those who provide training are articulate about values, elements, and practice requirements, and formal training materials are beginning to be available. Policy makers at the state level are beginning to craft wraparound into standards and devise methods for reimbursement, including managed care arrangements. Further, the research base demonstrating positive outcomes in multiple arenas is expanding, and the potential for greater growth is enhanced by attention to quality, measurement of outcomes, and demonstration of cost-effectiveness.

Definition and Description of Wraparound

Consensus among a range of partners was achieved during the Duke University meeting around the definition, values, essential elements, and requirements for implementation of wraparound. Each is presented in summary form below:

Definition

Wraparound is a philosophy of care that includes a definable planning process involving the child and family that results in a unique set of community services and natural supports individualized for that child and family to achieve a positive set of outcomes.

Values

An ecological perspective guides wraparound. This means that development occurs in the context of interactions between the child and his/her environment. To increase healthy functioning, environmental forces, including the family, the community, and the service system, must support the strengths of the child

and family. Values include voice and choice for the child and family, compassion, flexibility, and the core values of the system of care. (See Appendix B).

Essential Elements

Ten essential elements of wraparound were identified:

- Wraparound must be based in the community.
- Services and supports must be individualized, built on strengths, and meet the needs of children and families across life domains to promote success, safety, and permanence in home, school, and community.
- The process must be culturally competent, building on the unique values, preferences, and strengths of children and families, and their communities.
- Families must be full and active partners in every level of the wraparound process.
- The wraparound approach must be a team-driven process involving the family, child, natural supports, agencies, and community services working together to develop, implement, and evaluate the individualized service plan.
- Wraparound child and family teams must have adequate, flexible approaches, and flexible funding.
- Wraparound plans must include a balance of formal services and informal community and family resources.
- An unconditional commitment to serve children and families is essential.
- The plan should be developed and implemented based on an interagency, community-based collaborative process.
- Outcomes must be determined and measured for the system, for the program, and for the individual child and family.

Practice Requirements

In addition, 10 practice requirements were identified:

- community collaborative structure
- administrative and management organization
- referral mechanism
- resource coordinators to facilitate the process
- strengths and needs assessment

- formation of the child and family team
- interactive team process and formation of a partnership to develop individualized plan
- development of a crisis/safety plan
- measurable outcomes monitored on a regular basis
- review of plans by the community collaborative structure

Further operationalization of wraparound will benefit future training, quality monitoring, and research efforts. As wraparound is adapted for new child populations, organizations, or financing mechanisms, clear articulation of change will be important.

The Organization and Spread of Wraparound

Wraparound is actively being adopted across the country. Eighty-eight percent of states and territories report use of the wraparound approach, although it is unlikely that most operate consistently with the definition, values, elements, and requirements defined in this monograph. The wraparound approach, as designated by states, is serving a large number of youth across the country – an average of 3,800 youth per state where estimates were provided.

By and large, wraparound is initiated and led by the mental health sector. However, in several states, either child welfare or education are assuming the lead role. Many other human service sectors participate actively including juvenile justice, substance abuse, and developmental disabilities. Quite different types of organizational approaches (e.g., schools, private child welfare agencies, and multi-system managed care agencies) are observed, as seen in the three examples of site models. Although details such as the composition of the community team or additional service components may vary, it is apparent that these varied approaches are able to address uniquely and individually the same values, elements, and requirements of the wraparound approach.

Wraparound is quite amenable to managed care, particularly given the ability to provide flexible funds rather than having to bill for categorical services that may not match the needs of children and families. Wraparound initiatives have stressed that the availability of flexible funds is critical. However, an ability to access flexible funds can be a problem when wraparound is paid for solely by Medicaid on a fee-for-service basis.

Successful implementation of wraparound is dependent on the availability of and access to adequate community services (both formal and informal). When critical services (e.g., respite care) do not exist, the

wraparound initiative may have to facilitate development of them. Wraparound also needs to be understood in a consistent manner across system, program, and practice levels in order to work.

Clear policy and strong training within wraparound programs are consistent with measurable positive outcomes and quality of care. Such programs are likely to be seen as models and tapped for policy and training leadership state-wide and nationally, potentially underscoring the importance of building increased capacity and support for leadership to take on as additional functions.

Training and Quality Monitoring

To date, little has been done to identify the knowledge, skills, and training needed to accredit either programs or individuals as wraparound providers. The great majority of wraparound initiatives obtain training from a small cadre of national experts, suggesting a need to enhance training resources, particularly for ongoing inservice training. Training models for wraparound also are beginning to emerge in graduate schools, and further spread is necessary to prevent drastic retraining in the future. In addition, several states and organizations have developed formal training curricula that could be utilized more broadly if available and accessible in a published or Internet-accessible form. Other training tools are becoming available, including a manual and several training videos.

Some states have developed standards for wraparound. Existing ones tend to be quite general and could be enhanced with agreement within the field about the specification of wraparound. Few standards include benchmarks for monitoring purposes. Examples of well designed and tested standards should be made available to states that are in the process of developing their own specific standards. Early experience with developing and testing fidelity measures also has been reported. This requires further development to ensure that wraparound, as described, is actually being provided.

Research

Wraparound has been evaluated in 9 states through a total of 16 studies to date. Appropriate to early research on an innovative intervention, these studies are largely descriptive with the exception of two randomized clinical trials, calling for more evaluation and controlled research as dissemination continues across the country. The early studies consistently point to a number of positive outcomes: reduced restrictiveness of living situations, reduced cost of care in several studies, and improvement in social, school, and community functioning.

CONCLUSIONS AND RECOMMENDATIONS FOR FURTHER DEVELOPMENT OF WRAPAROUND

Policy

To sustain wraparound approaches and to ensure the integrity and quality of the wraparound process require strategies at multiple levels: policy, community, and practice. Policies and legislation at the federal and state level need to support the wraparound philosophy and practice, thus facilitating development of integrated service systems and planning, and the blending of formal and informal services, as well as funding streams and incentives. Standards and quality assurance mechanisms need to be built in at the national and state level and through accrediting bodies and state agencies.

At the community level, system change needs to support the development of community collaborative structures, cross-agency policies to support governance structures, the establishment of a broker organization for wraparound, the development of child and family teams that are cross-system, and the flexing and blending of dollars and funding streams.

Training

Training in the wraparound approach and its role in systems of care should occur such that wraparound is understood as a legitimate, replicable service approach that includes a set of interventions by policy makers, administrators, mid-level managers, and supervisors, as well as front-line practitioners. Training needs to involve state and local level agencies and all systems including mental health, substance abuse, social services, child welfare, education, early childhood, education, juvenile justice, and law enforcement. Attention to training for undergraduate and graduate students moving toward careers in human service sectors is also a high priority.

Training curricula must be comprehensive to include values, operational elements, and wraparound requirements, as well as cross-system issues (including jurisdictional issues, services, and financing), mentoring and coaching strategies, and evaluation strategies. Training can occur through a range of modalities including courses, supervision, coaching, mentoring, internships, certification, and degree programs.

Research

Research is critical to the ongoing development and implementation of wraparound, furthering knowledge about this service approach. Fertile areas for research include: elements essential to achieving positive and measurable outcomes, comparison of models in different settings and/or with different populations, and cost-effectiveness related to different funding mechanisms. Standardized data collection and information tracking procedures could contribute information for effective training strategies for disseminating the wraparound process. Ensuring the integrity of the wraparound process through monitoring its fidelity will be critical to the preceding types of research.

Chapter I
History of the Wraparound Process

John VanDenBerg, Ph.D.

INTRODUCTION

The wraparound process is an organized way that humans in communities support other humans who need help. The basic tenets of the wraparound process are as old as humankind. These tenets include, among others:

- Human beings typically prefer to live in communities with their families and friends of their choosing.
- Sometimes, the needs of humans are very complex.
- Human beings with complex needs often do better when they have support from other humans.
- Due to the unique aspects of human nature, needs and how needs should be optimally met vary from person to person.

A recent article in National Geographic described finding the remains of a prehistoric male whose bones showed evidence of clear trauma which would have left the individual without the ability to hunt or perhaps care for himself.[1] The healed bones showed evidence that the individual lived for many years after the accident, and would likely have been supported by the group he lived with – perhaps the first wraparound!

Worldwide, many cultures have instituted methods of supporting individual families and members of their society who need assistance, of providing support to others when they are in trouble. The field of anthropology gives us hundreds of examples of how cultures have configured this support, from the group survival traditions of the Bushmen of Africa to the communal subsistence ways of the Inupiaq Eskimo of the Arctic.

In the last 100 years, these supportive cultural traditions have evolved into formalized services delivered by professionals. North American children and families with complex needs now have access to a sometimes overwhelming array of services delivered by child welfare, juvenile justice, mental health, education, public health, and other organizations. At times, these services are not collaborative. Canadian human service professionals often refer to the services organizations as "silos"—containing different services

that don't mix even when families have needs that cut across the boundaries of each service category. Sometimes, services that are designed to help actually result in children being excluded from their communities, and in families that cannot stay intact due to competing regulations and funding policies. In his book *Stuck in Time*, author Lee Gutkind describes the pain of parents forced to give up custody of their children in order to obtain services.[2] In their seminal work, Stroul and Friedman cite the need for organized systems of care designed to right the wrongs of haphazardly developed, non-collaborative services.[3]

SIGNIFICANT LEGAL CASES

It is important to note that a number of U.S. law suits have encouraged states to consider alternatives such as the wraparound process and are an important element of the history of the process. One of the most important of these lawsuits was *Willie M. v. the State of North Carolina*.[4] In this case, the state of North Carolina was forced to develop highly individualized community-based services in lieu of long term institutional placement of youth. Another key case that legally supports the wraparound value of "voice and choice" was *Brewster v. Dukakis*, which encouraged client involvement in planning and implementing services.[5] Another important principle around the development of the wraparound process is that effective mental health services for children should be "delivered in the least restrictive setting appropriate for the child's specific needs." This principle is well defined in case law.[6,7,8] The right to individualized treatment formulated by an interdisciplinary team was set in *Brewster v. Dukakis*, where the court ruled that an interdisciplinary team must look at a broad base of client needs instead of a narrow, categorical set of needs.[9] Wraparound has also been highly focused on individualization of services as a right and not an option.

PROGRAMMATIC ROOTS OF THE WRAPAROUND PROCESS

The label of "wraparound" to describe a method of individualization and linkages to community was first used by Dr. Lenore Behar in an article in *Children Today*.[10] The roots of the wraparound process in North America began with the work of Canadian services provider John Brown, who developed the Brownsdale programs.[11] John Brown piloted some of the first small group homes as alternatives to the inhumane and ineffective grouping of youth with emotional problems in large facilities or institutions. He used program policies of unconditional care (i.e., don't kick the youth out when problems arise; change the services) and flexible programming based on individual needs. Later, Brown's concepts were adapted by founders of the Kaleidoscope Program in Bloomfield and Chicago, Illinois. Kaleidoscope developed a series of small group homes for troubled youth based on unconditional, individualized care. Many of these youth had been placed outside Illinois in large facilities or institutions. Eventually, the Chicago Kaleidoscope program became an independent organization. The Executive Director, Karl Dennis, developed a services

array based on unconditional care and individualization. He moved from a group home model to use of in-home family support services, therapeutic foster care, and development of other supportive services for families. Dennis found that placement outside the home could be diverted by use of these intensive family and youth supports.

Dr. Ira Lourie, the founding national director of the Child and Adolescent Service System Program (CASSP), in conceptualizing the needs of children and adolescents with serious emotional disturbance, described a wraparound-like approach in 1987 and was later to label that wraparound process as "the legs of CASSP."[12] The core CASSP values involved development of services that were child centered, family focused, community based, and culturally competent. These values were extremely compatible with the Kaleidoscope values around unconditional care and individualization. As the national CASSP effort was beginning to take root as a systems change movement, the wraparound approach became a major underpinning of how to apply system of care principles to individual children and families. CASSP and wraparound became symbiotic concepts.

COMMUNITY INVOLVEMENT CONCEPTS

About the same time that John Brown was developing his programs, other thinkers and leaders began to question the formal nature of services and the lack of services tied to communities, and the vital importance of community. In his last book, *Where Do We Go From Here: Chaos or Community?*, Martin Luther King, Jr. said: "I would say that other-preservation is the first law of life. It is the first law of life precisely because we cannot preserve self without being concerned about preserving other selves. . . . "I" cannot reach fulfillment without "thou."[13] King brought out the notion of community support to address cultural and racial issues. This concept of community support is basic to the evolution of the wraparound process as communities learn to "take care of their own."

THE ALASKA YOUTH INITIATIVE

In 1985, due to a fiscal crisis, officials from the state of Alaska social services, mental health, and education departments decided to return to Alaska all youth who were in out-of-state placements.[14] After a national search for precedents and alternatives, state officials located and sought consultation from Kaleidoscope. At the time, Alaska was a Child and Adolescent Service System Program state that had received grant funds from the National Institute of Mental Health to address the development of a system for children's mental health.

Alaska state officials decided to link the effort to repatriate the out-of-state youth with the Alaska Child and Adolescent Service System Program grant. As a result, Alaska Child and Adolescent Service System Program Director John VanDenBerg was appointed to develop and manage the effort, which was called the Alaska Youth Initiative (AYI). Kaleidoscope staff, including Karl Dennis and Mel Breed, came to Alaska and brought with them the values of unconditional care and individualization. The term "wraparound" was used to describe the Alaska Youth Initiative effort on both the system level and the intervention level. The Alaska Youth Initiative was managed by a cross-system team representing child welfare, education, juvenile justice, child mental health, and developmental disabilities. At this level, wraparound was conceptualized as a process that brought agencies together on the state and local level. At the intervention level, wraparound was used to describe the manner in which an individualized plan was configured and carried out.

The Alaska Youth Initiative, as a meeting place of the Child and Adolescent Service System Program and Kaleidoscope values, began to spur innovations that added to the existing knowledge about wraparound. In 1988, Jackie Rummel, an Alaska Youth Initiative staff person, configured the first formal child and family team, an innovation that quickly spread to all Alaska Youth Initiative youth and their families. Alaska Youth Initiative staff in Fairbanks began to experiment with more aggressive linkage of the formal part of the wraparound intervention with informal community resources. Robert Sewell, state level Alaska Youth Initiative staff coordinator, began to work on ways of training categorical services staff to tailor their services to fit the needs of Alaska Youth Initiative youth and their families. At a state level, John VanDenBerg, Barbara Minton, Tom Buckner, Yvonne Chase, and others began to experiment with sharing large amounts of flexible funding across state agencies. Alaska Youth Initiative was eventually successful in returning to Alaska almost all youth with complex needs who were placed in out-of-state institutions.

Early Replications of the Alaska Youth Initiative

At a national Child and Adolescent Service System Program conference in the fall of 1987, John VanDenBerg presented the initial Alaska Youth Initiative outcome data on the first 18 youth who were repatriated to Alaska. As a partial result of the initial promising data, Robert Friedman of the University of South Florida contracted with John Burchard of the University of Vermont to come to Alaska and review the initial methodology and findings of the Alaska Youth Initiative. John and Sarah Burchard later wrote the monograph, *One Kid at a Time* to describe his evaluation of Alaska Youth Initiative, after returning to Vermont in 1987 to start "Project Wraparound" which used the wraparound process to serve youth at risk of out-of-home placement.[15, 16]

There were two other early replications of the Alaska Youth Initiative. First, Washington State started a project called the Washington Youth Initiative, designed to repatriate Washington youth from out of state, and from long-term in-state placements. After a promising start, this project failed when the funding for the returned youth failed to follow the youth back to the state, and communities did not have the resources to adequately serve the youth and their families. Later, based on lessons learned and new ideas, Washington State developed an evolved and successful similar effort called "Individualized and Tailored Care".[17] At the same time, Jody Lubrecht with the Idaho Child and Adolescent Service System Program grant developed the successful North Idaho Rural System of Care project, which used a variation of the wraparound process as a way of developing the system of care at the rural family level.[18] Much of the early training in these efforts was done by John VanDenBerg and Karl Dennis.

Similar and Parallel Efforts

Although not directly linked to the Alaska Youth Initiative or Kaleidoscope, other similar important work was being done in the 1980s and early 1990s. For example, the work of Naomi Tannen in New York and Vermont has been instrumental in promoting a flexible, needs-based, family-centered approach.[19] The work of Mary Grealish and other staff of The Pressley Ridge Schools in West Virginia and Pennsylvania on rural and urban therapeutic foster care efforts is also important. The concepts of individualization and one-on-one advocacy were meshed with wraparound process technology by a large agency called the Youth Advocate Program, which is based on the East Coast of the United States. This agency came from the same philosophical roots as Kaleidoscope, but is a much larger effort now serving youth in more than six states.

It is also important to note that essentially similar parallel developments to the wraparound process have been occurring simultaneously in other fields. The work of John O'Brien and colleagues in the field of developmental disabilities has led to enormous system improvements through development of needs-based, individualized services in communities (i.e., person-centered planning models).[20] The work of John McKnight and his colleagues on restructuring communities to support individuals with complex needs has been vital to the field. National progress in the field of police reform has led to community policing projects in which the role of the officer is similarly tailored to the needs of the local community. State-of-the-art practice in social work and community mental health are evolving along parallel lines.

RAPID GROWTH OF WRAPAROUND

By 1995, the number of sites using variations of the wraparound process began to grow by leaps and bounds. One of the most important contributing factors to the growth of the model has been the 31

demonstration grants of the federal Center for Mental Health Services (CMHS). Many of these multi-year, multi-million dollar efforts include a focus on the development of local variations of the wraparound process. Efforts such as the *K'e Project* on the Navajo Reservation and the *Sacred Child Project* in North Dakota are demonstrating the process with Native American families. Big city wraparound is being done in Detroit, New York City, Milwaukee, Toronto, Minneapolis-St. Paul, Southern California, and other areas. By 1998, there were many national consultants involved with providing training for the wraparound process in the United States and in Canada, and interest is growing worldwide. In addition, several parts of Canada, including Ontario and Saskatchewan, are actively developing their own variations on the process.

SUMMARY

It is clear that the roots of the wraparound process are very old, and are based on common human values. Unlike other services innovations developed solely by an individual, a university, the federal government, or a state or local agency, the wraparound process has been developed by "all of the above." The knowledge about the wraparound process is being delivered to the field by a group of consultants who, although working out of many different organizations, agree on the core elements of the process. One of these consultants, John Franz, recently compared his work as a consultant to the role of a traveling minstrel in ancient feudal days in Europe.[21] John noted that a minstrel would leave a song with a village and travel to other villages. A year or more later, they would be back in the original village where the song was first shared, only to find that the villagers had changed and improved the song. The minstrel would then take the improved version to other villages. This is what is happening with the wraparound process. The best practice ways to implement the process are currently being refined and evolved by thousands of humans who are concerned about other humans. The cycle of support continues.

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Chapter II
The Conceptual Framework for Wraparound: Definition, Values, Essential Elements, and Requirements For Practice

Sybil K. Goldman, M.S.W.

INTRODUCTION

Wraparound is a process within a system of care that individualizes services for children and youth with complicated multi-dimensional problems; often such youth are those with emotional/behavioral disturbance having multi-system needs. The term "wraparound" originated from the idea that these youth could be best served in their home communities by "wrapping" individualized services around them in the home, in the mainstream regular education classroom, and in the community.[1] The framing elements of wraparound correspond closely with the philosophy and values of the Child and Adolescent Service System Program system of care (see Appendix B).[2,3]

Wraparound has been applied to children in child welfare, juvenile justice, special education, health, and mental health settings. But what exactly is wraparound? Is it a philosophy, a set of values, a process, an intervention, and/or a defined set of services? And are there certain elements that are essential to implementing the wraparound approach? Can they be clearly defined to achieve fidelity in implementing a wraparound approach? Too often, community leaders will say, "We do wraparound," which may mean only a case management approach to service delivery or a flexible pot of dollars to buy alternative services other than what is available through traditional providers.

As wraparound is being implemented in more and more communities, supported by state agencies and written into managed care contracts, there are calls for standards, greater replicability, consistency in implementation, and clearly defined outcomes. How can the integrity of the wraparound process be ensured when this approach is implemented on a large scale? And, how is the rapid diffusion of an innovative model managed in a rapidly changing environment? From April 29 to May 1, 1998, a group of leaders in wraparound representing developers, trainers, providers, family members, administrators, and researchers convened at Duke University to address some of these issues. The definition, core elements, and requirements for implementation presented here are based on the discussion that occurred at that meeting, as well as on training materials (including the *Wraparound Process Training Manual,* developed

by John VanDenBerg and E. Mary Grealish), and from materials and information provided by John Burchard, Karl Dennis, and other participants in the meeting. (See Appendix A).

Meeting participants recognized that the work accomplished at Duke in achieving a beginning consensus around the definition, values, core elements, and requirements for implementation of wraparound represented a major step forward. Headway was also made in addressing the tension that exists between specifying strict definitions yet leaving room for creativity and compassion. While participants believed that better delineating these concepts will help to advance and improve the implementation of the practice of wraparound as well as the ability to research and measure it, participants also acknowledged that ongoing work is necessary for further refinement, clarification, and development. In addition, it was acknowledged that more stakeholders would need to be involved in this process. A number of recommendations related to policy, training, and research critical for the future development of wraparound are reflected in the concluding chapter. The Duke meeting and the concepts provided in this document provide a foundation on which to build future work.

DEFINITION

Wraparound is a philosophy of care that includes a definable planning process involving the child and family that results in a unique set of community services and natural supports individualized for that child and family to achieve a positive set of outcomes. The planning process identifies the strengths of the child and family and inventories needs across multiple settings including home, school, and community. Wraparound is not only for "deep-end" youth, but can be an effective process for early intervention as well as addressing more complex needs; wraparound is currently being implemented for people with a range of needs including young people, elderly, families impacted by breast cancer, and others. Wraparound leaders stress that implementing wraparound requires a paradigm shift and a new point of view about service delivery and working with families; implementors must think and act "outside the envelope."

Operationalizing wraparound requires operationalizing the values of wraparound in order to define practice. Values, policies, and practice are inextricably linked. The wraparound leaders at the Duke meeting also stressed that wraparound is both an art and a science requiring a unique set of qualities and skills for accomplishment.

VALUES

The values that provide the foundation for the wraparound philosophy of care and the new paradigm for service delivery are interwoven and not mutually exclusive, but together constitute a conceptual framework. These values include:

- voice and choice* for the child and family (impacts process, information provided, and practice options);
- compassion for children and families;
- integration of services and systems;
- flexibility in approaches to working with families and in the funding and provision of services;
- safety, success, and permanency in home, school, and community;
- care that is:

  •unconditional
  •individualized
  •strengths-based
  •family-centered
  •culturally competent
  •community-based, with services close to home and in natural settings

Underlying these core values is the importance of the relationship developed with the child and family. This relationship is characterized by no blaming, no shaming, dignity, respect, empathy, listening, support, meaningful options, and self-determination. How these values are further defined and operationalized is explained in the sections that follow describing core elements and requirements.

