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Dedication

As described in the many pages of this *Resource Guide*, the wraparound process has evolved over time and developed through lessons learned from many "on the ground" experiments. As a result, the wraparound philosophy and practice model are now being used not just with youth with mental health needs, but also with children and families involved with the child welfare system, youth in juvenile justice, transition-age youth, adult offenders, elders, and many other types of individuals with complex needs. This *Resource Guide* is dedicated first and foremost to all the children, youth, parents, family members, advocates, team members, providers, administrators, researchers, and others who have promoted and participated in wraparound over the years of its continued evolution.

This *Resource Guide* is also dedicated to the memory of John D. Burchard (1936-2004). One of the first researchers to take an interest in the model, John was a tireless advocate for children, youth, and families, and he was passionate about wraparound's promise. As a professor at the University of Vermont, John dedicated much of the last two decades of his life to thinking about how to better support communities and programs to implement wraparound. He co-wrote *One Kid at a Time* about the Alaska Youth Initiative, led the evaluation of *Project Wraparound* in Vermont, and created the *Wraparound Fidelity Index*.

John embodied the principles of wraparound in all aspects of his life. From our first day in graduate school, John's students learned to practice by the philosophy that professionals do not have the answers, families do, and that our job is to do "whatever it takes" to ensure that children

are supported to live successfully at home and in their communities. He and his wife Sara opened their home to many young people throughout their life together, welcoming two Bosnian youths to join their family in Vermont. John and Sara also traveled around the world, visiting such far-away places as Australia, New Zealand, Russia, Europe, India, Mexico and Alaska, and made lasting friendships with people from different backgrounds and cultures wherever they went. John lived each day to the fullest, always demonstrating a sincere interest in others, a generous spirit, an indomitable optimism and a sense of humor that touched many, many lives. His dedication to developing communities of practice and innovative research methods to help the field understand and implement wraparound is a core inspiration for this *Resource Guide* and the NWI.

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Acknowledgments

We would like to acknowledge the many people and organizations that supported the creation of this *Resource Guide to Wraparound*. The *Guide* is a compilation of articles contributed by the advisors of the National Wraparound Initiative (NWI), who have generously shared their ideas and expertise. The guide also builds on previous work of the NWI's advisors, so our acknowledgements begin with those who supported the "founding" of the National Wraparound Initiative and provided it with initial support.

Key participants in the launching of the NWI included Jane Adams and Trina Osher, tireless advocates for families and children who saw the need for better understanding of the wraparound process so that more families would benefit from it. At the outset, along with Trina and Jane, we were joined by a number of key national experts, who provided us with direction and offered up their training and implementation materials for review. Among these, no one provided their time and expertise more generously than Pat Miles, John VanDenBerg, and Jim Rast, who sat through countless hours of meetings, writing, and reviewing of drafts. We also received consultation, materials, and reviews from other experts such as John Franz, Neil Brown, Mary Grealish, Karl Dennis, and Lucille Eber. In addition, leaders of many state and local wraparound initiatives helped us think through what was needed from the NWI and also provided tools and examples from their local programs. Chief among these were Mary Jo Meyers, Knute Rotto, Connie Conklin, Mary Stone Smith, Don Koenig, Gerry Rodriguez, Brad Norton, and Susan McLaughlin (though there were many others as well). Initial direction and support was also provided by several researchers, including Nancy Koroloff, Bob Fried-

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Once the inspiration and ideas for the NWI were established, there were a host of individuals and institutions who provided financial and logistical support. Thanks first to Denise Sulzbach, who had the unique vision of an NWI that would support wraparound implementation in her home state, and thus facilitated funding from the Maryland Governor's Office of Crime Control and Prevention and the Maryland Department of Juvenile Services. Support for the NWI has also been provided by ORC Macro, Inc.; a grant provided to the state of Maryland by the Center for Medical and Medicaid Services (award no. 11-P-92001/3-01); and by the National Technical Assistance Partnership for Child and Family Mental Health. The NWI has also benefited from resources provided by a grant from the National Institute for Mental Health (R41 MH077356) to support development of wraparound fidelity measures. Logistical support has been provided in countless ways by the Research and Training Center for Family Support and Children's Mental Health at Portland State University.

Very special acknowledgment in a whole separate paragraph must be provided to Gary M. Blau, Chief of the Child, Adolescent and Family Branch of the Center for Mental Health Services, SAMHSA. Since day one on the job as Branch Chief, Gary has been a supporter, cheerleader, and advisor of the NWI. Without his backing, this *Resource Guide* would not have been possible.

Thanks also to those who have supported the editors in compiling, proofreading, and doing page layout for all the materials in this *Resource Guide*, including Nicole Aue and Vicky Mazzone at Portland State University, and April Sather from the University of Washington. Without their day-to-day work coordinating review and design of materials, it is unlikely we would have been able to complete this work.

We also need to acknowledge those advisors of the NWI who have generously contributed their own local tools to the *Guide*, and those who contributed articles presenting examples and describing their experiences. Though their contributions are acknowledged in several places in this *Guide*, it is worth listing their names here as well: Kathy Cox, John Franz, Bob Jones, Karl Dennis, Mary Jo Meyers, Jesse Suter, John VanDenBerg, Matt Pierce, Trina Osher, Marlene Penn, Darrell Evora, Leyla Stambaugh, Pat Miles, Marvin Alexander, Brian Lombrowski, Tim Penrod, Debbie Manners, Doug Crandall, Connie Conklin, Denise Churchill, Kenyetta Matthews, Brad Norman, Aggie Hale, Lucille Eber, Neil Brown, Laura Champion, Jerry Doyle, Eleanor Castillo, Aggie Hale, Beth Berndt, Ira Lourie, Jim Rast, Gerri Rodriguez, April Sather, Sue Smith. In addition to these authors, we would like to offer special acknowledgment for Trina Osher and Marlene Penn, who facilitated the work of the Family Partner Task Group and its collaborative development of the description of the role of the family partner in wraparound and related materials.

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Foreword

Gary Blau, Chief
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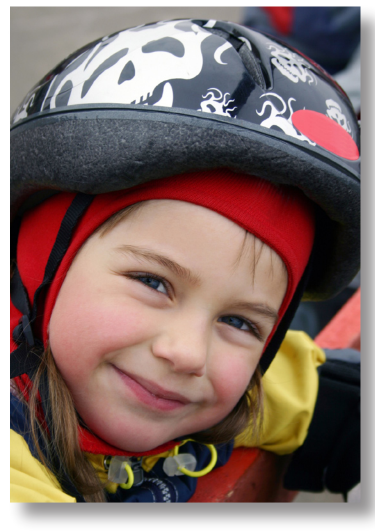

It has been over twenty years since the term "wraparound" was used to define an intervention approach that surrounds a youth and family with customized services and supports. Since that time perhaps no other term used in the field of mental health has been more praised or embraced, redefined or misunderstood.

The wraparound concept is one of the cornerstones of the Children's Mental Health Initiative, which started in the 1980's with the advent of the Child and Adolescent Service System Program (CASSP), and continues on today with system of care grants and cooperative agreements across the nation and in the territories of Guam and Puerto Rico. The concept of wraparound permeates this incredibly successful federal initiative to improve services for youth with mental health challenges and their families.

During my tenure as Chief of the Child, Adolescent and Family Branch at SAMHSA (the Substance Abuse and Mental Health Services Administration), we have seen an impressive increase in the understanding of how to operate from a family-driven, youth-guided perspective when designing services for youth and families. Yet we still suffer from empty rhetoric and misinterpretation of what it means to be family-driven and youth-guided; to fully operationalize the concept of "one family, one plan"; and to fully implement the principles of wraparound in practice.

We know *why* the wraparound process is important. This field is blessed with a rich complement of leaders in the wraparound movement who have written volumes over the past twenty years making the case for why a wraparound approach is an effective strategy for working with youth

and families. What we have yet to learn is *how* to consistently apply the principles of wraparound in practice.

The field of children's mental health is benefiting from more and more evidence about how to deliver treatments that work, and the field is also learning that children with the most complex needs and their families require more than just one specific evidence-based practice. Practice-based evidence affirms that a more comprehensive approach to meeting complex needs must include additional elements, such as those that are part of the wraparound process—additional coordination, more flexible supports, and a team approach.

Fortunately for our field, we have this *Resource Guide*, put together with painstaking love and great attention to detail by Eric Bruns and Janet Walker, the co-coordinators of the National Wraparound Initiative. Compiling over fifty articles and a large number of resources on the wraparound process was no easy task. Bruns and Walker recognize the living and ever-changing nature of the wraparound process. The more that families and practitioners become involved with the process, the more we learn. The more we learn, the more refinements and enhancements are made. This guide describes the current state of the art in wraparound, offering information and resources that you can apply in your work with youth and families.

What is also important to understand about this *Resource Guide* is the unwavering honoring of the original intent and vision of the early pioneers of the wraparound process. In the 1980's, the wraparound process was being developed in states like North Carolina, Kansas, Alaska and Illinois, with the philosophy of doing "whatever it takes" to meet the needs of the families being served. These guiding principles remain steadfast. Nowhere else is there a resource guide like this that cuts through the rhetoric and misinterpretation of wraparound and gives you clear examples of the wraparound process, solid research to support the effectiveness of the approach, and specific tools you can use today.

The National Wraparound Initiative strives to be flexible and collaborative. This *Guide* is evidence of that commitment. I encourage you to embrace this resource guide in your practice. Share the information with colleagues and contribute your thoughts and ideas to the National Wraparound Initiative. If we are to improve understanding of the wraparound process and expand its practical application in the field of children's mental health, we need an active dialogue and interchange among families, practitioners, researchers and policy makers.

This resource guide continues to take us on that path.

Gary Blau, Ph.D.

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Gary M. Blau, Ph.D., is a clinical psychologist who currently serves as Chief of the Child, Adolescent and Family Branch of the Center for Mental Health Services. In this role, he provides national leadership for children's mental health and for creating "systems of care" across the country. In his former role as a clinician, he was fortunate to have provided services using a wraparound approach, and later, as an administrator, he had the opportunity to train others in the use of wraparound. In his current role as Branch Chief, he feels privileged to support the National Wraparound Initiative, as well as other efforts to bring wraparound to all children and youth with serious mental health challenges and their families.

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Introduction

Eric Bruns, Co-Director, National Wraparound Initiative, and Associate Professor, University of Washington School of Medicine

Janet Walker, Co-Director, National Wraparound Initiative, and Research Associate Professor, Portland State University School of Social Work

The editors of the *Resource Guide to Wraparound* met one another some time during 2002. One of us (JW) was writing a monograph describing what her research team at the Portland State University Research and Training Center had found about communities implementing team-based planning to provide individualized services and supports for children and families. The team was finding that many of these initiatives called themselves "wraparound" projects, but what actually was happening with youth and families looked very little like the descriptions presented by wraparound's leaders. Teams were not coming up with creative ideas to meet the family's needs; extended family, advocates, friends, and informal helpers were rarely involved; teams often had not created a plan to guide their work, and rarely assessed their progress or outcomes; and there was little evidence of a strengths focus in planning. This was not the wraparound that was described in stories told by Karl Dennis, early research by John Burchard (e.g., Burchard & Clarke, 1990), manuals by John VanDenBerg and Mary Grealish (1998), or the monograph by Barbara Burns and Sybil Goldman (1999).

The other editor (EB) had just taken a job at a university after a few years overseeing service implementation at a community organization in a big city. While at this organization, he observed firsthand the same concerns that the Portland State team found in its research: There were few clear expectations about what the city's funded "wraparound" programs should be doing. Training was spotty, staff turnover was high, and fiscal arrangements did not encourage availability of flexible supports. There was not much of a

community commitment to the programs and no real community "ownership" of the process. These experiences aligned with what he had learned researching wraparound with his mentor, John Burchard, of the University of Vermont. Though they had devised a tool to measure fidelity to the core principles of wraparound (the *Wraparound Fidelity Index*), how to achieve fidelity was not so clear. How might a group of concerned citizens and practitioners realize these principles in practice? How best to replicate the successes found in wraparound projects elsewhere?

Not surprisingly, perhaps, we started working together almost immediately. We found that there were a lot of leaders in wraparound, and in children's mental health more generally, who were asking similar questions. In 2003, we suggested that a national meeting of the minds might help to identify the most crucial questions and to suggest some possible solutions. With very little notice and no financial support, just about everyone we invited showed up, and we filled a room in Portland to talk about the issues.

From the start, there was an interesting tension. The grassroots, decentralized nature of wraparound implementation nationally had been a blessing in many ways: Innovation was a hallmark of many initiatives, and bureaucracy was less likely to get in the way. But as interest and investment grew, these same blessings also complicated dissemination of the central ideas. Local practitioners could not find written information describing how to set up governance structures, achieve flexible funding, or build training and supervision capacity. Funders were not confident about how best to invest in the necessary capacity building or how to monitor the impact of their investments.

The leaders who convened in 2003 were also concerned about the impact that the evidence-based practice movement would have on communities seeking to implement wraparound. At that time, the movement was in full swing, and communities around the country were experiencing increased pressure to focus expenditures on practices that had been tested through rigorous research. Wraparound's development was highly conducive to generating real-world, practice-based evidence. But the lack of specificity regarding its procedures and necessary infrastructural conditions had historically restricted formal research. As investigators interested in advancing the research base on a model that was so enthusiastically embraced by families and their advocates, we realized that acceptance of wraparound as a researchable phenomenon would also require that it be better described.

So, for all the above reasons, and in full acknowledgment of the perils of overspecification, the founding advisors of the National Wraparound Initiative (NWI) set an initial goal of creating materials and resources that would help the field better understand the wraparound model; implement it with greater consistency and quality; and support research studies. We assumed that it would be important to do this collaboratively, in order both to tap into the full range of expertise on wraparound

and to engage as many stakeholders as possible. (For a more complete description of the methods of the NWI, see Walker & Bruns, 2006. Specific examples are also presented in various articles in this *Resource Guide*.)

One of the main benefits of coming together in this way is the opportunities that emerge for sharing resources and experiences. As the richness and abundance of this accumulated wisdom became clear, we began to think about how to tap existing knowledge in a way that it could be effectively and efficiently shared. Thus, the idea of a compilation of stories, examples, tools and other supports began to form. Over time, the scope of the project grew—it seemed important to solicit a wide range of relevant material, in order to highlight the diversity of approaches to achieving

the wraparound principles at many levels of practice. Finally, with encouragement (and financial support) from the Child, Adolescent, and Family Branch of the SAMHSA Center for Mental Health Services, we moved forward with a plan to make all this information accessible and available as a web-based resource.

The *Resource Guide to Wraparound*

The result is the *Resource Guide to Wraparound*—a collection of articles, tools, and resources that represent the range of expertise, experience, and shared work of the participants in the NWI. In the *Resource Guide*, you will find chapters of a number of different types, including:

- Foundational descriptions of the wraparound model;
- Examples of how different communities and programs have implemented wraparound and supported its implementation;
- Stories from youth, families, and communities;
- Review articles about wraparound's current standing in the field of community services; and
- Appendices containing tools and resources that can be used in everyday practice

We have organized the *Resource Guide* into six sections, each of which include a variety of different types of chapters. In **Section 1: Introduction and Basics**, we have included this preface and some background information, such as a description of the National Wraparound Initiative and a presentation of the history of wraparound by John VanDenBerg.

In **Section 2: The Principles of Wraparound**, we present the most basic of all the foundational documents, a description of the ten principles of wraparound, as confirmed by the advisors of the NWI over several iterations and several years. In this section, we also present a few specific examples of how practitioners and communities have made some of these principles come to life in the real world, including strengths-based practice (by John Franz and Kathy Cox) and community-based services and supports (by Bob Jones). Because the *Resource Guide* is a living, evolving document, we welcome and will continue to update this section with additional practice examples over time.

In **Section 3: Theory and Research**, we present the results of several studies and literature reviews. This includes an insightful presentation of the theory base for wraparound that summarizes the basic research that supports the model. Elsewhere in this section, you will also find articles on the state of the research base for wraparound and a comprehensive review of published outcomes research on the wraparound process. Finally, this section presents the results of a national study on wraparound implementation, original research that assessed how widespread wraparound deployment was in 2008, and how it was being supported by states and communities.

Section 4: Wraparound Practice presents the second major foundational document of the wraparound model – the *Phases and Activities of the Wraparound Process*. This document represents a key contribution of the NWI to the community services field, in that it provides a summary of the typical activities that take place in wraparound team practice. Supplementing this document are a number of additional resources, including descriptions of key roles that communities have developed to support wraparound practice, such as the family partner, the youth advocate, the behavioral support worker, and the wraparound clinician. Other chapters provide further detail on how to ensure family and youth voice throughout the wraparound process.

Recent research has illuminated how critical community and program supports are to implementing the wraparound model. As such, it is probably fitting that **Section 5: Supporting Wraparound Implementation** is the largest section of the *Resource Guide*. The foundational documents here include an overview of the necessary support conditions for wraparound, a summary of the critical monograph by Walker, Koroloff, & Schutte (2003, included as an Appendix in this *Guide*), as well as a description of the *Community Supports for Wraparound Inventory*, an assessment of the level of system support for wraparound. In addition, this section also presents multiple examples and descriptions of methods to train, coach, and supervise staff filling key roles in wraparound; a

description of financing basics for wraparound, as well as multiple financing examples; a review of methods for measuring wraparound implementation fidelity; and an example of how Wraparound Milwaukee built databases to support wraparound implementation. Finally, this section includes several additional chapters, such as a review of systems change issues by John Franz, a description of the community collaborative team model used by wraparound initiatives in Canada, and a description of how wraparound can be integrated into school settings, by Lucille Eber.

Finally, we have included **Appendices**, including the *Wraparound User's Guide* (a handbook for families) in English and Spanish, *Achieve My Plan!* (a how-to manual for helping youth participate actively in wraparound planning), and sample copies of a number of evaluation and fidelity instruments.

Conclusion

Needless to say, it is not without some anxiety that we have produced this compilation of materials. For one thing, there is already a wealth of resources out in the world describing wraparound and systems of care. Such information can be found in training manuals, book chapters, monographs, and academic journals, as well as in the stories and expertise of those who have been implementing wraparound for years and decades. No matter how hard we try to be "even more comprehensive," the idea of creating a resource on wraparound is hardly a new one.

Moreover, a key feature of *this* resource is the somewhat audacious idea that we can simultaneously define what wraparound is—in operational and measurable terms—and yet still insist that it must be tailored to the context of each local community and the needs of each participating youth and family. To do so requires a balancing act that will never be perfectly achieved. After four years of producing materials that attempt to present the consensus of a diverse community of practice about what wraparound should look like, we have begun to hear calls for less specification and more local innovation. Perhaps this is evidence that we have achieved the goals the NWI's founders set in 2003.

Regardless, for us, this seems like a good time to present this wealth of information, analyze some research data, and pause to consider what is needed next with respect to wraparound. We hope that you find these materials helpful and that you will give us feedback about their usefulness. Our feeling is that there are revisions to be done and new materials that will be added to these contents well after we write this introduction. This *Resource Guide* is not a product but part of a process that intends to continually improve our ability to support individuals with complex needs and their families.

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Introduction and Basics: Chapter 1.3

History of the Wraparound Process

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The wraparound process is a collaborative, team-based approach to service and support planning. Through the wraparound process, teams create plans to meet the needs—and improve the lives—of children and youth with complex needs and their families. The wraparound team members—the identified child/youth, parents/caregivers and other family and community members, mental health professionals, educators, and others—meet regularly to design, implement, and monitor a plan to meet the unique needs of the child and family. As is described in depth in other sections of this *Resource Guide*, the wraparound process can be described as one in which the team:

- Creates, implements, and monitors an individualized plan using a collaborative process driven by the perspective of the family;
- Develops a plan that includes a mix of professional supports, natural supports, and community members;
- Bases the plan on the strengths and culture of the youth and their family; and
- Ensures that the process is driven by the *needs of the family* rather than by the services that are available or reimbursable.

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Wraparound philosophical elements are consistent with a number of psychosocial theories of child development, as well as with recent research on children's services that demonstrates the importance of services that are flexible, comprehensive, and team-based. However, at its core, the basic hypothesis of wraparound is simple: If the needs of a youth and family are met, it is likely that the youth and family will have a good (or at least improved) life.

Much of the early work on wraparound was focused on children, youth, and their families with very complex needs. However, it is important to note that the process has been proven useful with children, youth, and families at all levels of complexity of need, including those whose needs are just emerging. The intuitive appeal of the wraparound philosophy, promising evaluation studies, and many success stories from communities around the nation have promoted explosive growth in the use of the term "wraparound" over the last two decades. As described in another article in this *Guide*, it has been estimated that the number of youth engaged in wraparound is well over 100,000 (Sather, Bruns, Stambaugh, & Burns, Faw, 2007).

History of the Wraparound Process

Dr. Lenore Behar of North Carolina coined the term wraparound in the early 1980s to describe the application of an array of comprehensive community-based services to individual families. North Carolina implemented these services as alternatives for institutionalization of youth as part of the settlement of the *Willie M*. lawsuit. Since then, the use of the term "wraparound" has become common shorthand for flexibility and comprehensiveness of service delivery, as well as for approaches that are intended to help keep children and youth in the community. As a result, the interpretations of what wraparound means have historically varied widely (Burchard, Bruns, & Burchard, 2002). The development of the wraparound process has been shaped by a unique combination of local, state, and federal innovations; contributions from individual consultants and researchers; influential local, state, and national family organizations; new federal law; and key lawsuits. The rest of this article describes some of these historical influences on wraparound.

Roots in Europe and in Canada

Some of the formative work in this area was conducted by John Brown and his colleagues in Canada, who operated the Brownsdale programs. These programs focused on providing needs-based, individualized services that were unconditional.

Some of the roots of the Brownsdale efforts were influenced by the Larch movement, a European approach that supports normalization and support from community members to keep individuals with complex needs in the community. These and other normalization concepts were employed in designing the *Kaleidoscope* program in Chicago, led by Karl Dennis, which began implementing private agency-based individualized services in 1975.

Similar Movements

It is important to note that during the era in which wraparound has developed, parallel developments have occurred simultaneously in other fields. For example, approaches such as *Person-Centered Planning* and *Personal Futures Planning* bear a strong resemblance to wraparound, and were developed to meet the needs of people with developmental disabilities. Similarly, within juvenile justice, several approaches use values and steps similar to those in wraparound to create individualized plans that balance the community's needs for safety and restitution with the goal of keeping young offenders in the community. Child welfare systems across North America have implemented *family group decision making*, a col-

laborative family-provider planning process with origins in New Zealand Maori tribal traditions. Within special education, federal legislation requires that many children receive individualized education plans designed by a collaborative family-provider team.

Major Efforts in Wraparound

In late 1985, officials of the State of Alaska social services, mental health, and education departments sought consultation from Kaleidoscope, and formed the *Alaska Youth Initiative* (Burchard, Burchard, Sewell & VanDenBerg, 1993). This effort was successful in returning to Alaska almost all youth with complex needs who had been placed in out-of-state institutions. The Alaska efforts were quickly followed by replication attempts in Washington, Vermont, and more than 30 other states. Major efforts based on wraparound and system-of-care concepts were funded by the Robert Wood Johnson Foundation in the late 1980s, and studies of these programs proved to be a rich source of information for further development of the process. Many jurisdictions involved in the National Institute of Mental Health's CASSP (Child and Adolescent Services System Program) program and state level grants also used the wraparound process during the late 1980s and early 1990s, while more recently, the Substance Abuse and Mental Health Services Administration's (SAMHSA) Comprehensive Community Mental Health Services for Children and Families program has awarded grants to dozens of communities who proposed to use the wraparound process to mobilize system-of-care philosophies for individual families.

In the early 1990s, several wraparound pioneers planned and carried out a series of national conferences on the wraparound process. These "Wraparound Family Reunions," in Pittsburgh, Chicago, Vermont, and San Jose, served to bring together early implementers of the process, and helped accelerate the growth of the movement. These national conferences were followed by dozens of state level wraparound gatherings, many of which have become annual events. For example, the state of Michigan recently completed its eighth annual wraparound conference, which was attended by over 500 administrators, service providers, family members, and youth.

In 1998, in response to concerns about the lack of specification of the wraparound model, a group of family advocates, wraparound trainers, providers, and researchers gathered at Duke University to debate the definition and core components of the wraparound model. This important gathering resulted in delineation of 10 elements that provided a foundation for the wraparound process (Goldman, 1999). In the years since this meeting, it has been recognized that further specification of the wraparound practice model is necessary. Though a number of monographs, training manuals, and book chapters described different aspects of the process for different audiences, there remained a need to synthesize these innovations into one description of a model that includes standards and parameters for practice. As is described elsewhere in this *Resource Guide*, the National Wraparound Initiative has attempted to serve this purpose through a process of research and collaborative consensus-based decision making by a national group of wraparound experts (Walker & Bruns, 2006).

> *"Wraparound" has become common shorthand for flexibility and comprehensiveness of service delivery, as well as for approaches that are intended to help keep children and youth in the community.*

The Family Movement and Wraparound

Over the last 15 years, the field of children's mental health has seen the rapid growth of a family advocacy movement. This growth has been fueled by the efforts of advocacy organizations such as the Federation of Families for Children's Mental Health and the National Mental Health Association. These organizations have embraced the wraparound process as a potential means for

ensuring the fundamental rights of families with mental health needs. In many communities, family members and/or advocacy organizations have organized programs that link family members who are experienced with wraparound with families who are receiving care through the process. For example, in Phoenix, the Family Involvement Center helps recruit, select, and prepare *"family support partners"* who work for the Center and other not-for-profit agencies to serve on wraparound teams. The growth of the family movement in children's mental health has been an important impetus for the ongoing development of wraparound. As with the basic description of the wraparound practice model, the NWI has also engaged an national task force of over 30 parents, youth, and family members to better describe, for example, what wraparound should look like from a parent or family member's perspective, and the typical role of a family partner in achieving the principles of wraparound.

EPSDT

In the U.S. Omnibus Reconciliation Act of 1989, the EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) became a mandated service for children and youth served under Medicaid. EPSDT services include screening, diagnosis, and treatment of behavioral health needs. Federal EPSDT requirements mean that if a child or youth is deemed, through an EPSDT screening, to need services, those services must be provided. States have varied in their compliance with EPSDT guidelines, but EPSDT has continued to spur further use of the wraparound process.

Lawsuits

Lawsuits, such as the *Willie M*. lawsuit in North Carolina and the earlier *Wyatt vs. Stickney*, continue to be an important factor in rapid growth of the wraparound process. There have been over 30 major U.S. state-level lawsuits focused on the lack of creative service provision alternatives for families and the use of overly restrictive residential and institutional placements. These lawsuits, such as the *Reisinger* lawsuit in Maine, and the *Jason K*. suit in Arizona, have resulted in settlements that have promoted the use of wraparound in a number of states, and that have forced changes in the flexibility of Medicaid funding for behavioral health needs.

In addition, the federal *Olmstead* decision in 2001 was an important factor leading to growth of the wraparound process. The *Olmstead* opinion supported the right of a child to community-based services instead of unnecessary institutionalization due to lack of community-based services. States have to submit plans on how they will comply with the *Olmstead* decision, and many are using the wraparound process as a cornerstone of their compliance.

Conclusion

In considering the history of the wraparound process, it becomes apparent that the idea it represents is nothing new. Humans have been creative in supporting one another for eons. Furthermore, though our efforts to support one another seem simple, they are actually very complex. Given the complexity of the undertaking, it is not surprising that it has been so challenging to design a process that unites government, service providers, community members, and family members toward the cause of improving the lives of children and youth.

Nonetheless, the wraparound process, as described in this *Resource Guide*, represents the rapid evolution of a process that has the potential to be extremely efficient and useful. This process has spread to all 50 U.S. states, across Canada, and to other countries. As widely cited in this *Guide*, interpretations of the wraparound philosophy and the quality of implementation have varied a great deal (Burchard, Bruns, & Burchard, 2002; Walker, Koroloff, & Schutte, 2003). However, it is becoming increasingly clear that positive outcomes follow when best practices and standards for the full wraparound process are followed closely. It is in those instances that wraparound consistently lives up to its potential to improve the lives of children with complex needs and their families.

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John Burchard was a tireless advocate for children, youth, and families, and he was passionate about wraparound's promise. As a professor at the University of Vermont, John dedicated much of the last two decades of his life to thinking about how to better support communities and programs to implement wraparound. He co-wrote One Kid at a Time about the Alaska Youth Initiative, led the evaluation of Project Wraparound in Vermont, and created the Wraparound Fidelity Index. This *Resource Guide* is dedicated to John's memory.

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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

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.

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."

In an accompanying article in this R*esource 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.

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 behavioral 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 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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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

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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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 highly 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

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.

For more information, contact
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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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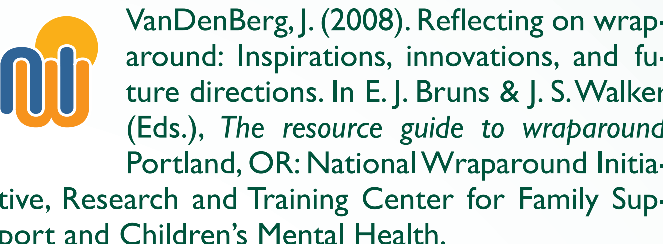

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Introduction and Basics: Chapter 1.5

The National Wraparound Initiative (NWI): Why? What? How?

Janet Walker, Co-Director, National Wraparound Initiative, and Research Associate Professor, Portland State University School of Social Work

Why?

As the history of wraparound (Chapter 1.3) clearly illustrates, wraparound originated as a philosophy and a grassroots movement as much as a specific intervention. This unique nature of wraparound has proven to be a source of both strength and difficulty. Normally, an intervention is designed and tested by a single person or group. In contrast, wraparound practice and supporting policies have evolved through a process of ongoing innovation on the part of families, trainers, and providers around the nation. This process has stimulated a kind of creativity that would never have occurred within a less flexible model. On the other hand, the lack of shared standards or guidelines for wraparound practice has created problems around issues of quality assurance and fidelity.

During the late 1970s and early 80s, wraparound emerged gradually from the efforts of individuals and organizations committed to providing individualized, comprehensive, community-based care for children and their families. While the term *wraparound* came to be more and more widely used throughout the 1990s, there was still no formal agreement about exactly what wraparound was. Many wraparound programs shared features with one another, but there existed no consensus about what was essential for wraparound. Some programs were able to document notable successes from using wraparound, but it also became apparent that many teams and programs were not operating in a manner that reflected the wraparound principles. Toward the end of the 1990s, it became increasingly

obvious that without a clear definition of what wraparound was (and wasn't), any practice could be called "wraparound," regardless of quality. Furthermore, it would be impossible to establish evidence for wraparound's effectiveness without a clear definition of the practice.

What?

In true wraparound fashion, a team approach emerged to address these difficulties. In June of 2003, the Research and Training Center on Family Support and Children's Mental Health hosted a national meeting in Portland, Oregon, and invited parents, parent advocates, wraparound trainers, practitioners, program administrators, researchers, and systems of care technical assistance providers. This was the first meeting of what became the Advisory Group of a new *National Wraparound Initiative*. At this initial meeting, the group reaffirmed the need to define a wraparound practice model, discussed potential methods for conducting such work, and described specific products that should result. By the end of the meeting, the group reached a consensus about what was most needed to promote high quality in wraparound:

1. Clear definitions of the wraparound philosophy and the wraparound practice model
2. Specific strategies on how to achieve high-quality wraparound at the family, team, provider, and system levels
3. Minimum standards for wraparound practice and for supporting families, teams, and practitioners
4. Implementation and fidelity tools—aligned with the strategies and standards for wraparound—that could inform quality improvement and be used in more rigorous evaluation
5. Handbooks for youth, caregivers, practitioners, and team members that explain Wraparound and what should be expected during implementation

Since that initial meeting, the collective efforts of the members of the NWI have been successful in meeting many of these needs and making progress toward meeting the others.

How?

Membership in the NWI's advisory group is open to anyone who has expertise in wraparound and who is willing to contribute 20 to 40 hours per year to the Initiative's work. The NWI's main products are produced collaboratively, through structured and semi-structured processes. A formal, structured consensus-building process used by the NWI is described in detail in an article about the process that was used to define the practice model (Chapter 4a.1). A similar process was used to clarify the principles of wraparound, to create the *Community Supports for Wraparound Inventory*, and to develop the document describing the role of family partners in carrying out the ten principles. Less highly structured but still collaborative processes were used to develop other NWI products, including the theory of change and the various guides and manuals. The *Resource Guide for Wraparound* is also a collaborative effort, with contributions from dozens of NWI advisors. The overall goal of the Initiative is to preserve the creative essence and innovative spirit of wraparound while also providing specific guidelines and resources to support high quality implementation.

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Janet Walker is Research Associate Professor in the School of Social Work at Portland State University and co-Director of the Research and Training Center on Pathways to Positive Futures. Her current research focuses on 1) exploring how individuals and organizations acquire capacity to implement and sustain high quality practice in human service settings, 2) describing key implementation factors that affect the ability of organizations and individuals to provide high quality services and treatment, and 3) developing and evaluating interventions to increase the extent to which youth with emotional or mental health difficulties are meaningfully involved in care and treatment planning. Together with Dr. Eric Bruns, Dr. Walker co-directs the National Wraparound Initiative.

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The Principles of Wraparound: Chapter 2.1

Ten Principles of the Wraparound Process

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National Wraparound Initiative Advisory Group

The philosophical principles of wraparound have long provided the basis for understanding this widely-practiced service delivery model. This value base for working in collaboration and partnership with families has its roots in early programs such as Kaleidoscope in Chicago, the Alaska Youth Initiative, Project Wraparound in Vermont, and other trailblazing efforts.

Perhaps the best presentation of the wraparound value base is provided through the stories contained in *Everything is Normal until Proven Otherwise* (Dennis & Lourie, 2006). In this volume, published by the Child Welfare League of America, Karl Dennis, former Director of Kaleidoscope, presents a set of stories that illuminate in rich detail how important it is for helpers to live by these core principles in service delivery. As described in the *Resource Guide*'s Foreword, these stories let the reader "experience the wraparound process as it was meant to be" (p.xi).

For many years, the philosophy of wraparound was expressed through the work of local initiatives and agencies such as Kaleidoscope, but not formally captured in publications for the field. Critical first descriptions were provided by VanDenBerg & Grealish (1996) as part of a special issue on wraparound, and by Goldman (1999) as part of an influential monograph on wraparound (Burns & Goldman, 1999).

These resources presented elements and practice principles that spanned activity at the team, organization, and

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This is an updated version of *The Ten Principles of the Wraparound Process,* which was originally published in 2004.

system levels. In other words, some elements were intended to guide work at the team level with the youth, family and hands-on support people, while other elements described activities at the program or system level. For many, these documents were the best means available for understanding the wraparound process. They also provided the basis for initial efforts at measuring wraparound implementation. (See the chapter on wraparound fidelity in chapter 5e.1 of this *Resource Guide*.)

The Ten Principles as Presented by the National Wraparound Initiative

At the outset of the National Wraparound Initiative's work, it was recognized that presentation of the principles of wraparound would be a central part of the NWI's mission to enhance understanding of wraparound and support high-quality wraparound practice. So what, if anything, was needed to communicate the principles clearly?

In the first place, the early descriptions of wraparound's philosophical base included a series of elements that were described only briefly, or not at all. If these values were truly to guide practice, it seemed important to provide some information about what was meant by key terms and phrases like "culturally competent," "based in the community" and "individualized." Secondly, since the principles were intended to serve as a touchstone for wraparound practice and the foundation for the NWI's subsequent work, it was important that a document describing the principles receive formal acceptance by the advisors who comprised the NWI. Finally, for clarity, it seemed optimal to express the principles at the level of the family and team. Once the principles were clarified and written in this way, descriptions of the organizational and system supports necessary to achieve high-quality wraparound practice (see Chapter 5a.1 of this *Resource Guide)* could be presented as "*what supports are needed to achieve the wraparound principles for families and their teams?*" Furthermore, descriptions of the practice model for wraparound (See chapter 4a.1 of this *Resource Guide)* could be presented as *"what activities must be undertaken by wraparound teams to achieve the principles for youth and families?"*

The current document began with the efforts of a small team of wraparound innovators, family advocates, and researchers working together over several months. This team started with the original elements and practice principles, reviewed other documents and training manuals, and drafted a revised version of the principles as expressed at a family and team level. These descriptions were then provided to a much larger national group of family members, program administrators, trainers, and researchers familiar with wraparound. Through several stages of work, these individuals voted on the principles presented, provided feedback on wording, and participated in a consensus-building process.

Though not complete, consensus on the NWI principles document, initially created in 2004, was strong. Nonetheless, there were several key areas where the complexity of wraparound made consensus difficult within our advisory group. In many cases, advisors were uncomfortable with brief definitions of the principles because they did not acknowledge tensions that could arise in "real world" efforts to put the principles into practice. These tensions were acknowledged and addressed in the consensus document in several ways:

- First, in addition to the one- to two-sentence definition for each principle, more in-depth commentary is also provided, highlighting tensions and disagreements and providing much greater depth about the meaning of each principle.
- Second, we have allowed our NWI "community of practice" to revisit the principles. Most notably, at the behest of a number of advisors, the NWI revisited the principle of *Persistent*, and asked whether the original name for the principle, *Unconditional Care*, might be more appropriate and a new definition possible. The results of this 2008 survey of advisors are reflected in the definitions presented here, and a description of this process is presented for your information in Chapter 2.5 of this *Resource Guide*.
- Finally, true to the wraparound model, all the materials of the NWI are intended to be resources for use by local initiatives, families, and researchers to use as

> they see fit. Thus, documents such as this one, as well as the *Phases and Activities of the Wraparound Process*, are conceived as "skeletons" to be "fleshed out" by individual users. For example, in Canada, a new nationwide initiative north of the border has adapted the NWI principles. As a result, they have used the NWI principles to describe the value base in ways to suit their purposes, such as a description of the paradigm shifts necessary for wraparound and the personal values expected of participating helpers.

Many have expressed a need to move beyond a value base for wraparound in order to facilitate program development and replicate positive outcomes. However, wraparound's philosophical principles will always remain the starting point for understanding wraparound. The current document attempts to provide this starting point for high-quality practice for youth and families.

Considered along with the rest of the materials in the *Resource Guide to Wraparound,* we hope that this document helps achieve the main goal expressed by members of the NWI at its outset: To provide clarity on what it means to do wraparound, for the sake of communities, programs, and families. Just as important, we hope that NWI documents such as this continue to be viewed as works in progress, updated and augmented as needed based on research and experience.

The Ten Principles of the Wraparound Process

> ***1. Family voice and choice.*** Family and youth/child perspectives are intentionally elicited and prioritized during all phases of the wraparound process. Planning is grounded in family members' perspectives, and the team strives to provide options and choices such that the plan reflects family values and preferences.

The wraparound process recognizes the importance of long-term connections between people, particularly the bonds between family members. The principle of family voice and choice in wraparound stems from this recognition and acknowledges that the people who have a long-term, ongoing relationship with a child or youth have a unique stake in and commitment to the wraparound process and its outcomes. This principle further recognizes that a young person who is receiving wraparound also has a unique stake in the process and its outcomes. The principle of family voice and choice affirms that these are the people who should have the greatest influence over the wraparound process as it unfolds.

This principle also recognizes that the likelihood of successful outcomes and youth/child and family ownership of the wraparound plan are increased when the wraparound process reflects family members' priorities and perspectives. The principle thus explicitly calls for family voice—the provision of opportunities for family members to fully explore and express their perspectives during wraparound activities—and family choice—the structuring of decision making such that family members can select, from among various options, the one(s) that are most consistent with their own perceptions of how things are, how things should be, and what needs to happen to help the family achieve its vision of well-being. Wraparound is a collaborative process (principle 3); however within that collaboration, family members' perspectives must be the most influential.

The principle of voice and choice explicitly recognizes that the perspectives of family members are not likely to have sufficient impact during wraparound unless *intentional* activity occurs to ensure their voice and choice drives the process. Families of children with emotional and behavioral disorders are often stigmatized and blamed for their children's difficulties. This and other factors—including possible differences in social and educational status between family members and professionals, and the idea of professionals as experts whose role is to "fix" the family—can lead teams to discount, rather than prioritize, family members' perspectives during group discussions and decision making. These same factors also decrease the probability that youth perspectives will have impact in groups when adults and professionals are present.

Furthermore, prior experiences of stigma and shame can leave family members reluctant to express their perspectives at all. Putting the prin-

ciple of youth and family voice and choice into action thus requires intentional activity that supports family members as they explore their perspectives and as they express their perspectives during the various activities of wraparound. Further intentional activity must take place to ensure that this perspective has sufficient impact within the collaborative process, so that it exerts primary influence during decision making. Team procedures, interactions, and products—including the wraparound plan—should provide evidence that the team is indeed engaging in intentional activity to prioritize the family perspectives.

The wraparound team should be composed of people who have a strong commitment to the family's well-being.

While the principle speaks of *family* voice and choice, the wraparound process recognizes that the families who participate in wraparound, like American families generally, come in many forms. In many families, it is the biological parents who are the primary caregivers and who have the deepest and most enduring commitment to a youth or child. In other families, this role is filled by adoptive parents, step-parents, extended family members, or even non-family caregivers. In many cases, there will not be a single, unified "family" perspective expressed during the various activities of the wraparound process.

Disagreements can occur between adult family members/ caregivers or between parents/caregivers and extended family. What is more, as a young person matures and becomes more independent, it becomes necessary to balance the collaboration in ways that allow the youth to have growing influence within the wraparound process. Wraparound is intended to be inclusive and to manage disagreement by facilitating collaboration and creativity; however, throughout the process, the goal is always to prioritize the influence of the people who have the deepest and most persistent connection to the young person and commitment to his or her well-being.

Special attention to the balancing of influence and perspectives within wraparound is also necessary when legal considerations restrict the extent to which family members are free to make choices. This is the case, for example, when a youth is on probation, or when a child is in protective custody. In these instances, an adult acting for the agency may take on caregiving and/or decision making responsibilities vis-à-vis the child, and may exercise considerable influence within wraparound. In conducting our review of opinions of wraparound experts about the principles, this has been one of several points of contention: How best to balance the priorities of youth and family against those of these individuals. Regardless, there is strong consensus in the field that the principle of family voice and choice is a constant reminder that the wraparound process must place special emphasis on the perspectives of the people who will still be connected to the young person after agency involvement has ended.

> ***2. Team based.*** The wraparound team consists of individuals agreed upon by the family and committed to the family through informal, formal, and community support and service relationships.

Wraparound is a collaborative process (see principle 3), undertaken by a team. The wraparound team should be composed of people who have a strong commitment to the family's well-being. In accordance with principle 1, choices about who is invited to join the team should be driven by family members' perspectives.

At times, family members' choices about team membership may be shaped or limited by practical or legal considerations. For example, one or more family members may be reluctant to invite a particular person— e.g., a teacher, a therapist, a probation officer, or a non-custodial ex-spouse—to join the team. At the same time, not inviting that person may mean that the team will not have access to resources and/or interpersonal support that would otherwise be available. Not inviting a particular person to join the team can also mean that the activities or support that he or she offers

will not be coordinated with the team's efforts. It can also mean that the family loses the opportunity to have the team influence that person so that he or she becomes better able to act supportively. If that person is a professional, the team may also lose the opportunity to access services or funds that are available through that person's organization or agency.

Not inviting a particular professional to join the team may also bring undesired consequences, for example, if participation of the probation officer on the wraparound team is required as a

condition of probation. Family members should be provided with support for making informed decisions about whom they invite to join the team, as well as support for dealing with any conflicts or negative emotions that may arise from working with such team members. Or, when relevant and possible, the family should be supported to explore options such as inviting a different representative from an agency or organization. Ultimately, the family may also choose not to participate in wraparound.

When a state agency has legal custody of a child or youth, the caregiver in the permanency setting and/or another person designated by that agency may have a great deal of influence over who should be on the team; however, in accordance with principle 1, efforts should be made to include participation of family members and others who have a long-term commitment to the young person and who will remain connected to him or her after formal agency involvement has ended.

> ***3. Natural supports.*** The team actively seeks out and encourages the full participation of team members drawn from family members' networks of interpersonal and community relationships. The wraparound plan reflects activities and interventions that draw on sources of natural support.

This principle recognizes the central importance of the support that a youth/child, parents/caregivers, and other family members receive "naturally," i.e., from the individuals and organizations whose connection to the family is independent of the formal service system and its resources. These sources of natural support are sustainable and thus most likely to be available for the youth/child and family after wraparound and other formal services have ended. People who represent sources of natural support often have a high degree of importance and influence within family members' lives. These relationships bring value to the wraparound process by broadening the diversity of support, knowledge, skills, perspectives, and strategies available to the team. Such individuals and organizations also may be able to provide certain types of support that more formal or professional providers find hard to provide.

The primary source of natural support is the family's network of interpersonal relationships, which includes friends, extended family, neighbors, co-workers, church members, and so on. Natural support is also available to the family through community institutions, organizations, and associations such as churches, clubs, libraries, or sports leagues. Professionals and paraprofessionals who interact with the family primarily offer paid support; however, they can also be connected to family members through caring relationships that exceed the boundaries and expectations of their formal roles. When they act in this way, professionals and paraprofessionals too can become sources of natural support.

Practical experience with wraparound has shown that formal service providers often have great difficulty accessing or engaging potential team members from the family's community and informal support networks. Thus, there is a tendency that these important relationships will be underrepresented on wraparound teams. This

principle emphasizes the need for the team to act intentionally to encourage the full participation of team members representing sources of natural support.

> ***4. Collaboration.*** Team members work cooperatively and share responsibility for developing, implementing, monitoring, and evaluating a single wraparound plan. The plan reflects a blending of team members' perspectives, mandates, and resources. The plan guides and coordinates each team member's work towards meeting the team's goals.

Wraparound is a collaborative activity—team members must reach collective agreement on numerous decisions throughout the wraparound process. For example, the team must reach decisions about what goals to pursue, what sorts of strategies to use to reach the goals, and how to evaluate whether or not progress is actually being made in reaching the goals. The principle of collaboration recognizes that the team is more likely to accomplish its work when team members approach decisions in an open-minded manner, prepared to listen to and be influenced by other team members' ideas and opinions. Team members must also be willing to provide their own perspectives, and the whole team will need to work to ensure that each member has opportunities to provide input and feels safe in doing so. As they work to reach agreement, team members will need to remain focused on the team's overarching goals and how best to achieve these goals in a manner that reflects all of the principles of wraparound.

The principle of collaboration emphasizes that each team member must be committed to the team, the team's goals, and the wraparound plan. For professional team members, this means that the work they do with family members is governed by the goals in the plan and the decisions reached by the team. Similarly, the use of resources available to the team—including those controlled by individual professionals on the team—should be governed by team decisions and team goals.

This principle recognizes that there are certain constraints that operate on team decision making, and that collaboration must operate within these boundaries. In particular, legal mandates or other requirements often constrain decisions. Team members must be willing to work creatively and flexibly to find ways to satisfy these mandates and requirements while also working towards team goals.

Finally, it should be noted that, as for principles 1 (family voice and choice) and 2 (team-based), defining wraparound's principle of collaboration raises legitimate concern about how best to strike a balance between wraparound being youth- and family-driven as well as team-driven. This issue is difficult to resolve completely, because it is clear that wraparound's strengths as a planning and implementation process derive from being team-based and collaborative while also prioritizing the perspectives of family members and natural supports who will provide support to the youth and family over the long run. Such tension can only be resolved on an individual family and team basis, and is best accomplished when team members, providers, and community members are well supported to fully implement wraparound in keeping with all its principles.

> ***5. Community based.*** The wraparound team implements service and support strategies that take place in the most in-

clusive, most responsive, most accessible, and least restrictive settings possible; and that safely promote child and family integration into home and community life.

This principle recognizes that families and young people who receive wraparound, like all people, should have the opportunity to participate fully in family and community life. This implies that the team will strive to implement service and support strategies that are accessible to the family and that are located within the community where the family chooses to live. Teams will also work to ensure that family members receiving wraparound have greatest possible access to the range of activities and environments that are available to other families, children, and youth within their communities, and that support positive functioning and development.

6. Culturally competent. The wraparound process demonstrates respect for and builds on the values, preferences, beliefs, culture, and identity of the child/ youth and family, and their community.

The perspectives people express in wraparound—as well as the manner in which they express their perspectives—are importantly shaped by their culture and identity. In order to collaborate successfully, team members must be able to interact in ways that demonstrate respect for diversity in expression, opinion, and preference, even as they work to come together to reach decisions. This principle emphasizes that respect toward the family in this regard is particularly crucial, so that the principle of family voice and choice can be realized in the wraparound process.

This principle also recognizes that a family's traditions, values, and heritage are sources of great strength. Family relationships with people and organizations with whom they share a cultural identity can be essential sources of support and resources; what is more, these connections are often "natural" in that they are likely to endure as sources of strength and support after formal services have ended. Such individuals and organizations also may be better able to provide types of support difficult to provide through more formal or professional relationships. Thus, this principle also emphasizes the importance of embracing these individuals and organizations, and nurturing and strengthening these connections and resources so as to help the team achieve its goals, and help the family sustain positive momentum after formal wraparound has ended.

Undesired behavior, events, or outcomes are not seen as evidence of child or family "failure" and are not seen as a reason to eject the family from wraparound.

This principle further implies that the team will strive to ensure that the service and support strategies that are included in the wraparound plan also build on and demonstrate respect for family members' beliefs, values, culture, and identity. The principle requires that team members are vigilant about ensuring that culturally competent services and supports extend beyond wraparound team meetings.

7. Individualized. To achieve the goals laid out in the wraparound plan, the team develops and implements a customized set of strategies, supports, and services.

This principle emphasizes that, when wraparound is undertaken in a manner consistent with all of the principles, the resulting plan will be uniquely tailored to fit the family. The principle of family voice and choice lays the foundation for individualization. That principle requires that wraparound must be based in the family's perspective about how things are for them, how things should be, and what needs to happen to achieve the latter.

Practical experience with wraparound has shown that when families are able to fully express their perspectives, it quickly becomes clear that only a portion of the help and support required is available through existing formal ser-

vices. Wraparound teams are thus challenged to create strategies for providing help and support that can be delivered outside the boundaries of the traditional service environment. Moreover, the wraparound plan must be designed to build on the particular strengths of family members, and on the assets and resources of their community and culture. Individualization necessarily results as team members collaboratively craft a plan that capitalizes on their collective strengths, creativity, and knowledge of possible strategies and available resources.

8. Strengths based. The wraparound process and the wraparound plan identify, build on, and enhance the capabilities, knowledge, skills, and assets of the child and family, their community, and other team members.

The wraparound process is strengths based in that the team takes time to recognize and validate the skills, knowledge, insight, and strategies that each team member has used to meet the challenges they have encountered in life. The wraparound plan is constructed in such a way that the strategies included in the plan capitalize on and enhance the strengths of the people who participate in carrying out the plan. This principle also implies that interactions between team members will demonstrate mutual respect and appreciation for the value each person brings to the team.

The commitment to a strengths orientation is particularly pronounced with regard to the child or youth and family. Wraparound is intended to achieve outcomes not through a focus on eliminating family members' deficits but rather through efforts to utilize and increase their assets. Wraparound thus seeks to validate, build on, and expand family members' psychological assets (such as positive self-regard, self-efficacy, hope, optimism, and clarity of values, purpose, and identity), their interpersonal assets (such as social competence and social connectedness), and their expertise, skill, and knowledge.

9. Unconditional. A wraparound team does not give up on, blame, or reject children, youth, and their families. When faced with challenges or setbacks, the team continues working towards meeting the needs of the youth and family and towards achieving the goals in the wraparound plan until the team reaches agreement that a formal wraparound process is no longer necessary.

This principle emphasizes that the team's commitment to achieving its goals persists regardless of the child's behavior or placement setting, the family's circumstances, or the availability of services in the community. This principle includes the idea that undesired behavior, events, or outcomes are not seen as evidence of youth or family "failure" and are not seen as a reason to reject or eject the family from wraparound. Instead, adverse events or outcomes are interpreted as indicating a need to revise the wraparound plan so that it more successfully promotes the positive outcomes associated with the goals. This principle also includes the idea that the team is committed to providing the supports and services that are necessary for success, and will not terminate wraparound because available services are deemed insufficient. Instead, the team is committed to creating and implementing a plan that reflects the wraparound principles, even in the face of limited system capacity.

At the same time, it is worth noting that many wraparound experts, including family members and advocates, have observed that providing "unconditional" care to youth and families can be challenging for teams to achieve in the face of certain system-level constraints. One such constraint is when funding limitations or rules will not fund the type or mix of services determined most appropriate by the team. In these instances the team must develop a plan that can be implemented in the absence of such resources without giving up on the youth or family. Providing unconditional care can be complicated in other situations, such as the context of child welfare, where unconditional care includes the duty to keep children and youth safe. Regardless, team members as well as those overseeing wraparound initiatives must strive to achieve the principle of unconditional care for the youth and all family members if the wraparound process is to have its full impact on youth, families, and communities.

10. Outcome based. The team ties the goals and strategies of the wraparound plan to observable or measurable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly.

This principle emphasizes that the wraparound team is accountable—to the family and to all team members; to the individuals, organizations and agencies that participate in wraparound; and, ultimately, to the public—for achieving the goals laid out in the plan. Determining outcomes and tracking progress toward outcomes should be an active part of wraparound team functioning. Outcomes monitoring allows the team to regularly assess the effectiveness of plan as a whole, as well as the strategies included within the plan, and to determine when the plan needs revision. Tracking progress also helps the team maintain hope, cohesiveness, and efficacy. Tracking progress and outcomes also helps the family know that things are changing. Finally, team-level outcome monitoring aids the program and community to demonstrate success as part of their overall evaluation plan, which may be important to gaining support and resources for wraparound teams throughout the community.

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The Principles of Wraparound: Chapter 2.2

ADMIRE: Getting Practical about Being Strength-Based

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A cardinal principle of the wraparound approach is that it must be a strength-based practice. But if one asks what it means to be strength-based, the answer often contains a tautology—a strength-based practice is one that is based on people's strengths. For wraparound to make a successful transition from a philosophy to a methodology, a more concrete formulation is needed. First we need to explain why being strength based is important, then we have to describe actions or behaviors that would characterize a strength-based practice, and finally we need specific metrics for determining whether and to what degree a given service, including wraparound, is being delivered in a strength-based way.

Why be Strength Based?

A variety of strength-based interventions have been developed in the mental health, child welfare, developmental disability, medical and juvenile justice fields (See accompanying box, next page). The rationale given for the shift from what is usually described as a deficit or problem-based model is that when an intervention focuses on what's right about a person or family who is in a difficult situation, rather than on what's wrong, a number of benefits accrue:

- First, a therapeutic relationship is likely to have a stronger foundation when a family experiences the provider as recognizing and valuing positive aspects of the family members' personalities, life histories, accomplishments and skills.

- Second, if the point of the service encounter is to help the family develop improved coping skills for dealing with the challenges in their life, it will be easier to start that process using the family's existing competencies and characteristics as a foundation.
- Third, since a significant challenge for many families served through the wraparound process is the lack of a natural social support network, a process that elucidates and illuminates the strengths of the family members will make it easier to identify potential points of attachment that can grow into informal sources of friendship and support.
- Finally, if our goal is to help families with complex needs transition from service dependence to normalized social interdependence, an approach that only focuses on eliminating negative characteristics and conditions is less likely to be successful than one that balances the reduction in vulnerabilities with a measurable and sustained increase in capabilities.

What Does Being Strength Based Look Like?

Despite the widespread advocacy noted above, it remains difficult to describe the common elements of a strength-based approach with sufficient clarity to support reliable implementation, maintenance and improvement. Existing descriptive materials often concentrate on a given model's underlying value structure, or focus on its highly specific process steps. The reason why it's hard to pin down the components of strength-based practice is that it is a metaskill[1]. As such it represents a context or perspective within which

1 A metaskill is a capacity for knowing not just how to do a particular task, but also why and when to do it, and having a grasp of the larger meaning of a given activity. Thus a skill would be knowing how to ask a youth to tell you a story about times when some of the problems she had been experiencing were less of a problem, as part of a strength-based inquiry. A metaskill would be recognizing the context of the conversation in terms of the youth's culture, immediate life situation, relationship with the person asking the question, and the purpose for learning about the youth's coping strategies, as well as a variety other aspects of the personal and interpersonal dynamics at play during the interaction.

Selected Strengths-Based Interventions

In addition to wraparound, strengths-based interventions have been developed within a variety of fields. Descriptions of a few are provided in the resources below:

Nissen, Laura. (2006). Bringing strength-based philosophy to life in juvenile justice. *Reclaiming Children, 15*(1), 40-46.

Linely, P. A. (2006). Counseling psychology's positive psychological agenda: A model for integration and inspiration. *Counseling Psychologist, 34*(2), 313-322

Green, B. L., McAllister, C.L. & Tarte, J.M. (2004). The strengths-based practices inventory: A tool for measuring strengths-based service delivery in early childhood and family support programs. *Families in Society, 85*(3), 326-334.

Neff, J.M., Eichner, J.M., Hardy, D. R., Klein, M., et al. (2003). Family-centered care and the pediatrician's role. *Pediatrics, 112*(3), part 1, 691-696.

Blundo, R. (2001). Learning strengths-based practice: Challenging our personal and professional frames. *Families in Society, 82*(3), 296-304.

Rowlands, A. (2001). Ability or disability? Strengths-based practice in the area of traumatic brain injury. *Families in Society, 82*(3), 272-287.

Saleebey, D. (Ed.) (1997). *The strength perspective in social work practice.* New York: Longman.

a variety of services and activities can be carried out.

To help strength-based practice make the transition from an underlying value or philosophical goal to a consistent way of doing business, three things are necessary:

- First, the elements of strength-based practice must be defined with enough clarity to facilitate their implementation by practitioners and allow an objective observer to determine when they are, and are not, present.
- Second, sufficient resources must be in place to help practitioners acquire the understanding, knowledge and skills necessary to comfortably and consistently use a strength-based approach in their interactions with families.
- Third, the organizational climate of any agencies whose staff are expected to use a strength-based approach, and of the system of care in which those agencies are operating, must actively encourage and support the use of strength-based services.

Defining the Elements

What are the specific steps that a wraparound facilitator, family support worker, or other service provider should follow in developing a strength-based relationship with a family? The arc of involvement of any service encounter starts with the point of view the provider carries into the relationship, then moves to the process through which the provider gets to know the family, includes the way the provider shares information and develops a plan of action with them, flows into the interventions, actions or services that form the heart of the encounter, and concludes with the way that the provider captures and evaluates the results of the interaction and services.

One way to describe how these six steps could be carried out in a strength-based manner would be to use the acronym ADMIRE:

Attitude: A strength-based practitioner should enter into each service interaction with a disciplined and informed conviction that it is a family's strengths that will ultimately empower them to accomplish the changes or growth that are needed for them to have better lives.

Discovery: To put a strength-based attitude into practice, a provider needs a range of tools for identifying family member's functional strengths and key unmet needs, even when they are masked or hidden, and place them in a context that supports proactive and individualized planning, assistance and change.

Mirroring: To establish an effective relationship with a family based on this discovery of strengths and needs, the provider should reflect back these observed strengths to insure accuracy and mutual understanding, to facilitate engagement and to help family members see themselves as having strengths.

Intervention: To move this relationship into action, the provider must have a repertoire of strength-based and competency-building services that can be matched with or be adapted to fit with each family and family member's unique profile of strengths and needs.

Recording: To maintain consistency and accuracy, a strength-based practitioner should have a reliable system for documenting observations, assessments, interventions and impacts, as well as families' opinions, responses and outcomes.

Evaluation: Finally, to assess the fidelity and effectiveness of current practices and to build a foundation for service improvement, the provider should have a system for determining whether proposed practices are actually being implemented, whether they are helping families achieve their hoped-for goals, how families feel about the assistance they are receiving, and whether the provider is finding ways of improving the assistance.

Together the six ADMIRE characteristics define qualitative elements that should be present in any strength-based practice model[2] (Cox, 2006). These elements can be expressed in many ways, depending on the type of service being provided

2 The core elements of the ADMIRE system were inspired by the innovative research of Kathleen Cox, who developed a model linking the attitudes and behaviors of practitioners who were aspiring to be strength-based with the outcomes being achieved by their clients.

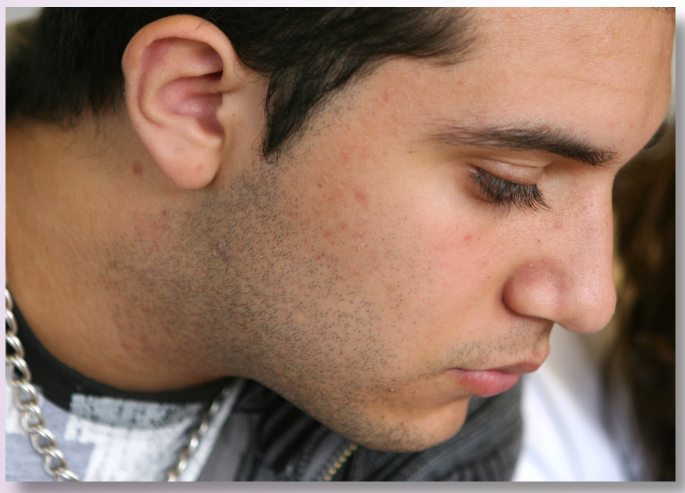
and its context.

For example, attitude in a strength-based juvenile probation service model might be founded on an understanding of the role that personal, family and community protective factors play in helping youth shift from a developmental pathway leading towards habitual delinquency to a more prosocial sequence, and be linked to assessment tools, structured interactions, interventions, documentation and evaluation that are built on this understanding (Pullman, Kerbs, Koroloff, Veach-White, Gaylor, & Dieler, 2006).

An equally strength-based service for women with co-occurring disorders who also have experienced severe traumas may be based on an understanding of the role that positive, mutual and reciprocal relationships play in supporting resiliency and recovery (Markoff, Finkelstein, Kammerer, Kreiner, & Prost, 2005).

Implementation at the Individual Level

A strength-based practice model must have at its foundation resources to help service pro-



viders understand why identifying and building on strengths is important, learn how to discover strengths and incorporate them into the service response, and acquire the skills to put this understanding and knowledge into action, even in challenging situations. The model must also provide the tools needed to determine whether these providers have in fact acquired and implemented a strength-based perspective. The understanding, knowledge and skills supported by the practice model should be expressed in providers' behavior during each element of a service encounter:

Attitude: The perspective or orientation with which providers enter into service relationships will have a major impact on the outcomes achieved through those relationships. While it is easy to say that they should start every new encounter with a positive regard for the person or family they are being asked to assist, in reality many factors make this a difficult practice to maintain. Just knowing that one is supposed to be looking for strengths is not enough. Providers should understand why the exposition of strengths supports effective engagement with clients, feeds into a proactive service response, and helps support development of a positive narrative of future success for the individual and/or family. Providers should know how to express this understanding in a variety of service encounters, and have the skill to maintain a strength-based orientation even when their own situation or the behaviors of the individual or family militate against this attitude.

Discovery: This element will be reflected at the practice level when providers understand that it is important to take the time to identify functional strengths in each service encounter, know how to use a variety of formal and informal tools and techniques to accomplish strengths discovery (to be discussed later in this article), and have the ability to use the right tool in each situation.

Mirroring: For this element, strength-based practice will be present to the degree that providers understand that families must see and validate the potential strengths that the provider is attempting to identify through the discovery process, know how to use a variety of techniques to provide feedback and obtain family input without cueing excessive defensiveness, and be able to facilitate reciprocal relationships with family members who come from a wide variety of personal situations and present with highly idiosyncratic characteristics.

Intervention: Unless a practice can link strengths discovery with strengths development, it is only halfway there. A strength-based practitioner should understand that the most effective interventions are those that help families acquire or improve key personal and interpersonal com-

Directive Supervision

Patricia Miles has developed a system that uses strength-based feedback on a selected group of service data points as a core element of staff support and supervision. In her system, key information from family satisfaction reports, activity documentation and client outcomes are gathered and interpreted at the direct service, unit and agency levels and organized in an integrated model of human resource management, continuous quality improvement, value clarification and skill development. To learn more about her model, visit www.paperboat.com and click on the section entitled "Directive Supervision."

petencies to counteract the challenges they are facing and know enough about the available range of interventions to decide which ones are best matched with the strengths and needs of a given family. The practitioner should also have the skill necessary to implement a chosen intervention, or to link families and family members with providers who can deliver those services.

Reporting: Documentation is rarely a practitioner's favorite activity. Nonetheless, without consistently recording the activities and results of a service encounter, the reliability of a given practice model can easily erode. Therefore a strength-based practitioner must understand why it is as important to gather and record information about family and family member strengths, culture and preferences as it is to identify and label the nature and extent of the challenges they face. These days, it is also important to know how to operate the information management system associated with the practice model, and to have the skills needed to accurately, succinctly and quickly record appropriate data, including how to tweak the system if necessary in order to include competencies and accomplishments in the chart.

Evaluation: For any methodology to become infused throughout the operations of an agency or system of care, it is essential that an ongoing dialog about purpose, performance, outcomes, impact and improvement be maintained among direct service providers, service recipients, supervisors and managers and community stakeholders. For complex methodologies like strength-based practice, this dialog must be anchored in concrete and measurable descriptions of what is being done, how it is affecting the people involved, and what is being learned about ways of doing it better.

Therefore if we are to identify wraparound as a strength-based practice, we must have a system in place that succinctly conveys both the reasons why establishing helping relationships through the discovery and support of families' functional strengths is essential to assisting them in the process of growth and change, and also the ways in which this discovery and assistance is carried out. In addition, the system must have the capacity to quickly and accurately gauge the degree to which the core elements of strength-based practice are being expressed at any given time in the interactions with specific children and families, in the ongoing conduct of individual staff and in the culture and functions of the agency as a whole.

Finally, the system must have the ability to acquire, aggregate, interpret, and feed back these evaluations to practitioners, managers and stakeholders in a timely, accurate and useful format so that they have the opportunity to translate the information they receive into better ways of helping the families they are serving. To do this, staff will need an understanding of why data about performance and its effects should drive continual practice improvement, knowledge of how to use evaluation tools and interpret their results, and the skill to translate evaluative information into service improvement. (See accompanying sidebar, left, for an example of one such method.)

Support at the Agency and System Levels

An agency seeking to accomplish a consistent implementation of strength-based practice throughout its operations, or a system designed to make this happen across all of the participating agencies, must diligently create an organizational climate that models, guides, supports and rein-

forces the practice model regardless of the specific modality in which it is being expressed. Five specific components of this climate that must be aligned to accomplish reliable implementation of the model are:

- Incentives for appropriate practice,
- Disincentives and corrections for digressions,
- Removal of barriers to consistent practice implementation,
- Provision of resources to enable effective practice activities, and
- Expressed understanding of and support for strength-based practice by leaders, managers and supervisors (Allen, Lehrner, Mattison, Miles, & Russell, 2007).

Putting all five elements together in an agency or system of care is no easy feat, but the more each is present, the greater the likelihood that the agency or system will acquire a pervasive strength-based orientation.

Incentives. The number one incentive to strength-based practice is establishing a staff recruitment, selection, retention and advancement system that reflects strength-based principles. Human resource departments should have the capacity to identify staff that bring a strength-based attitude to their work, and reward those who practice what they preach at each stage of their service encounters. Agencies can also post or circulate materials that support and encourage strength-based work. For example, a number of agencies using the wraparound approach publish a monthly newsletter that includes descriptions of successful efforts by family teams and celebrations of accomplishments and innovations by youth, families, facilitators and service providers. More recently some agencies are developing DVDs and on-line training programs to show what these skills look like in practice. Finally, agencies can hold pre-service and in-service trainings that teach this approach; host recognition events for those who display exceptional understanding, knowledge and skills; and present ongoing workshops to demonstrate new techniques for improving strength-base practice.

Disincentives. If those expected to implement a strength-based approach observe that while agency administration or system leadership give lip-service to the model, no repercussions occur for the failure to deliver it, a natural tendency will be to drop back to more familiar strategies for client interactions and services. Some hierarchy of response should be in place that is designed to encourage accurate implementation. At the system level, agencies that fail to document continual improvement in their ability to provide strength-based services may need to face reduction in or even loss of their contracts.

At the practice level, agencies should have the means to identify staff members who are having difficulty implementing strength-based approaches and remediation systems to help them find ways to improve their work. It is important, however, to take this suggestion in the strength-based context in which it is offered. The point is not to punish staff when they get it wrong, but to help them become more comfortable with doing it right. For example, a supervisor might see from family member feedback or from her staff person's self-report that a wraparound facilitator had a tendency to focus more on problems than solutions in a child and family's situation. Her response might be to team the staff person with a more accomplished facilitator to co-facilitate some teams. Or perhaps she might gather some of the other staff and set up some scenarios for them to role-play together. The point is that since strength-based practice is a

metaskill, knowing how to walk through the steps isn't enough; practitioners have to get a feel for it to be able to use it successfully.

Removal of barriers. Strength-based practice is a new approach and many of the traditional operational components of service systems aren't well aligned with the practice model. Service access, billing, quality assurance and productivity measures, the old practice manuals lying about the office, and the habits that have become a part of day-in, day-out work can all present barriers to the consistent implementation of strength-based work. To overcome these barriers, agencies and systems may form quality practice groups to help identify and resolve barriers to effective implementation of the model, to provide in vivo support to staff who are making the transition to the new approach, and to recognize and share innovations as they emerge. The transition from a standard model to a strength-based approach in any of the operational aspects of human service delivery is likely to be challenging. For example, service access in standard publicly-funded human service models is often based on things having gone terribly wrong. Many financially strapped child welfare agencies have limited intake to "petitionable" situations – meaning that there has to be grounds for filing a court petition on abuse or neglect – before services can be provided. The strength-based shift that is currently working its way through the nation's systems is called Alternative Response or Differential Response. Families who are at risk of disruption, but whose current situation is not so severe as to require formal intervention are being connected with a wide variety of resources (including wraparound in some cases) on a voluntary and informal basis.[3]

Billing may be an even more difficult barrier to overcome than access. Many programs using the wraparound process rely on medical assistance as a principal funding source. But medical assistance requires that a specific deficit—via diagnosis—must be present. This means that many wraparound facilitators have to start their supposedly strength-based relationship with a family by first diagnosing and labeling the child. Two trends are emerging to overcome this barrier. First, clinicians are discovering ways of using assessment and diagnosis in a more strength-based and productive way. When children and adults have serious behavioral, emotional or neurobiological conditions, having a clear grasp of what is going on and what can be done about it can be an important step in the healing process. Second, when a mental health diagnosis is not going to be a useful part of the assistance a child and family needs, agencies are learning how to "port" wraparound technology into non-mental health contexts: probation officers, child welfare workers, public health nurses and economic support specialists are all using child and family teams to support their clients.

Probation officers, child welfare workers, public health nurses and economic support specialists are all using child and family teams to support their clients.

Provision of resources. If an agency or system is serious about transforming its current practices into strength-based approaches, a rich array of resources to support this change should be provided. These ought to include consistent, practical training, mentoring and case consultation for staff, supervisors and managers, access to outside workshops to enhance staff understanding and skills, strength-based formal tools for assessment, planning and evaluation, opportunities to observe implementation of strength-based practices in other agencies either in person or through video recordings, and making sure that a strength-based orientation is built into the service access, delivery and funding pathways.

Support from leadership. Staff notice what leadership pays attention to. All the words in the

3 For more information on Alternative Response, visit http://www.childwelfare.gov/famcentered/overview/approaches/alternative.cfm.

Resources for Practitioners

For an example of a broad based application of mindfulness, see:

Thich Nhat Hanh (1987). *The Miracle of Mindfulness*. Boston: Beacon Press.

Or visit the website of the University of Massachusetts Center for Mindfulness in Medicine, Healthcare and Society at:

http://www.umassmed.edu/cfm/

Information about Nonviolent Communication and links to training opportunities around the world can be found at the website of the Center for Nonviolent Communication:

www.cnvc.org

Or, see:

Rosenberg, Marshall B. (2002). *Nonviolent Communication: A Language of Compassion*. Encinitas, CA: Puddledancer Press.

An extensive bibliography on Appreciative Inquiry can be found at a website maintained by Case Western Reserve University:

http://appreciativeinquiry.case.edu.

An overview by Dr. David Cooperrider, who developed the model, is available there as well. For a more detailed description of Appreciative Inquiry, published by the institute Dr. Cooperrider founded, see:

Barrett, Frank & Fry, Ronald (2005). *Appreciative Inquiry: A Positive Approach to Building Cooperative Capacity*. Chagrin Falls, OH: Taos Institute Publications.

world are quickly either reinforced or erased by a few actions by leadership. Specifically, staff will be guided by the way that leaders react to crises, provide recognition for accomplishments, share in learning experiences, allocate rewards, frame challenging situations and in the way that choices are made about advancement and dismissal of employees. If these events reflect the importance of using strength-based approaches with clients then that model will gradually become a part of the agency or system's culture. If the overt actions of leaders contradict the espoused value of strength-based practice, the labels may remain but the heart of the model will erode.

Resources

Many published and on-line resources are available to help agencies and practitioners learn about and adopt a more strength-based approach in their work. Some are practice specific; others are more generally oriented. A few examples are provided here as a sampling of what is available, but interested individuals will find that a few moments of research will identify a trove of useful ideas for bringing a strength-based perspective to the full breadth of human services and educational approaches.

