Introduction and Basics: Chapter 1.4

Reflecting on Wraparound: Inspirations, Innovations, and Future Directions

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The wraparound process has evolved from a small number of site-driven innovations to being a part of the services system for children and youth with complex behavioral health needs and their families in almost every state and province in North America. In this article, the author, one of the early developers of the wraparound process, extends his description of the history of wraparound (see Chapter 1.3) to describe the emergence of a newly defined continuum of care based on key principles of the wraparound process. He also presents a selection of innovative efforts which exemplify the "cutting edge" of wraparound practices.

The wraparound process is rapidly becoming a part of mainstream human services. The first state-wide system of care-based wraparound effort was established in Alaska in 1986 (VanDenBerg & Minton, 1987; Burchard, et.al, 1993). These efforts were based on creative, agency-based individualized planning being done at the Kaleidoscope agency in Chicago (Dennis & Lourie, 2005; Kendziora, 1999), which was based on de-institutionalization and normalization efforts from Canada. The process has grown to include locally innovated efforts across North America and in other parts of the world. Over its near 30-year history, wraparound has emerged as a primary method of integration and delivery of services and supports for children and youth with complex behavioral health needs, and their families.

In many sites, wraparound started in reaction to the common practice of use of long term and sometimes out-of-state placements of children and youth with complex

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behavioral health needs. States such as Michigan, Maine, and Kansas have used the process to reduce the use of these potentially harmful long term placements and serve children and youth in their homes. Wraparound has roots in the continuing movement to improve behavioral health services for children and youth, which was accelerated by Jane Knitzer's 1982 book, *Unclaimed Children*. In this book, Knitzer revealed that two-thirds of all children with severe emotional disturbances were not receiving appropriate services. These children were "unclaimed" by the public agencies responsible to serve them, and, said Knitzer, there was little coordination among the various child-serving systems. To address this need, Congress appropriated funds in 1984 for the Child and Adolescent Service System Program (CASSP) through the National Institute of Mental Health, which envisioned a comprehensive mental health system of care for children, adolescents and their families. Ongoing federal grants supported the development of wraparound practice and systems of care across the country. Subsequently, national technical assistance centers at Georgetown University, Portland State University, and the University of South Florida were founded to support best practice development, research and evaluation of systems of care.

In an accompanying article in this *Resource Guide*, a reprint of a 2003 piece for Portland State's *Focal Point*, we present more details on the long history of wraparound and related efforts (VanDenBerg, Bruns, & Burchard, 2003). In the remaining sections of the current piece, I will concentrate on important issues, current innovations, and future directions for the wraparound process.

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Initial Fidelity Drift

In the earliest days of the wraparound process in Alaska (VanDenBerg & Minton, 1987; VanDenBerg, 1993), Washington (VanDerStoep et al, 2001), Vermont (Burchard & Clarke, 1990), and in many other states, the efforts were based primarily on the key principles of individualization and unconditional care, and increasing family voice and choice. There was little, if any, clear definition or standardization of what the wraparound process actually entailed. Regardless, from the start to the present, this creative teaming process has been inherently attractive to human services administration and advocates. As the initial efforts began to multiply through funding through CASSP, Robert Wood Johnson's Grant Program and later the Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA) and other sources, the energy and growth of innovative services and processes such as the wraparound process was amazing.

By 1988, in early replications of the work in Alaska and Vermont, the wraparound process already began to vary in quality and in scope. By the early 1990's, efforts in several states had been identified as failures by implementers and funders. Close examination of these efforts revealed that what was called "wraparound" more closely resembled children's case management: no real individualization, no child and family teams, no integration of services, and certainly no youth and parent voice and choice. By 1997, many of the early innovators felt that although dozens of efforts were reporting positive results, overall the wraparound field was at risk of being "innovated to death" and becoming just another good idea that did not pan out once brought to scale and expansion. As a result, a meeting was held at Duke University and the first major organized effort to provide consistency to the definition of the wraparound process began (Burns & Goldman, 1999).