* These terms, which were agreed upon by the focus group, were based on the extensive work (unpublished) of Dr. John Whitbeck as he defined **access** (the parent/child had a valid option at inclusion in the decision making process), **voice** (the parent/child were heard and listened to at all junctures of planning), and **ownership** (the parent/child agree with and are committed to any plan concerning them).

TEN ESSENTIAL ELEMENTS

Related to these values are ten key elements that together constitute the essence of the wraparound process. The wraparound process creates meaningful choices for children and families. For each of these elements special factors or considerations related to implementation are indicated.

(1) ***Wraparound efforts must be based in the community.*** Children deserve to grow up where their families are—not in distant placements. An important part of the wraparound process is to map the services and supports where a child lives and to identify the "neighborhood" for that child and family, identifying the strengths and resources in that neighborhood.

(2) ***Services and supports must be individualized, built on strengths, and meet the needs of children and families across the life domains in order to promote success, safety, and permanency in home, school, and community.*** Each child and family is unique and must be treated as such throughout the wraparound process. Life domains must include *all* aspects of a child's life including living situation, safety, legal, medical and health, educational and vocational, cultural and spiritual, recreational, emotional and behavioral, alcohol and drug abuse, and social and life skills.

(3) ***The process must be culturally competent.*** Focusing on the strengths in families, learning about the family's culture and the natural resources in that family, neighborhood, and community are an integral part of the wraparound process and consistent with the principles and practices of cultural competence.

(4) ***Families must be full and active partners in every level of the wraparound process.*** Families are the most important resources of any child. Families should be viewed as capable and the experts regarding their children's lives. The process should support empowerment, self-reliance, voice, and choice. If a child is in the custody of the state and the goal is family reunification, a continual effort is made to involve the biological parents in all aspects of the planning process. If the plan does not include family reunification, then a committed caregiver (e.g. relative, adoptive parent) should be at the center of the planning process with the child, and provisions explored for child, sibling, and parent visitations. If a child is not in the custody of the state, the biological parents have access to all discussions related to the child's plans and are able to voice their preferences and make legitimate choices.

(5) ***The wraparound approach must be a team-driven process involving the family, child, natural supports, agencies, and community services working together to develop, implement, and evaluate the individualized service plan.*** For wraparound to be successful, members of the team must develop consensus and work together in partnership to support the family and child.

(6) ***Wraparound teams must have flexible approaches with adequate and flexible funding*** to develop and implement individualized plans, which can include an array of services and/or supports both categorical/formal and non categorical/natural, informal. The concept of flexible funding is important for creating critical individualized services and supports, but flexibility in wraparound goes beyond funding and includes a flexible approach in setting, location, time, and service response.

(7) ***Wraparound plans must include a balance of formal services and informal community and family resources.*** In working with families, efforts should be made to gradually replace formal services with informal, natural supports.

(8) ***The community agencies and teams must make an unconditional commitment to serve their children and families.*** If the needs of the child and family change, or if a family member's behavior is difficult, the child and family are not rejected from services or from their community. Instead, the services and supports will be changed and redesigned to reflect the needs of the child and family.

(9) ***A service/support plan should be developed and implemented based on an interagency, community-neighborhood collaborative process.*** In order for the implementation of the plan to be effective, the resources of the whole community must be involved in both design and implementation of the plan. If children and families have needs that cross formal systems, those systems must be involved as well. There are different and evolving ways for achieving broad community "ownership." Experience has shown that community ownership can contribute greatly to the integration of practice, program, and system levels–ensuring greater buy-in from the whole community; improved access to all necessary formal services; more availability of informal resources and supports; and greater likelihood of sustaining the wraparound process.

(10) ***Outcomes must be determined and measured for each goal established with the child and family as well as for those goals established at the program and system levels.*** Outcomes should be based on achieving success, safety, and permanence in home, school, and community settings.

TEN REQUIREMENTS FOR IMPLEMENTATION OF WRAPAROUND AT THE PRACTICE LEVEL

There are 10 requirements to ensure operationalization of the wraparound philosophy, values, and essential elements. These requirements represent the "how-to" of implementing wraparound. The basic steps in the wraparound process have evolved over the last 20 years. While these steps may appear simple or easy, their implementation is often difficult and painstakingly slow. This is because the wraparound process represents a threat to a long tradition of practice that has often removed children with complex and enduring needs from their communities; has structured services based on the limits of narrow categorical funding strategies; has not been accustomed to viewing parents as partners in the change process; has not been based on a collaborative system of care model; and has rarely been outcome oriented.

These requirements, in conjunction with the values and essential elements, become the basis for standards to ensure practice fidelity in implementing wraparound. However, it is important to note that while each of these elements and requirements is *essential* to the wraparound approach, the *essence* of wraparound is making the paradigm shift and tailoring the process to the particular community, cultural environment, and to the particular child and family, balancing both the art and the science of implementing wraparound.

(1) ***The community collaborative structure, with broad representation, manages the overall wraparound process and establishes the vision and the mission.*** Representation includes families (with extended family members), agencies, schools, cultural leaders, neighborhood leaders, advocates, law enforcement, spiritual leaders, the business community, and others.

(2) ***A lead organization is designated to function under the community collaborative structure and manage the implementation of the wraparound process.*** The lead organization can be either public or private; it can be a newly created entity or an established agency in the community; and its primary focus can be mental health, child welfare, education, or community development. However, the organization cannot be wed to a single focus or role but rather must embrace interagency collaboration and a holistic view of children and families.

(3) **A referral mechanism is established to determine the children and families to be included in the wraparound process.** The community collaborative structure (or other community entity) establishes, within its mission statement, a designation of the children and families its wraparound initiative is being designed to serve. Many communities start by designating children and families

with more complex needs, but the process can begin with an early intervention focus or both. It is important to emphasize that *wraparound is not a program* in which a child and family are placed, *it is a process* to meet needs and achieve outcomes.

(4) ***Resource coordinators are hired as specialists to facilitate the wraparound process, conducting strength/needs assessments; facilitating the team planning process; and managing the implementation of the service/support plan.*** Resource coordinators may work for the community collaborative structure or for the broker organization. Many sites use parents who have experience with the wraparound process. The best resource coordinators are those with flexible, open views of what children and families need and how those needs can be met to achieve positive outcomes.

(5) ***With the referred child and family, the resource coordinator conducts a strengths and needs assessment.*** This is a critical step in the wraparound process because it is this dialogue that provides the basis for the development of a positive, trusting, and constructive relationship. The process focuses on family strengths, not deficits. An initial conversation or semi-structured interview discovers strengths, family culture, informal resources, and needs across a life domain profile. Strengths, potential, resources, values, preferences, perspectives, and issues are determined before identifying needs. *This is also the initial step in designing a crisis and safety plan for the child and family, which is critical for the wraparound process.*

(6) ***The resource coordinator works with the child and family to form a family team.*** The team consists of 4 to 10 persons (in addition to the child and family) who represent a blend of the formal and informal resources that make up that child and family's support network. Ideally, professionals should not represent more than 50 percent of the team.

(7) ***The child and family team functions as a team <u>with</u> the child and family engaged in an interactive process to develop a collective vision, related goals, and an individualized plan that is family centered and team based.*** The team forms a partnership that blends perspectives to develop consensus and a common vision around outcomes, needs, and the services and supports to meet those individualized needs and to achieve the envisioned outcomes across priority life domains. The partnership is the key. The team develops a plan based on the discovered strengths, values, preferences, and priority life domain needs. The team helps implement the family vision.

(8) ***A crisis/safety plan is produced by the child and family team.*** The team should expect crises to happen and develop a plan with the child and family to address a potential crisis both proactively and reactively and to create a stabilization plan that will enable a child and family to move from crisis to safety. The strengths/needs assessment is the initial step in designing a crisis/safety plan for the child and family.

(9) ***Within the service/support plan, each goal must have outcomes stated in measurable terms, and the progress on each monitored on a regular basis.*** The tracking of progress and achievement of goals at the child and family level assist the team in evaluating areas of success and areas requiring different strategies. Goal achievement data are also extremely valuable when aggregated across families to assess progress in achieving program and system level goals.

(10) ***The community collaborative structure reviews the plans.*** The community collaborative structure (or its designated plan review subcommittee) does not change or alter the plan developed by the child and family team, but it is important that the individualized service plans be reviewed to gain community support and encourage a broader systems change strategy. This review can help break down barriers, build support (buy-in), create services and funding support, and ensure accountability and quality assurance.

Chapter III provides examples of how three different communities are implementing these values, elements, and requirements in their wraparound process.

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Chapter III
Three Wraparound Models as Promising Approaches

Sybil K. Goldman, M.S.W. and Leyla Faw, B.S.

INTRODUCTION

Around the country, there are many examples of how the wraparound approach and its core elements are being implemented in different types of communities, different contexts, and with different populations. Inherent in wraparound is its adaptability and flexibility. But in each of the examples described, the core elements and requirements of wraparound, delineated in Chapter II, are addressed. Milwaukee, Wisconsin has developed a wraparound approach for youngsters in the juvenile justice and child welfare systems and adapted it to the state's Medicaid managed care reform (to avoid duplication, greater detail is provided on Milwaukee than for the next two sites). La Grange, Illinois has implemented wraparound in its school system. Both of these examples are also sites funded as system of care communities for the Center for Mental Health Services' Comprehensive Community Mental Health Services for Children and Their Families Program. The California example describes a partnership between Eastfield Ming Quong, a private child welfare agency that has converted from a traditional residential treatment center to a wraparound approach, and Santa Clara County using a wraparound approach for county youth who are seriously emotionally disturbed. Variations among sites in implementing the requirements of wraparound are discussed in the conclusion of this chapter.

WRAPAROUND MILWAUKEE

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Background

Wraparound Milwaukee provides an example of how the wraparound approach has been implemented as a Medicaid managed care behavioral health carve-out for a specific population—children and adolescents with serious emotional disturbance who are under court order in the child welfare or juvenile justice system. In 1994, Milwaukee County was awarded a Comprehensive Community Mental Health Services for Children and Their Families Program grant by the Federal Center for Mental Health

Services. This grant is administered by the Child and Adolescent Services Branch of the Milwaukee County Mental Health Division. Through the grant, the Division initiated *Wraparound Milwaukee* and the *25 Kid Project* designed to use a wraparound approach for youth in residential treatment centers and return them to the community. The success of this pilot led to expansion of this project serving children identified by the Child Welfare Department or the Juvenile Court for residential placement. These include children who are in need of protective services or adjudicated delinquents. The expansion became operational in May 1996, and *Wraparound Milwaukee* began incrementally to assume responsibility for youth who were under court order for placement by child welfare and the juvenile court, with the goal of enrolling all of these youth in *Wraparound Milwaukee* by the end of 1997. In March 1997, *Wraparound Milwaukee* became a Medicaid managed care program operating as a behavioral health carve-out and received a monthly capitation for each Medicaid- eligible child enrolled in the program.

During the first two years (1994-95) wraparound served 175 children. By December 1997, wraparound had assumed responsibility for and served 571 youth who were seriously emotionally disturbed in the child welfare and juvenile justice systems, and by the end of 1998 it is expected that 610 youth and their families will be enrolled in *Wraparound Milwaukee*, a rapid growth rate in a relatively short time frame.

Wraparound Milwaukee is considered to be the system of care in Milwaukee County for children with serious emotional disturbance and their families. The goals of *Wraparound Milwaukee* include minimizing out-of-home placements, supporting families to function as autonomously as possible, building on family strengths, helping families access an array of services and supports, coordinating care, developing service capacity in the community, and delivering services in a cost effective manner.

Administration

Wraparound Milwaukee is administered by the Child and Adolescent Services Branch of the Milwaukee County Mental Health Division. That Branch also operates a 40-bed inpatient facility, day treatment, outpatient services, and a crisis team, which serves as the gatekeeper to any inpatient hospitalization. The Mental Health Division is part of Milwaukee County Human Services, which also includes Probation, Developmental Disabilities, Adult Services, and Aging. Child welfare used to be included in this department, but as of January 1, 1998, authority for child welfare was assumed by the state. Ultimate governance authority lies with the Milwaukee County Board and the County Executive; both the County Executive, an elected official, and Board are supportive of *Wraparound Milwaukee*.

Overall direction of *Wraparound Milwaukee* comes from the Director of the Child and Adolescent Services Branch of the Milwaukee County Mental Health Division, who is the Project Director, and from

the Wraparound Management Work Group, which meets weekly. That work group includes the Director and the Assistant Director of *Wraparound Milwaukee*, the Director of the Mobile Urgent Treatment Team, the Medical Director, the Clinical Psychologist, the Clinical Consultant, the Director of Intake, the Chief Financial Officer, the Provider Network Coordinator, the Coordinator for Quality Assurance/Quality Improvement, Care Coordinator Representative, and the Milwaukee County Family Advocate, as well as others.

Funding

Wraparound Milwaukee is funded through a blending of child welfare and juvenile justice funds, a monthly capitation for each Medicaid child enrolled in the project (approximately 85 percent of the children are Medicaid-eligible), and federal grant dollars from the Center for Mental Health Services. The child welfare and juvenile justice dollars are those funds that would be used for youth in residential facilities. The Medicaid capitation rate, which includes all mental health services, is $1,478 per child per month. The child welfare case rate is $3,300 per child per month. Overall, the projected budget for *Wraparound Milwaukee* for 610 youth is $27 million for 1998: $9 million from Medicaid, $7.8 million from child welfare, $7.3 from the county delinquency program, $2 million from the federal grant, and other financial resources from Social Security Income (SSI), inpatient diversion, and fees for service. Any dollars the project saves as a result of diversions from more expensive residential or hospital care can be reinvested in the system of care; these are generally allocated to serve more children in *Wraparound Milwaukee*.

System Level Changes

Wraparound Milwaukee is supported by a number of key policies and systems (including Medicaid, child welfare, welfare, and mental health). In Wisconsin, families who are on welfare are enrolled in health maintenance organizations for health, mental health, and substance abuse services; however, for those families with a child with a serious emotional disturbance, families may request an exemption to disenroll from the health maintenance organization. Milwaukee is a pilot site for a behavioral health carve-out, so that families have the option to enroll their child in *Wraparound Milwaukee* for mental health services. At the state level, Wisconsin's mental health system is structured to enable a high degree of local autonomy at the county level, but the state mental health agency is highly supportive of *Wraparound Milwaukee*.

The county child welfare system has been taken over by the state as a result of a class action suit; the state recently invested $40 million to expand and improve staff capacity and to train administrative and line staff. During this transition, the state and *Wraparound Milwaukee* are working together closely. In

addition, the state is contracting out responsibility in two of five new service areas in the county for provision of early intervention services to families in which there has been child abuse or neglect to the County Mental Health Child and Adolescent Services Branch. This program also involves using a wraparound approach to service delivery.

At the local level, education is not an equal funding partner with child welfare, juvenile justice, and mental health. The Milwaukee public schools are not required under statute to pay for residential treatment care or even for the educational component of residential treatment for youth under the jurisdiction of the courts. They do not have the same financial stake as do school systems in other states in reducing out-of-home placements (the school department does operate some alternative schools). School personnel are, however, very actively involved in the individual service planning level on the child and family teams and on the systems level in the Partnership Council and the Wraparound Review and IntakeTeam (WRIT). The role of schools is considered to be an important part of the care plan developed for a child and family, and individual schools are very supportive in working effectively with aides in the classroom and modifying school settings and educational services to assist the child. Parents are encouraged by wraparound staff to request an Individual Educational Program (IEP), if needed, and efforts are made to integrate the IEP into the wraparound plan of care.

Implementation

Values

Efforts are made to inculcate the values and core elements of the wraparound process, as articulated in Chapter II, throughout the implementation process of *Wraparound Milwaukee*. This takes place in the training of care coordinators and other key stakeholders, in supervision, in policies and in procedures, and in the requests for proposals (RFPs) and contracts.

Intake

In Milwaukee, entry into *Wraparound*, as indicated above, is determined by court order. Initially, an "enrollment" worker (one of three) will meet with the child and family in the youth's home or detention center—wherever that child and family are—to explain *Wraparound*, to conduct an initial screening, and to assess strengths, resources, and what is going on. A *Family Handbook* is also provided. This is a preliminary process, which generates a "bare bones" plan that the court will require to allow participation in *Wraparound Milwaukee*. The assignment of care coordination is also made at that time.

All enrollments are reviewed by the Wraparound Review and Intake Team (WRIT), which both approves enrollment into wraparound as well as disenrollments after goals are met for the child and family. This team, which includes members from the Management Workgroup, mental health, Milwaukee public schools, child welfare, probation, and family members, is required by the Medicaid contract. The Wraparound Review and Intake Team is also informed of the care coordinator assignment.

Care Coordinators

A Request for Proposals (RFP) process has established 15 lead agencies in the community who provide care coordinators for *Wraparound Milwaukee* and supervision for those coordinators. Many of these agencies are existing resources in communities and neighborhoods that are known by the youth and their families and represent the cultural diversity of the families in Milwaukee. *Wraparound Milwaukee* now has 90 care coordinators to handle the rapid increase of youth and families. Each care coordinator has a caseload of up to eight families. The Request for Proposals specifies the requirements and responsibilities of the agencies, care coordinators, and supervisors. Care coordinators are required to have a bachelor's degree in mental health or a related field (e.g., social work, psychology, criminal justice, or health) and participate in a four-day certification program conducted by *Wraparound Milwaukee*. Supervisors are required to have a bachelor's degree, as well as sufficient experience, including three years' in case management. Supervisors provide support and "daily nurturing" for care coordinators. In addition, all the agency supervisors and wraparound management team members meet every other week to address the complex systems issues that impact the effective implementation of wraparound.

> *"Care coordinators must have a natural sense of how to work with families and must possess a compassion for helping."*
> — Care Coordinator Supervisor, Wraparound Milwaukee

> *"This exploration with the family is a critical aspect of the wraparound process."*
> — Care Coordinator Supervisor, Wraparound Milwaukee

Once a youth and family are enrolled and a care coordinator assigned, that care coordinator meets with the child and family within a week. The first visit of the care coordinator with the family focuses on establishing rapport, hearing the family's story, discovering strengths, determining immediate needs, exploring what has worked, what hasn't, what would help, providing the family with important information (delineated in the *Family Handbook*), and establishing a crisis safety plan. The care coordinator assures the family that wraparound will do "whatever it takes" to support the family.

Formation of the Child and Family Team

Within the first month, the care coordinator works with the child and family to develop the child and family team. The family identifies all the resource people involved with that family as well as supports to the family and youth. Typically, the team would involve the care coordinator, all family members, natural supports to that family including relatives, church members, friends, and system staff such as mental health, teachers, and other school personnel. The probation officer (if a juvenile court case) and child welfare worker, if appropriate, are involved on the team as well. The team might also include a family advocate, if that is the family's desire. *Wraparound Milwaukee's* clinical psychologist might be involved on the team especially if the youth is higher risk such as a fire setter. Like the family, the care coordinator interfaces with all systems involved with that child and family.

Interactive Process to Develop Plan

The process for the team meeting is outlined in the care coordinator's training manual. Essentially the team works with the family to determine the family's vision and needs, identify the needs and expectations of the team, develop strategies to meet all those needs, prioritize strategies, determine outcomes to be realized, establish a plan, and assign roles and tasks. In developing the plan, the team explores with the family different domains (required domains include family, safety/crisis, legal, psychological, and educational/vocational; others, as appropriate, include living arrangements, medical, cultural/spiritual, social, and recreational). The team also develops long-term and short-term goals for each area, and works together with the family to develop consensus on the goals and how to meet those goals. The plan lays out the services and supports for the family to meet needs and achieve the outcomes agreed to. The resulting plan is disseminated to all the individuals on the team and must receive the family's sign-off. To the extent possible, the family plays a major role in setting up the services.

From that plan, the care coordinator generates a Service Authorization Request (SAR), which authorizes payment to providers that are part of the *Wraparound Milwaukee* network. The Service Authorization Request is submitted for processing to the Finance Office, which checks to determine any extreme outliers, but the family and team dictate the services to be authorized. Only inpatient and crisis services require any prior authorization. The Service Authorization Request requires the sign-off of the parent on a monthly basis to ensure that services are being provided and are meeting the family's needs.

The plan of care and the Service Authorization Request are reviewed together monthly with the care coordinator and the family. Medicaid requires that plans are also reviewed and checked by a psychiatrist or

EXHIBIT 1
WRAPAROUND MILWAUKEE PLAN OF CARE

POC Date_____
Enrollment Date_____
Anticipated Disenrollment Date_____

Youth's Name_____ DOB_____ Social Security #_____
Address_____
City, State, Zip_____
Phone: Home_____ Work/Other_____
Youth Lives With_____ Relationship_____
Legal Guardian_____ Relationship_____
Address_____ Phone_____
City, State, Zip_____
Care Coordinator_____ Agency_____
Phone: Office_____ Pager/Cell_____
Fax/E-Mail_____ Supervisor/Phone_____

Check All That Apply:
- ☐ CHIPS — Court Order Expiration Date
- ☐ Delinquency — Court Order Expiration Date
- ☐ JIPS — Court Order Expiration Date

Court File Number_____ Judge_____
Probation Officer or Child Welfare Worker_____ Phone_____
Permanency Plan – Only Required for those children in Placement (To be addressed under family or living situation domain)

☐ 1 – Return Home ☐ 2 – TPR - Adoption ☐ 3 – Adoption ☐ 4 – Sustaining Care
☐ 5 – Relative Replacement ☐ 6 – Foster Care ☐ 7 – Independent Living (TPR done, child in placement)

School Name_____ Grade_____ Phone_____
School Contact Person:_____ Circle for Special Ed: ED LD CD N/A

DSM Diagnosis: By Whom_____ Date_____ On Medication Currently? Yes No

Axis I_____ If Yes, What Type(s)?_____
Axis II_____
Axis III_____ Prescribed by Whom?_____
Axis IV_____ Phone_____
Axis V_____ Known Allergies_____

POC Dates >							
SCHOOL # Actual Days Possible	6 months pre-ceding enrollment	1st 90 days after enrollment	2nd 90 days after enrollment	3rd 90 days after enrollment	4th 90 days after enrollment	5th 90 days after enrollment	6th 90 days after enrollment
# Days Suspended							
# Days of Unexcused Absences							
# Days Expelled							
JUVENILE JUSTICE # Formal Charges							
# Adjudications							

Exhibit 1 (Continued)

NAME_____

COURT EXPECTATIONS: (Relevant to Court Order)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

STRENGTHS/RESOURCES: (Include Youth's and Family's)

EXHIBIT 1 (CONTINUED)

DOMAINS

Name:

Required:
- ❒ Family
- ❒ Psychological
- ❒ Safety/Crisis*
- ❒ Educational/Vocational
- ❒ Legal*

As Needed:
- ❒ Living Situation
- ❒ Social/Recreational
- ❒ Medical
- ❒ Cultural/Spiritual
- ❒ Other

LONG-TERM GOAL/FAMILY VISION

START DATE	NEEDS	SHORT-TERM GOAL (Steps to meet needs)	PLAN (Include roles and actions of child & family team members)	END DATE	OUTCOMES (To be filled out in subsequent plans)

* Set at least one goal that includes community safety and accountability.

a clinical psychologist (who are usually on staff at the various lead agencies). Quality assurance standards require that all plans of care must be reviewed every 90 days. The full child and family team can be reconvened at any point in time.