Attitude: Sometimes the best first step toward a more strength-based attitude in human service delivery is to step back and find a way of grounding one's perspective on a broader foundation. Examples of tools that can help one in this effort are the practice of mindfulness, the use of non-violent communication, and the technique of appreciative inquiry. (See accompanying box at left.)

Discovery: Wraparound uses a narrative approach to informal strengths discovery during the initial engagement phase of the process. A facilitator listens to the family's stories and extracts from them examples of descriptive, contextual and functional strengths that can serve as a foundation for an effective action plan. Another approach to identifying strengths can be found in the solution-focused practice model developed by Insoo Kim Berg and Steve DeShazer (1994) in which clients are asked to identify times when the current problem has been less of a problem and coping strategies that they have used to address

similar challenges in the past. Several tools for formal strengths discovery have been developed including the BERS, the CANS, the CALCAT and the YCA. (See accompanying box, right).

Mirroring: Agencies and systems looking for a way of helping staff become more effective at hearing what clients are saying and reflecting that information back to them to make sure information and meaning are being accurately shared need look no further than the well-known practice of active listening.[4]

Intervention: An increasing number of services and interventions are being designed from the ground up to help parents and children establish and enhance competency and resiliency (Caspe & Lopez, 2006). Many of these efforts are working their way through the evaluation process in an effort to gain recognition as evidence-based practices.[5] An agency or a system seeking to become firmly grounded in strength-based practice should regularly and carefully examine these options and maintain an up-to-date resource array well-aligned with the needs of the population they are serving.

Recording: The documentation and information management systems used by agencies and sys-

4 There are many references for active listening. For example, Joe Landsberger has posted a succinct summary on his website at http://www.studygs.net/listening.htm.

5 The federal Substance Abuse and Mental Health Services administration has established a National Registry of Evidence-based Programs and Practices that keeps an updated roster of interventions that have met the criteria to be identified as promising programs, effective programs or model programs. http://nrepp.samhsa.gov.

Measures and Instruments for Assessing Strengths

The ***Behavioral and Emotional Rating Scale*** assesses child strengths within the dimensions of interpersonal capacity, family involvement, intrapersonal competence, school functioning and affective ability. Scoring produces an overall strengths quotient and standard subscale scores within each domain. It can be obtained through its website at http://www3.parinc.com/products/product.aspx?Productid=BERS-2.

The ***Child and Adolescent Needs and Strengths Assessments*** are a suite of open use (no fee) tools designed to support effective service and support planning for children with complex needs and their families. Currently there are six tools available depending on whether the focus is on issues in early childhood, child welfare, developmental disabilities, mental health, juvenile justice, or sexual development. The tools can be used both for initial screening and for measuring client progress, and can also be used to look at system of care functioning. The manuals and forms and a description of their development are available from the CANS website, operated by the Buddin Praed Foundation, which was established by the developer of the CANS, John Lyons of Northwestern University, to support the dissemination of these tools. http://www.buddinpraed.org/.

The ***California Child Assessment Tool*** is a child welfare specific tool developed by the SPHERE Institute in Stanford for use in California's county-operated child welfare systems. The tool is designed to support consistency in assessing strengths and needs with regard to child safety, permanency and well-being and is being piloted in about 5 counties. Information about it is at http://www.spherein-stitute.org/cat.html.

The ***Youth Competency Assessment*** tool was developed by NPC Research in Portland, Oregon, to support strength-based restorative justice assessment of youth in the juvenile justice system. Although copyrighted, the tool can be reproduced and used for nonprofit purposes. Information is at http://npcresearch.com/ (Click on "materials" to get to the section on the YCA.)

tems seeking to support strength-based practice must evolve beyond being a time consuming obligation through which practitioners demonstrate rote compliance to become tools that guide appreciative, interpretive and reflective inquiry into the relationships they are forming with clients and the impact those relationships are having on the outcomes clients are achieving (Hornberger, Martin, & Collins, 2006). Two examples of such systems are the Synthesis data management system used by Wraparound Milwaukee (for more information visit their website at http://www.milwaukeecounty.org/WraparoundMilwaukee7851.htm) and the information technology system used by Choices, Inc. in a variety of its efforts, including the Dawn Project in Marion County, Indiana (Indianapolis). http://www.choicesteam.org.

Evaluation: Although many new methodologies identify themselves as strength-based, and there is a growing consensus that the use of strength-based approaches is a more effective way of helping people achieve and sustain positive outcomes, the true impact of these practices must be tested both in clinical settings and in the field to prove their promise. From a clinical perspective, well-designed experimental models are needed to reliably demonstrate what works and what doesn't (Harrell, [undated]). From the point of view of an agency or a system of agencies, the operational structure must include an information collection and analysis mechanism that provides practitioners, supervisors and managers with a functional and timely dashboard that keeps them reliably informed about key aspects of the services they are providing and presents this data in the context of a metric that reflects the core values of strength-based practice (Cohen, 2005).

Conclusion

Ultimately, the point is not to be strength based, but to be helpful and promote positive outcomes. The goal of an effective practitioner is to bring the best understanding of the current state of the art in a given area of service to each client interaction, and to use what is learned through these interactions to constantly advance the standard of practice in that art. One of the originators of the concept of evidence-based practice has put it this way (Muir Gray, 1997):

> *Evidence-based clinical practice is an approach to decision making in which the clinician uses the best scientific evidence available, in consultation with the patient, to decide upon the option which suits the patient best.*

Applying this principle to strength-based practice, the purpose of the ADMIRE framework is to identify a series of anchor points so that reflective practitioners can not only check themselves on the degree to which they are expressing a strengths orientation in their ongoing interactions with families, but also observe whether maintaining that orientation is associated with helping those families achieve positive changes in their lives.

In the specific case of wraparound as a strength-based practice, the framework can provide an outline for an ongoing conversation among facilitators, family members, agencies, formal and informal family supports and community stakeholders. To the extent that wraparound is a co-created system of reciprocal support for recovery, all of us participating in using this approach and in establishing the organizational and community environment that sustains it should regularly ask ourselves several questions:

- Are we consistently expressing a strength-based orientation in our interactions both with families and with other service providers and family team members?
- Do we begin each new relationship with a family with an engagement process that includes formal and informal processes for strengths discovery?
- Do we share the results of our observations with our families and teams in a way that supports an increase in mutual understanding and a shared commitment to finding a way to make things better?
- Do we build the interventions in our plans of care on the strengths of our families and design them to help families make progress toward accomplishing the mission they have chosen for themselves?
- Have we documented the essence of what we have observed, what we are doing, why we are doing it and what is happening as a

result, both in terms of family progress and family and community satisfaction? and

- Are we collecting and aggregating information about our services in a way that provides a useful overview of what works, where things could be better and how best to achieve this improvement?

These checkpoints can help us maintain our focus on strengths so that we bring to every service encounter the best of what we are learning about how to assist families with complex needs. Ultimately, the measure of our implementation of a strength-based methodology will be the degree to which both families and family teams experience a shared sense of recovery, growth and change.

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The Principles of Wraparound: Chapter 2.3

A Roadmap for Building on Youth Strengths

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A core element of the wraparound process is the planning of services that build not only on family assets, but also on youth strengths and capabilities. This principle is founded in the belief that by capitalizing on the capabilities of children and adolescents, wraparound providers create a sense of hope for the future and enhance motivation for change (Saleebey, 2002). To facilitate the process of assessing the internal and external resources of youth, a variety of methods and tools have been advanced, ranging from informal "strengths chats" (VanDenBerg & Grealish, 1996) to standardized measures, such as the Behavioral and Emotional Rating Scale (BERS; Epstein & Sharma, 1998). Little work has been done, however, to delineate the process of tapping the strengths identified through these and similar means. In an effort to fill this gap, this chapter provides a roadmap for wraparound practitioners, intended to guide their efforts in developing plans of care that build on the skills, interests, and capacities of the youth served.

A Conceptual Framework for Understanding Strengths

One conceptual model that is useful in guiding the assessment of youth strengths is offered by Cowger (1997). This author contends that a comprehensive assessment gathers information along two intersecting continuums: the environmental versus individual axis and the strengths versus obstacles axis. Four domains can be created when these continuums are enclosed and have been labeled as follows: *personal strengths*, *personal obstacles*, *environmental strengths*, and *environmental obstacles*. Strength-

based assessment does not ignore the challenges represented in the obstacles domains, but it does highlight and emphasize the personal and environmental strengths that each youth brings to the process of meeting needs, overcoming barriers, and resolving problems.

A concept that illuminates the role of environmental strengths in guiding intervention planning is that of the *enabling niche*. James Taylor (1997) defines the social niche as an "environmental habitat of a category of persons, including the resources they utilize and the other category of persons they associate with" (p. 219). Within the broader concept of the social niche, he draws a distinction between entrapping niches and enabling niches. Entrapping niches tend to stigmatize individuals and offer few incentives for skill development or goal attainment. In contrast, enabling niches are said to recognize capacities, and offer rewards for skill acquisition and/or progress toward goals. The development of such spaces and places for encouragement and enrichment can be critical to youth recovery and healthy development.

Building on Strengths in Wraparound

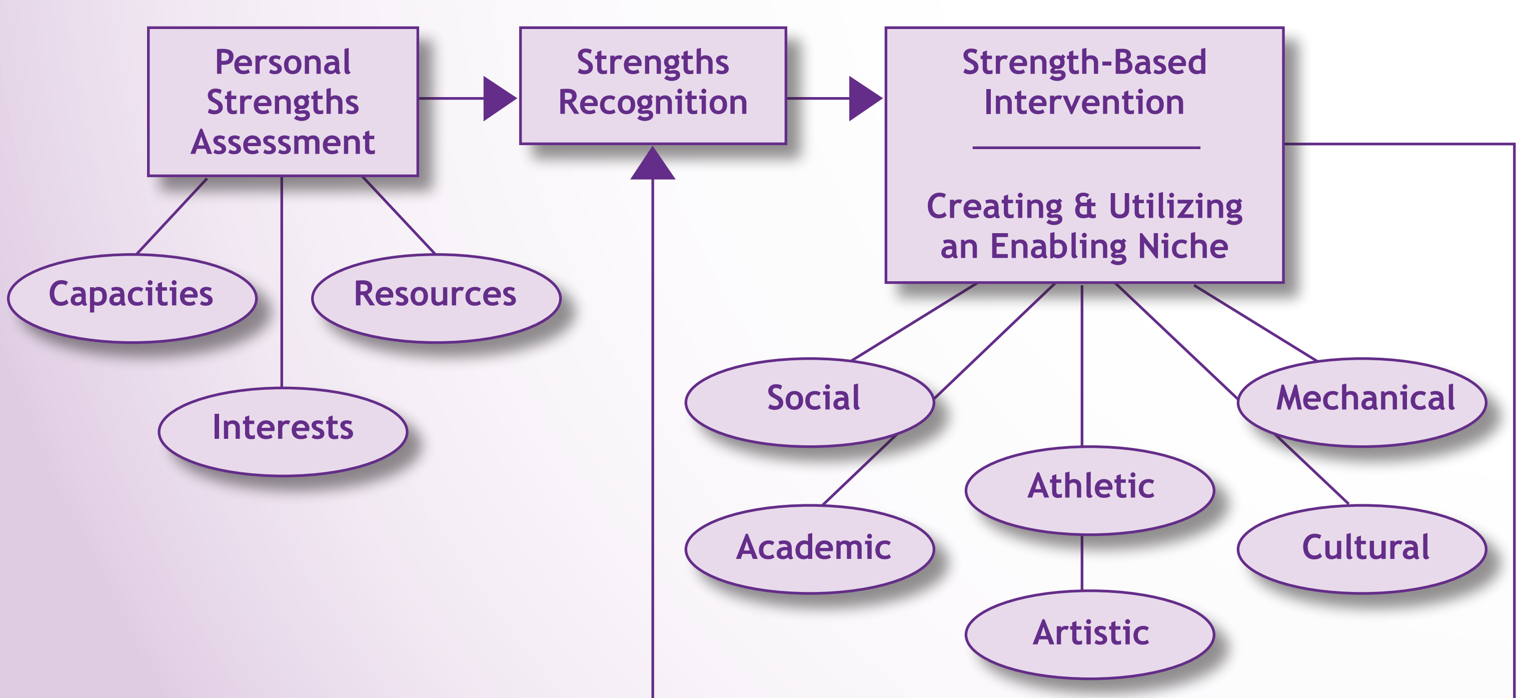
The practice model offered below aims to capitalize on the youth's personal strengths in order to enhance his or her environmental assets. It does so by first conducting an in-depth assessment of the youth's capacities, interests, and resources. It continues with a formal process of strengths recognition and, finally, the design and implementation of strength-based intervention focused on two main goals:

1. Creating an enabling niche, and
2. Utilizing this niche as a vehicle for furthering the youth's progress toward improved emotional or behavioral functioning. (See Figure 1.)

Assessing Youth Personal Strengths

A wide range of strategies, both formal and informal, can be used to facilitate the process of strengths assessment. The "strengths chat" recommended by VanDenBerg and Grealish (1996) involves the practitioner having a conversation with the individual about what they view their

Figure 1. Process for Building on Youth Strengths



strengths and resources to be (p. 12). This type of strengths chat conducted with a child or adolescent can be focused around the completion of an assessment tool developed by the current author, referred to as the *Personal Strengths Grid*. (See Table 1, end of this chapter.) This tool is designed to guide discussion of the youth's capacities, interests, and resources within the domains of social, academic, athletic, artistic, mechanical, and cultural/spiritual functioning.

Strengths Recognition

A key component of the wraparound process is the acknowledgement of the youth's skills, interests, aims, and abilities. This ideally takes place during team meetings, with participation by service providers, family members, and their natural supports, such as friends, neighbors, and mentors. One can speculate that this focus on assets increases the child or adolescent's willingness to engage with formal and informal providers and participate actively in the wraparound process. Additionally, parents have been found to be significantly more satisfied with human services when such strengths recognition is performed (Cox, 2006). The positive impact of this practice is likely to be enhanced, however, when combined with the use of interventions that build on the unique strengths of the child recipient of wraparound.

Strengths-Based Intervention

The wraparound team is also charged with designing a plan for services that is tailored to the unique strengths and needs of the youth. It is common for the needs to include the child's emotional or behavioral problems. Strength-based interventions aimed at resolving such challenges tap a particular youth asset, while striving to improve the child's functioning at home, in school, and/or in the community. For example, a boy who loves cars (and who has issues with impulsivity) might be taught to manage his behavior by learning to "put the brakes on" and "read the stop signs." His family might be encouraged to adopt language infused with auto-related metaphors while praising his progress toward following directions at home and at school. He might be offered an opportunity to work toward earning a remote control car by consistently completing tasks. While these interventions may prove beneficial, they would be enhanced by a plan to create or support an enabling niche for this youth. For instance, he might be enrolled in a stock car racing club or provided an opportunity to learn auto repair by assisting a mechanic at a neighborhood auto shop. During such endeavors the boy could be assisted in practicing his newfound skills in impulse control.

Case Example

Alicia is a 15-year-old girl who resides with her mother, Ana, and 10 year old brother, Jason. The family lives near Alicia's maternal grandmother and aunt in a semi-rural area. Mother was struggling financially as she sought employment as a nurse's aid. Alicia displayed symptoms of severe anxiety and traumatic stress stemming from an episode of sexual abuse by her mother's ex-boyfriend that occurred 2 years previously. She also appeared angry at her mother for initially refusing to believe her when she first disclosed the abuse. Alicia has a flare for dramatics and can be playful and engaging yet had difficulty sustaining friendships. She spent her free time alone in her room watching old movies on T.V. and writing in her journal.

A focus on assets increases the child or adolescent's willingness to engage with formal and informal providers and participate actively in the wraparound process.

During her assessment with the wraparound provider, the Personal Strengths Grid was used to guide discussion about Alicia's interests and abilities. As a result, she disclosed that she enjoys both writing and play-acting. These strengths were recognized at the first wraparound team meeting that included her mother, grandmother, aunt, school counselor, and therapist along with the wraparound facilitator and family partner. Her therapist began work in helping her acquire

coping skills in preparation for the creation of a written trauma narrative. When the narrative was completed, joint mother-daughter sessions were held in which Alicia shared parts of her narrative with her mother. Ana had been prepared by the therapist to respond to Alicia's story in a manner that was supportive and validating. In addition to therapy, the wraparound plan included a focus on job search assistance for mother and social skill development for Alicia. The school counselor helped Alicia connect with the drama club at school and she was offered a part in the school play. This counselor also coached her in strategies for initiating and maintaining friendships with the other students in the play. Alicia's mother, grandmother, aunt and brother were all present for opening night of the performance. Alicia's symptoms lessened as she neared the end of her therapy and found a social niche that was enabling.

Conclusion

If wraparound practitioners are to give more than lip service to the notion of building on strengths, they must embrace not only a philosophy that recognizes youth assets, but also a practice methodology that leverages child and adolescent capacities and interests toward the achievement of service planning goals. The framework above is intended to guide providers in the implementation of strength-based planning as it applies to children and adolescents. It is understood that the wraparound process entails much more than this one element of service. Indeed, strength-based planning often entails building on natural supports of families in order to meet their needs within a wide variety of life domains. However, a well-designed and strength-focused approach to addressing youth emotional and/or behavioral challenges is often critical to the overall effectiveness of wraparound.

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Table 1. Personal Strengths Grid

Sources of Information Regarding Strengths:

Youth's Name: ____________________

Age: ____________________

- ☐ Youth Interview
- ☐ Caregiver Interview
- ☐ Other
- ☐ Teacher Interview
- ☐ Observation

Strength Domain	Social	Academic	Athletic
Capacities	☐ Initiates relationships with ease ☐ Sustains relationships over time ☐ Good interpersonal boundaries ☐ Relates well with peers ☐ Relates well with adults Comments: ____________ ____________ ____________	☐ Good reading skills ☐ Good writing skills ☐ Good math skills ☐ Good verbal skills ☐ Good computer skills Comments: ____________ ____________ ____________	☐ Good at team sports (e.g. basketball, foot-ball, baseball) ☐ Good at independent or non-competitive sports (e.g. swimming, gymnastics, jogging, rock- climbing, yoga) Comments: ____________ ____________ ____________
Interests	☐ Wants to have friends ☐ Wants relationships with caring adults ☐ Wants to belong to peer groups, clubs ☐ Likes to help others ☐ Enjoys caring for animals Comments: ____________ ____________ ____________	☐ Enjoys reading ☐ Enjoys writing ☐ Enjoys math or science ☐ Enjoys computers Comments: ____________ ____________ ____________	☐ Wants to play team sports ☐ Wants to learn individual or non-competitive sports Comments: ____________ ____________ ____________
Resources	☐ Has close (pro-social) friend(s) ☐ Has access to adult mentor ☐ Has access to naturally occurring groups, clubs, volunteer work, opportunities etc. Comments: ____________ ____________ ____________	☐ Has access to oppor-tunities to display, share, or enhance academic abilities Comments: ____________ ____________ ____________	☐ School offers athletics programs ☐ Neighborhood offers athletics programs Comments: ____________ ____________ ____________

Personal Strengths Grid *(Continued)*

Strength Domain	Artistic/Creative	Mechanical	Cultural/Spiritual
Capacities	☐ Talent in visual arts (drawing, painting, etc) ☐ Talent in performing arts (singing, dancing, drama, music, etc.) ☐ Skills in domestic arts (cooking, sewing, etc. **Comments:**	☐ Able to assemble & disassemble bikes, appliances, computers, etc. ☐ Skills in using tools for carpentry, woodworking, etc. ☐ Skills in car maintenance/repair **Comments:**	☐ Knowledge of own heritage ☐ Knowledge of spiritual belief system ☐ Practices cultural/ spiritual customs/rituals **Comments:**
Interests	☐ Desires to develop talent in visual arts ☐ Desires to develop talent in performing arts ☐ Desires to develop talent in domestic arts **Comments:**	☐ Enjoys fixing appliances, etc. ☐ Enjoys building, woodworking ☐ Enjoys working on cars or desires to learn mechanics **Comments:**	☐ Likes to attend church or other place of worship ☐ Desires to learn about own heritage ☐ Desires to participate in cultural or spiritually oriented activities **Comments:**
Resources	☐ School offers programs in type of art preferred ☐ Neighborhood offers programs in type of art preferred **Comments:**	☐ School offers vocational program in mechanical area of interest/skill ☐ Has opportunity to serve as apprentice in mechanical area of choice **Comments:**	☐ Connected to place of worship ☐ Has access to opportunities to participate in culturally oriented activities **Comments:**

Other strengths: ______________________________

____

Completed by: ____________________ **Date:** __________

Supervisory Review: ____________________ **Date:** __________

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The Principles of Wraparound: Chapter 2.4

Creating Community-Driven Wraparound

Bob Jones, Planner and Program Developer
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The King County Blended Funding Project

The King County Blended Funding Project (the Project) was created as part of a Robert Wood Johnson grant designed to meet the needs of children who had experienced years of failure in the mental health, child welfare, education and juvenile justice systems. The Project demonstrated extraordinary success in working with a historically difficult and isolated group of families and youth. Youth referred to the Project had long histories of multiple placements. Their families had limited or no support systems. Thus, it was believed that the most effective wraparound effort would be one that emphasized building support systems to engage families in their communities.[1] Family participants were trained and supported in managing the process and were given control of the resources. Ultimately, the program evaluation for the Project demonstrated that the program's ability to develop community relationships and supports for families were among the most important factors in its success.

Many of the families had been involved in wraparound processes prior to coming into the Project. The teams had been primarily professionally driven because the families were so isolated they had few or no natural supports to participate on their teams. A lack of trust of systems was pervasive among the families. Families were not ready for "another program" that looked the same as other programs

[1] In this discussion, "community" refers to individuals and not agencies. When discussing system-driven wraparound, we are referring to wraparound based in service-providing agencies.

that they felt had failed them. There needed to be a different approach for engagement, program development and a shift in how the process was managed.

The Project went through several ups and downs. Initially the planning was totally centered on family needs and worked inside and outside of existing service structures and many of the system rules. This resulted in tension with funders and system regulators. The approach was described as “too pure” to wraparound principles. Changes were put in place as a requirement for funding. The energy was moving away from community to meeting bureaucratic requirements. The quality of outcomes and community involvement decreased. The Project was beginning to look like several other programs that families felt had failed them in the past. The introduction of the concepts of co-production (to be discussed later) to families helped move back to a more community-based approach while still meeting systemic requirements. Discussed here are some observations about factors that helped the Project and its participants move through the tension between system requirements and the desire to implement wraparound that is truly based in the community. In the end, achieving a wraparound process that focused on developing community where none was available was made possible by utilizing the strengths of family members in the Project to provide both services and support for each other.

What Did this Wraparound Effort Look Like?

From the beginning, the parents’ level of participation and involvement was unique. The parents took leadership roles in all aspects of the Project. Family members who had a lot of training in wraparound helped design the structure, trainings and project evaluation. They developed a wraparound program that relied heavily on parents supporting other parents.

One of the goals of the Project was to ensure that the families were part of a supportive community. This was achieved by using parent partners who reached out and engaged families. There was also a separate and independent parent-led organization that was created to become the hub of community activity for Project participants. The organization was a provider of parent partner and training services. The parent organization went through several iterations over the years and eventually focused less on service provision and more on mutual support and Co-Production.

The Project evaluation highlighted the need for developing a supportive community. Unlike many evaluations, the evaluation of the Blended Funding Project was used as a guide to keep the Project aligned with its values. When the Project strayed, the evaluation helped bring it back to its original vision. As was true in all parts of the Project, the evaluation was created and implemented by family members. The evaluation demonstrated that relationships among family members and the community were a significant factor in families’ success. As a result, connectedness to supportive individuals and institutions was measured as a key indicator of success in the evaluation. This reinforced the Project’s focus on building supportive community relationships for families and youth. (A fuller description of this innovative evaluation has been published previously. See Vander Stoep, A., Williams, M., Jones, R., Green, L., and Trupin, E., 1999.)

Creating Community-Driven Wraparound

To create a truly community-driven wraparound effort, the Project emulated early wraparound work that operated outside the mainstream of traditional service systems. Instead of conceiving itself as a system intervention or service, the Project took a community-based approach in working with children and families. Resources were directed at members of the community working together to do “whatever it takes” to achieve positive outcomes for children and families.

Historically, such an approach to wraparound has demonstrated success and became appealing to systems because it reduced need for services and kept children out of expensive residential services. However, as system-of-care thinking and family-centered work gained acceptance, it became a preferred approach for the formal system itself to use in working with children and families with complex needs. This once radical approach became a mainstream approach, often embedded in the mental health system. As it became codi-

fied in mental health, requirements increased and standards were established. Wraparound plans became surrogate treatment plans and the system itself began controlling the process. Wraparound began to look like the system. Wraparound did not transform the system but in many cases was transformed by the system.

As described by Mario Hernandez and Sharon Hodges in the Michigan Outcome Project (Hernandez, Hodges, Macbeth, Sengova, & Stech, 1996), different stakeholders propose different outcomes. The desired outcomes as stated by families are different than for system directors and providers. Families are concerned about the quality of their lives while, as mentioned above, systems want to reduce service utilization. Desired outcomes drive program design and structures. Thus, it is not surprising that the families in the Project wanted a structure very different than those that were in existence and that were "blessed" by the systems. As communities implement "high-fidelity wraparound," leaders of such efforts need to maintain a focus on creating community-driven wraparound and be aware that system-driven wraparound effects design and implementation. By being aware of these factors and looking to families and communities as resources, wraparound efforts will be more likely to achieve core principles such as "community based," "family driven," and "natural supports" in practice.

Wraparound did not transform the system but in many cases was transformed by the system.

Family-Run vs. System Ownership

Bureaucracies are managed from the top down. Policy decisions may be made with community input but rules and procedures are passed down through silos. Funding is managed through contracting requirements that put limits on spending and what can be purchased. Such limits shape the thinking of those providing wraparound. Funding of service selection is ultimately constrained within certain parameters. Those who know the system can manipulate it to make it work, but frequently those who know the rules limit creativity and dialogue by saying what cannot be done. As a result, conversations about family and community needs inevitably turn to a discussion about rules and services and creativity is lost.

This is in contrast to a family-driven system where controls and decisions are based at the family/community level. The management of funds in the Project was totally flexible. Decisions were made at the team level for all services and nonservices. Teams did not appreciate being restrained by bureaucratic rules. When limits were imposed, they would fight to maintain their independence. When questioned, families took great pride and power in saying, "It was a team decision," voicing their choices as rights.

Funding is usually seen as the most significant resource for helping children and families within systems. The use of families and individuals as non funded resources is frequently an afterthought to planning. In the Project there was a shift in emphasis and individuals and families were utilized as the major resources and giving more responsibility to communities helped this happen. This strategy became the most significant factor in creating change.

The example below demonstrates the difference between system-run vs. family-run teams:

One mother, referred to the Project, had adopted her nine-year old daughter from an Eastern European orphanage at the age of four. The girl had been severely abused, was nonverbal, and had experienced four years of extreme malnutrition. The daughter was in an acute psychiatric hospital because of her aggressive behavior. The mother had been asked by a hospital psychiatrist, "Why did you ever adopt this child? She will never be able to live outside an institution!" They saw no hope. A team representing the various systems was formed to find alternatives to hospitalization. No residential programs or foster homes would accept her.

During a referral call a team member said, "We have a great team but we do not know what to do with this child." The team perceived itself

as strong because it worked collaboratively across systems but it was at a loss to find workable options. For the team members there was a sharing of frustration that created a divide with the family. The reaction was projected as frustration with the family and they started to define the family as pathological. The mother's perception of the same team was that it was a huge barrier to getting needs met and that team members had no understanding of her or her child. Her response was to get an advocate and a lawyer to see if she could force the team to provide her with services, including residential care and specific therapies for her daughter.

Shortly after the family entered the Project, a new approach yielded different outcomes. Her first contact with the Project was a parent partner who took her to her neighbors to talk about her situation. To the mother's amazement, they found people not only willing to help but eager to reach out. For instance one of her neighbors was an emergency medical technician and was willing to be on call for her 24 hours a day. A local horseback riding business offered riding lessons in exchange for the daughter grooming horses. There were several other supports found in the community but the mother reported later that one of the most supportive things the parent partner did was buying her daughter a tooth brush. The smallest of basic needs had great importance to her and was symbolic of caring.

Universally, families and youth were more positive and hopeful when they felt in charge of their lives and were not dependent on the system to meet their needs.

The parent partner was very tuned in to the range of needs for the family, not just the behavioral problems of her daughter. This helped the mother feel very supported and with the help of her parent partner she created a team completely without professionals. Her experience with her new team was quite different. She saw them as supportive and available for her and her family. Services were added that she felt were effective, including alternative therapies that would not be available in traditional service systems. Since funds were flexible, those services were contracted for and purchased by the Project. Her daughter was returned to the community from the hospital and had a program designed to meet her needs and her family's needs. Help was available immediately when she needed it. The mother led the team and did much of her own case management. Eventually her daughter became her own team leader. The ownership of the process had shifted from system representatives to the family.

Dependence on the System

The example above is not uncommon for individuals who find themselves dependent on systems. The mother was desperate for help, had exhausted her resources and was being told there was nothing that could be done. It felt to her that help was being withheld from her family. That was not the case; it was just that no one could think of service options that would work. The mother and the team of professionals had all viewed the situation through the same lens, looking for professional resources and looking to the same source for funding: the bureaucracy. When she came into the Project, a whole new set of resources became available that no one had known how to access—neighbors and friends from whom she had withdrawn because of her family struggles. Her parent partner was aware of this and had a different idea of what kind of help to seek out and who to approach.

The situation the mother and daughter found themselves in has been described as a "connectivity trap," in which reduced connections in the community lead to a heightened need for professional services, which leads to further reduction of connections in the community. The spiral leads to greater isolation and a loss of the feeling of being able to control one's life. Typically, families with children with complex needs look to services to fix problems. Professionals are the experts. The relative position of anyone looking for service in this situation is "one down." There is a built-in

expectation that more services mean better outcomes. If individuals need more support, the way to get it is by being worse off or by continuing to have problems that require service. Many of the families in the Project came to realize this dilemma, and were united against reliance on the systems or "professionals." As often occurs, a schism had developed between professionals and families due to the lack of positive outcomes.

This is a typical problem in system-driven wraparound: When outcomes are not achieved, families are blamed or professionals are blamed, and the answer is frequently more of the same services. Universally, families and youth were more positive and hopeful when they felt in charge of their lives and were not dependent on the system to meet their needs. The challenge for the Project was to build an effective process by which the community and family were the drivers of the wraparound effort, with professionals and systems providing supports as needed, and most importantly, when identified by families.

Bridging the Gap from System to Community Using Co-Production

The Project supported parent-driven work and created an environment that encouraged mutual dependence, but it learned that it could go further than that. A new theoretical construct came to the Project with the introduction of co-production by Edgar Cahn, author of *No More Throw-Away People: The Co-Production Imperative*. Edgar and Chris Cahn visited the Project and talked with parents about the importance of the work in raising children, building families, and strengthening the sense of community. Their observations and views were invaluable in further directing the Project work.

They observed that wraparound incorporated community-based "natural" supports as a critical element of care. But in most cases those natural supports and services look very much like grassroots versions of their professional counterparts, as in mentoring, tutoring and so on. This is because the overall prevailing paradigm is treatment centered.

As an alternative, the Cahns have proposed co-production, the idea that clients/consumers can "co-produce" outcomes, as a new twist on wraparound. Incorporating a co-production framework turns wraparound from a treatment-centered modality to one that is contribution centered. It focuses on the contributions that clients can offer to one another, and to the larger community. The idea is that, through their contributions, families:

- Experience themselves as assets with skills, capacities and talents that others value,
- Are provided with both psychological and other rewards for doing the real work needed to build the family and community of which they are a part,
- Define themselves as providers as well as recipients of services, and
- Become the creators as well as the beneficiaries of natural support systems that help assure new levels of resiliency.

Thus, the co-production approach adds a new, extended role for community that stands as a critical countervailing force to professional, systematized care.

Co-production builds on the insight that for all its strengths, the wraparound process is limited by a framework that ultimately rests on the provision of services. Professionalized services are the norm. And because they had become the norm, they become the framework within which natural supports are offered. As a result, the difficulties associated with professionalized care, which the natural supports were intended to overcome, remain an inherent characteristic of the overall

system of care.

Identifying individual assets in planning is standard practice in wraparound planning. In the concept of co-production those strengths are put to use not just in the family but in the greater community as well. One of the parents in the Project whose daughter had severe problems, strongly objected to diagnoses. “My child is more than just a borderline personality disorder” was her complaint. She felt no one saw her child’s positive attributes. In the Project her strengths became apparent at family get-togethers. Even though the child had been very self-destructive, she was very gentle and very sweet to younger children. She helped provide child care during meetings. As she became more involved with others, her self confidence grew, her self-image changed, and others’ perception of her changed. She *was* more than just a borderline personality disorder. She had real personal gifts that were appreciated and she began to form relationships with others that supported her recovery and involvement in the community.

Parent Partners

As mentioned above, the Blended Funding Project was built on evaluation results that showed the number of relationships a family and child had was the most reliable indicator of improvement. Most of the families initially had far more professional relationships than informal relationships. Families had few people to turn to in time of need and they had limited options of people to be with socially. The family group recognized this and built in social activities for all family members. These were usually in the form of meals or picnics but also included recreational activities. Parent partners were used to engage families not only with the Project but also with social activities. The development of the relationship started with the outreach of the parent partner to introduce families to the Project.

As an example, a parent from one of the families referred had been ostracized by her family after an uncle had sexually abused her daughter. When the parent partner first met the mother, she had no one to include on her team, she was unemployed and had no friends or social groups. The parent partner took an active role in going with her to fill out paperwork, attending school meetings, helping deal with her children in the home, and negotiating with the residential treatment center in which her child was living at the time of referral. They also talked on the phone frequently and were involved in social activities. The relationship changed from being task oriented to social. The mother, who had been very cautious about becoming involved, began to see everyone as supportive. She was able to have her son home and when there were problems, she had professionals to call, but she maintained her closest contact with her original parent partner and called her first.

Utilizing Strengths in the Community

When the Project turned to the contribution-centered approach of co-production, families who were referred to the Project were now evaluated for what they could offer others, with the expectation that they would become an active part of a community. This was not always easy for families to accept because they were more accustomed to being judged and defined as problems.

With the contribution-centered approach, assets took on whole new meanings. One of the parent partners observed that her history with drugs and the prison system was her biggest strength in helping other families. She saw this as experience she would not have received in any education program. Her history was not seen as a strength when she applied for a job that required a background

check. It took some negotiating to hire her. At the same time, her life experience allowed her to be very comfortable with severe problems. She could confront people when necessary and was not shocked by extreme behaviors. She recognized that almost all families have dreams and want the best for their children, and she could draw on her experience and encourage people to find their dreams and contribute to a network.

As a parent partner she had a unique ability to engage families. She recognized it was important to set a tone that the Project was different and that families were valued. More than once she would introduce a family to the Project and find that she had known them years ago on "the streets." This was sometimes amazing to new families, but it helped them realize change was possible. At a lunch, she and another parent were sitting with one of the staff and she was relating her past on the streets to the staff member. The other parent kept looking at her. When they were alone, she said, in shock, "You tell them all of that?!" It helped develop trust between professionals and families.

With parent partners and family members playing new roles, the families were achieving new levels of success. The members of the family group had collectively been seen as dysfunctional to the system, but they were not seen as dysfunctional to each other. They began to share their abilities and to support each other in ways that were not available to them before. They were also available to meet others' needs informally. By knowing each other, they shared their capabilities. Some examples:

- A father who could not read wanted to start his own business. He was embarrassed about his inability to read and would not seek help with people he did not know. One of the parents in the group helped him with the paperwork to get his business license. He was able to start his business, which was a great point of pride for him. This father also hired one of the other family members. In addition, he also had mechanical ability and was able to help people with minor automotive repairs.
- A grandmother who was home all the time became an after school care provider for one of the other families who could not be at home during afternoons.
- Another one of the grandmothers in the Project became a support for grandmothers in and out of the Project who were raising their grandchildren.
- The best thing for the family members was having each other. In times of crisis the first call tended to be to other family members rather than crisis lines or professionals. In nearly every situation families were able to support each other through crisis.

These activities cost nothing but were invaluable to the families. If the above services were to be priced out they would be prohibitively expensive. They tended to be invisible and passed on in team meetings or at family groups. The family relationships were important in time of need but the friendships were equally important during good times.

Developing Connections to Community Resources

In the development of the Project there was an emphasis in creating relationships with community organizations to help support the development and functioning of wraparound teams. The effort was not very successful in most cases. Funds from the Project could be used to purchase services and some unique contracts were developed. For instance a staff position was paid for at a local Boys and Girls Club to supervise a youth without the staff being identified as an aide. It was a different story when a service was not contracted. Due to the background of the youth in the Project, many organi-

> *The members of the family group had collectively been seen as dysfunctional to the system, but they were not seen as dysfunctional to each other.*

zations were concerned about the child and the family. Liability was inevitably brought up. The Project experienced the same forces that families encountered in being rejected and isolated in their communities. There was moral support but not necessarily tangible supports.

The families became emissaries to the community for the youth and also great sources of information about community organizations that were supportive. When they approached organizations they were involved in for support they were much more successful. They referred families to those organizations because of the willingness of the organizations to work with their children. They also became a referral source for services to organizations that were perceived as family friendly and respectful. They shared opinions and impressions with each other that helped new families to guide themselves through community options and to learn of choices.

Conclusion

Families in the King County Blended Funding Project cared for children and youth with extremely complex needs. However, the focus on developing community meant that for many families, even when there were serious behavior problems, they were able to function with far fewer services. Support from the group enhanced their ability to handle problems. Reduced stress meant increased energy to support children. For example, the father who started his own business had to fight to get his child out of hospital and back home. Professionals felt he was not capable of meeting his son's needs. However, the support he received led him and his support system to a different conclusion. There were no problems that he could not deal with. He found great support from members of the group.

For most families, the formal role of the Project became diminished over time. This was especially true with the management of the Project. Relationships between professionals working in the Project and involved families became more collegial and less hierarchical. Families were seen as resources and when families were in crises or in need of support, other families were readily called upon for support and insight.

At a time when there were fiscal problems in the Project, the group was brought together to share responsibility for dealing with the problem. In one of the meetings the name of the Project was brought up. The Project was looking for a better name. It was thought everyone agreed "Blended Funding Project" was a poor name for this complex endeavor. However, a 17-year-old girl who was part of the Project said "You are not changing the name of *my* project." Others agreed with her. It was obvious that ownership had become shared. It was decided not to bring up the topic again. The families had transformed the Project and made it their own.

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The Principles of Wraparound: Chapter 2.5

Debating "Persistence" and "Unconditional Care": Results of a Survey of Advisors of the National Wraparound Initiative

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National Wraparound Initiative Advisory Group

In 2004, the National Wraparound Initiative (NWI) used a collaborative process to create two publications to help meet its stated goal of increasing clarity and consistency of wraparound implementation for youth and families. These two documents were the *Ten Principles of Wraparound* and *The Phases and Activities of the Wraparound Process*. Since these publications, the most contentious aspect of these formative documents has arguably been the reframing of the *Unconditional Care* principle of wraparound as *Persistence*, which was done in order to acknowledge the fiscal and logistical challenges of providing unconditional care in real-world systems.

In advance of publishing all the NWI documents in the *Resource Guide to Wraparound*, it seemed important to revisit the question of how best to present this core principle: Using the newer term of *Persistence*, or returning to the traditional wraparound term *Unconditional*. To help figure this out, approximately 200 NWI advisors were sent a two-page document that included the definition of the *Persistence* principle as it has been presented since 2004, as well as a new description of the principle *Unconditional Care*. Part 2 of this chapter reproduces this information as it was presented to the advisors. Advisors were provided a link to an on-line survey. The survey asked the advisors to give their opinion on whether the change represented an improvement to the ten principles of wraparound, and also invited open-ended feedback on the wording of the principle as well as the issue overall.

Part 1: Summary and Interpretation of Feedback

More detailed results from analysis of open-ended questions are presented in Part 3 of this chapter. Overall, results showed that:

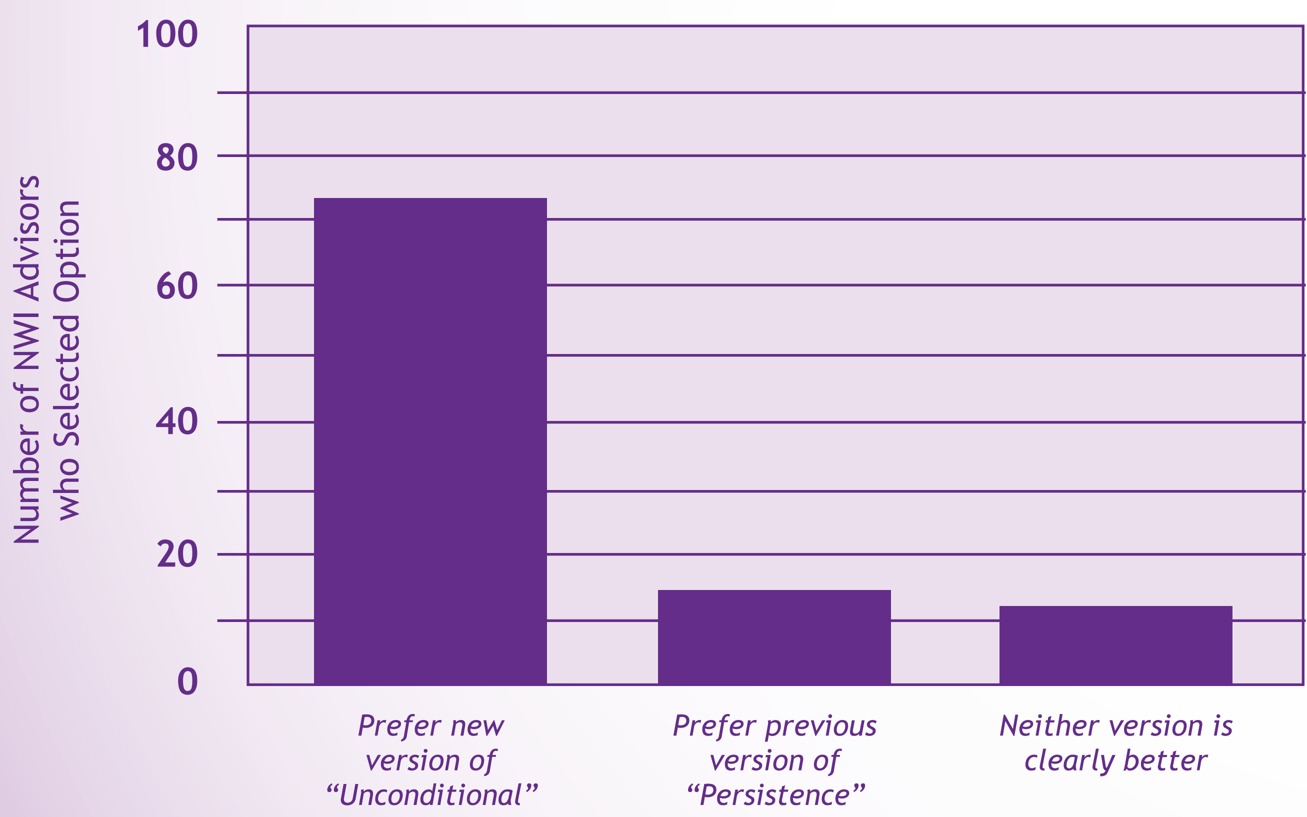
- One hundred members of the NWI Listserv (approximately 49%) responded to the request for input.
- 73% expressed preference for the new description of *Unconditional Care* (See Figure 1).
- 15% expressed a preference for the definition and description of *Persistence*.
- 12% endorsed the option "Neither version is clearly better."

Looking at the open-ended feedback, there was little disagreement with the content of the descriptions of either principle. Debate centered primarily on what ***title*** to assign this principle. Advisors seemed to be split between those who want to highlight the more value-based ideal expressed by ***Unconditional*** and those who seem to want to highlight a more practical or applied version of the principle expressed by the title ***Persistent***.

Discussion

Overall, nearly three-quarters of 100 NWI advisors who participated in this exercise expressed a preference for the description of the principle as "Unconditional Care." At the same time, 15 advisors expressed a preference for the previous version, entitled "Persistence."

Figure 1. Results of Survey of NWI Advisors



Despite different opinions among the advisors in terms of preferences for *Unconditional* versus *Persistence*, it should be noted that comments indicated substantial agreement about the main components included in the description of the principle. Each description (as presented in either the *Unconditional Care* or the *Persistence* version) contains two parts: The first paragraph describes the basic vision or value, while the second paragraph points to typical difficulties that are encountered in real-life wraparound.

In reviewing the results, we concluded that those who prefer *Unconditional Care* as the title of this principle tend to want to highlight the more value-based ideal expressed in the first paragraph of the description. Those who prefer the *Persistence* (or *Persistent)* title seem to want to highlight a more practical or applied version of the principle that acknowledges the limitations expressed in the second paragraph. In general, advisors' comments did not suggest disagreement either with the ideal of unconditional care or with the reality that systems are often not set up to provide care that is truly unconditional. Rather, comments seemed to focus more on which aspect of the principle should be emphasized over the other in the single term that will stand for the whole principle. Advisors also were interested in making sure this would be clear for audiences who are unfamiliar with wraparound and who may have difficulty grasping what this principle really stands for.

Now What?

Though we respect the feedback from advisors who voiced a preference for describing wraparound as *Persisten*t, advisors who prefer to present this principle as *Unconditional Care represent a clear majority*. In addition, a large majority of advisors seemed to be satisfied with the description of the practical limitations that were included in the second part of the new description. For these reasons, a shift to a principle description entitled *Unconditional* would seem to be a logical step. Depending on the future response from advisors, we may be asking (yet again) for review and feedback.

Part 2: Versions of *Unconditional Care* and *Persistence* Presented to Advisors for Review

Principle: Unconditional Care*. A wraparound team does not give up on, blame, or reject children, youth, and their families. When faced with challenges or setbacks, the team continues working towards meeting the needs of the youth and family and towards achieving the goals in the wraparound plan until the team reaches agreement that a formal wraparound process is no longer necessary.*

Description: This principle emphasizes that the team's commitment to achieving its goals persists regardless of the child's behavior or placement setting, the family's circumstances, or the availability of services in the community. This principle includes the idea that undesired behavior, events, or outcomes are not seen as evidence of child or family "failure" and are not seen as a reason to reject or eject the family from wraparound. Instead, adverse events or outcomes are interpreted as indicating a need to revise the wraparound plan so that it more successfully promotes the positive outcomes associated with the goals. This principle also includes the idea that the team is committed to providing the supports and services that are necessary for success, and will not terminate wraparound because available services are deemed insufficient. Instead, the team is committed to creating and implementing a plan that reflects the wraparound principles, even in the face of limited system capacity.

At the same time, it is worth noting that many wraparound experts, including family members and advocates, have observed that providing "unconditional" care to youth and families can be challenging for teams to achieve in the face of certain system-level constraints. One such constraint is when funding limitations or rules will not fund the type or mix of services determined most appropriate by the team. In these instances the team must develop a plan that can be implemented in the absence of such resources but in a way that does not give up on the youth or family. Providing unconditional care can be complicated in other situations as well. For example, when wraparound is being implemented in the context of child welfare, protection of children's safety may require that care is unconditional primarily

to the child or youth. Regardless, even in these circumstances, team members as well as those overseeing wraparound initiatives must strive to achieve the principle of unconditional care wherever possible for the youth and all family mem-

bers if the wraparound process is to have its full impact on children, families, and communities.

Principle: Persistence*. Despite challenges, the team persists in working toward the goals included in the wraparound plan until the team reaches agreement that a formal wraparound process is no longer required.*

Description: This principle emphasizes that the team's commitment to achieving its goals persists regardless of the child's behavior or placement setting, the family's circumstances, or the availability of services in the community. This principle includes the idea that undesired behavior, events, or outcomes are not seen as evidence of child or family "failure" and are not seen as a reason to eject the family from wraparound. Instead, adverse events or outcomes are interpreted as indicating a need to revise the wraparound plan so that it more successfully promotes the positive outcomes associated with the goals. This principle also includes the idea that the team is committed to providing the supports and services that are necessary for success, and will not terminate wraparound because available services are deemed insufficient. Instead, the team is committed to creating and implementing a plan that reflects the wraparound principles, even in the face of limited system capacity.

It is worth noting that the principle of "persistence" is a notable revision from "unconditional" care. This revision reflects feedback from wraparound experts, including family members and advocates, that for communities using the wraparound process, describing care as "unconditional" may be unrealistic and possibly yield disappointment on the part of youth and family members when a service system or community can not meet their own definition of unconditionality. Resolving the semantic issues around "unconditional care" has been one of the challenges of defining the philosophical base of wraparound. Nonetheless, it should be stressed that the principle of "persistence" continues to emphasize the notion that teams work until a formal wraparound process is no longer needed, and that wraparound programs adopt and embrace "no eject, no reject" policies for their work with families.

Part 3: Detailed Survey Results

In addition to analyzing votes from advisors, open-ended comments about the two versions and the exercise in general were analyzed for themes. Looking across all three open-ended survey items, five major themes were identified:

1. Support for returning to a principle focusing on *Unconditional Care*,
2. Support for using a principle focusing on *Persistence*,
3. Ideas for how to revise the name of the principle,
4. Ideas for how to revise the wording of the principle, and
5. General comments about this exercise and the issue of defining this principle.
6. Brief descriptions of the patterns of open ended comments in each of these areas is presented below.

1. Support for Unconditional

Approximately 58 advisors' open-ended comments included some type of support for returning to the notion of *Unconditional Care*. Most of these were simple statements such as:

- "The revised statement better reflects the intent of the wraparound process and provides more clarity to the definition," or

- "The wording is good and I think more strength based. *Unconditional Care* fits better into the wraparound philosophy."

In addition, however, there were more specific endorsements of the *Unconditional* wording. These tended to fall into two categories. First, many advisors expressed that *Unconditional* is a more appropriate expression of a *principle* than *Persistence*, which was viewed in these comments as more pragmatic and focused on how wraparound is actually implemented. For example:

- "Wraparound is a philosophy, not a mandate. It is unrelated to the funding of treatment. As such, I think it is preferable to unequivocally state that the highest fidelity to the wraparound philosophy is achieved when service recipients get their services "unconditionally."
- "These are principles—why replace a value-based term like *Unconditional* with *Persistence*?"
- "Dumbing down the principle because it is difficult is condescending to families—expect poor services, get poor services."
- "*Unconditional* is a higher bar to strive for."
- "Let's keep the high ground on these."
- "You can deliver 'wraparound' unconditionally. You may not be able to get FUNDING to deliver some specific services without complying with the rules of the funding agency, but it's worthwhile to note the difference, and strive for the highest fidelity to the wraparound philosophy no matter who funds your services."

The second specific rationale expressed by advisors in favor of *Unconditional* was that it would help ensure that specific challenges faced by youth or families would not be used as a reason for terminating services.

- "We don't want to give providers an excuse to give up when faced with a special challenge."
- "Keeping the value of unconditional care is all the more important to help us advocate for families."
- "*Unconditional Care* goes along with 'unconditional positive regard'—empathizing even if you disagree."
- "*Persistence* would bring us back to the idea that at some point a family can be kicked out of wraparound."
- "*Persistence* allows professionals an 'out,' as in: 'we've been persistent, *but*…'"

Several advisors also referenced this concern as a reason to eliminate some of the wording at the end of the explanation of the *Unconditional* principle that described instances in which systems may not be able to provide formal supports unconditionally.

2. Support for Persistence

Approximately 23 advisors gave open-ended comments that voiced support for using the *Persistence* principle. Virtually all of these comments expressed objections to the use of the term and concept "unconditional," stating a belief that presenting a service model as "unconditional" was unrealistic in real-world systems. For example:

- "The title *Unconditional Care* implies that services are unlimited. While team members do not give up on, blame or reject children, the term *Unconditional Care* in the context of wraparound systems of care is not sustainable and will cause some systems not to integrate wraparound into their services array."
- "I have always had a bit of a problem with the term *Unconditional* when applied in this context. Whether we like it or not, there are always conditions to just about anything we do. The term itself, *Unconditional* is so large in scope that it is difficult, if not impossible, to commit to in advance."
- "I don't like the name of the principle, *Unconditional Care*. I think it's misleading to families and can create resistance in system partners."
- "There are times when the payor holds the

cards and requires that services be ended. *Unconditional Care* is not possible."

- "*Unconditional Care* is not a reality when courts, child welfare, juvenile justice are engaged. The intent (to quote Karl Dennis) of this principle was 'never give up…. If the plan doesn't work change the plan.' *Persistence* more closely approximated this, not *Unconditional Care*. Wraparound is a model for organizing multi-system response, not a religion."

The other primary points advisors made in favor of *Persistence* were that this concept was more clear and less vague, and/or easier to train staffpersons to do:

- "I believe that of the two, *Persistence* provides a clearer description of the effort placed in team collaboration."
- "*Unconditional Care* is too vague—*Persistence* is more about doing than feeling, and thus easier to teach."
- "I have struggled with *Persistence* as a principle and yet when faced with changing it to *Unconditional Care* I find that *Persistence* is a more accurate description."
- "I recently asked a class of case management students which term they resonated most with. Most could identify with *Persistence* and understood how to apply it in support of the family. Some found *Unconditional Care* too vague."

3. Ideas for the name of this principle

Several advisors presented ideas for changing the wording or name of this principle to make it more palatable, descriptive, or clear.

- Three advisors suggested that *Unconditional **Care*** was less on target than *Unconditional **Commitment***. Another respondent suggested *Ongoing Commitment*, making for a total of four suggestions that "commitment" would be a better word choice than "care."
- Two advisors proposed that *Perseverance* would express the notion of *Persistence* more positively.
- One advisor suggested that *Persistence* refers to the duration and intensity of support while *Unconditional* refers to the nature of that support; thus the two terms should be combined into *Persistent and Unconditional Care*. Other suggestions included *Compassionate Care* and *Adaptability*.
- Finally, several advisors indicated that if persistence was to continue to be used, it should be expressed as *Persistent*, so its wording would be parallel to the other principles of wraparound.

4. Revisions to the wording

Many advisors presented feedback on the wording of the principle descriptions. Many of these comments suggested specific revisions to either *Unconditional* or *Persistence*. In addition, there were several general themes that arose across the comments received:

- At least four reviewers suggested that the term *Persistence* should be maintained, but the definition and description updated with the new language that was presented

in the new explication of *Unconditional*.

- Four additional advisors commented that, regardless of the definition used, the language of the principles document should be more "plain and simple," "less wordy," and/or "family friendly."
- Finally, three reviewers specifically suggested that the second section of the description of *Unconditional Care* (describing the challenges of providing support in this way) should be deleted. "Don't apologize for unconditional care," said one; "Sounds like excuses," said another.

5. General comments

Some of the most interesting pieces of open-ended feedback from this survey were not related to the question of how to present the wraparound principle of *Unconditional* vs. *Persistence*. These themes related to the exercise itself, or to the methods employed by the community of practice we have called the National Wraparound Initiative. For example, several comments expressed that the issue is more complex than can be expressed in a written principle, or that the effort transcends how the NWI presents the principle:

- "What seems to be most important is to let families know the intent of wrap team philosophy—which is to be pledged (committed) to ongoing flexible service (regardless of circumstance) until goals are met and/or the team is no longer needed or appropriate."
- "It is not the wording that we use, as the way that we teach the concept. *Unconditional Care* or *Persistence* both need to be explained and understood."

Consistent with the above theme, several advisors presented specific concerns about wraparound implementation related to the issue of providing unconditional or persistent care:

- "I have a problem with using team consensus rather than outcome achievement as a graduation criterion. I've been in lots of situations in which families that have the most complex needs are thrown out of the process because professionals find them 'difficult.' This consensus is often established in so-called sidebar sessions from which the family is excluded."
- "I find the language [of unconditional care] good but would add something to the effect of that the team should give attention to ensuring that the goals reflect the real goals of the family/youth. I have observed teams resort to blaming the family/youth when the plan does not work as the 'team' envisioned. Often I have observed the source of this failure as the result of the team substituting their values and practice experience for the family/youth's real desires/goals."

"It is not the wording that we use, as the way that we teach the concept. Unconditional Care or Persistence both need to be explained and understood."

- NWI Advisor

Several advisors also offered interesting alternative perspectives on how to express this principle. A couple advisors suggested ways to differentiate the two concepts. As mentioned above, one advisor suggested that *Persistence* is something related to "doing" while *Unconditional* is more related to "feeling." Another advisor suggested that the two versions of the principle may be related to people in different types of roles:

- "The wording *Unconditional Care* in my mind is reserved for natural supports who will be a resource for a child over a lifetime. This concept does not pertain to a group of professionals representing a system of care on a child and family team."

And one advisor offered this interesting perspective:

- "It does not seem to be the wording that is problematic, but rather the constructs themselves. In somewhat rhetorical fashion, I would ask you to consider what would be lost if both were simply dropped. The gains seem more obvious... there would be both a streamlining of the principles and concomitant increase in clarity."

Finally, 38 advisors expressed in their comments that they appreciated that the NWI was soliciting feedback on this issue and/or conducting this exercise. At the same time, there were several advisors who questioned the approach of using a community of practice/consensus building approach to defining the wraparound practice model:

- "There are many limitations in defining a model by consensus. It's time for us to move beyond this. If we are to remain with a consensus approach to model clarification then it is ESSENTIAL that proposed changes are identified by source and with a rationale rather than sending out a survey for 'consensus'."
- "Is this wraparound or that Survivor TV show? I'm not sure any of these focus group/survey methods are working."

Acknowledgments

We would like to thank the 100 advisors of the NWI for taking the time to participate in this survey. We would also like to thank all NWI participants who have participated in such exercises in the past and continue to do so in the future.

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The Principles of Wraparound: Chapter 2.6

Implementing Culture-Based Wraparound

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Connecting Circles of Care

Culture-based wraparound is an approach that expands on the wraparound services model defined by the National Wraparound Initiative by establishing a higher standard for cultural competence. This article describes how to implement these cultural components and offers preliminary comparative findings based on the experience of Connecting Circles of Care (CCOC), a SAMHSA-funded systems of care grantee. The enhanced model ensures that families can receive treatment services that are (a) grounded in their cultures; (b) designed by members of their cultures; and, (c) provided by culturally matched staff. CCOC focuses on four distinct cultural groups: African-Americans, Hmong, Latinos and Native Americans. The process of implementing culture-based wraparound services is examined relative to the community and organization structural supports, the four phases of wraparound, and the adaptations for specific cultural communities. Statistically significant differences were found among CCOC youth and family participants compared to other systems of care grantee sites.

Culture Based Wraparound

In this article, we describe "Connecting Circles of Care," a culture-based wraparound model that expands on the basic description of wraparound from the National Wraparound Initiative by establishing a higher standard for cultural competence. The concept of "culture" has its own definition, which is dependent upon the subjective view of an individual, community, and population. In this article, culture is defined as the wisdom, healing traditions, and transmitted values that bind people together from one generation to another (Duran, 2006); thus, "culture-based wraparound"

aligns with the healing power of culture. Wraparound, as defined by the federal Substance Abuse and Mental Health Services Administration (SAMHSA), is a “unique set of community services and natural supports for a child/adolescent with serious emotional disturbances based on a definable planning process, individualized for the child and family to achieve a positive set of outcomes.” Wraparound is a relational process of caring for youth that is designed to keep the family together, thus avoiding the risk of out-of-home placements. The wraparound planning process involves a community care team that consists of the youth, his/her natural support system (e.g., family members and friends), and formal supports (e.g., social workers, teachers, probation officers, and judges). The goal of the focused planning process is to help youth thrive and live harmoniously within their families and communities by respecting, honoring, and incorporating the families’ cultures and spiritual belief systems into the wraparound process.

Wraparound embraces cultural competence as one of its 10 principles (Bruns, Walker, and al., 2004). This principle reads, “The wraparound process demonstrates respect for and builds on the values, preferences, beliefs, culture, and identity of the child/youth and family, and their community.” Culture-based wraparound, as we propose to define it, distinguishes itself from the basic description of wraparound by setting higher standards for the cultural competence principle. For instance, in the basic description of wraparound, researchers and experts pose that by sharing a cultural identity with natural supports, family partners, treatment professionals, community-based organizations, and formal and informal supportive services, families may be more effectively served (Bruns, Walker, et al., 2004; Penn and Osher, 2008). Culture-based wraparound—as implemented by CCOC—is intended to build on this principle by affording specific mechanisms for achieving it, such as by allowing families the opportunity to select culturally and linguistically matched care team members, as well as culture-based services (i.e., Native American drumming group, Black Effective Parenting Group, or healing ceremonies led by a Hmong shaman). Additional examples of how CCOC extends basic expectations of cultural competence in wraparound are presented in Table I. It is important to note that many wraparound programs may use similar or other methods to exceed the basic standards of cultural competence, which reduces the differences presented in Table 1.

Connecting Circles of Care

Connecting Circles of Care (CCOC) is a SAMHSA-funded, six-year systems of care initiative in a rural northern California community that emphasizes its culture-based focus. While wraparound programs are intended to adapt to specific local needs and goals (Walker, 2008), attention to cultural components is generally not as decidedly focused upon as in CCOC. CCOC started in response to a palpable concern that one in fifteen African-American and Native-American children in the county were being placed in group homes or foster care, while Latino-American and Hmong-American children were typically not receiving mental health services due to language and profound cultural differences that impeded their access to and engagement in treatment.

In 2000, a multiservice health center serving Native Americans received a SAMHSA Circles of Care grant to engage in a needs assessment and planning process to address emotional and behavioral needs among Native-American youth. The in-depth planning process catalyzed local agencies to listen to the needs and wisdom of families and leaders from among other underserved populations. These cultural communities included African Americans, Native Americans, Latino Americans, and Hmong Americans. Members of each group reported common concerns about their ability to access and be well treated by youth and family service agencies. Issues included distrust of local law enforcement and child protective services agencies that were characterized as focused solely on removing children from their homes and placing them in institutional care, as well as mental health professionals who were perceived as (a) condescending and demeaning, (b) not trustworthy (e.g., assessments could lead to removing children from their families), and/or (c) not understanding of families’ needs. Additionally, language translator services were seen as inaccurate, extremely cumbersome, and ineffective. Out of Circles of Care, a vision for a culture-based wraparound program emerged by combining the

wisdom of local cultural communities, the wraparound implementation research in tribal groups (Cross, et al., 2000), and the commitment from representatives of local agencies to retool their service models. The effort to achieve the culture-based wraparound vision was primarily funded by SAMHSA through its Systems of Care funding program, starting in 2005.

This article will present lessons learned in implementing culture-based wraparound at the organizational level using the six areas identified by the Community Supports for Wraparound Inventory (Walker, 2008). This will be followed by lessons learned regarding implementation of culture-based wraparound at the service delivery level across each of the four wraparound phases. Finally, we will discuss outcomes and implications of culture-based wraparound for youth and families. To better understand these issues, examples will be provided on how culture-based wraparound operates within specific cultures.

Creating the Organizational Context for Culture-Based Wraparound

Families receiving services generally experience culture-based wraparound as a tapestry that interweaves culture with the 10 principles and

Table 1: Expanding on the Cultural Competence of Basic Wraparound

Wraparound with Cultural Competence	Culture-Based Wraparound
Integrates culture into wraparound	Integrates wraparound into the youth and family's culture
Trains staff to respect and understand family viewpoints and then adapt services to the culture	Staff are culturally matched and view the world through the eyes of a family's culture
Trains staff in the principle of cultural competence in 4-40 hours	Expertise in a particular culture requires decades of immersion
Focuses on culturally competent techniques of staff to develop therapeutic relations	Realizes that a youth or family member's perceptions of, and level of trust, for staff from different cultures may impair relationship formation no matter how culturally competent staff may be
Often does not offer youth and families the choice to have culturally and linguistically matched professionals	Offers youth and families the choice to have culturally and linguistically matched professionals
Translation with a qualified interpreter is considered sufficient	Fully bilingual staff provided to ensure that true meanings are not lost and family members can emotionally process easier in their first language
Culture is often seen as a family's traditions and ways of doing	Culture is seen as the wisdom, healing traditions, and transmitted values that bind people from one generation to another (family traditions are honored and valued, but not seen as culture)
Wraparound is accountable to families and local agencies	Wraparound is accountable to families, cultural communities, cultural organizations, and local agencies

four phases of wraparound. Their experiences, however, reflect the implementation of cultural-based processes and wraparound at the organizational level, which may or may not transfer to the client intervention level. Yet, successful wraparound requires transforming the organizational system to create a hospitable environment and culturally appropriate context to enable service delivery to families (Walker and Koroloff, 2007). Walker and Koroloff identified organization- and system-level conditions that foster wraparound implementation, and these were later grouped into six essential domains—community partnership, collaborative action, fiscal policies & sustainability, access to supports & services, human resource development & support, and accountability—that comprise the Community Supports for Wraparound Inventory (CSWI). The discussion that follows focuses on standards for implementing culture-based wraparound in each of the six domains.

Community Partnership

CSWI defines community partnership as "Collective community ownership of and responsibility for wraparound which is characterized as collaboration among key stakeholder groups" (Walker, 2008b). Ensuring that all community voices are represented and heard can be a challenge. For instance, institutional and professionally trained stakeholders from education, mental health, probation, the courts, protective services, and /or welfare can eclipse the voices of representatives from culturally diverse groups and youth and families.

Therefore, the first step toward ensuring that diverse stakeholders' voices are equally heard is the formation of a governance body and adjunct committees in which a minimum of one-half of the members are from the community members, families, and youth belonging to the culturally diverse populations targeted. In CCOC, this commitment to ensuring that family and youth have a meaningful voice in this process has led to each cultural group being represented on the governance body. This included an African-American minister as chair, a Native-American youth as co-chair, and the president of the leading Hmong organization as a parent partner. In an effort to be inclusive, CCOC also has translation services using wireless headsets that are available for public meetings, trainings, and for community events.

In addition, the collaborating agencies need to ensure that other community-based cultural organizations are full partners. Community-based cultural organizations promote a culture-based emphasis within the program and thereby counteract the tendency of public agencies to carry on business as usual. As a show of commitment to these values, CCOC established a co-directorship whereby a public behavioral health agency and Native American agency each provided equal oversight for the CCOC initiative. While the former brought experience in launching large scale initiatives, the latter offered years of experience in designing services in response to the cultural needs of Native Americans, as well as the credibility needed to propagate trust among other cultural communities that theretofore had perceived themselves as being marginalized from mainstream services and resources.

Collaborative Action

Collaborative action is the practical steps that stakeholders take "to translate the wraparound philosophy into concrete policies, practices and achievements" (Walker, 2008b). Collaborative action between governmental agencies is often easier than between a governmental agency and non-traditional cultural groups and cultural organizations. When involving culturally diverse groups, leaders, family members, and organiza-

tions, it can not be assumed that the representatives possess an understanding of public agency processes. It is thus important that people from governmental agencies meet with cultural group representatives so that institutional stereotypes are dispelled, a mutual understanding of how to satisfy cultural needs is fostered, and adherence to public policy regulations is maintained. Through this process, issues that might seem challenging at first—such as inviting cultural leaders to sit in on interviews and make recommendations on the hiring of agency staff—can become standard practice. Cultural leaders and families also need time to adequately acquaint agency leaders with their respective customs and traditions, as well as to orient other cultural groups to differing practices among partners. This will serve to ensure that the cultural groups' needs are effectively addressed, and that cross-cultural communication among agencies, among cultural groups and agencies, and among cultural groups, is standard practice. In short, these strategies collectively facilitate CCOC's ability to take collaborative action with the support of all stakeholders.

Fiscal Policies and Sustainability

Fiscal policies and sustainability pertain to how the "community has developed fiscal strategies to meet the needs of children and methods to collect and use data on expenditures from wraparound-eligible children"(Walker, 2008b). To be culture-based in this area means that youth, families, staff members, and cultural leaders must have access to accurate, up-to-date financial information. More precisely, they need to actively participate in the making of financial decisions that affect budget expenditures, thus ensuring that funds are available for healing ceremonies and other cultural activities. This also means that sufficient dollars are set aside to make certain that service providers receiving CCOC funds receive training in culturally competent services and that funds are available to support internships in wraparound services or other activities that enhance short- and long-term sustainability of culture-based services. Supplemental funding may be required to sustain training and internships, along with the engagement of volunteer experts sometimes drawn from the target communities.

An important component of this process has been the CCOC family partner and youth empowerment specialist staff. Individuals occupying these positions have been certified in county-sponsored training programs that permit them to bill Medicaid (Medi-Cal in California) to support their services. Moreover, a non-profit CCOC offshoot entity has been created to provide culture-based training outside of the service area as a revenue generation strategy for supporting local culture-based services, as well as for engaging in grant writing and other fundraising activities on behalf of CCOC.

Access to Needed Supports and Services

Access to needed supports and services indicates that the "community has developed mechanisms for ensuring access to the wraparound process and the services and supports that teams need to fully implement their plan" (Walker, 2008b).

In the culture-based wraparound model, CCOC families exercise choice over the services they receive, and may elect, for example, culture-based parent education; coping and social skills training for youth embedded in cultural activities;

and counseling from culturally and linguistically matched staff members. They may also request the use of flex funds for healing ceremonies and other cultural activities, as well as access to peer support from members of their cultural group. Additionally, it is important to have a cultural competence coordinator and a cultural competence subcommittee of the governance body to ensure that these types of services and supports are available, and that they address the needs of participants.

Human Resource Development and Support

Human resource development and support relates to how "the community supports wraparound and partner agency staff to work in a manner that allows full implementation of the wraparound model" (Walker, 2008). Culture-based wraparound requires the recruitment, hiring, and retention of culturally diverse staff so that families can have the choice of working with staff members who are of their culture. CCOC staff members from the local cultural communities report being naturally drawn to culture-based wraparound due to several factors: (a) their own culture is embraced, (b) clinical consultation and supervision is provided by culturally diverse supervisors, and (c) they can effectively serve their cultural communities. To obtain the best staff, it is important to have the cultural communities actively participate in the recruitment and hiring process. In this context, cultural matching is facilitated by having family members and leaders recruit prospective candidates from individuals whom they not only know, but also have observed helping youth and families in their community. Family members and cultural leaders also participate on the hiring panels.

In CCOC, this selection process has led to the hiring of several limited-English-speaking staff who are respected elders within their ethnic communities. They are among CCOC's most effective staff as they have the trust and respect of their community. In cultural groups where many members have recently arrived in the U.S., hiring younger, more fluent English-speaking staff members is often interpreted as a failure on the part of the agency to adequately embrace the cultural values and traditions of the ethnic group in question particularly since elders are often perceived as being most knowledgeable in these matters. Indeed, in some cultural groups it may be deemed culturally inappropriate to seek advice from a young adult rather than from a respected elder.

If it is not possible for a program to hire a member from a given culture, it is still imperative that members of that cultural community participate in the hiring process. This is because they bring penetrating insight into the process of identifying individuals who possess the requisite skills to work effectively in a particular cultural milieu. However, perhaps the best way to identify superior candidates for staff positions is through responses obtained from the following questions: (a) Do the cultural communities and families trust and respect the staff member? (b) Does the staff member understand and embrace the families and cultural community? (c) Does the staff member help families to achieve their goals while embracing their culture?

Accountability

Accountability pertains to the community having "implemented mechanisms to monitor wraparound fidelity, service quality, and outcomes, and to assess the quality and development of the overall wraparound effort."(Walker, 2008b) While at the service level, wraparound teams are clearly accountable to the family, at the organizational and system levels, it is important to clearly define to whom the wraparound program is accountable, and what data and other information will be used to determine whether programmatic, collaborative, managerial, and fiscal goals are reached. In culture-based wraparound, primary accountability is to the cultural communities, their leadership, and organizations that they represent. There is also accountability to funders and participating community-based group and agencies.

While collecting quantitative data that measures fidelity to culture-based services, the wraparound process, and treatment outcomes are important, this information is sometimes difficult to interpret due to the lack of normative data on specific population groups. Furthermore, many cultural groups' internal values are not easily captured quantitatively. Conducting interviews and focus groups with culturally diverse families, and involving cultural leaders in the interpretation

of findings, are necessary steps to ensuring that cultural needs are being met. It is also of consequence to operationally define what is meant by cultural competence and culture-based processes, so that the project can assess for these elements within the context of continuous quality improvement (CQI). For example, if cultural competence is defined as the ability to interact effectively with people within a cultural context, it could be assumed that we will not see differences in outcomes across cultural groups, assuming that high quality wraparound is provided. Identifying culture-specific elements, however, and reviewing their implementation and client satisfaction, is important information for the CQI process.

Wraparound Phases

The process of culture-based wraparound implements the four phases of wraparound—engagement, initial plan development, plan implementation, and transitioning; however, within each phase there is an enhanced focus on culture. The following discussion of the wraparound phases concentrates on explicating the context of culture and implementing culture-based processes at each phase.

Phase One: Engagement Phase

The engagement phase, lasting from one to two weeks, is characterized by wraparound staff meeting with the family to explain the wraparound process, hear the family's story, explore the family's cultural preferences and strengths, and identify informal supports (e.g., people who currently help the youth and family members to thrive) (Walker et al., 2004). Explaining the wraparound process to families from cultural communities is often easy to do as the wraparound approach reflects a way of caring for youth and families that has been practiced by indigenous cultures for thousands of years (Cross et al., 2000).