Later, the National Wraparound Initiative (NWI; Walker & Bruns, 2006) was established, which has led to standardized definitions of the principles of wraparound and the steps, or phases and activities, of the process (Walker et al., 2004). In addition to serving as a web-based clearinghouse of information and resources sharing across sites, the

NWI is currently making progress on defining key jobs in the process such as family support partner (Penn & Osher, 2007), and in developing innovative evaluation methods (Bruns et al., 2006). Many states and provinces have accepted the standardized Principles and the Phases and Activities of the NWI as the definition of the wraparound process, and the field is increasingly stable and consistent in terms of clarity of purpose and forward movement.

Lawsuits

A group of key lawsuits have influenced the speed of the growth of the wraparound process. The first major lawsuit that shaped the field was *Willie M. vs. Hunt*, in 1980 (Behar, 1986). A more recent and representative lawsuit was the *Jason K.* lawsuit in Arizona, which has led to the inclusion of over 16,000 children and youth in the wraparound process (Frank Rider, personal communication October 13, 2007). Another recent crucial lawsuit was *Emily Q. vs. Bonta* (Bird, 2006), which has resulted in a major expansion of the process in California. These lawsuits have supported a basic right to effective services and supports. The lawsuits share a similarity—they all have been instigated by parents whose children were placed outside the home when the state decided to not establish viable alternatives such as wraparound, due to cost or administrative policy such as state Medicaid definition of reimbursable services. Out of over 30 successive similar class action lawsuits over 25 years, not one has been lost by the advocacy organizations bringing the suits. Now, the field is expanding and many innovative efforts have emerged.

Similar Innovations in Other Fields

Development of team-based planning models such as the wraparound process have simultaneously emerged in other core services areas for children and youth with complex behavioral needs. The work of John O'Brien and colleagues (1989) in the field of developmental disabilities has led to exciting system improvements through development of needs-based, individualized services in communities which are based on person-centered planning. The field of juvenile justice is further individualizing youth corrections responses through

the use of innovations such as the Balanced Approach (Guarino-Gheezi & Loughran, 1996). The work of Kretzmann and McKnight (1993) on restructuring communities to support individuals with complex needs has been vital to the field.

Future Directions for the Wraparound Process

Global Expansion and Research

Recently, the government of Norway (Flessen, 2007) launched a nation-wide effort to establish NWI-inspired wraparound, which is being supported by trainers from the United States and from a successful wraparound effort in Toronto, Ontario in Canada. Karl Dennis (personal communication, September 11, 2007) has been supporting wraparound implementation in New Zealand. The author receives weekly queries from around the planet as "the word" gets out about the process viability and growth.

As is described in other chapters of this *Resource Guide*, the available research on the process is expanding (Bruns, 2008). Although many regard the evidence base as still "weak" (Farmer, Dorsey, & Mustillo, 2004), the number of quality research studies is growing (Suter & Bruns, 2007). The U.S. Surgeon General's report (2000) listed wraparound as a "promising" intervention, and depending on the source, wraparound has been identified variously as an "evidence-based," "emerging," or "best" practice (Walker, Bruns, &

Penn, in press). Almost a decade ago, Faw (1999) estimated the number of children and youth enrolled in wraparound-like service processes at 200,000. A more recent survey has found that at least 100,000 youths are engaged in an intensive wraparound process that meets the definition provided by the NWI (Sather et al., 2007; see also Chapter 3.4). This survey also found that the number of states with some wraparound project is over 90%, and that the rate of states with standards for wraparound implementation and/or resources for training and credentialing providers is growing.

Wraparound and the Silo Effect

One of the factors that has influenced growth of wraparound at the family level is the "silo effect," caused by separately developed models of care from child welfare, juvenile justice, education, mental health, developmental disability, public health, addiction, housing, welfare, medical, vocational, legal, and other services. Even though families did not come in neat packages that fit the silos, these systems often did not interact at the policy, agency, and practice levels. As a result, many families received multiple plans with sometimes competing instructions from different systems. When these disjointed plans failed, families were often blamed and labels such as "noncompliant with services" were attached to the child, youth, or family.