Crisis/Safety Plan (See example in Exhibit 2). When a family is first visited by a worker from *Wraparound Milwaukee*, discussions include the development of a crisis safety plan that will work for that family. The plan identifies natural resources as well. The family is also given the number of the Mobile Urgent Treatment Team that is operated by the county mental health system on a 24-hour basis. That team can authorize emergency placement in a hospital, inpatient psychiatric facility, or crisis group home if necessary. The child and family team, when it convenes, also explores crisis and safety issues as critical domains in the child and family's life. At that time the initial crisis plan may be revised or changed.

Outcomes

In the plan of care, the family and the members of the child and family team must indicate outcomes to be achieved consistently through the plan. Outcomes tracked by the project include any changes in school attendance, changes in the incidence of juvenile justice charges and adjudications, changes in restrictiveness of living situation, and changes in behavioral functioning as measured by the Child and Adolescent Functioning Assessment Scales (CAFAS), the Child Behavior Checklist, and other measurement instruments. System outcomes such as costs are also tracked (see later section on Outcomes).

Disenrollment

Youth and families can disenroll in *Wraparound Milwaukee* when the service plan goals are met, and they can transition to other less intensive services and/or more natural supports. Usually the court dates are established for a year. Each disenrollment must be approved by the Wraparound Review and Intake Team and the courts. Typically, those youth involved with probation have stayed in Wraparound for two years. Average length of stay is 14.2 months. Since the inception of the project in 1995, more than 200 children and families have been disenrolled, which is consistent with the project's goal to strengthen and empower families to develop their own natural resources and not be dependent on formal services.

Community Team

In Milwaukee, the community team is called the Partnership Council, which is made up of approximately 25 members representing the judges, district attorneys, probation, child welfare, public health

EXHIBIT 2
CRISIS PLAN

NAME_____ DOB_____
Important Phone Numbers:_____
Caregiver(s):_____
_____
_____

Care Coordinator_____
_____

Family/Community Supports_____
_____
_____
_____
_____

Interests and Strengths of the Youth relevant to Crisis Situations:
_____
_____
_____
_____
_____

Specific Effective Techniques in Resolving Crises
(What does the child respond to? What should be avoided? Please use examples):
_____
_____
_____
_____
_____

What helps the Caregiver? (Please use examples):
_____
_____
_____
_____

Current Medications for Youth_____
Prescribed by_____ Phone_____

Potential Respite/Support Resources:
Pathfinders (ages 12-17)
Walker's Point (ages 11-17)
La Causa (ages 0-5, siblings 6-12)
Mobile Urgent Treatment Team (MUTT) hours of service are
Monday-Friday 9:00 a.m. – 10:00 p.m.; Sat., Sun., Holidays 1:30 p.m. – 10:00 p.m.
Alternative Resources (e.g., relatives and friends)

nurses, mental health, schools, care coordinator supervisors, family members, and others. The Council meets monthly and addresses broad issues related to *Wraparound*, engages in problem solving, and communicates information about wraparound to the media and the public. This group is written into state law and has prescribed functions, but is not the ultimate governing body. Governance authority rests with the Milwaukee County Board of Supervisors.

Family Involvement

Families are involved at all levels in *Wraparound Milwaukee*. As indicated in the discussion of the implementation process above, families are involved at intake in expressing their desires and needs, in choosing and running their team, in developing their plan (which they must sign off on), in selecting their providers, in implementing their plan, and in providing feedback evaluating services.

Families are also involved in policy, planning, training, and advocacy. This process of involving families at these levels has had a slower development in Milwaukee, primarily because: (1) Milwaukee lacked a local family advocacy and support organization for families with children with serious emotional disturbances, and (2) families and other stakeholders were concerned that families involved in these roles of policy, planning, and advocacy be representative of, and in touch with, the needs, concerns, and issues of families in the communities and systems that are part of *Wraparound Milwaukee*.

Currently, a Milwaukee County Family Advocate, who is associated with the newly developed Milwaukee Federation of Families, is supported by the state through federal grant funds. This Advocate sits on the Management Work Group and the Quality Assurance/Quality Improvement Committee. She and other families are involved in multiple committees and teams such as the Partnership Council, the Wraparound Review and Intake Team, and the Utilization Review Committee. The Family Advocate, as well as other families, conducts sessions in the certification training for the care coordinators and provides support and consultation to the care coordinators. Families are paid for their time and contribution to these activities. To the extent possible, and this is becoming more difficult because of the increase in the population now included in *Wraparound Milwaukee*, the Family Advocate contacts the families in *Wraparound* to offer support and advocacy from herself or other families. *Wraparound Milwaukee* also holds numerous social events such as picnics and parties for families and staff to develop a sense of community, to provide support, and to encourage families to become involved in leadership roles.

The building of a strong family organization for leadership, advocacy, and support in Milwaukee has been a struggle, but the families are feeling increasing success. One goal is to achieve independent funding

for a family organization and resource center to strengthen the autonomy of families to provide advocacy, to participate in various governance and planning activities, and to provide services.

Cultural Competence

"It takes patience and a listening ear to work effectively with families. And it is important to tell everyone the successful stories."
—Milwaukee County Family Advocate

The population served by *Wraparound Milwaukee* is approximately 47 percent African American, 38 percent Caucasian, 8 percent Hispanic, and 3 percent Native American, so the need to address issues of cultural competence is important. The project convened a Cultural Diversity Work Group to identify concerns and undertake strategies. Some of the efforts undertaken have included ensuring that policies and procedures are more culturally competent, building requirements into the Requests for Proposals and contracts, improving hiring practices (currently approximately 50 percent of the care coordinators are people of color), incorporating cultural competence in the certification training, including the key grass roots organizations in the provider network and as lead agencies, and ensuring that families play a central role at all levels.

Service Network

Wraparound Milwaukee has 120 provider agencies in its network, including the 15 lead agencies responsible for providing care coordination/case management and supervision services. As indicated previously, the lead care coordination agencies respond to a Request for Proposals to be designated a case management agency, and a contract is negotiated for that agency; however, the other service providers apply to be part of the network and they render services on a fee-for-service basis if included in a plan of care for a family. In the application process, the provider lists the services to be provided and agrees to a negotiated rate per unit of service. Milwaukee County specifies in the application that it does not guarantee a specific volume of referrals and retains the right to add or delete providers or services in the system at any time. The Provider Network Coordinator conducts site visits as well as an orientation to *Wraparound Milwaukee* for the agencies. In addition, a provider network meeting is held monthly, usually attended by 40 to 50 agency directors, and provides an opportunity to review policies and procedures, discuss issues and concerns, and address community service needs.

A wide range of services, supports, and agencies is included in the provider network, and these are all listed in the Resource Guide. The provider network includes the more "formal" services available to a child and family such as outpatient counseling services, in-home services, day treatment, and therapeutic foster care; it also includes services such as therapeutic camps, mentors, respite care, vocational counseling,

self-esteem programs, judo training, art and music therapy, and transportation services. In all, more than 50 different types of services and supports are included in the network. A Resource Fair is also conducted annually to introduce families to the service providers in the network.

Wraparound Milwaukee also has established a separate system and mechanism for paying for some of the more natural supports such as mentors that are not employed by formal agencies. A fiscal intermediary agency is used to pay for the services rendered. The family is the employer and signs off, along with the care coordinator, on the days and hours the services were provided.

For those services provided by the agencies in the network, the family and the care coordinator complete a Service Authorization Report, which is submitted to the Finance Office for processing. The Finance Office receives on average 1,200 Service Authorization Requests per month. The agencies providing services as part of a plan of care then invoice *Wraparound Milwaukee* on a monthly basis.

The *Wraparound Milwaukee* Provider Network has the advantage of making a wide array of services and agencies available to a family, only paying for those services rendered. However, with such a large network of providers, it is a challenge to ensure quality control and ensure that all agencies do actualize the values and core elements of wraparound. As a result, *Wraparound* is considering mandating participation in the provider orientation and ongoing training. Those agencies that are less "in sync" with wraparound values and elements also are those agencies that receive fewer referrals.

Training

Training has from the outset been integral to Milwaukee's wraparound approach. Before initiating the *25 Kid Project*, national wraparound trainers were brought in to meet with county officials, judges, and child welfare to demonstrate how wraparound can be an effective approach to meet the needs of youth and families with complex needs. Based on the values, elements, and requirements of wraparound articulated by national experts, *Wraparound Milwaukee* has developed a comprehensive training and curriculum that is used to train all care coordinators in a four-day certification program. Refresher courses are available to care coordinators as well. Training is also offered to providers and to key system stakeholders (such as the judges, probation, and child welfare) on an ongoing basis. Even given the extensive training provided, Project staff say that more is needed to ensure effective implementation of wraparound and fidelity to wraparound values and concepts. Ongoing training on systems issues is also necessary because of all the cross-system policy issues and changes that the care coordinators, supervisors, families, and other players must be knowledgeable about.

Quality Assurance

As part of the grant from the federal Center for Mental Health Services, the state of Wisconsin has funded a position for an evaluator for the national evaluation required by the federal government. For this evaluation, data will be collected for 610 youth on the Child and Adolescent Functional Assessment Scale (CAFAS) and the Restrictiveness of Living Environment Scale (ROLES). And, all families will be asked to complete a family satisfaction survey that was recently developed by a group of families. In addition, for 200 youth, data will be collected on the Achenbach.

Since 1997, *Wraparound Milwaukee* also has a Quality Assurance/Quality Improvement (QA/QI) Coordinator; this was a requirement of the Medicaid contract. A Quality Assurance/ Quality Improvement Executive Committee was created as part of the Wraparound Management Work Group and meets monthly. The Committee addresses the primary quality issues and concerns that arise from studies, surveys, and reports that are conducted within the wraparound system of care and proposes, as well as implements, changes to address these concerns. Examples of some of the actions of the Quality Assurance/Quality Improvement Committee include the establishment of a Peer Review Group for youth who are in residential treatment over 90 days, and a survey of families and care coordinators related to the quality of provider services. In addition, an Audit Committee was created to conduct audits on the plans of care to track a number of dimensions including whether goals and outcomes are being established and achieved. Audits of records represent one way to determine fidelity of implementation to wraparound standards, but as one staff suggested, "Good things may be happening, they just may not be written down." In process is an agency performance report to track outcome indicators for agencies that are a part of the wraparound system of care network. The Partnership Council receives and reviews the quarterly reports of the Quality Assurance/ Quality Improvement Coordinator, as does the Wraparound Review and Intake Team, the Director of Health and Human Services, and the County Board.

Wraparound Milwaukee engages in a utilization review process of its service delivery system through its Management Information System (MIS) and the Finance Office Data System. The MIS tracks utilization at three- and six-month intervals, disenrollments, financial information, demographics, as well as other information. There is also a formal grievance process to handle complaints about agencies rendering services, staff or other issues.

Recently, the Quality Assurance/Quality Improvement Coordinator instituted a Positive Recognition Announcement whereby anyone in the community could acknowledge a youth, parent, service provider, or care coordinator for a positive contribution so they could be recognized at some of the community events that are an integral part of the Milwaukee wraparound initiative.

Outcomes

Wraparound Milwaukee has reduced the use of restrictive placements: the number of children in residential care on a daily basis has decreased from 360 to 240, and utilization of psychiatric hospitalization has declined from the 1995 pre-Wraparound level of 23,000 days per year to approximately 13,000 days. Wraparound has also reduced costs. The child welfare case rate of $3,300 per month is significantly less than the $4,700 per month that child welfare and juvenile justice had been paying for residential placements for this population of youth. The costs of placing children in psychiatric hospital care ($15,000 per month) and residential treatment ($4,800 per month) are higher than the cost of Wraparound services ($3,200 per month). Savings are being reinvested in increasing service capacity and serving more children and families. Evaluative scales, used for the national evaluation, continue to show that children served by *Wraparound Milwaukee* have significant improvements in functioning and are living in less restrictive environments. In a site visit conducted for a national Health Care Reform Tracking Study, stakeholders noted the following positive effects at the individual and family level: children being able to stay at home, growth in families' ability to meet their own needs, families "owning" responsibility for their children's care and treatment, families more satisfied, and the ability of families to learn new skills. At the systems level, stakeholders noted that in addition to a reduction of children in residential facilities and a reduction of costs, there was an improved relationship between child welfare, juvenile justice, and mental health. A challenge for *Wraparound Milwaukee* is improved data collection and documentation of individual outcomes on school attendance, reduction of adjudications, and improvements on such measures as the Child and Adolescent Functioning Assessment Scales.

Lessons Learned

Features That Make Wraparound Milwaukee Work

Wraparound Milwaukee has proven to be a successful implementation of the wraparound approach and has grown relatively quickly over a 4-year period from a demonstration project of 25 youth to approximately 600 youth who are seriously emotionally disturbed and at risk of out-of-home placement. This growth has occurred because wraparound has demonstrated that it can be both cost effective as well as an effective way of serving youth with complex needs and their families, gaining the acceptance of wraparound from the courts, the child welfare system, and families. The wraparound approach also is compatible with managed care and its goal to ensure that the right services are delivered in the right amount at the right time, maximizing flexibility to allocate resources most efficiently and effectively. The strong and competent leadership of *Wraparound Milwaukee* has clearly been an important factor in generating the

confidence that the community has shown in the initiative. Other staff and families believe that the commitment to the key concepts of wraparound and the integrity of their implementation have been essential. Some of the other features that the Project Director attributes to *Wraparound Milwaukee*'s success and growth include the following:

- assuming responsibility for a population of youth that has not been effectively served in the past, and demonstrating positive outcomes for that group;
- starting with a pilot—starting small and then growing as resources and expertise in working with those children and families grow;
- building relationships with all systems, and developing trust with them that the job can be done;
- blending funding streams to ensure flexibility in the use of money;
- developing a system of community services and providers that involves the whole community in the project; and
- implementing effective support mechanisms, i.e. good Quality Assurance/Quality Improvement programs.

Challenges

But implementing a wraparound approach that balances a commitment to the values and elements with functioning in real world systems that have complex and ever-changing policies, rules, and politics, is filled with challenges. Some of the challenges facing *Wraparound Milwaukee* include:

- turf issues and system issues—bridging terminology, staying abreast of policy changes and their implications for wraparound, continuing to meet the needs of the partner agencies and systems, expanding the players and stakeholders, and creating a true system of care;
- maintaining quality with the rapid growth of the population to be served, which involves hiring competent care coordinators and supervisors, providing ongoing training, and ensuring quality control mechanisms that don't stifle the art, creativity, and compassion of wraparound;
- ensuring that providers understand the wraparound values, philosophy, and core elements and integrate these concepts in their service delivery; and
- strengthening the roles families play in all aspects of *Wraparound Milwaukee* and fostering support for a strong family organization in Milwaukee to increase the power of families—the numbers involved, the avenues of influence, and the resources available to families.

LA GRANGE, ILLINOIS

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Background

In La Grange, Illinois, a school-based wraparound program has been in place for the past seven years. This site was selected for our review because it is a school-based model, it is a Center for Mental Health Services (CMHS) demonstration site, the director of the program is a national trainer, and some research has been conducted on the project. The program started in 1990 when the director of the local school-based program became concerned about the number of children with emotional and behavioral disorders (EBD) who did not show promise toward transitioning out of self-contained special education placements. Recognizing that their program was in need of a change, the administrators contacted *Project Wraparound* in Vermont in order to learn how to implement their own wraparound initiative. They started with a small, one-year grant from a private psychiatric foundation, which funded interns to be placed in the schools. The purpose of this pilot project was to move toward getting the children to function effectively in less restrictive school settings by fostering more collaboration between the families and the teachers.

After one year, there was a high rate of return among children from self-contained classrooms to less restrictive settings, and this was mainly attributed to effective communication between the interns and the school and family. As a result, a grant proposal was submitted to the U.S. Office of Special Education Programs (OSEP), Department of Education, the following year, and La Grange was given a systems change grant in 1991. Subsequently, the *Wraparound Interagency Network* (WIN) was formed and operated for 18 months, during which 15 children were served using the wraparound process. The basic tenets of that program were very similar to the wraparound elements that remain today. Specifically, *Wraparound Interagency Network* values were delineated as:

- family-centered
- family access, voice, and ownership
- strengths-based services
- needs-based services
- wraparound teams which include both traditional and non-traditional players

This project was successful in creating teams and support services to effectively return children to their homes and communities from residential placements. The project continued for a total of three years due to refunding by the U.S. Office of Special Education Programs and initiation of support from the Illinois State Board of Education (ISBE). As the *Wraparound Interagency Network* program progressed, and the children continued to move to less restrictive placements, the La Grange Area Department of Special Education (LADSE) recognized the need to move the wraparound process deeper into the schools. The Illinois State Board of Education grant created a model named *Wraparound in Schools* (WAIS), which included Family Service Facilitators who worked with families, and Team Teachers who worked with the local school teachers. Beginning in the fall of 1993, Family Service Facilitators began working in three schools with self-contained programs for students with emotional and behavioral disorders. They assisted school staff in identifying children from their self-contained programs who could benefit from the wraparound process. For children at risk of developing emotional and behavioral disorders in regular classrooms, wraparound would serve as more of a preventative measure, as opposed to the treatment that the process provided for those children who were already in self-contained emotional and behavioral disorders classrooms.

Each school team started the school year with a caseload of five children, and extensive training on wraparound and ongoing technical assistance was provided in the schools. After one year of implementation of the *Wraparound in Schools* model, both the school personnel and the families felt there was a substantial difference between the traditional model and the wraparound model, and the results of the *Wraparound in Schools* program were indeed quite dramatic. Thus it was clear that the local Special Education Department needed to restructure its emotional and behavioral disorders program to use the wraparound approach as the standard method of service provision for this population of students. At the onset of the 1994-95 school year, the La Grange Area Department of Special Education Emotional and Behavioral Disorders Network began, a special education program for children with emotional and behavioral disorders, which had been restructured around the wraparound process and the wraparound philosophy.

Since the LaGrange Area Department of Special Education began applying the wraparound process, the number of self-contained K-8 classes for children with emotional and behavioral disorders has dropped from eight to zero as students with emotional and behavioral disorders, their families, and their teachers now receive comprehensive supports and services in a variety of settings. Although an option for self-contained classrooms is available, these programs have evolved into classrooms that serve multi-needs children such as those with autism, pervasive developmental delay, and multiple disabilities. Children who traditionally had been placed in self-contained emotional and behavioral disorders classrooms are now

served through the wraparound approach in their home schools with wraparound teams, Family Service Facilitators, and Team Teachers.

System Level Changes

The changes that happened in Illinois while the La Grange Area Department of Special Education (LADSE) was first experiencing the implementation of wraparound are significant in terms of the system structures that exist today. Specifically, there are now 62 local area networks (LANs) across Illinois, a structure that began in 1992. The early Wraparound Interagency Network Coordinating Council (from 1990 to 1991) essentially functioned as the first Local Area Network, and today they exist throughout the state. Each local area network consists of local leaders with access to interagency flexible funds from the state, and each also has additional fiscal support from the child welfare system, which provides specialized funding for wraparound. Extensive statewide training and technical assistance (TA) has been provided from the Illinois State Board of Education, with support from other agencies, since 1992. Since 1993, LADSE has administered a grant from the Illinois State Board of Education to coordinate TA and evaluation of wraparound efforts across schools and local area networks (see subsequent section on training and TA).

Administration

The La Grange Area Department of Special Education Emotional and Behavioral Disorders Network is administered through the La Grange Area Department of Special Education, a special education cooperative which serves 16 school districts in the La Grange area. The total child population is around 20,000 to 23,000, and there is a total of 55 school buildings. LADSE funds the Emotional and Behavioral Disorders Networks with a combination of state, local, and federal money. The target population for the network is K-8 children who have a primary or secondary designation of emotional and behavioral disorders. All students have Individual Educational Programs developed through the wraparound process. Each emotional and behavioral disorders Network has three levels through which children receive services:

- *Level 1:* Children with a label of emotional and behavioral disorders who are served in self-contained classrooms (primarily children with pervasive developmental disorders, autism, or multiple disabilities).
- *Level 2:* Children with a primary label of emotional and behavioral disorders who are served in their home school district by individual wraparound teams.
- *Level 3:* Children who show the potential to be labeled with emotional and behavioral disorders in the future and receive a wraparound approach as a preventative process.

As previously stated, the children in Level 1 have multiple needs, and are currently unable to benefit greatly from a general education setting. Level 2 now includes up to 50 children who are all served by school-based teams who use wraparound plans. The La Grange Area Department of Special Education Emotional and Behavioral Disorders Network includes three Family Service Facilitators, three Team Teachers, flexible funds for in-school respite (provided through paraprofessionals, interns, and other community members), a family resource developer who is a family member of a child and serves as a parent-to-parent resource on the team, and a coordinator. The Network staff meets every Friday for case review, program review, and ongoing supervision from the coordinator. These meetings periodically include staff from the local mental health setting who frequently are members of individual wraparound teams.

Funding

The budget structure of the La Grange Area Department of Special Education Emotional and Behavioral Disorders Network is similar to a managed care approach. First, the number of children who will need Level 2 services in a year is estimated, based on surveys sent to schools and the previous year's experience. From this, the number of Family Service Facilitators and Team Teachers is calculated (estimated by caseload). Then, a line-item for respite is included as well as the support of a family resource developer and coordinator. By dividing this by the number of children who will be in the Emotional and Behavioral Disorders Network, a yearly tuition rate is determined. Before the Network was developed, the schools paid a tuition rate to place a child in a self-contained classroom, but since most children remain in their home school, the cost is much cheaper.