Referrals for culture-based wraparound preferably come from families requesting services after hearing about the program from a family member, friend, or cultural leader. When a family is referred by someone they trust, they often approach the program with greater trust than if they are referred by an arm of the criminal justice or social services systems (e.g., the courts, probation, or child protective services). Most families in CCOC self-refer based on an informal recommendation. Families referred by local agencies are often aware of the program since CCOC hires family partners and professional members from local cultural communities. Most enrolled families in small communities are extended family members of at least one of the team members or have friends who know team members. Family members often make inquiries regarding wraparound team members in their own cultural community to determine whether these members are people whom they can trust and have the skills to help them. Therefore, it is important that every team member has the respect of the cultural community, and can act as a cultural liaison (i.e., a person who knows and understands the cultural values, supports, and treatments available to community members, as well as the educational, mental health, and social service systems in the larger community).

> *Culture is defined as the wisdom, healing traditions, and transmitted values that bind people together from one generation to another (Duran, 2006); thus, "culture-based wraparound" aligns with the healing power of culture.*

A family's first contact with CCOC is generally with a family partner from their own culture. While each of the CCOC-employed family partners has gained expertise through having a youth that has struggled in school, at home, or in the community, he or she is also selected for having strong connections and effective leadership skills in their cultural group. Many wraparound programs have discovered that involving a family partner accelerates the trust-building and engagement process. CCOC staff has also observed that having the family partner culturally and linguistically matched

to the family generally increases the speed and efficacy of trust building. Trust is exemplified when both families receiving services and CCOC team members refer to each other in such familial terms as brothers, sisters, and uncles when it is culturally appropriate. Cultural matching thus emphasizes the salient relational and trust processes that are crucial for success in the engagement phase. Cultural matching, however, does not preclude the need to discover and embrace each family's unique traditions and values that are not part of the cultural community.

CCOC's psychotherapy, family meetings, case management, counseling, parenting education, and social skills training are provided in the languages of the families -- primarily English, Hmong, and Spanish, but also available in Laotian, Mien, Thai, French, and Korean. This is because a range of potentially adverse dynamics may otherwise occur, which include: (a) information is often lost or distorted in translation; (b) services in English shift power from parents and elders to the English-speaking children (using children to translate creates family dysfunction as it increases the power of the child and often breaks cultural taboos where traditions have focused on deference and respect toward elders); (c) speaking in English for a limited-English speaker requires effort, particularly when speaking about complex and emotionally difficult problems, such as trauma, which is generally encoded and interpreted in a person's primary language and culture; and,(e) immigrant families feel further isolated and estranged from processes when translation is provided for them rather than for the English-only team members. Moreover, if psychiatric consultations or psychological evaluations are needed and the psychologist or psychiatrist is not fluent in the participant's native language, a bilingual/bi-cultural wrap-team member provides translation, including cultural information.

Phase Two: Initial Plan Development

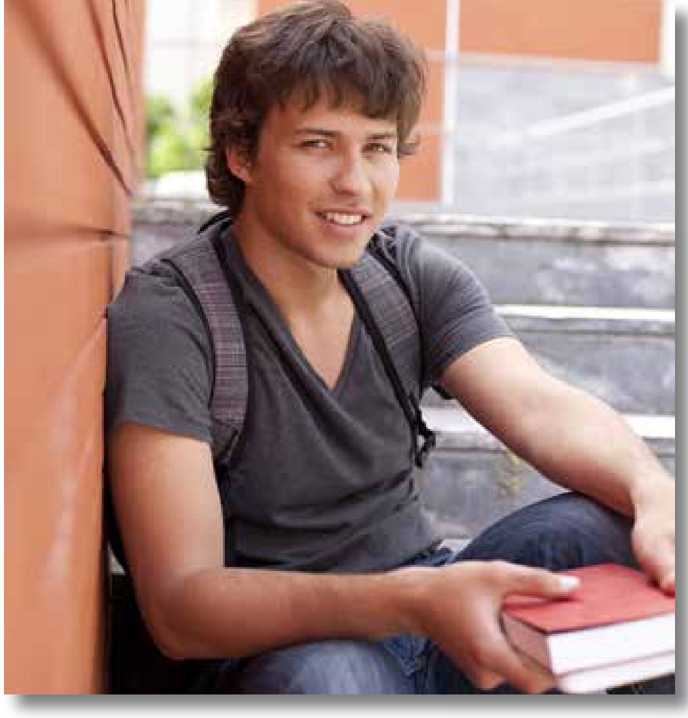
In this phase of culture-based wraparound, the family invites relatives, friends, culturally-matched CCOC staff (i.e., family partners, family support workers, and clinicians), church members, community members, probation officers, school teachers, and other supportive persons to form a wraparound team and create a family plan (plan of care). The wraparound team identifies the youth and family's strengths, challenges and-values, and the influential people in their lives. Based on this information, the team produces a family vision, develops goals to actualize the vision, and establishes action steps and services to accomplish the goals. When services are needed to reach goals, implementing culture-based wraparound requires that families have the option of culture-based services. If these services are not readily available, they need to be created. Examples of services available in a successful culture-based wraparound program can be found in the services CCOC offers:

- Ability to select culturally-matched family partners, facilitators, and clinicians for targeted cultural communities (e.g., Native American, Latino American, Hmong American, and African American);
- Mental health, family partner, and youth coordinator services, as well as wraparound facilitation, are available in languages families understand (e.g., Hmong, Spanish, and English).
- Inclusion of cultural leaders within wraparound teams.
- Cultural-based parenting education groups (e.g., Positive Indian Parenting, Southeast Asian Parent Education, Los Niños Bien Educados, and Effective Black Parenting)
- Multicultural events that honor each culture through cultural performances and community convenings (the honor of one is the honor of all)
- Flex funds available for cultural and spiritual activities (e.g., shamans and healing ceremonies).
- Culturally based activities (e.g., weekly Native American youth drumming group).
- Multicultural youth program with youth staff hired from the local cultural communities, where youth staff serve as mentors devising activities that honor the local cultures.

Phase Three: Plan Implementation

Phase three comprises the implementation of the family plan (plan of care). Family meetings

focus on reviewing accomplishments, assessing whether the plan of care has worked, adjusting action steps for goals not being met, and assigning new tasks to team members (children and families included) to reach the family's vision (Walker et al., 2004). CCOC has observed that when the plan of care is achieved, family vision and goals are strongly associated with the youth's pride in his or her cultural background, appreciation for the contributions of elders, and development of a strong connection between family and culture. For instance, a Latino child who has refused to speak Spanish to his mother shows pride after seeing her lead Latino families and other CCOC families in cooking Latino foods. He begins speaking in Spanish and taking pride in his heritage, demonstrating dramatic improvements at school and stopping his gang activity. Another example is a Native American child participating in a drum group during which he receives positive feedback from Native-American elders and from leaders outside of the Native-American community. Embracing his culture and experiencing success lead to his achieving success both at school and at home.



Phase 4: Transitioning

During this phase, plans are made for a purposeful transition from formal wraparound to a mix of formal and natural supports in the community (and, if appropriate, to services and supports in the adult system). It is important to note that the focus on transition is continual across all phases of the wraparound process in that preparation for transition is apparent even during the initial engagement activities (Walker et al., 2004), though it culminates in phase 4.

Successful transition requires a plan for the family to cope with stressors that occur after the formal wraparound process is no longer available. Though families have acquired problem-solving skills and learned how to work effectively as a team with their formal and natural supports, their skills have not been put to the test. Often, the most challenging and difficult task for transitioning families is to sustain formal and natural supports. Culture-based wraparound helps in building and sustaining community supports. CCOC helps families create a community by providing opportunities for families to develop friendships with other families in CCOC and the community (e.g., culturally-matched parenting groups, culture-specific parent education programs, multicultural youth activities, and multicultural family activities). Youth and families continue to participate in these activities even after successful graduation from CCOC, which helps to maintain cultural connections.

Integrating Wraparound into Different Cultures

A youth and a family's difficulties may reflect the trauma that the family has experienced due to past or current racism, persecution, and oppression, as well as the state of balance and well-being within their local cultural community. Many families in CCOC discover that much of the disharmony and dysfunction in their lives are related to the trauma that their family members have endured for generations, as with Native Americans and African Americans. This perspective often liberates family members to release feelings of guilt, despair, stigma, and hopelessness as they realize their problems are not self-created. By studying the strengths and healing traditions from their culture, families find new pride in their culture and in their personal identity.

Many of the families in CCOC have become isolated from their relatives, their cultural communities, and the general community. CCOC staff have observed that taking pride in their culture raises families' hope, confidence, and self-esteem, and also leads them to connect with others. Additionally, CCOC staff has found that cultural healing practices (e.g., seasonal and life-stage ceremonies) are often effective ways of healing and bringing balance to families. Successful implementation of culture-based wraparound requires that it is shaped by the specific needs of the cultural communities targeted by the program. CCOC staff members integrate wraparound services into the family's culture, rather than integrating the family's culture into wraparound. Examples of how CCOC implements culture-based wraparound services for Native American, Latino-American, African-American, and Hmong-American cultural communities are described in the following sections. While the following sections deal with CCOC's methods for tailoring its services to different cultures, this does not negate the fact that the wraparound principle of individualization demands that each family's traditions, values, and circumstances need to be explored, understood, and embraced, and used as the basis for that family's wraparound plan.

Native American Wraparound

The CCOC Native American wraparound services occur on Maidu tribal lands, though most of these lands were confiscated years ago. Trauma within the Maidu community is the result of various losses, including loss of homeland, spiritual practices (which were outlawed from 1883 to 1978), local Maidu language, federal tribal status, and family members who have been involuntarily taken away to federally-mandated boarding schools (where children were often severely abused) and to out-of-home placements through adoption or foster care. Cumulatively and individually, these losses have led many individuals and their families to develop coping mechanisms, some of which are harmful, such as alcohol and other substance abuse, antisocial behaviors stemming from distrust and fear of the dominant society, and lateral oppression (family members act out the violence and oppression they have received on other family members). Such responses have contributed to medical problems (e.g., diabetes, high blood pressure, and obesity), mental health issues, and other socioeconomic difficulties ranging from poverty to limited social connections (Duran, 2006). In turn, these issues lead to disharmony, or imbalance within the "sacred circle." Dave Chief from the Oglala Lakota Tribe explains the "sacred circle":

> *The Circle has healing power. In the Circle, we are all equal. When in the Circle, no one is in front of you. No one is behind you. No one is above you. No one is below you. The Sacred Circle is designed to create unity. The Hoop of Life is also a circle. On this hoop there is a place for every species, every race, every tree and every plant. It is this completeness of Life that must be respected in order to bring about health on this planet.*

Healthy relationships complete the sacred circle, bringing unity, harmony, and balance. Maidu basket makers, for instance, are renowned for using plants to weave baskets capable of holding water. Basket weavers begin by creating strong, balanced circular weaves using materials necessary for the basket's purpose. In this manner of creation, they gather the best materials for their endeavor, using them to create a balanced, secure basket.

Native American wraparound works similarly in helping families become part of the sacred circle. Healing often involves the family and natu-

ral supports reconnecting to cultural traditions. Outdoor activities are important to help the youth and family connect to the sacred circle. The circle becomes stronger as extended family members are added. Elders mentor the children and connect the children to the natural world. This circle is connected to other circles, such as family gatherings, powwows, ceremonies, dances, and holistic healing celebrations. The family can also connect to concentric circles of the larger community (i.e., local schools and other cultural groups). In this way, a child and family learn to live harmoniously, engulfed by a dynamic sacred circle. Maidu and Native Americans' emphasis on cultural traditions thus serve as sources of strength and motivation, and also as the wellspring from which healing unfolds.

Hmong Wraparound

The Hmong are a subgroup of Asian descent with no country of origin, but are known as strong and collective mountain tribesmen who have forcefully fought their way to become free from slavery and warfare (Yang, 1995). After the fall of Saigon, many Hmong escaped Laos due to fear of prosecution because they had assisted the U.S. during the Vietnam War, and more than one million resettled in the U.S. between 1975 and 2004. Many faced trauma, torture, rape and starvation in Laos or in refugee camps prior to leaving Southeast Asia. Due to these experiences, the Hmong community suffers from high rates of mental health disorders that include posttraumatic stress disorder, anxiety, and depression, among others (University of California Irvine Southeast Asian Archive, 1999). The Hmong's transition from a simple agrarian lifestyle based on strong cultural traditions to the fast-paced, technological industry of western culture has resulted in significant cultural adjustment issues among this population, and especially the elders (Mouanoutoua and Brown, 1995).

The Hmong culture has strong traditions that value family and clan leadership (Yang, 1995). Accordingly, it is essential to develop a strong relationship with elders and culturally competent agencies in the service area. For instance, CCOC responded to the needs of the Hmong mental health community by embracing the values and garnering respect of Hmong elders. CCOC hired an elder to be the Hmong team's family partner in recognition that this position needs to be trusted among community members so as to provide credible cultural expertise and guidance for implementing Hmong wraparound services. To additionally enhance its rapport with the Hmong community, CCOC developed a support network with the only Hmong family services agency in the region. This linkage provided the Hmong services team with cultural consultation on difficulty cases and assistance for families in obtaining bi-cultural parenting education, English as a second language classes, and assistance with accessing social services.

CCOC's approach ensures consistently incorporated culturally competent services that are effective in reducing clinical problems in youth.

Another important component of the program is the integration of cultural traditions and healing practices into the client's mental health treatment, and the education of allied providers regarding these practices. For example, the Hmong team has utilized a Hmong Shaman/Shawoman in treating mental health difficulties through hand tying and soul calling ceremonies. And, CCOC's Hmong staff has been instrumental in educating school personnel and medical providers about Hmong cultural healing practices.

Latino-American Wraparound

"La familia" and "la comunidad," which means family and community, are central elements of the Latino culture, which includes its language (Spanish or Indian dialect), traditions, folklores/mythology, music, food and religious or spiritual affiliation; all of which are fundamental

for family norms to be transmitted from one generation to the next. The Latino families served by CCOC are predominately from family systems that have ceased to bond and prosper due to assimilation, acculturation, severe trauma associated with violence in the home, strict male patriarchy (machismo), ongoing immigration-related legal issues, and traumatic deportation history. Although migration experiences to the U.S. may be similar, each family has its own story that often reflects painful generational traumas. Situations leading to immigration from Mexico and Central America include poverty, political persecution, drug cartel wars, the hope of a better future for children, and limited job opportunities. When Latino families experience mental health problems or alcohol and substance abuse issues, or engage in gang behaviors or experience violence within the home, the result can be shame and embarrassment for family members, ostracism from their religious community, and the fracturing of the family system.

CCOC assists Latino youth and families to integrate the past with the present, to reclaim their heritage, and redefine family roles with a positive, strength-based approach. There may be monolingual Spanish-speaking parents trying to communicate with their first generation English-speaking child who speaks and understands limited Spanish. Although parents are often proud to say that their child speaks English, they are grieved over the communication difficulties this creates in the family system and over the way it impedes cultural bonding within the family and community. There is a severe level of segregation in these family systems between the parents and children, a deep level of denial, and often resignation that the fracturing of the Latino family system is necessary to achieve the American dream. CCOC wraparound works with each family and incorporates Latino folklore/mythology, traditions, food, music, and religious or spiritual affiliation to help define what la familia and la comunidad means to them. CCOC also helps families focus on reclaiming their mental health, family unity, and cultural pride. One of the simplest, and yet most effective interventions is having la familia sit together for a meal and start the integration of the past (family stories, folklore/mythology) with the present (education and opportunity).

Integrating la comunidad is also vital for the healing of the family, as well as creating or strengthening support systems for each family. La comunidad is often inclusive of the extended family, including individuals who are not blood relatives (i.e., godparents, religious or spiritual community members, neighbors or friends from the same country of origin). They offer important emotional and cultural support systems for the family. CCOC strives to create within each family the opportunity to develop new traditions, to preserve traditions, to pay respect to past generations, to instill cultural pride, to promote emotional well-being, and to find a balance between the new and the old ways so that the Latino family system experiences la comunidad and la familia.

African-American Wraparound

Most African-American community members in the region are descendants of Africans who were forcibly removed from their homeland and enslaved in America. Many African Americans experienced forced separation of family members in slavery. After the civil war Black Codes and Jim Crow laws continued to break up African-American families. Many African-American families came to northern California for the assurance of good jobs associated with public construction projects, with the State promising an economic boom for the region. Unfortunately, this economic boom did not materialize and the African-American families that located for employment were left without local jobs. Many leaders and gifted members of the community moved again for higher paying jobs in other areas, separating families and relegating those remaining into poverty. Many local African-American families have for generations been subject to trauma, led disrupted family lives and struggled with low paying dead-end jobs. The experience of racial discrimination—actual or perceived—leads to lower levels of mastery and higher levels of psychological distress (Broman, Mavaddat, & Hsu, 2000). Some males respond to trauma and other stressors through aggressive and angry behaviors towards self and others or by using drugs. Amid difficulties of coping, and with bouts of anger, some males engage in illegal behaviors for which they are apprehended and incarcerated, further fracturing the African-American family.

Throughout its history, the mental health field has often pathologized religious or spiritual individuals (Bergin & Jensen, 1990). Nevertheless, reaching the African-American community usually involves collaborating with African-American churches. Many African Americans have used their church as a major coping mechanism in handling the often overwhelming pain of racial discrimination (Billingsley, 1994). Acknowledging this, CCOC has established strong participation of African American pastors on its governance body, including one who served as its president. Of the four African-American staff employed by CCOC, two are pastors and another is a pastor's daughter.

The African-American team incorporates the conceptual framework of the rites of passage, developed by Ron Johnson, Executive Director of the National Family Life and Education Center in Los Angeles. Rites of passage programs have gained popularity in many African-American communities as a way of developing a positive African-American identity in young male and female adolescents (Harvey, 2001). The rites of passage are based on meeting different developmental tasks from a biblical framework and African ceremonies. The 10 rites are: (a) personal; (b) emotional; (c) spiritual; (d) mental; (e) social; (f) political; (g) economic; (h) historical; (i) physical; and (j) cultural. The rites of passage personal domain says, "Life can seem hard and unfair, but our ability to Love, struggle and overcome obstacles produces the fruit of our labor and gives us the Faith to go on." The African-American team uses a faith-based approach that has arisen over the centuries of struggling to overcome persecution and legal obstacles to find personal, communal, and spiritual liberation. Families' struggles are discussed in relation to how they mirror the struggle of people in the Bible, as well as African Americans before and after emancipation. CCOC families draw strength from these references, and gain inspiration, insight, and resolve.

Outcomes of Cultural-Based Wraparound

A preliminary look at outcomes suggest that CCOC's approach ensures consistently incorporated culturally competent services that are effective in reducing clinical problems in youth. As part of the Cultural and Linguistic Competence Implementation Sub-study of the National Evalu-

Figure 1. Caregiver Ratings of Provider Cultural Sensitivity

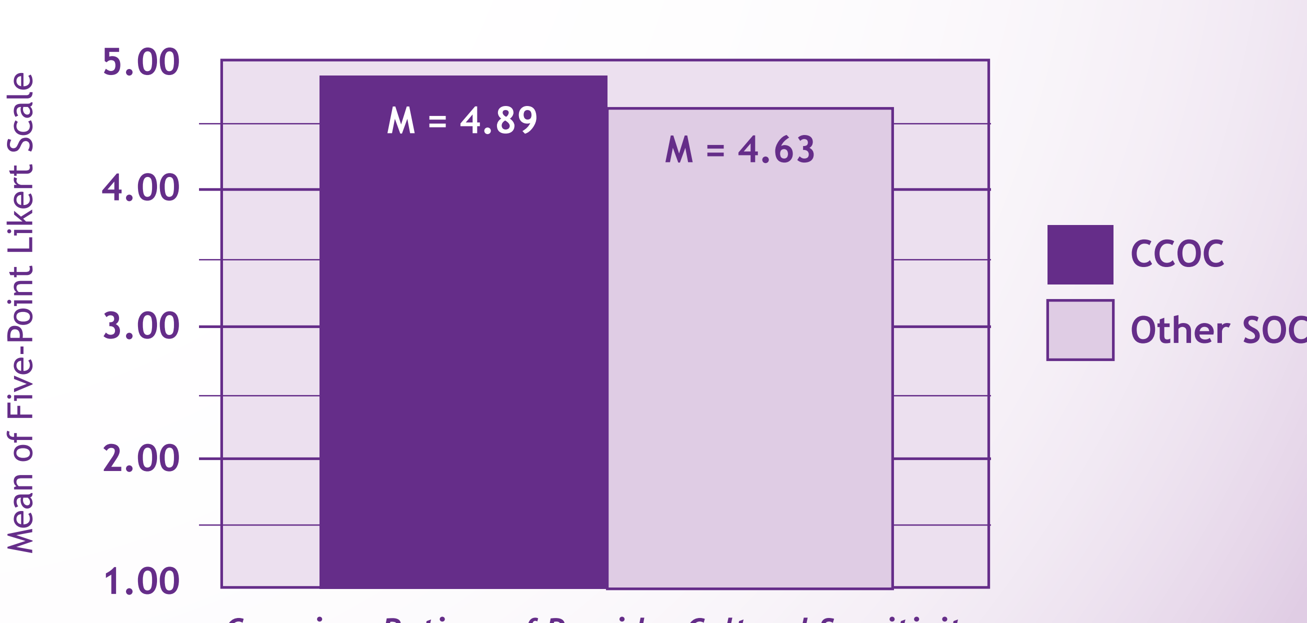
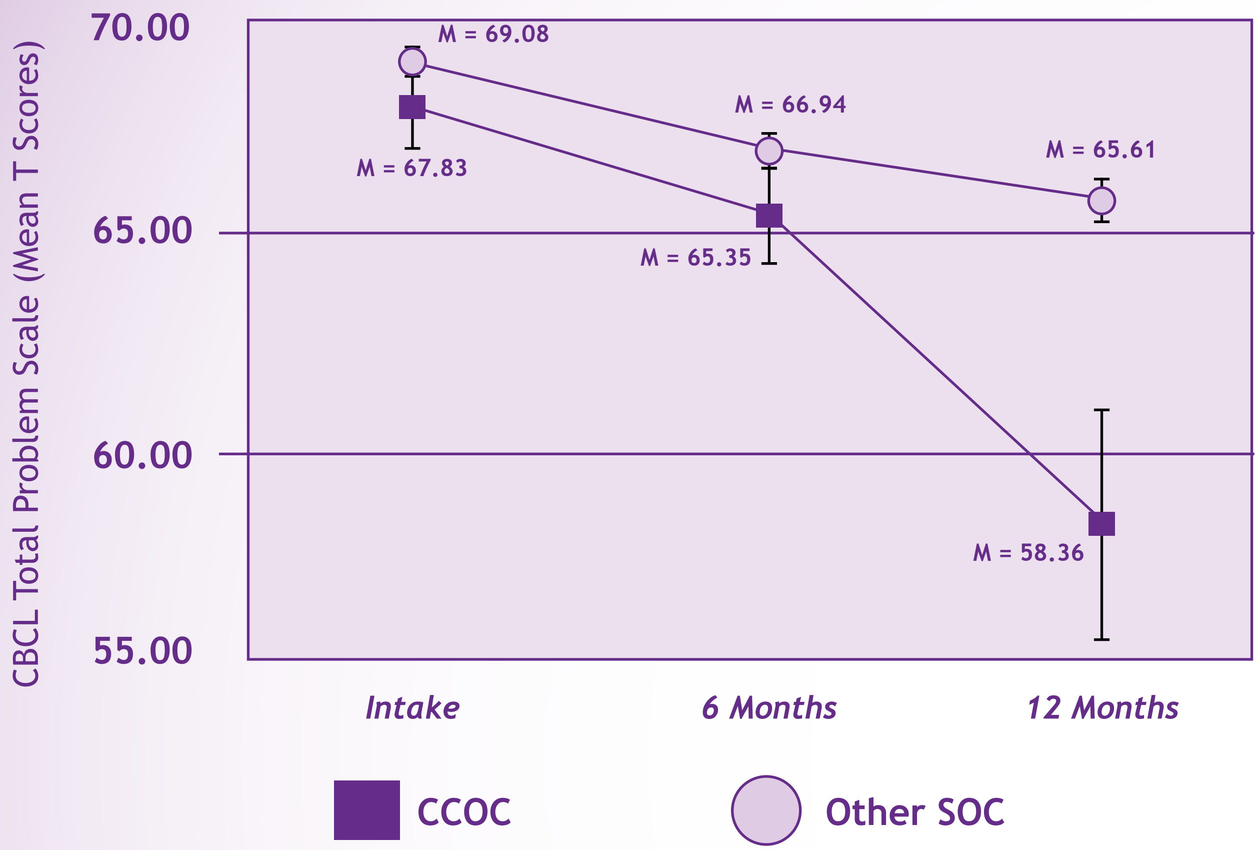


Figure 2. Total Problem Scale



ation conducted by Walter R. McDonald & Associates (WRMA), and ICF Macro (Macro 2009), CCOC families reported high satisfaction with cultural sensitivity and clinical services. WRMA and Macro (2009) also found that CCOC wraparound teams:

> *create an environment of safety, positive regard, and nonjudgmental support underpinned by the cultural beliefs and tradition of each community. Respondents reported services were delivered in the language and from the cultural belief system of the family member.*

CCOC participates in the National Evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program of SAMHSA funded systems of care grantees. CCOC youth and families are given the option of enrolling in the longitudinal study of the National Evaluation, which allows for the comparison of CCOC to other system of care grantee sites funded by SAMHSA. The study includes a Cultural Competence and Service Provision Questionnaire of 10 items that measure the cultural sensitivity of the primary service provider as reported by the youth's caregiver. The questionnaire uses a five-point Likert-type format ranging from 1 (never) to 5 (always). An aggregate mean score is created to produce a provider cultural sensitivity quotient. Mean CCOC scores were compared to those of 29 other system of care funded communities. At 12 months of service, the scores for CCOC compared with other system of care funded communities were significantly higher for provider cultural sensitivity (Figure 1; $t(33.7) = 4.59$, $p < 0.001$).

A second measure, the Child Behavior Checklist (CBCL; Achenbach, 1991) also suggests that CCOC outcomes are superior to average improve-

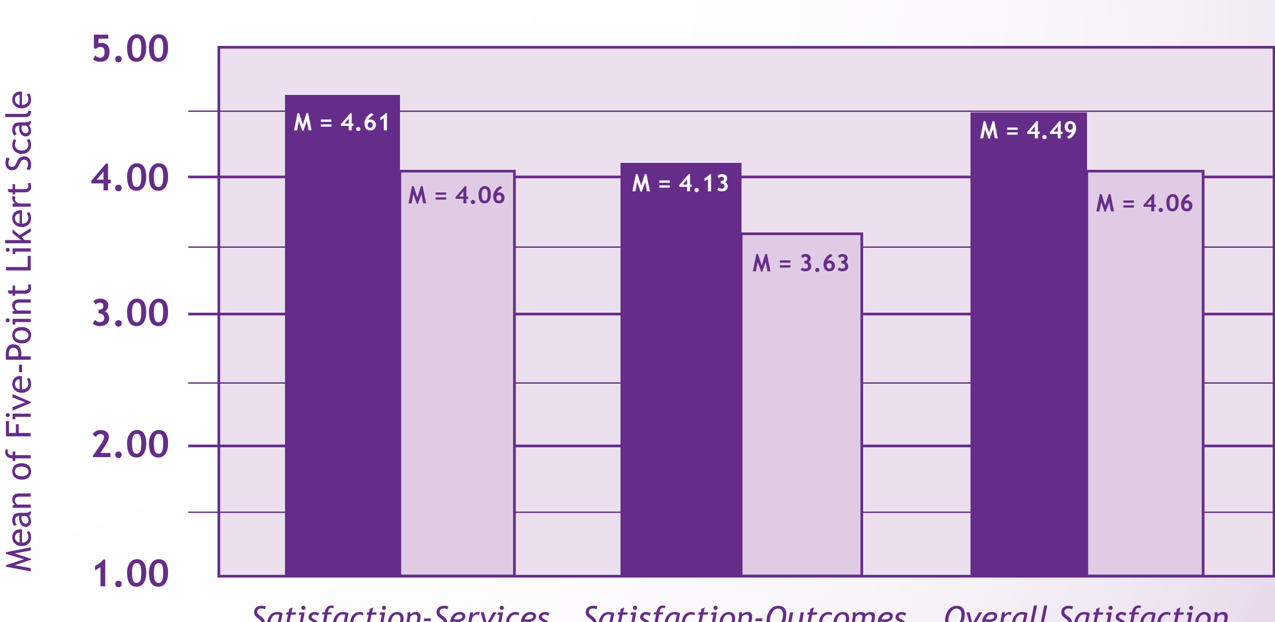
ments achieved in other sites based on mean score differences. The figure below illustrates that although CBCL Total Problem Scale for CCOC was similar to those of cohort communities at the time of intake, youth reassessed after 12 months in CCOC show fewer problem behaviors compared with other systems of care sites for a comparable 12-month period. The difference between CCOC and other sites is substantial (more than one standard deviation) and statistically significant for the Total Problem Scale (Figure 2, $t\ (27.7) = -2.43$, $p = 0.022$).

In addition to high scores in cultural sensitivity and greater reduction in problem behaviors, caregivers of youths enrolled in CCOC also report higher satisfaction with CCOC services compared with average satisfaction scores across caregivers at other systems of care sites. Satisfaction with services was measured by the Youth Services Survey for Families (YSS-F; Brunk, Koch, & McCall, 2000), which assesses satisfaction with services and outcomes, and produces an overall satisfaction score. As shown in Figure 3, CCOC was statistically higher for each scale of the YSS-F at 12-months compared to the mean of other systems of care sites, suggesting that culture-based wraparound services may contribute to higher service satisfaction levels (Services, $t\ (38.0) = 7.14$, $p < 0.001$; Outcomes, $t\ (33.2) = 4.61$, $p < 0.001$; Overall, $t\ (35.2) = 6.06$, $p < 0.001$).

Results of Youth Satisfaction Survey (Family)

Additionally the Wraparound Fidelity Index v. 4.0 (WFI) was used to assess wraparound fidelity across the four racial and cultural groups (Bruns & Walker, 2008). CCOC overall scores were above national means, which suggests that it is possible to provide culture-based wraparound without losing fidelity to the wraparound process.

Figure 3. Parent Satisfaction: CCOC Vs. Other SOC



Implications and Limitations

The culture-based wraparound model designed by CCOC is intended to establish a higher standard for cultural competence in wraparound implementation. The preliminary results from this small cohort of youth and their families are promising. Findings from this review suggest that a culture-based wraparound program is responsive to personal preferences of racially and culturally diverse youth and their families, and may contribute to greater reductions in problem behaviors coupled with higher caregiver satisfaction compared to non-culture based programs. The WFI results also suggest that it is possible to establish culture-based processes while maintaining fidelity to the wraparound model.

Additionally, independent program evaluations for cultural competence have found CCOC to be reaching its clinical and programmatic objectives. Conclusions drawn from these findings are limited, however, in that systems of care comparison data represents a range of interventions that while including wraparound services, also includes intensive case management and other modalities.

The statistical differences in results between CCOC and other SAMHSA System of Care sites also could be a result of extraneous factors, such as simply having a high quality wraparound program, rather than having incorporated higher standards for cultural competence at the organizational and service delivery levels. Other possible factors include CCOC's comprehensive approach to community engagement, its awareness of intergenerational and historical trauma, its explicit reference to spirituality, or the higher premium that it may place on relationships and trust building with families. This being said, additional research as to the benefit of infusing cultural competence into wraparound programs serving youth from diverse cultures is worthy of continued exploration, as well as the influence of other programmatic and thematic elements that transcend specific cultural groups.

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Theory and Research: Chapter 3.1

How, and Why, Does Wraparound Work: A Theory of Change

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Wraparound has always had implicit associations with various psychosocial theories (Burchard, Bruns, & Burchard, 2002; Burns, Schoenwald, Burchard, Faw, & Santos, 2000); however, until recently only preliminary efforts had been undertaken to explain in a thorough manner why the wraparound process should produce desired outcomes (Walker & Schutte, 2004). Using the foundation supplied by the specification of the principles (Bruns et al., 2004) and practice model (Walker et al., 2004) of wraparound, the National Wraparound Initiative (NWI) has proposed a more detailed *theory of change* to describe how and why wraparound works.

Figure 1 (see following page) provides an overview of this theory. Beginning at the left, the figure illustrates how, *when wraparound is "true" to the principles and practice* described by the NWI, the result is a **wraparound process** with certain characteristics. Moving across the figure to the right, the various boxes summarize the short-, intermediate- and long-term **outcomes** that are expected to occur. The figure illustrates with arrows several "routes" by which the wraparound process leads to desired outcomes.

It is important to remember, however, that this figure is a highly simplified representation of an extremely complex process. The various routes to change described here are not independent. They interact with and reinforce one another. Furthermore, the changes that emerge as a result of wraparound do not come about in a linear fashion, but rather through loops and iterations over time. Thus, an intermediate outcome that apparently emerges from one of the various "routes" may stimulate or reinforce a short-term

Figure 1. A Theory of Change for Wraparound: Overview

Ten principles of the Wraparound Process

Phases and Activities of the Wraparound Process

A wraparound process characterized by:

- High-quality planning and problem solving
- Respect for values, culture, expertise
- Blending perspectives/ Collaboration
- Family-driven, youth guided goal structure and decisions
- Opportunities for choice
- Individualization
- Evaluation of strategies
- Recognition/ Celebration of success

Short-term outcomes:

- Follow-through on team decisions
- Service/support strategies that "fit"
- Service/ support strategies based on strengths
- Improved service coordination
- High satisfaction with/ engagement in wraparound
- Experiences of efficacy and success

Intermediate outcomes:

- Enhanced effectiveness of services and supports, individually and as a "package"

Intermediate outcomes:

- Increased resources and capacity for coping, planning, and problem solving
- Self-efficacy, empowerment, optimism, self-esteem
- Social support and community integration
- Achievement of team goals

Long-term outcomes:

- Stable, home-like placements
- Improved mental health outcomes (youth and caregiver)
- Improved functioning in school/ vocation and community
- Program-specific outcomes
- Achievement of team mission
- Increased assets
- Improved resilience and quality of life

outcome that promotes changes through a different route. Finally, because wraparound is a highly individualized process, the various "routes" to change outlined here will operate to a different extent with different families and youth. After discussing the characteristics of the wraparound process and the main theoretical routes or mechanisms of change, we will offer some specific examples of this complexity.

Process: Effective, Value-Driven Teamwork

The theory assumes that, when wraparound is undertaken in accordance with the principles and the practice model specified by the NWI, the result is an effective team process that capitalizes on the expertise and commitment of all team members while also prioritizing the perspectives of the youth and family. Various strands of research provide a rationale for why this should be the case.

Research on teamwork across many different types of contexts provides strong evidence about what makes teams likely to be effective in reaching the goals they set for themselves. Specifically, a team is more likely to be successful when team members have decided on an overall, long-term goal or mission for the team (Cohen, Mohrman, & Mohrman, 1999; West, Borrill, & Unsworth, 1998), and when team members have clearly defined a set of intermediate goals specifying the major strands of activity that need to be undertaken to reach the long term goal (Latham & Seijts, 1999; Weldon & Yun, 2000). With this goal structure in place, effective teams work carefully to choose strategies for reaching the intermediate goals.

It is crucial that teams structure strategy selection deliberately, and that team members consider several different strategies before choosing one (Hirokawa, 1990; West, Borrill, & Unsworth, 1998). Research on collaborative problem solving clearly shows that groups and teams have a propensity to jump to strategies and solutions too quickly, without considering a range of options. Generating several options before choosing one is important for at least two reasons. First, options that are generated first tend not to be of as high quality as those generated subsequently; and second, the process of generating options helps team members gain a clearer understanding of the "problem" to be solved. Working through options in this manner enables groups and teams to be more creative and competent than individuals working separately at solving complex problems (Hirokawa, 1990; O'Connor, 1998; West, Borrill, & Unsworth, 1998).

Once strategies have been selected, effective teams set and use clear, objective criteria for judging whether or not the strategies are helping the team reach its goals (Cohen & Bailey, 1997; DeNisi & Kluger, 2000). Using these criteria, the team can then monitor whether or not a strategy is working, and can replace unsuccessful strategies with different ones. Finally, team effectiveness is also enhanced when teams acknowledge and celebrate success (Latham & Seijts, 1999).

The NWI's practice model for wraparound (Walker et al., 2004) prescribes activities consistent with the elements of effective teamwork described above. Teams must develop a team mission or family vision for the future (long-term goal) and prioritize a small number of needs or goals (intermediate goals) to work on. They generate options and select strategies, which they monitor regularly using indicators of success. When strategies are not working, teams are to select and then monitor different strategies. The principles of wraparound (Bruns et al., 2004) add further expectations to the process of developing goals and strategies. For example, the principles specify teams should focus on developing community- and strengths-based strategies for the plan. These criteria are specific to wraparound (as compared to teams generally), but are easily accommodated within a framework of practices associated with effective teamwork.

Not surprisingly, there is more to team success than simply having these elements of effective planning in place. Other research points for the need for teams to be collaborative—for team members to share the same goals and to feel that their perspectives have an impact in the decision-making process. Collaborativeness is enhanced when teams have clear expectations for how members should interact (Cohen, 1994; Cohen & Bailey, 1997), and when decision making is equitable (Beugre & Baron, 2001; Cohen & Bailey, 1997; Korsgaard, Schweiger, & Sapienza, 1995). Collaborative teams are more effective

than teams whose members do not feel invested in the team goals (Beugre & Baron, 2001; Cohen & Bailey, 1997; Korsgaard, Schweiger, & Sapienza, 1995; Tjosvold & Tjosvold, 1994). Team members who feel that their perspectives are not respected during the decision-making process tend not to follow through on tasks that the team asks of them, thus making the team as a whole less effective (Cropanzano & Schminke, 2001; Kim & Mauborgne, 1993).

Within wraparound, the principles call for a special sort of collaboration. The principle on collaboration emphasizes the general idea that the wraparound process should be characterized by a sharing and blending of perspectives such that all team members feel that their ideas and expertise are respected. Additionally, however, the principles further specify that the wraparound process is driven by family and youth "voice and choice." Essentially, this means that the perspectives of the youth and family are to have a greater impact on the wraparound process than other perspectives, and the youth and family must have the opportunity to make choices about the goals and strategies included on the plan. The principles also specify that the wraparound team should learn about the values, culture, and strengths of the youth and family and incorporate these into the goals and strategies for the plan. Various activities in the wraparound practice model are intended to reinforce this special form of collaboration; however, skilled facilitation, including a knowledge of group processes and participatory decision making, is essential to make this family- and youth-driven form of collaboration come to pass (Walker & Shutte, 2004).

The wraparound team should learn about the values, culture, and strengths of the youth and family and incorporate these into the goals and strategies for the plan.

In sum, when the wraparound process is carried out with fidelity to the principles and the practice model, it is an engagement and planning process that promotes a blending of perspectives and high-quality problem solving, and is thus consistent with empirically supported best practices for effective teamwork. Additionally, the wraparound process is driven by the perspectives of the youth and family. The team learns about youth and family values, strengths, and culture and actively uses this information in the planning process. Youth and family members also have the opportunity to make choices about the goals and strategies for the plan. These essential characteristics of such a wraparound process are summarized in the larger box at the left of Figure 1.

Routes to Outcomes

High-quality wraparound teamwork is characterized by collaboration and blending of perspectives, creative problem solving, and respect for each team member's expertise and background. As noted above, teams that adhere to best practices tend to come up with good solutions to problems, and team members are likely to follow through on decisions that the team makes. Adherence to these best practices thus is expected to directly promote "achievement of team goals" (shown as an intermediate outcome in Figure 1) and, ultimately, "achievement of team mission" (shown as a long-term outcome).

Because the mission and goals[1] in wraparound are selected by youth and family, it is assumed that achieving these goals will contribute to improved family quality of life, as well as other long term outcomes. Wraparound's underlying philosophy also makes it likely that certain particular types of goals will be included in the plan, and that outcomes reflecting these goals will be part of the plan. For example, the wraparound principle of

1. There are variations in terminology for certain elements of wraparound plans. Some wraparound trainers and programs emphasize a "*family long-term vision*" (rather than a team mission) as the central long-term outcome for the wraparound process. Similarly, identifying and prioritizing *needs* (rather than goals) sometimes represents the intermediate steps on which a team focuses its efforts.

"community based" stresses the importance of promoting family and youth/child integration into home and community life. This principle (which usually reflects family and youth priorities anyway) means that wraparound plans are often focused on increasing stability in relationships and living situation, and helping the youth and families live and thrive—just like their more typical counterparts—in their homes, communities, and other "natural" settings. Similarly, the principle of "strengths based" encourages teams to create goals or missions that reflect building family and youth/child assets, capacities, and resilience. Thus the wraparound team effort will generally include, if not prioritize, these general areas, and related outcomes will be realized through the various routes to change described below.

Additionally, team goals and mission are likely to be significantly influenced by the expectations for the specific wraparound program. This is because wraparound programs or initiatives are typically designed to meet particular needs of their target populations and since agency representatives will bring into the wraparound process perspectives that reflect the goals of the agencies and organizations that sponsor the program. Thus, for example, wraparound teams that are sponsored through a child welfare agency almost always include a focus on child safety, and wraparound that is implemented with youth with co-occurring disorders will likely include a focus on treatment for substance use.

Beyond this general result of achieving team goals, a faithfully implemented wraparound process can be expected to lead to desired outcomes through two main routes (illustrated by the two separate boxes labeled "intermediate outcomes" in Figure 1). In one of these routes, key features of wraparound process contribute to **enhancing the effectiveness of the services and supports** included in the plan, thus promoting desired outcomes. The second route highlights how increasing family and youth/child empowerment, optimism, and efficacy leads directly to positive outcomes (i.e., independently of therapeutic services/supports provided in the plan) by **developing capacity and resources for coping, planning and problem-solving**. As noted above, these routes are not independent from one another, and outcomes of different types may have impact on other outcomes and through several routes. After we describe the main routes, we will provide some examples to illustrate these interactions and iterations.

Enhancing the Effectiveness of Services and Supports

One of the main routes to outcomes proposed in this theory is that using the wraparound process to select and organize services and supports actually enhances the effectiveness of the chosen service/support strategies. For several reasons, the wraparound process is expected to lead to relatively high levels of youth and family motivation to fully engage in, and continue with, the services and supports that are included in the wraparound plan. Engagement and retention are perennial challenges in the delivery of children's mental healthcare, and this is particularly true for children with the most severe problems (Kazdin, 1996). No-show rates to first appointments range from 15-35%, and families who initiate treatment have been shown to drop out prematurely at rates as high as 60% (Morrissey-Kane & Prinz, 1999). Not surprisingly, outcomes for children's mental healthcare tend to be better when families are engaged and retained in services (Huey, Henggeler, Brondino, & Pickrel, 2000; Tolan, McKay, Hanish, & Dickey, 2002).

Choice and motivation. Within wraparound, decisions about what services and supports to access are made on the basis of family and youth

voice and choice. There is a wealth of research that compares the experiences of people who feel they are acting by their own choice and those who feel that they are externally controlled. People who feel they have chosen an activity or option tend to have more committed to the course of action and to have more success. (See the review in Ryan and Deci, 2000.) This result has also been found for people who are part of groups or teams.

People who feel included as part of a decision making process are more likely to follow through on their roles in the team plan (Maddux, 2002). Thus the collaborative, family-driven process of determining needs and selecting and monitoring strategies can be expected to lead to relatively high levels of youth and family commitment to the services and supports that are selected for the plan.

Relevance and feasibility. Additionally, the wraparound process works carefully to match services and supports with needs (as defined by the youth and family). This increases the likelihood that families and youth will find the individual services and supports, as well as the total "package" of services and supports in the plan, relevant and feasible. Parent perceptions of the relevance and feasibility of treatment has been linked in several studies to better outcomes from treatments (Kazdin, Holland, & Crowley, 1997; Morrissey-Kane & Prinz, 1999). Perceptions of service relevance and feasibility may be particularly important for families from minority populations, and thus participation in wraparound, with its careful attention to community-based and family-driven care and overall cultural competence, may be particularly valuable for them (Morrissey-Kane & Prinz, 1999). Finally, since the entire wraparound plan emerges in a structured way from youth and family perspectives, the wraparound process should result in family and youth perceptions of service coordination. Perceptions of greater coordination of services and supports have been linked to improved retention in services and enhanced outcomes (Bickman, Lambert, Andrade, & Penaloza, 2000; Glisson, 1994; Koren et al., 1997).

Shared expectations. Wraparound teams select service and support strategies to meet specific needs, and the success of a strategy is determined by how it impacts objective indicators of success that the team has chosen. Thus the team establishes clear, shared expectations for treatment—what it's for, what outcomes are anticipated—that can be shared with service providers. Often, providers become members of the wraparound team, and are thus part of the collaborative effort to define the purpose of service/support strategies. Even when providers do not join the core team, the team often facilitates communication with providers, aimed at clarifying the purpose of services and the criteria by which the success of the service/support is judged. There is evidence supporting the proposition that having shared parent-provider expectations for treatment increases the likelihood that parents will be engaged in/continue with treatment for their children (Morrissey-Kane & Prinz, 1999; Spoth & Redmond, 2000).

Similarly, there is clear evidence that shared client-provider expectations about treatment (as should be the case when children and youth are involved in making decisions for their wraparound plans) also contributes to treatment effectiveness (Dew & Bickman, 2005). Taking this line of reasoning one step further, there is also reason to expect that wraparound will enhance treatment effectiveness when, as often happens in wraparound, the team works with providers to tailor the services and supports to better fit child/youth and family needs. There is evidence that retention in and outcomes from mental health treatment interventions are enhanced when treatment is modified to reflect family concerns and needs (Morrissey-Kane & Prinz, 1999; Prinz & Miller, 1994).

Strengths-based understanding of behavior.

The wraparound process models and communicates a strengths-based understanding of difficult or troubling behavior to team members, including youth and families. This helps youth and families to see that behavior is malleable, rather than dispositional, which in turn increases motivation to engage in therapeutic interventions and contributes to improved outcomes from intervention (Morrissey-Kane & Prinz,1999).

Whole-family focus. Wraparound may also impact service/support engagement, retention, and outcomes by virtue of its focus on the needs of the family as a whole. Providing support to whole family, particularly mothers, appears to improve treatment initiation/retention and outcomes (Morrissey-Kane & Prinz, 1999).

Capacity and Resources for Coping and Planning

This route to change highlights wraparound's potential to increase family and youth resources and capacities related to planning, coping, and problem-solving. These resources and capacities are seen as contributing directly to positive long-term outcomes. In other words, these outcomes may arise directly from participation in wraparound, and do not result only from participation in services and supports (though services and supports may also contribute to these outcomes). These long-term outcomes include increased resilience and developmental assets, higher quality of life, improved mental health, and increased ability to initiate and maintain heath-promoting behavior change.

Self-efficacy, empowerment, and self-determination. The experiences of making choices and of setting and reaching goals contribute to the development of key human capacities of self-efficacy, empowerment, and self-determination. In fact these three constructs are interrelated, and have at their core the sense of confidence that people have about their ability to overcome obstacles in their lives and to reach goals they set for themselves (Snyder, Rand, & Sigmon, 2002). People develop these capacities in large part because of having successful experiences of achieving personally meaningful goals. Increases in self-efficacy, empowerment, and/or self-determination arise from several types of situations that are central parts of the wraparound process: participating actively in planning, directing services and supports, making choices, and experiencing success in reaching personally meaningful goals (Byalin, 1990; Curtis & Singh, 1996; Foster, Brown, Phillips, Schore, & Carlson, 2003; Maddux, 2002; National Council on Disability, 2004; O'Brien, Ford, & Malloy, 2005; Worthington, Hernandez, Friedman, & Uzzell, 2001). While much of this research focused on adults, similar findings have emerged from the smaller body of research with children and adolescents (Peterson & Steen, 2002), including specifically those with emotional, behavioral, cognitive, learning, and other disabilities (Chambers et al., 2007; Wehmeyer & Palmer, 2003; Wehmeyer & Schwartz, 1997).

People who are more optimistic experience a variety of positive mental health outcomes, and hope is strongly linked to successful psychiatric recovery among adults with serious mental illness.

There is robust research showing that people who believe that they can achieve the goals they set for themselves experience a variety of positive outcomes, including a variety of outcomes related to mental health and well-being. People with higher self-efficacy tend to be more optimistic and hopeful, and they persist and try harder in the face of obstacles (Maddux, 2002; Ridgway, 2004; Snyder, Rand, & Sigmon, 2002). In turn, people who are more optimistic experience a variety of positive mental health outcomes, and hope is strongly linked to successful psychiatric recovery among adults with serious mental illness (Ridgway, 2004; Russinova, 1999; Snyder, Rand, & Sigmon, 2002). More generally, people who believe they can solve problems in their lives have better general mental health and well-being, and they are more likely to avoid depression (Heppner

& Lee, 2002; Maddux, 2002, Russinnova, 1999, Snyder, Rand, & Sigmon, 2002; Thompson, 2002).

In general, people with higher self-efficacy cope better with stressful life circumstances. They are also more likely to take action to protect their health, to adopt new, healthy habits, and to maintain behavior change (Maddux, 2002; Thompson, 2002). Children and adolescents who are trained in problem-solving have more optimism and avoid depression (Peterson & Steen, 2002). Adolescents who are optimistic tend to do better in school and college, abuse drugs less, are less angry, have better health and fewer social problems including fewer externalizing problems (Roberts, Brown, Johnson, & Reinke, 2002).

Social Support. Social support is seen as an important resource that aids people's efforts to deal with stress and adversity. There is a large body of research that demonstrates that people who are involved in supportive social relationships experience benefits in terms of their morale, health, and coping (Cohen, Underwood, & Gottlieb, 2000; Cutrona & Cole, 2000; Walker, 2006). Conversely, low levels of social support have been repeatedly linked to poor physical and mental health outcomes. A common element of models of community-based mental healthcare—including wraparound—is the emphasis on strengthening youth and family ties to supportive people within the family's social environment (Cox, 2005). Within wraparound, the inclusion of family friends, neighbors, and acquaintances on the wraparound team represents an important effort to create and strengthen social support.

This theory of change includes the hypothesis that increasing social support contributes to the positive outcomes mentioned above. Some studies document the role of social support in recovery from psychiatric difficulties or general life troubles (Ridgway, 2004; Werner, 1993; Werner, 1995), and participants in wraparound anecdotally report that the social support offered through the team and its work is an important part of wraparound's positive impact in their lives. However, to date, there is a lack of definitive research showing that increasing social support for people who lack it actually leads to positive outcomes (Walker, 2006).

Conclusion: The "Positive Spiral" of the Wraparound Process

The dynamic complexity and the looping, iterative nature of the wraparound process is most obvious in the planning process itself, with the child/youth and family, together with the rest of the team, participating in an iterative process of creating, implementing, evaluating, and adjusting successive versions of the wraparound plan. The looping nature of change—and interactions between the various "routes" to change—play out in other ways as well, for example, as improved coping and problem solving contribute to increased self-efficacy, which in turn leads to more opportunities to experience success within the wraparound process, which in turn reinforces self-efficacy.

In this way, wraparound produces a sort of "positive spiral." Since people with higher self-efficacy are better able adopt and maintain healthy behaviors and behavior change, and to apply what they have learned from treatment (Maddux, 2002), it can be expected that increases in self-efficacy enable families and youth to profit more from therapy and other services and supports. Conversely, people who experience less stress feel more self-efficacy, so people for whom services and supports are working could be expected to contribute more actively and confidently to the wraparound process in general. Parents who have more optimism are more likely to engage in services (Morrissey-Kane & Prinz, 1999); thus increasing self-efficacy and empowerment through the wraparound process represents another route to making services more effective.

Essentially, wraparound can be seen as a driver of a positive, change-promoting spiral that reinforces itself through multiple mechanisms or routes. This seemingly fortuitous confluence of positive impacts occurs not so much because discrete activities or elements of the wraparound philosophy just happen to reinforce one another, but because the whole "package" of wraparound springs from a single, coherent posture or mode of helping that is fundamentally respectful, optimistic, and empowering. The diagram and explanations presented here are thus simultaneously both too simple and too complicated to explain how and why wraparound can be expected to work.

Nevertheless, this theory has clear implications for practice, quality assurance, evaluation, and research. For practice, the theory highlights the importance of adherence to the principles and practice model, since outcomes are predicated on fidelity. For quality assurance, then, measurement of fidelity is essential. Additionally, programs would likely benefit from assessing other key indicators that gauge how well the various "routes" appear to be functioning. Thus, programs might want to consider monitoring plans or assessing team cooperativeness or cohesiveness (for evidence of high quality teamwork and collaboration); assessing family and youth perceptions of service relevance, helpfulness, or coordination (for evidence that the "enhancing the effectiveness of services" route is functioning); and measuring family and youth empowerment, self-efficacy, and/or optimism (for evidence that the "capacity and resources for coping" route is operating).

The most obvious implications of the theory for program evaluation have to do with relevant outcomes. To begin with, the theory places a high level of importance on outcomes that are not often measured in human service contexts. These include the intermediate outcomes mentioned above, as well as long-term outcomes such as quality of life or assets. The theory suggests that evaluation that does not include these outcomes may well understate the effectiveness of wraparound, since these outcomes reflect the potentially profound impacts that wraparound can have in the lives of children, youth, and families. Additionally, the theory highlights the fact that wraparound, because it is an individualized process, will not always be focused on achieving the same outcomes. Prioritized outcomes will vary not only from program to program, but within programs as well. Sometimes the outcomes that are the main focus of a team's attention will be those that are commonly found on wraparound plans—stability of living situation, academic/vocational progress, etc.—but sometimes the most highly prioritized outcomes may be completely unique to a particular child and family. Again, this points to the need for program evaluation strategies that can capture the diversity of impacts that wraparound is anticipated to produce.

And finally, the theory has research implications simply because it *is* a theory. The routes to wraparound's effectiveness are at this point hypotheses in need of testing. In order to support (or disconfirm) the hypotheses, research is needed to test each of the main assumptions that are part of the theory. To do this would require research that measures an appropriate spectrum of the intermediate and long-term outcomes, and that allows for testing assumptions about how these outcomes are interrelated. Knowing more about whether and how these various avenues to wraparound "work" will in turn provide the foundation for future efforts to refine strategies for practice, quality assurance, and evaluation.

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Theory and Research: Chapter 3.2

The Evidence Base and Wraparound

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Over the past 20 years, the wraparound process has become a compelling and highly visible method for working with youth and families with intensive needs. As described in the articles in this *Resource Guide*, wraparound provides a method through which teams come together to create and implement plans to meet needs, achieve outcomes, and improve lives. At the same time, wraparound provides an "on the ground" mechanism for ensuring that core system of care values will guide planning and produce individualized, family-driven and youth-guided support that is community based and culturally competent (Stroul & Friedman, 1996).

Wraparound's alignment with system of care values and the aims of the family movement have made it extremely popular with states and communities. A 2007 update to the 1998 State Wraparound Survey shows that 42 of 46 U.S. states (91%) that returned a survey have some type of wraparound initiative in the state, with 62% implementing some type of statewide initiative. Over 100,000 youth nationally are estimated to be engaged in a well-defined wraparound process (Sather, Bruns, and Stambaugh, 2008). Compared to other prominent approaches to serving youth with serious and complex needs, wraparound is implemented through more programs and for more youth. Estimates show, for example, that Multisystemic Therapy (MST; Henggeler & Schoenwald, 2002) is received by about 16,000 youths annually, and that Multidimensional Therapeutic Foster Care (MTFC; Chamberlain, 2002) is received by about 1,000 youths (Evidence-Based Associates, 2007).

That wraparound should be such a frequently deployed service delivery model is not surprising. There is broad con-

sensus that the paradigm reflected in wraparound is an improvement over more traditional service delivery methods that are perceived as uncoordinated, inflexible, professional driven, and deficit based. In addition, the President's *New Freedom Commission Report on Mental Health* (US DHHS, 2003) recently concluded that all families with a child experiencing serious emotional disturbance should have an individualized plan of care. This statement further reinforces the need for approaches like wraparound.

In the current era of emphasizing "evidence-based practices," however, all service delivery decisions are legitimately open to scrutiny, regardless of how well they conform to current values of care. After all, there are many competing paradigms that could be used with youth and families who are experiencing intensive needs. These include traditional case management, uncoordinated "services as usual" (in which families negotiate services and supports themselves or with help of a more specialized provider such as a pediatrician or therapist), residential treatment, or inpatient hospitalization.

The picture is becoming increasingly complicated because wraparound is being used in more and more contexts and for more and more purposes. In juvenile justice, wraparound is being used as a means of diverting youth from detention and to help youth successfully transition to the community from secure placement. In child welfare, some state systems, such as Oklahoma, are experimenting with supporting child welfare care workers to use the wraparound model to achieve permanency, stability, and safety outcomes for children, youth and families (Rast & Vetter, 2007). States and localities are also deploying the wraparound process to help adult prisoners re-enter society (see Chapter 1.4), to improve outcomes for high-risk pregnant women (Calleaux & Dechief, 2006), and to meet the needs of many other populations. All these relatively new deployments of the basic wraparound model are alternatives to more traditional (or at least different) approaches to supporting the target population. As such, each of these examples raises the question: Does wraparound work?

Fifteen to 20 years after "wraparound" became common parlance, this is still not a simple question, because wraparound is not a simple phenomenon. The question is complex for several reasons. First, as noted above, wraparound has been deployed for many different populations. As such, the question "Does wraparound work?" needs to be answered for many different types of populations and proposed outcomes. This makes wraparound different from most treatments or interventions, which were designed to address a specific type of concern, such as, for example, adolescent depression, acting out by young children, or adult panic disorder. Thus, any synthesis of the wraparound evidence base has to ask both about the impact for specific populations as well as its impact overall, across these multiple purposes.

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Second, wraparound has been, and continues to be, an evolving phenomenon. Its development lies in "grassroots" movements to care for individuals in the context of their families and communities. No single developer owns wraparound, which means it typically is implemented differently from one site to another. This makes it more difficult to assess the evidence base, because until recently there was little consensus on the specific activities that make up the wraparound process. When a researcher finds no positive impact of wraparound, we must ask "What kind of wraparound was implemented?" and "Was it implemented well?" In addition, since no one "owns" wraparound, the model does not have the same systematic development and testing history as other evidence-based practices, which are often guided through developmental stages by researchers with a significant stake in finding the model to be effective. In contrast, wraparound has been created by family members and provid-

ers whose first priority is not to oversee rigorous research projects but to do whatever it takes to help families in their community.

Third, wraparound is multi-faceted and individualized. It is typically deployed for families (or adults) with complex and multiple needs, whereas many programs have achieved “evidence-based” status by virtue of their focus on a single problem area or diagnostic category. Focusing on broad populations with complex and overlapping needs makes it harder to find positive impact for several reasons. First, the target population is challenging and implementation is difficult. Second, wraparound projects are often “system-level” initiatives, required to enroll a wide range of children and families, as opposed to those with a specific complaint or concern. This means that target outcomes will be different for each participant, making it harder to find impact, especially when only one or two outcome measures are used (e.g., a standardized behavioral or functional scale).

Wraparound often is conceived as both an individual-level intervention (a defined team-based planning process) and as a “system level” intervention (requiring communities to collectively oversee implementation, agencies to collaborate, the service array to be comprehensive, and so on). As such, it is generally difficult to assess what types of outcomes are appropriate and how to interpret findings. For example, in a very interesting paper, Stambaugh et al. (2007) assessed trajectories of behavioral and functional improvement for N=320 in a system of care for youth with serious emotional and behavioral concerns, the majority of which (n=213) received the wraparound process while a small subgroup (n=54) received multisystemic therapy (MST; Henggeler & Schoenwald, 2002), a specified evidence-based intervention for youths. The authors found similar improvements in functioning for the two groups but somewhat better improvement in behavior for the MST group and concluded that MST was overall more effective.

At the same time, the authors recognized that MST targets a specific population: older youth with antisocial and offending behaviors who are in families that are intact and fully engageable in the intervention. Thus the MST group likely met criteria specific to MST while wraparound was made broadly available youth of all ages with any type of emotional or behavioral disorder. Cast in this light, the fact that youth in the wraparound group demonstrated quite impressive improvements (despite their heterogeneity and questions about the quality of specific services received) only slightly less positive than the MST group may be viewed as significant support for deploying wraparound as a method for addressing the needs of diverse youth in a large system of care. Regardless of one’s conclusions, the study demonstrates the complexity of interpreting research on wraparound.

The Evidence Base and Wraparound

In sum, because there are so many variations of “wraparound,” because it has been a grassroots and evolving phenomenon, and because it is a complex approach that impacts systems as well as individuals, the question “Does wraparound work?” has been difficult to answer. Instead of considering the evidence base on wraparound, it may be more appropriate to frame the issue as the evidence base *and* wraparound. Other articles in this section of the *Resource Guide* are also geared toward this topic, including a review of the theory of change for wraparound (Chapter 3.1), a discussion of fidelity measurement (Chapter 5e.1), and a review of relevant current outcomes studies (Chapter 3.3). In the remainder of this article, we present some of the major themes from the story about the evidence base and wraparound.

1. Current thinking in children’s mental health emphasizes the importance of joining evidence-based practices to family-driven and individualized service processes like wraparound.

Like “wraparound,” the “science-to-service gap” in children’s mental health is a topic that is receiving increased attention among researchers and service providers. Research finds significant impact of treatments for children and youth under controlled conditions, such as laboratory studies where clinicians have low caseloads and intensive supervision and the children or youth have a single problem. But then, when these treatments are administered in actual community settings, they often don’t produce the same positive outcomes. Thus there is a “gap” between what *can* work under ideal conditions, and what *does* work in community settings.

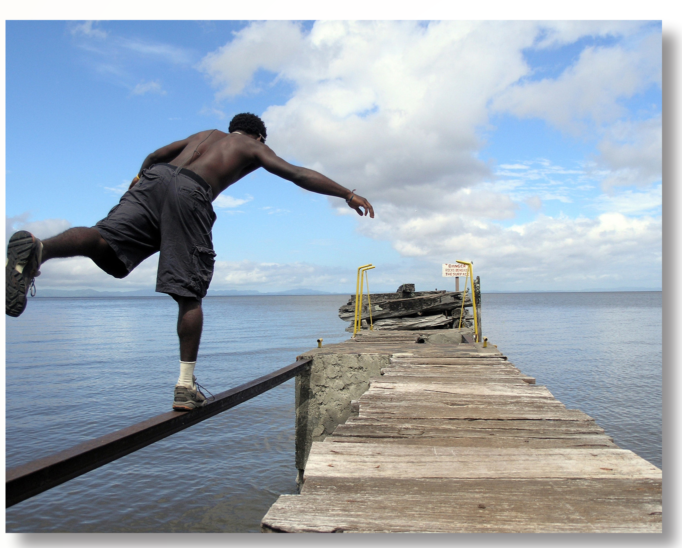
There have been many hypotheses about why this is so often the case. One prominent theory is that clinical services in "real world" communities are not delivered in a way that can achieve positive clinical outcomes. Once transported to a real clinic in a real community, larger case loads, lack of training, limited availability and quality of supervision, staff turnover, and restricted resources all conspire against a treatment that has been found to work under more ideal conditions.

However, research also suggests other problems. First, families tend not to be well engaged with their helping professionals. Second, care is often not well tailored to fit the full range of families' complex real-world needs. Researchers point to such lack of full engagement, individualization, and comprehensiveness to explain why families often feel the care they receive is not relevant or helpful.

Our interpretation of this broad set of findings is that the science-to-service gap is at least partly due to systems failing to support full engagement of families in the treatments they receive. For families with intensive needs or children with serious emotional and behavioral problems, such full engagement will usually require the creation of highly individualized and creative plans of care that address all the major issues and stresses the family is dealing with. What's more, such plans will need to respond meaningfully to the needs *as expressed by the family*. A well-implemented wraparound process provides for procedures to accomplish this for families with these most intensive needs. Thus, it is important that research on overcoming the science-to-service gap considers the potential of the wraparound process to improve outcomes in real-world community settings.

At the same time, researchers, advocates, and practitioners must realize that families participating in a wraparound *process* should also have available specific *treatments* (including evidence-based treatments) that might be part of their individualized plan of care. The two are highly compatible; after all, the intent of the wraparound process is to plan and implement the set of services and supports that is most likely to achieve positive outcomes for a family. At the individual youth and family level, this may include one or more empirically supported treatments.

At the organizational and system level, this means developing capacity to make available treatments that will be most beneficial to the target population, and in some cases integrating evidence-based techniques into wraparound itself. For example, a wraparound project in King County, Washington, is training wraparound facilitators in Motivational Interviewing to help address youths' substance abuse issues. In Maryland, a wraparound project for transition-age youth is making Supported Employment, an evidence-based practice, available as needed. And, as described by Lucille Eber in this *Resource Guide* (Chapter 5e.4), wraparound as implemented in the context of school-wide Positive Behavior Supports often integrates efforts by clinicians to design effective behavior plans.



The bottom line is that more and more children's mental health researchers are recognizing the importance of joining evidence-based practices to engagement and service coordination strategies such as wraparound (see, for example, Tolan & Dodge, 2005). The next wave of research on wraparound will likely feature studies of the impact of such innovations.

2. The principles of wraparound are supported by evidence from the research base as well as common sense and social justice.

As described above, current thinking in children's services supports the idea that the wraparound process holds promise for overcoming

commonly-cited barriers to achieving outcomes for children and families. Additionally, there is research that supports the hypothesis that the wraparound process, when carried out in accordance with the principles, contributes to positive outcomes. This is presented in more detail in Janet Walker's description of the theory of change for wraparound, found in this *Resource Guide*. A summary of support for several of the wraparound principles is described below.

Voice and choice. We have already described some of the reasons "voice and choice" may be critical to achieving outcomes. As discussed above, lack of full family engagement has been found to be a major impediment to treatment success. Research has shown that outcomes for children's mental healthcare tend to be better when families are engaged and retained in services (Huey, Henggeler, Brondino, & Pickrel, 2000; Tolan, McKay, Hanish, & Dickey, 2002). In addition, Heflinger et al. (1996) have created methods for better engaging families, and studies examining these approaches have found that family members' overcoming of negative experiences of past treatments received is critical to achieving engagement, and possibly outcomes. And Spoth & Redmond (2000) have found that family members' belief in the effectiveness of treatment influences engagement and outcomes. These findings and others provide support for the principles of prioritizing the family's perceptions of what the family needs to function better.

Team-based, collaborative planning. Meanwhile, the wraparound principles of "team-based" and "collaborative" have clear support from research across disciplines. Research on teamwork has shown greater success when teams set an overall, long-term goal or mission for the team (Cohen, Mohrman, & Mohrman, 1999; West, Borrill, & Unsworth, 1998), and when team members have clearly defined intermediate goals that help reach the long term goal (Latham & Seijts, 1999; Weldon & Yun, 2000). Effective teams also work carefully to choose strategies for reaching the intermediate goals, structure strategy selection deliberately, and consider several different strategies before choosing one (Hirokawa, 1990; West, Borrill, & Unsworth, 1998). These are all features of a well-implemented wraparound team process.

In the child services research field, Stone and Stone (1983) found that positive child outcomes were more likely to result when foster parents viewed themselves as part of a team with a goal of positive outcomes. Meanwhile, evaluations such as that conducted by Burns & Santos (1995) have found that team-based care for adults with serious mental illness (SMI) was found to be superior to "brokered" case management models. Assertive Community Treatment (ACT; Bond et al., 2001), which uses a team-based approach to aid adults with SMI, has long been a standard for delivering quality care to this population.

Community-based care. One of the signature principles of both wraparound and systems of care philosophy is that care is community based. Though honoring families' desire to obtain support while keeping their children at home is a principle based in social justice and the family movement, delivering care in the natural environment in which a child and family functions is also grounded in theory and research. Bronfenbrenner's (1979) and Bandura's (1977) models stress that to be generalizable, behaviors must be taught in the environment in which they will be practiced. These models underpin many evidence-based approaches to treatment (e.g., behavioral therapies and MST) that are intended to help youth and their families learn the skills they need to adapt more successfully to their everyday environments.

To be generalizable, behaviors must be taught in the environment in which they will be practiced.

The rationale for insisting on *community-based* treatment models wherever possible does not stop at theory. Many studies (e.g., Pfeiffer et al, 1990) have found that the best predictor of future out-of-home placements is whether out-of-home placement has been used in the past. Other studies show that both placement stability and youth perception of placement stability are significant predictors of

future outcomes (Dubovitz et al., 1993; James et al., 2006). Thus, assuming that we hope to ensure that young people will eventually live effectively in their home communities, we must strive to prevent unnecessary out-of-home placements. This becomes especially important when we consider that, historically, we have spent a disproportionate amount of our child behavioral service dollars on residential and inpatient care, despite the fact that this treatment approach has the most poorly developed research base of all major child and adolescent treatment options (Burns, Hoagwood, & Maultsby, 1998).

Individualized care. Finally, theory and research both support the importance of *individualized* care for individuals with complex needs. This may explain why individualization is a cornerstone of the wraparound process and systems of care, and also why it is prominent among recommendations of the *New Freedom* report. Several influential psychosocial theories of child development, particularly social-ecological (Bronfenbrenner, 1979) and systems (Munger, 1998) theories, stresses the importance of understanding the unique relationships between the child and various environmental systems (e.g., family, school, community). Effective intervention thus begins from an understanding of the child's unique social, cultural, and interpersonal systems environment, and requires the tailoring of services and supports to this unique set of relationships. Meanwhile, literature on case management for adults with serious mental illnesses has been consistent in its support of more intensive and early tailoring of community supports to client needs (e.g., Ryan, Sherman, & Bogart, 1997). Studies of case management have also found that a greater variety of community-based supports leads to greater client satisfaction and retention in services (Burns et al, 1996).

3. Despite support for the wraparound philosophy, research also has demonstrated a "fidelity problem" in wraparound that is important to overcome.

As described above, both theory and research support the principles of the wraparound process and its potential for impact. In the classic framework for developing a treatment model, theory and past research are prerequisites for moving forward with model development and tests of effectiveness. However, in the case of wraparound, such empirical testing has been challenged by the very grassroots evolution and individualized nature that has made the model so compelling. Though wraparound is included as a "promising practice" in the Surgeon General's Reports on Mental Health (USPHS, 1999) and Youth Violence (USPHS, 2001), its inclusion was based on its widespread use and testimonials about its importance within service systems. Typically, references to wraparound come with statements about its lack of specification and thin evidence for effectiveness. For example, in their review of treatments for youth with SED, Farmer, Dorsey, & Mustillo (2004) described the wraparound evidence base as being "on the weak side of positive."

Perhaps even more problematic, wraparound's history of being "value based" rather than explicitly described (Malysiak, 1998) has caused a "fidelity problem" that results in confusion for providers and families, and potentially poorer outcomes for children and youth. Even early on, there were warnings about defining the process and maintaining its integrity. As Clark & Clarke stated in 1996:

> The push to rapidly implement wraparound approaches has resulted in a plethora of service models that vary widely in their implementation, processes, structures, and theories. While this push has been an important part of… the shift to less restrictive, more integrated community-based service alternatives, it has also resulted in an unsystematic application of the wraparound process (p.2).

Research eventually supported these early concerns. In observing over 70 wraparound meetings in 11 programs nationally, Walker and colleagues (2003) found that less than one-third of teams maintained a plan with team goals. Only about 20% of teams considered more than one way to meet a family's stated need. Only 12% of interventions reviewed were individualized or created just for that family. Finally, only about half the teams included a team member in the role of natural or peer support for the family (another 32% had only one such support). Meanwhile,

studies with our Wraparound Fidelity Index (WFI; Bruns et al, 2004) have found similar results about the "fidelity problem."

The issue of defining, maintaining, and measuring fidelity in wraparound is discussed in another chapter of this *Resource Guide* (Chapter 5e.1). The point is that, despite the widespread promotion of wraparound principles such as being team based, individualized, outcome based, and relying on natural supports, our research suggests these principles are much more difficult to do in real-world practice than they are to embrace in principle. Programs and communities need help to move

from values to high-quality practice if we are to overcome the fidelity problem in wraparound. The pathway to accomplishing this includes ensuring that the wraparound process being implemented is well understood by both core and partner agency staff, and that adequate support is provided to families, teams, and providers to make sure that such a process can occur. The topic of how best to provide such support is also discussed later in this *Resource Guide* (Chapter 5a.1).

4. When high-fidelity wraparound is delivered, there is a greater potential for positive impact for families.

Research documenting the fidelity problem in wraparound begs the question: How important is it to achieve the wraparound principles when working with families? This question is only now being addressed, but results from some preliminary studies suggest that it may be quite important. Bruns et al. (2004) have found that families with higher WFI scores in the first six months of service achieved better outcomes in areas such as child behavior, residential restrictiveness, and parent satisfaction at both six months and down the line at 12 months after entry to service. Similar results were achieved in a study by Hagen, Noble, and Schick (2003), who studied the impact of different levels of wraparound fidelity on child negative and positive behaviors. Rast and Peterson (2004; described in Bruns et al., 2006) found that facilitators who were more adherent to the wraparound model had youth and families who experienced better outcomes.