In response to problems with silo-based, separately developed systems, the notion of a "system of care" was conceptualized by Beth Stroul and Robert Friedman in 1986. In the early days of CASSP funding from NIMH, states began to establish collaboration between systems as a major goal. This led to establishment of state and local community interagency teams, cross-system staffing of children, youth, and families with complex behavioral health needs, and many other efforts to build provider level knowledge of each system's operations and mandates. However, at the practice level, regardless of the level of collaboration, each system held a "staffing," made their own decisions about what services the family would receive, and determined what system consequences followed problem behaviors of the child, youth, or parent. For example, a building principal at a school may suspend a youth with be-

havioral health needs under a school district zero tolerance policy. This same youth is then at home during the day and ends up in trouble with legal authorities when vandalizing neighbors' apartments. The youth may then be adjudicated and placed outside their school district in a detention facility where limited mental health services are available. As a result, although each system protected their own mandate (e.g., education, safety), no positive behavioral health outcomes are achieved.

It has also become clear that system-level collaboration alone does not achieve improved behavioral health outcomes. Bickman and colleagues (2003) have questioned the outcomes in sites where collaboration has been extensive (such as Stark County, Ohio), and concluded that collaboration alone may not result in improved behavioral health outcomes. In reaction to the limitations of collaboration, the wraparound process has thrived as a process of *integration*. What is the difference? VanDenBerg and Rast (2006) define *collaboration* as "when agencies are familiar with each other's missions and roles, key staff work with each other at the child/family level, but often retain single system decision making power and planning." Alternatively, *integration* is defined as "when agencies are familiar with each other's missions and roles, and key staff work with each other at the child/family level, sharing decision making in a team format that includes the family in the driver's seat, producing a single plan that meets all system mandates and that is owned by the entire team." In other words, wraparound is a *process of integration*, based on core principles, which is supporting revision of the traditional continuum of care (VanDenBerg, 2007).

A Re-Definition of the Continuum of Care Based on the Principles of Wraparound

The original notion of a "continuum of care" described movement from service to service, with a child or youth rapidly moving up or down in restrictiveness of care. A child or youth essentially failed their way up the continuum. Children or youth quickly went through levels of the continuum as they left more restrictive care, such as going directly from psychiatric hospital to home. Solutions were deficit based, designed to "fix" the

problem. A new conceptualization of continuum of care is being attempted in Arizona (Rider, personal communication, October 11, 2007), and in many other states and sites nationally. This notion of continuum of care is represented by the following statement: "The more complex the needs of the child and/or family, the more intensive the individualization and degree of integration of the supports and services around the family" (VanDenBerg, 2007). In this model, child, youth, and family needs drive the *level of intensity of integration and individualization*, not the restrictiveness of services. Individualized options for meeting needs are based on the unique strengths and culture of the family, and on practice-based evidence.

While the primary point of the new continuum is "the more complex the needs, the more intensive integration and individualization," it is important to point out that in the old continuum and in most of current systems practice in North America, the reverse is true. The youth in the psychiatric hospital or other "deep end" services often have the least amount of system integration and individualization. In a continuum based on the principles of the wraparound process described by the NWI (Walker, et al, 2004), the children and families with the most complex needs will have the most integrated and individualized services and supports, although all children and youth with behavioral health needs at any level must have individualized services and supports.

The "Cutting Edge of Wraparound"

Variations of the wraparound process have emerged that range from wraparound for children under five years old (Hoover, 2006), to use of the wraparound process focused on reduction of youth in long term residential placements, to wraparound being used to reduce recidivism for adult prisoners in the correctional facilities of Oklahoma (VanDenBerg, 2006). (See sidebar at left.)

In addition, the wraparound process is being used in innovative community development efforts. The state of Rhode Island (Frank Pace, personal communication June 12, 2007) plans on experimenting with the use of Time Banks (see www.TimeBanks.org) for development of natural supports building and sharing as part of the wraparound process. With Time Banks, a wraparound family can access local neighborhood supports and assistance, and can pay back the supports through helping in ways that are based on their own strengths. When supports are used, the families' Time Bank account is reduced. When the family supports others or does assistance such as car repair or baking, or baby-sitting, the family Time Bank account is replenished. In Ontario, community development innovators (Debicki, 2007) are innovating neighborhood-based wraparound where neighborhood councils (see accompanying box) drive the funding and implementation of the process.