Flexible funding is available through two avenues. Within the special education program budget structure, there is line-item for in-school respite that allows the purchase of uniquely tailored services (such as hiring an extended family member). This allows more flexibility than in a traditional special education program where a designated teacher's aide is categorically assigned to a group of students. The other avenue is the community-based local area network, where funds blended from the state are available to support wraparound plans. These funds are accessed by the Network when specific needs of the child/ family extend significantly beyond school issues or when other family members, other than the identified child, need extensive support.

Implementation

The Family Service Facilitator and Team Teacher, working with the family and teacher(s), form the core of the wraparound team. The strength-based assessment process is conducted through the partnership of the Family Service Facilitator and the Team Teacher so that the assessment explores strengths in the

home, school, and community. Each child and family team meets regularly throughout the school year. Teams often meet more frequently at the onset (weekly or biweekly) and move to a quarterly schedule as the team functioning is solidified and progress is experienced. Most children have a crisis plan for the home and school. Transitioning the youth out of wraparound occurs when the child, family, and teacher show that they are able to access supports and services on their own. The fact that the program takes place in the schools provides a natural "trial period" during the summer when the children and family do not have daily contact with school personnel. Teams spend time preparing families for this natural transition at the end of each school year. For students who still need intensive support during the summer, community agencies provide more service. At the system level, individual schools begin to break away from intensive support of the Emotional and Behavioral Disorders Network staff when the school teams themselves become more skilled and confident at implementing interventions and services.

The Family Service Facilitators, formerly known as school social workers, perform duties similar to what other states refer to as wraparound care coordinators. Their primary role is reaching out to the family to let them know about the approach, and getting friends, extended family members, and community agencies involved on the team. They often serve as a buffer between the family and the school staff, clarifying their shared or different perspectives about the child, and modeling behavioral interventions. They also serve as a liaison between the youth and the system personnel by helping teams target the youth and family's immediate needs and accessing the appropriate resources. Team Teachers were previously known as crisis intervention teachers, but their role has been restructured to a more pro-active one. Initially, their role involves reaching out to teachers in the schools to make them aware of the wraparound approach, engaging them in the team process, and ensuring that their voice is heard. Team Teachers also model behavioral interventions for teachers and aides, as both they and the Family Service Facilitators are trained in effective behavior supports.

Each child has a team facilitated by a Family Service Facilitator and/or a Team Teacher, depending on the situation. Their roles can overlap when, for example, the Family Service Facilitator has to take over a classroom while the Team Teacher meets with the family. Some of the challenges faced by both include assisting the team in determining when to take the next step in terms of implementing new services when a child's needs change, overcoming families' fears brought on by negative past experiences with the system, and giving families enough confidence to acquire services without their help. (For some of the specific student, school, home, and community services, see Exhibit 3).

EXHIBIT 3
LA GRANGE AREA DEPARTMENT OF SPECIAL EDUCATION EMOTIONAL AND BEHAVIORAL DISORDERS NETWORK–EXAMPLES OF SERVICES PROVIDED THROUGH SCHOOL-BASED WRAPAROUND PLANS

Student Services	School Services	Family Services	Community Services
■Develop behavior change programs ■Develop transition plans for high school ■Medication management ■Secure peer buddies ■After-school tutoring ■Develop home/school homework plans ■Develop transition plans into regular education	■Coverage for in-school to prevent out-of-school suspensions ■In-school respite: • Lunchrooms • Physical education class • Recess • Computers • Library • Art ■Technical assistance: • Changing roles of school-based staff • Inclusion of students with emotional and behavioral disorders • Clinical consultation • Case review opportunities • Behavioral programming • Dealing with resistance • Developing school wraparound plans ■Provide substitutes to assure teacher participation at meetings ■Crisis intervention at school ■Individual observations and behavior programming ■Academic testing ■Coordinate out-of-school supports	■Home visits ■Accompany parents & students to court ■Facilitate the completion of needed neurological and psychiatric evaluations ■Facilitate communication between home and school ■Support for families in crisis ■Provide transportation to needed appointments ■Secure before-school child care ■Accompany parents & students to doctor's appointments ■Referral to the local area networks ■Develop home behavior plans	■Recreational coaching ■Develop transition plans for high school ■Business partnerships: • Subway Sandwiches • Brookfield Zoo • Bank One • Target Store • Sign Source ■Community service liaison to provide: • Christmas tree & gifts • Rent waiver to avoid eviction • Funds to pay utilities • Drug screening • Recreation activities • Mentoring by police • Mental health agencies ■Develop community resource directory

Table taken from:
Eber, L. (1996). Restructuring schools through the wraparound approach: The La Grange Area Department of Special Education experience. *Special Services in the Schools*, 2(2), 135-149.

Values

A special feature of the La Grange Area Department of Special Education Emotional and Behavioral Disorders Network is the value placed on the input of both teachers and families. One of the major tenets of the program is that teachers need their voice to be blended with the voice of the family, as both are important partners in the designing of supports and services. Bringing those voices together is the role of the Family Service Facilitators and the Team Teachers. Another value stressed is the concept of community-based services. Specifically, the La Grange Area Department of Special Education community includes the school and the general education classroom, and thus all students are served as close to the neighborhood school as possible. The wraparound plans are different than typical individual education plans in that they are more strength-based and include both formal and informal supports such as access to keyboard lessons, tutoring, or assistance for families to access community supports. Also, LADSE emphasizes normalized needs, so that the goal is for the child to function similarly to a child who is "doing okay" in general education, not necessarily a model student. This helps the team to look at what the child needs, and blend the strengths and needs into effective behavioral planning. Because the Team Teachers are well trained in behavioral interventions, the team is able to design and implement effective behavioral interventions for the classroom as well as the home.

Training and Technical Assistance

For the past seven years, La Grange Area Department of Special Education has conducted two-to-three-day training sessions for school teams every summer. Resources from the statewide component of the Illinois State Board of Education Emotional and Behavioral Disorders Network have supported these efforts since 1993. Additional training opportunities have been available for Family Service Facilitators through Illinois's local Center for Mental Health Services project. Illinois is developing a statewide interagency training structure on wraparound. This includes seven cycles of training starting with basic wraparound awareness, child and family team development, and how to be a facilitator. Wraparound has been disseminated across Illinois to the point that the federal education funds that were originally used for initiating new projects are now used to support regional technical assistance to existing programs using a wraparound approach. They are currently in the process of initiating a massive training effort to train trainers, so that each region of the state will have trainers who are certified by the Child Welfare Department. Since this is the only department that requires certification, the child welfare standards are used in training, and an interagency wraparound training project is developing the training curriculum with core competencies for trainers. This will eventually make the training uniform and consistent across the state, and will increase the number of trainers.

This curriculum offers a model structure for other states. Each cycle of the wraparound training plan includes a target audience, a specific number of trainers, and a maximum number of participants. Cycle 1 is

a half-day session intended to teach basic awareness of the statewide commitment to the process and values of wraparound. Trainers provide an overview of the key elements and the role of the Local Area Networks. Cycle 2 is a one-day session entitled "Basic Wraparound," which provides a historical context at the national and state level, core elements, life domains, effective teaming, team development, effective plan design and implementation, and an explanation of the infrastructure needed for sustainability at the system level. Next, Cycle 3 (also a one-day session), focuses on resource management and development. Specifically, the session provides knowledge of resources, strategies to assess the local community for resources, creative and reasonable resources that have been used in the past, strategies to assess the resource needs, strategies to access community resources, plan development using traditional and nontraditional resources, and the mechanics of how to access system resources.

The two-day sessions begin with Cycle 4, "Wraparound Facilitation," during which training focuses on the history of wraparound facilitation in Illinois; the philosophy, process, and values of wraparound; an overview of wraparound facilitation; an overview of the eight-step wraparound process; the infrastructure needed for sustainability at the program level; and the child and family team statewide evaluation. Cycle 5 then moves into the "Training of Trainers," beginning with the adult learning process and managing the physical environment. The session then moves on to increasing participant motivation, training methods and techniques, use of equipment, and specific material content. Cycle 6 teaches "Mediation and Conflict Resolution," by instructing on the following topics: understanding conflict, basic human needs and conflict, theory of negotiation, interest and positions, perspectives and assumptions, introduction to communication, listening to understand, preparing to negotiate, and process alterations. Finally, Cycle 7, entitled "Building Local Capacity: System, Program, and Practice Integration" focuses on structure, perspective, and mechanisms on the system, program, and practice levels.

Quality Assurance

An extensive set of quality indicators has been developed to guide the La Grange Area Department of Special Education Emotional and Behavioral Disorders Network's implementation of wraparound through schools. A companion checklist is used to acquire baseline information on the team's perceived level of implementation and areas that they feel need improvement. This set of indicators is used for four purposes: (1) program development, (2) training, (3) direction for staff in their roles within the child and family teams, and (4) program evaluation. The components of the educational program addressed by the quality indicators include academics, teaming, social/emotional and behavioral, family participation, community involvement, the planning process, and evaluation and technical assistance. The Level II Quality Indicator Checklist is presented in Exhibit 4. The quality indicators are initially presented during training, and the checklist is then used as an ongoing program evaluation and supervision tool, where team members, after team meetings, rate each indicator on the rate of implementation and need for improvement.

EXHIBIT 4
LADSE EBD NETWORK
LEVEL II QUALITY INDICATORS

School Program_____

Person Completing_____ Date Completed_____

LEVEL OF IMPLEMENTATION			FEATURE	NEED FOR IMPROVEMENT		
In Place	Partially In Place	Not in Place		High	Medium	Low
			Academics: Teachers make modifications to curriculum with a focus on outcomes. Effective group and individual instructional strategies are applied.			
			1. Mastery of skills are considered when setting academic expectations for students.			
			2. The team continually evaluates students' academic needs through daily classwork, formal testing and curriculum based assessments.			
			3. The team teacher consults with and supports the classroom teacher in developing academic modifications.			
			4. Homework plans are developed with student and family.			
			5. Cooperative learning groups are utilized to assure participation.			
			6. Teachers access technical assistance and professional development opportunities to meet the needs of students.			
			Teaming: Teaming is integrated in both planning and delivery of services.			
			1. The school team and the parent are contacted and consulted with within the first week after a referral is received.			
			2. Members of the team are determined with sub-teams identified to address specific life domains.			
			3. A wraparound plan for the entire school day is developed within three weeks of the referral.			
			4. The team teacher supports and consults with the teachers, and the family service facilitator supports and consults with the social worker to meet the needs identified through the wraparound plan.			

EXHIBIT 4 (CONTINUED)
LADSE EBD NETWORK
LEVEL II QUALITY INDICATORS

LEVEL OF IMPLEMENTATION			FEATURE	NEED FOR IMPROVEMENT		
In Place	Partially In Place	Not in Place		High	Medium	Low
			5. The EBD Network team is available to support the teacher in developing and implementing crisis plans to assure minimal disruption to the planned instructional day.			
			6. Students and teachers are provided with aides and respite workers to meet the needs identified in the wraparound plan.			
			7. The plan is reviewed/revised at least every 6 weeks.			
			8. Every plan identifies who will follow through on each strategy.			
			9. A communication chain is developed to assure all team members are kept informed of progress towards outcomes.			
			10. If a student moves to a more restrictive placement, the team members remain the same with additional team members identified from the new placement.			
			Social/Emotional/Behavioral: Desired outcomes for behavior reflect typical school expectations and consequences.			
			1. The behavioral expectations and consequences for a student remain as close to the general population as appropriate per the individual wraparound plan.			
			2. The Network team implements behavioral strategies and interventions that meet the student's identified needs. 3. The team teacher works with the student and teacher to incorporate the strategies into the classroom and monitor progress.			

EXHIBIT 4 (CONTINUED)
LADSE EBD NETWORK
LEVEL II QUALITY INDICATORS

LEVEL OF IMPLEMENTATION			FEATURE	NEED FOR IMPROVEMENT		
In Place	Partially In Place	Not in Place		High	Medium	Low
			4. The Network team identifies members who work directly with the student to teach or reteach appropriate social skills and review progress toward goals.			
			5. Students are provided the opportunity to have input into their plans.			
			6. Community agencies are identified to assist in meeting identified needs.			
			7. Family Service Facilitators assist families with the coordination of home behavior program.			
			Parent Participation: Parents are an integral part of the school-based team.			
			1. Wraparound planning meetings are scheduled to accommodate parent needs to assure their participation.			
			2. The Family Service Facilitator assists families in identifying and communicating their needs through the team process.			
			3. Parents are given the opportunity to participate in technical assistance and training opportunities.			
			Community: Community agencies are accessed to develop comprehensive plans to meet student/ family/school needs.			
			1. Parent relationships with community agents are encouraged, nurtured, and developed.			
			2. Family Service Facilitators assist school and family teams in communicating with medical and other professionals outside the school.			

EXHIBIT 4 (CONTINUED)
LADSE EBD NETWORK
LEVEL II QUALITY INDICATORS

LEVEL OF IMPLEMENTATION			FEATURE	NEED FOR IMPROVEMENT		
In Place	Partially In Place	Not in Place	3. Community supports are identified based on current and future needs; the Network team coordinates their participation.	High	Medium	Low
			4. Network staff develop ongoing working relationships with community agencies.			
			5. The LADSE WRAP Coordinating Council continues to provide networking opportunities for school personnel and community agency representatives.			
			Planning Process: Clear timelines are established to assure continued commitment.			
			1. The EBD network staff meets with teachers, social workers, and families to determine student's strengths and normalized needs for the student prior to the first meeting.			
			2. The initial wraparound meeting takes place within 3 weeks of the referral.			
			3. Unless otherwise determined the initial wrap-around meeting addresses the educational domain.			
			4. A crisis plan is addressed at the initial meeting.			
			5. The life domains to be addressed at subsequent wraparound meetings are determined at the end of the meeting and team members are identified to address the needs in that domain.			
			6. The date, time and location of the follow-up wraparound meeting is determined at the end of each meeting.			
			7. A team member is identified to coordinate each wraparound meeting and follow up on tasks to be completed.			

EXHIBIT 4 (CONTINUED)
LADSE EBD NETWORK
LEVEL II QUALITY INDICATORS

LEVEL OF IMPLEMENTATION			FEATURE	NEED FOR IMPROVEMENT		
In Place	Partially In Place	Not in Place	Evaluation and Technical Assistance: Through evaluation, progress is monitored and ongoing technical assistance is provided to maximize student growth and success.	High	Medium	Low
			1. Formal evaluation instruments are completed on all students receiving service through the Level II EBD Network.			
			2. Reports on academic and behavioral progress are shared by school teams at each meeting.			
			3. The EBD Network provides technical assistance at a team, school, district or cooperative level to assist in professional growth.			

Outcomes

As a special education entity, La Grange Area Department of Special Education is driven by individual education plans, and is accustomed to using measurable outcomes, most of which have to do with behavior and academic learning. The wraparound planning process incorporates this outcome focus across life domains as individual student progress is monitored in intervals that range from weekly to quarterly. With regard to program outcomes, fewer children are being removed from their home schools into self-contained classrooms, and there are better student outcomes for children who are in less restrictive classroom environments. Services are evaluated by periodically reviewing each plan, and assessing the amounts of services that are community- and family-based. Since wraparound began, communities and families have become increasingly more involved in services, supporting the positive trend toward less restrictive services.

Each program administers the Restrictiveness of Living Environment Scale (ROLES), Child and Adolescent Functioning Assessment Scale (CAFAS), Children Behavior Checklist (CBCL), Educational Information Form (EDInfo), and the Teacher Report Form (TRF). Some interesting trends in those scores over the years include a drastic reduction in self-contained placements, a substantial drop in psychiatric hospitalizations during the first year, and consistently low use of psychiatric hospitals or other out-of-home placements throughout the 1996-97 data. The data also indicate that when children do need to spend time outside the home, they are more likely to go to relatives or friends than to hospitals. Another interesting finding is that although the clinical functioning levels of the youth do not change as much over the years, the teachers report satisfaction with the supports teachers are receiving, and academic outcomes are improving. This suggests that although the disability does not necessarily go away, for some youth, they are being provided with the supports that they need to function well in a general education classroom. For more detail on the research, see the Illinois section of Chapter VI.

Lessons Learned and Future Directions

In 1994, the La Grange Area Department of Special Education Emotional and Behavioral Disorders Network was used as the basis to submit a Center for Mental Health Services service grant, part of a five-year grant that is now in its fifth year. The school-based program has supported more significant changes in the Illinois Mental Health system through this grant, and two neighboring special education programs are now applying wraparound approaches through school. One of the most important lessons learned from the La Grange Area Department of Special Education Emotional and Behavioral Disorders Network is that, like families, teachers must have voice and support in the development of the wraparound plan. The La Grange Area Department of Special Education defines core team members as those who have daily contact

with the youth, and this includes teachers. Also, the wraparound process must move the team into appropriate behavioral interventions (using the principles of applied behavior analysis), as inappropriate behavior is the most frequent cause of exclusion from school. Another lesson is the importance of ongoing technical assistance and support pertaining to the inevitable role changes that the parents, teachers, and other team members will face as the service delivery approach changes. Finally, the focus of the wraparound approach must be placed at the system, program, and practice levels. Those three levels must be in agreement about the process and concepts of wraparound in order for the implementation to succeed. Currently, some of the future goals of the La Grange Area Department of Special Education Emotional and Behavioral Disorders Network include a more in-depth analysis of longitudinal data, and wider implementation of wraparound-based programs in high schools.

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Background

Another model site, chosen because it is an example of wraparound services provided through a private agency, is located in Santa Clara County, California. This site has also provided leadership around the development of wraparound standards and training for the state. This wraparound program is a collaborative effort among Eastfield Ming Quong (a private agency), the Santa Clara Social Services Agency, Santa Clara County Mental Health, and the Santa Clara County Juvenile Probation Department. The program is called *Program: Uniting Partners to Link and Invest in Families Today (UPLIFT)*, and since it began as a pilot in 1994, it has become a permanent service within the local system of care. The major incentive to start the project was the belief that children in residential placements would have better outcomes from a wraparound process, and thus the county's funds would be better spent. At the time *Program: UPLIFT* began, there were no new funds available in the state of California to implement a new program, so the Eastfield Ming Quong administrators went to the county social services department and asked them to close 88 of their residential beds. They then convinced social services to give them the county share of the money that had been used for those 88 placements, and the money would be used to provide a wraparound approach for those children.

Eastfield Ming Quong then secured strategies to obtain both the state and federal share of the board and care rates of those beds, and talked to the board of supervisors in the community about the shift in

funds and what was needed to launch a wraparound effort. The supervisors gave them start-up money out of their general fund, after which the county experienced a fairly extensive organizational change process with their mental health, social services, and educational partners. The program then developed an individual transition plan for each child in the residential program, either placing them in wraparound or in some other service arena. Eastfield Ming Quong then developed a county system that tracked the money spent on each child in the program in order to document effectiveness.

System Level Changes

One of the ongoing goals of *Program: UPLIFT* is to facilitate systems change. Originally, the project was in essence a "grass roots" effort, in that Eastfield Ming Quong basically had to build the constituency in their county. The system structure in the county was run through a joint conference on children, youth, and families which included a planning and policy group run by a board of supervisors. Eastfield Ming Quong administrators decided to establish a separate community team instead of using those committee members. Eastfield Ming Quong has piloted some of the structures that now govern the entire system of care, and the community team has helped shape the policy directions in the community to the extent that the community team concept and the wraparound concept have formed the foundation of an upcoming Center for Mental Health Services grant.

Within the next year, the community team will be part of a larger policy group on children, youth, and families in the county, and under that group, Eastfield Ming Quong will implement the program that was piloted in *Program: UPLIFT*. The results of that pilot were so indicative of success, that wraparound expansion is now occurring statewide, and Eastfield Ming Quong staff had a key role in writing the wraparound regulations.

This work also led to a state role in training all of the other counties in California on wraparound. One of the factors that made *Program: UPLIFT* successful was the establishment of permanent community resources for each child. Wraparound services never actually terminated, but simply incorporated more and more informal supports until the professionals on the team were not needed to provide or acquire more formalized services. This not only helped to ensure a successful transition out of *Program: UPLIFT* services, but also proved to be substantially less expensive for the state of California because the children eventually became independent of the state service system—traditionally, these children would continue to receive funding from the state until they became adults. As a result of this decrease in costs, the state wisely asked Eastfield Ming Quong to begin statewide wraparound training, and this is how wraparound emerged across the state, through the original *Program: UPLIFT* pilot.

Administration

Program: UPLIFT targets children and youth who: (1) are at the deepest point of the service system (the top 1.5 percent), (2) are diagnosed with serious emotional disturbance, (3) are at-risk or have been placed in group home care, and (4) are involved with multiple county services. In 1997, 125 children were referred and accepted into services, each child averaging a total of 12 previous placements at the time of referral. They were referred through the departments of mental health (54 percent), social services (42 percent), and the probation office (4 percent). Each child is served by a child and family planning team consisting of the parent/caregiver, the child/adolescent, the teacher, mental health professionals, the social services caseworker and/or the probation officer, and the family support facilitator. Other team members are added based on the needs of the child and family.

Program: UPLIFT is available to families 24 hours a day, seven days a week, and provides the following services:

- individualized service plans
- intensive case management
- direct home-based and community-based services and supports
- resource identification and coordination
- interagency service coordination
- 24-hour, on-call UPLIFT availability
- service/resource monitoring and client progress evaluation
- parent advocacy and support
- flexible financial funding pool
- facilitating community systems change

Individualized service plans are put together by conducting a comprehensive, strength-based assessment of each child and his or her family. Using this information, a child and family team is created, and this team begins by performing an in-depth life domain needs assessment. Then, the individualized service plan is developed, and services are implemented and monitored on a regular basis using the Service Plan Evaluation shown in Exhibit 5. Direct services are provided to the child and family in the following areas:

- basic needs (e.g., housing or transportation);
- social environment (e.g., peer relations, recreation, psychosocial skills);
- family environment (e.g., parenting skills, family counseling, daily living skills);
- school/vocational support (e.g., tutoring and job training, functional skills);

EXHIBIT 5
PROGRAM UPLIFT SERVICE PLAN EVALUATION
(CLIENT FILE COLOR CODING KEY)

Source	Instrument	T1 Baseline	T3 6 Mo.	T5 12 Mo.	T6 18 Mo.	T7 24 Mo.	T8 30 Mo.	T9 36 Mo.	T10 42 Mo.	T11 48 mo.	Inactive
	Services and Events Data Collection Worksheet	X	X	X	X	X	X	X	X	X	X
	Child and Family Database	X									X
Parent/ Caregiver	Child Behavior Checklist (CBCL)	X	X	X	X	X	X	X	X	X	X
	Health Survey (SF-36)	X	X	X	X	X	X	X	X	X	X
	Social Skills Rating Scale (SSRS-Parent Version)	X	X	X	X	X	X	X	X	X	X
	Parent Satisfaction		X	X	X	X	X	X	X	X	X
	Family Centered Behavior Scale		X	X	X	X	X	X	X	X	X
Child/ Adolescent	Harter Self-Perception Profile	X	X	X	X	X	X	X	X	X	X
	Social Skills Rating Scale (SSRS-Student Version)	X	X	X	X	X	X	X	X	X	X
	Child Satisfaction Survey (to be developed)										
School/ Teacher	Walker Problem Behavior Identification Checklist	X	X	X	X	X	X	X	X	X	X
Facilitator	Child & Adolescent Functional Assessment Scale (CAFAS)	X	X	X	X	X	X	X	X	X	X
Child & Family Team											
	Client File Color Coding	Red	Yellow	Blue	Pink	Purple	Manila	Brown	Grey	Tan	White

- system involvement (e.g., advocacy and support, utilization of services, education);
- mental health needs (e.g., counseling, medication compliance, rehabilitation); and
- legal and safety (e.g., counsel or crisis management).