5. Achieving high-fidelity wraparound is a big challenge, requiring significant effort and resources.

The findings reported in the previous section provide evidence that communities that wish to achieve positive outcomes for families via the wraparound process must fully support "high-fidelity" wraparound. However, this is more easily said than done. Once a model for wraparound is well understood, with policies and procedures incorporated that reflect it, families, teams, and providers must be well supported to implement it. High quality training and staff support is necessary, as is the overall level of support to wraparound teams provided within the policy and funding context, often known as "the system." This issue is discussed in a separate article in this *Resource Guide*, and in an influential monograph by Walker, Koroloff, & Schutte (2003; see Appendix 6f). In this monograph, the authors describe the major types of supports required by wraparound teams, all of which need to be present in different ways at the team, organization, and system levels. After further research, these supports weresummarized in six major areas, including:

1. **Community Partnership.** Collective community ownership of and responsibility for wraparound is built through collaborations among key stakeholder groups.
2. **Collaborative Action.** Stakeholders involved in the wraparound effort take concrete steps to translate the wraparound philosophy into concrete policies, practices and achievements.

3. **Fiscal Policies and Sustainability.** The community has developed fiscal strategies to meet the needs of children participating in wraparound and methods to collect and use data on expenditures for wraparound-eligible children.
4. **Access to Needed Supports & Services.** The community has developed mechanisms for ensuring access to the wraparound process and the services and supports that wraparound teams need to fully implement their plans.
5. **Human Resource Development & Support.** The policy and funding context supports wraparound staff and partner agency staff to work in a manner that allows full implementation of the wraparound model.
6. **Accountability.** The community has implemented mechanisms to monitor wraparound fidelity, service quality, and outcomes, and to assess the quality and development of the overall wraparound effort.

Research is beginning to show the importance of achieving these types of supports in communities that wish to use the wraparound process. In one study, Bruns, Suter, Leverentz-Brady, & Burchard (2006) administered a survey to officials in ten communities that were implementing wraparound programs. These communities were also using the WFI to monitor wraparound fidelity. Results showed that higher wraparound fidelity was achieved in communities with more system and program supports.

6. What we have learned about wraparound so far is highly encouraging, and tells us we are on the right track.

We have learned much in recent years about wraparound from both experience and research. We have learned that administering individualized, team-based care planning and management to families with intensive needs is a high-priority activity being undertaken in hundreds of communities nationally (Sather, Bruns, & Stambaugh, 2008). In addition, providers and family members alike endorse the effectiveness of the wraparound process. One major survey of 615 providers working within the CMHS-funded systems of care communities demonstrated that 77% of all providers (18% of whom implemented wraparound personally) believed wraparound resulted in positive outcomes for youth and families. Interestingly, this percentile was higher than for several prominent treatment types with evidence for effectiveness, including MST (68%) Treatment Foster Care (67%) and Functional Family Therapy (49%) (Walrath, Sheehan, & Holden, 2004).

Unfortunately, we have learned that it is much easier to embrace the wraparound principles in theory than to actually do them in practice. Nonetheless, when model-adherent wraparound is achieved, it may well pay off in the form of better outcomes for families. To achieve such high fidelity, we need to:

- Have a good understanding of what faithfully implemented wraparound is,
- Provide adequate training and support to providers and partner agencies to do it, and
- Work with our organizations and systems to support it by setting up a hospitable policy and funding context.

Though embracing and supporting the model is a challenge for many, the enthusiasm for wraparound continues to be fueled by success stories from communities, evaluation studies, and individual families. The formal research base, described in detail in another article in this *Resource Guide* (Chapter 3.3), is small but growing. Such research findings are further supported by lessons that have been learned by local communities. In Milwaukee, for example, Wraparound Milwaukee has served over 700 youths via wraparound. As a result, the county's expenditures for out-of-

home placements have been drastically reduced (Kamradt, 2001). Similar community-level results found in Ventura County (and later, 3 additional California counties) in the late 1980s and early 1990s (Rosenblatt & Attkison, 1992) were attributed to the implementation of a systems of care approach to integrating services, and a wraparound-style care management model. Other prominent examples abound, including the Dawn Project in Indianapolis. These evaluations have found that youth served by the wraparound program show better improvements in clinical functioning and less likelihood of re-entry to public systems such as juvenile court or probation, at lower overall expenditures, compared to youth served by traditional means (Indiana Consortium for Mental Health Services Research, 2003).

Finally, success stories from families and providers alike abound. Some are captured in monographs (e.g., Burchard, Burchard, Sewell, & VanDenBerg, 1993; Burns & Goldman, 1999; Kendziora, Bruns, Osher, & Mejia, 2001), but many more are found in the stories told by family members and their advocates in communities across the country. Though research on the wraparound process has been challenging and slow to develop, there is a clear alignment between research and the evidence base. Though we will continue to refine the formal research base on wraparound, the enthusiasm for this important service approach, perhaps more than any other evidence, comes from these families' stories.

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Theory and Research: Chapter 3.3

A Narrative Review of Wraparound Outcome Studies

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The wraparound process has been described as having a promising body of evidence (Burns, Goldman, Faw, & Burchard, 1999; National Advisory Mental Health Council, 2001; New Freedom Commission on Mental Health, 2003), to the point it has been included in two Surgeon General reports (U. S. Department of Health and Human Services, 1999, 2000), recommended for use in federal grant programs (U. S. Department of Health and Human Services, 2005), and presented as a mechanism for improving the delivery of evidence-based practices for children and adolescents with serious emotional and behavioral disorders ([SEBD] Friedman & Drews, 2005; Tolan & Dodge, 2005; Weisz, Sandler, Durlak, & Anton, 2006). Not everyone, however, is convinced. Bickman and colleagues (Bickman, Smith, Lambert, & Andrade, 2003) have stated that "the existing literature does not provide strong support for the effectiveness of wraparound" (p. 138). Farmer, Dorsey, and Mustillo (2004) recently characterized the wraparound evidence base as being "on the weak side of 'promising'" (p. 869).

There are several significant concerns about the state of the wraparound evidence base. As presented in Figure 1, though the number of publications about wraparound has grown steadily over time, the number of outcome studies remains relatively small. Many outcome studies that have been published used less rigorous designs and included relatively small samples. Finally, the wraparound model has developed in a "grassroots" fashion and has been driven largely by local priorities. This means that there has his-

torically been a wide range of populations of children and families for which wraparound has been implemented and studied, as well as wide variation in adherence to the core principles of wraparound (Bruns et al., 2004). With many target populations, no real consensus on what exactly constitutes "wraparound," and no single research group invested in documenting wraparound outcomes, the outcomes research base has been slow to emerge, and results are less consistent than for more strictly defined models. In addition, reviews of outcomes studies of children's services have tended to mischaracterize some evaluation studies as pertaining to the wraparound process. For example, one widely cited review (Aos, Lieb, Mayfield, Miller, & Pennucci, 2004) cited evaluation studies of "systems of care" (e.g., Bickman, Sumerfeldt & Noser, 1997) as speaking to the evidence base on the wraparound process, even though the two models are quite distinct in practice (Stroul, 2002).

Taken together, these concerns have made it difficult to draw clear conclusions about wraparound's evidence base. Therefore, it is important to take stock of the full range of existing outcome studies on wraparound. To date, three wraparound narrative reviews have been published (Burchard, Bruns, & Burchard, 2002; Burns et al., 1999; Farmer et al., 2004). However, they did not capture all available outcome studies, and additional studies have been published since those reviews. Given that published research on wraparound seems to be growing at an increasing rate, it is important to conduct regular reviews of the literature to characterize the status of wraparound's evidence base.

The primary goal of the present narrative review was to identify and summarize the full scope of wraparound outcome studies, to serve as a resource for researchers and practitioners. While traditional reviews of outcome studies may use inclusion criteria to analyze only studies with the most rigorous designs, the current review was intended to be more inclusive of the full breadth of outcome studies on wraparound. Because much of the outcome literature on wraparound is composed of program evaluations, the studies are often not published in traditional outlets (e.g., peer-reviewed journals). Such studies are often referred to as "gray literature" (Petticrew & Roberts, 2006, p.90). This does not make them less important for a review (Lipsey & Wilson, 2001), just more difficult to find. Therefore, the authors acknowledge that the present review may not capture all empirical studies on wraparound. With this recognition, this review is conceptualized as a resource as well as a working document that will most likely need to be revised and amended as more studies on wraparound are conducted and identified.

Method

Selection Criteria

Studies chosen for this review evaluated interventions following the wraparound process at the child and family level. Because the goal was to provide a comprehensive resource to the field, selection criteria were chosen that were much more inclusive than most reviews. More specifically, the following selection criteria were chosen.

Intervention. The team-based planning process used in the study must have been identified as wraparound or sufficiently described by the authors as sharing the primary components of wraparound (see related descriptions elsewhere in this *Resource Guide*). Interventions that included community-based planning for children with emotional and behavioral disorders (e.g., case management), but did not explicitly incorporate other wraparound principles were excluded. Similarly, systems of care evaluation studies that followed similar principles as wraparound but were evaluated primarily at the system rather than the individual family level were also excluded.

Participants. The target population of the study was children or adolescents (5 to 22 years) with SEBD and significant functional impairment. Evidence of significant functional impairment included those at-risk of (or returning from) an out-of-home placement (e.g., psychiatric hospital, residential treatment center, juvenile justice facility, foster care), as this is a common target population for wraparound.

Design. Study design selection criteria were especially liberal to allow a full breadth of outcome studies on wraparound. As such, experimental (e.g., randomized controlled trials), quasi-experimental (e.g., non-randomized group compari-

sons), and non-experimental designs (e.g., single group pretest-posttest) were permitted. Qualitative and quantitative single subject designs were also permitted.

Outcomes. Study outcomes must have included measures of child functioning in their homes, schools, or communities. This could include emotional or behavioral functioning, academic or job performance, violence or delinquency, changes in living situation, or substance use.

Timeframe and Language. The study must have been made available between January 1, 1986 and February 29, 2008. This timeframe was

chosen because the wraparound process, as it is currently conceptualized, was reported to have begun in 1986 (VanDenBerg, 1999). To be accessible to the researchers, the study had to be in English.

Literature Search

Eligible studies for this review were identified through electronic and manually based searches of the literature. First, 16 studies identified in previous reviews were included.[1] Second, electronic databases (Web of Science, PsycINFO and ERIC) were used to search for the keywords: *wraparound*, *wrap-around*, *individualized services*, and *individualized service plans*. Third, a manual search was conducted of the *Journal of Child and Family Studies*, *Journal of Emotional and Behavioral Disorders*, and the annual research conference proceedings of *A System of Care for Children's Mental Health: Expanding the Research Base* hosted by the University of South Florida, Louis de la Parte Florida Mental Health Institute, Research and Training Center for Children's Mental Health. These three sources were chosen for a manual search because traditionally they have been the primary outlets for research on wraparound.

Findings

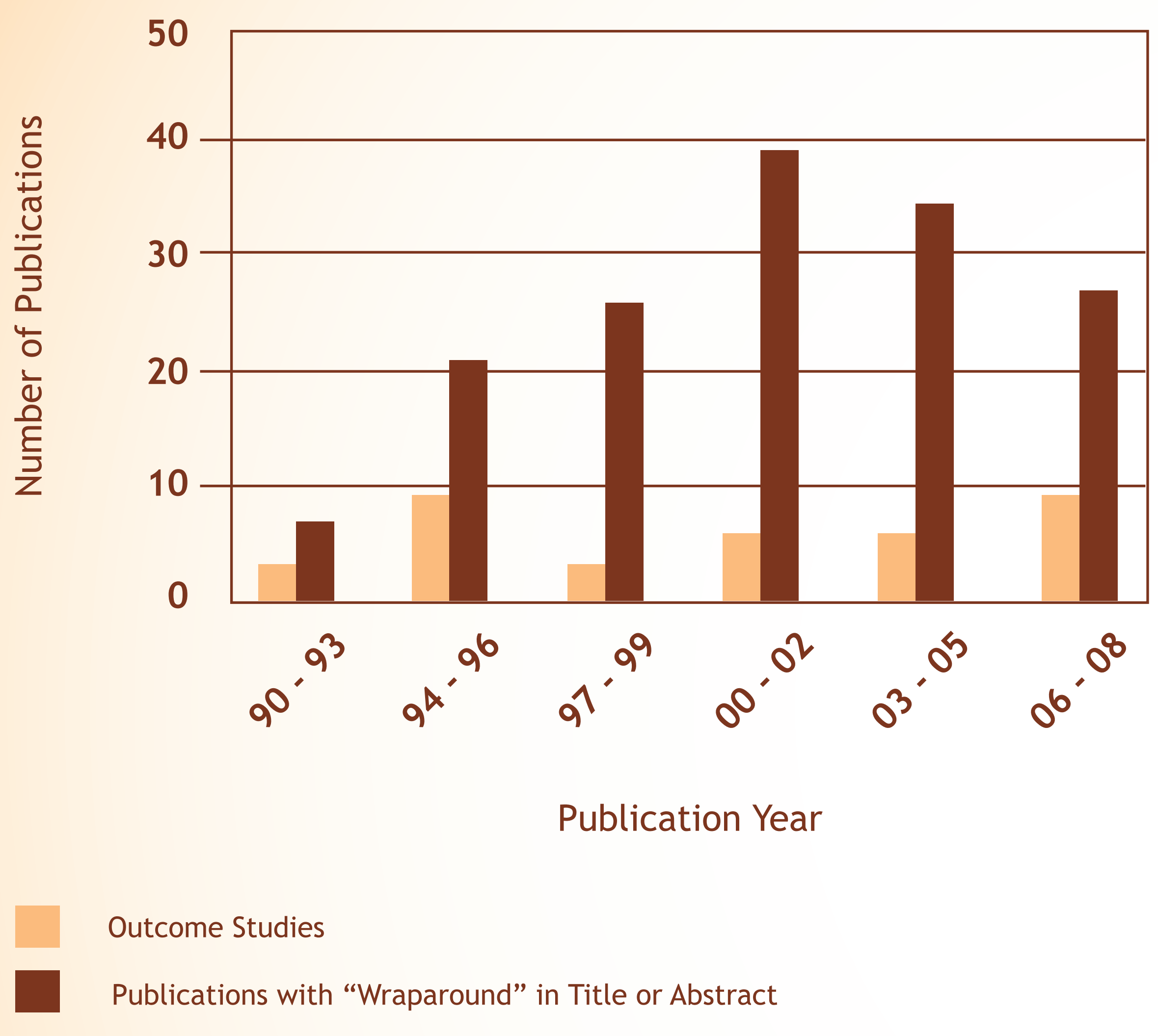
Study Characteristics

The literature search yielded 36 studies (20 more than the latest review, Farmer et al., 2004), presented in 56 separate reports. When multiple reports were available for the same study, all citations were included in this review. Additional reports for the same studies seemed to reflect either updates (earlier reports represented preliminary findings; Vernberg, Jacobs, Nyre, Puddy, & Roberts, 2004; Vernberg et al., in press), moves from unpublished to published sources (e.g., conference proceedings to journal article; Anderson, Kooreman, Mohr, Wright, & Russell, 2002; Anderson, Wright, Kooreman, Mohr, & Russell, 2003), or presentation of findings in evaluation reports and publications (Evans, Armstrong, Kuppinger, 1996; Evans, Armstrong, Kuppinger, Huz, & Johnson, 1998). Of these 56 separate reports, the most common outlet (45%) were peer-reviewed journals (*n* = 25), followed by conference proceedings (*n* = 19), book chapters (*n* = 4), doctoral dissertations (*n* = 3), federal reports (*n* = 2), paper presentations (*n* = 2), a manuscript submitted for publication, and a published monograph.

Focusing on the 36 unique studies, over 60% (*n* = 22) resulted in at least one publication in a peer-reviewed journal. The remaining studies were presented in conference proceedings (*n* = 9) dissertations (*n* = 3), 1 published monograph, and 1 paper presentation. Research designs included: 23 pretest-posttest single group designs; 6 quasi-

1. Studies identified from previous reviews are noted in Tables 2 – 5.

Figure 1. Number of Wraparound Publications by Year Including All Publications with "Wraparound" in Title or Abstract



n = 174) retrieved from PsycINFO (1/1986 through 2/2008) and primary outcome studies meeting criteria for inclusion in this review (*n* = 36).

experimental (non-equivalent comparison group designs); 4 randomized clinical trials; and 3 single case design studies (2 qualitative and 1 multiple-baseline). The lead agencies running the wraparound initiatives across the 36 studies included mental health (*n* = 20), education (*n* = 6), child welfare (*n* = 4), juvenile justice (*n* = 4), and interagency initiatives (*n* = 2). Figure 1 presents a timeline of wraparound outcome publications (including the 36 primary outcome studies and the 19 additional study reports). The most common publication year was 1996 (*n* = 9; the year the *Journal of Child and Family Studies* published a special issue on wraparound) followed by 2003 (*n* = 7) and 2006 (*n* = 7).

Participant Characteristics

Initial sample sizes for the 36 studies ranged

from 6 to 1031 (*M* = 183.31, *SD* = 251.34). However the largest study (Kamradt, Gilbertson, & Lynn, 2005) was an extreme outlier, being a large-scale evaluation of a statewide program. Attrition rates also varied widely, ranging from a low of 0 to a high of 92%. The majority of participant attrition was due to incomplete data rather than participants dropping out of treatment (though typically information on attrition was not reported). For example, one program stated that 324 participants received wraparound, yet data were available for only 27 (Robbins & Collins, 2003). As shown in Table 1, not all studies shared data on participant demographics, and there was great variability among the data that was presented. Participants received wraparound on average from 3 to 36 months. Mean participant ages ranged from 9 to 17 years. Approximately three-quarters of the studies presented information on participant gender (study samples ranged from 0 to 50% female), and less than two-thirds presented information on the race or ethnicity of participants (studies ranged from 0 to 73% participants identified as racial or ethnic minorities).

Narrative Review

The outcome studies are summarized in Tables 2-5, which present, respectively, single case design studies, pretest-posttest single group design studies, quasi-experimental group comparison studies, and randomized clinical trials. Each table presents the following information: study citation and source (e.g., journal article, book chapter, etc.), a brief program description, characteristics of the participants, primary measures and study findings, and notable details of study analyses. Each row represents a unique study. In cases where multiple reports exist for the same study, they were included in the same row, and findings from the most complete set of outcomes were presented (in a few cases this involved pooling information across multiple reports). For studies that compared wraparound to a comparison or control group, effect sizes were calculated whenever sufficient information was available (e.g., means, standard deviations). By Cohen's convention (Cohen, 1992), effect sizes have been classified as small (*d* = 0.20), medium (*d* = 0.50), and large (*d* = 0.80). Grouped by study design, the following sections briefly summarize the findings of these 36 empirical studies highlighting their strengths and limitations.

Single Case Design Studies

Three single case design studies were identified. Two qualitative case studies described two of the earliest formal applications of the wraparound process (Burchard, Burchard, Sewell, &

Table 1. Participant Demographics Reported by Wraparound Outcome Studies

Demographic Variable	*n*	*M*	SD	Min	Max
Sample size	36	183.31	251.34	6	1031
Mean number of months receiving wraparound	32	13.61	6.61	3	36
Mean age	26	13.05	2.40	8.8	17.3
Percentage of study participants identified as female	28	28.58	13.86	0	50
Percentage of study participants identified as racial or ethnic minority	23	34.73	23.94	0	73

Table 2. Single Case Design Studies on the Wraparound Process

Citation(s) / Source(s)	Program Description	Participants	Primary Measures / Findings	Design & Analytic Details
(Burchard et al., 1993)* *Published monograph*	Alaska Youth Initiative (AYI) *Lead Agency:* Mental Health *Setting:* urban & rural regions in Alaska *Duration:* M ≈ 22 months (9-36)	N=10 SEBD youth with history of residential treatment *Age:* 9-21, M=17.1 *Sex:* 50% female *Race/Ethnicity:* 60% Caucasian, 30% Native Alaskan,10% Latino	*Structured interviews and record reviews:* 9 out of 10 youth stabilized in community settings; 5 no longer requiring services, 4 receiving less intensive services, and 1 not stabilized in community	Qualitative retrospective analysis Participants selected because rated "successful" and "instructive" cases by AYI staff from initial sample of 84
(Cumblad, 1996)* Cited in (Burchard et al., 2002) *Doctoral dissertation*	Kaleidoscope Program *Lead Agency:* Private child welfare agency *Setting:* urban setting in Chicago, IL *Duration:* M = 36 months	N=8 SEBD youth referred due to high-risk behaviors *Age:* unknown *Sex:* unknown *Race/Ethnicity:* unknown	*Interviews and record review:* At assessment no youth were displaying problems behaviors that led to referral, no evidence of abuse/neglect, four youths reunited with families, two not reunited but ongoing contact (remaining two youths' parents were deceased)	Qualitative retrospective analysis
(Myaard et al., 2000)* *Journal article* (Myaard, 1998) *Conference proceedings*	Wraparound Initiative *Lead Agency:* Juvenile Justice *Setting:* rural Michigan *Duration:* M = 8.6 months (7-10)	N = 6 SEBD youth (with attrition: N = 4) *Age:* 14-16, M = 14.7 *Sex:* 100% male *Race/Ethnicity:* 100% Caucasian	*DAIC:* was used to provide daily longitudinal ratings of compliance (improved), peer interactions (improved), physical aggression (improved), alcohol/drug use (eliminated), and verbal abuse (improved) *CAFAS:* substantial reductions in CAFAS scores	Multiple baseline study Parent provided daily rating of behaviors and was not blind to start of treatment

Note: SEBD = serious emotional and behavioral disorders; DAIC = Daily Adjustment Indicator Checklist; CAFAS = Child and Adolescent Functioning Scales

**** Report included in a previous review***

VanDenBerg, 1993; Cumblad, 1996). These two studies have frequently been cited in the literature as providing compelling evidence for the positive changes wraparound can achieve for children with SEBD (Burns, 2002; Burns et al., 1999). The first study, conducted as a doctoral dissertation, provided a retrospective qualitative analysis of eight youth with SEBD receiving care through Chicago's Kaleidoscope Program (Cumblad, 1996). This program targeted children in the child welfare system with histories of abuse and neglect. After receiving services through Kaleidoscope for an average of three years, there was no longer any evidence of maltreatment and none of the participants were removed from their families. Further, the participants no longer presented the behaviors that led to their initial referrals.

Burchard and his colleagues authored a thorough description and evaluation of the Alaska Youth Initiative ([AYI] Burchard et al., 1993). AYI was modeled after the Kaleidoscope Program, and the authors' description of the model of care closely paralleled that program. This evaluation was also conducted retrospectively using qualitative data from interviews and record reviews of ten children with SEBD. Overall, nine of the youth were successfully maintained in community settings following the intervention (five no longer required services and four needed less intensive supports).

Myaard and his colleagues (Myaard, Crawford, Jackson, & Alessi, 2000) conducted a multiple-baseline study of four adjudicated children participating in a wraparound program in rural Michigan. This design demonstrates the effect of an intervention by showing that outcome change occurs with (and only with) the introduction of wraparound at different points in time. The authors used the Daily Adjustment Indicator Checklist (Bruns, Woodworth, Froelich, & Burchard, 1994) to track five daily behavioral ratings (compliance, peer interactions, physical aggression, alcohol and drug use, and extreme verbal abuse) for each of the youth. Participants began receiving wraparound after 12, 15, 19, and 22 weeks. For all four participants, on all five behaviors, dramatic improvements occurred immediately following the introduction of wraparound.

Bickman and his colleagues (2003) criticized this study on the grounds that it had a small sample size and lacked a control group. These concerns need to be addressed because they represent a misunderstanding of the multiple-baseline approach. The purpose of the small sample size in the multiple-baseline approach is to collect a wealth of data before and after an intervention begins (in this case daily ratings for one year). If the pattern of data changes abruptly with the start of treatment, one can be much more confident about making a causal inference than if only two data points (pretest and posttest) had been collected. While no specific rules exist regarding how many baselines a study should have, Kazdin has suggested "two baselines are a minimum, but another one or two can measurably strengthen the demonstration" (Kazdin, 2002, p. 219). Bickman and colleagues (2003) also implied that causal inferences could not be made because the study did not have a control group. On the contrary, the experimental nature of multiple-baseline designs makes them well suited for addressing threats to internal validity. A more inherent limitation of this design is with external validity (i.e., generalizability of findings); however, this problem pervades many of the between-group designs in the literature as well (Kazdin, 2002).

These case studies provided a wealth of qualitative information regarding both outcomes and implementations of wraparound. As descriptions of the Kaleidoscope Program and AYI, they have been used as rationale and as guides for creating new wraparound interventions around the U.S. However, it is important to note that these case studies do not provide definitive evidence connecting wraparound and positive outcomes. No comparison groups were used, participants were not selected at random (in fact the participants from AYI were selected because they were deemed successful cases), and findings were collected retrospectively. As such, selection bias is a strong threat to validity. Therefore, the studies should be interpreted as offering evidence for *potential* or *best case* outcomes.

Single Group Pretest-Posttest Studies

The majority of the outcome studies reviewed (n = 23) used a pretest-posttest, no control group design (Anderson et al., 2003; Bartley, 1999; Brothers, McLaughlin, & Daniel, 2006; Bruns, Burchard,

Table 3. Single Group Pretest-Posttest Studies on Wraparound Process

Citation(s) & Source(s)	Program Description	Participants	Primary Measures / Findings	Analytic Details
(Anderson et al., 2003) *Journal article* (Anderson et al., 2002)* *Conference proceedings*	Dawn Project System of Care *Lead Agency:* Mental Health *Setting:* Marion County Indiana *Duration:* 12 months	N = 384 SEBD youth (with attrition: N = 156) *Age:* M = 13 *Sex:* 35% female *Race/Ethnicity:* 70% African American or biracial	*CAFAS:* significant improvement in clinical functioning (total scores) Decrease in percentage of youth in restrictive living placements Completing project was related to a significant drop in recidivism rates	
(Bartley, 1999) *Doctoral dissertation*	Children's Health and Mental Health Preservation Services *Lead Agency:* Mental Health *Setting:* Philipsburg, PA; supports in home & school *Duration:* 16 months	N = 25 SEBD youth (5 prematurely discharged) No attrition *Age:* 6-13, M = 9.8 *Sex:* 20% female *Race/Ethnicity:* not reported	*SCICA:* 60% of participants improved *CBCL:* 59% of participants improved *TRF:* 40% of participants improved	No tests of statistical significance
(Brothers et al., 2006) *Conference proceedings*	Project T.E.A.M. (Tools, Empowerment, Advocacy, & Mastery) *Lead Agency:* Juvenile Justice *Setting:* Urban; King County, WA *Duration:* 12 months	N = 99 SEBD youth involved with court system *Age:* 7-17, M = 14.7 *Sex:* 37.4% female *Race/Ethnicity:* 62.6% Caucasian, 18.2% African American, 11.1% Multi-racial, 10.1% American Indian, 2% Asian, 1% Hawaiian/ Pacific Islander, (6.1% Hispanic)	No significant changes were found for number or type of parent reported community connections (i.e., relationships). *CAFAS:* Significant improvements in CAFAS total score from intake to 12 months	Purpose of study was to compare effects for Caucasian and minority youth.

CONTINUED: Table 3. Single Group Pretest-Posttest Studies on Wraparound Process

Citation(s) & Source(s)	Program Description	Participants	Primary Measures / Findings	Analytic Details
(Bruns et al., 1995)* *Journal article*	Vermont's statewide wraparound initiative *Lead Agency:* Mental Health *Setting:* urban & rural areas *Duration:* 12 months	N = 27 SEBD youth *Age:* 8-18, M = 13.6 *Sex:* 30% female *Race/Ethnicity:* not reported	*CBCL:* significant improvement on total, internalizing, and externalizing scales *DAIC:* significant improvement on total negative behaviors *ROLES:* no significant change *Costs:* no significant change	
(Bruns et al., 2005) *Journal article*	Nebraska Family Central System of Care *Lead Agency:* Mental Health *Setting:* Rural *Duration:* 6 months	N = 36 families with youth with SEBD Sample was split into two overlapping groups to compare fidelity and outcome data. Only one group is included in present review (n = 32). *Age:* 6-17, M = 12 *Sex:* 19% female *Race/Ethnicity:* 100% Caucasian	Means and standard deviations reported in article showed outcomes moved in negative direction for: *-BERS Total Score* *-ROLES* *-FSQ Satisfaction with services* *-FSQ Satisfaction with progress* One small positive effect was found with CAFAS Total Score	Purpose of study was to examine relationship between fidelity and outcomes, so no analyses were conducted on outcomes alone
(Clarke et al., 1992)* *Journal article*	Project wraparound providing individualized services to youth *Lead Agency:* Mental Health *Setting:* rural New England; in home & school *Duration:* 12-24 months	N = 28 SEBD youth receiving services in home and school [with attrition: school (n=12) home (n=19)] *Age:* 5-18, M = 11 *Sex:* 100% male *Race/Ethnicity:* 53% Native American 47% Caucasian	*CBCL (home):* significant improvement on total, internalizing, and externalizing scales *TRF (school):* no significant improvement on total, internalizing, and externalizing *SCRS:* significant improvement at home but not school *Connors Hyperkinesis Index:* significant improvement at home but not school *Child Well-Being Scale:* significant improvement	Outcomes examined separately for home and school-based wraparound groups

CONTINUED: Table 3. Single Group Pretest-Posttest Studies on Wraparound Process

Citation(s) & Source(s)	Program Description	Participants	Primary Measures / Findings	Analytic Details
(Copp et al., 2007) *Journal article*	Georgia SAMHSA Site *Lead Agency:* Mental Health *Setting:* Rural *Duration:* not reported (data collected every 6 months)	N = 15 youth with SEBD with pretest-posttest data (out of a larger group of 45) *Age:* 8-14, M = 10.5 *Sex:* 46.7% female *Race/Ethnicity:* 53.3% Caucasian, 46.7% African American	*CAFAS (total) and CBCL (total):* No statistically significant improvements were found over 6 months	
(Eber et al., 1996a)* *Journal article*	Wraparound in Schools (WAIS) & wraparound Interagency Network (WIN) *Lead Agency:* Education *Setting:* school-based *Duration:* 9 months	N = 44 [2 groups: WIN (n = 25) WAIS (n = 19)] *Age:* not reported *Sex:* 11% female *Race/Ethnicity:* 86% Caucasian, 7% African American, 7% Other	*ROLES:* positive change (statistical significance not reported) CBCL, TRF, CAFAS data provided only for baseline	No tests of statistical significance
(Eber et al., 1996b)* *Conference proceedings*	Emotional and Behavioral Disability Partnership Initiative *Lead Agency:* Education *Setting:* statewide in Illinois *Duration:* M = 12 months	N = 81 (at baseline) [with attrition: CBCL (n=25), FACES (n=46) CAFAS, TRF, ROLES (not reported)] *Age:* 7-19, M = 14.64 *Sex:* 18% female *Race/Ethnicity:* not reported	*CBCL:* significant improvement for females on internalizing scale; no significant improvements for males and females on externalizing and males on internalizing *TRF:* no significant changes *CAFAS:* significant improvements in performance and mood scales only; not significant: behavior, thinking, and drugs *FACES:* significant improvement for both adaptability and cohesiveness *ROLES:* positive change (statistical significance not reported)	

CONTINUED: Table 3. Single Group Pretest-Posttest Studies on Wraparound Process

Citation(s) & Source(s)	Program Description	Participants	Primary Measures / Findings	Analytic Details
(Eber & Hyde, 2006) *Conference proceedings*	Illinois Positive Behavior Interventions and Supports *Lead Agency:* Education *Setting:* public schools in Illinois *Duration:* outcomes measured at 3 months	N = 22 students with EBD *Age:* not reported *Sex:* not reported *Race/Ethnicity:* not reported	Study used internal assessment instruments to compare findings at intake to 3 months: -Reported need for behavioral supports in classroom decreased -No change reported in classroom behaviors -Significant improvements in academic performance -Reported improvements in emotional and behavioral functioning at home (not at school) -No reported improvements in functioning for medical/safety, social, or spiritual functioning -Significant reduction in 3 out of 10 high-risk behaviors -Parents were significantly more satisfied with program after 3 months	
(Hyde et al., 1995) *Conference proceedings*	Family Preservation Initiative of Baltimore City *Lead Agency:* Child Welfare *Setting:* urban *Duration:* M = 9.73 months	N = 70 SEBD youth *Age:* 9-21, M = 15.97 *Sex:* 36% female *Race/Ethnicity:* 67% African American, 33% Caucasian	*Costs:* lower than out-of-state residential placement ($269/day vs. $216/day) *ROLES:* shift from 20% to 88% of youth with living situation no more restrictive than group home Critical behaviors (suspension, hospitalization, suicide attempts, arrests) assessed post only	No tests of statistical significance

CONTINUED: Table 3. Single Group Pretest-Posttest Studies on Wraparound Process

Citation(s) & Source(s)	Program Description	Participants	Primary Measures / Findings	Analytic Details
(Illback, Nelson, & Sanders, 1998) *Book chapter* (Illback et al., 1993)* *Journal article*	Kentucky IMPACT Program *Lead Agency:* Mental Health *Setting:* rural and urban *Duration:* 16.43 months	N = 954 SEBD youth With attrition: CBCL (N=431) ROLES (N=953) *Age:* 0-21 *Sex:* 29.1% female *Race/Ethnicity:* not reported	CBCL: significant improvement on total, internalizing, externalizing, and social competence scales ROLES: significant decrease in participants in hospital placements, but also significant increase in residential placements	
(Kamradt et al., 1998; Seybold & Gilbertson, 1998) *Conference proceedings* (Kamradt, 1996)* *Paper presentation* Cited in (Burchard et al., 2002)	Wraparound Milwaukee Pilot Project update *Lead Agency:* Mental Health *Setting:* initially residential treatment center then community, urban *Duration:* M = 20.18 months	N = 25 SEBD youth placed in residential services *Age:* M = 14.36 *Sex:* 36% female *Race/Ethnicity:* 52% Caucasian, 44% African American, 2% Hispanic	Living situation: At the end of the two-years, the majority of youth had transition to less restrictive living situations: home (n=10), foster home (n=11), residential (n=2), corrections (n=2) School performance: 21 participants were rated as improved Costs: wraparound service plan less than 1/3 cost of residential placement	No tests of statistical significance
(Kamradt et al., 2005) *Book chapter* (Kamradt, 2000; Kamradt & Meyers, 1999) *Journal articles*	Wraparound Milwaukee *Lead Agency:* Mental Health *Setting:* Milwaukee County, WI, urban *Duration:* at least 12 months	N = 1031 SEBD youth receiving wraparound With attrition: CBCL (n=383); YSR (n=278); CAFAS (n=543) *Age:* M = 14.2 *Sex:* 20% female *Race/Ethnicity:* 65% African American, 27% Caucasian, 7% Hispanic, 1% Native American	*CBCL:* Significant reductions in mean T-scores from intake (73) to 6 months (64) to 12 months (55) *YSR:* Significant reductions in mean T-scores from intake (56) to 6 months (50) to 12 months (45) *CAFAS:* Significant reductions in total scores from intake (74) to 6 months (60) to 12 months (54)	Demographics not reported, but available from previous report (Kamradt & Meyers, 1999)

CONTINUED: Table 3. Single Group Pretest-Posttest Studies on Wraparound Process

Citation(s) & Source(s)	Program Description	Participants	Primary Measures / Findings	Analytic Details
(Kutash et al., 2002) *Journal article*	School, Family, and Community Partnership *Lead Agency:* Education *Setting:* school-based *Duration:* 2 years	N = 23 ED students With attrition: N = 15 *Age:* M = 11.7 *Sex:* 13% female *Race/Ethnicity:* 78% Caucasian	*CBCL:* no significant improvements on total, internalizing, and externalizing *CAFAS:* no significant improvements *WRAT-III:* no significant improvements reading & math *Discipline referrals:* significant decrease *% of day in special education:* no change *Absences:* no change *Fidelity:* significantly related to reading scores but no other outcomes	Initially study had a matched comparison group but dropped due to high and differential attrition Fidelity measure
(Levison-Johnson & Gravino, 2006) *Conference proceedings*	Monroe County Youth and Family Partnership *Lead Agency:* Interagency *Setting:* Monroe County, NY *Duration:* not reported	N = 84; 2 cohort groups: n = 29 & n = 55 *Age:* not reported *Sex:* not reported *Race/Ethnicity:* not reported	*CAFAS:* Functioning from intake to “most recent CAFAS scores” was measured. 69% of group 1 (and 71% of group 2) showed improvements in CAFAS Total Scores	No tests of statistical significance
(Lyman & de Toledo, 2002) *Conference proceedings*	Family Advocacy, Stabilization, and Support Team (FASST) *Lead Agency:* Mental Health *Setting:* intensive home-based program in Massachusetts *Duration:* M = 4.5 months	N = 79 SEBD youth *Age:* 4-19 *Sex:* not reported *Race/Ethnicity:* not reported	*CAFAS:* Reductions in mean total scores from intake (98) to discharge (80) *GAF:* Increase in mean scores from intake (49) to discharge (56)	No tests of statistical significance

CONTINUED: Table 3. Single Group Pretest-Posttest Studies on Wraparound Process

Citation(s) & Source(s)	Program Description	Participants	Primary Measures / Findings	Analytic Details
(Robbins & Collins, 2003) *Conference proceedings*	Bridges Project school-based wraparound *Lead Agency:* Education *Setting:* schools in rural Kentucky *Duration:* 12 months	N = 324 SEBD students With attrition: N = 27 *Age:* M = 12.4 *Sex:* 28% female *Race/Ethnicity:* 97% Caucasian	*CBCL:* decrease in mean total problems from baseline (71) to 12 months (62) *CAFAS:* improved mean total scores from baseline (104) to 12 months (79) *School indicators:* higher grades, fewer suspensions/detentions	No tests of statistical significance Large attrition due to incomplete data for post-treatment
(Taub et al., 2006; Taub & Pearrow, 2007) *Conference proceedings*	Coordinated Family Focused Care Initiative *Lead Agency:* Interagency *Setting:* 5 sites in Massachusetts *Duration:* enrolled for at least 6 months	Reports present data from two overlapping samples Sample 1: N = 159 youth with SEBD at risk of residential placement Sample 2: N = 377; 6 months (n=343) & 12 months (n=163) *Age:* not reported *Sex:* not reported *Race/Ethnicity:* not reported	Repeated measures analyses revealed significant improvements for the following scales: Sample 1: *CAFAS Total Score:* intake (142.9) to 9 months (101.7) *Child symptoms (YOQ):* intake (101.6) to 6 months (92.9) *BERS:* intake (98.7) to 6 months (104.5) Sample 2: *CAFAS School Scale:* intake (26.7) to 12 months (22.3) *BERS:* improvements in all domains (except School) at 6 months *School disciplinary data:* No improvements at 6 months	Fidelity measure
(Toffalo, 2000) *Journal article*	Nonprofit service agency providing wraparound *Lead Agency:* Mental Health *Setting:* rural Pennsylvania *Duration:* at least 6 months	N = 33 SEBD youth With attrition: N = 28 *Age:* 4-7, M = 8.78 *Sex:* 39% female *Race/Ethnicity:* 100% Caucasian	*CBCL:* significant improvement on total scale score *Fidelity metric:* not significantly related to outcomes; however metric was not specific to wraparound (mean # treatment hours provided/mean # of hours prescribed)	

CONTINUED: Table 3. Single Group Pretest-Posttest Studies on Wraparound Process

Citation(s) & Source(s)	Program Description	Participants	Primary Measures / Findings	Analytic Details
(Vernberg et al., 2004; in press; 2006 *Journal articles*	Intensive Mental Health Program a school-based program with home and service coordination *Lead Agency:* Education *Setting:* Lawrence, Kansas *Duration:* M = 12 months	N = 58 SED elementary school students N = 50 with attrition *Age:* 5-13, M = 9.6 *Sex:* 27% female *Race/Ethnicity:* 70% Caucasian, 16% African American, 8% Native American, 4% Biracial	*CAFAS:* average statistical (and clinical) significant improvements from intake to discharge on total scores. 42 of 50 enrolled students showed clinically significant improvement *CAFAS:* statistical improvements on CAFAS subscales: school performance, home performance, behavior, moods, self-harm, thinking; no improvements on community performance, material needs, and family / social support *BASC:* Average ratings moved from "clinically significant" to "at risk" for total behavioral functioning	Fidelity measure (see (Randall, et al., in press)
(Yoe et al., 1996)* *Journal article*	Vermont's Wraparound Care Initiative *Lead Agency:* Mental Health *Setting:* urban & rural settings *Duration:* at least 12 months	N = 40 SEBD youth *Age:* 7-20, M = 16 *Sex:* 48% female *Race/Ethnicity:* not reported	*ROLES:* significant decrease in mean level of restrictiveness and increase in community placements *QAIC:* significant decreases in total, externalizing, internalizing, and abuse related problems, but not public externalizing problems.	

Note. SEBD = serious emotional and behavioral disorders

Outcome measures abbreviations:

BASC = Behavior Assessment System for Children; BERS = Behavioral and Emotional Rating Scale; CAFAS = Child and Adolescent Functioning Scales; CBCL = Child Behavior Checklist; DAIC = Daily Adjustment Indicator Checklist; FACES = Family Adaptability and Cohesiveness Evaluation Scales; FSQ = Family Satisfaction Questionnaire; GAF = Global Assessment of Functioning; QAIC = Quarterly Adjustment Indicator Checklist; ROLES = Restrictiveness of Living Environment Scale ; SCICA = Semi-structured Clinical Interview for Children and Adolescents; SCRS = Self-Control Rating Scale; SSRS = Self-Control Rating Scale; TRF = Teacher Report Form; WRAT-III = Wide Range Achievement Test; YOQ = Youth Outcomes Questionnaire; YSR = Youth Self Report.

Report included in a previous review

Table 4. Quasi-Experimental Group Comparison Studies on Wraparound Process

Citation(s) & Source(s)	Program Description	Participants	Primary Measures / Findings	Analytic Details
(Bickman et al., 2003)* *Journal article* (Bickman et al., 2002) *Federal report*	Department of Defense managed care delivery of wraparound *Lead Agency:* Mental Health *Setting:* generally rural across 16 states *Duration:* 6 months	N = 612 SEBD youth With attrition: N = 111 2 Groups: wrap-around (n=71) Treatment as Usual (n=40) *Age:* 4-16, M = 12.2 *Sex:* 42% female *Race/Ethnicity:* 72% Caucasian	Service utilization for case management, in-home treatment, and nontraditional services higher for Wrap & lower discontinuity of care Pre-post data (CBCL, YSR, VFI) reported significant improvements over time, but amount of improvement equal across groups 7-wave longitudinal measures (Ohio Scales) reported no significant improvements over time, and no differences between groups Costs were significantly higher (42%) for Wrap group	Analyses only available in federal report Insufficient data to calculate effect sizes
(Bruns et al., 2006) *Journal article* (Rast et al., 2007) *Unpublished manuscript* (Peterson et al., 2003; Rast et al., 2003) *Conference proceedings*	Wraparound in Nevada *Lead agency:* Child Welfare *Setting:* urban & rural *Duration:* 18 months	N = 67 SEBD youth in custody of child welfare 2 Groups: wrap-around (n = 33) and traditional case management + mental health services (n = 34) *Age:* M = 11.9 years *Sex:* 49% female *Race/Ethnicity:* 43% Caucasian	Wraparound group showed greater improvements than comparison over time for: -CBCL Total Score (d = 0.71) -CAFAS Total Score (d = 0.25) -ROLES Score (d = 0.62) -School GPA (d = 0.28) -School disciplinary (d = 0.57) No differences between groups were found for -School attendance -Juvenile Justice involvement	Used multi-level modeling to analyze changes between groups over time Fidelity measure

CONTINUED: Table 4. Quasi-Experimental Group Comparison Studies on Wraparound Process

Citation(s) & Source(s)	Program Description	Participants	Primary Measures / Findings	Analytic Details
(Hyde et al., 1996)* *Journal article*	Family Preservation Initiative of Baltimore City, Inc. *Lead Agency:* Mental Health *Setting:* urban *Duration:* 6 – 36 months	N = 107 SEBD youth 4 Groups: 2 received wraparound either following (WR, n=25) or instead of residential treatment (WD, n=24); 2 received traditional services and measured before receiving wraparound (PW, n=39) or did not receive wraparound (NW, n=19) With attrition: N = 69 WR (n=21) WD (n=24) PW (n=14) NW (n=10) *Age:* M = 17.28 *Sex:* 25% female *Race/Ethnicity:* 63% African American	*Community adjustment rating in "good" range: Higher for wraparound groups WR had higher % in good range than PW (d=0.76) and NW (d=1.53) and WD higher than PW (d=0.72) and WD (d=1.49)* *% of youth with more than 10 days community involvement: WR higher than PW (d=0.53) and NW (d=1.94); WD higher than PW (d=0.28) and NW (d=1.69)*	No tests of statistical significance
(Pullmann et al., 2006) *Journal article*	Connections Program in Clark County, WA *Lead agency:* Juvenile Justice *Setting:* not reported *Duration:* M = 11.2 months (range: 1 to 24.5 months)	N = 204 juvenile offenders with SEBD 2 groups: youth in Connections Program (n = 106) and a historical comparison group (n = 98) *Age:* M = 15.2 years *Sex:* 31% female *Race/Ethnicity:* 88% White	Analyses demonstrated lower recidivism for wraparound group for: -Any type of offense (d = 0.25) -Felony offense (d = 0.26) -Whether they served in detention (d = 0.85) For those who did serve in detention, -Number of days served in detention (d = 0.66) -Number of times served in detention (d = 0.76)	Cox regression time-to-event analyses

CONTINUED: Table 4. Quasi-Experimental Group Comparison Studies on Wraparound Process

Citation(s) & Source(s)	Program Description	Participants	Primary Measures / Findings	Analytic Details
(Resendez, 2002) *Conference proceedings*	Riverside County Department of Mental Health provided "flexible wraparound funding" *Lead Agency:* Mental Health *Setting:* not reported *Duration:* not reported intake to discharge	N = 485 SEBD youth 2 groups: receiving flexible funds (n=284) and a group receiving services but not flexible funds (n=201) With attrition: flex funds (n=60), attrition for comparison not reported *Age:* M = 13 years *Sex:* majority male *Race/Ethnicity:* majority White	*CAFAS:* significant improvement in total scores from intake to discharge for flexible funds (71 to 51) and non-flexible funds (73 to 50); there were no between group differences	Insufficient data available to calculate effect sizes
(Stambaugh et al., 2007) *Journal article* (Reay et al., 2003; Stambaugh et al., 2008) *Conference proceedings*	Nebraska Family Central System of Care *Lead Agency:* Mental Health *Setting:* Rural *Duration:* Months in treatment differed for wraparound (M=15), MST (M=5.5), and wrap + MST (M=10.2) groups	N = 320 SEBD youth 3 Groups: wraparound (n=213), MST (n=54), both (n=53) With attrition: 6 months (n=285), 12 months (n=230), 18 months (n=202) *Age:* M = 12 years (4 to 17.5 years) *Sex:* 27% female *Race/Ethnicity:* 90% White, 4% American Indian, 6% Other (11% Hispanic)	*CBCL:* significant improvement in total scores from intake to 18 months for all groups. Significant Group x Time interaction effect with the trajectory of the MST group showing significantly greater improvement than wraparound group. *CAFAS:* significant improvement in total scores from intake to 18 months for all groups; however, there were no significant between group differences	Linear mixed models No control group Insufficient data available to calculate effect sizes Fidelity measure

Note. SEBD = serious emotional and behavioral disorders. Outcome measures abbreviations: CAFAS = Child and Adolescent Functioning Scales; CBCL = Child Behavior Checklist; ROLES = Restrictiveness of Living Environment Scale; TRF = Teacher Report Form; VFI = Vanderbilt Functional Impairment Scale; YSR = Youth Self Report.

Report included in a previous review

Table 5. Experimental Randomized Controlled Trial Studies on Wraparound Process

Citation(s) & Source(s)	Program Description	Participants	Primary Measures / Findings	Analytic Details
(Carney et al., 2003) *Journal article*	Juvenile Delinquency Task Force Implementation Committee (JDIC) demonstration project *Lead Agency:* Juvenile Justice *Setting:* Urban *Duration:* 18 months	N = 307 youth referred to court or adjudicated and/or entered children's services for delinquent behaviors With attrition: N=141 2 groups: wraparound (n=73) and conventional services (n=68) *Age:* M = 14.8 *Sex:* 38% female *Race/Ethnicity:* 50% Caucasian 48% African American 1% Biracial	Wraparound group missed less school (d=0.48), suspended less (d=0.48), less likely to run from home (d=0.46), less assaultive (d=0.47), and less likely to be stopped by police (d=0.51), but conventional services more likely to have a job (d=-0.39). Wraparound group somewhat less likely to be arrested (d=0.23) somewhat more likely to be incarcerated (d=-0.18)	
(Clark et al., 1998)* *Book chapter* (Clark et al., 1997) *Conference proceedings* (Clark et al., 1996) *Journal article*	Fostering Individualized Assistance Program (FIAP) *Lead Agency:* Child Welfare *Setting:* foster care in Florida *Duration:* not reported	N = 132 SEBD youth in foster care 2 groups: FIAP (n=54) and standard practice (SP) foster care (n=78) With attrition: SP (n=77) *Age:* 7-15 *Sex:* 40% female *Race/Ethnicity:* 62% Caucasian, 33% African American, 5% Hispanic & biracial	*Permanency status:* FIAP group significantly more likely to live in permanency-type setting following program Significantly fewer days on runaway and fewer days incarcerated for FIAP No group differences on rate of placement changes, days absent, & days suspended *DISC conduct disorder:* FIAP males showed significantly less, but FIAP females significantly more *Delinquency score:* FIAP males demonstrated significantly less YSR (n=43) & CBCL (n=41) *Internalizing & Total scores:* no repeated measures differences; yet significantly smaller % boys (not girls) in clinical range for FIAP *Externalizing:* repeated measures showed significant improvement over time for boys not girls, plus significantly smaller % of FIAP group in clinical range	

CONTINUED: Table 5. Experimental Randomized Controlled Trial Studies on Wraparound Process

Citation(s) & Source(s)	Program Description	Participants	Primary Measures / Findings	Analytic Details
(Evans et al., 1998)* *Book chapter* (Evans et al., 1998) *Evaluation report* (Evans et al., 1996) *Journal article*	Family Centered Intensive Case Management (FCICM)- similar to wraparound and Family Based Treatment (FBT) *Lead Agency:* Mental Health *Setting:* rural New York home-based and foster care *Duration:* 12 months	N = 42 SEBD youth 2 Groups: FCICM (n=27) and FBT (n=15) Differential attrition among measures Age: 5-13, M = 9 Sex: 10% female Race/Ethnicity: 83% Caucasian, 5% African American, 5% Native American, 5% Biracial, 2% Hispanic	*CAFAS (n=31):* significant improvement for FCICM overtime on behavior and moods subscales but not role performance and cognition *CBCL (n=28):* no significant improvements for FCICM vs. FBT overtime on total, internalizing, and externalizing scales *FACES (n=35):* no significant differences between groups *Piers-Harris (n=23):* no significant differences between groups *TRF:* dropped due to missing data	Insufficient data available to calculate effect sizes
(Rast et al., 2008) *Paper Presentation*	Wraparound as implemented by child welfare caseworkers or by wraparound facilitators hired and supported by an allied mental health agency. *Lead agency:* Child Welfare *Setting:* Urban and suburban Oklahoma *Duration:* 18 months	N = 108 youth with high level of behavioral health needs. 3 Groups: Wraparound implemented by caseworkers (CW Wrap; n=36), Wraparound implemented by MH (MH Wrap; n=36), treatment as usual (n=36). *Age:* 3-17 *Sex:* Not reported *Race:* Not reported	Permanency: Significantly more days in permanency placement and a higher percent of youth in permanency placement at 12 and 18 months for both CW Wrap and MH wrap than TAU *Residential:* Fewer placement changes for CW Wrap than either MH Wrap or TAU; Lower restrictiveness for both wrap groups than TAU *Behaviors:* Greater reduction in problem behaviors as reported by the Ohio Scales for CW Wrap than MH Wrap or TAU *Functioning:* Greater reduction in CAFAS scores for CW Wrap than MH Wrap or TAU *Caregiver Strain:* Greater reduction for CW Wrap than MH Wrap or TAU	Insufficient data available to calculate effect sizes Fidelity measure

Note. SEBD = serious emotional and behavioral disorders. Outcome measures abbreviations: CAFAS = Child and Adolescent Functioning Scales; CBCL = Child Behavior Checklist; DISC = Diagnostic Interview Schedule for Children; FACES = Family Adaptability and Cohesiveness Evaluation Scales; TRF = Teacher Report Form; YSR = Youth Self Report.

Report included in a previous review

& Yoe, 1995; Bruns, Suter, Force, & Burchard, 2005; Clarke, Schaefer, Burchard, & Welkowitz, 1992; Copp, Bordnick, Traylor, & Thyer, 2007; Eber & Hyde, 2006; Eber, Osuch, & Redditt, 1996a; Eber, Osuch, & Rolf, 1996b; Hyde, Woodworth, Jordan, & Burchard, 1995; Illback, Neill, Call, & Andis, 1993; Kamradt, Kostan, & Pina, 1998; Kamradt & Meyers, 1999; Kutash, Duchnowski, Sumi, Rudo, & Harris, 2002; Levison-Johnson & Gravino, 2006; Lyman & de Toledo, 2002; Robbins & Collins, 2003; Seybold, 2002; Taub & Pearrow, 2007; Toffalo, 2000; Vernberg et al., 2004; Yoe, Santarcangelo, Atkins, & Burchard, 1996). As such, they conducted within subjects comparisons across time, typically measuring outcomes at intake and 6 to 12 months later (*M* = 11.63 months, *SD* = 5.39). The advantage of this design over the qualitative case study design is that it includes larger (and ideally more representative) samples and often employs standardized measures of outcomes. However, due to lack of comparison groups, these studies cannot confirm that any observed changes occurred as a result of wraparound. Consequently, they provide evidence that wraparound may be associated with positive outcomes but do not offer the same level of confidence as provided by comparison studies.

Rather than discuss each of these 22 studies individually, key characteristics about the studies and findings were summarized. Just over half of these studies (*n* = 13) were published in peer-reviewed journals. Although all studies indicated that the participants received wraparound, the interventions were fairly heterogeneous with regard to setting, participants, and the types of outcomes measured. It should be noted that three of the studies used different samples to evaluate the same wraparound initiative (Wraparound Milwaukee, Kamradt et al., 1998; 2005; Seybold, 2002). Many of the interventions provided services in the home and community, though several others also (or exclusively) took place in schools (e.g., Eber et al., 2006). Most of the youth participants were reported to have SEBD, yet referral problems ranged from imminent risk of hospitalization to impaired functioning at school. Some interventions served primarily child or adolescent groups, while others simply targeted anyone 21 years or younger.

Examining outcome analyses from the pretest-posttest no comparison studies, approximately one third (*n* = 7) did not conduct any tests of statistical significance and reported primarily positive effects. Of the studies that did conduct statistical analyses, significant positive effects were found for youth living situation (e.g., youth were able to return to their communities following wraparound) and reported number of negative behaviors. Other findings were more difficult to interpret due to the range of measures used. Examining two of the most commonly used measures revealed mixed results. The ten studies that used the Child Behavior Checklist ([CBCL] Achenbach & Rescorla, 2001) were evenly split between showing significant improvements (*n* = 5) and no improvement or mixed findings (*n* = 5). Nine studies used the Child and Adolescent Functional Assessment Scale ([CAFAS] Hodges, Wong, & Latessa, 1998) with only slightly more than half finding statistically significant improvements in functioning (*n* = 5). Burchard and colleagues (2002) noted that there was some evidence for greater improvements at home than at school (Clarke et al., 1992; Eber et al., 1996b; Kutash et al., 2002; Yoe et al., 1996), however the null findings in the schools could be attributed to the relatively low power of these studies.

Quasi-Experimental Studies

Five quasi-experimental studies that compared outcomes for youth enrolled in a wraparound initiative compared to usual care were identified. These studies (Bickman et al., 2003; Bruns, Rast, Peterson, Walker, & Bosworth, 2006; Hyde et al., 1996; Pullmann et al., 2006; Resendez, 2002) adopted pretest-posttest, comparison group designs without random assignment. This design exerts a greater level of control over the independent variable (i.e., provision of wraparound) than either of the previously discussed designs, allowing the researcher to be more confident that changes in outcome may be attributed to the intervention. This does not mean that this type of design allows one to unequivocally make causal inferences. Yet quasi-experimental design represents a major leap forward in methodology compared to single group design, thus each of these studies was reviewed individually.

The earliest of these quasi-experimental studies was conducted in urban Baltimore with children returned or diverted from residential out-of-

state placements (Hyde et al., 1996). The authors examined outcomes for four groups: (a) youth who received wraparound after returning from residential placement (Wrap+Return or WR), (b) youth who received wraparound as an alternative to residential placement (Wrap+Diversion or WD), (c) youth who received traditional services during the year prior to the wraparound program initiating (Prior to Wrap or PW), and (d) children who received traditional services instead of wraparound (No Wrap or NW). The authors stressed that the four groups were not equivalent (e.g., PW group was older, WD had not experienced residential placement), and thus they cautioned against making direct comparisons. A community adjustment scale was developed for this study to provide a single rating of several relevant indicators (restrictiveness of the youth's living situation, school attendance, job/job training attendance, and serious problem behaviors). Children received ratings of "good" if they were living in regular community placements, attending school and/or working for the majority of the week, and had fewer than three days of serious behavior problems during the course of a month.

After approximately two years of wraparound, 47% of the wraparound groups (WR and WD) received a rating of good community adjustment, compared to 8% of children who received traditional mental health services. Unfortunately, high rates of attrition in the non-wraparound groups further compound the problem that the groups were not equivalent at baseline. As the authors stated, "this is not a comparison study" (Hyde et al., 1996, p. 70), so perhaps the biggest contributions are the identification of these groups for future comparison studies and the creation of a measurement tool that directly assessed the key indicators important to providers and families.

Bickman and his colleagues have conducted experimental evaluations of systems of care at Fort Bragg, NC (Bickman et al., 1995) and Stark County, OH (Bickman et al., 1997). More recently, they completed a quasi-experimental study on a demonstration project of wraparound through the Department of Defense (Bickman et al., 2003). A managed care company oversaw the demonstration, organizing the delivery of services hierarchically with professionals at the family level (case managers), program level (care managers), and system level (clinical management committee). The demonstration group (n = 71) received both traditional (e.g., psychotherapy, psychiatric hospitalization) and nontraditional services (e.g., respite, recreation services, therapeutic foster homes). A comparison group (n = 40, treatment as usual) was formed from families referred to the demonstration project but who refused to participate or were ineligible because the demonstration group had different exclusionary criteria.[2] Outcomes for the two groups were assessed from baseline to six months later.

The authors' findings included (a) largely no baseline differences between the two groups, (b) higher utilization of "wraparound services" (e.g., case management, in-home supports, and nontraditional services) for the demonstration group, (c) higher costs for the demonstration group (primarily due to this group remaining in treatment longer), and (d) no consistent differences between the groups on the outcome measures. Limita-

2. Exclusionary criteria for the demonstration that were *not* exclusionary criteria for TAU included: requiring long-term residential care, history of treatment resistant drug use, persistent antisocial behavior not resulting from a treatable mental disorder, developmental or cognitive disorder that negatively impacts treatment, conviction/adjudication for sexual perpetration, and being amenable to treatment.

tions of this study include the short time span (6 months) and whether the demonstration project truly followed the wraparound process. The authors stated that the services were community-based, included informal services, and included availability of flexible funding. However, they were not aware if any of the remaining seven elements had been followed. Strengths include the similarities between the groups at baseline, use of standardized measures, adequate power, and sophisticated data analyses.

Another quasi-experimental study (Resendez, 2002) compared groups of youth who did (*n* = 284) or did not (*n* = 201) receive "flexible wraparound funding" (p. 243) while receiving mental health services from the same agency. Flexible funds were primarily directed toward financial aid as well as recreational and social supports. The average amount of flexible funds allotted was $155.81. Participants' functioning and impairment was measured at baseline and six months later. Like the previously reviewed study, significant improvements were found for both groups over time, but no between-group differences were detected. Limitations include high attrition for the flexible funds group, relatively short time span (6 months), and weak manipulation of the independent variable. With the only difference between groups being an award ranging from $5 to $200, a significant difference on functioning scores seems unlikely. The main strength of this study was the assessment of the impact of a single wraparound element: Flexible Resources and Funding. As researchers begin to question the importance of the hypothesized components of wraparound, dismantling studies (that investigate the impact of specific components or principles) similar to this one will be important. However, it is questionable whether this study truly meets criteria for inclusion in this review of wraparound, given our inclusion criteria.

Pullmann and colleagues (2006) conducted a two-year longitudinal matched comparison study of youth involved in the juvenile justice system and receiving mental health services. Overall, 110 youth enrolled in wraparound were compared to 98 receiving conventional mental health services. Youths in the comparison group were three times more likely to commit a felony offense during the follow up period than youths in the wraparound group. Among youth in the wraparound program, 72% served detention "at some point in the 790 day post identification window" (p. 388), while all youth in the comparison group served detention. Of youth in the wraparound program who did serve detention, they did so significantly less often than their peers. Wraparound youth also took three times longer to recidivate than those in the comparison group. According to the authors, a previous study by Pullmann and colleagues showed "significant improvement on standardized measures of behavioral and emotional problems, increases in behavioral and emotional strengths, and improved functioning at home at school, and in the community" (p. 388) among youth in the wraparound program.

The final wraparound vs. control condition quasi-experimental study was a matched comparison pilot study conducted to demonstrate the effectiveness of the *Wraparound in Nevada* (WIN) program for youth in custody of the child welfare system due to abuse or neglect. Thirty-three youth with SEBD receiving wraparound were compared to a sample of 34 youth receiving traditional mental health services. The comparison group was matched on location, age, severity of emotional and behavioral symptoms, and residential placement. Findings from this pilot study were presented in a policy paper on wraparound (Bruns et al., 2006), two conference proceedings (Peterson, Rast, Gruner, Abi-Karam, & Earnest, 2003; Rast, Peterson, Earnest, & Mears, 2003), and a manuscript currently under review that was shared by the authors (Rast, Bruns, Brown, Peterson, & Mears, 2007). After 18 months, approximately 82% of youth in WIN moved to less restrictive environments, compared to 38% of comparison group youth, yielding a large estimated effect (d = 0.93). In addition, family members were identified to provide care for 11 of the 33 youth in the wraparound group (33.3%) compared to only six in the comparison group (17.6%). Mean scores on the CAFAS for youth in wraparound decreased significantly across all waves of data collection (6, 12, 18 months) in comparison to the traditional services group. More positive outcomes were also found for the wraparound cohort on school attendance, school disciplinary actions, and grade point averages. No significant differences were found in favor of the comparison group.

In addition to the positive impact found for wraparound, the study also reported fidelity data from the Wraparound Fidelity Index (WFI; Bruns et al., 2005). Scores from the WFI were quite high compared to other programs nationally (Bruns et al., 2006; Bruns, Leverentz-Brady, & Suter, in press). These results provide information for the field about the level of adherence that may be necessary to achieve outcomes such as those observed for the wraparound-enrolled youths in this study.

In addition to the five studies described above that compared outcomes for youth enrolled in wraparound to treatment as usual conditions, a unique quasi-experimental study was conducted (Stambaugh et al., 2007) that compared n = 213 children receiving wraparound to n = 54 youths receiving Multisystemic Therapy (MST; Henggeler, Schoenwald, Rowland, & Cunningham, 2002) in a single system of care in rural Nebraska. (A third group received a combination of MST and wraparound.) Although MST and wraparound have been conceptually compared (Burns, Schoenwald, Burchard, Faw, & Santos, 2000), this study provided a unique opportunity to contrast the two approaches empirically. MST has a more established evidence base than wraparound and meets criteria as an empirically supported treatment for children with conduct problems (Brestan & Eyberg, 1998). Results showed that both groups showed significant improvements in functioning as assessed by the CAFAS and behavior as assessed by the CBCL, and similar downward trajectories in scores for each of these measures. Rates of improvement in behavior problems were significantly better for the MST group; however, rates of improvement in child functioning over time were the same for the two groups.

Though the authors speculate that the results indicate greater benefit of using specific models such as MST as opposed to more general care coordination models such as wraparound, it is difficult to conclude that the results demonstrate the superiority of MST to wraparound, given that youth in the MST group were selected based on meeting criteria for MST while wraparound was used to support a much larger number of youth and families with a much more diverse set of needs. Thus, though statistical controls were used in between-group comparisons, the two groups were inherently non-equivalent at baseline by definition. Nonetheless, the paper points to an important direction in wraparound outcomes studies, and provides interesting information about the types of outcomes that might be achieved for youth receiving care through these two models in a single system of care, as well as potential methods for organizing a system of care to meet the needs of a diverse group of youth and families.

Experimental Studies

Four randomized trials (Carney & Buttell, 2003; Clark, Lee, Prange, & McDonald, 1996; Evans, Armstrong, Kuppinger, Huz, & McNulty, 1998; Rast, Vetter, & Poplin, 2008) constitute the wraparound evidence base employing experimental designs. Experimental studies provide the strongest protections against threats to internal validity, thus allowing researchers to draw more confident connections between interventions and outcomes. However, one cannot assume that the findings will necessarily generalize to other settings or environments (referred to as external validity). This is a particularly noteworthy point for the randomized studies reviewed here because they represent specific groups of children receiving wraparound in several different contexts, including a foster care-based program (Clark et al., 1996; 1997; 1998), an intensive case management approach (Evans et al., 1996; Evans, Armstrong, Kuppinger, Huz, & Johnson, 1998; Evans, Armstrong, Kuppinger, Huz, & McNulty, 1998), a program for adjudicated or court-referred youths (Carney & Buttell, 2003), and a program for youth involved with the child welfare system (Rast et al., 2008). These programs were deemed consistent enough with the wraparound process to be included in the evidence base (Burchard et al., 2002); however the findings may not generalize to wraparound programs in other settings.

Clark and his colleagues (Clark et al., 1996; Clark et al., 1998) conducted the most frequently cited empirical outcome study on wraparound. Participants included children in foster care randomly assigned to either the Fostering Individualized Assistance Program ([FIAP] n = 54) or standard practice foster care (n = 78). The program provided individualized services for children in foster care with the primary goals being to achieve an ef-

fective permanency plan and improve behavioral outcomes. Findings from this study demonstrated significantly fewer placement changes for children in the FIAP program, fewer days on runaway, fewer days incarcerated (for subset of incarcerated youths), and older children were significantly more likely to be in a permanency plan at follow-up. No group differences were found on rate of placement changes, days absent, or days suspended. Significantly fewer boys in the treatment program met criteria for conduct disorder compared to the children in standard practice foster care, but significantly *more* girls in the treatment group were diagnosed with conduct disorder. No group differences were found for internalizing disorders, but boys in the treatment program showed significantly greater improvement on externalizing problems than the comparison group. Taken together, the findings provided moderate evidence for better outcomes for the wraparound program, though the differences appear limited to boys and externalizing problems.

Though there may not yet be sufficient evidence in peer-reviewed journals to state that wraparound consistently results in better outcomes.... the evidence base is encouraging and certainly growing.

The second randomized clinical trial (Evans et al., 1996; Evans, Armstrong, Kuppinger, Huz, & Johnson, 1998; Evans, Armstrong, Kuppinger, Huz, & McNulty, 1998) assigned children referred for out-of-home placements to either family centered intensive case management (n = 27) or treatment foster care (family based treatment, n = 15). The case management program largely followed the elements of the wraparound process by providing individualized, team-based, and comprehensive services and supports. Significant group differences in favor of the case management program were found for behavioral and mood functioning. No differences were found with regard to other types of functioning (role performance or cognition), behavior problems (internalizing and externalizing), family cohesiveness, or self-esteem. Probably the most serious limitation of this study is the small sample size, plus further loss of data on many of the outcome measures. As a result, the study had very low power to detect differences between the groups.

A third randomized clinical trial (Carney & Buttell, 2003) evaluated the effectiveness of a wraparound program designed to reduce recidivism of adjudicated or court referred youths. Participants included 141 youths (out of 500 invited to participate) randomly assigned to a team-based wraparound program (n = 73) or conventional services (n = 68) after being referred to juvenile court. The two groups were followed for 18 months. Youths receiving wraparound were absent from school less often, suspended from school less often, ran away from home less frequently, and were less assaultive than those in the conventional services group. However, youths receiving conventional services were more likely to obtain a job, and no differences were found for subsequent arrests or incarceration. Thus, though the "weight of evidence" from this study indicates better interim outcomes for the wraparound condition, the study's proposed ultimate outcomes—subsequent arrests and incarceration—were not found to be significantly impacted by assignment to wraparound.

The most recent randomized trial is currently being completed in the context of the Oklahoma child welfare system (Rast et al., 2008). Though this study is not yet complete, interim findings have been reported at the annual research conference of *A System of Care for Children's Mental Health: Expanding the Research Base* hosted by the University of South Florida Research and Training Center for Children's Mental Health (one of the sources for this review). Participants were 108 children in the child welfare system who were nominated for the study because they were high users of behavioral health services. These children were randomly assigned to three groups (each n = 36): (1) wraparound facilitation conducted by the child welfare caseworker; (2) wraparound conducted by a facilitator employed by a local mental health center; or (3) services as usual. Re-

sults found that the group of children and youths receiving wraparound experienced fewer school and residential placement disruptions, more days overall in a permanency setting, and improved behavioral and functional outcomes, when compared to the services as usual group. There was also a trend toward better outcomes for children in the group for which the wraparound process was facilitated by the child welfare caseworker, as opposed to the group for which wraparound was implemented by the local mental health center.

Discussion

This review was intended to present results from the full range of outcome studies on wraparound as a way to both (1) evaluate the weight of the evidence as well as (2) explore the methodologies used. Overall, the findings from this review are encouraging with respect to the potential for wraparound to have a positive impact on youth and families. Though the majority of the studies that have been published and that were reviewed here have serious methodological limitations, there is a growing body of more rigorous research on wraparound that is now emerging. This includes experimental and quasi-experimental studies recently completed or nearly completed (e.g., Pullmann et al., 2006; Rast et al., 2008), as well as additional randomized studies that are now underway, such as an NIMH sponsored study of wraparound compared to intensive case management for youth in the child welfare system in Clark County, Nevada (Walker & Bruns, 2006). Though there may not yet be sufficient evidence in peer-reviewed journals to state that wraparound consistently results in better outcomes than alternative treatments for specific populations, the evidence base is encouraging and certainly growing.

At the same time, if advocates of wraparound hope to provide convincing evidence that wraparound is an effective process for meeting the needs of children with SEBD, a number of methodological limitations must be addressed. First, more studies on wraparound are needed that utilize rigorous methodological design and appropriate comparison groups. This includes comparing wraparound to traditional control groups (e.g., treatment as usual) as well as conceptually relevant alternatives. For example, although wraparound developed as a less restrictive substitute for residential placements, no studies that directly compared these two interventions were found.[3] Without question, increasing the number of studies that included randomized selection of participants would be a major benefit to the field.

Second, many of the studies provided incomplete data on participant demographics and outcomes. As noted in one previous narrative review (Burchard et al., 2002), few of the reviewed studies specified how participants were selected for inclusion. Most likely, the researchers chose youth based on staff nominations or simply by using all available data. More care needs to be taken in future studies to specify how samples were selected in order to determine if they are truly representative of their programs or children with SEBD in general. Similarly, several studies presented detailed findings only when the effects were statistically significant. In order to better synthesize the evidence base, it is crucial for authors to include basic information (e.g., means, standard deviations, effect sizes) for all analyses.

Third, outcomes were measured on average from 3 to 36 months after baseline, often as post-

3. Although Hyde and her colleagues (1996) examined outcomes for youth assigned to both wraparound and residential treatment, comparisons were explicitly not conducted.

tests with children still engaged in services. A goal of wraparound is to create long-standing changes in the youth in family. Thus, more longitudinal follow-ups are necessary to see if changes last beyond the end of treatment.

And fourth, one cannot conclude that all reviewed studies offered equivalent versions of wraparound. The programs varied on a number of factors including setting, target population, stated goals, and outcomes measured. Only seven (19%) of the studies reported systematic assessment of the degree to which wraparound was delivered as intended (Bruns et al., 2006; Bruns et al., 2005; Kutash et al., 2002; Rast et al., 2008; Stambaugh et al., 2007; Taub & Pearrow, 2007; Vernberg et al., 2004). Without evaluating the fidelity of an intervention, it is difficult to determine if the program offers wraparound or merely "wannabe wraparound" (Walker & Bruns, 2003). Fortunately, it appears that recent studies of wraparound have more consistently reported results of fidelity assessment using tools that are widely available. The accumulation of evaluation results that include reports of fidelity assessments will facilitate interpretation of the results as well as help synthesize findings across studies.

Conclusions

As summarized above, this review of wraparound outcomes studies yielded a large number of publications describing a wide array of target populations and study designs, most of which were far from rigorous. Regardless, because of the diverse ways in which wraparound is applied for children and families, it is important to keep a "catalog" of the breadth of the overall evidence base on this model, especially in the absence of a well-developed set of randomized controlled studies. By presenting this summary in this way, we hoped to provide a format that can be updated over time, and create a resource for program developers, administrators, practitioners, and researchers who wish to seek out published studies on a specific target population or context in which wraparound has been implemented. This review can also serve as a tool for answering more specific research questions, such as typical trajectories in behavioral or functional improvement over time, or the relationship between wraparound fidelity and outcomes. Finally, with greater recognition of the broad range of wraparound outcomes studies, perhaps more local evaluators will be encouraged to publish their results, and/or design their evaluations to feature greater rigor, integrate fidelity assessment, and otherwise help the field move forward.