In the state of Oklahoma (Pirtle, 2006), major progress has been made in the definition and use

The Oklahoma Wraparound Re-Entry Program for Adult Corrections

In 2005, the state of Oklahoma initiated a novel effort to reduce recidivism in adult offenders. Oklahoma is the first state to attempt to apply the wraparound process to a corrections effort, and the exact role and function of the prison-based wraparound facilitators is being built one offender at a time, with the help of all concerned with the effort. The pre-wraparound baseline levels of offender recidivism are over 50% for the target population of 52% of all Oklahoma adult offenders who are released from prison with no aftercare plan beyond a case manager-produced discharge plan. The Principles and Phases and Activities of the Wraparound Process from NWI have been adapted for use with the prison population. The wraparound facilitators begin with the offender six months prior to discharge, form teams, and initiate engagement with the offenders to set their own goals and determine top needs for after discharge. Initial results from the Oklahoma Prison Wraparound efforts are promising, with dramatic reductions in the rates of recidivism.

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Neighborhood-Based Wraparound Programs in Ontario

In 2005, local human services in Hamilton, Ontario began a partnership with faith-based and other neighborhood-based efforts to establish an innovative version of the wraparound process in which neighborhoods establish local community mobilization teams and base volunteer wraparound facilitators in local faith-based organizations. This effort has spread to a number of nearby communities in Ontario. Initial research on the effort has been promising, resulting in cost savings to child welfare and juvenile justice agencies when youth are returned from residential services into the neighborhood wraparound efforts. Similar efforts are currently being contemplated in communities in Washington state.

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ly skilled FSPs who have the ability to acquire and learn the skills of this very complex job, or who already have many of the skills. In Wraparound Tulsa, the FSPs are seen as one of the major variables in why hundreds of children and youth with complex behavioral health needs and their families have successfully graduated from wraparound. (See sidebar below.)

Summary

At the heart of wraparound is the belief that we as humans have better lives when our biggest needs are met, when we have a say in our own lives through self-determination, when we build our skills to manage the challenges of the future, and when we are surrounded with support from

of family partners, called "family support providers" (FSP). It is clear that the FSP is a viable position in the behavioral health system as implemented in the Oklahoma system of care, and one that contributes to the positive outcomes currently being experienced with the wraparound process in Oklahoma. The current group of over 50 FSPs are skilled, dedicated, and working as competent team members to deliver individualized behavioral health services to children, youth, and families in Oklahoma who have very challenging behavioral health needs. (See sidebar, top of this page.)

Currently, Oklahoma counties have wraparound supervisors who oversee local wraparound efforts through agencies participating in county-based systems of care, covering most Oklahoma counties. These supervisors oversee both care coordinators (facilitators of the wraparound process) and FSPs, who provide direct support to the children, youth, and families. Both the care coordinators and the FSPs are vital parts of achieving outcomes with children and youth who would otherwise be placed in out-of-community or out-of-home care. New hiring efforts are recruiting high-

A Family Support Provider from Wraparound Tulsa: Grace McCombs

Grace is one of ten children who were raised in poverty, and has been on her own since she was 16 years old. She was a mother at 20 years old, and is the parent of two children, one of whom is the first graduate of wraparound in the state of Oklahoma. As a mom, she was involved with several systems. Grace says that in previous services, "No one ever asked me what I needed or wanted." She says what worked about wraparound was that the care coordinator and the FSP worked with all the systems to come up with one plan, based on her definition of the needs of her family. After graduating wraparound, she began working as an FSP for up to 20 families. She says "I provide support however the family wants support—24 hours, in homes, in schools, with extended family, in church, wherever." In addition, her son Luke has recently accepted a position as one of the first wraparound siblings to work as an FSP. Grace has now begun to present at conferences and workshops in other parts of the United States.

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others. The work in prison-based wraparound in Oklahoma is an example of the potential of the process. The importance of the work of the NWI in supporting the sharing of resources and options must be emphasized. The coming products of the NWI in the areas of further defining the work of the FSP, the development of clear overall standards for the field, and the completion of a clear theory of change are important steps towards the continuing excellence of the wraparound process. Innovations such as Time Banks, community and neighborhood partnering efforts, and the demonstration of true system integration will drive the survival of the wraparound process.

In the early days of the wraparound process, the innovators operated from a strong belief in the power of individualization, in persistence and unconditional care, and in voice and choice of consumers. These beliefs must remain, but must be accompanied by further innovation, as the field continues to mature and evolve.

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