There are five program components that support all of the services of *Program: UPLIFT*. The first is the *individualized child and family team*, which institutes the basic services, and supports planning and implementation teams. The facilitator of the team is responsible for conducting a strengths assessment and a life domains analysis, and for designing the individualized service plan. Another program component is *parent advocacy and support*. This is led by many efforts, all aimed at developing and implementing processes that enhance parents' access and voice, promote family-centered services, and provide for parent-to-parent support, self-help, and parent professional partnerships/coalitions. There are three Family Partners (employed consumers) who report to a Parent Involvement Coordinator. Their duties are to engage families entering care, advocate for families, educate parents, and offer parent-to-parent support.

Administrative support is another program component, mainly involving the services of a service management team, consisting of the Director of Clinical Services (who leads the team), the Vice President of Clinical Services, Clinical Program Managers, and the Parent Involvement Coordinator. The functions of this team are as follows:

- reviewing team and service performance (training, cost, outcomes, and interagency coordination);
- identifying monthly activities/goal;
- setting performance objectives;
- identifying persons responsible for specific targets and establishing timelines;
- monitoring continuity of care and service integration;
- monitoring community support and involvement;
- facilitating community systems linkage and change; and
- establishing quality of service and support measurements.

Service/resource teams make up the fourth program component. These teams are led by Program Managers and include facilitators, Family Specialists, Family Partners, Program Support Specialists, and a Community Development Specialist. The teams provide services and resources, consultation, and strategies to support the needs of the child and family as determined by the child and family teams.

The final program component is *community team linkage and systems development*. One of the primary goals of *Program: UPLIFT* is to form strong relationships with the community. The specific purposes for establishing this partnership are:

- creating a shared vision of a better future;
- supporting implementation of a cross-system, family-centered approach to human services (i.e., wraparound integrity);
- creating a vehicle for readiness and support for wraparound;
- ensuring participation and collaboration;
- assessing and developing community resources and supports;
- influencing policy and human services infrastructures to support wraparound values;
- ensuring strong/sustainable alliances with and among parents of children with complex, multi-system needs;
- promoting the identification, documentation, and implementation of "best practices" in cross-system human service practice and organizational design; and
- identifying and supporting community and cross-systems education, awareness, and skills training.

In order to consolidate this partnership, the community team functions as a gatekeeper for services by establishing the protocol to determine client eligibility and by monitoring the availability and accessibility of services to the target population. The community team also establishes a panel to review the individualized child and family service plan, and identifies community and interagency barriers to service delivery. It is their responsibility to develop strategies to remove those barriers and to create an operational team that works with the service management team to monitor and facilitate interagency coordination, collaboration, and integration.

Funding

The sources of funding for *Program: UPLIFT* are social services (75 percent), mental health (19 percent), and grants/donations (6 percent). Since Eastfield Ming Quong was successful in getting wraparound into the California state legislation, money from the state foster care system is re-routed toward wraparound programs. This ultimately saves money because most children eventually transition out of services, with the average length of stay about 14 months. Most of *Program: UPLIFT* funds go to salaries and payroll taxes, system capacity and development, and capital expenditures. A percentage of all dollars is pooled and set aside for flexible use when service and support needs cannot be met through other funding streams. The average amount of flexible dollars used to fund each child per month ranges from $200 to about $350. These funds are most often used to meet basic needs such as housing, food,

transportation, and clothing. A large portion of the funds is also used for service needs such as respite, mental health, social/recreational, education, and vocational.

Implementation

Specific staff members often model skills for the parents so that they are eventually able to take control of situations. In addition, some staff members serve as "shadows" who do practically everything with the child on a daily basis. For example, they might help the child get out of bed in the morning, support them at school with their peers, and help them pursue interests in the community. The long-term goal is to gradually decrease the number of formal services and increase the number of services provided by the community. This is consistent with one of the values of *Program: UPLIFT,* which states that increased informal supports lead to more successful outcomes.

In the past year, *Program: UPLIFT* has developed two new programs for delivering special services. One is a volunteer mentor program called "Neighbor-to-Neighbor." This program provides mentors for the children in *Program: UPLIFT*, and during the first year, 25 mentors were matched with youth. They have also developed a scholarship program to enhance academic or trade interests of youth. This is called the SPARK Program, and was created with the donation of a benefactor. Examples of services that SPARK has funded include music mentors, karate lessons, drafting equipment, hockey equipment, piano lessons, and art school tuition.

Values

The values of *Program: UPLIFT* are basically the same as those of other wraparound initiatives. However, there are three aspects of this project that make it slightly different. First, the consumer-driven aspect of wraparound is strongly emphasized. The program believes that the family should be at the center of the wraparound plan, and that this value goes beyond family voice, access, and ownership. As such, they emphasize that the whole team must come to consensus around the needs of the family in all aspects of planning. Another value stressed is the use of informal supports. *Program: UPLIFT* tries to include informal supports as 60 percent of each service plan. This is based on their belief that more natural supports lead to more successful outcomes. Finally, case managers are used at the front end of each plan because in many cases the children are at a high level of serious emotional disturbance, and it might be dangerous to wait for a planning team to form. From the time of referral and acceptance in the program, the case manager immediately starts to work with the child.

Training and Technical Assistance

Program: UPLIFT has a fairly extensive training program consisting of a three-day schedule that covers the following topics each day:

- *Day 1:* Wraparound Introduction and Engagement Program
- *Day 2:* Delivering Wraparound—Best Practice Methods
- *Day 3:* Creating a Host Environment for the Wraparound Approach.

The training is divided into eight sections, each with several topics. The purpose of Section 1 is to set a context for understanding wraparound, and some of the topics within that section include an explanation of the wraparound process, paradigm shifts, and 10 most commonly asked questions. Section 2 deals with parent professional partnerships, and includes a checklist for organizations and administrators on building parent access, voice, and ownership, and another checklist for service providers. This section also covers the ground rules for parent-professional partnerships and critical questions for parent inclusion. Section 3 trains on how to have strengths conversations. This section includes an explanation of the rationale for a family strengths conversation, the key elements of strengths discovery, and a small-group practice exercise.

Training on the actual formation of teams begins in Section 4, which presents the key elements of wraparound teams, and an introduction to the Personal Skills Checklist (discussed further in the Quality Assurance segment). Section 5 begins to train on how to develop individualized resource plans. Some topics include 13 core tasks delineated in individualized care, individualized planning techniques, life domain areas for planning, 10 steps for developing a wraparound plan, and 10 lessons for improvement. Developing individualized budgets and paying for the plan are taught in Section 6. Specifically, staff are trained on managing flexible funds and working with the fiscal staff.

Hiring and staff development are the focus of Section 7 of the training. Within this section, training centers on the stages of staff response to wraparound care, the Child and Family Team Observation Form, and individualized service planning. Finally, Section 8 deals with capacity building, covering each of the following topics: defining wraparound process implications, implementation challenges, the mechanics and art of community teams, lessons learned, tips for community infrastructure, and system structures.

Quality Assurance

In Section 4 of *Program: UPLIFT's* training program, staff members are trained on how to use the Team Behaviors Checklist after each planning meeting. Specifically, each team member evaluates his or her

own behavior during the team meeting by filling out a personal skills checklist immediately after the meeting. Some of the specific behaviors include taking responsibility, following through on commitments, contributing to discussions, listening to understanding, getting your message across clearly, giving personal feedback, and accepting feedback.

On a wider scale, the program is currently conducting a two-level evaluation of service provision. This includes tracking and analysis of each service plan goal attained, and an overall program performance evaluation that includes process data. These data were obtained by administration of the Family Center Scale, which measures the implementation of family-centered behaviors by staff. This scale was chosen because it correlates with many of the values of wraparound. The overall scores at six months and at one year suggest that the model is being implemented correctly, or in accordance with the elements of wraparound. Specifically, families report that the wraparound staff operate in ways that promote family centeredness.

Outcomes

Outcomes are assessed at baseline (just prior to the onset of treatment), at three-month intervals during treatment, and at the time of termination of treatment. The data are collected from parents, teachers, and facilitators on scales that measure problem behaviors, role performance, thinking, behavior toward others, school behavior, aggressive behavior, and moods and emotions. Some of the outcomes from the past year (July 1996 to July 1997) include trends toward improvement. More precisely, participants showed decreases in total problem behaviors, acting out behaviors, inward destructive behaviors (depression, suicidal), delinquency, aggressive behavior, and anxious/depressed behavior. They experienced increases in overall competency, normal functioning in school, and social behavior. Overall, the children showed more normal functioning across time.

Placement outcomes have also been reported for the past three and a half years. Of those children who have been served since 1994, 86 percent have been maintained successfully with their families in the community. There have been 51 discharges since 1994, and 67 percent of those children have been removed from the county rolls in either social services or mental health. Finally, in the last year, 85 percent of children who have been discharged were successfully returned to the community, with 21 percent having their social services dependency status removed.

Lessons Learned and Future Directions

The two major lessons learned from implementing *Program: UPLIFT* involve family inclusion and flexible funding. First, high family inclusion rates seem to have been indicative of more success for children. As a result, since the initiation of the project in 1994, families have become continually more involved, and this has changed the whole system in the sense that they have added a value that states that services must be "family-focused." The other lesson learned is one that is commonly reported in wraparound programs across the country: flexible funds are critical. The basic needs of the family must be met before their emotional needs can even be addressed, and often this cannot be facilitated without the availability of flexible funds.

Some of the current goals of *Program: UPLIFT* have to do with its infrastructure and service delivery. These goals include the development of a respite care component, continued expansion of the role of families in the program, expansion of the informational database with increased accessibility to staff and families, refinement of data collection and dissemination of data for the child and family team improvement process, and development of a wraparound audit to ensure viability of the model. In addition, goals pertaining to community involvement include continuing to develop ways to involve more of the community in providing resources for children and families, and developing other resources in the community to provide crisis respite services and foster care. Also, Program Uniting Partners to Link and Invest in Families Today would like to increase their capacity to provide services for the juvenile justice population.

Other goals of the program are concerned with training and development. The most important issues involve refining staff training to ensure quality wraparound implementation, developing management training for implementation of wraparound, and continuing to provide system-wide training on the implementation of wraparound. Finally, systems reform goals include assisting the county system of care grant in meeting its goals, continuing to provide technical assistance and training for others interested in learning about wraparound, and continuing to assess community needs and develop collaborative strategies to eliminate obstacles to implementing wraparound.

SUMMARY AND CONCLUSIONS

As indicated in the descriptions of the three examples, they all have *incorporated the values, core elements, and requirements* into the implementation of their wraparound model, although each has adapted these requirements to fit with the unique contextual features of that locality, community culture, system, and agencies. In La Grange, Illinois, the *organizational entity* administering wraparound is the educational system; in Milwaukee, Wisconsin, the local child mental health branch; and in Santa Clara County,

California, a private child welfare agency. All sites have *resource coordinators*, but they are called by different titles. In each community, "the resource coordinator" plays a key role in facilitating the child and family team and providing case management services, but in each community there are some distinctions as well. In La Grange, the teacher and family facilitator work as a team with the family; in Milwaukee, the care coordinator is under contract to work with the family and the child and family team for youth who have been court ordered by child welfare and juvenile justice; and in Santa Clara, a family support facilitator and caseworker are assigned to each child and family from the time they are referred for services.

Each of the sites makes available a *range of formal services and natural supports* for the child and family as part of the plan of care, but the structure for service provision differs. In Milwaukee, services are purchased through a network of community providers on a fee for service basis. In Santa Clara, funds are provided through social services, mental health, and grants/donations, and are allocated to specific services as well as basic needs. In La Grange, the school system provides services and flexible funds, which are also supplemented by funding through a community-based Local Area Network. Each of the sites has *flexible funding*, but the mechanism and source for the funds varies. In Milwaukee, each Medicaid-eligible child has a capitation rate and a case rate that has been negotiated with child welfare; these funds constitute the pool that is used to pay for the full array of services that a child and family need. In Santa Clara, funds from the general pool are distributed across several service arenas, creating an overall capitation rate for each service area. Flexible funds are identified as one of those areas, and this provides money for services that are not covered by the other areas. And in La Grange, a yearly tuition rate is pre-determined for each child based on records from the previous year.

Families are central in the process and in defining goals with the child and family teams. However, in each community, *families* play some different *roles in system level activities*. In Milwaukee, families are increasingly more involved on key committees such as Utilization Review and the Wraparound Review and Intake Team. In Santa Clara, parent advocacy and support is one of five core program components, and provides Family Partners (consumers) who engage and support all families entering care. And in La Grange, families work directly with teachers to ensure that the goals of the individualized service plan are shared across home, school, and community. Each of the sites has some form of a *community-based collaborative structure*, but the structure, powers, and roles of that team vary considerably. In Milwaukee, the Partnership Council consists of key leaders and systems in the community, but it plays more of an advisory, public relations role. In Santa Clara, the primary goal of the community team is to form strong linkages with the community, with one particularly notable purpose of influencing policy and human services infrastructures to support wraparound values. And in La Grange, local special education cooperatives as well as the Illinois State Board of Education place strong emphases on technical assistance and quality assurance.

There are other similarities across sites that are worth noting and have implications for implementation of wraparound:

- In each site, key players convinced community leadership and stakeholders to reallocate resources from residential treatment to support implementation of the wraparound process for a specific population of youth and families.
- In the examples provided, the target population of youth are those with serious emotional disturbance, who are at risk of out-of-home or more restrictive placements, and are most costly to public systems.
- Each of the sites also started with a small pilot to demonstrate success before expanding to include larger numbers of youth and families.
- A consistent feature of all the sites is the involvement and buy-in from multiple community systems as partners, although the roles of those partnering agencies may differ—some may provide funds, administration and management, staff and/or services.
- All of the sites have found it necessary to develop and provide training for major stakeholders; each of these sites has developed its own training programs and curricula for administration, mid-level, and front-line staff for the agencies involved in wraparound.
- As demonstrated in these examples, wraparound has changed the traditional roles of professionals. Clinical staff serve as consultants to teams or supervise resource coordinators. Across the sites, mentors play an important role and are frequently incorporated in the plan of care.

All of the sites included have demonstrated *successful system outcomes* as a result of the implementation of wraparound. These outcomes have included serving more youth in the community and in less restrictive, more normalized settings; and reducing problem behaviors in the school, home, and community. In addition, more efficient allocation of resources results in cost savings.

The sites described have also experienced some similar *challenges*—the continuing struggle to implement wraparound in complex, bureaucratic systems; the opportunities and barriers presented by the changes and "reforms" that all the human service delivery systems are currently undergoing; the need to improve processes to better track and manage data and outcomes and to ensure quality without overburdening staff and families with onerous "paperwork"; and changing the mind-set of policy makers, educators, senior administrators, mid-level managers, and clinical and other front-line staff, enabling them to make the paradigm shift necessary to implement wraparound.

Chapter IV
The State Wraparound Survey

Leyla Faw, B.S.

INTRODUCTION

In order to understand how the wraparound process is being implemented across the country, a survey was developed and mailed, in the Spring of 1998, to the state child mental health directors in all of the 55 U.S. states and territories. The topics covered included target population, number of children served, agencies involved, wraparound by other names, inclusion of community stakeholders, training, and the availability of standards and evaluation data (see questionnaire in Appendix C). The response rate was 89 percent, with 46 states and three territories represented.

METHODS

A definition of wraparound was delineated on the survey form to encourage a consistent response. However, the survey did not seek clarification about the presence of specific elements. Thus, whether responses reflected wraparound, as defined for this survey and monograph, was not certain. Child mental health directors were asked to complete the survey and return it to the author within a few weeks. Follow-up phone calls were then made to states who did not respond to the mail survey. The three states who did not respond were either experiencing changes within the government or personnel changes within their departments. The two territories not responding proved difficult to reach for follow-up.

RESULTS

Availability of Wraparound

Among those states and territories who responded to the survey, 88 percent stated that they did provide wraparound. All of those initiatives targeted youth with serious emotional disturbance who were at risk of out-of-home placement. Only eight states reported having geographical restrictions, meaning that wraparound was only available where specific counties or regions implemented the wraparound process as part of a local system of care.

The number of children being served by wraparound ranged from as low as 30 to as high as 22,028 in states that were able to provide estimates (n=24). The total number of children served, as reported by all of those respondents, was 91,327, and the average number of children served per state was 3,805. Most of these estimates of number of youth served came from medical information systems within the state or territory.

Organization

The next part of the survey was intended to identify variations in the lead organizations for wraparound programs. The respondents were first asked to indicate what systems were involved in the implementation of wraparound, and of those systems, which one was in the lead role. The service sectors most frequently involved were mental health, followed by child welfare, juvenile justice, education, services designated "other" (such as local community agencies and supports, government offices, county-based organizations, and parent advocacy groups), substance abuse, developmental disabilities, and finally public health. The service sector with the lead role was most often identified as mental health or a combination of mental health and other agencies. Two states reported that child welfare was the single lead agency, and in one state, child welfare and education shared the lead role. Two states reported that "other" services were in the lead role.

Wraparound by Other Names

The author suspected that the term "wraparound" might not be used in some states, thus making wraparound programs difficult to identify. For example, in North Carolina "wraparound" did not sound like a billable service to the Medicaid policy administrators, and instead was called "High Risk Intervention." This was the case in many other states as well. The most common "other" name reported was "Individualized and Tailored Care." Other common names included "Family Support Services," "Person-Centered Planning," "Intensive Family Based Treatment," and "Children's System of Care."

Standards and Training

Respondents were asked whether wraparound initiatives were guided by standards. Standards are usually established at the state level for purposes of reimbursement, accreditation, and licensure. Only 40 percent of states with wraparound reported that a set of standards had been established, the content of which is discussed in Chapter V. To ensure competence in wraparound, most programs depended more upon short training sessions instead, performed in most states by one of a small group of national wraparound experts. Of those states providing formal training (86 percent), 62 percent of them had been

trained by one or more of these experts, and did not report any additional, internal training. Sixteen percent of respondents stated that they had held sessions led by both internal and external trainers, and 19 percent reported only internal training. The remaining 3 percent did not specify who did their training. Though a few states had formal curricula for wraparound implementation, most states had not developed their own statewide training program.

Community Involvement

The survey also addressed the question of whether or not informal community resources (e.g., local service organizations, church groups, volunteer groups) were actually being used in wraparound implementation. This is a concept and approach that was not formally added to wraparound until 1991, when John Burchard and Richard Clarke first attempted to delineate the elements of wraparound. Ninety-one percent of the respondents who had wraparound services stated that their programs used community organizations/stakeholders as an integral part of the services package.

Program Evaluation

There was limited evidence that wraparound was being evaluated across states. One-third of states with wraparound initiatives stated that they either had evaluated or were in the process of evaluating their programs. Although the number of respondents with evaluations was almost equal to the number of respondents with standards, these two factors did not seem to correlate. That is, many states who were conducting evaluations reported that they had no state standards for wraparound.

Lessons Learned

The final question on the survey asked what lessons had been learned through implementing the wraparound process. The most common answer was that the service system must be integrated across agencies, meaning that every child service agency must be a partner and working toward the same goals. Another common answer was that providers must change the *philosophy* of service provision in order to make it completely individualized for each child and family. Most states said they found this to be extremely challenging, but that they try to train their staff in how to approach service delivery so that the full complement of resources are accessed to meet the needs of each family.

Another point made by many states was that wraparound seems to work best at the local level. Most states seemed to agree that communities know their own needs best and what services they are able to provide. Many states also stressed that informal resources should not be overlooked during the planning

stage of the process. When these services are overlooked, often the teams begin to rely on formal resources that are much more costly and in many cases much more difficult to access. Other frequent issues raised included needs for: 1) ongoing training and technical assistance, 2) tools for quality monitoring, 3) clear articulation of cultural sensitivity, and 4) an emphasis on the necessity of flexible funds.

DISCUSSION

The results received from the 49 respondents to the state survey gave an indication of the current state of wraparound service provision across the country. The responses indicated that the wraparound process was available over a wide geographical area, and that the number of children actually being served by the process was quite large. Since the estimate of the total number of youth in the United States who were being served by the wraparound approach was based on only half the states who responded, the actual number might have been as much as twice that figure. With regard to the organization of wraparound service provision, the responses to the survey indicated that there was a fair amount of variability. Programs appeared to differ in the service sectors involved, and in those taking the lead role.

The finding that wraparound was referred to by many different names not only spoke to the lack of a concurrent definition at the time when most of the programs were created, but pointed to the need for a definition as well as an established set of standards. The observation that only 40 percent of states reported having wraparound standards further emphasized this need. An example relevant to inconsistent implementation of wraparound elements is the finding that 91 percent of states who were providing wraparound used community organizations in wraparound service provision. This indicated that nearly 10 percent of those respondents who stated that they implemented a wraparound approach did not use community organizations in service provision. It would be most interesting to know why these programs have not involved other resources in their local communities.

Many states who reported not having established standards were conducting evaluations of their wraparound programs. It was therefore not surprising that many of the evaluations did not include measures of fidelity (adherence to the model), and this lack of quality monitoring could have made outcome data difficult to interpret. The need for wraparound fidelity measures is discussed more thoroughly in Chapter V. The lack of standards uncovered by the survey was most likely one of the reasons fidelity measures would be difficult to develop.

Most of the lessons learned by the states providing wraparound were centered around issues at the program and practice levels. This indicated that providers were monitoring to some extent the effectiveness of their wraparound approaches. The finding that many administrators had recognized some of their major

implementation barriers and had begun to work through them suggested that the ability to change, which is fundamental to the wraparound philosophy, was present in many different wraparound approaches across the country.

CONCLUSIONS

The results obtained from this survey suggest that at the time the survey was administered, the wraparound approach was available in a wide majority of U.S. states and territories. Furthermore, there seemed to be almost as many variations on the wraparound approach as there were wraparound initiatives. Based on these findings, it would be most interesting to conduct future surveys dealing with issues such as how wraparound is funded, how comparable interagency agreements are across states, how wraparound is staffed (from what disciplines), and variations in the service arrays utilized.