While the goal was to be exhaustive, we recognize that this review may not include all relevant wraparound outcomes studies. As a result, we are continuing to search for additional gray literature not identified by the inclusion criteria used for this review (e.g., unpublished local evaluation reports). Such findings will likely expand our understanding of outcomes typically found for systems as well as children and families and may facilitate a future exercise of benchmarking commonly measured outcomes such as behavior, functioning, and residential placement.

In addition, as results emerge from the controlled studies of wraparound currently underway, a more systematic appraisal of the quality of the wraparound evidence base is needed, which will make reviews such as this one more complete as well as "evidence based" unto itself. At that point, we can also identify the specific gaps in the literature (e.g., specific target populations, specific types of outcomes), beyond simply noting that "more needs to be done." Finally, we need to translate the results of quasi-experimental and experimental studies into a meta-analysis that can generate average effect sizes for different types of outcomes, as determined by between group comparisons of wraparound and control groups. Given that we have now identified 8-10 unique studies that provide some type of ability to generate estimates of the size of effects of implementing wraparound, this can be an immediate next step that further informs the field about wraparound's potential for positive impact on the lives of children and families.

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National Trends in Implementing Wraparound: Results from the State Wraparound Survey, 2007

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One of the most frequently cited studies on the wraparound process is a national survey conducted in 1998 examining wraparound implementation across the U.S. This study (Faw, 1999), conducted by Duke University and the Georgetown National Technical Assistance Center for Children's Mental Health and published in the Burns & Goldman (1999) monograph on wraparound, used surveys of state mental health directors to estimate that wraparound was available in 80%- 90% of states and U.S. territories. Based on estimates provided by 24 of the responding 49 states and territories, the authors also estimated that as many as 200,000 youth may be served by the wraparound process annually.

Though the number of youth served by wraparound was impressive, the study also found that fewer than half the states had any defined standards for wraparound implementation, that only about half had dedicated resources to support wraparound training and professional development, and that few states measured fidelity or were conducting program evaluation. The authors concluded that there was a "lack of a concurrent definition" of wraparound at the time of the survey, and that results pointed to "a need for a definition as well as an established set of standards" (p.64).

Nearly 10 years later, Dr. Faw (now Dr. Stambaugh) partnered with the National Wraparound Initiative (NWI) and the University of Washington Division of Public Behavioral Health & Justice Policy, to conduct a follow up of the 1998 survey. With wraparound having indeed become better un-

derstood and standards more consistently established in the intervening years, the purpose of the new study was to gain an updated and more refined estimate of the number of wraparound initiatives and participating youth. As with the original study, the intent was also to better understand how wraparound implementation was being supported in different places across the country, and collect qualitative information about implementation successes, barriers, and lessons learned. In the rest of this article, we will present an overview of the methods and results from this nine-year follow-up to the State Wraparound Survey.

Methods

A 17-item survey about wraparound implementation in the respondent's home state was created, based on the original 13-item survey used in 1998. This survey was mailed to Children's Mental Health Directors (as identified by the National Association of State Mental Health Program Directors or NASMHPD) in all 50 states, 4 U.S. territories, and the District of Columbia.

For this update to the original 1998 study, wraparound was defined using more precise language, using descriptions based on the model specification work of the National Wraparound Initiative (Walker & Bruns, 2006). Specifically, respondents were asked to report on initiatives in their state that adhered to the following definition:

Wraparound is a team-based process to develop and implement individualized service and support plans for children with serious emotional and behavioral problems and their families. Wraparound implementation is typically facilitated by a trained wraparound facilitator or care coordinator, who works with a team of individuals relevant to the youth and family. The wraparound process also ideally includes the following characteristics:

1. **Efforts are based in the community;**
2. **Services and supports are individualized to meet specific needs of the children and families;**
3. **The process is culturally competent and strengths-based;**
4. **Teams have access to flexible funding;**
5. **Family and youth perspectives are sought and prioritized;**
6. **Team members include people drawn from family members' natural support network;**
7. **The wraparound plan includes strategies that draw on sources of natural support;**
8. **The team monitors progress on measurable indicators of success and changes the plan as necessary.**

Respondents could complete the survey online, via hard copy, or via email. Respondents that did not return surveys were sent two email reminders, after which they were reminded by phone calls from the study team. For approximately 10 states whose identified respondent did not respond to email or phone reminders, the research team contacted colleagues in the state for potential alternate respondents who would be adequately knowledgeable about wraparound implementation in the state to complete the survey. Five states' surveys were completed through this mechanism.

Results

Response rates. Surveys were ultimately completed for 47 states, one territory, and D.C., for a total return rate of 89.1% (49 out of 55 possible states and territories). This is the same overall return rate as for the 1998 survey, when 46 states, two territories and D.C. responded. (For convenience sake, we will refer to responding states, territories, and D.C. collectively as "states" in the rest of this report.).

Numbers of programs and youth served. Of the 49 states who responded to the survey, 87.8% (n = 43) reported having some sort of wraparound program in their state in 2007. This is exactly the same number and percent that reported wraparound availability in 1998. Of the 43 states reporting a wraparound initiative, 42 gave estimates of the number of children served statewide. Among states that could provide estimates, a total of 98,293 children were estimated to be served by wraparound, in a reported 819 unique

programs across the 43 responding states. The mean number of youth served in states reporting wraparound programs was 2,337, and the median was 852.5. This is compared to a mean of 3,802 in 1997 (median 1,162).

There were wide variations in the number of children served per state, which was very positively skewed and ranged from 66 to 18,000 (SD = 3,676). Five states (North Carolina, Arizona, Kentucky, Maine, and Florida) reported over 5,000 youth served annually, while there were also five states reporting fewer than 100 youth served annually and 21 that reported under 1000 served annually. There were also vast differences in the number of unique wraparound initiatives or programs estimated to be operating in each state, which ranged from 1 to 134 (SD = 30.5). Five states (Georgia, Ohio, Michigan, Illinois, and Indiana) reported at least 50 unique wraparound programs in the state.

Statewide or local implementation. In 2007, 60% of states with wraparound projects (26 of 43) reported that wraparound is a statewide effort, as opposed to 17 (40%) which were implemented through one or more local effort(s). This is a decrease in reported state wraparound initiatives from 1998, when 81% of states (35 of 43) reported that wraparound was a statewide effort. States reporting statewide implementation reported a mean of 3,227 youth served (SD = 4367) versus only 946 youth served (SD = 1366) for states with local implementation only ($t(39) = 2.47$; $p<.05$). Overall, 13 of the 16 states serving 2,000 or more youth via wraparound reported having a statewide wraparound initiative.

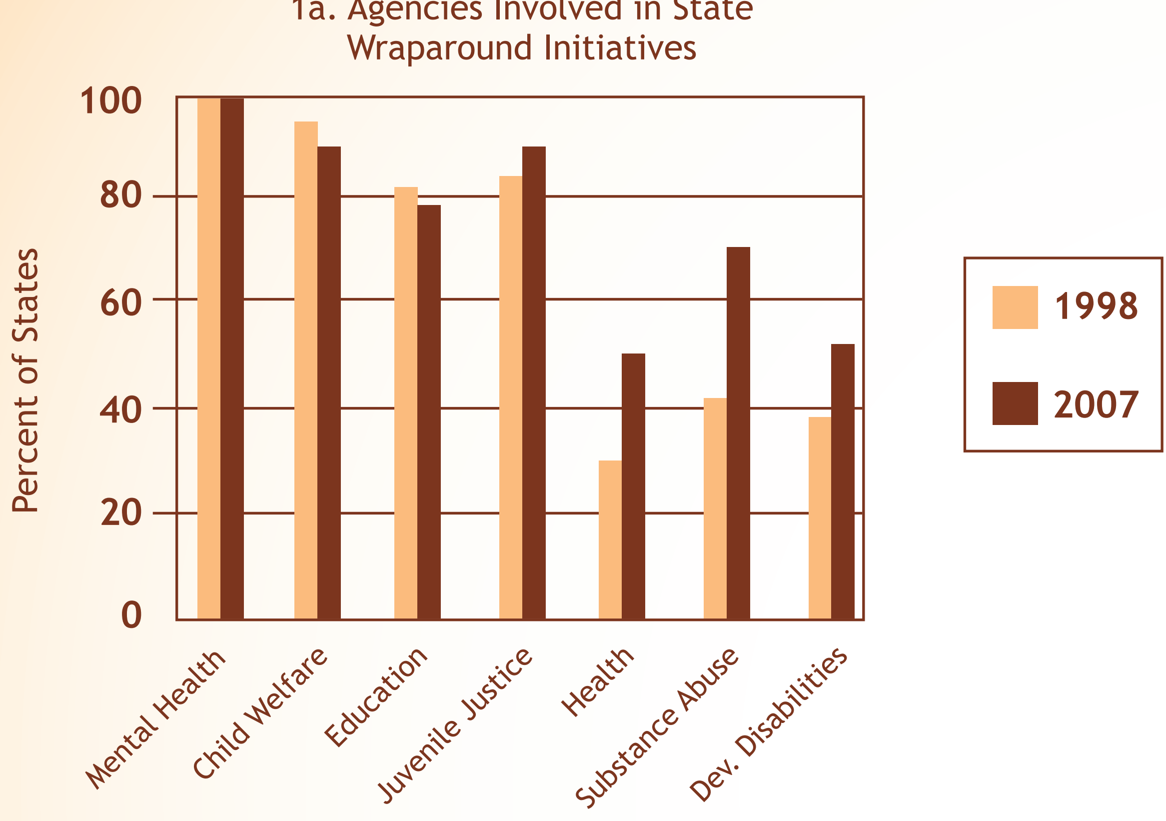
Not surprisingly, states with statewide implementation also had a higher mean number of wraparound programs. States with statewide implementation reported a mean of 22.5 (SD = 36.2) unique wraparound programs in the state compared to 14.3 (SD = 18.9) for states with local implementation only. At the same time, about half (7/16) of the states serving 2,000 or more youth reported only one "unique wraparound program or initiative" in the state, and all of these states said that wraparound is a statewide initiative. This suggests that the reported number of wraparound programs in a state may be influenced by semantics, with some respondents considering a statewide initiative to be a single program, with others reporting unique programs in terms of local catchment areas, counties, or lead provider agencies implementing wraparound within an overall statewide effort.

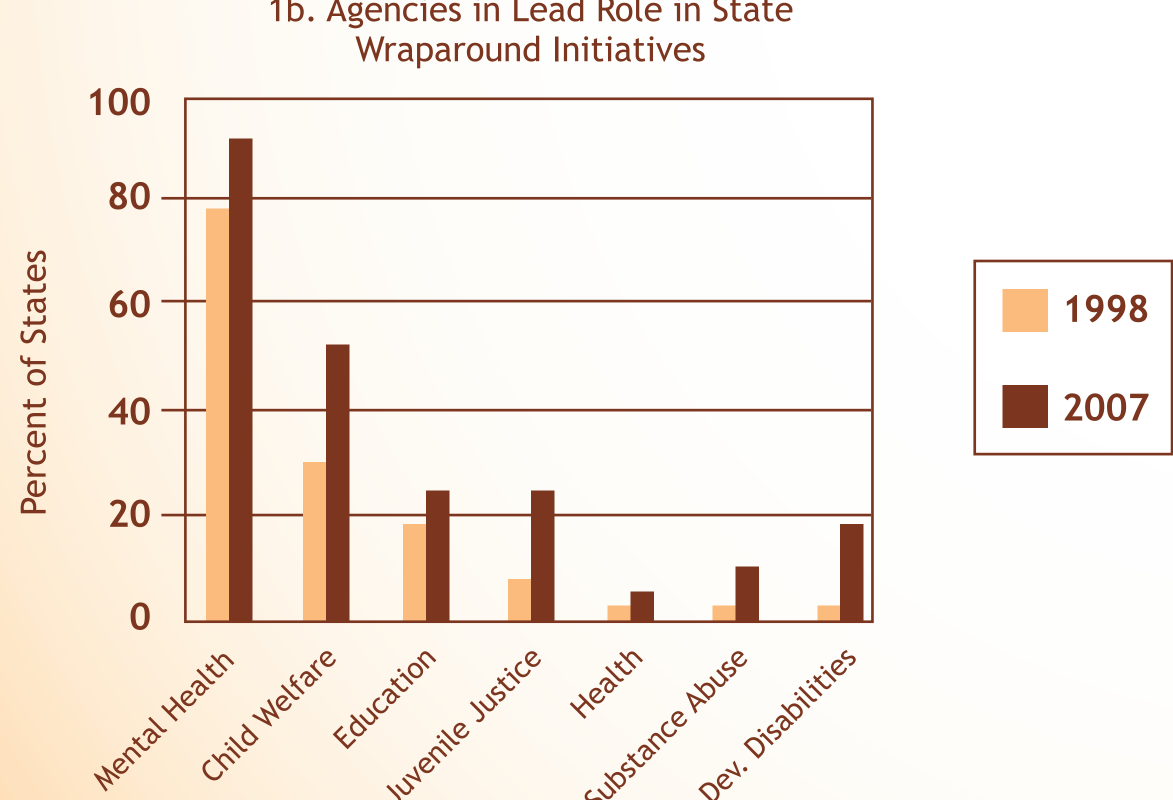
Agencies taking part in wraparound initiatives. Figure 1 presents the percent of states for which different child-serving agencies were reported to be involved in the state's wraparound initiative(s), both in 1998 as well as 2007. As shown, the agencies most frequently involved in implementing wraparound efforts in 2007 were, in order of frequency: (1) Mental Health (100%); (2) Child Welfare (90%); (3) Juvenile Justice (90%); and Education (81%). These agencies were represented at similar rates in wraparound initiatives in 1998. However, more states are reporting active involvement by health, substance abuse, and developmental disabilities agencies in 2007 than was reported in 1998. Overall, in 2007 a mean of 5.26 (SD = 1.69) agencies were reported to be involved in the state wraparound initiative(s), compared to 4.67 (SD = 1.62) in 1998, a marginally significant difference (t (39) = 1.704; $p < .10$).

We also investigated whether statewide implementation of wraparound was associated with greater number of agencies involved. Indeed, states reported to be implementing wraparound statewide were found to have a mean of 5.54 agencies involved (SD = 1.56), compared to 4.94 (SD = 1.77) for states in which wraparound was being implemented locally. This difference, however, was not significant.

Agencies in lead role. The agencies most

Figure 1. Agencies Involved with State Wraparound Initiatives





often identified as taking the lead role in wraparound efforts were: (1) Mental Health (93%); (2) Child Welfare (52%); (3) Juvenile Justice (24%); and Education (24%). As shown in Figure 1, child welfare, juvenile justice, and developmental disabilities were all much more likely to be in a lead role in 2007 than in 1998. However, it is important to note that more agencies in general were reported to be in a "lead role" in 2007 than in 1998.

Wraparound by any other name. In 2007, 76% of states reported that terms other than "wraparound" were used to describe their programs. This was compared to only 54% of states in 1998. The most common terminologies used for wraparound-type initiatives in 2007 were: (1) Child & Family Teams (34% of states had at least one program that used this term); (2) Care Coordination/Coordinated Services (14%); (3) Individualized Treatment Plan or Individualized Service Agreement (14%); and (4) Team (or Family) Decision Making (14%). Other reported terms included: Children's System of Care Initiative, Family Centered Practice, Intensive Community Based Treatment & Supports, and Family Support Teams.

Wraparound standards. The 2007 survey showed that 23 of the 41 states (56%) with wraparound programs (and that responded to the item) reported having some type of written standards for wraparound. This is an increase in use of written standards for wraparound from 1998, when 17 states (40%) reported having written standards.

Though this increase may be viewed as a positive change toward greater accountability, it should be noted that many of the respondents who provided details said that standards were from a training entity or that are incorporated into a fidelity scale that is being used in the state. Thus, the number of states that have incorporated practice standards directly into provider or agency contracts or reimbursement codes is likely to be much fewer than the 23 that reported having some type of standards.

Interesting differences emerged for states

Table 1. Characteristics of States with and without Written Standards for Wraparound Implementation

	States with Written Standards (n = 23)	States without Written Standards (n = 18)
Statewide wraparound initiative	74%**	44%
Local initiative(s) only	26%	56%
In-state resources for training and professional development	74%	61%
No such state resources	26%	39%
Fidelity is monitored in the state	83%**	50%
Fidelity is not monitored	17%	50%
Mean number of agencies involved (SD)	5.65 (1.37) *	4.78 (1.87)
Mean number of programs (SD)	25.4 (34.2)	12.7 (25.6)
Mean number of youth served (SD)	2914 (4274)	1823 (2852)

**$p < .05$; *$p < .1$

with standards versus those without standards. (See Table 1.) First, among states with written standards, more reported having statewide wraparound initiatives (74%) than among states without standards (44%) (*chi*-square (1) = 3.69; *p*=.05). Second, as shown in Table 1, 83% of states with written standards reported formal fidelity monitoring in the state, versus only 50% of states without standards (*chi*-square (1) = 4.96; *p*<.05) Third, states with written standards also reported more agencies being involved in their wraparound initiative than states without written standards, 5.65 on average versus 4.78 ($t(39) = 1.73$; $p<.1$). Finally, states with written standards also tended to have more sites implementing wraparound in their state (25.4 versus 12.7 on average); and served more youth overall (2,914 versus 1,823).

Implementation resources. In the current survey, 71% of states that reported having wraparound in their state also reported that there were in-state resources available for wraparound training and professional development. Though fewer than three-fourths of states reported having in-state resources for training, 97% of states reported having some sort of in-service training in the last 5 years. This is compared to 86% in 1998. Interestingly, unlike existence of standards, availability of in-state resources for wraparound implementation did not differ significantly for states with statewide versus local wraparound initiatives.

Fidelity measurement. Of the 42 states that responded, 28 (67%) stated that fidelity measurement was conducted. As shown in Table 2, whether states collected fidelity data did not differ by statewide versus local implementation. Among states that measured fidelity, a higher percentage reported having standards for wraparound, compared to the percentage among states not measuring fidelity (68% versus 31%; *chi*-square (1) = 4.96; *p*<.05). States that measured fidelity were also more likely to have an in-state training and TA resource (75% versus 61%), but this difference was non-significant. In summary, states that measured wraparound fidelity were more likely to have written standards and in-state resources for training and professional development. Whether a state measures fidelity does not appear to relate to the existence of statewide vs. local initiatives.

Evaluation. In 2007, 42 states responded to an item inquiring about whether a formal evaluation had been conducted in the state on one or more of its wraparound programs. Thirty-one respondents reported that one had been conducted (74%). This is in comparison to only 9 of 31 states (29%) that responded affirmatively to this item in 1998. As shown in Table 3, states that reported formal evaluation were more likely to have a statewide

Table 2. Characteristics of States that Report Conducting Fidelity Monitoring

	States Reporting Fidelity Measurement (n = 28)	States without Fidelity Measurement (n = 14)
Statewide wraparound initiative	61%	64%
Local initiative(s) only	39%	36%
Written standards for wraparound	68%	31%
No written standards	32%	69%*
In-state resources for training and professional development	75%	61%
No such state resources	25%	39%

*$p < .05$

Table 3. Characteristics of States with and without Recent or Ongoing Formal Wraparound Evaluation

	States with Written Standards (n = 23)	States without Written Standards (n = 18)
Statewide wraparound initiative	65%	55%
Local initiative(s) only	35%	45%
Written standards for wraparound	61%	36%
No written standards	39%	64%
Fidelity is monitored in the state	74%*	45%
Fidelity is not monitored	26%	55%
In-state resources for training and professional development	74%	55%
No such state resources	26%	45%

*$p < .1$

wraparound initiative, to have written standards, and to measure fidelity of implementation. The only significant difference among these, however, was for measurement of fidelity (*chi*-square (1) = 3.018; $p<.05$).

Responses to open-ended questions. Respondents were asked "what lessons have you learned from your experience with implementing wraparound in your state?" Thirty-six of the 43 states reporting wraparound programs responded to this item, providing a total of 92 unique statements. As shown in Table 4, over two-thirds of these statements were related to three issues: Maintaining fidelity (n=28), ensuring stakeholder buy-in and engagement (n=18) and maintaining active family and youth participation and engagement (n=17). After these, funding/sustainability (n=13), interagency collaboration (n=8), outcomes (n=6), and definitional issues regarding wraparound (n=4) were all identified as themes.

Regarding the topic of **maintaining quality and fidelity**, the majority (n=15) of statements emphasized the importance of training, quality assurance, and maintaining fidelity to the wraparound model. For example, one respondent reported "Fidelity processes are very important but are time consuming and it is difficult to find funds to support the process." Others reported that staff training and coaching were important for ensuring certain aspects of the model were achieved, such as using a strengths based approach or including natural supports on teams and in plans.

In other statements (n=5), respondents noted specific types of data collection necessary to support wraparound implementation. For example, one respondent stated, "treatments should be monitored for congruence to the plan, otherwise you end up with two distinct plans/approaches." Finally, n=5 respondents reported specific approaches in their state for ensuring fidelity, training, and/or support. Examples included using national experts, developing local training entities, and/or efforts to train and mobilize family advocates. One respondent gave this advice: "utilize technical assistance from the "experts," but don't be afraid to challenge them to look 'outside the box' of unique characteristics of your local area."

Of the 18 statements pertaining to **stakeholder engagement and buy-in**, the vast majority simply

emphasized the need to "build community buy-in and meaningfully engage stakeholders before implementing wraparound." Stakeholders were identified broadly as individuals such as partner agency leaders and middle managers, as well as partner agency staff and members of the provider

Table 4. Summary of Statements (n=94) Coded from Qualitative Data in Response to the Question "What Lessons Have you Learned About Implementing Wraparound in Your State"

Theme	N Statements	Percent of Total (n=96)
Fidelity and Quality Assurance	**28**	**30%**
General – important to maintain fidelity	15	16%
Developed specific methods for monitoring	5	5%
Specific models for Training/Professional Dev.	5	5%
Problems with staffing/turnover	3	3%
Buy-in/Stakeholder Engagement	**18**	**19%**
Community & Stakeholders engagement	16	17%
Staff engagement and buy-in	2	2%
Family & Youth Voice	**17**	**18%**
Importance of having family/youth engagement	9	10%
Family members as Facilitators/Trainers	5	5%
Family Voice at the Service Delivery Level	3	3%
Funding Needs/Cost	**13**	**14%**
General – fiscal issues	8	9%
Importance of flex funds	5	5%
Interagency Collaboration	**8**	**9%**
Methods to develop/importance of	8	9%
Outcomes	**6**	**6%**
Importance of and difficulty documenting	6	6%
Defining Wraparound	**4**	**4%**
General concerns	4	4%
Total	**94**	**100%**

community.

In a related theme, n=17 statements pertained to the importance of **youth and family member participation** at the community as well as engagement at the individual family level. Most of these statements underscored the importance of this buy-in and participation across all levels of effort, but a number (n=5) also referred to the importance of or local efforts to train youth and family members as navigators, facilitators, and support partners.

Respondents' statements related to **funding and sustainability** were very diverse. Five of the 13 statements in this theme highlighted the importance of flexible funding to implementing wraparound on the ground level. The remaining open-ended feedback provided a range of insights, including the following statements:

- "Seed funding is artificial. Better to make agencies commit to blending funds and recapturing savings."
- "Financial support for families' involvement is hard to come by, but it is very important."
- "Whenever you share funds, you share accountability."
- "Need to set up payment mechanisms very carefully so that they do not become unwieldy as program services grow."
- "The importance and difficulty of blended funding… we struggle when children fit many funding silos."
- "Joint funding gave communities the initiative to create other funding sources."
- "Fundraising is critical key to sustainability."
- "Need to ensure that planning activities with the model are reimbursed through either Medicaid or state funding."

Eight statements presented suggestions, challenges, and lessons learned about **creating infrastructure for collaboration.** For example, "training [is needed] on how to integrate different plans from different systems into a single plan of care." And, "although it has been a positive process for coordinating services among multiple agencies, [wraparound] has not been able to address the development of specialized services and supports that are not available within traditional funding streams." Another respondent noted that "The team approach is what sustained wraparound through funding cuts, leadership changes, and overall changes in our system."

The remaining coded statements fell into two categories. Regarding **outcomes** (n=6), most respondents lamented not having better ability to measure and document outcomes. One was much more specific, stating that, "we have been doing 'low fidelity wraparound' for 15 years. It is costly and we have little data to demonstrate effectiveness." Finally, four respondents provided responses related to **understanding the wraparound model**. One simply said that "understanding what 'wraparound' is, is a challenge," while another said, "after seven years, communities still struggle with the term." Another stated, "the wraparound process should be considered as a *strategy,* not as a model—the strategy is more adaptable to each specific community and populations, while the *model* is more restricted and less flexible."

Discussion

This paper presents some basic results of a follow-up survey about the scope and nature of wraparound implementation nationally. Identical to 1998 results, 49 states returned a survey and 43 (88%) reported one or more wraparound efforts in their state. Among the six states that reported no wraparound availability in 2007, four also reported no wraparound in 1998. Only one state—Virginia—reported having wraparound in 1998 but not in 2007, and follow up conversations with officials in Virginia reveal that a state wraparound conference and initiation of two wraparound efforts occurred in late 2007. Thus, the official number of states implementing wraparound in 2007 might be more accurately reported as 44 of 49.

Though the number of states reporting wraparound implementation may be stable or increasing, the total estimated number of youth served nationally was found to be lower than the 1998 estimate of 200,000. This is likely due to the more stringent definition of wraparound used in the 2007 survey, which was provided in order to ensure that estimates of wraparound reflect im-

plementation of a more specific model, such as that defined by the National Wraparound Initiative (Walker & Bruns, 2006). Though the definition presented in the 2007 survey includes components of the previous description, it also specifies, for example, that wraparound features a specific individual who serves as a care coordinator or facilitator, that there is a team, and that certain activities are occurring, such as engaging sources of natural support, monitoring progress on measurable indicators of success, and regularly reviewing and changing an individualized wraparound plan. In general, movement in the past decade toward viewing wraparound as a definable team-based care coordination model for youth with the most serious and complex needs (rather than a philosophy of care for all youth with behavioral and emotional concerns) is likely to have led to lower estimates of total enrolled youth.

Such shifts in conceptualization may also be responsible for the reduction in the percent of states reporting statewide wraparound efforts, from 81% in 1998 to 58% in 2007. In 2007, with wraparound being conceived as a model as well as a philosophy, more state informants are reporting that wraparound is available through local providers, programs, and initiatives.

At the same time, however, the percent of states reporting existence of standards for implementation has increased, from 40% to 56%. Though having a statewide wraparound initiative is significantly associated with existence of standards, it is not just states with statewide wraparound initiatives that are reporting existence of standards: A number of states that reported that wraparound is overseen by local efforts nonetheless reported having state standards. In general, this trend toward use of standards probably reflects recent emphasis on defined and/or manualized "evidence based practices," more specific descriptions of the wraparound process, and a growth in literature on system and program conditions required to implement wraparound (e.g., Bruns, Suter, & Leverentz-Brady, 2006; Walker, Koroloff, & Schutte, 2003). Thus, there seem to be trends toward addressing a concern that was prominent in the children's services field in the late 1990s: that wraparound was not well-enough specified to be implemented consistently and subjected to research (Clark & Clarke, 1996; Rosenblatt, 1996).

Along with greater prominence of standards, a number of seemingly positive trends were observed from the 2007 survey results. For example, states are reporting a greater number of agencies being actively involved in wraparound implementation, and a greater diversity of child-serving systems taking a lead role, including child welfare, juvenile justice, and education. This latter finding likely reflects the expansion of the wraparound model toward serving a more diverse set of purposes and populations (see John VanDenBerg's article on this phenomenon elsewhere in this *Resource Guide)*. In addition, results show that 71% of states providing wraparound have in-state resources for wraparound training and professional development, 67% report measuring fidelity, and 97% have had some sort of training provided in the past five years (an increase from 86% in 1998). Perhaps not surprisingly, all the trends reported above, particularly involvement of multiple agencies and fidelity monitoring, are associated with the presence of written standards for wraparound implementation, and nearly all of these associations are statistically significant.

Finally, 74% of states report having conducted formal evaluation of their wraparound initiative(s) in 2007, compared to only 31% in 1998. States with formal evaluation studies were significantly more likely to report measuring fidelity as well. This finding may speak to a greater overall attention to evaluation in these states; however, it may also mean that the evaluation that is being conducted in these states is largely focused on fidelity or implementation assessment, more so than out-

comes. This hypothesis is supported by responses to open-ended questions in which many respondents reported difficulty in collecting outcomes data and documenting outcomes in general.

Implications & Recommendations. Extrapolating from current results leads us to an estimate of over 800 wraparound programs nationally, serving approximately 100,000 youth and their families. As mentioned above, this number is lower than was derived from the 1998 survey. The estimate may be considered more accurate, however, given that it is based on a more stringent definition based on work done in the intervening decade to better specify wraparound (Walker & Bruns, 2006). Unfortunately, the definitional change makes it difficult to determine trends in numbers of youths served via the wraparound process over time. The fact that the same number of states report implementation of wraparound in 2007 as did in 1998, however, suggests that efforts to deploy wraparound (however it may be conceptualized) have been relatively stable over the past 10 years. But it remains difficult to say with any real certainty.

Nonetheless, if accurate, the estimate provided from this survey would mean that wraparound is being employed far more often than other prominent community-based treatment models for youth with serious and complex needs. This includes five times as many youth as multisystemic therapy (MST; Henggeler et al., 1998), which is estimated to serve 19,000 youths; three times more youth than Functional Family Therapy (FFT; Alexander, Pugh, Parsons, & Sexton, 2000), which is estimated to serve 30,000 youth annually; and many times more youth than Multidimensional Treatment Foster Care (MTFC; Chamberlain & Reid, 1998), which is estimated to serve 1,000 youth annually (Evidence-Based Associates, 2008).

This is probably not surprising, given that wraparound is conceived as a system-level intervention that has the capacity to serve children with a range of concerns, as opposed to MST, FFT, and MTFC, which are tailored to serve children who meet specific eligibility criteria. But nonetheless, one major implication of the current research is that the wraparound process, even with the greater specification and narrowing of its definition, is quite extensively implemented relative to other community-based models for the same population. As such, it deserves significant attention from researchers and developers so that the likelihood of its *successful* deployment for these many youth is as likely as possible. Given that MST, FFT, and MTFC generally are considered to have been tested through more rigorous research than wraparound, this implication becomes all the more important.

Fortunately, far from a reluctance to deal with these issues, results of this study show that there has been an increase in the attention paid to wraparound quality and fidelity over the past decade. Results indicate that use of state-level standards, in-state training and TA resources, fidelity monitoring, evaluation, and other implementation supports are all on the rise. This is also being reflected in an increase in the number and rigor of research studies on wraparound in the past five years (see review by Suter and Bruns in this *Resource Guide)*.

In 2007, nearly every state and approximately 100,000 children and their families had some involvement with the wraparound process.

At the same time, however, fewer states report that their wraparound initiatives are being overseen at the state level. This may be unfortunate, because results suggest statewide initiatives are associated with greater deployment of standards, active involvement by more agencies, and more consistent fidelity and quality monitoring. Even if counties or local programs are now more likely to oversee wraparound efforts, it may be advantageous for states to be in the business of overseeing implementation efforts in some way, such as through establishment of standards and/or monitoring of adherence to standards of quality.

A final conclusion to take from the open-ended question posed to respondents is that wrap-

around implementation remains challenging for states, communities, and providers. Though the majority of comments suggested that wraparound is viewed as a major asset to states and their communities, many respondents noted the difficulty of maintaining fidelity to wraparound components such as flexible funds, individualization, and team-based coordination in the face of siloed systems, staff turnover, and limited and increasingly inflexible resources. It may be that, over the years, the accumulation of implementation failures related to such barriers is what has led to the term "wraparound" being used less and less frequently (as was found in this survey), in favor of finding new names for team-based individualized care programs that are less associated with past disappointments.

Conclusion

The State Wraparound Survey is one part of a broad research agenda to better identify national trends and challenges regarding wraparound implementation. Though the research base on wraparound is progressing, it has been slow to develop due to its individualized and grassroots nature. Wraparound is also conceived as both a systems intervention as well as a strategy for working with individual children and families (Stroul, 2002; Walker, Bruns, & Penn in press), making it all the more challenging to implement. In general, much more research is needed on what factors lead to high-quality implementation of wraparound and improved health and well-being for the individuals who are engaged in it. This is particularly important when one considers that, in 2007, nearly every state and approximately 100,000 children and their families had some involvement with the wraparound process.

Though 100,000 may seem like a large number, one possible implication of the current study could be that far *too few* children and youth receive wraparound. According to the most recent estimates, there are 5-8 million youths with a serious emotional disturbance (SED) nationally (Costello, Messer, Bird, Cohen, & Reinherz, 1998; Friedman, Katz-Leavey, Manderscheid, & Sondheimer, 1998),and about one out of five of these youth receives mental health services of any kind (Kataoka, Zhang, & Wells, 2002). This means that, at best, assuming no overlap in treatments received per youth, only 1-2% of youths with SED are engaged in the wraparound process and another 1% in one of the other intensive community-based treatments mentioned above. As for those 20% of youths with SED who receive some kind of service, our findings raise questions about the nature of supports provided to these youth, given that over 90% apparently do not receive wraparound or one of these other intensive community-based treatments. Though not all youth with SED require the intensity of wraparound, MST, FFT, or MTFC, it is unlikely that so few as 2-3% annually would benefit from engagement in one of these models.

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Theory and Research: Chapter 3.5

Summary of the Wraparound Evidence Base: April 2010 Update

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Wraparound is a team-based planning process intended to provide coordinated, holistic, family-driven care to meet the complex needs of youth who are involved with multiple systems (e.g. mental health, child welfare, juvenile justice, special education), at risk of placement in institutional settings, and/or experiencing serious emotional or behavioral difficulties (Walker & Bruns, 2008). Wraparound provides an "on the ground" mechanism for ensuring that core system of care values will guide planning and produce individualized, family-driven and youth-guided support that is community based and culturally competent (Stroul & Friedman, 1996).

In the children's services field, there is broad consensus that for youth and families with multiple and complex needs, the wraparound paradigm is an improvement over more traditional service delivery methods that are uncoordinated, professional-driven, deficit-based, and overly reliant on out of home placement. This is reflected in wraparound's widespread adoption nationally and worldwide. A 2007 survey shows that 91% of U.S. states have some type of wraparound initiative, with 62% implementing some type of statewide initiative. Over 100,000 youth nationally are estimated to be engaged in a well-defined wraparound process (Bruns, Sather, & Stambaugh, 2008).

Regardless of how popular an intervention is with providers or families, or how well it conforms to current values of care, such criteria can not be used as the sole basis for policy making or treatment decision making. In the current era

of "evidence-based practice," decisions regarding how we invest our scarce health care resources—as well as decisions about what treatment approaches will be used with a given youth or family—must also be based on evidence derived from properly designed evaluations. After all, youth with complex needs may be served via a range of alternative approaches, such as via traditional case management or through uncoordinated "services as usual" (in which families negotiate services and supports by themselves or with help of a more specialized provider such as a therapist). Other communities may choose to invest in an array of more specialized office- or community-based evidence-based practices that address specific problem areas, in the absence of wraparound care coordination. And of course, many communities continue to allocate significant behavioral health resources to out-of-community options such as residential treatment, group homes, and inpatient hospitalization. The range of options in which states and localities may invest, combined with resource limitations, demands that we develop evidence for what models work for which youth under which conditions.

Increasingly, investment in wraparound is backed by controlled research. As of 2003, when the first meeting of the National Wraparound Initiative was held, there were only three controlled (i.e., experimental or quasi-experimental) studies of wraparound effects published in peer-reviewed journals. As of 2010, there are now nine controlled, published studies. Several of these newer studies include fidelity data as well as cost data, increasing our understanding of wraparound's potential for impact and what is required to achieve that impact. In addition, the first meta-analysis of wraparound has now been published (Suter & Bruns, 2009). As a result of this expansion in controlled research, as well as the greater availability of dissemination materials, Wraparound is currently being reviewed for inclusion in the Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Evidence-based Programs and Practices (NREPP).

Kazdin (1999) says there are four criteria for assessing the status of an intervention's evidence base: (1) A theory to relate a hypothesized mechanism to a clinical problem; (2) Basic research to assess the validity of the mechanism; (3) Outcome evidence to show that a therapeutic approach changes the relevant outcomes; and (4) Process-outcome connections, which display the relationships between process change and clinical outcomes.

With respect to criteria 1 and 2, for youth and families with complex and overlapping needs, the theory of change for wraparound (Walker, 2008) provides rationale (with supportive basic research) for why wraparound treatment planning is likely to be more effective than services provided in the absence of this process. Some of the specific mechanisms of change include better treatment acceptability and youth/family engagement; better teamwork; an emphasis on problem solving; and an emphasis on increasing optimism, hope, self-efficacy, and social support.

For condition 4, research is increasingly showing associations between system-, organizational, and team-level fidelity and child and family outcomes. Bruns et al. (2005; 2006; 2008) as well as other authors (e.g., Walton & Effland, 2010) have shown that communities that adhere more closely to the wraparound principles as assessed via measures such as the Wraparound Fidelity Index tend to show more positive outcomes. On the flip side, communities with better developed system supports for wraparound tend to demonstrate higher fidelity scores. (You can see an entire section in the Resource Guide to Wraparound on this evidence).

Ultimately, however, it is outcomes evidence from rigorous studies (criterion no.3) ***that is most relevant to evaluating an intervention's evidence base***. As described in our review of wraparound research, as of 2008, we found 36 published outcomes studies of wraparound. However, only a small number of these (n=7) were controlled studies that used random assignment or some type of comparison group design. In 2009, we published a meta-analytic review of these seven studies (Suter & Bruns, 2009). This analysis found that, on average across these studies, significant effects of wraparound were found for all four outcome domains we examined, including living situation, youth behavior, youth functioning, and youth community adjustment. Mean effect sizes across these domains (calculated as the difference between wraparound and control group means at posttest divided by the pooled standard

deviation, or Cohen's *d*) ranged from .25 to .59, with the largest effects found for living situation outcomes (e.g., youth residing in less restrictive, community placements and/or greater stability of placement). The mean effect size across all outcomes was .33–.40, depending on whether studies for which effect sizes were imputed were included (*d*=.33) or excluded (*d*=.40). These effect sizes are quite similar to effects found for established EBPs implemented under "real world" conditions and compared to some type of alternative treatment condition (Weisz, Jensen-Doss, & Hawley, 2006).

As of 2010, there have been nine controlled studies of wraparound that have been published in peer reviewed publications. In the rest of this document, we present a summary of each of these studies (Table 1), followed by a summary of all significant behavioral outcomes found across the controlled studies (Table 2).[1]

Though many of these studies have significant methodological weaknesses, the "weight of the evidence" of these studies indicates superior outcomes for youth who receive wraparound compared to similar youth who receive some alternative service. On the strength of these studies, as well as others currently being completed, it is likely that wraparound will increasingly be referred to as an "evidence-based" process in the future.

At the same time, much more wraparound research is needed. The diversity of contexts in which wraparound is implemented (e.g., for youths from birth to transition age as well as adults, and in contexts as varied as mental health, juvenile justice, child welfare, and schools) demands more effectiveness studies, so that we can better understand for which individuals and in what contexts wraparound is most likely to be effective. The many ways in which wraparound can be implemented also demand an expansion of the implementation research base on wraparound. For example, what are outcomes and costs of achieving different levels of fidelity? What modifications to the practice model achieve the best results? What training, coaching, and supervision yield the best fidelity, staff, and youth and family outcomes? What is needed at the organizational and system level to support high-quality wraparound implementation? Though the wraparound research base continues to grow, so does the list of questions for which we seek answers.

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References continued on p. 6

1 Two notes on the studies included in Tables 1 and 2 and the Suter & Bruns (2009) meta-analysis are worth making. First, one study included in Table 1 (Myaard et al., 2000) studied outcomes for N=4 youths participating in wraparound with outcomes assessed using a multiple baseline experimental design. Given this research design, this study is worthy of inclusion in a review of rigorous wraparound studies; however, due to its unique multiple baseline design, this study was not included in the 2009 meta-analysis nor are its outcomes included in Table 2. Second, one of the studies included in the meta-analysis (Bickman et al., 2003) presented evidence indicating that the "wraparound" condition that was evaluated did not conform to the principles or practice model of wraparound and was not meaningfully different from the comparison condition. Thus, while this study was included in the meta-analysis to be conservative, it is not included in Table 1 or 2.

Table 1. Summary of Nine Published Experimental and Quasi-Experimental Outcomes Research Studies of Wraparound**

Study	Citations	Outcomes
Child Welfare		
Randomized control study (18 months) of youth in child welfare custody in Florida: 54 in wraparound vs. 78 in standard practice foster care.	Clark, Lee, Prange, & McDonald, 1996; Clark et al., 1998.	Significantly fewer placement changes for youths in the wraparound program, fewer days on runaway, fewer days incarcerated (for subset of incarcerated youths), and older youths were significantly more likely to be in a permanency plan at follow-up. No group differences were found on rate of placement changes, days absent, or days suspended. No differences on internalizing problems, but boys in wraparound showed significantly greater improvement on externalizing problems than the comparison group. Taken together, the findings provided moderate evidence for better outcomes for the wraparound program; however, differences appear somewhat limited to boys and externalizing problems.
Matched comparison study (18 months) of youth in child welfare custody in Nevada: 33 in wraparound vs. 32 receiving MH services as usual	Bruns, Rast, Walker, Bosworth, & Peterson, 2006; Rast, Bruns, Brown, Peterson, & Mears, 2007	After 18 months, 27 of the 33 youth (approximately 82%) who received wraparound moved to less restrictive environments, compared to only 12 of the 32 comparison group youth (approximately 38%), and family members were identified to provide care for 11 of the 33 youth in the wraparound group compared to only six in the comparison group. Mean CAFAS scores for youth in wraparound decreased significantly across all waves of data collection (6, 12, 18 months) in comparison to the traditional services group. More positive outcomes were also found for the wraparound cohort on school attendance, school disciplinary actions, and grade point averages. No significant differences were found in favor of the comparison group.
Matched comparison study (12 months) of N=210 youth in child welfare custody in Los Angeles County: 43 discharged from Wraparound vs. 177 discharged from group care.	Rauso, Ly, Lee, & Jarosz, 2009	Initial analyses for a larger matched sample of youth (n=102 wraparound vs. n=210 for group care) found that 58% (n=59) of youth discharged from wraparound had their case closed to child welfare within 12 months, compared to only 16% (n=33) of youth discharged from group care. Of those youth who remained in the care of child welfare for the full 12 months follow-up period (n=43 for wraparound vs. n=177 for group care), youth in the wraparound group experienced significantly fewer out of home placements (mean = 0.91 compared to 2.15 for the comparison group). Youth in the wraparound group also had significantly fewer total mean days in out of home placements (193 days compared to 290). During the 12-months follow-up, 77% of the Wraparound graduates were placed in less restrictive settings while 70% of children who were discharged from RCL 12-14 were placed in more restrictive environments. Mean post-graduation cost for the wraparound group was found to be $10,737 compared to $27,383 for the group care group.

***NOTE: The research selected for inclusion in this Table includes the nine experimental and quasi-experimental outcomes research studies published in peer-reviewed journals relevant to the wraparound process (8 controlled studies and 1 multiple-baseline study). Studies are organized by the population studied. These include four studies of youths served through the child welfare system, two studies of youths served because of their involvement in (or risk of involvement in) juvenile justice, and four studies of youths served because of their intensive mental health needs.*

Table 1. (CONTINUED) Summary of Nine Published Experimental and Quasi-Experimental Outcomes Research Studies of Wraparound**

Study	Citations	Outcomes
Child Welfare		
Matched comparison study (6 months) of N=126 youths involved in the child welfare system in Clark County, NV: 96 in wraparound vs. 30 in traditional child welfare case management.	Mears, Yaffe, & Harris, 2009	Youth in the wraparound group approach showed significantly greater improvement in functioning (d=.50) as assessed by the Child and Adolescent Functional Assessment Scale (CAFAS) compared to youth receiving traditional child welfare services. Youth in the wraparound group also showed significantly greater movement toward less restrictive residential placements (d=.71) as assessed by the Restrictiveness of Living Environment Scale (ROLES). More wraparound youth experienced a placement change during the 6 month follow up (23% vs. 49%); however, this was due to youth in the wraparound group being more likely to move to less restrictive placements during the study period. No differences were found for child behavior as assessed by the CBCL, school, or juvenile justice outcomes.
Juvenile Justice		
Randomized control study (18 months) of "at risk" and juvenile justice involved (adjudicated) youth in Ohio: 73 in wraparound vs. 68 in conventional services	Carney & Buttell, 2003	Study supported the hypothesis that youth who received wraparound services were less likely to engage in subsequent at-risk and delinquent behavior. The youth who received wraparound services were less likely to miss school unexcused, get expelled or suspended from school, run away from home, or get picked up by the police as frequently as the youth who received the juvenile court conventional services. There were, however, no significant differences, in formal criminal offenses.
Matched comparison study (>2 years) of youth involved in juvenile justice and receiving MH services: 110 youth in wraparound vs. 98 in conventional MH services	Pullmann, Kerbs, Koroloff, Veach-White, Gaylor, & Sieler, 2006	Youths in the comparison group were three times more likely to commit a felony offense than youths in the wraparound group. Among youth in the wraparound program, 72% served detention "at some point in the 790 day post identification window" (p. 388), while all youth in the comparison group were subsequently served in detention. Of youth in the Connections program who did serve detention, they did so significantly less often than their peers. Connections youth also took three times longer to recidivate than those in the comparison group. According to the authors, a previous study by Pullman and colleagues also showed "significant improvement on standardized measures of behavioral and emotional problems, increases in behavioral and emotional strengths, and improved functioning at home at school, and in the community" (p. 388) among Connections youth.
Mental Health		
Randomized control study (12 months) of youths referred to out-of-home placements for serious mental health problems in New York State: 27 to family centered intensive case management (wraparound) vs. 15 to treatment foster care.	Evans, Armstrong, & Kuppinger, 1996; Evans, Armstrong, Kuppinger, Huz, & McNulty, 1998	Significant group differences were found in favor of the case management/ wraparound program for behavioral and mood functioning. No differences were found, however, with respect to behavior problems (internalizing and externalizing), family cohesiveness, or self-esteem. No differences found in favor of the TFC group. Overall, small sample size plus loss of data on many of the outcome measures resulted in the study having very low power to detect differences between groups.

Table 1. (CONTINUED) Summary of Nine Published Experimental and Quasi-Experimental Outcomes Research Studies of Wraparound**

Study	Citations	Outcomes
Mental Health		
Quasi-experimental (24 months) study of youths with serious mental health issues in urban Baltimore: 45 returned or diverted from residential care to wraparound vs. 24 comparison youths.	Hyde, Burchard, & Woodworth, 1996	Primary outcome was a single rating that combined several indicators: restrictiveness of youth living situation, school attendance, job/job training attendance, and serious problem behaviors. Youths received ratings of "good" if they were living in regular community placements, attending school and/or working for the majority of the week, and had fewer than three days of serious behavior problems during the course of previous month. At 2-year follow-up, 47% of the wraparound groups received a rating of "good," compared to 8% of youths in traditional MH services. Limitations of the study include substantial study attrition and group non-equivalence at baseline.
Experimental (multiple-baseline case study) study of four youths referred to wraparound because of serious mental health issues in rural Michigan.	Myaard, Crawford, Jackson, & Alessi (2000).	The multiple baseline case study design was used to evaluate the impact of wraparound by assessing whether outcome change occurred with (and only with) the introduction of wraparound at different points in time. The authors tracked occurrence of five behaviors (compliance, peer interactions, physical aggression, alcohol and drug use, and extreme verbal abuse) for each of the youths. Participants began receiving wraparound after 12, 15, 19, and 22 weeks. For all four participants, on all five behaviors, dramatic improvements occurred immediately following the introduction of wraparound.

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References continued on p. 8

Table 2. Summary of All Behavioral Outcomes for the Wraparound Process with Supporting Citations from Eight Controlled Studies

Section 1: Statistically Significant (p<.05) Behavioral Outcomes		
Outcome	**Effect Size**	**Citation**
Less assaultive	0.30	Carney & Buttell, 2003, p. 561
Ran away less	0.45	Carney & Buttell, 2003, p. 561
Suspended from school less	0.47	Carney & Buttell, 2003, p. 561
Missed less school	0.47	Carney & Buttell, 2003, p. 561
Less likely to be picked up by police	0.49	Carney & Buttell, 2003, p. 561
Less likely to be suspended from school	0.22	Clark et al., 1998, p. 529
Less likely to spend more time incarcerated	0.31	Clark et al., 1998, p. 529
Fewer days on runaway	0.34	Clark et al., 1998, p. 528
Residing in more permanency-type settings	0.17	Clark et al., 1998, p. 526
Less likely to spend time on runaway	0.22	Clark et al., 1998, p. 529
Less likely to experience a high number of placement changes	0.25	Clark et al., 1998, p. 529
Improved behavioral functioning on CAFAS	0.61	Evans et al., 1998, p. 566
Improved moods / emotions on CAFAS	0.61	Evans et al., 1998, p. 566
Improved overall functioning on CAFAS	0.50	Mears et al., 2009, p. 682
Residing in less restrictive placements	0.71	Mears et al., 2009, p. 682
Reduced recidivism for any offense	0.25	Pullman et al., 2006, p. 386
Reduced recidivism for felony	0.26	Pullman et al., 2006, p. 388
Fewer days served in detention	0.66	Pullman et al., 2006, p. 388
Fewer episodes in detention	0.75	Pullman et al., 2006, p. 388
Less likely to serve in detention	0.85	Pullman et al., 2006, p. 388

Note on effect sizes: The effect size reported for these outcomes is the standardized mean difference, typically referred to as Cohen's d (1988). Effect sizes were calculated as the difference between wraparound and control group means at posttest divided by the pooled standard deviation. Effect sizes were generated using an effect size program created by Wilson (2004) and presented such that positive values always indicated positive results for youth receiving wraparound relative to youth in control groups. All effect sizes were adjusted using Hedges' small sample size correction to create unbiased estimates (Hedges & Olkin, 1985). The magnitude of effects is typically interpreted using Cohen's (1988) guides for small (0.20), medium (0.50), and large (0.80) effects.

Table 2. (CONTINUED) Summary of All Behavioral Outcomes for the Wraparound Process with Supporting Citations from Eight Controlled Studies

Section 1: Statistically Significant (p<.05) Behavioral Outcomes		
Outcome	**Effect Size**	**Citation**
Improved school GPA	0.69	Rast et al., 2007, p. 22
Improved overall functioning on CAFAS	0.69	Rast et al., 2007, p. 20
Fewer disciplinary actions	0.95	Rast et al., 2007, p. 22
Moved to less restrictive living environments	1.09	Rast et al., 2007, p. 21
Fewer emotional and behavioral problems on CBCL	0.86	Rast et al., 2007, p. 19
Fewer out-of-home placements	0.84	Rauso et al., 2009, p. 65
More stable living environment	0.57	Rauso et al., 2009, p. 66-67
Residing in less restrictive placements	0.98	Rauso et al., 2009, p. 66
Section 2: Behavioral Outcomes That Were Not Statistically Significant, But with Positive Effect Sizes		
Outcome	**Effect Size**	**Citation**
Less likely to be arrested	0.23	Carney & Buttell, 2003, p. 561
Less likely to be in clinical range on CBCL or YSR	0.23	Clark et al., 1998, p. 532
Fewer unexcused absences	0.50	Rast et al., 2007, p. 22
Combined rating indicating lower restrictiveness of placement, improved school attendance, and fewer negative behaviors.	0.68	Hyde et al., 1996, p. 78

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Authors

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Wraparound Practice: Chapter 4a.1

Phases and Activities of the Wraparound Process: Building Agreement About a Practice Model

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In 2004, the National Wraparound Initiative (NWI) focused its attention on building agreement about essential elements of wraparound practice.[1] To begin this work, a small core group came together to review existing wraparound manuals and training materials. This core group, which included researchers, trainer/consultants, family members and administrators, used these materials as the basis for an initial version of a practice model. This initial version saw the wraparound process as consisting of a series of activities grouped into four phases: engagement, initial plan development, plan implementation, and transition.

This initial version of the practice model was circulated by email to an additional ten NWI members, primarily administrators of well-regarded wraparound programs. These stakeholders provided feedback in written and/or verbal form. This feedback was synthesized by the NWI coordinators and incorporated into a new draft of the practice model, which was reviewed and approved by the core group. The practice model that emerged from this process did not include any activities that were completely new (i.e., all the activities had appeared in one or more of the existing manuals or materials). However, the overall model was still quite different from any single model that had been described previously.

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1 A more detailed description of the process for defining the practice model can be found in Walker, J. S., & Bruns, E. J. (2006). Building on practice-based evidence: Using expert perspectives to define the wraparound process. *Psychiatric Services, 57,* 1579-1585.

As a next step in building agreement about practice, the core group sought feedback from the entire NWI advisory group which, at the time, had grown to include 50 members. Advisors were asked to rate each activity in the model in two ways: first, to indicate whether an activity like the one described was essential, optional, or inadvisable for wraparound; and second, whether, as written, the description of the activity was fine, acceptable with minor revisions, or unacceptable. Advisors were also given the opportunity to provide open-ended feedback about each activity, about the grouping of activities into phases, and about whether or not there were essential activities missing from the practice model.

Teams may use a variety of processes or procedures for eliciting needs or goals.

Overall, the 31 advisors who provided feedback expressed a very high level of agreement with the proposed set of activities. For 23 of the 31 activities presented, there all or all but one of the advisors agreed that the activity was essential. Advisors also found proposed descriptions of the activities generally acceptable. For 20 of the 31 proposed activities, the advisors were unanimous in finding the description acceptable.

The coordinators again revised the phases and activities, incorporating the feedback from the advisors. A document was prepared that described the phases and activities in more detail, and provided notes on each activity. These notes provided additional miscellaneous information, including the purpose of the activity, documentation or other products that should emerge from the activity, and/or cautions or challenges that might arise during the course of the activity. This document was reviewed by the core group and accepted by consensus.

The practice model, together with some of the commentary that accompanied it in its original form, is reproduced in the pages that follow. The final model included 32 activities grouped into the four phases. The intention was to define the activities in a manner that is sufficiently precise to permit fidelity measurement, but also sufficiently flexible to allow for diversity in the manner in which a given activity might be accomplished. The intention is to provide a "skeleton" of essential activities that can be accomplished or "fleshed out" in ways that are appropriate for individual communities or even individual teams. For example, an important activity during the phase of initial plan development is for the team to elicit a range of needs or goals for the team to work on, and then prioritize a small number of these to work on first. The practice model specifies that both of these two steps must happen, but does not specify *how* the steps should happen. Teams may use a variety of processes or procedures for eliciting needs or goals, and priority needs or goals can be selected using any of a variety of forms of decision making, including forms of voting or consensus building.

The remainder of this chapter is reproduced from the original *Phases and Activities* document. It begins with a few points that are important to keep in mind when reading about the phases and activities. Following these notes, the document lists and defines each of the four phases of the wraparound process. For each phase, the document describes the main goals to be accomplished in the phase and the activities that are carried out to meet each goal.

Phases and Activities of the Wraparound Process[2]

Some notes:

- *The activities that follow identify a facilitator as responsible for guiding, motivating, or undertaking the various activities. This is not meant to imply that a single person must facilitate all of the activities, and we have not tried to specify exactly who should be responsible for each activity. The various activities may be split up among a number of different people. For example, on many teams, a parent partner or advocate takes responsibility for some activities associated with family and youth engagement, while a care coordinator is responsible for other activities. On other teams, a care coordinator takes on most of the facilitation activities with specific tasks or responsibilities taken on by a parent, youth, and/or other team members. In addition, facilitation of wraparound team work may transition between individuals over time, such as from a care coordinator to a parent, family member, or other natural support person, during the course of a wraparound process.*
- *The families participating in wraparound, like American families more generally, are diverse in terms of their structure and composition. Families may be a single biological or adoptive parent and child or youth, or may include grandparents and other extended family members as part of the central family group. If the court has assigned custody of the child or youth to some public agency (e.g., child protective services or juvenile justice), the caregiver in the permanency setting and/or another person designated by that agency (e.g. foster parent, social worker, probation officer) takes on some or all of the roles and responsibilities of a parent for that child and shares in selecting the team and prioritizing objectives and options. As youth become more mature and independent, they begin to make more of their own decisions, including inviting members to join the team and guiding aspects of the wraparound process.*
- *The use of numbering for the phases and activities described below is not meant to imply that the activities must invariably be carried out in a specific order, or that one activity or phase must be finished before another can be started. Instead, the numbering and ordering is meant to convey an overall flow of activity and attention. For example, focus on transition activities is most apparent during the latter portions of the wraparound process; however, attention to transition issues begins with the earliest activities in a wraparound process.*

2 The remainder of this article was originally published as Walker, J.S., Bruns, E.J., VanDenBerg, J.D., Rast, J., Osher, T.W., Miles, P., Adams, J., & National Wraparound Initiative Advisory Group (2004). *Phases and activities of the wraparound process.* Portland, OR: National Wraparound Initiative, Research and Training Center on Family Support and Children's Mental Health, Portland State University.

Phases and Activities of the Wraparound Process: Phase 1

MAJOR GOALS	ACTIVITIES	NOTES
PHASE 1: Engagement and team preparation *During this phase, the groundwork for trust and shared vision among the family and wraparound team members is established, so people are prepared to come to meetings and collaborate. During this phase, the tone is set for teamwork and team interactions that are consistent with the wraparound principles, particularly through the initial conversations about strengths, needs, and culture. In addition, this phase provides an opportunity to begin to shift the family's orientation to one in which they understand they are an integral part of the process and their preferences are prioritized. The activities of this phase should be completed relatively quickly (within 1-2 weeks if possible), so that the team can begin meeting and establish ownership of the process as quickly as possible.*		
1.1. Orient the family and youth GOAL: To orient the family and youth to the wraparound process.	*1.1 a. Orient the family and youth to wraparound* In face-to-face conversations, the facilitator explains the wraparound philosophy and process to family members and describes who will be involved and the nature of family and youth/child participation. Facilitator answers questions and addresses concerns. Facilitator describes alternatives to wraparound and asks family and youth if they choose to participate in wraparound. Facilitator describes types of supports available to family and youth as they participate on teams (e.g., family/youth may want coaching so they can feel more comfortable and/or effective in partnering with other team members).	This orientation to wraparound should be brief and clear, and should avoid the use of jargon, so as not to overwhelm family members. At this stage, the focus is on providing enough information so that the family and youth can make an informed choice regarding participation in the wraparound process. For some families, alternatives to wraparound may be very limited and/or non-participation in wraparound may bring negative consequences (as when wraparound is court ordered); however, this does not prevent families/youth from making an informed choice to participate based on knowledge of the alternatives and/or the consequences of non-participation.
	1.1 b. Address legal and ethical issues Facilitator reviews all consent and release forms with the family and youth, answers questions, and explains options and their consequences. Facilitator discusses relevant legal and ethical issues (e.g., mandatory reporting), informs family of their rights, and obtains necessary consents and release forms before the first team meeting.	Ethical and legal considerations will also need to be reviewed with the entire team as described in phase 2.

Phases and Activities of the Wraparound Process: Phase 1 (CONTINTUED)

MAJOR GOALS	ACTIVITIES	NOTES
1.2. Stabilize crises GOAL: To address pressing needs and concerns so that the family and team can give their attention to the wraparound process.	*1.2 a. Ask family and youth about immediate crisis concerns* Facilitator elicits information from the family and youth about immediate safety issues, current crises, or crises that they anticipate might happen in the very near future. These may include crises stemming from a lack of basic needs (e.g., food, shelter, utilities such as heat or electricity).	The goal of this activity is to quickly address the most pressing concerns. The whole team engages in proactive and future-oriented crisis/safety planning during phase 2. As with other activities in this phase, the goal is to do no more than necessary prior to convening the team, so that the facilitator does not come to be viewed as the primary service provider and so that team as a whole can feel ownership for the plan and the process.
	1.2 b. Elicit information from agency representatives and potential team members about immediate crises or potential crises Facilitator elicits information from the referring source and other knowledgeable people about pressing crisis and safety concerns.	Information about previous crises and their resolution can be useful in planning a response in 1.2.c.
	1.2 c. If immediate response is necessary, formulate a response for immediate intervention and/or stabilization Facilitator and family reach agreement about whether concerns require immediate attention and, if so, work to formulate a response that will provide immediate relief while also allowing the process of team building to move ahead.	This response should describe clear, specific steps to accomplish stabilization.
1.3. Facilitate conversations with family and youth/child GOAL: To explore individual and family strengths, needs, culture, and vision and to use these to develop a document that will serve as the starting point for planning.	*1.3 a. Explore strengths, needs, culture, and vision with child/youth and family.* Facilitator meets with the youth/child and family to hear about their experiences; gather their perspective on their individual and collective strengths, needs, elements of culture, and long-term goals or vision; and learn about natural and formal supports. Facilitator helps family identify potential team members and asks family to talk about needs and preferences for meeting arrangements (location, time, supports needed such as child care, translation).	This activity is used to develop information that will be presented to and augmented by the team in phase 2. Family members should be encouraged to consider these topics broadly.

Phases and Activities of the Wraparound Process: Phase 1 (CONTINTUED)

MAJOR GOALS	ACTIVITIES	NOTES
1.3. Facilitate conversations with family and youth/child GOAL: To explore individual and family strengths, needs, culture, and vision and to use these to develop a document that will serve as the starting point for planning. *(Continued from previous page)*	*1.3 b. Facilitator prepares a summary document* Using the information from the initial conversations with family members, the facilitator prepares a strengths-based document that summarizes key information about individual family member strengths and strengths of the family unit, as well as needs, culture, and vision. The family then reviews and approves the summary.	
1.4. Engage other team members GOAL: To gain the participation of team members who care about and can aid the youth/child and family, and to set the stage for their active and collaborative participation on the team in a manner consistent with the wraparound principles	*1.4 a. Solicit participation/ orient team members* Facilitator, together with family members if they so choose, approaches potential team members identified by the youth and family. Facilitator describes the wraparound process and clarifies the potential role and responsibilities of this person on the team. Facilitator asks the potential team members if they will participate. If so, facilitator talks with them briefly to learn their perspectives on the family's strengths and needs, and to learn about their needs and preferences for meeting.	The youth and/or family may choose to invite potential team members themselves and/or to participate in this activity alongside the facilitator. It is important, however, not to burden family members by establishing (even inadvertently) the expectation that they will be primarily responsible for recruiting and orienting team members.
1.5. Make necessary meeting arrangements GOAL: To ensure that the necessary procedures are undertaken for the team is prepared to begin an effective wraparound process.	*1.5 a. Arrange meeting logistics* Facilitator integrates information gathered from all sources to arrange meeting time and location and to assure the availability of necessary supports or adaptations such as translators or child care. Meeting time and location should be accessible and comfortable, especially for the family but also for other team members. Facilitator prepares materials—including the document summarizing family members' individual and collective strengths, and their needs, culture, and vision—to be distributed to team members.	

Phases and Activities of the Wraparound Process: Phase 2

MAJOR GOALS	ACTIVITIES	NOTES
PHASE 2: Initial plan development — *During this phase, team trust and mutual respect are built while the team creates an initial plan of care using a high-quality planning process that reflects the wraparound principles. In particular, youth and family should feel, during this phase, that they are heard, that the needs chosen are ones they want to work on, and that the options chosen have a reasonable chance of helping them meet these needs. This phase should be completed during one or two meetings that take place within 1-2 weeks, a rapid time frame intended to promote team cohesion and shared responsibility toward achieving the team's mission or overarching goal.*		
2.1. Develop an initial plan of care GOAL: To create an initial plan of care using a high-quality team process that elicits multiple perspectives and builds trust and shared vision among team members, while also being consistent with the wraparound principles	*2.1 a. Determine ground rules* Facilitator guides team in a discussion of basic ground rules, elicits additional ground rules important to team members, and facilitates discussion of how these will operate during team meetings. At a minimum, this discussion should address legal and ethical issues—including confidentiality, mandatory reporting, and other legal requirements—and how to create a safe and blame-free environment for youth/family and all team members. Ground rules are recorded in team documentation and distributed to members.	In this activity, the team members define their collective expectations for team interaction and collaboration. These expectations, as written into the ground rules, should reflect the principles of wraparound. For example, the principles stress that interactions should promote family and youth voice and choice and should reflect a strengths orientation. The principles also stress that important decisions are made within the team.
	2.1 b. Describe and document strengths Facilitator presents strengths from the summary document prepared during phase 1, and elicits feedback and additional strengths, including strengths of team members and community.	While strengths are highlighted during this activity, the wraparound process features a strengths orientation throughout.
	2.1 c. Create team mission Facilitator reviews youth and family's vision and leads team in setting a team mission, introducing idea that this is the overarching goal that will guide the team through phases and, ultimately, through transition from formal wraparound.	The team mission is the collaboratively set, long-term goal that provides a one or two sentence summary of what the team is working towards.

Phases and Activities of the Wraparound Process: Phase 2 (CONTINTUED)

MAJOR GOALS	ACTIVITIES	NOTES
2.1. Develop an initial plan of care GOAL: To create an initial plan of care using a high-quality team process that elicits multiple perspectives and builds trust and shared vision among team members, while also being consistent with the wraparound principles *(Continued from previous page)*	*2.1 d. Describe and prioritize needs/goals* Facilitator guides the team in reviewing needs and adding to list. The facilitator then guides the team in prioritizing a small number of needs that the youth, family, and team want to work on first, and that they feel will help the team achieve the mission.	The elicitation and prioritization of needs is often viewed as one of the most crucial and difficult activities of the wraparound process. The team must ensure that needs are considered broadly, and that the prioritization of needs reflects youth and family views about what is most important. Needs are not services but rather broader statements related to the underlying conditions that, if addressed, will lead to the accomplishment of the mission.
	2.1 e. Determine goals and associated outcomes and indicators for each goal Facilitator guides team in discussing a specific goal or outcome that will represent success in meeting each need that the team has chosen to work on. Facilitator guides the team in deciding how the outcome will be assessed, including specific indicators and how frequently they will be measured.	Depending on the need being considered, multiple goals or outcomes may be determined. Similarly, for each goal or outcome determined by the team for measurement, multiple indicators may be chosen to be tracked by the team. However, the plan should not include so many goals, outcomes, or indicators that team members become overwhelmed or tracking of progress becomes difficult.
	2.1 f. Select strategies Facilitator guides the team in a process to think in a creative and open-ended manner about strategies for meeting needs and achieving outcomes. The facilitator uses techniques for generating multiple options, which are then evaluated by considering the extent to which they are likely to be effective in helping reach the goal, outcome, or indicator associated with the need; the extent to which they are community based, the extent to which they build on/incorporate strengths; and the extent to which they are consistent with family culture and values. When evaluating more formal service and support options, facilitator aids team in acquiring information about and /or considering the evidence base for relevant options.	This activity emphasizes creative problem solving, usually through brainstorming or other techniques, with the team considering the full range of available resources as they come up with strategies to meet needs and achieve outcomes. Importantly, this includes generating strategy options that extend beyond formal services and reach families through other avenues and time frames. These are frequently brainstormed by the team, with the youth and family and people representing their interpersonal and community connections being primary nominators of such supports. Finally, in order to best consider the evidence base for potential strategies or supports, it may be useful for a wraparound team or program to have access to and gain counsel from a point person who is well-informed on the evidence base.

Phases and Activities of the Wraparound Process: Phase 2 (CONTINTUED)

MAJOR GOALS	ACTIVITIES	NOTES
2.1. Develop an initial plan of care GOAL: To create an initial plan of care using a high-quality team process that elicits multiple perspectives and builds trust and shared vision among team members, while also being consistent with the wraparound principles *(Continued from previous page)*	*2.1 g. Assign action steps* Team assigns responsibility for undertaking action steps associated with each strategy to specific individuals and within a particular time frame.	Action steps are the separate small activities that are needed to put a strategy into place, for example, making a phone call, transporting a child, working with a family member, finding out more information, attending a support meeting, arranging an appointment. While all team members will not necessarily participate at the same level, all team members should be responsible for carrying out action steps. Care should be taken to ensure that individual team members, particularly the youth and family, are not overtaxed by the number of action steps they are assigned.
2.2. Develop crisis/ safety plan GOAL: To identify potential problems and crises, prioritize according to seriousness and likelihood of occurrence, and create an effective and well-specified crisis prevention and response plan that is consistent with the wraparound principles. A more proactive safety plan may also be created.	*2.2 a. Determine potential serious risks* Facilitator guides the team in a discussion of how to maintain the safety of all family members and things that could potentially go wrong, followed by a process of prioritization based on seriousness and likelihood of occurrence.	Past crises, and the outcomes of strategies used to manage them, are often an important source of information in current crisis/safety planning.
	2.2 b. Create crisis/safety plan In order of priority, the facilitator guides team in discussion of each serious risk identified. The discussion includes safety needs or concerns and potential crisis situations, including antecedents and associated strategies for preventing each potential type of crisis, as well as potential responses for each type of crisis. Specific roles and responsibilities are created for team members. This information is documented in a written crisis plan. Some teams may also undertake steps to create a separate safety plan, which specifies all the ways in which the wraparound plan addresses potential safety issues.	One potential difficulty with this activity is the identification of a large number of crises or safety issues can mean that the crisis/safety plan “takes over” from the wraparound plan. The team thus needs to balance the need to address all risks that are deemed serious with the need to maintain focus on the larger wraparound plan as well as youth, family, and team strengths.
2.3. Complete necessary documentation and logistics	*2.3 a. Complete documentation and logistics* Facilitator guides team in setting meeting schedule and determining means of contacting team members and distributing documentation to team members.	

Phases and Activities of the Wraparound Process: Phase 3

<table>
<tr><th>MAJOR GOALS</th><th>ACTIVITIES</th><th>NOTES</th></tr>
<tr><td colspan="3">PHASE 3: Implementation
During this phase, the initial wraparound plan is implemented, progress and successes are continually reviewed, and changes are made to the plan and then implemented, all while maintaining or building team cohesiveness and mutual respect. The activities of this phase are repeated until the team's mission is achieved and formal wraparound is no longer needed.</td></tr>
<tr><td rowspan="4">3.1. Implement the wraparound plan
GOAL: To implement the initial plan of care, monitoring completion of action steps and strategies and their success in meeting need and achieving outcomes in a manner consistent with the wraparound principles.</td><td>3.1 a. Implement action steps for each strategy
For each strategy in the wraparound plan, team members undertake action steps for which they are responsible. Facilitator aids completion of action steps by checking in and following up with team members; educating providers and other system and community representatives about wraparound as needed; and identifying and obtaining necessary resources.</td><td>The level of need for educating providers and other system and community representatives about wraparound varies considerably from one community to another. Where communities are new to the type of collaboration required by wraparound, getting provider "buy in" can be very difficult and time consuming for facilitators. Agencies implementing wraparound should be aware of these demands and be prepared to devote sufficient time, resources, and support to this need.</td></tr>
<tr><td>3.1 b. Track progress on action steps
Team monitors progress on the action steps for each strategy in the plan, tracking information about the timeliness of completion of responsibilities assigned to each team member, fidelity to the plan, and the completion of the requirements of any particular intervention.</td><td>Using the timelines associated with the action steps, the team tracks progress. When steps do not occur, teams can profit from examining the reasons why not. For example, teams may find that the person responsible needs additional support or resources to carry out the action step, or, alternatively, that different actions are necessary.</td></tr>
<tr><td>3.1 c. Evaluate success of strategies
Using the outcomes/indicators associated with each need, the facilitator guides the team in evaluating whether selected strategies are helping team meet the youth and family's needs.</td><td>Evaluation should happen at regular intervals. Exactly how frequently may be determined by program policies and/or the nature of the needs/goals. The process of evaluation should also help the team maintain focus on the "big picture" defined by the team's mission: Are these strategies, by meeting needs, helping achieve the mission?</td></tr>
<tr><td>3.1. d. Celebrate successes
The facilitator encourages the team to acknowledge and celebrate successes, such as when progress has been made on action steps, when outcomes or indicators of success have been achieved, or when positive events or achievements occur.</td><td>Acknowledging success is one way of maintaining a focus on the strengths and capacity of the team and its members. Successes do not have to be "big", nor do they necessarily have to result directly from the team plan. Some teams make recognition of "what's gone right" a part of each meeting.</td></tr>
</table>

Phases and Activities of the Wraparound Process: Phase 3 (CONTINTUED)

MAJOR GOALS	ACTIVITIES	NOTES
3.2. Revisit and update the plan GOAL: To use a high quality team process to ensure that the wraparound plan is continually revisited and updated to respond to the successes of initial strategies and the need for new strategies.	*3.2. a. Consider new strategies as necessary* When the team determines that strategies for meeting needs are not working, or when new needs are prioritized, the facilitator guides the team in a process of considering new strategies and action steps using the process described in activities 2.1.f and 2.1.g.	Revising of the plan takes place in the context of the needs identified in 2.1.d. Since the needs are in turn connected to the mission, the mission helps to guide evaluation and plan revisions.
3.3. Maintain/build team cohesiveness and trust GOAL: To maintain awareness of team members' satisfaction with and "buy-in" to the process, and take steps to maintain or build team cohesiveness and trust.	*3.3 a. Maintain awareness of team members' satisfaction and "buy-in"* Facilitator makes use of available information (e.g., informal chats, team feedback, surveys—if available) to assess team members' satisfaction with and commitment to the team process and plan, and shares this information with the team as appropriate. Facilitator welcomes and orients new team members who may be added to the team as the process unfolds.	Many teams maintain formal or informal processes for addressing team member engagement or "buy in", e.g. periodic surveys or an end-of-meeting wrap-up activity. In addition, youth and family members should be frequently consulted about their satisfaction with the team's work and whether they believe it is achieving progress toward their long-term vision, especially after major strategizing sessions. In general, however, this focus on assessing the process of teamwork should not eclipse the overall evaluation that is keyed to meeting identified needs and achieving the team mission.
	3.3 b. Address issues of team cohesiveness and trust Making use of available information, facilitator helps team maintain cohesiveness and satisfaction (e.g., by continually educating team members—including new team members—about wraparound principles and activities, and/or by guiding team in procedures to understand and manage disagreement, conflict, or dissatisfaction).	Teams will vary in the extent to which issues of cohesiveness and trust arise. Often, difficulties in this area arise from one or more team members' perceptions that the team's work—and/or the overall mission or needs being currently addressed—is not addressing the youth and family's "real" needs. This points to the importance of careful work in deriving the needs and mission in the first place, since shared goals are essential to maintaining team cohesiveness over time.
3.4. Complete necessary documentation and logistics	*3.4 a. Complete documentation and logistics* Facilitator maintains/updates the plan and maintains and distributes meeting minutes. Team documentation should record completion of action steps, team attendance, use of formal and informal services and supports, and expenditures. Facilitator documents results of reviews of progress, successes, and changes to the team and plan. Facilitator guides team in revising meeting logistics as necessary and distributes documentation to team members.	Team documentation should be kept current and updated, and should be distributed to and/or available to all team members in a timely fashion.

Phases and Activities of the Wraparound Process: Phase 4

MAJOR GOALS	ACTIVITIES	NOTES
PHASE 4: Transition *During this phase, plans are made for a purposeful transition out of formal wraparound to a mix of formal and natural supports in the community (and, if appropriate, to services and supports in the adult system). The focus on transition is continual during the wraparound process, and the preparation for transition is apparent even during the initial engagement activities.*		
4.1. Plan for cessation of formal wraparound GOAL: To plan a purposeful transition out of formal wraparound in a way that is consistent with the wraparound principles, and that supports the youth and family in maintaining the positive outcomes achieved in the wraparound process.	*4.1 a. Create a transition plan* Facilitator guides the team in focusing on the transition from wraparound, reviewing strengths and needs and identifying services and supports to meet needs that will persist past formal wraparound.	Preparation for transition begins early in the wraparound process, but intensifies as team meets needs and moves towards achieving the mission. While formal supports and services may be needed post-transition, the team is attentive to the need for developing a sustainable system of supports that is not dependent on formal wraparound. Teams may decide to continue wraparound—or a variation of wraparound—even after it is no longer being provided as a formal service.
	4.1 b. Create a post-transition crisis management plan Facilitator guides the team in creating post-wraparound crisis management plan that includes action steps, specific responsibilities, and communication protocols. Planning may include rehearsing responses to crises and creating linkage to post-wraparound crisis resources.	At this point in transition, youth and family members, together with their continuing supports, should have acquired skills and knowledge in how to manage crises. Post-transition crisis management planning should acknowledge and capitalize on this increased knowledge and strengthened support system. This activity will likely include identification of access points and entitlements for formal services that may be used following formal wraparound.
	4.1 c. Modify wraparound process to reflect transition New members may be added to the team to reflect identified post-transition strategies, services, and supports. The team discusses responses to potential future situations, including crises, and negotiates the nature of each team member's post-wraparound participation with the team/family. Formal wraparound team meetings reduce frequency and ultimately cease.	Teams may continue to meet using a wraparound process (or other process or format) even after formal wraparound has ended. Should teamwork continue, family members and youth, or other supports, will likely take on some or all of the facilitation and coordination activities.

Phases and Activities of the Wraparound Process: Phase 4 (CONTINTUED)

MAJOR GOALS	ACTIVITIES	NOTES
4.2. Create a "commencement" GOAL: To ensure that the cessation of formal wraparound is conducted in a way that celebrates successes and frames transition proactively and positively.	*4.2 a. Document the team's work* Facilitator guides team in creating a document that describes the strengths of the youth/child, family, and team members, and lessons learned about strategies that worked well and those that did not work so well. Team participates in preparing/reviewing necessary final reports (e.g., to court or participating providers, where necessary)	This creates a package of information that can be useful in the future.
	4.2 b. Celebrate success Facilitator encourages team to create and/or participate in a culturally appropriate "commencement" celebration that is meaningful to the youth/child, family, and team, and that recognizes their accomplishments.	This activity may be considered optional. Youth/child and family should feel that they are ready to transition from formal wraparound, and it is important that "graduation" is not constructed by systems primarily as a way to get families out of services.
4.3. Follow-up with the family GOAL: To ensure that the family is continuing to experience success after wraparound and to provide support if necessary.	*4.3 a. Check in with family* Facilitator leads team in creating a procedure for checking in with the youth and family periodically after commencement. If new needs have emerged that require a formal response, facilitator and/or other team members may aid the family in accessing appropriate services, possibly including a reconvening of the wraparound team.	The check-in procedure can be done impersonally (e.g., through questionnaires) or through contact initiated at agreed-upon intervals either by the youth or family, or by another team member.

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Wraparound Practice: Chapter 4a.2

The Phases of Wraparound: Real Life & Teams

Matt Pierce, Wraparound Trainer/Administrator

Andrew is a nine-year-old boy who was referred to the behavioral health system for the third time after being removed from his mother, Ms. Smith, and placed in Child Protective Services custody. Child Protective Services removed Andrew as a result of potential abuse and multiple unsuccessful attempts, despite implementation by family preservation services, to support Ms. Smith and Andrew to live together. The referral also noted Andrew had significant behavior challenges in the home and at school including property destruction and verbal and physical aggression towards peers and adults. Finally, the referral noted that Andrew was having difficulty establishing and maintaining relationships. Andrew is currently living in a group home shelter placement.

Molly, a case manager for a small behavioral health agency in her third week of employment is excited to start directly working with families. She has spent the first two weeks on the job in training, learning about wraparound and the child and family team process (Arizona's specific term for its team-based care management process). Molly is jazzed about the opportunity to serve families utilizing approaches that view families as partners and recognize strengths within children and their families.

Andrew is Molly's first referral, and her first assignment is to determine which practice model she's going to use in serving Andrew and his family. After reviewing the referral information and a brief conversation with the Child Protective Services case worker, Angie, she finds herself confused as to what her initial steps should be in beginning a team process for Andrew and his family. Molly approached Jim, her supervisor, and asked him for guidance around where to begin, Jim's response was pretty simple: "Do you know

what to do? If you do, follow child and family team practice steps. If you don't know how to move ahead, use wraparound." Molly asked for more clarity. Jim continued to explain, stating "If you are clear and confident in the fit between what's needed and what you can provide then go ahead and do it. If you're undecided and unclear as to what is needed or what will work due to the complexity of the situation or limitations of the system resources, wraparound would be the proposed practice model to implement."

He then took out a piece of paper and said, "We try at our agency to practice using the wraparound principles for all 10,000 families we serve, but we also know we can't possibly follow all of the steps of the wraparound process with any reliability for all of those families. So when we're confident about having a clue about what to do and how to do it, we move fast and work collaboratively with the family. When we're confused or pretty sure that we don't have a good grasp on the answers we follow the wraparound process."

Jim then sketched out some differences between child and family team practice and wraparound practice on a piece of paper. Table 1 displays what he identified.

Molly explained she wasn't clear about what to do in Andrew's situation, especially since counseling and other system responses hadn't worked. Since that was true, she proposed following the wraparound process with Andrew and Ms. Smith. Jim smiled and responded "You're a quick learner. Go have some fun."

Table 1. Differences in Practice

	Standard Child and Family Team Practice	Wraparound Practice
Engagement	Engagement is primarily between us and the family with secondary engagement with others involved.	Engagement is ecological: facilitator, team, family, agencies, broader community and everyone else.
Crisis Stabilization	Stabilization is a big part of what the case manager does with the family. "The team" is family and case manager with others.	We try to avoid too much in the stabilization step. We do just enough to hold on until we can get the team process started.
Strengths	We do strengths discovery, but it's more limited—strengths are seen as grounded in the family and child, and may be less explicit drivers of practice. We share information on strengths with whoever is involved on as-needed basis.	Strengths discovery is more ecological, and we identify and use strengths and capacities of the family, child, community, and potential team members. Reframing the family as people with potential solutions, the gathered information is public and shared with all of the team being present.
Team	"Teaming" is a verb—something we do with the family usually through a team of two perspectives (case manager and family), though case manager may interact with natural supports.	The team is an entity—something we are. The addition of natural supports is important and their participation is a formalized part of the process as we make decisions.
Who is Served	All enrolled youth are served through the child and family team process.	Wraparound is utilized with youth for whom formal and traditional services have proven to be ineffective and folks involved don't know what to do.

Engagement and Team Preparation

Molly visited Andrew's mother, Ms. Smith, at her apartment and Andrew at the shelter to get to know them and explain the wraparound process. During these visits Molly focused on explaining her role and responding to immediate crisis needs. She also explored strengths, needs, culture, and Andrew and his mother's vision of the future. Throughout all this, she attempted to establish trust. After a series of visits it became increasingly clear that Andrew and his mother wanted to be together.

During this time Andrew wasn't doing well at the group home. He was having trouble sleeping through the night and was fighting with some of the other kids at the group home. He also had some altercations with staff that resulted in many of his privileges being taken away from him, including phone contact with his mother. Molly started to receive requests for assistance from the group home manager, Mike, about Andrew's behavior. She met with the group home staff and the CPS caseworker, Angie, and developed a crisis plan to stabilize Andrew's placement. Molly looked forward to meeting with others to develop a crisis plan partially because she was comfortable with this type of planning thanks to her previous employment completing functional behavioral assessments for individuals with developmental disabilities. During the meeting Molly used her experience and skills and guided the team to look at reasons why some of the behavior was occurring. It was noted the fights or altercations usually occurred after dinner when Andrew was instructed to do a chore or something that he didn't want to do. Fights would also occur when he asked to call his mom and was told no. Steps in the crisis plan included getting a direct support provider from 4pm-8pm daily to help Andrew through this portion of the day. The group home staff also agreed to quit using contact with mom as a reward or consequence and allowed Andrew to contact his mom daily no matter how he behaved.

The crisis plan was developed and put into action within two weeks from the time Molly received the referral. As the crisis plan was implemented, Andrew's behavior started to improve. This allowed Molly the opportunity to focus on other activities necessary to build a team and start proactively planning with the Smith family. The next step for Molly was to meet with the CPS worker to review what she had learned during her meetings with Andrew and Ms. Smith. Molly was also gathering Angie's perspective on the hopes and dreams she had for the Smith family and what would be needed for Andrew and Ms. Smith to be able to live together. Angie was apprehensive about the idea of Andrew returning home to live with his mom during these initial conversations. Angie made statements like "Mom has to prove that she's willing to change the way she's parenting," and "I have to make sure Andrew will be safe, it's my tail if something bad happens to Andrew again."

> *Molly was able to establish a relationship with the CPS worker by validating her concerns and fears and creating a mantra of "shared accountability" between systems to ensure safety.*

Molly's initial response was emotional and focused on "That's not right, if mom and Andrew want to live together it's up to us to figure out how we're going to make it happen." She decided to go to her supervisor, Jim, to help design some specific strategies to engage the CPS worker. Jim suggested that Molly slow down and validate Angie's concerns and work with her on achieving some common ground. Molly took this instruction and changed her approach from "I'm right and you're wrong." At this point she started having conversations with the CPS worker around developing a shared vision that included ensuring the safety of Andrew while returning to live with his mom. Molly was able to establish a relationship with the CPS worker by validating her concerns and fears and creating a mantra of "shared accountability" between systems to ensure safety. This didn't happen overnight but over the course of three weeks Molly and Angie built a trusting relationship that allowed both perspectives to be understood and respected.

As Andrew's behavior stabilized, Molly devoted more time to exploring the family's strengths, culture and vision. She also contacted other people in the family's life, including:

- Andrew's favorite teacher, Mrs. Franklin;
- Ms. Smith's friend from work, Sandy; and
- two neighbors who provided after school care.

During the next two weeks Molly took notes on each encounter. She approached her supervisor again. "OK, I feel like I have a lot of information but I'm not sure what exactly to do with it. I know it's valuable, but how do I make it useful?" Jim's response was, "Take the information and write it into a working document that outlines the vision, strengths, needs and culture of the Smith family. Present that to team members at the first team meeting. You will update the document as you go along. This information will help the team to develop a plan of care for the family." As Jim was talking Molly was thinking to herself, "Duh, I learned that in training," but politely nodded her head and thanked Jim for his help.

After this discussion, Molly developed a document reflective of the Smith family. Molly scheduled the first team meeting which included the following individuals:

- Ms. Smith
- Andrew
- Angie - CPS case worker
- Mike – Group home manager
- Jamie- Neighbor
- Sandy- Mom's best friend
- Mrs. Franklin- Andrew's 2nd grade teacher
- Dave – Direct support worker
- Jane - Therapist
- Molly- Facilitator

Initial Plan Development

Molly contacted all of the team members shortly before the meeting to confirm their attendance. She oriented them to the overall wraparound process, the way the team meeting would proceed, and the initial purpose of the team (Andrew safely returning to live with his mother). She then developed the meeting agenda. As she was doing this, Jim stopped by and offered some words of wisdom to Molly about facilitating the first team meeting stating "Don't try to be a hero—the team was created for a reason. Rely on everybody's expertise in developing the plan. Think of yourself like a movie director. Your role in producing a successful team meeting is ensuring the stage is set so the actors can act."

The initial team meeting began with everyone introducing themselves and their relationship to the family. After introductions, Molly urged team members to be creative and generate a mission statement that would describe the team's purpose. After much discussion, Andrew spoke up and said "I belong home with my mom." Things got silent until Angie said, "How about the mission statement of Andrew belongs home." Everyone agreed. After the team mission was established, Molly led the team in developing ground rules for future meetings. The team established the following five ground rules:

- No shaming or blaming of any team member
- Stay focused on the mission
- Be on time
- Do what we say we're going to do
- There are no dumb ideas

Molly then shared her document that outlined the vision, strengths, needs, and culture of the family. She asked the team to review for accuracy and to voice any additions they would like to make. The team members verified the document's accuracy but Ms. Smith and Mike added some additional strengths for Andrew. Molly stated she would send an updated version to everyone. She then guided the team in prioritizing the needs statements listed in the document. Molly led the team in discussing the needs and made sure Ms. Smith's perspective was well represented. Ultimately, the team agreed to focus on the following needs:

- Andrew needs to know others will keep him safe when he's unable to do so

- Ms. Smith needs to feel a sense of safety within her home
- Andrew needs to see that love doesn't always have to hurt
- Ms. Smith needs to be validated for her efforts in what she's trying to do

The next step involved developing goals for each of the needs. Molly moved the discussion to brainstorming options on how the team is going to meet the targeted goals. Molly asked the team to come up with at least 10 possible strategies for each goal. She referenced the "no dumb ideas" ground rule. Everyone participated in brainstorming, including Andrew.

The team selected from their list of strategies and developed specific action steps that they were going to implement to meet the identified goals. Molly clarified who would do each action step and when it would be completed. After the team completed the initial plan, the energy in the room was extremely high. Molly nervously asked the team, "What could go wrong with this plan?' The energy instantly diffused as the room became quiet. Molly found herself becoming increasingly nervous and at a loss for words, when Ms. Smith stepped up and said "Molly, I appreciate you asking that, because we've had professionals and people involved in the past that we thought we could trust and they were famous for saying they were going to help but they never followed through and ended up causing more harm than good." The team listened intently to Ms. Smith, and decided to work on holding each other accountable. They spent the rest of the meeting developing a communication plan for the primary purpose of getting updates and ensuring timely follow through.

Table 2 (following page) exhibits a portion of the Andrew Belongs Home Plan that was developed during the initial meeting.

Implementation:

Molly wrote up the team meeting notes, the plan, and the updates to the strengths document and sent out copies to the team members. Molly became unsure about next steps. She wasn't clear about how to make sure team members were following through. She approached Jim for guidance. Jim stated "The team is at a crucial place, and your role right now is extremely important. In this situation you are not an implementer. As the facilitator, you need to be ensuring people are following through and that information regarding what is and isn't working is being collected. You also need to help break down any barriers that are getting in the way of the plan." Molly asked "OK, but how do I do that?" Jim replied "I would love to be able to answer that but I don't sit on this team. With each team it will look a little bit different. Your job is to work collaboratively with everyone to figure out what would work best." This was a little frustrating for Molly but she started to develop plans for implementing this approach.

Approximately a week after the initial team meeting, Molly started contacting the team members to see how it was going. She discovered a lot of things were going well. Ms. Smith and Jamie (neighbor) had attended the parent support group twice. Ms. Smith reported that she enjoyed the support meetings and had even met other parents that were in similar situations. They had exchanged phone numbers and were meeting for dinner over the weekend. Ms. Smith also stated that she met with Andrew's teacher, Ms. Franklin. She reported a positive discussion with her around ways she could change some of her responses when Andrew came home stressed out. Molly learned from Angie that everything was on schedule for Andrew's return home. In addition to noting Ms. Smith's follow through, Angie reported she was feeling more optimistic about a safe return home for Andrew.

Molly was feeling confident about the updates she was receiving from the team members until

she contacted Mike (group home manager). He reported that Andrew has been struggling lately at the group home. Andrew had received five incident reports over the last week that involved Andrew becoming physically aggressive to staff and peers. Mike felt the majority of these incidents were a result of turnover in staff at the group home. Some of the new staff didn't have a relationship with Andrew and were not following the crisis plan as designed. When Molly contacted Dave, the direct support provider, he reported that he had resigned from his position as of the following week. Hearing this information and looking at the Andrew Belongs Home Plan, Molly became increasingly concerned about how the plan could possibly work. She remembered her conversation with her supervisor about not trying to be a hero. She decided to bring the team together and discuss this new information.

Molly was able to get the team together within the week. She prepared for the team meeting by ensuring all team members had received the updates and were clear as to what the purpose of the meeting was going to be. The two agenda items that required focus were

1. How to improve Andrew's life at the group home and
2. How to ensure that the direct support activities would still occur.

Molly opened the team meeting by reviewing the ground rules and having the team members remind each other of the mission. She then led the team by reviewing progress, noting and celebrating the strengths and accomplishments that occurred from the last time the team had met. Af-

Table 2. Excerpt from "Andrew Belongs at Home" Plan

Need	Goal	Action Steps
Andrew needs to know others will keep him safe when he's unable to do so.	Ms. Smith will feel safe when Andrew returns home.	• The group home staff will continue to use the crisis plan. • Mom will spend time with the group home staff 3 times per week to learn how to interface with Andrew when he becomes stressed. • Direct support worker Dave will accompany Andrew for home visits three times per week. • Andrew will play basketball for one hour after school by himself.
Ms. Smith needs to feel a sense of safety within her home	Andrew will return home within the next two months.	• Ms. Smith will get a lock installed on her bedroom door. • Ms. Smith and Jamie will attend a support group for parents two times per week. • Angie and Ms. Smith will meet with family preservation team two times per week. • Mrs. Franklin will meet with Ms. Smith to discuss "what works for Andrew" information and to assist in home changes. • Mike, Jamie and mom will meet within the next month to develop crisis plan for when Andrew returns home.
Andrew needs to see that love doesn't always have to hurt	Andrew will form relationships with his peers	• Direct support worker Dave will take Andrew to boys and girls club two times per week. • Andrew will work with therapist Jane to work on a "person I would like to be" project once per week. • Group home manager Mike and staff will work on including Andrew in activities with other kids at group home. • Andrew will help out in Mrs. Franklin's class once per week.

ter all the updates were shared on what was going well, the team had a positive mindset about its effectiveness. The then moved into brainstorming around the items requiring action. The team generated a variety of creative options to choose from. To resolve the direct support area, it was decided Mrs. Franklin would take over those responsibilities by becoming a part-time employee for Molly's agency. The team decided to resolve the group home concerns by conducting an all staff meeting with Andrew and Mike co-facilitating to share what works and doesn't work, and to ensure all are familiar and comfortable with utilizing the crisis plan.

The team implemented the adjusted plan, and quickly Andrew became more comfortable at the group home. Mrs. Franklin was enjoying the work she was able to do with Andrew and his mom. As time went on Molly continued to receive updates on what was working and what wasn't. The team met every week to once every other week to continue to make adjustments to the plan and be proactive in discussing the question, "What could go wrong?" Molly's focused on supporting team members and ensuring all involved stayed committed to the mission of Andrew Belongs Home.

About two months from the initial team meeting, the team's work started really paying off. Andrew returned home safely with his mom and the team continued to stay focused in making the necessary accommodations to support both of them. Ms. Smith was still attending support groups and facilitating a new support group for parents that were going through similar situations. She also had developed a renewed confidence on how to interact with Andrew under stress, and was starting to develop a social life—something she had dreamed about for years. Andrew was playing basketball on a team, receiving passing grades at school, and, though at times reluctantly, helping out around the house. Angie, the CPS worker, was very pleased with the status of the reunification process and was developing a report to send to the court that recommended CPS involvement end.

Transition

Instead of meeting at least once every two weeks, meetings were now being held once a month to every other month. Mike and Angie ended their involvement when the team went to court and presented a summary of the accomplishments. The judge was extremely impressed and agreed with the plan. The team celebrated the closure of CPS involvement by having a party at Ms. Smith's and Andrew's home and playing a variety of different games that Andrew developed.

The team continued to meet at least quarterly. Molly was still enjoying the many successes that Andrew and his mom were having. During this time Molly also became a little confused about what the purpose of her involvement was and when to introduce the concept of transition. This was the first time she had reached this place with the process. This time Molly's answer came from a phone call from Ms. Smith. Ms. Smith noted the progress made and her appreciation for the team's hard work and dedication. Molly took this opportunity and asked Ms. Smith what she saw as the future role of the team. Ms. Smith responded, "I guess to make sure that if Andrew or I are having trouble in the future that we will be able to get help right away so we don't go back to the place where we were when we first started." Ms. Smith and Molly developed steps to transition the team.

Molly set up a team meeting to discuss the concept of formal team transition. The team members present were Ms. Smith, Andrew, Jamie, Sandy, and the therapist, Jane. This meeting started their normal ritual of going over the ground rules, the team mission and vision of the family, and updates on progress and accomplishments. Molly worked with everyone to create a transition plan outlining team accomplishments while updating the crisis plan. The team decided

to have a party celebrating their work together.

Molly wrote up the meeting results and distributed the transition, crisis and re-engagement plan. Then it was time to have a little fun since the day of the team celebration had arrived. They all went to one of Andrew's basketball games and cheered as Andrew scored his first basket of the season. Afterwards everyone went to the park for a barbecue. Team members shared memories of their experience together. People expressed their happiness at the accomplishments but noted that the ending was bittersweet. Ms. Smith was last to speak. She said "Thank you all for everything. We did what we said we were going to do. We were oh so right when we developed our mission statement. Andrew indeed belongs home with me." Molly thinks of those words often as she continues this work today.

Postscript

When I agreed to complete this article or summary, I wanted to stay away from sharing an "idealized" wraparound story because I've found that it almost never happens that way. I also wanted to avoid going to a story that was so unsuccessful as to cause anyone considering Wraparound to move away from it. This story doesn't adequately capture the ups and downs of the team nor the amount of confusion experienced by Molly as she was implementing and learning this process. Rather it merely provides a snapshot of the learning process. What I tried to do is explain how things happen in our agency while recognizing that families are human and they don't always fit into our phases exactly as we wish.

Some points I wish the reader would consider include:

- We chose to follow the wraparound process in serving Andrew and Ms. Smith. This took the supervisor helping the case manager deciding what to do. From then on, Molly was coached to follow the wraparound phases as closely as possible.
- The first plan wasn't easily implemented. Unfortunately, people and their plans change. Our first ideas had to be modified and reinforced. The thing to remember and consider in the implementation of wraparound is when you get to implementation, you need to make sure your plans were actually implemented rather than assuming they were wrong. Notice that the group home plan wasn't substantially changed. Instead the analysis of the problem is that it hadn't been implemented. So Andrew and Mike, the group home manager, found a way to get it implemented.
- People do make a difference. We use words like "celebrate" and we do have barbecues because those small rituals make a difference for youth, families and helpers. This is more than mere words. Ms. Smith continues to talk about the barbecue today. Those are often the first things that get cut when agencies are faced with budget shortfalls but we've learned that families may often value those things more than anything else that we do.
- The wraparound facilitator doesn't have to have all of the answers, but rather a commitment in getting the right people to the table. Molly learned through this process that by developing trust and creating meaning for team members, shared solutions can be brainstormed and achieved. Formal and informal supports don't like to be told what to do but appreciate being part of a team that genuinely wants to achieve positive outcomes for others.
- Quality supervision and coaching is instrumental in achieving high fidelity wraparound. This work isn't easy no matter how experienced you are. All wraparound facilitators need someone to support them, bounce ideas off of, and provide clarity and direction around next steps.
- In addition to training and supervision, there were a lot of supports necessary to achieve this success:
  - The CPS worker recognized the potential of wraparound and was supported by her supervisor and home agency to participate on the team;
  - Molly's caseload was maintained at a manageable level, allowing her to engage the family and team members, follow-up with team members, and follow-through with all the strategies in the plan;

- Molly's agency was able to do things like pay a team member with expertise (Matt's teacher), so that she could carry out her role on the team;
- Resources for things like barbeques, basketball leagues, and celebrations were readily available to the team.

Author

Matt Pierce has been working with children/ families for over ten years in a variety of different capacities. Matt has had the opportunity to hold positions within the wraparound context as a facilitator, direct support provider, supervisor, trainer, and as an administrator. Matt has also developed a variety of training materials, informational guides, and practice level tools to assist facilitators, supervisors and administrators in operationalizing the wraparound philosophy.

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Pierce, M. (2008). The phases of wraparound: Real life & teams. In E. J. Bruns & J. S. Walker (Eds.), *The resource guide to wraparound.* Portland, OR: National Wraparound Initiative, Research and Training Center for Family Support and Children's Mental Health.

Wraparound Practice: Chapter 4b.1

The Application of the Ten Principles of the Wraparound Process to the Role of Family Partners on Wraparound Teams

Marlene Penn, Co-Chair, Family Partner Task Force
Trina W. Osher, Co-Chair, Family Partner Task Force

National Wraparound Initiative

Fidelity to the wraparound process requires effort on the part of the team and its individual members to intentionally engage in activities that are consistent with all ten principles. This document briefly describes what the family partner does on wraparound teams to put each of the ten principles of the wraparound process into practice.

The family partner who is well grounded in the principles of wraparound will confidently perform his or her role and manage the tasks and unique situations that emerge on a daily basis. Family partners must receive wraparound training as well as training specific to their role.

The family partner is a formal member of the wraparound team whose role is to serve the family and help them engage and actively participate on the team and make informed decisions that drive the process. family partners have a strong connection to the community and are very knowledgeable about resources, services, and supports for families. The family partner's personal experience is critical to earning the respect of families and establishing a trusting relationship that is valued by the family.

The family partner can be a mediator, facilitator, or bridge between families and agencies. Family partners ensure each family is heard and their individual needs are being addressed and met. The family partner should communicate and educate agency staff on wraparound principles, the importance of family voice and choice, and other key aspects of ensuring wraparound fidelity.

As the family moves through the stages of the wraparound process, it is anticipated that their sense of self-empowerment and their level of sophistication as advocates

will increase. Self-advocacy takes many forms along a continuum from getting one's own child and family services, to being a support to other families, to influencing the policies and procedures that govern the child-serving systems. The family partner is conscious of where each family is at any point in time. The family partner coaches and encourages families to find and develop their own voices and learn how to use it effectively in their own wraparound team and beyond.

Each family should have a choice of individuals to serve as their family partner—though this is not the case in every community. As a general practice, the family partner should serve on the team only so long as the family needs their support to effectively speak for themselves. There may be some families who feel they do not need the support of a family partner once they have been introduced to the wraparound team or who may wish to facilitate their own team.

The rest of this document describes the family partner's role in supporting achievement of the ten principles of wraparound for the children, youth, and families with whom they work.-

Thanks to the people on the Family Partner Task Force of the National Wraparound Initiative for their hard work and dedication in helping to establish these ten principles.

Wraparound Principle	Family Partner’s Role in Implementing the Principle
1. Family voice and choice. Family and youth/child perspectives are intentionally elicited and prioritized during all phases of the wraparound process. Planning is grounded in family members’ perspectives, and the team strives to provide options and choices such that the plan reflects family values and preferences	Coaching, educating, supporting and encouraging family members to use their own voices to express their views clearly and to make informed choices are the very essence of the role of the family partner. The family partner actively ensures that the family’s own voice drives the wraparound process and their wraparound plan. The family partner helps to create a safe environment in which families may express their needs and views or vent frustration. The family partner can help the family discover and learn ways to describe negative experiences and express their fears and anxieties to the team in ways that promote communication. The family partner makes a special effort to ensure the family’s point of view—not the family partner’s—is heard by the team. The family partner is sensitive to the fact that perspectives of individual family members may differ and that conflicts may need to be addressed by all parties to achieve the consensus necessary for the team process to move forward. The family partner has a responsibility to educate the other team members on the significance of family voice and choice and how their own practice and behavior can create an environment where families feel safe using their voices and expressing their choices. When a family member feels unwilling to talk about an issue, he or she may ask that the family partner (or someone else) act as a spokesperson. In such cases the family partner encourages the family member to find a way to express him- or herself before accepting responsibility of being a temporarily designated spokesperson. When acting as a spokesperson, the family partner invests as much time as is necessary to develop a complete understanding of the family’s perspective. When family members specifically ask the family partner to speak on their behalf, the family partner always makes sure the family member is present and confirms what is communicated.

Wraparound Principle	Family Partner’s Role in Implementing the Principle
2. Team based. The wraparound team consists of individuals agreed upon by the family and committed to them through informal, formal, and community support and service relationships	The family partner coaches the family through an ongoing process of discovery and inquiry about possible team members to make sure they are connecting with individuals or agencies who can meet their needs. As a result, the family is prepared to make informed choices about team membership and understands why some team members are mandated by systems working with the family. The family partner helps the family understand how to influence the building of their team. Family partners use their knowledge of the schools, communities, services, and neighborhoods to help the family identify friends, neighbors, relatives, providers , and others from their culture and community who could serve on their team. The family partner coaches the family through the process of deciding who they want to have on their wraparound team. The family partner helps the family understand why some team members are assigned by agencies without consulting them. The family partner helps the family recognize what each of these individuals could contribute as well as the advantages and possible challenges that might arise from their participation on the team.

2. Team Based

Wraparound Principle	Family Partner's Role in Implementing the Principle
3. Natural supports. The team actively seeks out and encourages the full participation of team members drawn from family members' networks of interpersonal and community relationships. The wraparound plan reflects activities and interventions that draw on sources of natural support.	The family partner helps families understand how natural supports can contribute to the overall success of their wraparound plan and helps the family identify natural supports they want to bring onto their team and incorporate into their wraparound plan. The family partner encourages the family to bring their natural supports to the wraparound process. However, they must also respect the family's choice to withhold information about natural supports if they so wish. The family partner helps the family to develop and discover natural supports already present in their lives, as well as opportunities to develop new supportive relationships in their community. The family partner describes the wealth of resources they have identified in the community (for example, sports teams, scouts, and religious groups) and helps the family see the possible benefits of involving some of these resources on the wraparound team, and the possible costs of not involving them. The family partner supports family members as a peer throughout the wraparound team process. The family partner gives them opportunities to become part of the larger circle of families where they can find support from other parents and caregivers with similar experiences who have faced similar challenges and overcome them. Family partners connect families to local family groups and organizations where, through participation in support groups, classes or other events, they have the opportunity to develop relationships with individuals who can serve as natural supports on a team or independently. Once the family has developed its own network of informal peer support they may feel they have the confidence to participate in the wraparound team without the support of a family partner. However, the family partner may remain a resource for the family because they are connected through the larger family network in the community and, at the family's request, could rejoin their team at any time.

3) Natural Supports

Wraparound Principle	Family Partner's Role in Implementing the Principle
4. Collaboration. Team members work cooperatively and share responsibility for developing, implementing, monitoring, and evaluating a single wraparound plan. The plan reflects a blending of team members' perspectives, mandates, and resources. The plan guides and coordinates each team member's work towards meeting the team's goals.	It is the family partner's role to model, coach and encourage the process of collaboration. Having this sort of model will help families become empowered in the present and over time to work successfully with diverse individuals and providers. In addition, the family partner is a collaborative advocate, helping the family to understand the mandates and perspective of other members of the team. The family partner helps to make sure the individual family's perspective is at the forefront of all team discussions by strategizing with the family members about how they can deliver their own messages clearly and with the desired impact. Seasoned family partners report that this is the principle that tests their skills most. There are two parts to this challenge. First, it requires keeping their own views in check, respecting the family's culture, aligning themselves with the family, and using their own voice to support the family's choices. Second, the family partner must also remain engaged in strategic and mutually respectful partnerships with the wraparound facilitator and other team members. The family partner helps ensure that family voice and choice is driving the wraparound team and plan as all team members work collaboratively.

Wraparound Principle	Family Partner's Role in Implementing the Principle
5. Community-based. The wraparound team implements service and support strategies that take place in the most inclusive, most responsive, most accessible, and least restrictive settings possible; and that safely promote child and family integration into home and community life	It is the family partner's role to explain why the wraparound process focuses on community-based living and services for children and youth. The family partner helps the family understand the philosophy behind this principle and consider how it could be applied to their own situation. Regardless of their own views, family partners strive to understand the reasons behind the family's placement preferences and helps the rest of the team understand what the family thinks is best for their child. The family partner informs the family about supports, services, and placements available in their community and helps them frame questions they might want to ask specific providers or agencies. The family partner helps families and their teams implement practical strategies for getting access to whatever it will take to successfully transition home or stay in the community. The family partner encourages thinking beyond the customary services and supports. The family partner helps the family clearly expresses the "why" behind their choices (including critical needs still to be addressed) to the rest of the team. The family partner also helps the family understand why others on the team might make a different recommendation and works towards blending the best from each team member's perspective and expertise into the family's plan.

5. Community Based

Wraparound Principle	Family Partner's Role in Implementing the Principle
6. Culturally competent. The wraparound process demonstrates respect for and builds on the values, preferences, beliefs, culture, and identity of the child/youth and family, and their community.	Family partners recognize and value differences among families, ethnic and cultural groups, and communities. Delivering culturally competent services begins with discovering what is important to the family. Each family has its own unique culture, as do any groups with whom the family identifies. This influences how the family approaches the tasks of daily living (for example, food, dress, work, school, spiritual beliefs and practices). This cultural context can also direct how a family faces the challenges of raising children. Families work in different ways, have different resources at their disposal and achieve differing degrees of success at meeting the needs of all their members. Family partners draw on their own experiences of raising and loving a child with emotional or behavioral issues as they work with the family and its whole team to discover the family's values, priorities, and preferences. Family partners can use their own experiences to illustrate cultural intelligence, to guide discussions about cultural needs, and to help the family and their team develop a relationship. The family partner makes sure that the culture of the family, as they define it, is respected and that the plan is grounded in the family's ethnic and cultural background in the manner the family feels it is culturally relevant for them. Implementing this principle can be facilitated by assigning a family partner who comes from the same or a similar community as the family engaged in the wraparound team. A community's wraparound initiative should recruit family partners who represent the diversity of families served through the wraparound effort, as well as individuals with varied kinds of parenting experience (such as single parents, gay or lesbian parents, grandparents, or adoptive parents).

Culturally Competent

Wraparound Principle	Family Partner's Role in Implementing the Principle
7. Individualized. To achieve the goals laid out in the wraparound plan, the team develops and implements a customized set of strategies, supports, and services	The family partner helps the family ensure the plan is customized to meet their unique needs and is related to their values, history, and traditions. The family must feel that the plan is theirs and is tailored to their daily schedule, transportation requirements, and other specific conditions. The family partner helps the family form a better vision of what it would look like to be "doing okay." The family can then identify their needs and goals to make sure the plan addresses the whole family not just a single individual. With coaching from the family partner, the family develops the skills and confidence to present these to the team and realize their vision. Family partners draw on their own experiences of negotiating services and supports for their own children to help teams understand how, regardless of system mandates, each child and family has different needs. Family partners can help the team understand how strategies used to meet one family's needs may need to be different from those effective for other families that have similar goals and needs.

7. Individualized

Wraparound Principle	Family Partner's Role in Implementing the Principle
8. Strengths based. The wraparound process and the wraparound plan identify, build on, and enhance the capabilities, knowledge, skills, and assets of the child and family, their community, and other team members.	Family partners, like all members of the team, should model a strengths-based approach in all their interactions with the family. Family partners spend time with families in their homes and communities; they can observe how each family copes with simple and complex tasks in daily life. Family partners use these observations to help families get in touch with their strengths, their children's strengths, and the positive features of their communities. Family partners help families realize how their strengths (for example their resilience) may help address their needs. By sharing their own family's journeys, family partners describe the process of discovering strengths, thereby showing other families how they can acquire this strength-based skill. A family's view of itself can be compromised by systems that focus on risk factors and diagnosis or pathology. The family partner, by sharing his or her experience of discovering strengths and assets, helps the family develop new skills and competence and hope for a productive future. The family partner helps to coach other team members on always utilizing a strengths-based approach.

Wraparound Principle	Family Partner's Role in Implementing the Principle
9. Persistence. Despite challenges, the team persists in working toward the goals included in the wraparound plan until the team reaches agreement that a formal wraparound process is no longer required.	Their own histories and determination in finding support and getting services for their own children and families deeply commit family partners to the principle of persistence. The family partner helps families find hope and encourages them to persist through difficulties to find solutions that work for them. The family partner works creatively with the family and their team to make sure that care does not cease when barriers and challenges are encountered. Using identified strengths, they vigilantly ensure that any undesired or unachieved outcomes are recognized by the team as a deficiency in the plan - and are not seen as the failure of the family or a particular team member. These strengths are used to promptly change in the plan when something is not working as anticipated. The family partner helps the team discover how the plan should be modified to ensure the family will get everything they need to succeed. Ideally the family partner should be committed to remaining with the family as long as (and no longer than) the family needs or desires. The family partner supports the family through self-advocacy. Phasing out the family partner should be a gradual process as families expand their role.

9. Persistence

Wraparound Principle	Family Partner's Role in Implementing the Principle
10. Outcome based. The team ties the goals and strategies of the wraparound plan to observable or measurable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly.	The family partner ensures that indicators of success are not wholly driven by providers' or systems' goals for the family, but includes the family's expression of what success will look like from their perspective. The family partner plays an active role in ensuring that the family's vision of a positive future is the basis for indicators of success and that the team does indeed regularly and actively track progress toward these indicators and revises the wraparound plan when progress is not being achieved. In addition, a family's success often is defined by the extent to which they have become self-empowered advocates. The family partner can play a key role in documenting the degree to which—and the specific ways in which—the family has moved along this path. Where wraparound teams are conducting assessments and collecting evaluation data, the family partner understands and is able to share this information with the family so that they can assess practices and progress and modify their plan to improve outcomes.

Authors

Marlene Penn's initial experience on care planning teams was as the parent of her own child. She subsequently became an advocate for other families and trains and coaches extensively on the role of the Family Partner on wraparound teams. Marlene served as one of the faculty members on the University of South Florida Louis de la Parte Florida Mental Health Institute Course "Wraparound Interventions and the System of Care" and is co-chair of the Family Partner Task Force of the National Wraparound Initiative.

Trina W. Osher co-chairs the Family Task Force of the National Wraparound Initiative. She is a recognized leader in the family movement, working to promote family-driven practice by building collaborative alliances between families and the programs, agencies, and systems that serve their children.

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This document was produced through the full NWI consensus process.

Wraparound Practice: Chapter 4b.2

How Family Partners Contribute to the Phases and Activities of the Wraparound Process

See page 2 for proper viewing instructions

Trina W. Osher, Co-Chair, Family Partner Task Force
Marlene Penn, Co-Chair, Family Partner Task Force

National Wraparound Initiative, Portland, OR

Fidelity to the wraparound process requires effort on the part of the team and its individual members to intentionally engage families in all phases and activities in a manner that is consistent with the principles of wraparound. *The Application of the Ten Principles of the Wraparound Process to the Role of Family Partners on Wraparound Teams* (Penn & Osher, 2007) briefly described what the Family Partner does on wraparound teams to put each of the ten principles of the wraparound process into practice. This document explains in detail what the Family Partner does during each phase of the process to support the family's engagement in key activities. It also describes how the Family Partner's work complements that of the Wraparound Facilitator and how the Family Partner works in partnership with other members of the team. Examples given of practices are intended to be illustrative as individual family and community contexts vary and wraparound planning is unique for each child and family.

Completion and publication of this document fulfills one of the major goals of the Family Partner Task Force of the National Wraparound Initiative. The Task Force is a diverse group of more than 50 family members, youth, practitioners, advocates, administrators, policy makers and others committed to promoting high fidelity wraparound and developing resources and tools to facilitate its implementation.

The Task Force uses the National Wraparound Initiative's Participatory Community of Practice model to develop tools and materials to support family partners and the organizations they work for in the field. All members of the Task-

Force had the opportunity to contribute to this document at every stage of development which included three rounds of feedback (two from the Task Force and one from the entire group of National Wraparound Initiative advisors) using web-based surveys. Trina Osher and Marlene Penn, co-chairs of the Task Force, were responsible for writing this document. April Sather's assistance with gathering and compiling the multiple rounds of feedback was invaluable. Many individuals looked at various drafts and the following made significant contributions to the work either by providing content or making comments: Angela Igrisan, Art Navalta, Barbara Kern, Carol LaForce, Claudette Fette, Denise Baker, Dennis Grannis-Phoenix, Heather Woldemar, Hillary Gaines, Jeff Guenzel, Jennifer Mettrick, Kathleen Screen, Lyn Farr, Madge P Mosby, Pamela Marshall, Rosalyn M. Bertram, Sharon Madsen, Sue Smith, Jeanette Barnes, Lynette Tolliver, Mary Ellen Collins, Twila Yingling, Carolyn Cox, Susan Boehrer, and Alice Preble.

Definition of Family Partner

The Family Partner is a family member who is a formal member of the wraparound team. The family partner's role is to serve the family, help them engage and actively participate on the team, and make informed decisions that drive the process.

Family Partners have a strong connection to the community and are very knowledgeable about resources, services, and supports for families. The Family Partner's personal experience raising a child with emotional, behavioral, or mental health needs is critical to earning the respect of families and establishing a trusting relationship that is valued by the family.

The Family Partner can be a mediator, facilitator, or bridge between families and agencies. Family Partners ensure each family is heard and their individual needs are being addressed and met. The Family Partner should communicate and educate agency staff on wraparound principles, the importance of family voice and choice, and other key aspects of ensuring wraparound fidelity. The family partner works in close partnership with the wraparound facilitator.

VIEWING INSTRUCTIONS

Proper viewing of this document is essential to understanding the role of the family partner in the context of the phases and activities of the wraparound process. When viewed as intended, the reader should see a table explaining the phases of the wraparound process on the left page, and the family partner role in that phase on the right page. To achieve this view in Adobe Acrobat, choose View > Page Display > Two-Up. When viewing a printed copy, make sure the odd page is on the left and the even page is on the right (if printing on both sides, begin printing with page 2 and print page 1 separately).

Family Partner Role in the Wraparound Process: Phase 1

PHASE 1: Engagement and team preparation**

During this phase, the groundwork for trust and shared vision among the family and wraparound team members is established, so people are prepared to come to meetings and collaborate. During this phase, the tone is set for teamwork and team interactions that are consistent with the wraparound principles, particularly through the initial conversations about strengths, needs, and culture. In addition, this phase provides an opportunity to begin to shift the family's orientation to one in which they understand they are an integral part of the process and their preferences are prioritized. The activities of this phase should be completed relatively quickly (within 1-2 weeks if possible), so that the team can begin meeting and establish ownership of the process as quickly as possible.

MAJOR GOALS	ACTIVITIES	NOTES
1.1. Orient the family and youth GOAL: To orient the family and youth to the wraparound process.	*1.1 a. Orient the family and youth to wraparound* In face-to-face conversations, the facilitator explains the wraparound philosophy and process to family members and describes who will be involved and the nature of family and youth/child participation. Facilitator answers questions and addresses concerns. Facilitator describes alternatives to wraparound and asks family and youth if they choose to participate in wraparound. Facilitator describes types of supports available to family and youth as they participate on teams (e.g., family/youth may want coaching so they can feel more comfortable and/or effective in partnering with other team members).	This orientation to wraparound should be brief and clear, and should avoid the use of jargon, so as not to overwhelm family members. At this stage, the focus is on providing enough information so that the family and youth can make an informed choice regarding participation in the wraparound process. For some families, alternatives to wraparound may be very limited and/or non-participation in wraparound may bring negative consequences (as when wraparound is court ordered); however, this does not prevent families/youth from making an informed choice to participate based on knowledge of the alternatives and/or the consequences of non-participation.
	1.1 b. Address legal and ethical issues Facilitator reviews all consent and release forms with the family and youth, answers questions, and explains options and their consequences. Facilitator discusses relevant legal and ethical issues (e.g., mandatory reporting), informs family of their rights, and obtains necessary consents and release forms before the first team meeting.	Ethical and legal considerations will also need to be reviewed with the entire team as described in phase 2.

** Wraparound phases defined in: Walker, J. S., Bruns, E. J., & the National Wraparound Initiative Advisory Group. (2008). Phases and activities of the wraparound process. In E. J. Bruns & J. S. Walker (Eds.), *The resource guide to wraparound*. Portland, OR: National Wraparound Initiative.

VIEWING INSTRUCTIONS ON PAGE 2

Family Partner Role in the Wraparound Process: Phase 1 (CONTINTUED)

PHASE 1: The family partner role

The family partner has a collaborative relationship with the wraparound facilitator. Together they establish mechanisms to keep each other informed, make sure the family partner knows when new families are enrolled as well as when and where team meetings will occur, and insure all newly enrolled families have the opportunity to have support from a family partner if they choose.

HOW FAMILY PARTNERS SUPPORT THE PROCESS

1.1 a. Orient the family and youth to wraparound

The family partner helps the family understand wraparound as an opportunity to get what they need and to also feel comfortable with getting engaged in the wraparound process. The family partner listens without bias, blame, or judgment in their approach. The family partner encourages and models commitment, demonstrates respect for the family's culture, builds trust with the family, and eases their fears. This is an interpersonal process. The family partner gets to know the family by meeting with family members (sometimes with the wraparound facilitator) in locations in which and at times that the family feels comfortable. The family partner explains wraparound from a family perspective, including the role of the family partner, sharing selected personal experiences as examples when relevant and appropriate. Together they explore the extent to which the family feels comfortable supporting and advocating for their child and family and how much coaching and support they will want from a family partner. The family partner gives the family helpful written materials such as family organization newsletters and brochures and materials about wraparound such as a copy of The Wraparound Process User's Guide: A Handbook for Families. The family partner reviews the guide or other informative materials with them and answers questions about what a wraparound team is and how it is created and functions. The family partner invites the family to support groups and other organized family activities in the community and encourages them to attend.

The family partner explains the limits of their own role including any time limits imposed by the program or system in which they are working. The family partner explains that they will not reveal any information the family wants to keep confidential except in cases where the safety of family members is involved.

Once the family has agreed to participate, the family partner can offer to help the family identify and organize various documents and information they will need to support and advocate for their child. This information placed in a binder, box or folder can be updated as new materials are accumulated through the wraparound process.

1.1 b. Address legal and ethical issues

The family partner explains informed consent from a family point of view. The family partner discusses system mandates with the family and helps them understand what they might expect in court proceedings.

The family partner can help them prepare for court appearances and, when invited, may attend to provide support to the family.

The family partner discusses any evaluation, data collection, or research activities associated with the wraparound initiative including how the family's participation might benefit them or others. The family partner makes sure the family understands how data will be collected and what steps will be taken to insure their personal identities are protected.

The family partner addresses the sensitive issue of mandated child abuse reporting by explaining their duty as a mandatory reporter of child abuse or neglect and what that means from a family's perspective.

Family Partner Role in the Wraparound Process: Phase 1 (CONTINTUED)

MAJOR GOALS	ACTIVITIES	NOTES
1.2. Stabilize crises GOAL: To address pressing needs and concerns so that the family and team can give their attention to the wraparound process.	*1.2 a. Ask family and youth about immediate crisis concerns* Facilitator elicits information from the family and youth about immediate safety issues, current crises, or crises that they anticipate might happen in the very near future. These may include crises stemming from a lack of basic needs (e.g., food, shelter, utilities such as heat or electricity).	The goal of this activity is to quickly address the most pressing concerns. The whole team engages in proactive and future-oriented crisis/safety planning during phase 2. As with other activities in this phase, the goal is to do no more than necessary prior to convening the team, so that the facilitator does not come to be viewed as the primary service provider and so that team as a whole can feel ownership for the plan and the process.
	1.2 b. Elicit information from agency representatives and potential team members about immediate crises or potential crises Facilitator elicits information from the referring source and other knowledgeable people about pressing crisis and safety concerns.	Information about previous crises and their resolution can be useful in planning a response in 1.2.c.
	1.2 c. If immediate response is necessary, formulate a response for immediate intervention and/or stabilization Facilitator and family reach agreement about whether concerns require immediate attention and, if so, work to formulate a response that will provide immediate relief while also allowing the process of team building to move ahead.	This response should describe clear, specific steps to accomplish stabilization.
1.3. Facilitate conversations with family and youth/child GOAL: To explore individual and family strengths, needs, culture, and vision and to use these to develop a document that will serve as the starting point for planning.	*1.3 a. Explore strengths, needs, culture, and vision with child/youth and family.* Facilitator meets with the youth/child and family to hear about their experiences; gather their perspective on their individual and collective strengths, needs, elements of culture, and long-term goals or vision; and learn about natural and formal supports. Facilitator helps family identify potential team members and asks family to talk about needs and preferences for meeting arrangements (location, time, supports needed such as child care, translation).	This activity is used to develop information that will be presented to and augmented by the team in phase 2. Family members should be encouraged to consider these topics broadly.

VIEWING INSTRUCTIONS ON PAGE 2

Family Partner Role in the Wraparound Process: Phase 1 (CONTINTUED)

HOW FAMILY PARTNERS SUPPORT THE PROCESS

1.2 a. Ask family and youth about immediate crisis concerns

The family partner participates in discussions regarding stabilization of immediate concerns to ensure that the plan is individualized and realistic for the family. The family partner is someone the family can talk with to validate how they might be feeling at the time. The family partner can help define the nature of the family's immediate concerns by listening carefully and encouraging the family to speak frankly. The family partner can ask about the signs that a crisis is likely to occur and learn what has been done by the family before so that strategies that have worked are included in the plan and those that have failed in the past are not repeated. Family partners help families identify reasonable alternatives, possible natural supports, and share what they know about resources in their communities that may give respite, food, shelter, clothing, and other necessities to help the family stabilize. Family partners offer hope and can have a calming effect and decrease the family's anxiety and fears of the unknown, when necessary, by sharing how they survived stressful experiences.

1.2 b. Elicit information from agency representatives and potential team members about immediate crises or potential crises

The family partner helps the family define crisis or safety concerns from their own experiences and clarifies for the family how other team members may view potential crisis concerns including events that could trigger a report for abuse or neglect. The family partner also helps communicate the family's perspective regarding potential crisis to the team members. The family partner encourages family members to identify both the formal and natural supports that have worked well to resolve crisis in the past and to look at what it would take to mend bridges of past natural supports.

1.2 c. If immediate response is necessary, formulate a response for immediate intervention and/or stabilization

The family partner will make sure the family feels the planned response for immediate intervention and/or stabilization can be readily implemented when it is needed. The family partner assists the family in expressing any concerns they might have about the immediate intervention and/or crisis stabilization plan.

1.3 a. Explore strengths, needs, culture, and vision with child/youth and family.

Consistent with the principle of family voice and choice, the family partner begins to prepare the family for effective self-advocacy by helping them to comfortably participate in this conversation. As a peer, in down-to-earth and heartfelt conversations, the family partner helps the family begin to think through their strengths, needs, culture, and vision so they are ready to contribute useful and valuable information that drives the process. The family partner also helps the family find ways to talk about sensitive issues, reframe negative concerns, and manage their emotions so the conversation remains respectful.

The family can plan and write their presentation and practice or "role play" with their family partner to develop their confidence and communicate clearly.

At times, the family partner may need to help the adult family members recognize when their child's behaviors and reactions are typical for their age and help the family allow their child to express their own views during the wraparound process. The family partner asks the family if they need or want support with school issues, court issues, and physical or mental health appointments. When relevant the family partner provides the family with information about their rights in the education, mental health, and other systems and connects them to expert advisers as needed.

The family partner attends to language and attitudes of all team members to promote family friendliness and avoid blaming and shaming the family or anyone else on the team.

Family Partner Role in the Wraparound Process: Phase 1 (CONTINTUED)

MAJOR GOALS	ACTIVITIES	NOTES
1.3. Facilitate conversations with family and youth/child GOAL: To explore individual and family strengths, needs, culture, and vision and to use these to develop a document that will serve as the starting point for planning. *(Continued from previous page)*	*1.3 b. Facilitator prepares a summary document* Using the information from the initial conversations with family members, the facilitator prepares a strengths-based document that summarizes key information about individual family member strengths and strengths of the family unit, as well as needs, culture, and vision. The family then reviews and approves the summary.	
1.4. Engage other team members GOAL: To gain the participation of team members who care about and can aid the youth/child and family, and to set the stage for their active and collaborative participation on the team in a manner consistent with the wraparound principles	*1.4 a. Solicit participation/ orient team members* Facilitator, together with family members if they so choose, approaches potential team members identified by the youth and family. Facilitator describes the wraparound process and clarifies the potential role and responsibilities of this person on the team. Facilitator asks the potential team members if they will participate. If so, facilitator talks with them briefly to learn their perspectives on the family's strengths and needs, and to learn about their needs and preferences for meeting.	The youth and/or family may choose to invite potential team members themselves and/or to participate in this activity alongside the facilitator. It is important, however, not to burden family members by establishing (even inadvertently) the expectation that they will be primarily responsible for recruiting and orienting team members.
1.5. Make necessary meeting arrangements GOAL: To ensure that the necessary procedures are undertaken for the team is prepared to begin an effective wraparound process.	*1.5 a. Arrange meeting logistics* Facilitator integrates information gathered from all sources to arrange meeting time and location and to assure the availability of necessary supports or adaptations such as translators or child care. Meeting time and location should be accessible and comfortable, especially for the family but also for other team members. Facilitator prepares materials—including the document summarizing family members' individual and collective strengths, and their needs, culture, and vision—to be distributed to team members.	

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Family Partner Role in the Wraparound Process: Phase 1 (CONTINTUED)

HOW FAMILY PARTNERS SUPPORT THE PROCESS

1.3 b. Facilitator prepares a summary document

The family partner works with the facilitator to summarize the strengths, needs, culture and vision of the family unit and individual family members.

The family partner reviews the document with the family to make sure the family completely understands the document and that it really reflects their view of themselves, their strengths and the challenges they face.

1.4 a. Solicit participation/orient team members

The family partner, by spending time with the family and in the family's own home and community, becomes aware of individuals who could be members of the family's wraparound team including those who might provide support even though they cannot be physically present. Through frank discussions about the strengths and gifts of potential team members as well as any risks associated with their involvement, the family partner helps the family decide who they would like on their team.

The family could ask the family partner to help them invite some individuals to be on their team and explain to them what their responsibilities would be.

The family partner acts as a role model by educating system representatives on wraparound's principle of family voice and choice and helping them apply this principle to their work on the team in the context of their agency's mandates.

The family partner acts as a bridge builder encouraging understanding and collaboration between the family, and their team members.

1.5 a. Arrange meeting logistics

The family partner collaborates with the facilitator and the family to make sure that all meetings are held in places and at times comfortable and convenient for the family.

The family partner, in collaboration with the facilitator and family, may send out meeting notices and reminders, and, when necessary, identifies the need for travel, childcare, translators, or other supports for participants.

Before the meeting, the family partner works with the facilitator and family to create an agenda and consider what refreshments might be required and how to get them.

Family Partner Role in the Wraparound Process: Phase 2

*PHASE 2: Initial plan development***

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

MAJOR GOALS	ACTIVITIES	NOTES
2.1. Develop an initial plan of care GOAL: To create an initial plan of care using a high-quality team process that elicits multiple perspectives and builds trust and shared vision among team members, while also being consistent with the wraparound principles	*2.1 a. Determine ground rules* Facilitator guides team in a discussion of basic ground rules, elicits additional ground rules important to team members, and facilitates discussion of how these will operate during team meetings. At a minimum, this discussion should address legal and ethical issues—including confidentiality, mandatory reporting, and other legal requirements—and how to create a safe and blame-free environment for youth/family and all team members. Ground rules are recorded in team documentation and distributed to members.	In this activity, the team members define their collective expectations for team interaction and collaboration. These expectations, as written into the ground rules, should reflect the principles of wraparound. For example, the principles stress that interactions should promote family and youth voice and choice and should reflect a strengths orientation. The principles also stress that important decisions are made within the team.
	2.1 b. Describe and document strengths Facilitator presents strengths from the summary document prepared during phase 1, and elicits feedback and additional strengths, including strengths of team members and community.	While strengths are highlighted during this activity, the wraparound process features a strengths orientation throughout.
	2.1 c. Create team mission Facilitator reviews youth and family's vision and leads team in setting a team mission, introducing idea that this is the overarching goal that will guide the team through phases and, ultimately, through transition from formal wraparound.	The team mission is the collaboratively set, long-term goal that provides a one or two sentence summary of what the team is working towards.

** Wraparound phases defined in: Walker, J. S., Bruns, E. J., & the National Wraparound Initiative Advisory Group. (2008). Phases and activities of the wraparound process. In E. J. Bruns & J. S. Walker (Eds.), *The resource guide to wraparound*. Portland, OR: National Wraparound Initiative.

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Family Partner Role in the Wraparound Process: Phase 2 (CONTINTUED)

PHASE 2: The family partner role

The family partner collaborates with the wrap facilitator to establish the trust and mutual respect necessary for the team (including the family) to function.

HOW FAMILY PARTNERS SUPPORT THE PROCESS

2.1 a. Determine ground rules

With permission from the family, the family partner attends the initial care planning meeting. Before the meeting, the family partner should have a discussion with the family about where they would like the family partner to sit (next to, across from) to offer the best means of communication and support that feels comfortable for the family.

The family partner offers support to the family by encouraging family member to:

- Participate in constructing the ground rules so that they are relevant and individualized;
- Express strengths, visions, and needs;
- Describe the family's cultural, spiritual, and moral beliefs;
- Contribute to the development of strategies they feel are realistic; and
- Speak up and say "no" when suggestions are made that they do not agree with.

The family partner makes sure the family's perspective is visible and heard by asking questions of the family to be sure they are comfortable with the plan as it evolves.

The family partner encourages the meeting facilitator to use visual tools (such as chart paper, colored markers, stickers, etc.) so that family members can see the language of the plan as it develops.

The family partner helps other team members understand and feel comfortable with the principle of family voice and choice.

The family partner agrees to take responsibility for follow up tasks that are compatible with their role description and expectations.

By sharing their own experience (relevant self-disclosure) family partners help the team gain some insight into the family's situation so they can think "outside the box" and be creative in developing a practical plan. The family partner helps the family decide if the plan is likely to be workable for them. They do this by asking them questions like:

- "Is the plan flexible enough to meet your changing needs?"
- "Does the plan incorporate the natural supports you need?"
- "Do you feel your voice has been heard?"
- "Does the plan incorporate the formal and clinical services you need?"
- "Is the financing of services and supports realistic?"

2.1 b. Describe and document strengths

The family partner explains why strengths are important and how to recognize them. The family partner may describe a personal experience to illustrate the value of being strengths-based.

Drawing on prior discussion with the family, the family partner works with the family to see how their strengths and team and community strengths can be used to help address their needs with the goal of assuring natural supports are developed and used to sustain the family goal.

2.1 c. Create team mission

The family partner helps the family express changes in their vision of the future to their team. The family partner makes sure that the team mission incorporates the family's and the youth's perspectives, abilities, and preferences.

The family partner makes sure the family understands that their wraparound team's mission may need to be revised as changes occur in their child and family.

Family Partner Role in the Wraparound Process: Phase 2 (CONTINTUED)

MAJOR GOALS	ACTIVITIES	NOTES
2.1. Develop an initial plan of care GOAL: To create an initial plan of care using a high-quality team process that elicits multiple perspectives and builds trust and shared vision among team members, while also being consistent with the wraparound principles *(Continued from previous page)*	*2.1 d. Describe and prioritize needs/goals* Facilitator guides the team in reviewing needs and adding to list. The facilitator then guides the team in prioritizing a small number of needs that the youth, family, and team want to work on first, and that they feel will help the team achieve the mission.	The elicitation and prioritization of needs is often viewed as one of the most crucial and difficult activities of the wraparound process. The team must ensure that needs are considered broadly, and that the prioritization of needs reflects youth and family views about what is most important. Needs are not services but rather broader statements related to the underlying conditions that, if addressed, will lead to the accomplishment of the mission.
	2.1 e. Determine goals and associated outcomes and indicators for each goal Facilitator guides team in discussing a specific goal or outcome that will represent success in meeting each need that the team has chosen to work on. Facilitator guides the team in deciding how the outcome will be assessed, including specific indicators and how frequently they will be measured.	Depending on the need being considered, multiple goals or outcomes may be determined. Similarly, for each goal or outcome determined by the team for measurement, multiple indicators may be chosen to be tracked by the team. However, the plan should not include so many goals, outcomes, or indicators that team members become overwhelmed or tracking of progress becomes difficult.
	2.1 f. Select strategies Facilitator guides the team in a process to think in a creative and open-ended manner about strategies for meeting needs and achieving outcomes. The facilitator uses techniques for generating multiple options, which are then evaluated by considering the extent to which they are likely to be effective in helping reach the goal, outcome, or indicator associated with the need; the extent to which they are community based, the extent to which they build on/incorporate strengths; and the extent to which they are consistent with family culture and values. When evaluating more formal service and support options, facilitator aids team in acquiring information about and /or considering the evidence base for relevant options.	This activity emphasizes creative problem solving, usually through brainstorming or other techniques, with the team considering the full range of available resources as they come up with strategies to meet needs and achieve outcomes. Importantly, this includes generating strategy options that extend beyond formal services and reach families through other avenues and time frames. These are frequently brainstormed by the team, with the youth and family and people representing their interpersonal and community connections being primary nominators of such supports. Finally, in order to best consider the evidence base for potential strategies or supports, it may be useful for a wraparound team or program to have access to and gain counsel from a point person who is well-informed on the evidence base.

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Family Partner Role in the Wraparound Process: Phase 2 (CONTINTUED)

HOW FAMILY PARTNERS SUPPORT THE PROCESS

2.1 d. Describe and prioritize needs/goals

The family partner helps the family to determine their priorities and express them to the team. The family partner helps the family to understand that needs not immediately addressed will be attended to once the greatest needs are taken care of. The family partner helps the family to learn the phases of the wraparound process. Attention is paid to understanding the distinction between needs, traditional services as an attempt to meet those needs, and individualized, natural supports and resources.

2.1 e. Determine goals and associated outcomes and indicators for each goal

Family Partners help the family express their views about all the goals identified in their plan of care. They encourage the family to talk about how well the goals meet their needs and priorities. The family partner makes sure the family considers how workable and realistic the plan is for them and raises any concerns they have,

The family partner helps the family to actively participate in choosing how progress on their goals will be tracked and measured. The family partners helps the family define how its members will be involved in collecting data and working with the team to understand what it means.

2.1 f. Select strategies

The family partner encourages and coaches the family to speak about how practical each proposed strategy is in the context of the family's day to day activities. The family partner also encourages the family to talk about strategies that have and have not worked for them in the past.

The family partner can support the other team members in understanding the family's perspective.

Family Partner Role in the Wraparound Process: Phase 2 (CONTINTUED)

MAJOR GOALS	ACTIVITIES	NOTES
2.1. Develop an initial plan of care GOAL: To create an initial plan of care using a high-quality team process that elicits multiple perspectives and builds trust and shared vision among team members, while also being consistent with the wraparound principles *(Continued from previous page)*	*2.1 g. Assign action steps* Team assigns responsibility for undertaking action steps associated with each strategy to specific individuals and within a particular time frame.	Action steps are the separate small activities that are needed to put a strategy into place, for example, making a phone call, transporting a child, working with a family member, finding out more information, attending a support meeting, arranging an appointment. While all team members will not necessarily participate at the same level, all team members should be responsible for carrying out action steps. Care should be taken to ensure that individual team members, particularly the youth and family, are not overtaxed by the number of action steps they are assigned.
2.2. Develop crisis/ safety plan GOAL: To identify potential problems and crises, prioritize according to seriousness and likelihood of occurrence, and create an effective and well-specified crisis prevention and response plan that is consistent with the wraparound principles. A more proactive safety plan may also be created.	*2.2 a. Determine potential serious risks* Facilitator guides the team in a discussion of how to maintain the safety of all family members and things that could potentially go wrong, followed by a process of prioritization based on seriousness and likelihood of occurrence.	Past crises, and the outcomes of strategies used to manage them, are often an important source of information in current crisis/safety planning.
	2.2 b. Create crisis/safety plan In order of priority, the facilitator guides team in discussion of each serious risk identified. The discussion includes safety needs or concerns and potential crisis situations, including antecedents and associated strategies for preventing each potential type of crisis, as well as potential responses for each type of crisis. Specific roles and responsibilities are created for team members. This information is documented in a written crisis plan. Some teams may also undertake steps to create a separate safety plan, which specifies all the ways in which the wraparound plan addresses potential safety issues.	One potential difficulty with this activity is the identification of a large number of crises or safety issues can mean that the crisis/safety plan "takes over" from the wraparound plan. The team thus needs to balance the need to address all risks that are deemed serious with the need to maintain focus on the larger wraparound plan as well as youth, family, and team strengths.
2.3. Complete necessary documentation and logistics	*2.3 a. Complete documentation and logistics* Facilitator guides team in setting meeting schedule and determining means of contacting team members and distributing documentation to team members.	

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Family Partner Role in the Wraparound Process: Phase 2 (CONTINTUED)

HOW FAMILY PARTNERS SUPPORT THE PROCESS

2.1 g. Assign action steps

The family partner encourages the team to assign tasks to natural supports and makes sure that the family and team are likely to experience success within a reasonably short period of time. The family partner helps the family to assess which tasks it can realistically work on. Tasks the family partner takes responsibility for should relate directly to providing support to help the family accomplish tasks it has agreed to do.

2.2 a. Determine potential serious risks

The family partner contributes to crisis/safety plan development by encouraging the family to draw on their past experiences and knowledge of conditions such as environments, people, health issues, or other circumstances that could trigger a crisis or safety situation. Family partners can offer suggestions based on how they or other families have used a crisis plan.

The family partner helps the team work with the family to think about the future and what may happen that would require the use of a crisis/safety plan.

2.2 b. Create crisis/safety plan

The family partner needs to explain to the family and the team the specific responsibilities of their role and limitations imposed on them with regard to responding to crisis situations.

The family partner strongly encourages the family and the team to talk with the child or youth to understand what are likely to be the most effective strategies to avoid or de-escalate a potential crisis.

The family partner actively questions proposed responses to crisis to ensure that the crisis/safety plan includes solutions the family will use (i.e., alternatives to calling the police) and is something that the family truly feels can benefit them in the midst of a crisis and that they can follow in times of high stress.

The family partner makes sure the family has a copy of the crisis/safety plan at the end of the meeting and that they have a realistic plan for where to keep it so they can find and use it when necessary.

2.3 a. Complete documentation and logistics

The family partner reviews the initial written plan with the family to make sure that the family understands the plan, that it accurately reflects what the family has said (preferably in their own words) and what they expect from those responsible for implementing it. The family partner helps the family strategize about how to work with their team to modify anything in the plan that they are not comfortable with.

The family partner completes contact notes, individual service planning reports or other documentation according to the requirements of their employer.

The family partner helps the family use tracking procedures provided by the team and develop their own method of organizing and preserving their family's important papers and plans so they are available for future use.

If the family partner develops their own system, they need to be sure it complies with all confidentiality and record keeping requirements for personally identifiable information.

Family Partner Role in the Wraparound Process: Phase 3

*PHASE 3: Implementation***

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

MAJOR GOALS	ACTIVITIES	NOTES
3.1. Implement the wraparound plan GOAL: To implement the initial plan of care, monitoring completion of action steps and strategies and their success in meeting need and achieving outcomes in a manner consistent with the wraparound principles.	*3.1 a. Implement action steps for each strategy* For each strategy in the wraparound plan, team members undertake action steps for which they are responsible. Facilitator aids completion of action steps by checking in and following up with team members; educating providers and other system and community representatives about wraparound as needed; and identifying and obtaining necessary resources.	The level of need for educating providers and other system and community representatives about wraparound varies considerably from one community to another. Where communities are new to the type of collaboration required by wraparound, getting provider "buy in" can be very difficult and time consuming for facilitators. Agencies implementing wraparound should be aware of these demands and be prepared to devote sufficient time, resources, and support to this need.
	3.1 b. Track progress on action steps Team monitors progress on the action steps for each strategy in the plan, tracking information about the timeliness of completion of responsibilities assigned to each team member, fidelity to the plan, and the completion of the requirements of any particular intervention.	Using the timelines associated with the action steps, the team tracks progress. When steps do not occur, teams can profit from examining the reasons why not. For example, teams may find that the person responsible needs additional support or resources to carry out the action step, or, alternatively, that different actions are necessary.
	3.1 c. Evaluate success of strategies Using the outcomes/indicators associated with each need, the facilitator guides the team in evaluating whether selected strategies are helping team meet the youth and family's needs.	Evaluation should happen at regular intervals. Exactly how frequently may be determined by program policies and/or the nature of the needs/goals. The process of evaluation should also help the team maintain focus on the "big picture" defined by the team's mission: Are these strategies, by meeting needs, helping achieve the mission?
	3.1. d. Celebrate successes The facilitator encourages the team to acknowledge and celebrate successes, such as when progress has been made on action steps, when outcomes or indicators of success have been achieved, or when positive events or achievements occur.	Acknowledging success is one way of maintaining a focus on the strengths and capacity of the team and its members. Successes do not have to be "big", nor do they necessarily have to result directly from the team plan. Some teams make recognition of "what's gone right" a part of each meeting.

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Family Partner Role in the Wraparound Process: Phase 3 (CONTINTUED)

PHASE 3: The family partner role

The family partner maintains a strategic partnership with the facilitator. Together they ensure everyone on the team is comfortable with the process and their responsibilities, encouraging team decision making in an open atmosphere where everyone, especially the family, has all the information needed to participate and make decisions.

Roles and responsibilities for all team members to implement wraparound plans should be clearly defined according to local policy. These policies and procedures should include what to do when someone fails to fulfill their responsibilities.

HOW FAMILY PARTNERS SUPPORT THE PROCESS

3.1 a. Implement action steps for each strategy

The family partner supports plan implementation by carrying through on the action steps they have agreed to take on.

The family partner mentors and coaches the family in their journey towards self-empowerment and independence. The family partner provides support as needed, to follow through on action steps without taking over. Some examples are:

- Accompanying family members to meetings with the school, court appearances, and other meetings as requested;
- Inviting family members to support groups, training and other group family activities;
- Encouraging family members to contact their care coordinator, teacher, physician, or other provider as questions or concerns emerge;
- Cheering the family on as they complete each significant stage of activity;
- Helping the family monitor implementation of their plan.

The family partner can practice communication techniques with family if necessary, and help work any concerns or barriers of the family about conversations with any team members or providers.

In some communities when specified in the wraparound crisis plan, family partners can be called upon to help avert a crisis by supporting the family's efforts to intervene before troubling behaviors escalate into a full crisis.

3.1 b. Track progress on action steps

Between meetings, the family partner checks with the family to see if they are following through on tasks and keeping track of other's actions they agreed to monitor. The family partner may provide additional support to family members and their informal supports if needed.

If the family feels things are not going well, the family partner encourages them to bring this to the attention of the team so any issues can be resolved quickly.

3.1 c. Evaluate success of strategies

The family partner encourages the team to present data in ways that make it easy for the family to understand what is being measured and what it means. The family partner also encourages the family to ask questions and provide their own views on progress in order to be an active participant with the team.

3.1. d. Celebrate successes

The family partner encourages the team to honor the family's efforts in a manner that is culturally relevant and meaningful to the family. The family partner also highlights the family's accomplishments and acknowledges what team members have done to facilitate achieving goals.

The family partner remembers to acknowledge small steps along the way as well.