Chapter V
Training and Quality Monitoring

Leyla Faw, B.S., E. Mary Grealish, M.Ed., and Ira S. Lourie, M.D.

INTRODUCTION

Training and quality monitoring are methods used to facilitate and ensure the competent provision of services. This can include a combination of many efforts, which often come in multiple forms. Training might involve workshops, formal curricula, degrees and coursework, videos, and manuals. Quality monitoring involves the initial use of standards established typically for reimbursement, and range from very broad definitions of wraparound to comprehensive, well delineated standards that accompany training materials. A few states also have fidelity measures that are used to determine whether the actual services provided in their wraparound process are consistent with their particular set of standards. Finally, initial attention is being given to the issue of accreditation and licensure of wraparound personnel and programs. All of these components are crucial to the dissemination of the wraparound process because it must be implemented completely to ensure good outcomes and to accurately attribute those outcomes to wraparound. Such a linkage must occur to assure the continuation of funding for wraparound programs across the country.

TRAINING

Formal Training Curricula

According to the state wraparound survey (see Chapter IV), a few states have a formal training curriculum. The most comprehensive were developed in California, Illinois, North Carolina, and Florida. Since the training curricula of California and Illinois were discussed in Chapter III, this section will focus on those of North Carolina and Florida.

The *PEN-PAL* project in North Carolina is a federal Center for Mental Health Services service site that is unique because training was developed and provided at the university level through East Carolina University. Although this curriculum is not yet used statewide, as wraparound and system of care development continues to grow in North Carolina, it is likely that a statewide curriculum might be developed and modeled after the *PEN-PAL* materials.

The training manual includes seven chapters that begin with an orientation, and then guide the staff through the entire wraparound process.[1] The first chapter focuses on the values and principles of wraparound, the governance structure of the state, and the referral process. It concludes with a brief introduction to individualized service teams. Chapter II follows by explaining the role of the Coordinator of the team. Chapter III focuses on how to approach and carry out the strengths and needs assessment, and includes an explanation of a special feature called an Eco-Map. This is in essence a strategy for identifying the various strengths of the family and the community. Chapter IV delineates the actual mechanics for holding a planning meeting and includes sample agendas and a conflict resolution protocol. Crisis Planning is discussed in Chapter V, where staff are taught how to manage crisis situations. This includes a sample crisis plan and a sample of hospital admission criteria. Chapter VI instructs the staff on how to create an individualized service plan that includes measurable outcomes, and how to monitor progress (see sample service plan in Exhibit 6). The final chapter includes examples of various forms (e.g., release forms, referral forms, exchange authorization forms), and provides instructions on how to use them. The core training curriculum that is the companion to the manual includes exercises, videos, worksheets, and other activities that reinforce the steps laid out in the training manual. There is also a quality improvement protocol consisting of a child and family service record assessment and a system of care assessment, which was developed by *PEN-PAL* administrators and is specific to their program.

The training curriculum in Florida is also quite extensive in that it includes an orientation, and then explains how to implement each step of the wraparound process.[2] Like the *PEN-PAL* training program in North Carolina, the Florida curriculum also includes activities and worksheets to accompany the information provided in the training.

The manual is divided into five sections. Section 1 provides an orientation to the project by presenting examples of best practices, and some of the essential elements of effective interventions. Section 2 introduces an approach to team building and shared values. Each value discussed in this section is followed by an activity. For example, in order to facilitate understanding of the value of "unconditional help," participants are asked to list some problems that they find personally offensive and challenging to the concept of unconditional help. Some of these problems are then discussed by the whole training group.

Section 3 teaches fundamental skills for effective partnership. The basic core group of skills includes communication, having a positive approach to behavior change, coordinating treatment plans with individual education plans (IEPs), creating culturally competent plans, and ensuring that the efforts of the partnership process are outcome-focused. Section 4 gives an overview of the planning process, encompassing perceptions and attitudes, integrated plans of action, planning meetings, and assessing

EXHIBIT 6
SAMPLE SERVICE PLAN

Date:_____ Child's Name_____

Record No._____

Page_____of_____

Life Domains (Check all that apply):

Family or Surrogate Family (one-on-one)	Educational or Vocational	Medical or Legal	Safety	Interpersonal
Social (team activities)	Communication	Self-reliance	Personal Qualities	Emotional/Sensibility
Home/A Place to Live				

PEN-PAL Interagency Individual Service Plan

Life Domains (briefly describe)	Strengths	Needs, Issues, or Problems	Strategies	Goals or Outcomes Desired	Service Providers	Barriers	Estimated Completion Date	Date Completed	Flex Funding (Wraparound) or Other Cost Information

Signature/Agency	Date	Signature	Date	Signature	Date
Signature/Agency	Date	Signature	Date	Signature	Date
Signature/Agency	Date	Signature/Client, Parent or Legal Guardian	Date	Signature/Physician	Date

strengths, needs, barriers, and actions. Section 5 trains on the actual implementation of the plan, dividing the planning process into four phases, delineated as:

- *Phase 1*: Prior to the first planning team meeting
- *Phase 2*: During the first planning team meeting
- *Phase 3*: After the plan is established
- *Phase 4*: Reviewing, continuing, and amending the plan

The specific goals of each phase are shown in Exhibit 7. Each phase is discussed extensively, and accompanied by various training activities such as role playing to help trainees gain understanding of the perspectives of different service sectors. The entire training program takes approximately three days.

DEGREES AND COURSEWORK

The formal approach to training may also include degrees and coursework. An example was found at the University of Alabama and at Wayne State University in Detroit. At these schools, wraparound training has been incorporated into the graduate curriculum within the Department of Social Work. In this program, students work with families and children for academic credit. Their specific tasks are determined by the specific parameters of individualized service plans, and the students are supervised by social workers assigned to the particular children and families. Examples of those tasks include tutoring, teaching positive recreation, modeling and teaching age-appropriate social skills, and providing respite for families and foster families by spending time with children at home or out of the home. In addition, students participate in team meetings, training sessions, and other support activities.

Videos and Manuals

On a national level, VanDenBerg and Grealish have developed the first published training manual and professional training videos.[3] The manual consists of 12 chapters, which provide a clear and detailed explanation of each step of the wraparound process, and then gives examples of actual child and family plans. The videos provide background on wraparound development and a mock planning meeting.

EXHIBIT 7

CRITICAL ELEMENTS OF THE PLANNING PROCESS

Planning Phase	Goal
Phase 1:	
Prior to the first planning meeting	■ Parent/guardian(s) contacted ■ Other team partners contacted ■ Meeting organized (room, equipment, etc.) ■ Notices sent to all team ■ Team participants greeted as they arrive
Phase 2:	
During the first planning meeting reviewed	■ Meeting facilitated by team member ■ Student's Individual Education Program ■ *School, Family, and Community Plan* drafted ■ Plan actions reviewed ■ Plan monitor selected ■ Next meeting scheduled
Phase 3:	
After the plan is established	■ *School, Family, and Community Plan* written ■ Plan distributed to all team ■ Plan actions carried out ■ Plan monitored ■ Reminder of next meeting
Phase 4:	
Reviewing, continuing, and amending the plan drafted	■ Meeting facilitated by team member ■ Plan reviewed ■ Revised *School, Family, and Community Plan* ■ Next meeting scheduled

Table taken from:
Duchnowski, A., Kutash, K., & Rudo, Z. (1997). School, family, and community team manual. Tampa, FL: Research and Training Center for Children's Mental Health, Louis de la Parte Florida Mental Health Institute.

QUALITY MONITORING

Formal Standards

The first step in quality monitoring is the development of standards to which all services provided through wraparound must be held accountable. One of the questions on the state wraparound survey (see Chapter IV) was directed toward obtaining examples of wraparound standards from across the country. The examples received were primarily broad sets of standards to be used within the state child mental health services program (n=11). Each of those states has different policies within their governance structures that affect the ways in which wraparound can be implemented, and some even have different names for wraparound. The contents of these standards, however, are all fairly similar—two examples are provided below.

Michigan

One example of a general set of wraparound standards is found in Michigan, where all child mental health service providers are given a document entitled, "Information Advisory for Multi-Purpose Collaborative Bodies."[4] This document explains the fundamental elements of the wraparound process, which states that wraparound must involve the following: (1) a structure involving a community team, a resource coordinator, and child and family teams; (2) the processes of strengths assessment and life domains planning; and (3) the philosophy of unconditional care. The membership and functions of the community team and the child and family team, along with the specific functions of the resource coordinator, are listed. Finally, the document includes an outline of the purposes and tenets of strengths assessment and life domain planning, and provides a definition of unconditional care. Although this set of standards is not particularly extensive, it does establish provider expectations for the wraparound process.

Vermont

A second example consists of the standards used in Vermont, where wraparound is provided through a treatment foster care model.[5] The standards start with an explanation of the wraparound philosophy, and then the principles of wraparound are laid out as follows: (1) family-focused services, (2) creation of an interdisciplinary team, (3) unconditional care, (4) individualized service planning, (5) strength-based services, (6) community-based services, (7) culturally competent planning, and (8) flexible funding. Next, providers are instructed about how to acquire further information on wraparound within their county, and this is followed by a brief explanation of funding, including which agencies are involved. The last section focuses on the procedures for implementing the wraparound process, seven of which are presented as

follows: (1) complete a child and adolescent services intake form; (2) develop an individualized plan of care and crisis plan based on identified life domains (residential, family, educational, vocational, social/ recreational, psychological, medical, safety, and legal); (3) develop an individualized services budget; (4) submit a cover letter with the budget and plan of care in order to advocate for services; (5) submit the final documents for individualized service budget approval; (6) send a termination letter when the child or youth no longer needs wraparound services; and (7) re-activate clients with submission of the appropriate materials. This step-by-step approach to providing services gives the provider a chance to see how the philosophy and elements of wraparound are translated into service provision.

Fidelity Measures

Fidelity measures create a more specific mechanism for monitoring care at the child and family level. Such measures are typically designed for research to ensure that the intervention under study is actually what was provided. Fidelity measures can also be used to monitor whether an intervention is being appropriately administered under conditions of usual clinical care. Two examples were identified, one developed in Florida and one in Illinois. A special feature introduced in Florida's wraparound training session and then used throughout the course of the intervention is a fidelity form to be administered to all team meeting participants immediately after each child and family team follow-up meeting. This fidelity form is, according to the state survey, a rare feature of wraparound. It is specific to the wraparound process used in Florida, but represents a major step in quality monitoring in that it actually measures whether the services provided by the wraparound process are consistent with the standards and goals delineated during the initial training session.

The first section of the fidelity measure includes questions about the number of individuals present at the team meeting within specific categories (e.g., child, family, teacher, behavior specialist, community agency professional). The next section consists of a series of questions within four categories. The first is titled "Preliminary Meeting Activities," and asks questions about who was present at the meeting, who facilitated the meeting, and whether or not the purpose of the meeting was made clear. The second category, "Developing the Plan," includes questions about the content of the plan and whether or not everyone at the meeting had a fair amount of input. The third category is "Student/Family as Partners," where questions are centered on the amount of involvement the child and family had during the meeting. The last category is called "School/Community Involvement," and basically asks to what extent school staff and community representatives were included in the meeting. The final section of the form asks the meeting participants to rate, on a scale from 1 to 10, the extent to which the school staff and community representatives provide unconditional help to the family, and the extent to which the "spirit of equal

partnership" was evident at the meeting. This measure appears to be user-friendly, but to date, psychometric properties have not been reported.

Only a few states actually have wraparound fidelity measures similar to Florida's, but some attention has been given to validating a measure that wraparound programs across the country will be able to use. In Illinois, Epstein and colleagues have developed a fidelity measure called the Wraparound Observation Form. This form was used to evaluate the services of the Kaleidoscope program in Chicago. In a study of the form's psychometric properties, inter-rater reliability was high.[6]

The Wraparound Observation Form (or the WOF) consists of 34 questions that cover eight elements of the wraparound process: (1) community-based services, (2) individualized services, (3) family-centered services, (4) interagency collaboration, (5) unconditional care, (6) measurable outcomes, (7) management of team meetings, and (8) cooperation of team members. Independent observers and/or child and family planning team members who attend a given planning meeting complete the form at the conclusion of the meeting. They answer Yes, No, or N/A (not applicable) to questions such as: "The service plan goals are discussed in objective, measurable terms"; "The family is asked what problems he/she would like to work on"; and "Professionals from other agencies who care about or provide services to the family are at the meeting." Since this form has been evaluated and determined to be reliable, it is probably the best candidate currently available for a fidelity measure to be further tested in other sites.

Accreditation

Another regulatory mechanism to promote quality is the establishment of accreditation/licensing criteria for training and performance. At this time, there are two major reasons why it is important to develop accreditation standards for wraparound services. The first relates to the need for programs implementing the wraparound approach to comply with regulations that require provider agencies (including those who act as the hosts for wraparound processes) to be accredited in order to receive state funding. The current managed care environment creates a context in which accreditation is valued, if not required, for inclusion in provider networks of those agencies acting as hosts for wraparound.

The second reason that supports accreditation standards follows from the growing need to validate wraparound as a form of service delivery that is equal in standing to more traditional approaches. Because of an inability to operationally define wraparound, and poor results sometimes following from the failure of projects incorrectly labeled "wraparound," questions have been raised about wraparound. Funders, evaluators, and researchers need methods to differentiate between when a process is truly wraparound, and

when it is merely a wraparound-like process that is based on only a small number of the values and elements of true wraparound.

The development of accreditation standards for wraparound will not be an easy endeavor. It will not only require the development of an accepted definition of what the wraparound approach is, compared to both traditional and wraparound-like services, but also the development of those criteria that will demonstrate when an entity is performing wraparound at a level deemed to be accreditable. To create such a set of standards, a process must be entered into in which an accrediting body, such as the Council on Accreditation (COA), is brought together with wraparound experts, similar to the focus group meeting that was held at Duke University as part of this project, to explore how to translate the elements and values of wraparound into practice and to draft accreditation standards for testing and future adoption by an accrediting organization.

NOTES

1. *System of Care Core Curriculum: Trainer Guide*. (1997). Raleigh, NC: North Carolina Division of Mental Health, Developmental Disabilities, Substance Abuse Services, Child and Family Services Section.

2. Duchnowski, A., Kutash, K. & Rudo, Z. (1997). *School, Family, and Community Team Manual.* Tampa, FL: Research and Training Center for Children's Mental Health, Louis de la Parte Florida Mental Health Institute.

3. VanDenBerg, J. & Grealish, M. (1998). *The Wraparound Process Training Manual.* Pittsburgh, PA: The Community Partnerships Group. Available Through Authors—see Appendix A.

4. Multipurpose Collaborative Bodies and Collaborative Initiatives. (1996). *Putting it Together with Michigan Families*, 9.

5. Tannen, N. (1991). Guidelines for Implementing an Individualized Plan of Care for Children and Adolescents Experiencing a Severe Emotional Disturbance and Their Families. Vermont Department of Mental Health and Mental Retardation.

6. Epstein, M., Jayanthi, M., McKelvey, J., Frankenberry, E., Hary, R., Potter, K., & Dennis, K. (1998). Reliability of the Wraparound Observation Form: An Instrument to Measure the Wraparound Process. *Journal of Child and Family Studies*, 7 (2), 161-170.

Chapter VI
The Wraparound Evidence Base

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INTRODUCTION

To provide information on the research that has been conducted on wraparound and the evidence base, a number of steps were taken. The scientific literature was searched for studies of wraparound. Next, research presentations on wraparound at child mental health conferences were identified, particularly those from the annual research conferences on a System of Care for Children's Mental Health held by the Florida Mental Health Institute in Tampa, Florida. Further, authors were contacted for follow-up data since the publication of the paper or presentation. Published studies were identified in nine states (i.e., Alaska, Florida, Illinois, Indiana, Kentucky, Maryland, New York, Vermont, and Wisconsin).

In order to be eligible for inclusion, studies were required to involve programs whose services met wraparound criteria as delineated by VanDenBerg.[1] All initiatives were described as family-centered, culturally relevant, strengths-based, and community-based. In addition, a major tenet of each wraparound program was that children and families must be served unconditionally in the least restrictive environment whenever possible, and in their natural environments. Each initiative used individualized services, flexible funding, and interagency involvement in creating wraparound plans.

Approaches varied in the primary human service sector with the lead role, including mental health, child welfare, and education. The clinical services most often provided to youth receiving wraparound included individual and group therapy, case management, medication management, family therapy, support groups, and respite care. Other services were provided (and in some cases created) depending on the individual and changing needs of each child and family. Some examples of these services and supports included mentors, crisis management, family management, school support specialists, intensive in-home services, community mental health services, community residential treatment facilities, and paid friends.

Each wraparound intervention plan targeted specific areas of the child and family's life. The most common of these areas were behavioral adjustment, restrictiveness of the living environment, school attendance, school achievement, and family functioning. Within these broad areas, each wraparound plan included more specific targets based on both the needs of the child and family, and the goals of the initiative.

For example, wraparound approaches that were school-based had specific targets within the school system and classrooms, whereas another initiative designed as a pilot to build greater commitment by stakeholders identified cost reduction as a primary target.

The population targeted by these wraparound initiatives always included children at risk for out-of-home placement, others who were being diverted from out-of-state residential placements into programs that would keep them in their home communities, or some who were returning home from residential placements. Other studies utilized more stringent criteria for study selection based on variables such as number of specific behavioral occurrences over a specific time span, evidence that the referred individual had exhausted all other treatment options, and specific indicators of negative school adjustment, based on defined indicators.

These studies varied by research design: case study design, pre-post design, and randomized clinical trials. Two studies used a case study design—the first in Alaska and another in Chicago, Illinois, which focused on the well-established Kaleidoscope program designed and directed by Karl Dennis. The most common design, used in 10 studies, was identified as pre-post, where change is assessed between baseline and follow-up without a control group. Two studies used randomized clinical trials. Studies are presented by design type, chronologically within each group.

These early studies offer preliminary evidence of the effectiveness of the wraparound approach. The research designs are largely uncontrolled (either case study or pre-post) and potentially subject to problems such as bias and regression to the mean, although these designs are appropriate to the early study of new interventions. The encouraging results from the two randomized clinical trials that were reported (Florida and New York) open the door to more controlled studies. The consideration of other designs is also recommended.

Sample sizes tended to be small and study attrition relatively high, thus reducing the reliability of the studies. Nonetheless, this early set of studies conducted in nine states demonstrates the potential of this approach to reduce institutional care and costs, to stabilize living situations in the community, and to offer other indications of benefits in the realms of behavioral, family, and school adjustment (see Exhibit 8 for summary). Future research with larger samples and a standard set of client, family, and outcome measures is recommended. The Center for Mental Health Services child service system demonstrations offers a strong example of one opportunity for more extensive research on the wraparound approach.

EXHIBIT 8
SURVEY OF WRAPAROUND STUDIES IN NINE STATES

Site	Cooperating Service Sectors	Study Design	Sample Size/% Attrition	Significant Findings
Alaska				
Burchard et al., 1993	Mental Health Social Services Special Education	Case Studies	10 youths No attrition	Community adjustment: ↑ -Trend only School/career adjustment: ↑ -Trend only
Chicago, Illinois				
Cumblad, 1996	Child Welfare	Case Studies	8 families No attrition	Negative behaviors: ↓ Stability of living environment: ↑
Vermont				
Clarke et al., 1992	Special Education AFDC (Child Welfare)	Pre-post	28 families Home: 32% attrition School: 57% attrition	Home adjustment: ↑ Home environment -Composite score: ↑ -Parental disposition: ↑
Vermont				
Yoe et al., 1996	Social Services Mental Health Special Education	Pre-post	40 youths Attrition not reported	Restrictiveness of living environment: ↓ Total problem behaviors: ↓ Externalizing behaviors: ↓ Abuse-related behaviors: ↓ Internalizing behaviors: ↓
Vermont				
Bruns et al., 1995	Foster Care Mental Health	Pre-post	27 youths No attrition	Negative behaviors: ↓
Kentucky				
Illback et al., 1993	Mental Health Foster Care	Pre-post	497 youths No attrition	Restrictiveness of living environment: ↓ (trend only) Behavioral problems: ↓
Baltimore				
Hyde et al., 1994	Mental Health	Pre-post	70 youths Attrition not reported	Critical adjustment behaviors: ↓ Restrictiveness of living environment: ↓

EXHIBIT 8 (CONTINUED)
SURVEY OF WRAPAROUND STUDIES IN NINE STATES

Site	Cooperating Service Sectors	Study Design	Sample Size/% Attrition	Significant Findings
Baltimore				
Hyde et al., 1996	Mental Health	Pre-post	106 youths NW: 44% attrition PW: 36% attrition Wraparound: no attrition	Wraparound subjects-- Behavioral adjustment: ↑ (trend) Community Adjustment: ↑ (trend)
Illinois				
Eber et al., 1995	Special Education	Pre-post	81 students Attrition not reported	Behavioral adjustment: ↑ Family adjustment: ↑
Illinois				
Eber et al., 1996	WAIS -School system	Pre-post	44 students -CBCL: 39% attrition -TRF: 30% attrition -CAFAS: 43% attrition	Restrictiveness of living environment: ↓ in both groups School adjustment: ↑ (trend)
Eber at al., 1994	WIN -Private providers -Families -Schools			
Milwaukee				
Kamradt et al., 1996	Schools Child Welfare Juvenile Justice	Pre-post	25 youth No attrition	19 successfully returned to community living environments 24 regularly attending school
Indiana				
Rotto et al., 1998	Dept. of Education Social Services Juvenile Justice Mental Health	Pre-post	20 subjects No attrition	Restrictiveness of living environment: ↓ (trend) Behavioral adjustment: ↑

EXHIBIT 8 (CONTINUED)
SURVEY OF WRAPAROUND STUDIES IN NINE STATES

Site	Cooperating Service Sectors	Study Design	Sample Size/% Attrition	Significant Findings
New York				
Evans et al., 1996	Mental Health	RCT	42 youth -Control: n=15 -Wraparound: n=27 Family-Based Treatment: 53% attrition Wrap: 63% attrition	*Family-Based Treatment* No significant improvements *Family-Centered Intensive Case Management (wrap)* Behavioral adjustment: ↑ Family adjustment : ↑ (trend)
Florida				
Clark et al., 1998	Foster Care	RCT	131 subjects -Control: n=77 -Wraparound: n=54	*FIAP Wraparound* -Permanency placements: ↑ -Restrictiveness of living environment: ↓
Clark et al., 1996			No attrition	-Behavioral adjustment: ↑ -Delinquency (males) and incarceration: ↓ -School adjustment: ↑

CASE STUDIES

Alaska

The Alaska Youth Initiative (AYI) involved a case study design. Specifically, after three years of services, 10 children were chosen to be included in a retrospective look at some of the positive outcomes that had been attained by the Alaska Youth Initiative.[2] All children selected to receive wraparound through the Alaska Youth Initiative were chosen by an interdepartmental "jury," and basically consisted of children placed out-of-state in residential treatment centers, as well as those in Alaska who had exhausted all available resources but had not shown substantial improvements at the time of referral. In choosing the 10 youths to include in the report, the authors analyzed rates of success given to each of 81 candidates by the state Alaska Youth Initiative director and three regional Alaska Youth Initiative coordinators. The 10 cases selected had been rated among the most successful with regard to community, family, and behavioral outcomes, and the most instructional regarding the use of innovative wraparound services.

The intervention included an interdepartmental team that facilitated wraparound in general. They met at least every 90 days to evaluate and update service plans. In addition, a child and family team was created for each family and child. These teams consisted of the parents, youth, their case worker or probation officer, an education representative, a therapist or counselor, a caretaker (if the youth did not live at home), a case manager who served as service coordinator, and any other instrumental person in the youth's life that might have a positive effect on the delivery of services. The child and family teams met on an as-needed basis. The adjustment of the youth was measured by Proactive Client Tracking, a special feature of the Alaska Youth Initiative, carried out by paraprofessional workers in weekly telephone interviews with up to five critical adults in each child's life. At the end of 5 years, most of the 10 youths included in the report had completed high school, were currently enrolled in school, or were working full-time. Three of the youths were living independently, three were living in specialized foster homes, two were in specialized apartments, and two were living at home with their families.

Chicago

The oldest wraparound initiative in the United States began in Chicago, Illinois, under the name *Kaleidoscope*. Actually a non-profit child welfare organization, *Kaleidoscope* provides wraparound through a service called the Satellite Family Outreach Program. This program serves some of the most challenging families in the child welfare system in Illinois. At any point in time, Satellite serves 48 families, and over the course of one year, services are provided to about 60 families. A majority of Satellite families are low income, urban, and minority. About two-thirds are headed by women, and most rely on public

assistance. The goals of the program are to reunite with their families those children who are placed outside of the home, to deflect placement of children who would otherwise be placed outside of their homes, and to assess family functioning to determine placement needs.

Each family is served by a team consisting of four family workers and one social worker. Family workers provide a range of direct and indirect services, and social workers coordinate clinical services and provide collateral services. When a family enters services, a comprehensive ecological assessment is conducted, and a family plan is developed by a team that includes the family, Satellite staff, representatives from other agencies serving the family, and the natural supports to the family such as neighbors and extended family members. Satellite is not able to provide flexible funds because costs are reimbursed by Medicaid services. However, all other wraparound elements are present.

The Satellite program was evaluated in 1994, using a case study design. The study included eight families who had received services from Satellite and had been discharged from Satellite in 1994.[3] Each family's case records were reviewed, and interviews were conducted with parents (n=7), youths (n=3), extended family members (n=3), and Satellite staff (n=10) to explore the participants' perceptions of their lives, the services they received, and to verify recorded information.

The families received Satellite services for an average of three years. Services included foster placement and support, in-home services, advocacy, and extended outreach and community support. The foster family placement and support encouraged the development and maintenance of positive relationships between the natural parents and the foster parents while the children were in placement. In-home support provided direct instruction and guidance on daily living and parenting skills. Community support services included networking the families with vocational and career training agencies, substance abuse rehabilitation programs, recreational services, and medical facilities.

At the time of the evaluation, all of the children were living in homes that were safe, whether it was the natural home or a foster care setting. Four families had been fully or partially reunited, and in two of the families that were not reunited the parents maintained contact with their children. The other two families were not reunited because the parents were deceased. There were reductions in suicide attempts, aggressive behaviors, depression, alcohol and substance abuse problems, and criminal activities. Children and youth from the families with the most risk factors (history of alcohol abuse, criminal activities, abusive behaviors, poor parenting skills, and unstable housing) did not demonstrate any of those patterns of behavior. Perhaps most significantly, the children were no longer being abused or neglected, no more children had been removed from the parents' care, and subsequent children born into these families

appeared to have been receiving adequate parenting. Overall, the cycle of abuse and neglect had been broken, and the homes were more stable.

PRE-POST DESIGN STUDIES

Vermont

Project Wraparound in Vermont has been evaluated in at least three different research efforts. The first study examined the home and school adjustment of 19 youths who were around 12 years old.[4] All of the subjects were children in special education who had been mainstreamed into regular education, with the main premise being that all children and youth, regardless of any emotional or behavioral adjustment difficulties, should be educated with their same age non-handicapped peers. In addition, all subjects had to fall within the clinical range of impairment on both the Child Behavior Checklist (CBCL) and the Teacher Report Form (TRF).

Home adjustment data were obtained for one year, whereas collection of school data continued for an additional year. As a result, only 12 subjects had two years of school data due to attrition and not yet having completed two years with the project. The intervention used family support specialists who worked in the homes and integration specialists who worked in the schools. Both the family support specialists and Integration specialists held at least a bachelor's degree and received weekly supervision from two licensed clinical psychologists. Average caseloads were five families per family support specialist and eight children per integration specialist. Family support specialists and families met to develop a service plan for each youth, and weekly school-based planning team meetings were held including teachers and family, thus ensuring that home and school interventions were complementary.

Service intensity was high. Family support specialists and integration specialists each spent an average of 5 hours per week in direct service to the child, family, and school. Both were available for crisis situations around the clock. Some of the specific services included family management, parent training in advocacy for their children, play therapy, anger control, and social skills training.

Measures of home adjustment were completed by parents and family support specialists during a 2-week intake period, and at 3, 6, and 12 months. School data were obtained by integration specialists and teachers at referral, during the last 6 weeks of the first school year, and during the first and last 6 weeks of the second school year. Outcomes for home adjustment were statistically significant for the Self Control Rating Scale (SCRS), the Connors Hyperkinesis Index (CHI), and all subscales of the Child Behavior Checklist. Findings for school adjustment were not significant as measured by the Teacher Report Form,

the Self Control Rating Scale, or the Connors Hyperkinesis Index. With regard to the home environment, scores on the Composite and Parental Disposition subscales of the Child Well-Being Scales (CWBS) reflected significant changes, whereas scores on the Household Adequacy and Child Performance subscales did not.

The second pre-post design study in Vermont centered on 40 subjects (average age, 16 years), assessing change over 12 months.[5,6] Most of these youths were in state custody at the time of referral, but as resources were added, the group included youths at lower risk for residential placement. The program used case managers within the therapeutic foster care program in roles similar to the family support specialists in the previous study. Some of the specific clinical interventions included group therapy, family education programs, and miscellaneous supportive activities such as karate lessons. Case managers, with an average load of four to seven children, were trained on appropriate use of the Quarterly Adjustment Indicator Checklist (QAIC). The specific duties of case managers are outlined in the study, and include, most importantly, facilitation of regularly scheduled team meetings to review individual plans.

The youth were assessed on two basic measures: (1) restrictiveness of living arrangements (using the Restrictiveness of Living Environment Scale—ROLES, and (2) behavioral adjustment (using the Quarterly Adjustment Indicator Checklist). These instruments were given at 3-month intervals for 12 months. The average Restrictiveness of Living Environment Scale score decreased from 4.67 at referral to 3.83 at 12 months, demonstrating a shift on the scale from treatment-oriented foster care to regular foster care. The percent of subjects living in the community (with their immediate family or other relatives, independent living, or foster care of some type) increased from 58 percent at referral to 88 percent at 12 months. On school adjustment, the number of youths mainstreamed with some form of special education support increased, while both the number of youths enrolled in alternative residential schools and the number completely mainstreamed decreased. As measured by the Quarterly Adjustment Indicator Checklist, there were significant reductions in externalizing behaviors, abuse related behaviors, and internalizing behaviors, but there was no change in the occurrence of public externalizing behaviors. The actual costs of this program were not reported, but the researchers do report that as problem behaviors decreased, costs subsequently declined, suggesting that children who benefitted from the wraparound program probably received less intensive care and thus, cost less to treat as a result of their improvement.

The third *Project Wraparound* study in Vermont targeted children in child welfare, specifically those placed in therapeutic foster care. This study also utilized a pre-post design, including 27 children with an average age of 13.6 years, 70 percent of whom had been served in residential settings before beginning wraparound.[7] Case managers coordinated the creation of treatment plans in an initial wraparound team meeting, then brokered service delivery throughout the course of the study. Services were established as

they were needed, and commonly included parent support groups, group therapy, and self-help groups. At the time of the report, all 27 subjects had been enrolled in wraparound for 13 months, with the average cost of services having declined from $3,859 in the first month to $3,556 in the 13th month (not a statistically significant difference).

The Daily Adjustment Indicator Checklist (DAIC) was administered for four weeks at the beginning of services and for four weeks at one year after entry; the Child Behavior Checklist (CBCL) was completed by care givers at entry and at one-year follow-up; and the Restrictiveness of Living Environment Scale (ROLES) was completed using record reviews and telephone interviews. On the Daily Adjustment Indicator Checklist, total negative behaviors decreased from 6.6 to 1.9, on average. On the Child Behavior Checklist, the average Total Problem T-Score dropped 5 points from 72.8 to 67.8, with significant decreases in externalizing and internalizing scores. There were no significant findings on the Restrictiveness of Living Environment Scale.

In an attempt to monitor quality of services, researchers measured the change in service provision in response to changes in behavior. Correlations between change in Daily Adjustment Indicator Checklist behavior variables and change in service variables were moderate to high, but behavioral changes as measured by the Child Behavior Checklist did not correlate significantly with change in service provision.

Kentucky

The Kentucky IMPACT program was evaluated in 1993, after one year of services, using a pre-post design with repeated measures, with participant functioning measured at intake, 6 months, and 12 months.[8] Services used in the program included community residential development, case coordination, wraparound aides in the home, school support specialists, and therapeutic foster homes. Services were administered through 18 regional interagency councils to 497 youths, ages 3 to 20, with most falling within an age range of 11 to 16. The authors characterized the behavioral and ecological characteristics of the sample, noting that each child had an average of 8.5 risk factors, such as poverty, divorce, physical abuse, and a history of family mental illness. At each measurement interval, the adults on the team and the children were asked to rate the child's progress on behavioral self-control, emotional adjustment, relationship skills, educational achievement, and school adjustment.

The outcomes reported in this study were mostly trends as opposed to statistically significant changes. A substantial trend toward less restrictive placement, a decrease in psychiatric hospitalization rates, increases in living with family, increases in group home utilization, and small increases in the use of therapeutic foster care were reported. In addition, substantial gains were reported by teachers with respect

to behavior problems (particularly externalizing), and there was a concomitant rise in the use of special education resource rooms. Although there were no gains in social competence in home settings (as reported by parents), there was a significant decrease in the use of home-bound instruction, and the number of children with a large number of placements (13 or more) decreased from 2.8 percent to none during the initial 6 months of the program (relative to the year prior to the intervention).

Baltimore, Maryland

The Baltimore City Wraparound project, titled the Family Preservation Initiative (FPI), was a youth and family-centered intervention program that specifically targeted job placement and training in addition to both child and family therapy, and one-on-one mentoring programs. The first of two studies on this initiative was conducted on youths who had been in wraparound service an average of 293 days.[9] The sample consisted of 42 children returned from out-of-state placements, and 28 children diverted from being placed out-of-state. Their average age was 16 years, with the majority having primary Diagnostic and Statistical Manual of Mental Disorders - III-R diagnoses of affective disorders (33 percent) and conduct disorder (30 percent). The adjustment of each youth was measured by examining the numbers of school suspensions, psychiatric hospitalizations, attempted suicides, and delinquent arrests. In addition to a monthly report issued to case managers (called family care coordinators) which noted changes in school and residential placement, fiscal expenditures were tracked for each youth served in this study. Those costs were then compared to out-of-state placements.

Prior to entering Family Preservation Initiative services, 20 percent of the youth had a Restrictiveness of Living Environment Scale rating of less than 5.5 (group home placement), but at the end of one year, 88 percent of the youths fell below the 5.5 level. In addition, after over one year of services, incidents of critical adjustment behaviors were fairly low for the group as a whole, with 30 percent having no episodes at all, 29 percent experiencing school suspensions, 21 percent having psychiatric hospitalizations, 6 percent with suicide attempts, and 14 percent having been arrested. Approximately 65 percent of the subjects experienced only one school placement, while 26 percent had two, and 19 percent had three. Cost data was also encouraging, with the average per diem rate for a Family Preservation Initiative youth falling at $216, while the average rate for a youth in out-of-state treatment was $269. Researchers also administered a youth and family satisfaction survey, written with input from parents who had children in residential facilities. This survey, conducted by interviewers who had little to no contact with the youths and families, indicated how involved the families felt in the planning and implementation of services. On a 5-point scale with 1 equal to very dissatisfied and 5 equal to very satisfied, the parents rated satisfaction with services at 3.54, while the youth rating was similar (3.89). Ratings for satisfaction with the program were 3.78 for parents and 3.47 for youth.

A second study of the Family Preservation Initiative in Baltimore took a report card format, with youth, parents, and family care coordinators completing questionnaires rating the community adjustment of each child on a scale of good, fair, and poor.[10] Most of the youths included in the study had received wraparound services for at least two years. The family care coordinators carried an average caseload of six families at one time and coordinated teams made up of family members and human service providers to create and execute an interagency plan for each child. The teams met every 60 to 90 days, with the family care coordinators completing updates on team progress in meeting the goals of the treatment plan. Designated staff within the study served as contract monitors, assuring implementation and maintenance of the services contract.

The sample consisted of four groups: (1) Wraparound Return (WR, n=25)—all youth who returned from residential services; (2) Wraparound Diversion (WD, n=24)—all youth who were regarded as at risk for residential treatment; (3) Pre-Wraparound (PW, n=39)—youth returned from out-of-state during the year prior to initiation of wraparound services; and (4) Non-Wraparound (NW, n=18)—youth who returned from out-of-state during the same period as the WR group, but did not receive wraparound services. All subjects in the wraparound groups completed the study, compared to 56 percent of the Non-Wraparound group and 36 percent of the Pre-Wraparound group, thus limiting comparison of results across groups since bias related to attrition was not reported.

Two years into the study, youths involved in wraparound were the most involved in community activities, and only 7 percent were living in residential settings, substantially less than the 32 percent rate of recidivism to residential treatment centers or correctional facilities (after one year) found in a national study two years earlier.[11] About 50 percent of the youths in the wraparound groups were living in the community and attending school or working on a regular basis, whereas, of the few youths that could be located in the groups who were not receiving wraparound, 6 were living in a very restrictive environment, and 2 were working or attending school. An average of 47 percent of the subjects in the two wraparound groups had reached adjustment level ratings of 'good,' whereas none of the Non-Wraparound group and 14 percent of the Pre-Wraparound group received that rating.

La Grange, Illinois

A school-based wraparound pilot began in La Grange, Illinois, in 1990, called the *Wraparound Interagency Network*. Positive findings from this pilot resulted in a subsequent program with more school involvement, *Wraparound in Schools* was implemented. After *Wraparound in Schools'* first year of operation, a study was conducted that compared the *Wraparound Interagency Network* and *Wraparound*

in Schools programs.[12, 13] The main difference between the two groups was the basis for referral and the central location of wraparound initiation. *Wraparound Interagency Network* eligibility was based on imminent risk of out-of-community placement or return from placement, and need for multi-agency coordination. *Wraparound in Schools* students fell into three different categories: students in self-contained emotional and behavioral disorders classrooms whose success could be maximized with more comprehensive services; students at risk of placement in self-contained emotional and behavioral disorders classes; and students at risk of placement out of the public school system. Once the youths were accepted for the wraparound process, they all received services in both the schools and the community, regardless of whether they were designated *Wraparound in Schools* or *Wraparound Interagency Network*. Both groups in this study received services based on a wraparound approach for one school year. For the purposes of this study, core services were divided into four categories: family supports, referral and coordination, respite services, and teacher supports. *Wraparound in Schools* services were concentrated on one high school, one junior high school, and one elementary school, whereas *Wraparound Interagency Network* services were spread across the community depending on where the children lived.

The *Wraparound in Schools* wraparound teams were led by a team teacher, who assisted in forming the wraparound teams, helped develop behavioral intervention plans, and provided various supports for regular teachers. In the *Wraparound Interagency Network* group, these roles were filled by a family service facilitator. The teams also included family service managers who assisted in brokering services and helped to form partnerships between school personnel and other team members. Wraparound plans typically included team teaching (special education and regular education), curriculum adaptations, sports and extracurricular participation, in-school respite workers, and "peer buddies."

The sample consisted of 44 students, of which 19 were referred to *Wraparound in Schools* and 25 to *Wraparound Interagency Network*. Subjects' home, school, and community adjustment were assessed at referral and at the end of the year using the Child Behavior Checklist, the Teacher Report Form, the Child and Adolescent Functional Assessment Scale (CAFAS), the Demographic Risk Factor, and the Restrictiveness of Living Environment Scale. At referral, 70 percent scored in the clinical range for Internalizing Behaviors on the Child Behavior Checklist and 74 percent on the Teacher Report Form. In addition, 85 percent scored in the clinical range for Externalizing Behaviors on the Child Behavior Checklist and 90 percent on the Teacher Report Form. Rates of completion after one year of services were 61 percent for the Child Behavior Checklist, 70 percent for the Teacher Report Form, and 57 percent for the Child and Adolescent Functional Assessment Scale, with no significant differences noted between the subjects with and without complete clinical data.

At the end of one school year, the average level of restrictiveness of living environments, as measured by the Restrictiveness of Living Environment Scale, had decreased from 2.5 (living with family member or relative) to 1.9 (independent living) in the *Wraparound in Schools* group and from 3.5 (non-treatment oriented foster care) to 2.5 in the *Wraparound Interagency Network* group. The average number of placements for each *Wraparound Interagency Network* subject decreased from 1.6 to 1.1, although there was a minor increase in the *Wraparound in Schools* group. The average number of days spent in psychiatric hospitals over a year decreased from .83 to 0 for the *Wraparound in Schools* group, and from 24.5 to .95 for the *Wraparound Interagency Network* group.

The *Wraparound in Schools* program then evolved into the La Grange Area Department of Special Education (LADSE) Emotional and Behavioral Disorders Network, and in 1995 a study was conducted on six wraparound projects across Illinois, one of which was the La Grange Area Department of Special Education program. This study involved 81 students (average age, 15 years) enrolled in wraparound involving a support team within the school.[14] The study design was pre-post, with measures obtained at referral and again one year later. Measures included the Family Adaptability and Cohesiveness Scale (FACES), Time Two Parent Survey, Child Behavior Checklist, Child and Adolescent Functional Assessment Scale, Teacher Report Form, and Restrictiveness of Living Environment Scale.

At one year, family adaptability and cohesiveness had increased significantly as measured by the Family Adaptability and Cohesiveness Evaluation Scale II (FACES), and parents reported satisfaction on the Parent Survey with regard to their perception of inclusion in decision making. On the Child Behavior Checklist measures for Internalizing Behaviors, females (n=15) demonstrated significant improvement on the Withdrawn and Attention subscales, and males (n=66) improved significantly on the Social Problem and Thought Problem subscales. There were no significant changes on the Teacher Report Form, but on the Child and Adolescent Functional Assessment Scale, students improved significantly in Role Performance and Moods. In addition, students had fewer out-of-home placements and reduced use of psychiatric hospitalization.

Milwaukee, Wisconsin

For the purpose of building greater buy-in from principal stakeholders in the local system of care, *Wraparound in Milwaukee* initiated a pilot project in 1994 to test the wraparound model and to obtain outcomes for a group of youths with complex needs placed in residential treatment centers.[15] In the report that was completed on the pilot project, the authors described the program and the outcomes of 25 youths who were enrolled. This project only targeted youths who were in residential treatment centers with no immediate plans for discharge at the time of enrollment. The major goal was to see if these youths could be

returned to their home or a community placement through the provision of wraparound services as an alternative to institutional care; the plan would ensure that their needs would be met, and that the cost of keeping the child in the community could be lower than that of a residential treatment center. Referrals into this pilot were made by child welfare and juvenile justice agencies with no children being denied enrollment (100 percent acceptance). As families were accepted into the program, case managers assembled child and family teams, with all participants having a plan of care within 30 days of referral.

Wraparound Milwaukee staff prepared reports of the project's results at six months, one year, and two years. The variables assessed were services received through wraparound, current status and accomplishments through the project, future plans and needs, and the comparable costs of care in wraparound versus residential treatment center placement. At referral, 10 subjects were placed in residential treatment centers based on committing a delinquent act. All subjects had Child and Adolescent Functional Assessment Scale scores at or above the high level, and almost all had poor school attendance prior to residential placement. At one year, 22 of 25 youths had moved into the community, with 3 of those youths eventually being placed back in an institution. Of the 19 who remained in the community, 12 returned home or to a relative placement, and 7 went to foster homes. Recidivism rates for new delinquencies were low, with only 4 youths committing any new delinquent acts. All 19 youths were reported by their caretakers to be attending school on a regular basis. The average monthly costs per youth were $3,250 for community-based wraparound services, representing a 32 percent reduction from $4,700 for residential treatment center care.

Indiana

A wraparound pilot project called the *Dawn Project* began in Indianapolis in 1997. This ongoing project is outcome-driven and based mainly on family, functional, and fiscal incentives.[16] Participants are required to: (1) be between 5 and 18 years old; (2) qualify for services of two or more Consortium agencies (such as child welfare, mental health, social services, and juvenile justice); (3) be at risk of separation (or already separated) from their family; (4) have a Diagnostic and Statistical Manual of Mental Disorders-IV diagnosis; and (5) reside in Marion County. In addition, they are all required to have functional impairment in at least two of the following areas: self-care, relationships, emotional, and self-direction. Services include therapeutic mentoring, recreation mentoring, and parent mentors. At referral, families are assigned a Service Coordinator who then leads the planning team by authorizing payment and guiding the assessment of progress toward the goals of the service plan. Each client is allotted an average of $4,000 per month for services and supports, and 12 to 14 months is the estimated duration of services until clients stabilize and consider withdrawal. A special feature of the *Dawn Project* is a crisis support service called Youth Emergency Services (YES). This consists of a team with one Child Protective Services case manager and

one YES crisis counselor that provides mobile, community-based services and crisis support around the clock. There are 16 crisis counselors, supervised by 4 masters-level counselors.