Family Partner Role in the Wraparound Process: Phase 3 (CONTINTUED)

MAJOR GOALS	ACTIVITIES	NOTES
3.2. Revisit and update the plan GOAL: To use a high quality team process to ensure that the wraparound plan is continually revisited and updated to respond to the successes of initial strategies and the need for new strategies.	*3.2. a. Consider new strategies as necessary* When the team determines that strategies for meeting needs are not working, or when new needs are prioritized, the facilitator guides the team in a process of considering new strategies and action steps using the process described in activities 2.1.f and 2.1.g.	Revising of the plan takes place in the context of the needs identified in 2.1.d. Since the needs are in turn connected to the mission, the mission helps to guide evaluation and plan revisions.
3.3. Maintain/build team cohesiveness and trust GOAL: To maintain awareness of team members' satisfaction with and "buy-in" to the process, and take steps to maintain or build team cohesiveness and trust.	*3.3 a. Maintain awareness of team members' satisfaction and "buy-in"* Facilitator makes use of available information (e.g., informal chats, team feedback, surveys—if available) to assess team members' satisfaction with and commitment to the team process and plan, and shares this information with the team as appropriate. Facilitator welcomes and orients new team members who may be added to the team as the process unfolds.	Many teams maintain formal or informal processes for addressing team member engagement or "buy in", e.g. periodic surveys or an end-of-meeting wrap-up activity. In addition, youth and family members should be frequently consulted about their satisfaction with the team's work and whether they believe it is achieving progress toward their long-term vision, especially after major strategizing sessions. In general, however, this focus on assessing the process of teamwork should not eclipse the overall evaluation that is keyed to meeting identified needs and achieving the team mission.
	3.3 b. Address issues of team cohesiveness and trust Making use of available information, facilitator helps team maintain cohesiveness and satisfaction (e.g., by continually educating team members—including new team members—about wraparound principles and activities, and/or by guiding team in procedures to understand and manage disagreement, conflict, or dissatisfaction).	Teams will vary in the extent to which issues of cohesiveness and trust arise. Often, difficulties in this area arise from one or more team members' perceptions that the team's work—and/or the overall mission or needs being currently addressed—is not addressing the youth and family's "real" needs. This points to the importance of careful work in deriving the needs and mission in the first place, since shared goals are essential to maintaining team cohesiveness over time.
3.4. Complete necessary documentation and logistics	*3.4 a. Complete documentation and logistics* Facilitator maintains/updates the plan and maintains and distributes meeting minutes. Team documentation should record completion of action steps, team attendance, use of formal and informal services and supports, and expenditures. Facilitator documents results of reviews of progress, successes, and changes to the team and plan. Facilitator guides team in revising meeting logistics as necessary and distributes documentation to team members.	Team documentation should be kept current and updated, and should be distributed to and/or available to all team members in a timely fashion.

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Family Partner Role in the Wraparound Process: Phase 3 (CONTINTUED)

HOW FAMILY PARTNERS SUPPORT THE PROCESS

3.2. a. Consider new strategies as necessary

The family partner goes over the plan each time they visit or speak by phone with the family. They discuss what is working and what may not be working. The family partner encourages the family to request a team meeting whenever they feel the need to make adjustments to the plan - such as when there are frequent crises.

The family partner assists and supports the family in bringing updates back to their team to identify barriers and select strategies that may work better. The family partner encourages the family to discuss their feelings and commitment to the evolving plan and to tell their team what they are experiencing and thinking.

3.3 a. Maintain awareness of team members' satisfaction and "buy-in"

The family partner acts as a collaborative advocate by being non-adversarial and coaching the family to find ways of keeping the conversation and approaches honest and respectful even in difficult moments. Because they are peers with similar experience, family partners can ease family members' fears, listening (without passing judgment) to what they are saying, and assuring them that they have a voice on their team.

The family partner may need to help the family bring their concerns, dissatisfactions, or conflicts to the surface. In such cases, the family partner explores ways to communicate with the team that the family feels are safe and can lead to resolution with other team members.

The family partner collaborates with team members to maintain their confidence with the process and help them stay engaged, use the plan, adapt it when needed, and continue to develop better ways to communicate with the family, understand and meet their needs.

3.3 b. Address issues of team cohesiveness and trust

The family partner's own behavior can help maintain the team's cohesiveness and trust. Family partners can model how to frame and reframe an issue to facilitate collaboration, being patient, and being strengths-based all through the wraparound process.

By reminding the team of the meaning of the Principles of Wraparound the family partner can help the team examine how their actions are building trust, cohesiveness, and collaboration to achieve shared goals.

The family partner encourages the family or team members to bring issues into the open where they can get supports to resolve conflicts quickly.

3.4 a. Complete documentation and logistics

The family partner reviews updates to the written plan with the family to make sure that the family understands the plan, that it accurately reflects what the family has said (preferably in their own words) and what they expect from those responsible for implementing it. The family partner helps the family strategize about how to work with their team to modify anything in the plan that they are not comfortable with.

The family partner completes contact notes, individual service planning reports or other documentation according to the requirements of their employer.

The family partner helps the family to use tracking procedures provided by the team or to develop their own method (such as a binder or folder or storage box) of organizing and preserving their family's important papers and plans. The family partner participates in evaluating the implementation of wraparound such as collecting data, interviewing families, participating in data analysis and reporting results to the team, community, families, and funding sources.

Family Partner Role in the Wraparound Process: Phase 4

*PHASE 4: Transition***

During this phase, plans are made for a purposeful transition out of formal wraparound to a mix of formal and natural supports in the community (and, if appropriate, to services and supports in the adult system). The focus on transition is continual during the wraparound process, and the preparation for transition is apparent even during the initial engagement activities.

MAJOR GOALS	ACTIVITIES	NOTES
4.1. Plan for cessation of formal wraparound GOAL: To plan a purposeful transition out of formal wraparound in a way that is consistent with the wraparound principles, and that supports the youth and family in maintaining the positive outcomes achieved in the wraparound process.	*4.1 a. Create a transition plan* Facilitator guides the team in focusing on the transition from wraparound, reviewing strengths and needs and identifying services and supports to meet needs that will persist past formal wraparound.	Preparation for transition begins early in the wraparound process, but intensifies as team meets needs and moves towards achieving the mission. While formal supports and services may be needed post-transition, the team is attentive to the need for developing a sustainable system of supports that is not dependent on formal wraparound. Teams may decide to continue wraparound—or a variation of wraparound—even after it is no longer being provided as a formal service.
	4.1 b. Create a post-transition crisis management plan Facilitator guides the team in creating post-wraparound crisis management plan that includes action steps, specific responsibilities, and communication protocols. Planning may include rehearsing responses to crises and creating linkage to post-wraparound crisis resources.	At this point in transition, youth and family members, together with their continuing supports, should have acquired skills and knowledge in how to manage crises. Post-transition crisis management planning should acknowledge and capitalize on this increased knowledge and strengthened support system. This activity will likely include identification of access points and entitlements for formal services that may be used following formal wraparound.
	4.1 c. Modify wraparound process to reflect transition New members may be added to the team to reflect identified post-transition strategies, services, and supports. The team discusses responses to potential future situations, including crises, and negotiates the nature of each team member's post-wraparound participation with the team/family. Formal wraparound team meetings reduce frequency and ultimately cease.	Teams may continue to meet using a wraparound process (or other process or format) even after formal wraparound has ended. Should teamwork continue, family members and youth, or other supports, will likely take on some or all of the facilitation and coordination activities.

** Wraparound phases defined in: Walker, J. S., Bruns, E. J., & the National Wraparound Initiative Advisory Group. (2008). Phases and activities of the wraparound process. In E. J. Bruns & J. S. Walker (Eds.), *The resource guide to wraparound*. Portland, OR: National Wraparound Initiative.

VIEWING INSTRUCTIONS ON PAGE 2

Family Partner Role in the Wraparound Process: Phase 4 (CONTINTUED)

PHASE 4: The family partner role

The family partner focuses on making sure the family is well prepared for transition, is connected to necessary supports, and has the skills and knowledge they need to feel comfortable and capable of getting help without the formal support of the wraparound team in the future.

HOW FAMILY PARTNERS SUPPORT THE PROCESS

4.1 a. Create a transition plan

The family partner helps the family to look back on their wraparound experience, identify what they have learned, review their plan, and determine if the outcomes they hoped for were achieved.

The family partner checks the family's comfort level with the cessation of formal wraparound and the time frame in which it will occur. The family partner supports the family in self-advocacy if time frames do not work for them.

The family partner talks with the family about what graduating from wraparound will mean for them and how they can manage to maintain whatever gains were made. The family partner helps the family acknowledge their own level of self empowerment and identify the specific strategies the family is able to use to advocate for their child, use natural supports and services, or get help in a crisis.

The family partner supports the creation of a post transition or after care plan in format family will be able to use. The family partner can give the family a file or binder of community and state resources and places they could in the future. . use

Some family partners are able to provide supportive contact via phone, consistent with employer policy, after formal wraparound has ended.

The family partner encourages the family to join a family-run organization and participate in family activities in the community where they can receive ongoing peer support as well as provide support to others if they are ready.

4.1 b. Create a post-transition crisis management plan

Family partners can encourage the family to call a team meeting when they need it, create their own agendas, and to facilitate their own team meetings.

The family partner makes sure the family has a crisis plan they can implement. The family partner makes sure family members know who to contact and how to get in touch with people quickly if a crisis occurs.

4.1 c. Modify wraparound process to reflect transition

At the time of transition, the family assumes responsibility for advocating for themselves. Family partner may help the family assume the facilitation of their own team post formal wraparound. The family may call on the family partner to help them refresh their skills when difficulties arise.

Family Partner Role in the Wraparound Process: Phase 4 (CONTINTUED)

MAJOR GOALS	ACTIVITIES	NOTES
4.2. Create a "commencement" GOAL: To ensure that the cessation of formal wraparound is conducted in a way that celebrates successes and frames transition proactively and positively.	*4.2 a. Document the team's work* Facilitator guides team in creating a document that describes the strengths of the youth/child, family, and team members, and lessons learned about strategies that worked well and those that did not work so well. Team participates in preparing/reviewing necessary final reports (e.g., to court or participating providers, where necessary)	This creates a package of information that can be useful in the future.
	4.2 b. Celebrate success Facilitator encourages team to create and/or participate in a culturally appropriate "commencement" celebration that is meaningful to the youth/child, family, and team, and that recognizes their accomplishments.	This activity may be considered optional. Youth/child and family should feel that they are ready to transition from formal wraparound, and it is important that "graduation" is not constructed by systems primarily as a way to get families out of services.
4.3. Follow-up with the family GOAL: To ensure that the family is continuing to experience success after wraparound and to provide support if necessary.	*4.3 a. Check in with family* Facilitator leads team in creating a procedure for checking in with the youth and family periodically after commencement. If new needs have emerged that require a formal response, facilitator and/or other team members may aid the family in accessing appropriate services, possibly including a reconvening of the wraparound team.	The check-in procedure can be done impersonally (e.g., through questionnaires) or through contact initiated at agreed-upon intervals either by the youth or family, or by another team member.

VIEWING INSTRUCTIONS ON PAGE 2

Phases and Activities of the Wraparound Process: Phase 4 (CONTINTUED)

HOW FAMILY PARTNERS SUPPORT THE PROCESS

4.2 a. Document the team's work

Family partners, as part of the team, ask the family what kind of commencement they would like and how they want to celebrate.

Family partners participate in planning this event to make sure this is the family's time in the sun.

The family partner makes sure the family has collected all its important plans and papers in an organized way so they have ready access to them in the future.

4.2 b. Celebrate success

The family partner encourages the family to participate in the commencement celebration. If the family does not participate, the family partner finds a way to acknowledge the family success and bring closure to their relationship.

4.3 a. Check in with family

Depending on the community policies and resources that are available to support family partner work, the family partner and family may create a plan to stay connected by phone or face-to-face meetings on an individual basis. In most communities the family partner calls the family three to four weeks after transition to see how they are doing. In some communities family partners support families long after all other formal wraparound services are finished.

The family partner's connection with family organizations in the community can give rise to opportunities for them to see and connect with wraparound graduates through newsletters, support group meetings, invitations to special events, conferences, volunteering or employment in the family movement or system of care, or joining workgroups, taskforces, advisory groups, and governing bodies.

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Wraparound Practice: Chapter 4b.3

Family Partners and the Wraparound Process

Patricia Miles, Consultant

As communities and organizations begin to develop capacity to implement the wraparound process, issues of staffing will arise. It is generally accepted that wraparound projects will need some type of process/team facilitator, who may also be referred to as a "care coordinator," "resource coordinator," or "wraparound facilitator." Depending on the funding stream and generally acceptable wraparound practice within the state or local municipality, other staff roles may also be a part of creating infrastructure to implement a quality process. One such staff role is that of a family partner, who may be referred to as a parent partner, family support partner, peer support or family advocate. Family partners employed in wraparound are individuals who have experienced the child/family service system from the "other side of the counter," as caregivers or loved ones of recipients of service.

History of Family Partners in Wraparound

Early wraparound efforts typically began with a target population of young people who had spent a great deal of time in restrictive environments in order to access treatment. Initial projects focused on returning these young people to their families and communities by redirecting funds, creating new interventions and arranging for people to serve and support one child at a time. Since these early efforts typically began with a need to redirect dollars that were already being spent, they started with a minimum of staff to keep overhead low. This minimal staffing usually involved someone to take on a facilitation role to bring people together and to follow though on managing bureaucra-

cy, funding issues and assuring that services were provided. In the early 1990s, many system of care projects began to experiment with hiring family members, including parents, in addition to funding free-standing family organizations. For those family members who were hired within service delivery organizations, a number of challenges arose.

To start off, several things quickly became clear about the organizational environments that employed these parents/family members. The first was that it had to be everyone's responsibility to interrupt bias, blame, and judgment as it impacted families and caregivers accessing services. Those sites that expected the hired family member to take on sole responsibility of correcting institutional bias soon found that those family members felt isolated and burdened by this responsibility.

The second lesson was that it wasn't enough to just hire a family member. In order to achieve results, family members' efforts were more effective when paired with a practice change strategy. It wasn't helpful if the "host environment" employing these parents and family members wasn't prepared to change the way it interacted with families receiving services. If the model of service remained expert-driven, there wasn't enough room to allow the designated experts to continue in their role while also integrating the expertise brought to the table by the family support partner. In effect, without changing the way of doing business, there seemed to be room for only one "expert" at the table.

In contrast, some agencies engaged in hiring parents and family members were also implementing wraparound efforts in order to move from an expert-driven model to a collaborative model. This was an attempt to align direct service with system of care values. It was not unusual for the parents and family members hired at these agencies to find a sense of coherence, belonging and purpose within the wraparound process. Indeed, parents hired at these service provider agencies often found themselves as the primary advocates for implementation of a quality wraparound process.

Models for Integrating Family Partners in the Wraparound Process

As wraparound expanded, second- and third-generation projects began to hire parents and family members as part of initial program design. Some early wraparound projects had designed and funded structures to support family involvement, but later projects were more likely to pair family members with wraparound facilitation staff to facilitate high-quality wraparound delivery as well build family involvement into the overall system.

As projects began to experiment with the roles of family members in wraparound projects, regional variances and opportunities presented themselves. These regional variations were sometimes driven by funding streams, as in the case of projects that were heavily dependent on federal entitlements. Other variations came from community or system context. Communities that had a strong, free-standing family organization might approach it one way while other communities that were experiencing broad-scale system change through lawsuit or legislative action might choose to implement differently. Regardless of the particular design, the vast majority of these projects involved in employing family members found that they could see direct benefits from the peer-to-peer support and activities of family members sharing with other family members.

The tables that follow describe and define various roles for family members hired within wraparound projects. The first model that a project selects may not prove to be the model they ultimately implement. Additionally, there are many more roles for family members within an overall system than those typically attached to a wraparound project. Regardless of the model chosen, if you are an administrator who is planning or implementing a wraparound project, it is important to keep in mind several principles about family partners:

1. *The wraparound family partner has to be someone who has experienced the service system from the consumer perspective.* This unique perspective allows these indi-

viduals to relate to families in unique ways and also helps professionals see their activities from a different perspective.

2. *Wraparound family partners bring a wealth of formal training in addition to their personal experiences*. Many wraparound projects who have employed family partners have found that they come to the table with a variety of formal education in addition to their personal experiences. Journalists, marketers, website designers, party planners and social workers are some of the professional roles that family partners have brought to the table, in addition to their personal experience of caring about someone who has received services.

3. *It* is *personal to the family partners*. We hire family partners because of their personal experience. It doesn't make sense to turn around and ask them to "not take things personally" when their first condition of employment is their personal experience.

Possible Models for Implementing Family Partners in Wraparound Projects: 1. Paired Facilitator + Family Partner Team

Option	Defined	Advantages	Disadvantages
1. Paired Facilitator + Family Partner Team	This model consists of a wraparound facilitator and family partner paired to implement the wraparound process. The first responsibility of the family partner is to assure that the parent/caregiver's voice and perspective is understood by other wraparound staff and the child and family team. When the Family Partner is sure that the parent's perspective is understood, they will also ensure that wraparound implementation is done with quality and adherence to practice steps. Typically, this model involves increasing caseload size somewhat since both parties are working directly with the same families. The family partner will also perform support activities with families as they go through the wraparound process.	1. Wraparound is a complex process: having two people see it through together can increase reliability of wraparound practice. 2. Having a shared caseload increases continuity in the event of turnover. 3. The paired approach models a true parent/professional partnership when implemented well. 4. Multiple perspectives blended in a team may associate with a broader and more inclusive view of the family.	1. Both parties can end up "stepping" on each other's roles. 2. Issues of caseload size and cost have not been resolved. If a facilitator can manage a caseload of a certain amount, how should that increase when the project also hires one or more family partners? 3. This model runs the risk of these two people being so tightly connected that the family or other team members can feel on the "outside." 4. Creating the sense of both parties on the same team can be challenging.

Possible Models for Implementing Family Partners in Wraparound Projects: 2. Peer Parent Support

Option	Defined	Advantages	Disadvantages
2. Peer Parent Support	This model is more interdependent than the paired model in that family partners are hired to provide peer support to families experiencing the wraparound process. In this model, the family partner meets the family either with or around the same time as the wraparound Facilitator. The family partner uses a method to identify whether the family will need contact that is intensive, moderate or supportive. This range includes at least weekly face-to-face contact and attendance at most child and family team meetings (intensive) to regular phone contact and attendance at child and family team meetings. In this model, family partners provide accurate and reliable information to families they can use in decision making as well as connecting to families to others who have a shared experience.	1. Allows the wraparound facilitator and family partner to be connected when they need to be and independent when they need to be. 2. Allows the family partner to tailor their response to each family's unique needs. 3. Direct support can be delivered at the family's pace rather than in pace with wraparound.	1. Both parties (family partner and wraparound facilitator) have to work at keeping communication open and accurate. 2. Either party (facilitator and family partner) can end up at cross purposes. 3. Wraparound administration must make sure that support activities performed by family partners aren't seen as somehow "less important." 4. More challenging to build accountability for family partners, because much of their direct work with families may be "unseen." Thus, a project using this model needs to develop means to recognize and document good work.

Possible Models for Implementing Family Partners in Wraparound Projects: 3. Parents as Peer Interveners

Option	Defined	Advantages	Disadvantages
3. Parents as Peer Interveners	This model creates a capacity for family partners to deliver direct services, supports and interventions to parents and caregivers. This model starts with an expectation that some parents/caregivers will benefit from direct interventions that are provided using a peer-to-peer model. In this model, the child and family team will work collaboratively with the family and other team members to identify needs, goals and strategies. If the team reaches agreement about a need, the parent intervener will be called in to accomplish that need. These individuals will spend minimal time in team meetings and much more time working directly with families, in particular parents and caregivers. Examples of activities these peer interveners will work on include helping a parent locate and access community resources, coaching skills that will help the parent/caregiver cope successfully, assisting the parent/caregiver with building a social network and other imaginative responses that are identified by the child and family team. These peer parent interveners are typically time limited and goal oriented.	1. Creates capacity to get work done outside of team meetings. 2. Opens up a possibility of peer-to-peer work with parents who are struggling with building new skills or resources. 3. Creates more options for parents to be hired within the system outside of a wraparound process. This role doesn't need wraparound to happen for the work to occur. 4. Can bill federal entitlements for this work as long as the peer-to-peer work with parents is tied to the identified child's diagnostic needs.	1. This model may lend itself to a "fix-it" mentality with parents or caregivers. Projects must guard against this. 2. The time-limited, goal-oriented nature of this arrangement can cause parents to feel let down if they counted on support provided by the peer parent Intervener. 3. If using federal Medicaid funding to support this role, the program has to demonstrate how these peer services to the caregiver relate to the identified child's diagnosis.

Possible Models for Implementing Family Partners in Wraparound Projects: 4. Parents as System Developers or Family Involvement Coordinators

Option	Defined	Advantages	Disadvantages
4. Parents as System Developers or Family Involvement Coordinators	This design is especially well suited in those projects that don't have full funding to hire as many family partners as they would prefer, or in sites that are struggling to locate and hire parents/caregivers who are willing to work in the wraparound project. In this model, the project hires a relatively small number of parents or caregivers to assist with start-up activities. In this model, the role of the family involvement coordinator is to develop the hospitality of the wraparound project specifically as it welcomes parents and caregivers into the project. Typically, in this role, the family involvement coordinator will meet with parents/caregivers as they enter the project to provide an overview of the wraparound process as well as inviting the parent/caregiver to call any time with concerns or questions. The family involvement coordinator may not have contact again with that parent as they go through wraparound. If problems occur, either through identification by the parent or program staff, the family involvement coordinator or parent system developer can troubleshoot the situation to ensure that it is resolved and that the parent's perspective is understood.	1. This role is effective when the parent system developer or family involvement coordinator has influence and access to the project's administration. It assures family perspective in wraparound management. 2. Creates a capacity for parents to connect even when the project can't hire enough parents to be available on every team. 3. The family involvement coordinator can develop some community activities such as support groups so that families can connect outside of wraparound.	1. Staff can "over-rely" on the family involvement coordinator to "fix" conflicts with caregivers rather than resolving differences themselves. 2. The family involvement coordinator/parent system developer who gets called in as the troubleshooter may never get a chance to really connect with teams that are working. This can lead to discouragement. 3. Other wraparound staff can experience the family involvement coordinator/parent system developer as "policing" their practice as families are invited to call them with concerns. Projects have to guard against a backlash around this role.

Possible Models for Implementing Family Partners in Wraparound Projects: 5. Families as Wraparound Facilitators

Option	Defined	Advantages	Disadvantages
5. Families as Wraparound Facilitators	Parents and family members are effective advocates for high-quality wraparound implementation. As a result, some wraparound projects have hired parents and caregivers as wraparound facilitators. In this role, the parent or caregiver will take on the responsibilities of any wraparound facilitator. Those sites that have elected to hire wraparound alumni as facilitators expect that the person in the facilitator role will share information about their personal wraparound experience as part of implementing the process, as a way to fully engage family members.	1. Personal experience allows for strong connections between the family and the wraparound facilitator (who is also a parent). 2. Many parents can bring their personal experience of navigating systems and communities to the wraparound planning table. 3. This model enables efficient use of staff roles, especially for projects that don't have a great deal of funding available for staffing. 4. There is some thought that family members "get" wraparound quicker because of their personal experience.	1. Wraparound family partner and wraparound facilitator are two different, full-time roles. Placing these roles together may result in neither getting done well. 2. Projects have to guard against creating a dual workforce of those "professionally" trained and those "personally" trained. 3. Regardless of which "type" of training the facilitators received, all facilitators require consistent support and supervision.

Summary

There are many roles for hired family members within the wraparound process. These descriptions are not intended to be exhaustive but rather should be seen as starting concepts. Wraparound managers who are interested in hiring family members as part of their wraparound delivery should start by creating a model with clear assumptions, and then monitor that model to assure that the initial assumptions are being realized and make informed adjustments based on results. Key ingredients for building an effective family partner capacity include building a strong training component so family partners can continue to develop and refine their skill sets, developing an adequate career ladder so family partners can continue to grow and improve, and developing an adequate feedback loop so family partners can modify their role as the project matures.

A word about youth partners: Many wraparound projects are beginning to experiment with hiring youth partners, peers or "near peers" who have experienced wraparound or system intervention. This is a relatively new development in wraparound implementation and should be treated with the same careful consideration of other innovations in wraparound. As with the family partner, the youth partner requires model development, ongoing training and support as well as creating opportunities for individuals in these roles to grow, advance and develop.

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Wraparound Practice: Chapter 4b.4

Building a Quality Family Partner Foundation: Tips for Implementers

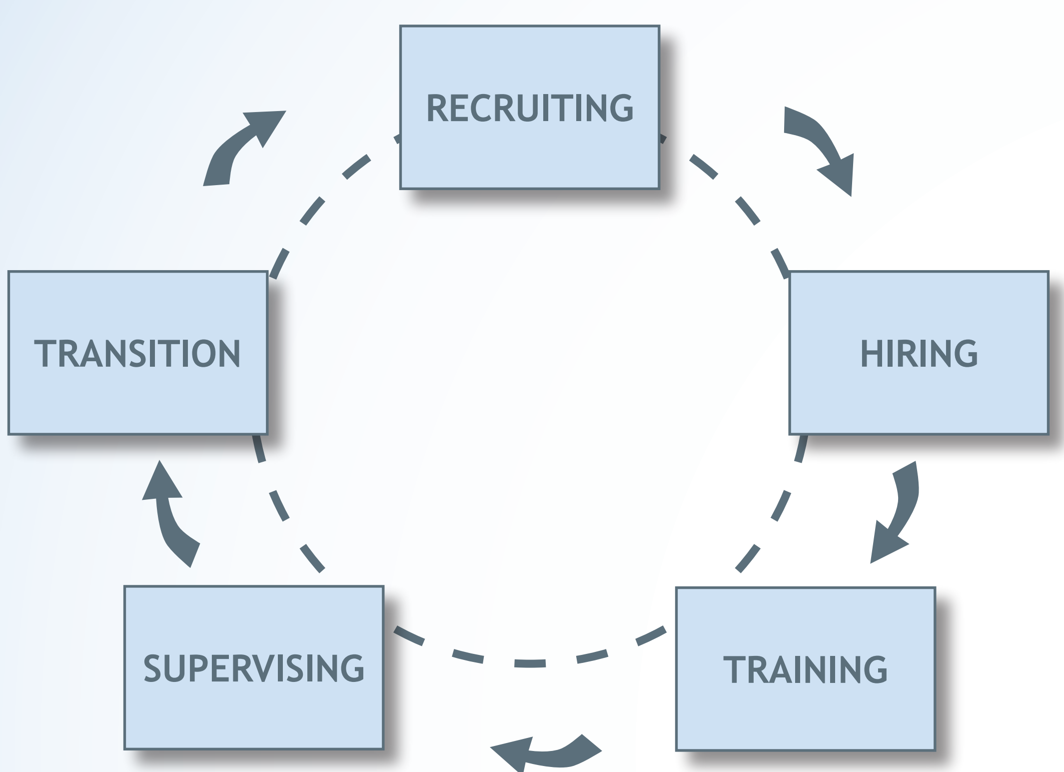
Patricia Miles, Consultant

Many wraparound projects have enhanced their delivery of wraparound planning by hiring family partners. Family partners in wraparound serve many purposes, including providing direct peer-to-peer support for family members, providing consultation to wraparound staff members about the perspective of the parent/caregiver, developing resources and supports on behalf of families, and participating in oversight efforts of wraparound. Figure 1 (next page) defines a cycle for employing family partners in wraparound projects. This summary will review each of these stages and identify typical mistakes as well as tips to build a strong foundation integrating family partners within wraparound projects.

The first opportunity for wraparound projects involves ***recruiting*** potential family partners. Family partners are individuals who have experienced the system from the "other side of the counter." Typically, in wraparound, these individuals are parents or caregivers of children who have received direct services although in some cases, other family members are hired. Projects that want to enhance wraparound through the use of family partners must make arrangements to recruit people who have had direct experience within the system rather than simply using the title of family partner for people who haven't had that direct experience.

When the recruitment process is underway, wraparound projects should move to ***hiring*** family partners. A project interested in hiring should be prepared to make accommodations to facilitate hiring. Administrators and managers should be prepared to accommodate both the personal and professional experience of family partners when making job

Figure 1. Stages in Building a Strong Family Partner Capacity



assignments and outlining pay. Family partners are hired because of their personal experience. Recognition of this personal experience can be accommodated by working with the human resource department. When building this recognition for personal experience, the project should also develop ways to recognize this through salary levels.

When a hire has been made, wraparound leadership should begin a ***training*** initiative to assure that the family partners have adequate access to the resources, tools and information they may need. Not all parents or family members who have experienced the system turn into family partners. Many individuals who apply for family partner positions have reached a place in their own life that causes them to want to share their experiences in a way that helps other families. In fact, many family partners reflect that their journey to becoming a family partner has often followed this path:

- First, parents/caregivers reflect that they have been "brought to their knees" by their child's diagnosis. This is often described as a sense of disequilibrium and feeling of powerlessness.
- Second, the parent/caregiver recognizes that they and their family have become part of a system whether they like it or not.
- Third, the parent/caregiver realizes that if their family is likely to survive this experience, they will need to engage in the process of help as they never imagined.
- Finally, the parent/caregiver develops an interest in helping engage others on their own journey towards resilience and recovery.

Even the most self aware family partner deserves to be engaged in a process of skill and com-

Table 1. Stages in Building a Strong Family Partner Capacity

DO:	DON'T:
Openly recruit all family members who have participated in system services	Screen out individuals based on their compliance as a service recipient
Make accommodations to assure families can access system services in the future while having their privacy protected	Tell families if they become Family Partners they can no longer use services
Anticipate the need for career growth by building capacity for Family Partners to move into lead, supervisory or management positions within the Family Partner job cluster	Set up a hierarchy between other Wraparound staff and Family Partner staff
Encourage Family Partners to share their personal experience with professionals and other family members	Limit what the Family Partner is able to share by using one working definition of professional boundaries
Empower the Family Partner to interrupt bias, blame and prejudicial stances	Make interrupting bias the responsibility of only the Family Partner
Train Family Partners along with other Wraparound staff	Confuse Wraparound training with Family Partner training. They are two different things.
Develop specific training opportunities for Family Partners as it fits with the model your project is pursuing	Choose training activities in a vacuum. Family Partners should have access to the same training opportunities as all other Wraparound staff. On the other hand, Family Partners deserve to have some specialized areas of training that are unique to the role of peer support provider.
Prepare the rest of the workforce to develop alliances with Family Partners	Assume that alliances will form without attention. Family Partners are recruited and hired because of their unique vantage point about the way the system operates. Other differences may include age of Family Partners as well as formal training. Alliances will not form easily and will require administrators to nurture similarities and normalize differences in perspective.
Hold Family Partners accountable to produce results and activities	Over-accommodate Family Partners
Create meaningful roles for Family Partners in the operations of your Wraparound project	Use Family Partners as window dressing or a symbol of your commitment to families
Involve families in the Wraparound project operations	Confuse Family Partners with family involvement. Avoid over-reliance on Family Partners when seeking family voice about the functioning of the system or program.

petency development. The wraparound project that fails to create a skill development capacity is building a project based on personality rather than competency.

While training is an ongoing process, ***supervision*** of the family partner is another element in creating a strong foundation for the wraparound project. Family partners should have clear expectations for how they should perform within the wraparound project. This allows supervisors to manage to the skill set rather than the personality of the people in the role. Supervisory issues include developing the capacity for family partners to work cooperatively with other wraparound staff, managing supportive relationships with family members, and managing around their own situation. Family partner boundaries are different than boundaries for people who have been professionally trained for their roles. Supervisors have to join with family partners in order to establish helpful limits and structures to manage their personal stories.

Some family partners indicate they anticipate staying in the position forever. Others, however, are interested advancing and developing additional skills. Wraparound projects have to be prepared to help family partners ***transition*** in their jobs, either through promotion, reassignment, or termination. A common error involves failing to create a career ladder that allows the family partner to advance while remaining in the family peer job cluster. In some projects, family partners find their only mechanism to advance involves moving into a more traditional role such as facilitator or care manager. Reassignment may involve helping the family partner to move into another department that allows for lateral growth rather than promotional growth. Many wraparound projects managed by nonprofit, multi-purpose agencies find that after experimenting with family partners in wraparound, they would like to see family partners in other departments. Creating capacity for wraparound family partners to move into other departments can keep family partners sharp, invested and interested. Finally, the last step in transition involves terminating a family partner when they can't demonstrate the necessary skills in enough time to help the families the project serves. If the person can't develop the ability to deliver peer-to-peer support, the wraparound manager has to be prepared to hold the person accountable and help them transition out of the project. When the transition phase is complete, the project should being with recruitment again.

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Wraparound Practice: Chapter 4b.5

A Dozen Mistakes in Using Family Partners in Wraparound

Patricia Miles, Consultant

Mistake 1

Making Family Support a Specialty Service: Wraparound was designed to be a supportive process. Supporting families, including parents/caregivers, is the responsibility of all wraparound staff. Some projects make the mistake of using family partners as the sole supporters or providers of family perspectives.

Mistake 2

Creating an Assistant Class: family partners are hired because of their personal experience. This personal experience should be recognized and equated to traditional sources of expertise, including professional and/or educational experience. If this personal experience is not recognized, family partners can wind up being seen as assistant facilitators or as assistants to other wraparound staff. While everyone can use more help, if the project evolves in this direction, the potential of family partners in creating conditions for family voice is not likely to be realized.

Mistake 3

Failing to Hire Family Members in this Role: The power of family partners is that they have direct experience from another perspective. Family partners who have "been there" help families who are experiencing loneliness by creating capacity to see themselves in others who have had similar experiences. While everyone can be supportive to families, not everyone can relate on this personal level.

Mistake 4

Confusing Agreement and Understanding: Family partners are intended to increase the capacity of project staff to understand the perspective of the family, especially as it is experienced by the parent or caregiver. Some family partners, however, find themselves in the position of advocating for team members to agree with the parent's perspective rather than ensuring that team members understand that perspective. This puts the family partner in an advocacy role and can lead to team members "taking sides" instead of participating in a collaborative process.

Mistake 5

Family Partners as Parent Correctors: A strength of family partners is that they can engage parents and caregivers in candid and realistic conversations through use of their personal stories and experiences. This engagement process seems to lead to greater engagement with the wraparound project. Some projects, however, will use this connection to put family partners in the role of correcting parents. This undermines the power of the position to build supportive peer-to-peer relationships.

Mistake 6

Family Partner as Ultimate Role Model: Family partners are hired because of their personal experience. At the time of hire, the family partner's life may be going well and their loved one's diagnosis or symptoms may be well managed. It is tempting to use that scenario as a example of what the family should expect to happen to them. This is a problem for two reasons. The first is that if the family partner has a child who is living with a mental illness, things can go out of balance quickly. Putting the family partner on a pedestal just means they are likely to fall when the mental illness requires intervention. Second, putting a family partner on a pedestal undermines the power of peer-to-peer support. Instead, projects should ensure that staff are realistic and accepting about what family partners are likely to go through in their role. Projects that do an effective job of supporting family partners will make accommodations for family partners who are going through their own struggles, and ensure that the family partner doesn't feel like a "failure" when their loved one's challenge requires attention.

Mistake 7

Turning family partners into youth workers: Most Wraparound projects rest in the child and youth service world. This focus on young people typically encourages development of various staff roles that are effective in working with children and youth. Family partners, especially those first hired, can find themselves functioning as an "extra pair of hands" in working with young people rather than holding the perspective of other family members. This is a problem when the opportunity to understand the parent's perspective is lost as family partners stay too busy working with youth, too.

Mistake 8

Family Partners as the Values Police: Making wraparound principles and system of care values real is the responsibility of all wraparound staff. Values statements are often very personal to family partners. Some projects will find that family partners are often the first ones to comment on situations that don't fit with the values. Putting the family partners in the policing role can result in organizational isolation as well as creating dependence within the rest of the project.

Mistake 9

Family Partner as Decoration: Family partners seem to make wraparound work better. Family partners can also take on symbolic importance by reflecting the project's commitment to involving and listening to families. Projects must strive to create meaningful roles for family partners rather than using this role solely as a symbol of family involvement.

Mistake 10

Confusing Personalities and Skills: The first family partners hired are usually true pioneers who are in a position to extend their personal lives to help others. These strong personalities with a sense of vision are usually successful because of who they are rather than anything the project does. As the project matures it is important for projects to move from simply hiring strong personalities to assuring that family partners have the right skill set to perform the job.

Mistake 11

Confusing Peer-to-Peer Support and the Wraparound Process: There are many roles for parents within the service system. Being a family partner within wraparound is just one among many possible peer-to-peer support roles. Many quality projects can use peer-to-peer support to enhance the family's experience of service and to increase the capacity of the system to provide customer centered care. Wraparound is not the only vehicle for peer-to-peer support to occur. Indeed, the entire service system including outpatient mental health clinics, in-home counseling programs, family resource centers and school based interventions, can realize benefits from hiring family members in peer support roles.

Mistake 12

Stopping at One: Family partners represent a very real enhancement to the way the wraparound process is implemented. Depending on the project's capacity, stopping at the first family partner may keep the project from building real capacity for peer-to-peer support. Projects should be strategic and take a long view in building their capacity for peer-to-peer support. Projects that think they have built this capacity when they have hired only one family partner—even as the project continues to grow—are failing to realize the potential and power of peer-to-peer support and its potential impact on the efficacy of the wraparound process.

Author

Patricia Miles is a consultant who lives in Oregon and helps communities, agencies, schools and others work to improve outcomes with people who are receiving public services.

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Wraparound Practice: Chapter 4b.6

Family Stories about Family Partners in Wraparound

Marlene Penn, Co-Chair, Family Partner Task Force
National Wraparound Initiative

Marlene Penn shares three stories of families who benefited from having a family partner involved in their wraparound process.

Family Involvement Center, Phoenix, Arizona

In this story, Dawn, the mother of a 13-year-old son with mental health concerns, shares her story about the critical role her Family Support Partner from the Family Involvement Center played in her family's experience with wraparound and in her own journey toward self-empowerment.

Having a family support partner [FSP] at first was a little scary for us. We had a lot of complex situations and needs in our family, and we had some bad experiences in the past with individuals who claimed to offer us support and help, so I was really skeptical. The FSP asked me to coffee and I thought, "OK what is this all about?" The last time I was asked to coffee by a behavioral health professional, it was to try and coax me to leave my husband because they thought he was not good for our family.

Well, this person gave me a totally different perspective. She was genuinely concerned and shared her personal experiences, which made me feel she was there to help me and not just my child. She began attending my child and family team meetings and was able to help get across what I was either wanting or trying to say. She also helped others to hear what our family needs were. In the child and family team meetings, she often stopped conversations, which were going full speed, to ensure people were really hearing us. She supported our

goals and desire to stay together as a family in a way that was strengths based. She understood the love in our family and how we needed to be there for each other. She was also very supportive when we had juvenile justice involved regarding our son, and attended court hearings with us often. That was not expected but greatly appreciated.

She was not the case manager, but was great at keeping us all on target, to move my family towards outcomes. She's truly seen us through the thick and thin of our lives, and let me tell you, we have been through a lot—trying to find community resources, and so forth. Just the time to get away and talk to someone without feeling like you are being judged was so important to us. Without our family support partner, I would have felt like I was wavering in deep waters without so much as a raft in sight. She was my anchor many times, and taught me how to advocate for my family in a way that was strengths-based and solution-focused for everyone involved in our team, but especially our family. My husband began to feel acceptance and support, rather than a harsh, judgmental atmosphere.

She continues to be a resource and a creative problem solver for us, and for other families. I call her and get her advice for others. I now work in the system to help families, and it was the excellent model that she set for me that allowed me to become a family leader. She did not encourage me to go in this direction, but she definitely inspired me greatly by her example alone.

Family Support Organization of Burlington County, New Jersey

Marie Vandergrift of Southampton New Jersey was actually the first to enter the wraparound process in her county, and she describes her experience of having a family partner as well as the overall impact of wraparound in her life.

They told me that a family support partner [FSP] would be coming with my care manager to meet me and my family. I didn't have to go anywhere! They came right to my trailer in a very heavy snowstorm. The care manager and her supervisor came in with the FSP for our first "face to face." Within about five minutes, my son said of the FSP, "finally, someone who understands." My family partner really did understand because she had been through so many of the same problems with her family and child welfare. Our care management organization really tried to help my son and they did a lot. My family support partner and her whole organization were always there for me. They gave me so much courage. I was very timid. I would not speak up and I was very much afraid of child welfare. I learned so much from having my family partner there with me always.

She had invited me to come and speak at a legislative event. While we were in the car, I got a call from the residential facility telling me that my son would be discharged the following week. There was no transition plan to speak of. I was very upset and just kind of accepted it. My family partner coached me to discuss this with my care manager and to request a child and family team meeting, if I wanted to. My FSP dialed the number and asked me to take the phone. I felt timid but I wanted to do it. When the care manager wasn't there, she suggested that we call back and ask to speak to the supervisor. I was willing to try. The supervisor wasn't there either. "Let's try the clinical coordinator," my family partner said. So I did and I reached her. I did all of the talking with my cheerleader sitting right next to me. A child and family team meeting was called together promptly and I feel like I changed forever.

That day, I spoke with confidence before the legislature. My FSP never pushed me to do anything I didn't want to do, but she encouraged me to try things to empower myself. Today, I serve on the board of directors of the care management organization, Partners for Kids and Families. From my family partner and the whole family organization, I learned not to blame myself; I learned to empower myself and my family. I am a partner to the system, not a victim of the system. I didn't understand in the beginning why only my son was referred for wraparound. My other son needed more. The wraparound team supported my whole family.

Today, my daughter is on the planning board of the family support organization's Youth Partnership. Both of my sons are doing well and living independently. They are about to become fathers, and I am about to become a grandmother.

The Montgomery County Federation of Families for Children's Mental Health, Maryland

Celia Serkin, Executive Director, describes how important wraparound and having a family support partner was to Valerie Oliver and Sheila Ward before they both became family support partners themselves.

Valerie Oliver became engaged in the wraparound process when she felt that her life was spinning out of control and going downhill. She felt isolated and alone. She had no outside or natural supports to help her address her child's mental health challenges. Wraparound came into her life, and Valerie began to embark on a journey toward self-advocacy and self-efficacy.

Valerie had a care coordinator and a family support partner who jointly facilitated her child and family team. Her team members extended a helping hand and opened many doors that had previously been closed to her. Valerie's family support partner encouraged her to acquire survival tools that helped her to work towards achieving self-sufficiency. Her family support partner stressed the importance of Valerie maintaining her dignity and respect and having a choice about what she wanted and needed for her family. She guided Valerie and supported her in her decision to select the right path for her family. She acknowledged Valerie's strengths and needs.

Valerie began leading her own child and family team and creating a viable support system for her family. With the help of her family support partner and the care coordinator, Valerie and her team members implemented a clearly defined plan of care that had individually tailored goals. Her son got back on his feet and was able to be maintained in the community. Valerie restored her faith and had hope for a better future.

Sheila Ward felt that she was desperately in need of assistance when she began participating in wraparound. She had a child with mental health challenges, who had psychiatric hospitalizations and was having many difficulties. When Sheila became involved in wraparound, she was assigned to a partnership dyad consisting of a family support partner and a care coordinator. They came to Sheila's home when she felt that she was at her lowest point and in need of many services and supports to uplift and empower her. They were caring and compassionate and helped Sheila build her own child and family team. Sheila related to her family support partner because they had similar experiences. Her family support partner explained the value of the wraparound process. Sheila felt hopeful because she saw that her family support partner was "in a good place." Sheila witnessed her family support partner co-facilitating her team and realized that she could learn to run her own child and family team meeting. Sheila is now a family support partner who provides support to families involved in wraparound in Montgomery County through Maryland Choices.

From my family partner and the whole family organization, I learned not to blame myself; I learned to empower myself and my family.

Author

Marlene Penn's initial experience on care planning teams was as the parent of her own child. She subsequently became an advocate for other families and trains and coaches extensively on the role of the Family Partner on wraparound teams. Marlene served as one of the faculty members on the University of South Florida Louis de la Parte Florida Mental Health Institute Course "Wraparound Interventions and the System of Care" and is co-chair of the Family Partner Task Force of the National Wraparound Initiative.

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Wraparound Practice: Chapter 4b.7

Community Stories About Family Partners in Wraparound

Marlene Penn, Co-Chair of the Family Partner Task Force
National Wraparound Initiative

Marlene Penn shares three stories about engaging family partners in wraparound efforts—and how it benefited the community.

Coordinated Family Focused Care (CFFC), Massachusetts

In this essay, Linda Roy, Senior Family Partner, Behavioral Health Network in Springfield Massachusetts describes how the family partners in one of the Coordinated Family Focused Care (CFFC) projects in Massachusetts found that, by reaching out to the community, they could achieve tremendous success in providing a way for families to connect to other families during the wraparound process, and stay connected after formal wraparound ends.

There are five CFFC projects administered through the Massachusetts Behavioral Health Partnership throughout Massachusetts. Each agency employs five wraparound family partners.

The (CFFC) family partners initiated and hosted an event they called the "Family Support Summit." All organizations that offered children's services in their community were invited to answer the question, "What is available in our community for ongoing family support?" One clearly identified need was for a weekly support group for parents that offered childcare. Two local organizations committed to working with the CFFC Family Partners to develop a weekly support group for all parents in their community. They decided to call it Family Fun Night.

They tackled a series of challenges along the way. They

had to find a central location and set up adequate transportation for families to attend. They had to get child care workers and work with them to structure and provide age-appropriate activities for children over a wide age range. They needed to find local speakers for family-driven topics, and they hoped to find sources for donations of food to serve both the adults and the children. Finally, they had to publicize the initial event throughout the community. A further challenge was to negotiate responsibilities among the collaborating organizations.

Families who are current recipients of wraparound are emerging as the next generation of family leaders.

Their diligence and collaboration efforts paid off. A local elementary school offered them space for weekly meetings. They received many other donations from the community as well, including food, children's games, art supplies and materials for a "May Is Mental Health Month" children's art show. A local college donated exhibit space for the art show, which has since become an annual event. They found area professionals willing to donate their time and expertise presenting to families on several key topics. Two other local colleges committed college students to execute service projects with the children's group. Together, the three organizations comprising the collaborative publicized the group and the first planned event.

Today, Family Fun Night meets weekly and is completing its second year. The Family Support Summit continues to meet every other month and has published a booklet of direct-access supports for area families.

The Montgomery County Federation of Families for Children's Mental Health, Maryland

Celia Serkin presents this essay entitled "Passing the Baton: Building Generations of Family Leaders through the Wraparound Process."

The Montgomery County Federation of Families for Children's Mental Health (the Federation) is a family organization in Maryland that serves families of children with emotional, behavioral, and mental health challenges. The Federation underwent a revitalization to sustain the family component of Montgomery County's Substance Abuse and Mental Health Services Administration (SAMHSA) funded system of care grant, which utilized wraparound and family support to help children and youth with serious emotional disorders and their families. The Federation is building generations of family leaders and developing an organically grown peer support network that is integrated into the County's wraparound project. This network strengthens both the individual family members linked to it and the community at large.

Families who were engaged in wraparound for their own children and families are now Federation staff who are delivering family support to other families currently receiving wraparound. Families who are current recipients of wraparound are emerging as the next generation of family leaders. They are giving testimony before legislators, offering peer support to other families involved in wraparound, and organizing family support events. They are part of a grassroots peer support network, which is intricately tied to the national family movement. Building a family-to-family support network not only empowers individual members of that network, but it also strengthens a community. Increasing family-to-family support on a grassroots level improves community well being.

As one example of this process, consider Valerie Oliver, whose individual story was presented earlier in the section in the "Family Stories" chapter. Valerie emerged as a natural born leader. Currently, Valerie is working with the Federation as a family support partner. She serves on the child and family teams and helps families to engage in wraparound, which is provided through Maryland Choices. Valerie runs two support groups for family members. Families can participate in these groups even if they are not involved in wraparound. The community can refer families to

these groups, which are free of charge. Valerie is empowering and educating other family members, and building leaders from within the population she is serving. She has recruited families to organize family support events, to do system advocacy, and to provide one-on-one support to other family members.

Karina Funes, a Latina family support partner at the Federation, works with both English speaking and non-English speaking families. She is the family liaison on the Local Coordinating Council (LCC), an interagency group with representatives from public agencies serving children and youth. It is through the LCC that families begin to access wraparound. Karina serves as a cultural broker who advocates for family voice and choice, and for culturally sensitive treatment of family members. She goes with families to IEP meetings, discharge planning meetings at hospitals, court hearings, and meetings with social services agencies. She works to ensure that community agencies treat family members who do not speak English with dignity and respect, and as partners in decision-making.

The community has elicited the support of family support partners to connect and engage families in wraparound. Community members have asked family support partners for help in identifying natural supports and showing family members how to use specific advocacy strategies to access needed services. They have asked family support partners to help families feel less isolated by connecting them to the Federation's family support activities. The community has asked family support partners to give presentations and conduct trainings.

The family support partners sometimes face challenges from the community. They are asked at times to perform tasks that do not promote family members' independence or empowerment; for example, asking a family support partner to do tasks that the family members are capable of doing for themselves. Another challenge is how a community representative may misinterpret "family-driven" as it relates to the wraparound process and the role of both the family member and the family support partner. A community representative may feel frustrated when the family support partner will not tell the family member what to do. The community representative may want the family support partner to dictate to family members what action needs to be taken. The family support partner wants the family members to acquire knowledge and skills that will help them make their own decisions.

As a result of the work of family support partners, families who were once disenfranchised are testifying before the County Executive, writing to the County Council, and meeting with their legislators. They are speaking up in meetings and encouraging other family members to participate in family support events and leadership opportunities.

Family Involvement Center, Phoenix, Arizona

Lynette Tolliver, Systems Transformation Manager of the Family Involvement Center (FIC), describes the many roles family support partners play in Arizona's system of care and on individual families' child and family teams.

Family support partners (FSP) in Arizona are engaged in the community primarily through the Behavioral Health system. As families in wraparound are generally served by multiple child-serving agencies, the FSP tends to serve as a bridge-builder. The FSP assists in building communication and relationships between the parent, child, school faculty and other wraparound team members to explore whether there are appropriate supports in place at school. FSPs, having "walked the walk" with their own children, are often the best prepared team member to provide assistance in getting an IEP or 504 plan in place and then ensuring it is adhered to. Through this type of bridge-building and on-going

support, the FSP helps ensure the child and family are consistently supported across both the behavioral health and education systems. This helps ensure the wraparound team can move towards positive outcomes in both arenas.

The FSP provides support to parents on issues or challenges that may have contributed to the family becoming involved with child protective services. The FSP can often more easily engage the parents and get them involved with formal services and informal supports that are geared towards helping the parent achieve reunification goals. This, in turn, often leads to positively impacting the perspective of the professionals involved with the family's plan.

The family support partners in Arizona have also helped address larger community issues through their support to individual families. For example, there was a major void in one family's life due to losing their faith-based support system due to the struggles they regularly encountered related to their child's behavioral health needs. Their house of worship was not equipped to support the family due to their child's challenges, and thus discouraged the family from coming back again. For the family this was a major loss and their trust was shaken because their faith community had been an important part of their culture and values.

Because the FSP was able to help the family feel comfortable talking about this issue, the team was better able to understand how this loss affected the family, and the importance of addressing this need. With this new understanding, the FSP served as a bridge builder and assisted the family in rebuilding this part of their community support system. They also assisted the faith community in better understanding and supporting the needs of families raising children with behavioral health needs.

The major challenge for FSPs is for other professionals to respect the uniqueness of their role and to understand that, in the clinical arena, there are certain ethical boundaries that simply do not apply to the role of the FSP. They go "in deep" and share their own experiences in order to provide support and hope to other families in their journey. They also assist families in finding their voices as opposed to becoming the voice for families. Finally, they assist professionals in seeing the family perspective, the families with whom they work.

Author

Marlene Penn's initial experience on care planning teams was as the parent of her own child. She subsequently became an advocate for other families and trains and coaches extensively on the role of the Family Partner on wraparound teams. Marlene served as one of the faculty members on the University of South Florida Louis de la Parte Florida Mental Health Institute Course "Wraparound Interventions and the System of Care" and is co-chair of the Family Partner Task Force of the National Wraparound Initiative.

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Wraparound Practice: Chapter 4c.1

Youth Engagement, Empowerment, and Participation in Wraparound

Marvin Alexander, Vice-Chair
Youth MOVE National

Everyone benefits when young people are actively engaged in the decisions that directly affect their lives! Youth, families, adults, organizations, policymakers, and communities as a whole benefit when young people have a voice that is listened to, respected, and utilized.

Engaging youth in decision making is essential to their overall development. This is true for all youth, even youth with behavioral and emotional issues. All youth are developing; all youth have strengths; all youth have needs; all youth can contribute to their communities; all youth are valued. Youth are agents of their own development (Pittman, 1998). They should be involved in every decision that will have an effect on their lives. This does not mean that young people shouldn't have caring and positive adults standing in roles of support available to them at all times.

Involving youth in service planning and decision making would seem to be a no-brainer for practitioners that serve children and adolescents. However, many struggle with understanding that the right to self-determination should be afforded to all families and to youth based on their level of maturity.

It is important to remember that children and youth grow into adults and that, as they mature, the foundation for adulthood is being built. Youth must be allowed opportunities to develop. For young people with severe behavioral and emotional challenges that foundation is built while he or she is also experiencing ongoing crisis, feelings of mistrust, wanting to be "normal," and the typical stressors of most all youth experience during transition from childhood to adulthood. It is important to leave a positive impression

and to be supportive of youth. Efforts to do so will be remembered and have a direct affect on a human life.

Treatment Planning

Being the only young person in a wraparound team meeting may be intimidating. It is the responsibility of the adults involved to remain youth-guided, remembering that the young person is ultimately responsible for obtaining his/her goals. Team members must remain strengths-based throughout the entire engagement process. Meetings could be counterproductive if the youth feel as if everyone is against them. Remember to focus on the positive behaviors and address negative behaviors in a functional, non-degrading way.

Authentic involvement in treatment planning helps youth take personal responsibility for their treatment. Because young people are actively engaged and "own" their plans, the chances of successful outcomes in treatment are significantly improved.

Youth as Leaders

With strong adult and system support, a young person is able to develop new skills and knowledge that will allow him or her to participate in system building and to be of support to peers. In this manner, young people are able to reframe their personal identities from an "SED/ problem kid" to a leader contributes positively in the community. Youth develop confidence and their involvement strengthens their sense of pride, identity, and self-esteem.

Adults who work with youth often have to work hard to overcome ingrained habits of adultism. Adultism is the assumption that adults are better (or more competent) than youth and should therefore act on behalf of young people without their agreement because youth lack life experience and are inferior. Adults should listen to and partner with young people by supporting them, not controlling them. Comments such as "You're all kids to me," and referring to youth projects or activities in ways that make them seem inferior to those of adults fosters the undervaluing of youth.

Case in Point:

While in a regional governance board meeting a project director was asked about upcoming youth group activities. The project director responded, very happy that the person had asked, and said: "Well, they're having a little retreat this weekend." The youth coordinator took this as an offense--he and the youth group had worked extremely hard on planning the retreat and the project director chopped all of their efforts down to a "little retreat." Not only did the project director not acknowledge their hard work but she separated the youth group from the rest of the team by saying "..*they*'re having...." Youth should be engaged as equal partners. Their contributions should be valued.

A Win-Win

When youth are engaged, involved, and actively participating in wraparound, there are benefits for the young people and for the community. What is more, the philosophy of wraparound states the importance of youth voice. There should be no question in anyone's mind about the importance of making this ideal of youth empowerment come to life.

Author

Marvin Alexander is the Vice-Chair of YouthMOVE National, a national youth-run organization devoted to uniting the voices and causes of youth and young adults who have serious emotional disorders and are involved in multiple systems. Marvin is a national leader who has provided technical assistance, consultation and training to groups and organizations across the country. He is an advocate of youth rights and voice, not only in their own treatment but also in the development of policies, research, program evaluation, and the overall transformation of systems that directly touch the lives of American youth.

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Wraparound Practice: Chapter 4c.2

Youth Advocates: What They Do and Why Your Wraparound Program Should Hire One

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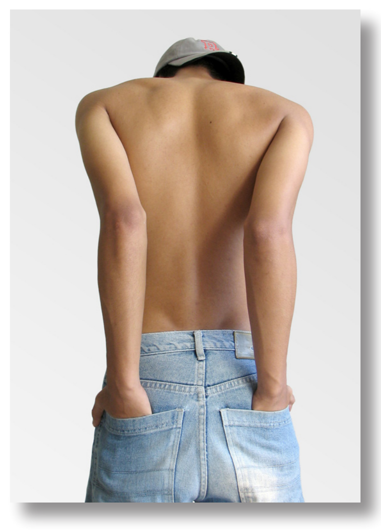
SAMHSA System of Care

Gloria Fields, Youth Advocate
Antoine Griffin-Van Dorn, Youth Advocate
Melissa Castillo, Youth Advocate
Mental Health Association of New York



Our perspectives on youth advocacy have been shaped by our personal experiences as recipients of mental health and child welfare services, as well as our experiences as a Care Coordinator and as Youth Advocates within New York City's system of care. We know first-hand how hard it is for youth to feel supported and heard as they make their way through the educational and service systems. We have also seen what a difference youth advocates can make in engaging youth and empowering them to be full partners in their own care. As an integral part of a wraparound team, youth advocates keep it real for their team members and serve as a continuous reminder of the importance of staying strength based and youth guided. For the youth who participate in wraparound, the presence of youth advocates provides concrete evidence that their care teams just might really mean what we say—that the youth's voice matters.

Potential Roles of the Youth Advocate Within the System of Care

Engagement. Too often a youth's strengths, voice and preferences remain unrecognized and unheard by their service providers. The past disappointments that youth have experienced with service providers, peers and family members can also leave youth feeling mistrustful, without hope and reluctant to engage in relationship-building with people on their care team. The opportunity to speak with another youth who has undergone similar experiences and who is a part of their wraparound team is often the first step in building trust and reducing the isolation that is typical for youth

who struggle with mental health challenges.

Support. Perhaps the most important role for the youth advocate is providing peer support to the youth whom they work with. For a youth, just knowing that there is somebody there for them who understands, and who has got their back, can be the basis for creating a new sense of hope and possibility.

Voice. Through the time that the youth advocate spends with the youth there is an opportunity to learn the youth's strengths, interests, and needs from the youth's perspective, and to coach and support the youth to voice their concerns and wants with their service providers and families. When youth have difficulty in making their voices heard or wishes known in meetings, youth advocates can, by agreement with the youth, advocate on the youth's behalf.

For a youth, just knowing that there is somebody there for them who understands, and who has got their back, can be the basis for creating a new sense of hope and possibility.

Mentor. Like a traditional Big Brother or Big Sister, the youth advocate is a role model for the youth that they work with. Youth advocates are able to share their experiences about what has helped and hurt them in their process of recovery, and to offer suggestions about alternative ways of handling situations that may arise with peers, parents, providers and others within the community. Youth advocates also have the flexibility to meet youth where they feel comfortable, and to participate in activities ranging from meeting for lunch or going shopping to meeting at family court or at the youth's school.

Bridge/Culture Broker. The gulf between the youth and service providers can be large, both culturally and in terms of control. The youth advocate can act as a bridge between the two. Ideally, the youth advocate will be fluent in both the language of the youth culture as well as the language of the provider culture, and prevent the breakdown of communication between the two. This role is particularly important in settings such as hospitals and residential treatment facilities where the power differential between youth and adults is greatest. A young person who is trusted by both youth and adults in such a setting can help to ameliorate the effects of the power differential.

Group Facilitator. Youth advocates can also play an important role in building and maintaining opportunities for youth to meet and socialize in a non-stigmatizing environment. In New York City, youth advocates facilitate several peer support, skill building and socialization groups for youth involved in the system of care.

Systems Transformation. Youth advocacy positions provide important opportunities for youth leadership development, creating a pool of well-informed youth who can provide a youth perspective on governance boards and planning and advisory bodies. In New York City, youth advocates also serve as part of the training team that delivers training on system of care principles and values and the family network (wraparound) process. Youth advocates are also called upon to provide presentations on issues of concern to youth, families and providers such as gang involvement and youth engagement. Making a place for youth at all of these tables and involving youth at all levels of decision making is an important part of realizing our effort to create a youth guided system of care.

Who Are Youth Advocates?

Youth advocates are generally young adults from the ages of 18-25 who have had personal experience within child- and family-serving systems (mental health, special education, child welfare, juvenile justice), and who are interested in ensuring that their peers receive high quality services that are responsive to their needs. More often than not, youth advocates are motivated by their desire to create more positive experiences for youth within the system of care than the ones that

they had. The opportunity to make a difference to other youth facing emotional and behavioral challenges can also make a positive difference in the youth advocate's own recovery.

What to Look for When Hiring a Youth Advocate

In addition to the credibility that youth advocates have by virtue of their age and experience within the system of care, successful youth advocates are far enough along in their own recovery process that they can handle the stress of the job and serve as a positive role model for the youth they work with.

The ideal candidate will be young yet mature, and will have had experience within the child- and family-serving systems. Although as an organization we have employed youth advocates as young as 16, older youth more typically have the maturity it takes to balance the demands of the job with their personal life and self-care.

Past experience working with children (working for the YMCA, as a camp counselor, etc.) or an interest in working in the helping professions can be a plus. However, for many youth advocates, it is important to remember that this may be their first job. Far more important than work experience or educational credentials is a willingness to learn, the ability to relate well to other youth from diverse backgrounds, the capacity to follow through and a willingness to share their own experiences with child-and family-serving systems. Stigma is a factor that may influence a candidate's willingness to speak openly about his or her mental health challenges in an interview situation. Remember, this is a process and the youth doesn't really know how safe disclosure is. The presence of other youth advocates in the interview or a separate meeting with another youth advocate can create a safer environment in which to assess whether the youth will be comfortable enough acknowledging their own challenges to other youth when appropriate.

How to Find the Ideal Candidate

Using the same search practices as you would to find a qualified social worker is likely to yield few applicants. Personal referrals have led to some of our most productive hires. Another strategy is to meet the young people where the young people are. Find community organizations within systems of care where youth are likely to be, and post flyers in those locations. Use the Internet. Go onto Myspace and post job announcements in public forums that are mental health related. Contact organizations of independent self-described youth advocates like the National Youth Rights Association (NYRA), Youth Advocates for Community-Based Treatment (Youth ACT), the National Youth Leadership Council (NYLC) or local chapters of the Federation of Families for Children's Mental Health. Individuals who, with no profit to themselves, have already decided to organize to fight for youth rights are likely to be good candidates for the job.

Training and Supervision of Youth Advocates

Experience as a recipient of services from mental health, special education, juvenile justice and/or the child welfare system is a necessary but not sufficient condition to being successful as a youth advocate. Organizations that hire youth advocates have a great responsibility to provide training and supervision that will help youth advocates to feel valued and supported, and to develop skills, set appropriate boundaries and engage in self-care.

Good training of youth advocates involves fostering the development of listening, engagement, collaboration, boundary setting and, last but not least, public speaking skills. Excellent listening

skills play a major factor in the work of youth advocates. Because so many youth have not been included in planning for their own care and are turned off to services, the development of good engagement and listening skills is critically important. Listening and engagement skills form the basis for discovering the youth's needs and preferences and a starting place for giving voice to the youth's concerns.

Specific skill training about system of care principles and values, community resources and collaboration across systems is also needed. Other important areas for skill development include wraparound principles and processes, and group facilitation. Information about the cultures and language used by the various child and youth service systems is also needed to help youth advocates function effectively as culture brokers for the youth. The availability of coaching and help with public speaking is also important for youth advocates, who are often called on to present a youth perspective in public forums and to make presentations about youth-related topics to other youth or providers within the community.

The work that we do is hard work and the challenges of many of the youth and families that we work with can be overwhelming for even the most seasoned professional. Close relationships between youth advocates and the youth they work with often develop. Individual supervision, opportunities to meet with other youth advocates and group supervision are important vehicles for providing the support needed so that advocates can safeguard their own well being and maintain appropriate limits and boundaries with the youth they serve.

Accountability and Evaluation

Since many organizations have never had youth advocates as staff members, it is especially important for the hiring organization to be very clear about the expectations for youth advocates and to revisit these expectations frequently as the organization and staff gain clarity about the role of youth advocates within their organization. These expectations should be clearly communicated in job descriptions and as part of performance appraisals.

Team meetings where all team members discuss how their work with youth is progressing provide a more informal means of ensuring that youth advocates are delivering quality services. Work with individual youth can be discussed and contact notes reviewed in the context of individual supervision meetings with all team members including youth advocates.

Final Thoughts

Youth advocacy, as defined in this article, is still in its infancy. There is still much that remains to be defined about the role and the proper place of youth advocates. As with any new frontier in social service practice, there is worry about using an unknown variable in the treatment process.

While there is a great deal of upside as we have described in involving peers within the wraparound team, there is also the concern that negative outcomes can occur when vulnerable youth are put in contact with someone whose perspective has been formed through negative experiences in child-and-family serving systems.

We hope that by providing this primer on how to find youth advocates, how to utilize youth advocates, and how to train and develop youth advocates, we can put these concerns to rest, and increase the numbers of young people in the systems of care who are getting paid to help motivate others through their voices of experience.

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Wraparound Practice: Chapter 4c.3

Youth Participation in Wraparound Team Planning: Why and How

Janet Walker, Co-Director, National Wraparound Initiative, and Research Associate Professor, Portland State University School of Social Work

Human service and educational agencies and systems often convene teams to work collaboratively on plans for serving children or youth. This is particularly true for children and youth who are involved with multiple systems or who are felt to be in need of intensive intervention. Here, we focus on wraparound planning teams, but similar planning goes on in IEP (Individualized Education Plan) teams, foster care independent living program teams, transition planning teams, youth/family decision teams, and other teams that create service or treatment plans. Unfortunately, it is often true that these plans are created *for* youth, with little input or buy-in from the young people themselves.

In previous research on wraparound, we found that many adults who participated on teams were eager to involve youth in planning in a more meaningful way, but were unsure how to feasibly accomplish this goal. One difficulty they cited was that some of their colleagues were not really committed to the idea that youth should have an important role in making decisions for their care, service, education and treatment plans. These colleagues were seen as raising a range of objections, such as:

- Involving youth is not worth the time it would take;
- We know what's best for youth and we should make the decisions;
- We already do give youth the opportunity to participate in planning, but they just aren't interested;
- Our youth have emotional and behavioral difficulties—they don't know what's good for them and any-

way they can't work productively in meetings;

- Our youth have attentional problems—they really don't want to sit through long meetings;
- Our youth have cognitive delays—they don't have the skills to contribute to plans;
- Our youth have difficult lives—their feelings will be hurt if they come to meetings and we discuss what's going on, and so on.

In response, we began work on AMP. AMP—*Achieve My Plan*—is a five-year project that is developing and testing ways to increase the meaningful participation of youth in collaborative team planning meetings. The work of the AMP project is undertaken with the guidance and active participation of an advisory group that includes youth, caregivers and providers who have extensive personal experience with multiple service systems and interdisciplinary planning. Advisors have worked together with research staff to design and evaluate the products from the AMP project.

Early on in our work together, we came to the realization that changing practices related to youth participation in team planning would require developing materials that could answer two big sets of questions and doubts that people raise when thinking about youth participation. First, *Why?* Why is it worthwhile for organizations and agencies that participate in team planning for youth to change what they do, to adopt new practices that increase young people's role in team discussions and decisions? And second, *How?* What do these organizations and agencies need to do—and what do the people who participate on teams need to do—to ensure that planning with youth is collaborative and productive rather than confrontational or (as youth fear) one more opportunity for adults to lecture young people all about the bad things they did in the past and tell the young people what they are going to have to do now.

To respond to the *Why* question, we put together a document called *Youth Participation in Collaborative Team Planning: Research Tells us we Should be Doing Better*. In the next part of this chapter, we will summarize some of what is written in that document. The document reviews published research, and presents empirical evidence that supports the idea that meaningful youth participation in team planning is practical, feasible, and worthwhile. The entire document is included as an appendix for this *Resource Guide*. We also created a video called *Youth Participation in Collaborative Team Planning: Why it Matters*. To make the video, AMP advisors interviewed one another about their experiences with team planning and youth (non)participation. The video uses clips from these interviews to show in a very immediate way how a lack of participation contributes to youth powerlessness, hopelessness, and plan failure; and how collaboration with youth has the potential for opposite outcomes. This video can be accessed at http://www.rtc.pdx.edu/AMP/pgVideo_AMP_ImportanceOfYPP.shtml.

To respond to the *How* question, we created another document called *Best Practices for Increasing Meaningful Youth Participation in Collaborative Team Planning*. This document combines insights gained from published sources with insights from our advisors and from other youth, caregivers, and providers who have provided feedback to the AMP project. (Again, the full document is included as an appendix to this *Resource Guide*.) In the later sections of this chapter, we outline these best practices that, together, describe a vision of what it takes to create plans *with* youth, so that youth will see the plans as a means to help them move towards important life goals. Some of these practices require time and resources, and many require that teams organize their work in ways that are different from usual. But this is to be expected—getting a higher level of youth participation will require an investment.

Organizations and teams that implement practices to ensure meaningful youth participation in wraparound will of course need some way of gathering data that can tell them how they are doing. The last section of this chapter focuses on strategies for evaluating youth participation and related outcomes.

Finally, the AMP project has developed an intervention that includes the best practices outlined in this chapter. Currently, we are conducting a formal evaluation to document the impact that the AMP intervention has on youth participation in planning, the quality of plans, team member satisfaction with planning, organizational attitudes about the feasibility and usefulness of youth participation in planning, and youth empowerment with respect to mental healthcare. In the near future, we will know the outcomes from that evaluation. We will also have the full range of materials available to help organizations and communities implement the AMP intervention.

The *Why* of Meaningful Youth Participation

Youth Participation in Collaborative Team Planning: Research Tells us we Should be Doing Better reviews published research as a means to providing answers to a series of questions or doubts that people may have regarding the usefulness and feasibility of youth participation. Here, we review the main questions and answers. Please see the full document for more detailed answers and research citations.

Aren't young people already involved in their education, care, and treatment planning? The best available research indicates that few students participate meaningfully in creating their Individualized Education Plans (IEPs). It also appears that youth with emotional or behavioral disorders do not usually participate meaningfully in creating their own care, treatment, or service plans. Professionals who participate in this kind of planning are also dissatisfied with the level of youth participation.

Participating meaningfully in planning means that young people have to take part in making decisions and setting and monitoring goals. Can youth who have significant mental health, learning, and/or cognitive difficulties really be expected to master the skills needed to do this? Children and youth of all ages and with a variety of disabilities and challenges have successfully learned the necessary skills and participated in planning.

Why is it so important to include young people in planning for their education, treatment or care? What's to be gained? There are a lot of potential benefits to increasing youth participation in planning. First of all, when people feel they are doing something because they want to, they tend to be happier and more engaged, and do a better job, than when they don't feel they have a choice. Second, learning to make plans and achieve goals is an important part of growing up for any young person. People who are confident that they can solve problems in their lives and reach the goals they set for themselves experience many positive outcomes—including positive emotional and behavioral outcomes. Developing these feelings of "self-efficacy" would seem particularly important for youth who face high levels of challenge in life. However, it appears that children with disabilities and children who are involved with the child welfare or mental health systems have far fewer opportunities than their peers to experience self-efficacy. In addition to all these reasons, perhaps the most important reason for including youth meaningfully in planning is because it's the right thing to do.

The *How* of Meaningful Youth Participation

The *how* of promoting meaningful youth participation in wraparound team planning has several distinct aspects. First, the organization(s) that take the lead in convening wraparound teams need to build an organizational culture that prioritizes and values youth voice in team discussions and decisions. Additionally, the organization needs to define and build capacity for new ways of working directly with youth. These include practices for preparing youth for participation, running meetings that encourage youth participation, and holding teams accountable for carrying out collaborative decisions.

Organizational Culture

Agency staff are more likely to support youth participation if they see that it is a priority within

the agency, and if the agency provides resources—like time and training—so that staff can gain the skills they need to carry out activities that encourage youth participation. Staff, families, and youth themselves will be more open to youth participation if they are exposed to information—like the AMP video and other publications—that demonstrates that increasing youth participation is both desirable and possible. The agency should be clear about its commitment to youth participation in decision making by affirming that:

- once decisions are made (with youth participation), the decisions should not be changed later without further youth participation;
- youth should be invited to participate in their entire wraparound meetings; and
- important information should not be shared when youth are absent.

Preparation for the Meeting

One of the things that our youth advisors were clearest about that a team meeting should not have surprises. Many of the youth had had bad experiences with meetings when they felt blindsided by topics that were to be discussed. Or they were told they would have input into a decisions and then (surprise!), the actual decision was made without consideration of their what they thought or what they wanted. Because of experiences such as these—and also because of a natural anxiety about sitting in a room with a group of adults who have power over their lives—youth are likely to anticipate a meeting with distrust, anxiety, or even anger. If, however, a young person knows what will happen in the meeting, he or she can feel more of a sense of security that there will be no unpleasant surprises. Additionally, knowing what is going to happen at the meeting means that the young person can prepare his or her thoughts and ideas in advance. Thus, an organization that promotes meaningful youth participation helps make sure that a young person knows what is going to happen during a meeting, and further ensures that the young person has adequate support to prepare for the meeting. Specifically, such an organization ensures that…

- *In consultation with the youth, an agenda is formulated before the meeting.*
- *Adequate preparation is provided so that a young person has an opportunity to be supported through a process of thinking about what and how he or she wants to contribute to the topics on the agenda.*
- *Preparation includes an opportunity for the youth to formulate goals that will be part of the plan.*
- *Preparation also includes helping the youth plan to contribute to the meeting in whatever manner feels comfortable to him or her.*
- *The youth is supported in planning specific strategies he or she might use during the meeting to help stay calm and/or focused.*
- *Someone helps the youth figure out who can support him or her during the meeting and prepare that "support person" for this role.*

Running a Meeting that Feels Safe for Participation

Young people report that, during team meetings, they are often ignored, lectured at, and/or harshly criticized. To help the meeting feel safe, the team should agree to a set of ground rules, and the facilitator should be able to control the meeting in a way that ensures that people follow the rules. Ground rules should include the following:

- *All team members treat each other respectfully, the youth no less than others.*
- *Remain strengths-based and solution-focused.*
- *During the meeting, stick to the agenda that the youth has helped create.*
- *Make sure that everyone can understand what is going on.*
- *Speak in ways that don't alienate or hurt the youth.*
- *Be clear about exactly who is doing what to follow up on decisions made in the meeting.*

During the meeting, team members must act and interact in ways that ensure that the youth will have real influence in discussion and decision making. Thus, the tem should purposefully structure discussion in ways that provide multiple opportunities for the youth to express his or hers ideas or offer comments, even if he/she doesn't want to say a lot at any one time.