Preliminary findings are presented from the first seven months of the study.[17] The project is designed to take on 10 new subjects each month, so at the time of the evaluation, there were 70 children with baseline data, 50 with first quarter data, and 20 with six-month data. The most common primary diagnosis was depression (31 percent), followed by Attention Deficit Hyperactivity Disorder (ADHD) (25 percent). Most clients fell into the 11 to 14 age range. The subjects were assessed with the Child and Adolescent Functional Assessment Scale, Child Behavior Checklist, Family Adaptability Cohesiveness Scale II, Restrictiveness of Living Environment Scale, Behavioral and Emotional Rating Scale (BERS), and a Client Satisfaction Survey developed by *Dawn Project* staff. At six months after enrollment, placement in residential treatment facilities had declined slightly from 34 percent to 27 percent. There were statistically significant score reductions on the total scale and on seven of eight subscales of the Child and Adolescent Functional Assessment Scale. In addition, there was a perceived improvement of over 25 percent (a numeric determination made by the team) toward the desired level of overall functioning in children diagnosed with Child and Adolescent Functional Assessment Scale, impulse control disorder, and major depression at intake. There was some evidence of lowered costs associated with wraparound.

RANDOMIZED CLINICAL TRIALS

New York

In New York, a randomized, controlled study has been conducted that compared wraparound, called Family-Centered Intensive Case Management (FCICM), to Family Based Treatment (FBT).[18] Of note, the intervention studied employed most of the values and elements of wraparound. However, since the combination of client, agency, and state teams did not exist at the time in New York, the authors do not consider this a full wraparound model.[19] Children who were referred to out-of-home placement in treatment foster care were assigned to either Family Based Treatment (n=15) or to Family-Centered Intensive Case Management (n=27). The wraparound condition (Family-Centered Intensive Case Management) was based on the Child and Adolescent Service System Program (CASSP) values (see Appendix B), with both case managers and parent advocates as part of a treatment team that worked with a maximum of eight families at a time.[20] A Parent Skills Training Program provided behavioral management skills training for natural parents, and each cluster of eight families had two respite families available to provide out-of-home, respite care as needed. The case managers worked with parents on three major issues: (1) behavior management; (2) service planning; and (3) psycho-education. Parent advocates served

six main functions: (1) translating for parents who were unfamiliar with system jargon; (2) advocating for working within the system; (3) educating professionals with whom they worked; (4) providing information to parents; (5) listening to parents; and (6) helping parents build confidence and skills to advocate for children. The teams were given $2,000 of flexible money per year for each child, in order to purchase various individualized services.

The Family Based Treatment condition was based on one of the first community-based programs implemented by the New York State Office of Mental Health. The goal of this program was to provide training, support, and respite care for treatment foster families caring for children with serious emotional disturbance, with the ultimate aim of reuniting the children with their natural families whenever possible. Treatment included family specialists who trained and supported five treatment foster families and one respite family. The treatment also included parent advocates who were parents of children with serious emotional disturbance. This intervention did not use case managers or treatment teams.

Data were obtained at admission to treatment, and then at 6-month intervals until the children had been in treatment for 18 months, or at the time of discharge, depending on which occurred first. Behavioral and family adjustment were measured, using the Client Description Form (CDF), Child and Adolescent Functional Assessment Scale, Child Behavior Checklist, and the Family Adaptability and Cohesiveness Evaluation Scale (FACES III). Negative behavioral symptoms as measured by the Client Description Form decreased in the Family-Centered Intensive Case Management group, but not in the Family Based Treatment group. More favorable outcomes were found for children in Family-Centered Intensive Case Management on the role performance, behavior, and overall functioning subscales of the Child and Adolescent Functional Assessment Scale, and on externalizing behavior, social problems, and thought problems as measured by the Child Behavior Checklist. On the Family Adaptability Cohesiveness Scale III, there was no significant difference between groups. In the final report, the authors state that the children in Family Based Treatment did not show more positive outcomes than the wraparound children on any measure.[21] The reported average annual cost for Family-Centered Intensive Case Management children in 1994 was $18,000, as compared to $51,965 for a child in Family Based Treatment.

Florida

A second randomized clinical trial of wraparound, called the Fostering Individualized Assistance Program (FIAP), was conducted in Florida, focusing on youths who represented the most challenging (at-risk) 10 percent of the foster care population.[22] This study utilized a randomized design, with the wraparound subgroup (Fostering Individualized Assistance Program) compared to a group who received standard practice (SP) in the foster care system. Children in the at-risk pool were randomly assigned to

either group, including 50 percent more subjects assigned to the SP group to account for expected attrition. Eligibility requirements were clearly delineated, accepting only children who had exhibited at least 2 of 18 specific behavioral indicators within two months prior to screening and who met at least 1 of 7 situational indicators (e.g., long-term dependency status, failed home placement, placed in a more restrictive setting in the past 6 months). Candidates who met those requirements also had to be between 7 and 16 years old, living in a regular foster home or an emergency shelter placement, a resident of either the large urban county or the rural or small town county that collaborated with the study, and not have a primary diagnosis of mental retardation.

The final subject pool consisted of 54 children in the Fostering Individualized Assistance Program group (average age, 11.8 years), and 77 children in the standards practice group (average age, 11.6 years). Both groups were given standard foster care treatment services, with the Fostering Individualized Assistance Program group receiving additional services through the wraparound program. Each child in the Fostering Individualized Assistance Program group was assigned to one of four case managers, referred to as family specialists with credentials of at least a bachelor's degree and 3 to 12 years of relevant experience with this population of children and families. Subjects in both groups were phased in over a 15-month period, depending on the availability of the family specialists, who carried an average caseload of 12 active cases and up to 10 maintenance-level cases. The family specialists facilitated monthly team meetings for each child to develop and monitor individualized service plans, with these team meetings occurring only on an as-needed basis as the child's situation stabilized. Some of the specific services used included family systems therapy, tutors, vocational training for parents, behavior specialists, grief counseling, child abuse counseling, and flexible funds to secure needed services or supports not available through categorical funding.

Interview data were collected at referral and once every 6 months, across 8 waves, for 3.5 years.[23] Measures included child and caregiver interviews, the Child Behavior Checklist, the Youth Self-Report (YSR), and the Conduct Disorder subscale of the Diagnostic Interview Scale for Children (DISC). In addition, placement data for out-of-home settings and incarceration facilities were tracked for each individual, along with indicators of delinquency and school related behavior.

The research results for this controlled study are summarized most concisely in the article by Clark and colleagues, which states the following:

- Fostering Individualized Assistance Program children were significantly less likely to change placements than were those in the Standard Practice group during the intervention period.
- Both groups showed significant improvement in their emotional and behavioral adjustment over time.

- Fostering Individualized Assistance Program boys were more likely to show significantly lower rates of delinquency and better externalizing adjustment than their Standard Practice counterparts.
- The older Fostering Individualized Assistance Program youths were significantly more likely than Standard Practice youths to be in permanency settings with their parents, relatives, adoptive parents, or living on their own.

The only statistically significant differences between the groups regarding school performance were that extreme numbers of days absent were lower for the Fostering Individualized Assistance Program youth than for the Standard Practice youth, and extreme numbers of days of suspensions were lower for the Fostering Individualized Assistance Program group than for the Standard Practice group. Examinations of other community adjustment indicators, for subsets of youth who had any history of runaways or incarceration, suggest that the older Fostering Individualized Assistance Program youth spent, on average, fewer days per year on runaway or incarceration status during the post period than did the older Standard Practice youth.[24]

CONCLUSIONS

Two specific areas where additional research is needed pertain to: (1) the integrity of the intervention (is there adherence to the significant elements of the wraparound process?), and (2) the effectiveness of the intervention (do the outcomes associated with the wraparound process differ from those associated with other types of interventions?).

Concern with the integrity of the wraparound process is partly a function of the increasing popularity of the intervention. Given the promising results from the preliminary studies described above, more and more services are being labeled as wraparound. However, based on observation and anecdotal data, it is clear that some of these services do not adhere to the values, elements, and requirements that are basic to the wraparound concept. For example, "wraparound services" have been identified that are administered only within residential treatment programs, or are located within the community but do not utilize individualized child and family treatment teams, or place little emphasis on cultural competence, unconditional care, flexible funding, or parent and youth involvement.[25,26,27] These reasons underscore the importance of operationally defining the essential elements of the process in order to ensure that wraparound providers and evaluators are referring to the same intervention.

Unless the intervention can be operationally defined and measured, there is no way to assure that the intervention that is evaluated can be applied in practice and have an impact on outcomes, or achieve certain outcomes. Thus far, there have been at least three studies that have focused on some aspects of the integrity of the wraparound process, and a more comprehensive study is in progress. In one of the

completed studies, it was determined that 20 youths who were receiving wraparound services did feel they were involved in the process (e.g., "the members of my treatment team ask for my ideas and opinions," and "I have a choice in the services I receive"), and that they did feel that their care was unconditional (e.g., "I believe my service providers will stick with me no matter what").[28] A second study demonstrated that 20 youths who were receiving wraparound services felt more involved and had a greater sense of unconditional care than 20 comparable youths who were receiving traditional services.[29] The third study demonstrated that a 34-item observation form that measured the occurrence of critical elements of the wraparound process in treatment planning meetings was reliable and could be used for evaluating wraparound services.[30]

The study in progress involves an analysis of 16 elements of the wraparound process (see Appendix D) that were identified by a small panel of people who were involved in the development of the wraparound process. Questionnaires designed to measure the elements are being administered by trained third party interviewers to 20 youths, their parents, and their case managers. In order to validate the measures, the study also includes a matched control group of 20 youths who are receiving traditional child welfare services.[31]

In addition to the research that relates to the integrity of the wraparound process (and more is needed), there is a critical need for more research that compares and contrasts the effectiveness of the wraparound process with other interventions. The two "effectiveness" studies involving random assignment that were conducted in New York and Florida provide some support for the wraparound process; however, the findings are limited by the lack of data on the integrity of the intervention. While it seems clear that some of the elements of the wraparound process were in place in both studies, there are indications that critical elements may have been missing. For example, in the New York study the authors make clear that they do not believe that their intervention was a full wraparound model, and in the Florida study (in which all the youth were in foster care), it is not clear that the biological parents had the "access, voice, and choice" that are critical to the wraparound process. Questions such as appropriate comparison conditions in future studies of wraparound will need to be considered by the research community and other key stakeholders.

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Epilogue: A Letter from Karl Dennis on Exciting Innovations and Future Directions of Wraparound

Over the last two and a half decades I have participated and watched the evolution of the wraparound process, from its infancy to a well-structured movement. I have been encouraged by its growth and have personally witnessed its success in many states. I have also observed the interest in wraparound in places such as China, Australia, Canada, Romania, Great Britain, and New Zealand. I want to share with readers some of what I believe is exciting and innovative about wraparound, and some future directions.

The wraparound process now has a firm foothold in every human service sector. These include Special Education, Child Welfare, (where Kaleidoscope has its roots), Juvenile Justice, and Mental Health, which has spearheaded a number of the initiatives in both the public and private sectors. I have also seen its growth in the initiatives sponsored and funded by those private foundations whose primary interest is in the well being of children and families.

Some of the most innovative initiatives and approaches developing informal resources as part of the wraparound process have come out of the community itself. Many of these were related to, but not necessarily part of, a formal system. As an example, upon discovering the need for respite in one area, the religious community went into their churches and synagogues and recruited volunteers, a private agency provided training, and the child welfare department became the clearinghouse for families in need of respite. Within six months a service gap had been filled using a natural community resource.

Under the auspices of one of the foundation grants in Houston, a curriculum has been developed with a local university that trains and certifies parents as "friends of family" service supporters. Their services are now reimbursable through managed care.

In Washington, DC, the Time Dollar Institute has helped many communities set up a barter system of services. In a Chicago school system, children who are having difficulty in school themselves are taught to be tutors of younger children. For each hour of service they earn one time dollar. After accumulating 100 time dollars, they can turn in their shares and go home with their very own computer. Most of these children would never have dreamed of owning a computer. Their grades and attendance have dramatically improved with a minimal investment of dollars.

In Phoenix, the Sustaining Systems Project, developed by the Institute for Community Initiatives, is helping communities design, implement, and evaluate a community-based model for planning the long-term financing of services for children and families. Its emphasis is to ensure that services for children and their families can be sustained over time. The project involves a planned, long-range approach to financing systems of care by assessing areas of future needs, comparing those needs to the available future resources, and formulating strategies to close the gap between the service needs and the cost of providing those services.

In the Sustaining Systems Project, business, financial, and corporate experts from all sectors of the community are cross-trained with individuals from the social services arena in order to create common priorities, language, and goals. The methodology includes the use of state-of-the-art financial planning and analysis tools within the community in order to maximize the effectiveness of local decision making and to maintain relationships of accountability. In addition, this project can help communities to illuminate, identify, and develop private and existing revenue that can help to reduce the effects of public money shortfalls.

I have been amazed by the growth of the family movement in this country that found its validation in the Child and Adolescent Service System Program movement and underlies wraparound. Dr. Ira Lourie observed that often public service initiatives tended to have a well- defined life span that included a diminution of spirit leading to its death after about 7 to 10 years. In order to protect a new movement of family-focused services, Dr. Lourie and Ms. Judith Katz-Leavy encouraged parents to organize and to advocate for their children and families. In the early years many people felt that this approach would not work due to families' fear of being stigmatized by their identification with mental health services. However, parents of children with emotional and behavioral problems have readily identified themselves and appeared ready to do anything they could to create a greater national presence for services that followed the principles. In Portland, the Families as Allies conference was so successful that it was replicated nationwide. Another critical building block occurred when a foundation administrator noted that a disproportionate number of children of color were found in the child welfare and juvenile justice systems regardless of their challenges. Funding from this foundation to parent organizations helped to widen the net to include families of color in this movement.

We have learned valuable lessons from the parents. Not only are they valuable as advocates, but they have taught us that:

- Parents are the most important resource for their children.
- They are not to blame for the uniqueness of their children.

- They know best what their children's problems are and what resources they need to help the situation.
- No one will advocate and fight for their children as doggedly as their parents.

Today parents no longer sit in the back of the room. They are found as equal partners on state policy-making bodies, have run for legislative offices, and are advisors to presidential initiatives.

Not only are they advocates, but also service providers. The Safety Net is a program of the Georgia Parent Support Network that provides community services to juvenile sexual offenders that, in the past, would have been sent to prison where they would receive little treatment and often become victims themselves. This program builds a "Safety Net" of community volunteers. These volunteers are people already invested in the child's life. They may include neighbors, relatives, friends, school personnel, little league coaches, tutors, parole officers, and often employers. These volunteers are educated and coordinated by a case manager. They provide 24-hour-a-day surveillance of the youth. Each case manager has eight youth in his or her care. They are in daily contact with the youth and family and coordinate all services to ensure that everyone is working together. All agencies work from one individual service plan. Only one case manager works with a family. The case manager often becomes a knowledgeable extended family member. As the family and community take over the care of the child, the level of services is stepped down and eventually phased out. Although the process follows the same pattern each time a Safety Net is tailored to meet the unique needs of the individual youth and family being served. No two are ever alike. During Safety Net's four years of existence, no child has reoffended.

In one community, Champaign, Illinois, a child and family team was assembled in response to the needs of a troubled 14-year-old young man. Everyone believed that he was certainly on his way to jail or an institution. His team included his father, his stepmother, and three friends who had learned of the wraparound process from listening to their parents. It was at their initiation that this process was begun. Each person had a specific role and purpose for being on the team. The direct service providers were primarily his peers, friends between the ages of 13 and 16. They tutored him, monitored his whereabouts and behaviors 24 hours a day, and even gave him advice on "appropriate" girlfriends. The young man checked in via telephone, particularly during crisis times. His peer team members accompanied him to his church as he sought support and refuge in new places and planned his weekend social agenda. When he began pulling away and returning to "old" behaviors, his team's support intensified—they never gave up. In June, 1998, he graduated from the 8th grade. Between February and June, 1998, his behaviors and grades at school improved significantly; there were no incidents resulting in detentions, suspensions, or Saturday school consequences.

These mentioned projects are only a sample of the many creative and exciting services that have developed through our partnerships with families, communities, foundations, and the public and private sectors. As I look to the future, if wraparound is to continue and be effective, I see the need for several things. First, it is imperative to see this process as not being owned by professionals or any one discipline, but owned by the community and the children and families who are served in this process in partnership with the private and public sectors. Secondly, I am concerned about the sustainability of wraparound. I have seen many initiatives that have been successfully started only to be scrapped when the funding or the leadership changed. It has been my experience that when state leadership changes, often refinement of services follows regardless of previous success.

In order to protect the advances that have been made in delivering family-focused services, we need to expand our circle of advocates. The businessman who finds a job for someone needs to be encouraged to call the state legislator he roomed with in college; that journalist who wrote that uncomplimentary article needs to be invited to talk to people who have been successfully served in this process; and the neighbor who provides respite care for an at-risk child needs to talk to her mayor, and so the circle grows. To remain viable, we all will have to continue to grow, to change, and to look for more creative ways of helping the people that we are so privileged to serve.

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APPENDICES

Appendix A

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Appendix B

VALUES AND PRINCIPLES FOR THE SYSTEM OF CARE

Core Values

- The system of care should be child centered and family focused, with the needs of the child and family dictating the types and mix of services provided.

- The system of care should be community based, with the locus of services as well as management and decision-making responsibility resting at the community level.

- The system of care should be culturally competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve.

Guiding Principles

(1) Children with emotional disturbances should have access to a comprehensive array of services that address the child's physical, emotional, social, and educational needs.

(2) Children with emotional disturbances should receive individualized services in accordance with the unique needs and potentials of each child and guided by an individualized service plan.

(3) Children with emotional disturbances should receive services within the least restrictive, most normative environment that is clinically appropriate.

(4) The families and surrogate families of children with emotional disturbances should be full participants in all aspects of the planning and delivery of services.

(5) Children with emotional disturbances should receive services that are integrated, with linkages between child-serving agencies and programs, and mechanisms for planning, developing, and coordinating services.

(6) Children with emotional disturbances should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs.

(7) Early identification and intervention for children with emotional disturbances should be promoted by the system of care in order to enhance the likelihood of positive outcomes.

(8) Children with emotional disturbances should be ensured smooth transitions to the adult service system as they reach maturity.

(9) The rights of children with emotional disturbances should be protected, and effective advocacy efforts for children and youth with emotional disturbances should be promoted.

(10) Children with emotional disturbances should receive services without regard to race, religion, national origin, sex, physical disability, or other characteristics, and services should be sensitive and responsive to cultural differences and special needs.

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Appendix C

WRAPAROUND SURVEY OF STATE CHILD MENTAL HEALTH DIRECTORS

Date:

Respondent:

State:

Wraparound is usually defined as a process used to establish community-based support systems for children with emotional disturbance and their families. Wraparound typically includes the following elements, although not all are present in every system with wraparound:

- Efforts must be based in the community.
- Services and supports must be individualized to meet the needs of the children and families.
- The process must be culturally competent and strengths-based.
- Agencies must have access to flexible, non-categorized funding.
- The process must be implemented on an inter-agency basis and owned by the community.
- Services must be unconditional.
- Outcomes must be measured.

Please answer the following questions about wraparound services in your state.
Circle No or Yes.

1. Is thc wraparound process of service provision for children with emotional/behavioral disturbance available in your state?

   NO Stop here and return the questionnaire.
   YES Complete the questionnaire.

2. Are services limited to a specific geographic area or a specific population?

   NO
   YES If yes, please specify.

3. Do you have an estimate of the number of children receiving wraparound in your state on an annual basis through multiple or single system efforts?

NO If no, go to question 4a on the next page.
YES If yes, what is the estimated number of children receiving those services at this time?

What source of information did you use to make the above estimate?

4a. What systems are involved in the wraparound process of service provision in your state? Please check the appropriate box(es).

Mental Health	❒
Education	❒
Child Welfare	❒
Juvenile Justice	❒
Public Health	❒
Substance Abuse	❒
Developmental Disabilities	❒
Others: Please specify	_____

4b. Of the service systems above, identify those in the lead role in your state.

5. Are other names (labels) used to identify Wraparound (e.g. "high-risk intervention," "individualized and tailored care," "person-centered planning," "circles of support," "support clusters")?

NO
YES If yes, please specify.

6. Are community organizations/stakeholders utilized to provide informal support for wraparound in your state?

NO
YES

7. Are there written standards for wraparound? Often these are developed by Medicaid for reimbursement.

   NO
   YES If yes, please attach.

8. Has inservice training on wraparound been conducted in your state?

   NO
   YES If yes, by whom?

9. Have there been any evaluations of wraparound programs in your state?

   NO
   YES If you would like to share such reports, this would be highly appreciated; please attach.

10. Are there special lessons you have learned from your experience with implementing wraparound in your state? Please describe.

Appendix D

POTENTIAL ELEMENTS ESSENTIAL TO THE WRAPAROUND PROCESS: (e.g., if it isn't happening, it's not Wraparound)

1. There is a Child and Family Team that is comprised of family members, neighbors, professionals, and friends who are committed to a partnership designed to help the child and family meet their needs.

2. Initially at least half of the members of this Child and Family Team are persons the child and family see as non-professionals. Ultimately the professionals fade out of the process.

3. The Child and Family Team produces a written individualized service and support plan that addresses the most current and critical life domain needs.

4. The Child and Family Team produces a crisis plan that describes who does what and when if a crisis occurs.

5. Child and family strengths, family culture and informal resources are discovered and then used as the basis for developing the individualized plan.

6. If the child is in the custody of the state, and the plan is family reunification, a continual effort is made to involve the biological parents in all aspects of the planning process, even if they are resistant or they are perceived as a major part of the child's problems.

7. If the child is not in the custody of the state, the biological parents have access to all discussions related to their plans and are able to voice their preferences and make legitimate choices.

8. To the extent possible, the child has access to all discussions related to the planning process and is able to voice his or her preferences and make legitimate choices.

9. Representatives of the agencies that are important to the child and family work together to provide integrated services and supports.

10. The people who provide services and supports to the child, and family supports to the child and family, respect their traditions, their lifestyle, and their spiritual beliefs.

11. Services and supports are based on the concept of normalization and are provided in the home community of the child and family as much as possible.

12. The primary purpose of the Child and Family Team is to support the child and family, not to direct them.

13. The Wraparound process for an individual child and family is responsive to changing needs and ensures that services and supports occur in a timely manner.

14. Wraparound plans are a blend of formal and informal resources, drawing on as many child and family resources as possible. Ultimately the resources are almost entirely informal.

15. Services and supports are unconditional. If the needs of the child and family change, the child and family are not rejected. Instead, the services and supports are changed.

16. The goals of the Wraparound plan are stated in a measurable way and monitored on a regular basis.

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