Beyond this, it is also important for the team to structure decision making in ways that support collaboration. Collaboration (with youth or with anyone else) is supported when people are able to keep an open mind and explore different perspectives and different options fully before making decisions about what to do. Thus, collaborative teams do not make decisions about solutions until they have had a chance to think carefully about what the goal, problem, or need really is. Furthermore, a collaborative and creative team will consider several different strategies to solve a problem or meet a need before selecting an option to pursue.

Holding Each Other Accountable

Finally, team members earn each other's trust—and accomplish their work—by following through on the action steps they commit to during planning. Seeing people follow through on their commitments to the plan is particularly important for young people who have been heavily involved with service systems. Often, these young people have experience with being let down by providers. Youth who have had input into decisions for a plan may be particularly skeptical, thinking it entirely possible that providers will be unmotivated to follow through on decisions that reflect a young person's priorities rather than their own.

Thus it is important for team members to hold each other accountable for carrying out the action steps that they commit to during planning. In order for this to happen, these commitments must be made clear during planning and they must be recorded. The team must also have a process for checking in later on to see whether or not team members have actually followed through.

How Are We Doing?

While a philosophical commitment to increasing youth participation in team planning is a first step, organizations and teams will not really know how well they are putting this philosophy into practice unless they gather some data. One straightforward way of doing this is through basic checklists that assess whether or not the steps, strategies, or structures that are intended to support youth participation were actually employed. Suppose, for example, an organization has agreed that a staff member will work through a series of activities with a youth before his or her first team meeting to prepare him or her for participation.

When these activities have been completed, the young person and the staff member can fill out a checklist together, affirming that each step in the preparation has been completed. When this basic fidelity checklist is completed, the staff member and the young person sign it, and the organization retains the checklist for its records. Similar checklists can be used to assess whether appropriate steps and structures to support participation have occurred during the meeting itself, and whether appropriate steps are taken to ensure accountability.

In addition to these kinds of process checklists, it is helpful for organizations to measure whether or not the processes and steps they are implementing are actually increasing youths' perceptions of participation and empowerment in their mental healthcare. There are various strategies for doing so. One is to collect simple post-meeting surveys that ask team members to rate the planning process in terms of its success in achieving youth participation. Organizations can also benefit by using valid, reliable measures for assessing par-

ticipation and empowerment. The Research and Training Center on Family Support and Children's Mental Health has created and tested measures designed precisely for this purpose.

- The *Youth Participation in Planning scale* (YPP) assesses youth perceptions of whether interdisciplinary teams that create service, care, or treatment plans support meaningful youth participation in the planning process. The YPP has 16 items on three subscales: preparation for planning, plan and process, and accountability.
- The *Youth Empowerment Scale—Mental Health* (YES/MH). Is designed to assess young people's perceptions of capacity and confidence with respect to managing their own mental health conditions, working with providers to optimize services and supports, and using their experience and knowledge to help peers and improve service systems.

More information about these measures can be found at www.rtc.pdx.edu, or by contacting rtcpubs@pdx.edu.

Conclusion

Agencies, organizations, or teams that are serious and ethical about promoting youth participation in planning must start with a systematic and intentional plan about the specific organizational strategies and practices that they will adopt. As they undertake this work, they should do so with the full participation of youth who are representative of those who will be participating on teams. In this way, the organization can select specific strategies that are appropriate for supporting the youth that are served.

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Wraparound Practice: Chapter 4c.4

Youth Involvement in Wraparound at the Organization and System Levels

Janet Walker, Co-Director, National Wraparound Initiative, and Research Associate Professor, Portland State University School of Social Work

As Marvin Alexander points out in Chapter 4c.1 of the *Resource Guide*, ensuring youth participation in treatment planning is only part of what it means for wraparound to promote youth voice. Youth voice is also needed as part of leadership and decision making at the program, agency, and system level. The Technical Assistance Partnership has produced a valuable guide to help youth and adults understand how to cultivate youth voice at these "higher" levels of wraparound. *Youth Involvement in Systems of Care: A Guide to Empowerment* is included in its entirety as an appendix to this *Resource Guide* (see Appendix 6e.3).

The Guide is organized into ten sections:

I. Youth Involvement: Moving From a Good Idea to a Necessary Solution

Youth involvement is a necessary solution to meet the needs of youth and families in systems of care. This chapter will provide you with the rationale for involving youth, including literature on the positive youth development approach and additional information providing support for youth involvement. Readers will understand how the power of youth participation helps to rebuild the community, fosters resiliency, and combats stigma around mental illness.

II. Who Benefits From Youth Involvement?

Everyone does. This chapter informs readers of the key

benefits from authentically involving youth in systems of care. It addresses benefits for youth, families, programs, organizations, planners, policymakers, and the community as a whole.

III. History of the System of Care Youth Movement

The history of youth involvement has followed a path similar to that of the Family Movement. This chapter highlights critical milestones of the Youth Movement.

IV. Advancing the Youth Movement: Establishing the Value Base

Advancing the movement requires an understanding and commitment to the values around youth involvement. This chapter will inform readers about these values and how to utilize them in climbing the ladder towards authentic youth involvement.

V. Getting Started: Hiring the Coordinator and Forming the Group

This chapter provides the blueprint for the steps necessary to develop a youth-directed group in systems of care. It will guide readers through the steps of hiring a youth coordinator and developing the youth group.

VI. Cultivating the Environment for Growing Leaders

Leadership development requires an environment of support and training. Youth and adults need to build partnership and understanding in order to foster a youth-guided system. This chapter will enhance the readers' understanding of what it takes to cultivate this type of environment and build partnership.

VII. Youth Involvement in Systems of Care: Making It Happen

How do you make it happen? Readers will be guided through examples of involving youth in every level of system of care development from developing a communitywide event to meaningful engagement on boards, to evaluation and social marketing, and working towards sustainability.

VIII. On the Horizon

Youth involvement is continuously evolving within systems of care. On the Horizon informs readers about upcoming developments, including the development of the National Youth Development Board as well as focus group studies conducted by ORC Macro on youth involvement in system of care communities.

IX. Resources for Youth Involvement

This final chapter provides readers with a resource list that focuses on various components of youth involvement.

X. References

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Wraparound Practice: Chapter 4d.1

Direct Support Services in Wraparound

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Direct Support services are the flexible, creative, community-based services that help put an effective wraparound plan into action. Broadly defined, they are individualized support services provided in the home or community by anyone, whether paid or unpaid, that cares about the family. For example, just as a paid support worker may help a child learn to purchase groceries and cook a meal, that same support could be provided by the child's uncle, a volunteer from the community, or anyone else that plays an important role in the family's life. However, for the purposes of this paper, the focus is primarily on paid direct support employees that help carry out the work outlined in a wraparound plan.

Wraparound as a Service or Process?

Debates often occur regarding whether wraparound is a team-based planning process guided by an underlying set of principles, or whether it is a set of services provided to a family. For example, some agencies advertise that they offer "wraparound services," yet those services may not be provided in the context of effective and creative team-based planning, or they may not be family-driven, strengths-based, or flexible. Other agencies may offer "wraparound facilitation" or care coordination, but do not have the flexible, community-based workforce to help implement the creative plans designed by wraparound teams. In order to provide helpful and meaningful support for a family, all of the following elements are important: a) creative, team-based planning, b) adherence to the ten principles of wraparound (as developed by the National Wraparound Initia-

tive), and c) a flexible workforce to help provide the support designed by the team.

Direct support services are needed in a system to support individualized, community-based practice. However, equally important to the success of community-based care is the tie to the values and process elements of wraparound. Families consistently report that home-based services alone, without grounding in the principles of wraparound, are of little use. Similarly, creative planning and quality needs identification may be less than fruitful without a flexible, community-based workforce to help implement the plans. For this reason, it is essential that direct support services are tied intimately with the wraparound process and that wraparound initiatives in a community include a strong component of direct support workforce development.

Overview of Direct Support Services

Direct support services (also known in some communities as direct services, home-based services, or community-based services) may be organized in a variety of formats, but those that are most effective share a set of important values, regardless of program configuration. The following are the six core values of direct support services:

1. *Direct support services occur in the home and community, not in the office.*

Less Effective Example of this Value: A direct support provider agency operates by default out of its clinic office, providing a variety of classes and groups for children to attend. They do not have employees that work in the community due to concerns about liability, insurance, scheduling inefficiency and transportation costs.

Effective Example of this Value: A direct support provider agency works entirely in the homes, schools and neighborhoods of the children and families with which it works. The agency has made the adjustments needed to provide services in this context because it believes this is where services are most needed and helpful.

2. *Direct support services are commissioned by a family-driven collaborative team, such as a wraparound team, which helps define the needs to be addressed through the direct support services as well as the frequency, duration and time of delivery.*

Less Effective Example of this Value: A case manager, without the involvement of the wraparound team, requests services from a direct support provider. That provider, independent of the team, meets with the family to develop a service plan. The provider never works with the wraparound team to identify the needs that should be addressed through direct support.

Effective Example of this Value: A wraparound team identifies that it would like a direct support provider to help a young man explore his career interests. The team commissions a provider to accompany the young man to a variety of places in the community, where he can gain experience learning what is involved with various professions in which he thinks he may have an interest. These include places such as a blacksmith shop, an attorney's office, a dairy farm and an accountant's office. The team asks the provider to report back after doing these activities.

3. *Direct support services are individualized to the strengths and culture of the child and family rather than delivered as a scripted or pre-packaged set of services.*

Less Effective Example of this Value: Despite the wraparound team's request to work with a youth on career exploration, a direct support provider tells the team that they cannot do this because they do not have a career exploration program. (There has not been enough interest in the community to develop one.) Instead, they want to

include the youth in their social skills and public transportation curriculum.

Effective Example of this Value: Rather than having a pre-set program, the direct support provider listens to what the team needs and develops the services based on those needs. The direct support provider arranges visits to each of the career exploration places in which the youth is interested and helps the young man come up with the types of questions he would like to ask at each place. Arrangements are made to allow the youth to help with some activities on site at each place to get a feel for each type of career.

4. *Direct support services are geared toward helping children live in the community rather than in institutions or congregate care settings.*

Less Effective Example of this Value: Upon receiving a referral to help a youth transition home from a treatment center, the direct support provider learns of his challenging behavior and declines the referral, saying he needs to spend more time in the treatment center becoming stable before they can help him.

Effective Example of this Value: A direct support provider works with a young man who, without intensive support, would not be ready to leave the treatment center at which he resides and live again with his family. The young man has some very challenging behavior, such as running away, punching people when he is angry, and making threats of violence using weapons. The provider works closely with the team to develop a comprehensive safety plan and does what it takes to put the plan into action and help the child return home, knowing there will be difficult challenges ahead behaviorally.

5. *Direct support services are provided when the family needs them most and in the frequency and duration needed by the family, rather than having pre-determined, program-driven time slots, frequencies or durations.*

Less Effective Example of this Value: A direct support provider tells a team that it cannot meet its request for services because the request is for three hours on a Saturday. The provider explains that the agency only works Monday through Friday from 8 am to 7 pm, and that the services must be ordered in four-hour segments, so as to not interfere with the agency's scheduling pattern. Additionally, the agency's program calls for visits twice per week for a duration three months.

Effective Example of this Value: A direct support provider has no arbitrary structure that limits the frequency, duration, time of day, day of the week, or length of participation in support services. Services can be configured in any manner needed by the wraparound team.

Direct support services are provided when the family needs them most and in the frequency and duration needed by the family, rather than having pre-determined, program-driven time slots, frequencies or durations.

6. *Direct support services are based on positive actions and opportunities. They are provided using an approach that builds on capacities and strengths, opportunities to participate in activities that are important to the child and family, chances to make choices and learn from mistakes without criticism, activities that promote dignity and respect for the individual and family, and opportunities that help an individual practice (rather than just talk about) living a life full of dignity and respect in the community. Direct support services avoid punishment, behavior level systems, ultimatums, coercion, removal of opportunities to participate in the community, and criticism.*

Less Effective Example of this Value: A direct

support provider is working with a child who says something disrespectful to a peer. In front of the peer, the support worker corrects the child by saying, “Stop speaking disrespectfully to your friend (a verbal punishment).” When they get back to the house, the support worker relates the experience to the child’s mother and recommends that he not be permitted to attend his sister’s graduation the next week because of the behavior.

Effective Example of this Value: A direct support provider is working with a child who says something disrespectful to a peer. Rather than embarrassing the child by directly correcting him in front of friends, the support worker ignores the disrespectful comments and models a positive comment to the peer. The worker then searches for the next possible opportunity to notice something respectful that the child says, and when he does, the worker immediately provides a wealth of attention and positive feedback regarding the respectful comment. The provider engages the help of the entire wraparound team to systemically provide positive feedback every time anyone notices the child acting respectfully.

Which Services Are Direct Support Services?

Questions sometimes arise as to whether a particular type of traditional service, such as counseling, is a direct support service, if it adheres to the six values of direct support, or whether direct support only includes certain services such as peer mentoring, respite and skills training. The answer depends on the degree to which the service in question is congruent with the core values of direct support. For an example, consider the examination of the service, family counseling, in Table 1.

This same analysis may be conducted regarding services that are often, without second thought, classified as direct support services, such as a peer mentoring. However, if the service does not adhere to the core values underlying direct support, it may be that the third example of family counseling cited above is more of a true direct support service than the peer mentoring, despite the service titles. Consider the examples in Table 2.

Table 1. Family Counseling as Direct Support

Service	Context	Direct Support?
Family Counseling	Provided in the therapist’s office, focused primarily on sharing feelings and talking.	Not a direct support service.
Family Counseling	Provided in the family’s home, conducted seated around the living room table, focused primarily on sharing feelings and talking.	Debatable, but may not be if focused on talking rather than on actions and activities or if driven by the professional in terms of content, duration and frequency.
Family Counseling	Provided in the family’s home at the time requested by the wraparound team (Friday night after dinner), focused on the needs identified by the team (relationships in action) as the family does yard work together. The counselor helps two siblings weed a flower bed collaboratively and supports the mother in her role as parent by helping her direct the activity.	Most likely could be considered a direct support service.

Table 2. Peer Mentoring as Direct Support

Service	Context	Direct Support?
Peer Mentor	Provided at the clinic office with a group of other youth, focused on psychoeducational materials regarding impulse control, based on a theory of depriving youth of community-based activities as a consequence for lack of impulse control.	Probably not a direct support service.
Peer Mentor	Provided in the community at a horse stable owned by a friend of the peer mentor because "all youth could benefit from interactions with horses" and because the peer mentor likes horses.	Probably not a true direct support service because it is based on the interest of the peer mentor, is not individualized, and does not tie to a need identified by the wraparound team.
Peer Mentor	Provided in the youth's neighborhood, helping him start a pick-up game of basketball at the park, with the focus on learning to make friends (an area of need identified by the wraparound team).	Definitely a direct support service

Keeping Children in the Community

A primary focus of direct support is helping children live successfully in the community rather than in institutions or congregate care settings. Direct support services play a critical role in preventing out-of-home placements and returning children from out-of-home placements.

Because direct supports can be used in so many different configurations, it is important for the wraparound team to identify the needs of the family related to the risk of out-of-home care. While safety is often identified as a reason for seeking out-of-home placement (either safety of the individual, siblings, parents, or the community in general), it is often not the only, and sometimes not even the primary, underlying need, despite initial presentation. Consider the following examples:

Example 1: A young man was placed in a treatment center because he physically attacked his siblings and parents when angry, sometimes causing injury. However, upon closer examination, the wraparound team found that he did not have aggressiveness in any other setting, and the young man's mother explained that there were significantly strained relationships at home affecting the family's interactions. Therefore, the primary focus for support services upon return to the home was not simply physical protection of others in the home. Instead, it was upon family relationships and interactions.

Example 2: A twelve-year-old girl was hospitalized for cutting herself when sad. The hospital was reluctant to send her home without someone to monitor her situation 24 hours per day to ensure she would not cut herself. However, the wraparound team viewed the primary need of the girl to be positive attention and activities rather than simply preventing self-harm. Spending a few hours a week with a mentor from her church as well as paid direct support mentors for a few hours several times per week helped create an environment where she could safely live at home. The team reflected that simply monitoring her for cutting activity would have never addressed her primary need, and therefore may not have sufficiently addressed the safety issue.

The reasons for risk of out-of-home care may be as varied as the number of people participating in wraparound. They may include the need

for a break for a parent, employment or financial needs, impulse control, boredom, lack of friendship, need for positive attention, strained sibling relationships, or a number of other needs. Effective wraparound teams help discover the types of support that will address the underlying needs of the family rather than simply employing one-to-one monitoring services.

Once the needs are identified, direct support providers may be commissioned to help address them through community-based activities such as mentoring, modeling, living skills training, positive behavior support, respite, peer support, family support, or a variety of other activities.

What Families Have to Say About the Value of Direct Support

The following quotes regarding the value of direct support come from families who have been recipients of direct support services (some details have been changed to protect privacy).

- "My child's direct supports, which we refer to as his "coaches," are his teachers in life skills; manners, personal care, chores, taking responsibility for his actions, kindness, self-control, and even in helping him in nurturing his relationship with God!"
- "My son participated in soccer last winter through the YMCA and that was quite an accomplishment, even though there were a couple of times we had to leave in the middle of a practice or game. Because of the help of direct support services, it was the very first time he was able to participate in a group activity. He is learning to ice skate, bowl, and ride a dirt bike right now."
- "I would not even be here had we not been recipients of direct support services because we wouldn't have a story with a happy ending in sight to share."
- "He was kicked out for bad behavior of every single day care setting we placed him in and we had to remove him from the mainstream school setting because he could not function in an appropriate way to get him to behave for any length of time... I was even asked to keep him from his church Bible study and remove him from the children's choir; this also meant that I couldn't attend Bible study or church either. Our direct support services worked with him at his school, and slowly his grades and behavior started improving. Now he is in a mainstream classroom. They also attended church, Bible study and choir with my son, helping him integrate back into our regular community activities. Now, I can attend church again as well."
- "My daughter had no friends at school, church, or in the neighborhood, and even family members didn't want to be around us for long periods of time. No one would baby-sit; so I was exhausted, frustrated, and felt very isolated. Direct support services helped me get a break, find some hope, helped my daughter make and keep friends, helped us find babysitters who could work with her, and helped us reconnect with my extended family."
- "If direct support services were not involved, my children would no longer be in my home and I would have to deal with that guilt. I've been married 14 years and we've had a wonderful marriage. The children were taking up so much of our time and energy that we only saw each other in passing and under stress. It's been so much better than it had been. We all learn from each other."
- "Life is much better now. Like before, my daughter used to throw a tantrum when we went to the store and she wanted something I couldn't buy for her. Now, she doesn't throw a tantrum. Now I can take her out to public and stuff; it is much better."

Examples of Direct Support Provision

Some people ask for examples of the types of direct support that have helped children and families. Because each situation leads to a unique configuration of support that is tailored to the interests, strengths, needs and culture of the family, it is impossible to list all of the different examples

of direct support. In addition, as discussed earlier, direct support is not simply a list of service categories, such as respite or living skills training. Please consider the following examples of direct support to be illustrations of some of the possible configurations of direct support, rather than as a comprehensive listing.

- An eight-year-old boy struggling with impulse control loves trains. His direct support worker takes him to the library to learn about trains and to a train park to watch the trains in action. Together, they create a train book that shows a variety of the boy's favorite trains. The book shows how a train is slow to get started as well as to slow down. This framework is used with the boy in his response to impulses, using the language of a train slowing down or starting up.

- A direct support worker accompanies a young girl to her Girl Scout troop, which she would not otherwise be able to attend due to behavior struggles. The worker helps the girl transition into the group setting and helps others in the troop understand how to interact effectively with the girl.
- A direct support worker helps a sixteen-year-old boy research recipes that look good to him and create a shopping list of items needed to prepare the recipes. Together, they go to the local grocery store to find and purchase the items. They bring the items back to the home, cook them together, and serve the meal to the boy's family.
- A direct support worker helps a teenage girl prepare a resume that highlights her skills and attributes effectively. Together, they collect job applications and complete them, attaching a resume to each. They practice how she will introduce herself to a prospective employer, how to have a phone conversation following up on the application, and how to dress for and participate in the job interview.
- A young boy, struggling with self-image partially due to weight issues, participates in a number of physical activities with his direct support worker, such as soccer, basketball and jogging. The worker helps the young man learn to organize a pick-up game in the neighborhood, and models handling insults from peers without taking them personally.
- A direct support worker helps a young woman create an appreciation card for her mother, with whom she has a strained relationship. Together they practice what she will say to her mom as she gives her the card and how to be prepared to respond positively to a number of different responses she may receive.

Note that in the examples above, an important consideration is the needs being addressed by each activity, not simply the activity itself. For example, the same activity (such as going to a movie theatre) may be carried out to help with a number of different purposes or needs. A direct support worker may take a child to a movie to practice social skills in public, or to have a positive interaction with a distant sibling, or to learn about an important life skill being taught in a particular movie, or as a reward built into a structured incentive system, or simply to give his or her parent a break. In order to understand direct support service activities, one must know the purpose behind the activity, not just the activity itself. This concept is discussed in more detail in the section titled "Purposeful Support."

Coordinating Through the Team

As mentioned earlier, the wraparound team identifies the need for direct support services, finds a direct support provider which it commissions to do certain tasks, monitors progress and communicates with the provider on a regular basis, adjusts the plan based on the results of the service provision, and makes decisions about how to transition the child and family away from paid direct support services when goals have been met. The following section provides information about each of these roles of the wraparound team.

Identifying a Provider: The facilitator of the team considers whether direct support services would help meet one or more of the needs identified by the team. The facilitator ensures that the team has relevant information and makes an informed choice regarding the different sources of direct support available, including natural supports, community supports and paid direct supports. Some teams choose to invite prospective providers to team meetings in order to learn about the approach of the provider and determine the goodness of fit for the child and family. An essential role of the team is to determine whether the direct support provider operates according to the six principles of direct support outlined earlier. Prior to meeting with potential providers, the facilitator helps the team consider questions such as the following: "What are we asking the provider to help with?", "What availability are we seeking (days of the week, times of day, frequency, etc.)?", and "What can we ask the provider to help determine if it is a good match for our needs?"

Commissioning the Provider: Once a provider has been selected, the team commissions the provider to do certain tasks based on the needs of the family. Experience shows that when this step is missing, providers often get involved without knowing exactly what the team and family want them to be working on. This may result in inefficient use of resources. The provider must understand that it works for the team and that it needs to report regularly to the team. This means that the team may help define its role and the expectations associated with it. It also means that the team makes the decision to end the provision of support.

Monitoring and Communicating Progress: The team regularly monitors the progress of the direct support work. This may be accomplished by having the support provider attend team meetings in order to report, by submission of regular written reports or data collection, or by a combination of these methods. The section of this paper concerning outcome measurement contains additional suggestions for tracking, reporting and using information obtained by support providers.

Adjusting: The team often needs to adjust the approach to support provision. This may be indicated by the data collected from outcome measurement, or it may simply be at the request of the family or another team member. Adjustments to support are common and expected in direct support provision in a wraparound context. At a provider level, the company should be prepared to be asked to do things differently, provide alternate support workers, or otherwise make adjustments. At a team level, members may consider how to best adjust the current configuration of support, how to supplement the support with other sources, or even how to replace the support with another provider if it is not working.

A key responsibility of the team is to work toward independence by trying to use less paid direct support over time and more natural and community resources.

Working Toward Transition: A key responsibility of the team is to work toward independence by trying to use less paid direct support over time and more natural and community resources. However, this does not happen automatically. It requires consistent effort by the team and should be a regular part of consideration when a team is using a direct support provider. This may be an area of fear or concern for some families. They

may have experienced services being pulled from them without warning in the past, they may worry friends or community members would be unwilling or unable to provide the type of support needed, or they may have a number of other concerns about discussions toward transition of support. However, rather than bypassing discussions about support provision, teams should listen carefully to all the concerns of the family and create a safe place for them to be expressed. It is a careful balancing trick to transition support effectively and respectfully. However, teams have an obligation to their community to use resources effectively. Because no community has unlimited resources, every hour of paid support consumed means another child or family elsewhere is doing without. Therefore, teams should seriously consider the need to transition the amount and type of support provided over time, always respecting the opinions of each of the team members, particularly the family. The trap many teams fall into is waiting to discuss transition of support until late in the process or choosing not to even consider the need to transition support for a particular child due to fears about the implications of such discussions. This is an area that requires a great deal of diplomacy, respect and honesty, and it is a significant part of creating a community where the needs of as many families as possible can be addressed.

What If There is Not a Team in Place?

Sometimes a direct support agency may receive requests to provide support when there is no wraparound team in place, or when there is a team, but it is not functioning well. In these cases, the direct support provider may play an important role in helping form or improve the group planning process, even if informally. For example, the direct support worker can help the team consider the types of activities desired from the direct support agency, helping them explore interest, strengths, needs and culture. Or, the direct support worker may help organize the people that care about the child into an informal team in order to make sure everyone is working together to help the child. Rather than refusing to participate unless there is a high-quality wraparound team in place, a strong direct support provider agency will jump in and help the team process along.

Individualizing Support

As mentioned above, direct support services are tailored to fit with family needs, strengths, interests and culture.

Sometimes, these areas have been identified by the team prior to the referral for direct support services. Other times, the direct support provider must play a more active role in helping discover and build consensus around these areas with the family and the team. A direct support provider may use tools, such as a functional behavioral assessment, to help discover these and other areas important to conducting quality positive behavior support. Such an assessment is often requested by the team of the direct support provider when particularly challenging behavior is present. The following areas are often parts of a functional behavioral assessment:

- Family story, elements of family culture
- Presenting behavioral needs or concerns
- A deconstruction of the context of the behavior:
  - Slow (setting events) triggers
  - Fast (antecedents) triggers
  - Specific descriptions of the behavior when it occurs
  - Consequences being experienced as a result of the behavior (note: consequences do not mean punishments—they are simply the “what happens next” that follows a behavior)
- Relationships
- Choices map (what choices the individual is allowed to make in various contexts)
- Behavior that develops respect and positive reputation
- Behavior that detracts from respect and positive reputation
- What works for this individual
- What is known not to work for this individual
- Recommendations for consideration in support planning

Support Planning

Once needs, strengths, culture and interests have been identified, the team begins planning the support. In some instances, the entire wraparound team is part of developing the support plan used by the direct support provider. At other times, the team simply commissions the direct support provider to develop the specific support

plan with the family based on the needs identified by the team and report back to the team regarding the plan development.

In either case, the direct support provider plays a key role in developing a plan for individual support based on all available information and materials, with special consideration to the functional behavioral assessment, if one has been conducted. The support plan may take a variety of formats, but some of the universal elements are the following:

1. Goals of support provision, as stated by the family
2. Needs of the child/family underlying the identified goals
3. Strategies/activities to be conducted by the direct support provider, answering the specific "who, what, where, when and how" questions associated with the plan
4. Measurement of progress—how the progress toward the goals will be measured

Support planning involves consideration of both prevention and reaction. Prevention planning is similar to crisis planning in wraparound because it identifies what could go wrong and what can be done to prevent concerning behavior from occurring in the first place. Planning also needs to focus on how to react if the challenging behavior does in fact occur. Direct support providers may ask questions such as the following to help develop an effective prevention plan:

- What adjustments to the setting/context could be made in order to prevent the concerning behavior from ever occurring in the first place (without criticizing or blaming any member of the team, especially the family or child)?
- Which activities are most likely to help keep the concerning behavior from occurring, and how can we get all the members of the team working together to use these types of activities uniformly?
- How do we integrate what we have learned from the functional behavioral assessment into the prevention plan (such as what works/doesn't work)?
- What signs show us when things are starting to get concerning for the child (such as mannerisms, words, etc.).
- What can be done when things start to escalate, and in what way can we uniformly implement them as a team?

Provider-Side Individualization

We have discussed various ways a wraparound team can work with a direct support provider to individualize support services. There are also important considerations solely on the side of the direct support provider that help tailor the support to the individual and family. For example, the provider must consider which of its staff members best match the request for services and how to mobilize those individuals to meet the support needs.

While this may appear to be a simple task, in reality it is full of challenges. For example, smaller agencies may have a more difficult time finding an ideal match for a particular child. While an agency with 50 support workers may be able to

find within its ranks a male support worker from an African nation who plays basketball (an actual request that came to a support provider from one wraparound team), an agency with only five employees will be far more restricted in being able to do so. Nevertheless, finding the best match possible for each child is critical to success, so direct support providers must do whatever they can to help find the best match possible.

Prevention planning is similar to crisis planning in wraparound because it identifies what could go wrong and what can be done to prevent concerning behavior from occurring in the first place.

One option providers may use is recruiting and hiring specifically for an individual or family. Some providers have the family help interview the prospective employees who would be hired to work with their family. However, a challenge to this approach is it takes some time to go through the hiring process in order to find the right person, and there may be challenges associated with human resources laws in specifically targeting specific ages, races, genders, and so forth.

An important aspect in finding the best match for a child and family is knowing the attributes, skills and interests of the employees of the support provider organization. If a request arises for a worker who loves crocheting and softball, yet the company has no idea what the particular interests and skills are of its support workforce, the company severely limits its ability to provide the best match possible for the family.

However the right match has been identified for a particular child or family, there may still be challenges ahead in deploying that worker. For example, most agencies cannot afford to have workers sitting by idly waiting for the request to come along for which those workers would be the perfect match. Instead, typical agencies have most of their workforce busy working in the field on a continual basis and have openings of availability only when families transition out of service or when new hiring occurs. Perhaps a request comes for a support worker from an African nation who is a young male and loves basketball and the organization has just the employee in its workforce. However, that employee is currently working to capacity with a young man with who has had tremendous success and who would likely experience difficulty if an abrupt transition were to occur to accommodate the request made by the new referral.

This is where creative management of the direct support agency becomes critical as there are often no easy answers when trying to find the best matches possible for youth. The provider may consider some of the following questions:

- Which child would benefit (or be harmed) more from working with (or not working with) this particular support worker?
- How can we meet both needs at once? For example, spending less time with the first child than the worker is currently, and less time with the new child than the request specifies, and supplementing the remaining time with additional workers for both children.
- How can we find another worker who will meet the needs equally well?
- What can be changed about the context to reduce the degree to which a particular person is needed? For example, could a relative of the child fill some of the cultural and social needs, while a paid support worker fills other needs?

Purposeful Support

Even when a team has masterfully outlined needs, strengths, culture, a functional behavioral assessment, and a detailed support plan, direct support providers face the challenge of ensuring that the support is carried out as planned, with consistent, purposeful interactions. While the team may be experiencing the vision of what the

support worker should do, sometimes the support worker, for a number of reasons, may experience challenges catching the same vision.

One reason this may occur is the support worker is the one working each day with the family. Theoretical progress and activities may be difficult to translate into daily interactions, especially across an entire visit with a child or family. For example, the worker may understand that the team would like him to take a child grocery shopping in order to gain real-life experience in independent living. However, if the worker is scheduled to be there for five hours and the shopping only takes one, the worker may wonder what to do the rest of the time. One temptation is to just "hang out" the rest of the time. Another may be to leave earlier than planned. Another may be to create forced learning opportunities falling back on tradition psychoeducational techniques so as to not "waste the time."

Again, there are no easy answers in this scenario, and quality supervision (discussed in the next section) is perhaps the best answer to this situation. What if that worker were part of a 24-hour safety network helping keep a child safe in the community and the provider agency had committed to the entire five hour period with the child? The answer of leaving early would not be acceptable (nor would it be for a number of other circumstances, some as simple as the family is counting on the support worker to be with the child until the agreed-upon time and has built its plans around that commitment). Support workers must be prepared ahead of time to think about what to do throughout their entire time working with a child and family, even when the unexpected occurs. A constant dialogue within the worker's head should occur, processing the following question: "Why am I doing what I am doing right now?" The answer to that continual question should always be "Because it relates to the goals, needs, and plans for this child."

If direct support regresses into simple "hanging out" without a clear purpose, much of the benefit of the support may be lost. But what about if the purpose of the support is companionship and mentoring? The answer is the worker would know and constantly be considering that this is the purpose of the support that day. A breakdown occurs when everyone else on the team thinks the support worker is working on social skills in the community, while the support worker himself thinks he is simply spending time to build rapport. What could otherwise be remarkable progress toward goals may instead turn into months of stalled progress.

Consistent, purposeful support is perhaps the single biggest challenge for an effective direct support provider agency. Significant amounts of energy in the form of training, supervision and constant encouragement may be required before an agency is successful in having a support workforce that is providing support in this manner. One clinical director at a support provider agency is famous for having employees always on their toes prepared for his question: "Why are (or were) you doing what you are (were) doing?"

Supervision of Support

In many professions, direct supervision is a key factor in the quality of product or service provided by the company. In the field of direct support, this could not be more accurate. Consider the following critical roles a quality supervisor plays in a direct support provider agency:

- **Knowing where support workers are at any given time.** This helps reduce the chance of their getting hurt and reduces the chances of their doing something that will be harmful to the child or the agency. One significant concern people often have about running a direct support agency is

how they will know what all those employees are doing out there in the field. Supervisors are a key to knowing this information.

- **Instilling the culture of the company.** Despite what a company teaches in new employee orientation or claims in its mission statement, it is the day-to-day interactions with a supervisor that teach employees what is the true culture of the agency. This is the way effective direct support agencies instill the six values of direct support into their operations and their workforce. For example, a supervisor who emulates the values of positive support and strengths-based practice with a support worker, despite a variety of challenges that worker may be facing in the work, helps that employee learn to think in a positive and strengths-based manner each day, even when times get tough.
- **Clinical guidance.** While direct support may be a less traditional form of clinical service, it is clinical nonetheless, and therefore requires quality clinical guidance and support. In this context, clinical means that the services help provide assistance for challenging behavioral circumstances for a child and family. Because direct support workers are often behavior technicians and paraprofessional level employees, the amount of clinical support is often more than in a traditional outpatient clinic setting.
- **Consistency for the family and other agencies.** Especially when multiple support workers from a single agency work with a single family, a supervisor plays a critical role in providing cohesion and consistency in the support provided. The supervisor often acts as the liaison between the family and the support agency, as well as between the wraparound team including other stakeholder agencies and the support agency. Quality supervision helps provide a more consistent experience with direct support for families and other agencies.
- **Handling the complexity of flexibility.** The more an agency is flexible in its response to requests for support, the more complex running the agency becomes. Supervisors play a critical role in helping families get the amount of support they need from the best match of support workers possible, while also helping support workers get the help they need finding enough hours of work to sustain their employment and handling the inconveniences they sometimes experience by providing flexible support. For example, if an agency's best match for a child is an individual who lives two hours away, this creates challenges for that employee if the agency chooses to deploy him or her in that role. Supervisors need to maintain an awareness of the needs of the direct support workers and communicate these to other management staff. Some agencies choose to place some supervisors over direct support employees and appoint others to coordinate the support with families so that they can help assure that the needs of both get addressed.

Program Models of Direct Support

The first step in having an effective model of direct support is not to have a model at all. This may sound extreme and unorganized, but program models often interfere with a direct support provider agency's ability to be flexible and meet the needs of the family. For example, if a program pairs a master's level clinician with a bachelor's level technician as a support team for all families, this may be helpful for some families, but it also may be a hindrance for others. If the provider model is that the support workers make two one-hour visits per week to the home, but the family needs five six-hour periods of support, conflict between family need and program models occur again.

Perhaps the best program model for a direct support provider is to do whatever the wraparound team needs them to do. Whether one support worker coming to the home once per month or whether six support workers coming every day, the team knows best what a family needs and a support provider's job is to help the team meet their

needs. Of course, a team may combine the support from a variety of provider sources, including the natural and community resources of a family. However, this should not be reason for a provider to develop limiting program structures. Instead, direct support providers may be most effective when maintaining as flexible program model as possible.

Having a flexible program model does not mean the organization should lack structure. As discussed earlier, the more flexible the organization, the more complex the management of the company. Therefore, flexible providers actually require higher degrees of structure and support. Flexible program structure with inadequate supervision and protocol structure is a recipe for disaster. On the contrary, organization and quality administrative structures and processes help support the greatest degree of flexibility possible for a support provider.

An effective support provider develops tools and reporting mechanisms to help measure, monitor and report behavioral progress.

While there is room in a community for support providers that specialize in the provision of a single type of support service, such as respite, or that work with a specialized population, such as children using substances, it is important that there are support providers available that use more of a "generalist" model of support. Generalist providers work with children of any age and with any type of presenting situation. They mold their support entirely around the needs of a family. It may be difficult to keep children living in the community safely without access to the services of a generalist support provider because support needs do not occur in isolation (a child who uses substances may require a variety of types of support) and it would be extremely difficult to predict and organize a community consisting exclusively of specialty providers. This concept is similar to the reason grocery stores have evolved into supermarkets. It simply did not work for families to have to make separate trips to so many different specialty stores to get what they need in the current busy lifestyle.

Although helpful for the effort to keep children in the community, operating under a generalist direct support provider approach is challenging for the support provider as it requires greater degrees of flexibility, supervision, consultation on specialty topics, and insurance protection. For example, a generalist provider could be used to work with any specialty behavior challenge such as gang involvement, sexual offenses, or eating disorders. However, the provider will need to bring in specialized consultation in the presenting subject to help orient and train the support workers in the approach to use with the particular specialty topic.

Measuring Outcomes

One of the most challenging functions of a provider organization is agreeing on and using outcome measures. However, without measurement and reporting of outcomes, progress is less likely. Therefore, an effective support provider develops tools and reporting mechanisms to help measure, monitor and report behavioral progress.

The starting place for outcome measurement is establishing a baseline. This does not have to involve complex university-level statistics. Instead, it may be as simple as plotting on a chart how often a child wets the bed or threatens his sibling for one week and using the average as the baseline. Each team should work with the direct support provider to develop agreed-upon baselines for the behavior for which the help of the support provider is sought.

A common temptation is to measure negative behavior. For example, the situation above describes measurement of the frequency of bed wetting or threatening behavior. However, that measurement could easily be reversed to measure how often the bed is kept dry or days of positive interactions.

Another pitfall of outcome measurement is stating the measurement in terms of the absence of a behavior. This is sometimes called the "dead man's rule." In other words, never describe the

behavior you are trying to monitor in terms of something a dead man can do. For example, if the goal were "Tom will stop lying," this is something a dead person could do, because it is simply the absence of a behavior. Additionally, "Justice will refrain from hitting and biting peers" is something a dead person could do. Effective measurement states goals in terms of something a living person could accomplish. For example, "Tom will tell the truth" or "Justice will keep her hands (and mouth) to herself."

A third trap of outcomes is being too general. Both examples listed in the preceding paragraph would be difficult to measure because they are not specific enough. The support provider must work with the team on making the measurement as specific as possible. One way to do this is to ask how we will know when the behavior being measured occurs. For example, "Justice will keep her hands to herself during her school class as evidenced by observation from the teacher and the support worker."

Once a specific statement relating to the behavior has been created, a system for tracking the measurement is easy to develop. For the example of Justice keeping her hands to herself, for example, a simple form could be developed for the teacher and support worker to mark each 30 minute period in which Justice does indeed keep her hands to herself.

The information tracked by team members, including the support workers, on a day to day basis will require some form of organization in order to be meaningful. Teams may organize the data into scatter plots, histograms, narrative reports, or many other formats. The critical element is that the information is compiled so that it can be considered by the team.

The team uses the complied information to consider the progress being made and to make any needed adjustments to the plan. For example, one team decided to help encourage positive playground behavior for a child by using a peer his own age as the intervention source (the paid support worker helped the peer to develop and implement strategies to help the student). Weeks later, the data showed no improvement in social behavior on the playground. The team decided to modify the approach by having the paid support worker interact directly with the child, and weeks later the data showed significant improvement. This was not the only option available to the team. They could have stayed the course with the current plan, modified the approach with the peer, found a different peer, or any number of different options. The important point is that the team reviews the data and makes decisions about how to modify the approach.

Agency Outcomes

Effective support providers are interested in the feedback of youth and families regarding their services and provide a manner for them to comfortably provide input that helps shape the company. Whether this information is sought directly by a company employee or by a third party (such as a local family organization), keep in mind the following considerations:

1. *Families may fear they will lose their services if they report negative information about a direct support worker or agency.* Create an environment where they can share concerns openly while reducing this fear as much as possible. For example, the agency may use a third party to collect the information, allow anonymous feedback, or provide a statement that the information will only be used in the aggregate.
2. *Make changes to the agency based on the feedback*. Do not simply collect the feedback and place it on a shelf. This is not respectful to the families contributing the input.
3. *Consider using a peer or family member to collect the input from families.*
4. *Before relying extensively on electronic media to collect input from families, keep in mind they may not all have access to it, or even if they do it may not be a preferred communication method for them.* Consider at least offering alternatives to electronic submissions.
5. *Be considerate. Do not take too much of a family's time with a burdensome survey or try to collect the information too often.* The experience should be geared toward the family rather than the benefit of the

agency. Do not leave a survey for a family to complete without providing an envelope and stamp. Consider providing a small gift for families that complete surveys that is not tied to their answers.

How Are Direct Support Services Funded?

Direct support services may be funded using a number of different methods, ranging from private pay services in the community to public sector social services such as those provided by Medicaid. As evidence grows concerning the benefit of community-based direct support services, more funding methods become available.

One funding model for direct support is a fee-for-service arrangement, where services are paid on an hourly or daily basis for the work performed. These arrangements may be helpful to a direct support provider because they ensure the agency will be paid for every hour of service performed. However, a challenge with this model is it may be difficult to predict the amount of support that will be purchased over the course of a year, and cash flow is often delayed as agencies try to collect payment following the provision of service.

Another funding model is block purchase with encounter claims. In this model, a contract with the direct support provider specifies a desired amount of funding for a period of time (such as a year) and an anticipated amount of direct support that will be provided in return. The funding amount is typically divided into equal payments over the course of the contract period and paid in advance to the provider. The provider earns credit back toward the funded amount through the provision of services, but adjustments for delivery under or over the contracted amount are not made each month. Instead, the equal payments continue month to month and adjustments in service provision are made to ensure that the provider earns credit for the amount of funding that has been provided. This model provides a cash flow advantage for the direct support provider and helps the agency plan regarding utilization across the contract period. However, this approach also carries some risk. If the amount of funding is not earned by the provider, it often must be returned to the contracting agency, regardless of whether that money had been spent. In addition, when a provider accepts too many referrals and provides work above and beyond the contracted amount, the provider does not necessarily receive additional funding for those services. This is part of the tradeoff in a block funding arrangement: The provider must closely manage spending, capacity and encounter claim value.

Conclusion

Direct support is one of the most critical aspects of helping children live safely and successfully in their own communities. However, effective direct support that operates according to the six values of direct support outlined in this paper may be difficult to operationalize. Therefore, it is important that communities carefully consider the needs they have for direct support service capacity development and devote the resources required for successful creation and support of these essential services.

Author

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Wraparound Practice: Chapter 4d.2

The Role of the Clinician Employed in a Wraparound Program

Debra Manners

How does a clinician become a valuable contributor to the wraparound process? Many wraparound providers struggle with the fit between a support perspective and clinical focus. At Hathaway-Sycamores, we have defined a new role, the Wraparound Clinician, who works exclusively with child and family (wraparound) teams. For clinicians to be successful in this role, they need to transform their participation from a traditional clinical role to a community-based and family-centered practice approach. When this transformation occurs, the wraparound project can successfully integrate all perspectives effectively and efficiently.

Recruitment

Defining the role of the Wraparound Clinician begins with recruitment. The role requires that the applicant be licensed or eligible in a behavioral health field. Not all applicants will be a good fit for the job, however. For example, many clinicians seeking employment are looking for an agency that allows them to practice independently and provide an "outpatient" approach akin to a private practice. In contrast, the Wraparound Clinician is a team player that must interact, consult, and collaborate not only with youth and families but with other professionals as well. In many wraparound projects, licensed clinicians have a hard time accepting that they are one among equals on the treatment team and providing services alongside staff in the community and in family homes. Another qualification required is to have the critical thinking and communication skills that are needed in order to act as a "bridge" or translator between the strength-based, needs-driven, family-centered wraparound process and the Medicaid planning and billing processes that are built around a medical model of men-

tal illness. When recruiting for a clinician to enhance wraparound operations, it is important to assess the applicant's values, beliefs and clinical approach to assure a fit with wraparound principles. Key attributes in the selection process are skills such as maintaining a non-judgmental attitude toward families, engaging and working with others from diverse backgrounds, appreciating the various training and life experiences of other staff, and reaching agreement without needing to prevail as the expert.

When recruiting for a clinician to enhance wraparound operations, it is important to assess the applicant's values, beliefs and clinical approach to assure a fit with wraparound principles.

Conducting the initial interview in a group format and including a parent partner sets the stage for collaboration. One technique utilized is to assess the applicant's response to the question, "the worst home is better then the best placement." In the applicant's response, their values and critical thinking skills become obvious. Having a conversation about this question is an opportunity to assess the applicant's ability to provide non-judgmental, family-centered interactions and interventions. Teaching skills and coaching to wraparound practice can be fruitful only after selecting a clinician who has values consistent with wraparound.

Role

Typically, a wraparound clinician works with fifteen to twenty child and family teams, providing consultation, coordination, oversight, intervention, and evaluation. In doing so, a clinician hired by a wraparound project provides benefits for other staff as well as for families.

Direct Benefits to Families and Their Teams: Providing consultation is helpful to the family. Often families want clarity around specific issues. Talking to a clinician provides support and a level of understanding about their child, who may be experiencing mental health symptoms. For example, parents of a child who is experiencing specific behaviors and has the diagnosis of bi-polar may not understand the volatility of mood and rapid changes that occur from agitation to silliness. The clinician can help them understand why interventions work or may fail to work and how to support and assist the child depending on what is happening at home and at school. The clinician is also available to consult with the child's psychiatrist and assist in supporting symptom monitoring with the family. Consultation, evaluation and direct mental health services are provided as needed and defined by the child and family team. The clinician's activities are performed differently within each child and family team process. Each family that enters the wraparound process will have an opportunity to engage with the clinician from the wraparound process. It is important during the engagement phase that the clinician explains his or her role to the child, family and other formal and informal supports on the team. The clinician thus sets the stage for two types of interactions with the child and family team: consultation and/or providing intervention.

Often, youth enrolled in wraparound programs are involved in multiple formal systems and therefore they may have more than one clinician. In this case, the wraparound clinician's role is to develop strategies and interventions that complement the work of the other clinicians. Wraparound clinicians also provide risk assessments, assist with hospitalizations, educate the other team members around particular symptoms and diagnoses, and implement evidence-based practices. The clinician also completes court reports regarding client participation, frequency and progress. The clinician interventions are not "stand alones"; they build on or set the stage for the work of the other team members.

Direct Benefits to Other Employed Staff and Program Operations: At our agency, the clinician is typically only one of several staff working with a child/youth and family. A central part

of the clinician's goal is to coordinate the work provided by these staff members, and to provide oversight. This is guided through a comprehensive psychosocial assessment. In wraparound, the clinician completes the assessment that captures the facts of the child and family's history and situation, and that also includes their strengths and what has worked with interventions and services in the past. The clinical skills and knowledge provides other staff with a better understanding of behaviors and how interventions are selected or created so that they fit a family's strengths and unmet needs. For example; in developing a family safety plan it is important for the team to understand the seriousness of diagnosis, behaviors, and specific interventions. The clinician's understanding of behavior and past experience offers support and direction to those staff who do not have clinical training or extensive experience in working with children and families experiencing emotional stress and disturbance. The clinician is valuable during the safety planning process because they are able to assess for safety and risk. In addition the clinician is part of the rotating 24/7 crisis response team for all enrolled children and families and can be a consultative resource to the staff that is called to a family home during a crisis. The clinician is available to assess the situation, determine if the child's behavior or mental health condition can be met with interventions in the home or whether temporary placement in a respite group home or other emergency setting is required such as psychiatric inpatient hospitalization.

Funding & Wraparound Clinicians: In Los Angeles County, funding to support wraparound projects consists of a blend of state and federal Medicaid dollars. Thus, each child enrolled in wraparound must have a diagnosis and meet medical necessity to draw down the federal dollars. Medical necessity can only be assessed by a licensed clinician, and Medicaid requires a treatment plan that links interventions to specific mental health goals. In contrast, the wraparound plan starts with ascertaining child and family needs, and building holistic strategies to address needs and build on strengths. Thus the clinician must be able to take the wraparound plan, developed by the child and family team, and "translate" it to create a Medicaid plan that documents mental health goals and interventions in a way that will satisfy state requirements. The clinician is responsible for creating the treatment plan to meet the state's Medicaid plan and to

meet the needs of the child and family. In keeping true to the values and practices of wraparound, the clinician documents the mental health goals and interventions for team review after the wraparound plan of care has been developed by the child and family team. The mental health goals are integrated across twelve life domains. For example; the wraparound plan may be built around meeting an unmet need such as "Juan needs to know that even when he gets upset adults will be there for him." The Medicaid plan, in contrast, would focus on the mental health goal of reducing anxiety. For both plans, the interventions then would be helping Juan's mother to respond to him when he is upset and assisting Juan in understanding his own process and escalation when he begins getting anxious. These types of interventions are agreed upon by the child and family team. Various staff can bill Medicaid for providing these services once a Medicaid treatment plan is completed. The wraparound clinician continually monitors the treatment plan to assure that it is driven by the child and family team wraparound planning process. Finally, the clinician is also responsible for collecting data for treatment planning and outcomes. Specific tools most often utilized are the Child & Adolescent Functional Assessment Scale, Child Behavior Checklist, Youth Self Report, Restrictiveness of Living Environment Scale, and the Global Assessment of Functioning.

Training of The Wraparound Clinician

Preparing clinicians to be successful in their role requires on-going training and supervision. All trainings must build on a family-centered foundation. Much of this is fairly standard clinical training. Typical courses provided are diagnosis and symptom reduction, evidence-based practices, legal and ethical issues, confidentiality, and child abuse reporting. On the other hand, wraparound clinicians find that while their knowledge base is similar to other clinically trained positions, the wraparound process changes the focus and application of that knowledge. Two examples are presented below:

Child Abuse Reporting. During the engagement phase it is important that the clinician explain to the family their obligation as a mandated reporter. Often, in the traditional clinical model, if child abuse is suspected the report is made without knowledge of it happening by the family. After the investigation, the parent/suspected individual may be angry and lose trust in the clinician and other providers. What is essential for a clinician in wraparound is to learn when child abuse is suspected, and if the child is not in immediate danger, to work with the family/suspected individual to make the report together. This process is essential to maintain the integrity of the team approach.

Confidentiality is another area of challenge for wraparound clinicians. The clinician in wraparound needs to know how to translate important issues for the team without violating any of the family's privileged information. The wraparound clinician also needs to help the different family members share with the whole team what others need to know so they can provide reliable help. Developing precision and competence in these skills is best taught in supervision.

In addition, the clinician role in wraparound requires skills in working collaboratively within the child and family team, with other professionals and families. As all team members, the clinician receives basic training in the philosophy of wraparound, the team meeting process, and an overview of each role.

Supervision of The Wraparound Clinician

Our agency uses a formal structure titled "Directive Supervision" when supervising the wraparound clinician. The clinician is supervised by another, more experienced, licensed clinician. This structure aligns practice with the agency's core organizational mission, values and principles. Data is gathered initially on the employee's self-rating and the supervisor's rating. Areas of practice needing improvement are targeted to be addressed through observation and coaching. In addition, family members are queried to assess if specific activities related to the clinician's role occurred. This data provides feedback to the clinician and his or her supervisor with a real-time dashboard of key performance and practice areas. During clinical supervision and at periodic reviews this information is used to help guide the clinician's growth and development, to determine gaps in training and supervision, and to celebrate achievements.

A clinician's role in wraparound is a radical departure from the traditional role. He or she serves as an asset to other staff, the child and family team and provides information and support for the child and family. Although recruiting for this role can be challenging, those who fill the role have found it to be very rewarding. It gives them flexibility and the opportunity to use a variety of skills and to work in a team where the responsibilities are shared. As the process of wraparound is utilized for different populations, a clinician who functions in a way that is compatible with the wraparound principles and practices can provide versatility, adaptability and enhance the family's experience of the process.

In the appendix of this *Resource Guide*, you can find:

- A job description for a wraparound clinician (Appendix X.1).
- The clinician self-rating form for use in directive supervision, as described above (Appendix X.2).

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Wraparound Practice: Chapter 4d.3

How School Sector Coordinators and Family Resource Developers Support the Wraparound Process

Elizabeth Berndt, Family Leadership Director
McHenry County, IL Family CARE

One never knows why we find ourselves traveling the journeys we take. I certainly never set out to work in the human service field but once I helped my first family, and heard that their experience was very similar to mine, I was hooked. I am the parent of a young man who suffers from a mental illness. Together we found ourselves embarking on a journey familiar to many parents across our country. Our family was one of the first families in McHenry County to experience wraparound and from that process I learned how to process my feelings of anger and channel my energy in a positive direction. With the help of very patient and committed professionals, I was able to turn a negative experience into a passion to help other parents.

As a family new to the community, we struggled to identify natural supports and non-traditional resources to support our plan. Although we benefited from services like family therapy, it was not until natural helpers and informal supports were identified and applied that we began to consistently practice what we learned, and began to experience success on our own.

My personal experience led me to several positions as a paid parent/professional that paired me with a variety of mentors along the way. I was fortunate to work for the Illinois Federation of Families, a statewide family support organization, for several years. In 2005, I returned to the community where it all began. I am now the Family Leadership Director for McHenry County Family CARE, a child mental health System of Care initiative. My charge is to design a family leadership process to increase family involvement in our system of care and develop a workforce of parent professionals, all of whom have children with serious emotional disorders.

The concept of relying on peer support is not a new idea. Various organizations have been using people to support other people in similar situations for many decades. What is relatively new, however, is the reasoning that parents (defined as primary caregivers for children with serious emotional disturbance) who have children with mental health disorders have a perspective based on personal experience that will benefit both other parents as well as professionals. Throughout the past 14 years, I have been part of a movement that validates the strengths of parents and caregivers and provides opportunities for those parents to support other parents. We have created a community of care that demonstrates collaboration with a variety of agencies infusing the parent voice across all systems.

We have had wraparound in our community for 14 years. In the past, wraparound facilitators, many times accompanied by the families, came to a single central location to present wrap plans. While this proved beneficial for some families, in our rural/suburban county of 600 sq. miles, it presented access barriers for others. It also meant that members of the panel were not as familiar with, or well connected to the families' communities and their resources. Another challenge was scheduling conflicts for school professionals who had to take time off from school to drive quite a distance to attend the meetings. McHenry County values the input we receive from our education professionals, so denying them the opportunity to provide insight into the academic portion of a child's day not only did a disservice to the child, but eliminated an opportunity for the teachers and other school staff to benefit from the resources and support wraparound can provide for them as well.

Resource Review Panels

In an effort to begin to address some of these challenges, the county has been divided into five sectors with all the county school districts assigned to a sector based on geographical location as well as number of children and families in the districts. Within each sector a Resource Review Panel is facilitated by a School Sector Coordinator. Local educators are encouraged to attend the Resource Review Panel meetings and learn about resources and strategies for students in their schools who are struggling.

Through our evaluation of the wraparound process over the last several years, we have learned that teachers, school social workers, and others are often unaware of the wealth of resources they have available to them. By having access to the Resource Review Panels, they are now linked to a much stronger network for themselves as well as their students and families. In addition to learning about the resources and networking, they become involved in seeking out solutions to many of the problems that prevent families from accessing services and supports, and they participate in collective brainstorming to figure out different ways to address these problems. As a result, they experience more ownership of the process and begin to feel like they are part of the community at large.

One of the many innovative qualities of McHenry County Family CARE is the incorporation of two new community resources: School Sector Coordinator (SSC) and Family Resource Developer (FRD). The SSC is similar in many respects to the community school coordinators used by the Coalition for Community Schools. The FRD positions are very similar to other positions filled by parents in other communities. The parent mentor, parent partner, parent resource specialists, just to name a few, are all very similar to each other but the differences may be the agency where they are assigned, or that the families are receiving services within a specific system. The unique quality of the SSC and FRD is that they are parents or caregivers

of a youth with serious emotional disorders. Once hired they build on their personal experience and professional training to engage families and community members in developing resources, to guide Wraparound Child and Family Teams, to access non-traditional supports and to help families navigate complicated youth serving systems. These two positions add to the value of our wraparound planning process by supporting the professionals as well as the families and identifying additional resources and supports. We have enhanced our ability to develop relationships with community members so that we may tailor the planning to meet individual youth and family needs by including more informal supports.

School Sector Coordinators

The School Sector Coordinators (SSCs) are employed by the McHenry County Mental Health Board which has entered into partnership agreements with various school districts. The agreements encourage collaboration between school districts and the mental health community to support a new way of providing services to youth and their families. Several school districts have provided office space for the sector coordinators, who split their time between different districts. Schools are required to develop student assistance teams, comprised of special educators, regular education teachers, administrators, support staff, and any others who have a vested interest in academic outcomes for students in that school district. These individuals meet regularly to discuss students who are not achieving academic success, or who may be experiencing difficulties because of their behavior.

With the addition of a sector coordinator, resources are identified and accessed much sooner for some of these students. The sector coordinators also provide workshops about mental health topics and link the schools to community resources that were often unknown because of a lack of time to develop the connections.

There are many ways that the School Sector Coordinators support the wraparound process. First, they facilitate the Resource Review Panel meetings. Community members such as business owners, parents, teachers, coaches, police officers and agency personnel meet each month to review wraparound plans and make suggestions to further strengthen the plan that has been developed by the child and family team. Wraparound plans are presented to the panel periodically for review and to request additional flexible funds. The panel members offer guidance to our wraparound facilitators by encouraging them to find community resources instead of relying completely on flexible funds to support the plan.

Second, in order to increase the responsiveness and the capacity of the Resource Review Panel to strengthen the natural support process for children and families, and offer a vast array of non-traditional services and supports, the sector coordinators network throughout the community and have developed relationships with business owners, parent leaders, faith-based organizations, among others within their sector and encourage them to become members of the panel. As a result, demographics of the community are much better reflected on each panel, and the panel more appropriately reflects the cultures and the values of the communities in each sector. These efforts have increased the buy-in from members of the community at large, who understand that their effort will support the children and families in their own communities. The addition of parents on the panel assures that the parent perspective is represented in all discussions. The panel then approves any request for flexible funding that is needed to support the wraparound plan. In addition, since they are community members they are more aware of who might be willing to provide non-traditional support thereby increasing the network of resources.

The unique quality of the School Sector Coordinator and Family Resource Developer is that they are parents or caregivers of a youth with serious emotional disorders.

Third, in order to better inform and involve parents in the wraparound process, we have used the SSC's to strengthen our initial engagement method for families entering wraparound. Upon receiving a wraparound referral, the SSC meets with the family who has been referred to Wraparound, explains the Wraparound process using the "Wraparound Process User's Guide – A Handbook for Families," and has them sign a consent form that we use to reinforce the importance of family participation in the process. And finally, sector coordinators are trained wraparound facilitators, facilitating child and family teams outside of their own sector.

The addition of a School Sector Coordinator to a school district has brought about changes in three major areas: educators' awareness of mental health issues has increased, accessibility to resources has improved, and there is an enhanced connection with individual family members. Administration and staff have commented about how the presence of the SSC has helped them function better in their own positions. Through expertise and experience, the SSC has proven to be a bridge between families, school, mental health child welfare, and juvenile justice.

Following the assignment of the wraparound facilitator and the development of a child and family team, the school reports the girl's behavior has improved and they are no longer looking at alternative placement.

School Sector Coordinator Paula Briedis illustrates this change with an example from a middle school in her sector. "The social worker and assistant principal contacted me about a 13 year-old student who was experiencing increasingly problematic behavior. They wanted direction as to how to engage the teen and her family in a more effective course. With the conversations that followed, I was able to provide many resources for the school professionals, and suggest many strategies including a referral to wraparound. I then met personally with the mother, hearing her concerns about her daughter. As a parent-professional, I could understand and empathize, bringing comfort and hope to her. After that home visit, the family agreed to enter wraparound and I worked with the school social worker to initiate the referral process. Following the assignment of the wraparound facilitator and the development of a child and family team, the school reports the girl's behavior has improved and they are no longer looking at alternative placement. Legal concerns have also been allayed, with improved behavior in the community. The family states that they are experiencing more stability within the home, and have enjoyed the supports placed by the wrap team."

Our county has a rapidly growing Latino community. Currently, 10% of McHenry County residents are Latino and it is anticipated that over the course of the next 20 years the proportion will increase to 40%. In order to create an environment that is culturally competent and responsive to community needs, we have placed an emphasis on hiring bilingual staff that reflects the cultural diversity of our county.

Ricardo Leon is a school sector coordinator in a sector that includes a large percentage of our Latino families. During the time he has been a sector coordinator, he has met with most of the schools staff, including nurses, social workers, special education teachers, regular education teachers, parent's liaisons, and support staff. He attends training, conferences and meetings, and shares his experiences and knowledge in order to influence members of the community. His personal belief is to be a good role model for the community. "I have helped with cases of truancy, cases of gang involvement… helping with doctor's appointments related to children with serious emotional disturbance. I helped a family with a daughter involved in gang practice, whose parents have very limited English." Riccardo goes on to say, "There are many situations in which the job of a SSC is crucial, important, and necessary. There is a great deal of literature on different topics

related to mental illnesses that are written originally in English, and need to be translated in some languages such as: Spanish, Polish, and Korean to reach some underserved populations. There are a good amount of people that for different reasons did not have access to education or simply did not finish their secondary, or even elementary education, I can certainly be influential on this specific topic."

Family Resource Developers

Many times, when families have children with serious emotional disorders, their lives become very complicated, which can lead to isolation and feelings of being overwhelmed. Over the last several years we surveyed families within our county to better gauge the supports they felt were lacking with our services. A common theme expressed repeatedly was the importance of having someone to listen to them who understood what they were going through, whom they could talk with, who could relate to what they were experiencing, and who didn't judge them as parents. They identified the need for more time to share their concerns and problem solve for answers.

Timing of meetings was also a factor as families told us job retention was often a challenge because the people they needed to meet with at school couldn't always meet with them when it was most convenient. This obstacle created the need for parents to take additional time off work, and was not always met with approval from their supervisors. Eventually many parents left their jobs. Many were fired. We addressed these concerns and others in the design of the Family Resource Developer program. Like the School Sector Coordinators, the Resource Developers go into the home, sometimes with a therapist, to meet with families when it is most convenient for the families.

The FRDs support the work of the School Sector Coordinators. Each FRD provides resources and support to parents as well as professionals, works in tandem with a CARE manager for our crisis intervention program, provides wraparound facilitation, and guides parents through the various system mazes. More important, they listen to the family's stories and help them begin to process what they are experiencing and offer guidance and support as they learn strategies that will impact their children's futures.

Currently, the FRDs work with families that enter the system through our intensive crisis management program, establishing a connection with the family and working in tandem with a therapist. It is during this initial phase with the family that the FRD begins to build trust and brainstorm with the family to identify potential team members within that family's life that have a vested interest in continuing positive outcomes for the youth and family. In this manner, the FRDs help create a balance between informal supports and traditional services. An emphasis is also placed on helping the family develop a team that reflects the cultural beliefs of that family. As the family moves away from crisis, the FRD transitions with that family into wraparound planning and begins to encourage and empower the family to take over the team facilitation.

Aurora Flores, a resource developer with the Latino Coalition works with our Latino families. Upon referral into SASS (Screening Assessment and Support Services) our crisis management program, Zack Schmidt, a SASS therapist brought Aurora in to assist him and a family in developing an effective treatment plan and to strengthen the support to the family. The 5-year-old child had been referred because she had been crying so hard she would end up vomiting at school each day. She had been given a diagnosis of attachment disorder but no services were currently being provided at the school.

The family is originally from Mexico and the child and father had been separated for months

from the mother and older brother before being reunited. In addition to being separated from her mother, this young girl was pulled from her father's care to live with her grandmother, while the father secured a safe living arrangement for his family. Finally, after a successful reunification with his family, the father was injured on the job and as a result, lost his employment. After months of trying to find ways to pay for medical help, suffering the loss of income, and having no interpersonal support, the family was in danger of losing their home. Living in a home under such financial stress, and having endured the trauma of abandonment earlier, the little girl was falling apart, and the family was doing their best to meet the challenges. Recently, while taking in a friend's child to baby sit, the child ran away. A hotline call was made to child welfare and an investigation was opened. As if the situation could not get any more complicated, the mother learned she was pregnant with her third child and didn't know how she was going to pay the bills.

Aurora spent time with the family in their home listening to their concerns. Language was not a problem but even though the SASS worker is bilingual, he is not from Mexico and struggled to relate to some of the cultural barriers. Aurora however, who was born in Mexico herself, was able to help Zack understand the issues so that as a team they could help the family better. Aurora attended appointments with the family, and sat with them and helped them make phone calls, which was different from the supports the family was used to. They quickly learned that they had someone willing to go the distance with them rather than just hand them phone numbers and promise to call and check in.

Aurora's effort strengthens the treatment plan by securing supports within the community. The church paid the family's rent so they would not lose their home. Clothing was a problem so Aurora asked her fellow resource developers if they knew of a place where she could get clothes for the family. They referred her to a resale shop but it was quite a distance from the family's home. Aurora took the family shopping for clothes and was able to link them to other resources that helped to stabilize their home situation. In addition, the family has developed a strong support team of community members, including a Pastor who speaks Spanish, to help them maintain their success. The child has stopped crying at school and the family is feeling much more connected to and supported by their school and community. The SASS plan was closed and the family is doing well.

Hiring Parents

As a way to infuse the concept of hiring parents throughout our system, Family Resource Developers were employed by numerous youth-serving agencies that collaboratively could support them as a team. Seven McHenry County organizations--Family Services Community Mental Health Center, The Youth Service Bureau, McHenry County Mental Health Board, Options and Advocacy, the McHenry County Latino Coalition, The Family Health Partnership Clinic and the McHenry County Regional Office of Education—built upon existing relationships to develop a collaborative partnership with the local community to support the Family Resource Developers and the youth and families they serve. Together, these organizations currently support a team of eleven Family Resource Developers.

Collaboration among these organizations began with formal letters of commitment. Each organization committed time and resources to the development of the Family Resource Developer program through multiple joint planning meetings. Over a six-month period, representatives of each organization met regularly to learn about Systems of Care and Family Resource Developers. Together, they outlined a potential program structure identifying job responsibilities, key operating principles, necessary resources, and the training process. Finally, all the collaborating organizations signed formal Memoranda of Understanding outlining their commitment to sustainable funding, joint training, joint supervision and continued participation in the planning process.

Hiring parents into our system of care presented some initial challenges. One of our challenges was the struggle to place a value on life experience vs. book knowledge when it came to developing a pay scale for parents, many of whom do not have any college credits. We finally settled on providing the organizations with guidance about hourly figures based on what other family organizations paid their parent partners. The FRD's are

salaried at that base rate for having a high school diploma, and it increases accordingly if they have a degree.

We utilized our county website for recruiting. Since these were new positions, Family CARE staff wanted to screen applicants prior to the interviews with the different agencies, so they could be assured the person possessed the right qualifications for the job. Determining the qualifications of the resource developers proved to be an interesting topic of discussion in the early months of the project. After much discussion it was decided that it is not the level of education that makes the person the right candidate, but whether they possess the necessary skills needed to perform all functions of the job.

The Family CARE interview team used a checklist with statements directly related to the qualifications necessary for the position: excellent written and verbal communication skills, flexible time schedule, availability to attend professional development workshops, friendliness, and leadership potential. Other statements centered on the candidates' experience in the field of support and their ability to relate and work with a team. If the applicants met the criteria we sent their application packages to the five organizations who agreed to participate in the first round of hiring. We provided each organization with a copy of the resume and interview team checklist for each applicant. As they found the ideal person to complement their team, the partner organizations hired the FRDs. While there were certainly occasions when more than one organization was interested in a candidate, all organizations managed this challenge with grace and respect for each other and the Family Resource Developers involved.

Supervision of FRDs is also a joint effort. In addition to each organization's clinical director providing supervision to their Family Resource Developers, Family CARE's Clinical Director and the Family Leadership Director provide group supervision as it relates to the System of Care principles for promoting family driven, youth-guided, evidence-based, culturally competent, individualized and strengths-based care. Finally, on a monthly basis, the leaders from each organization meet with all Family Resource Developers to review the program, problem solve and provide additional support.

Staff Development

Training is a major focus of our effort because most of the parents being hired into the system have not had access to a formalized method of preparation for a job of this magnitude. The training that is offered is attended by both the resource developers and the sector coordinators since both positions are being filled by parents. They participate in one week of orientation and then begin an intensive training program. Training topics include Introduction to System of CARE, Wraparound Facilitation Training, Public Speaking and Presentation Skills, Special Education IDEA Updates, and Balancing Work and Home. Staff also provided training and ongoing support regarding the Illinois All Kids insurance program, Medicaid documentation, evaluation and data collection, evidence based practice strategies, and legislative information and updates. Future topics identified by the FRDs so far include cultural competency training and time management. Administrators and staff of partner organizations also participate in multiple training opportunities along with the School Sector Coordinators and Family Resource Developers.

Since the main function of both the FRD and the SSC positions is to support the wraparound process, it was imperative to give them a variety of ways to learn about wraparound. A wraparound facilitator mentoring process has been designed that allows the SSCs and the FRDs to attend child and family team meetings with skilled wraparound facilitators to observe the way they facilitate meetings. After they have observed another child and family team three to four times, the FRDs and SSCs co-facilitate three to four meetings with an

experienced facilitator and then test their own abilities with a facilitator/mentor observing them. If all goes well, at that point, they are ready to facilitate on their own. We have increased our capacity to serve at minimum an additional 65 families in the wraparound process with the addition of these two types of positions.

Once a month the FRD's and the SSC's attend a team meeting. These meetings are a chance to share information with each other regarding resources in the county, a chance to continue trainings with speakers on topics relevant to their job, and a place to express concerns and share successes.

Cost of the Program

The cost of the School Sector Coordinators and Family Resource Developers can vary depending on how they are paid. In our community, we chose to pay an average hourly figure of $12.00/hour. Each organization that hires a FRD receives a certain amount of money that is to be used for salary and fringe, and they decide how much they will pay the FRD depending on the level of education they have. The average salary for a school sector coordinator is $36,000.00. In addition to salary, there are other costs associated with the program. Each SSC and FRD has a wireless laptop and computer software that assure they can process their paperwork efficiently. Costs for computers, software, training, travel, and other miscellaneous items, such as printing can add up, but are necessary for the professional development and productivity of each parent professional.

Benefits of Hiring Parents into the System

The School Sector Coordinators are just beginning to meet regularly with their Resource Review Panels. The number of additional community members attending these panels, including consumers, who are now aware of system of care work, has more than doubled. School administrators are recognizing the benefit of having a liaison in their district to provide staff and families with extra information and support. The agency partners are beginning to see a shift in the way therapists work with families and the dialog is now including how they can recruit parents and youth for their committees and boards. Families that have provided feedback on their experience with SSCs and FRDs have been very positive, and they advocate for more parents being hired into the system. Faith-based and other community members are embracing the philosophy of a family-driven system and volunteering to participate on workgroups, boards, committees, and child and family teams.

The integration of Family Resource Developers within and across these collaborating community organizations has already begun to directly fight the stigma associated with youth with serious emotional disorders. Providers working as colleagues with caregivers of youth with serious emotional disorders learn not only the challenges but also the multiple strengths these youth and families possess. Families and caregivers are no longer viewed as part of the problem, but as part of the solution.

Families and caregivers are no longer viewed as part of the problem, but as part of the solution.

Jason Keeler, one of the resource developer partners at the Youth Service Bureau (YSB) comments, "I think it has proven to be a validating experience. It has generated meaningful conversations in meetings that allow for a richness and diversity when talking about families. It has promoted alternative perspectives for everyone involved. More directly, within an open and collaborative framework, Family Resource Developers and staff have jointly been able to engage with those families who have unfortunately experienced 'system' failure and have been disheartened and disempowered. We have been able to reinstate some level of hope and empowerment in these families and restore some of their faith in themselves as capable and caring parents who, when it is all said and done, simply want to help their children be healthy and

happy. Parents have often stated that they more readily become more comfortable with a [parent] who has been through some of the [similar] things that they are going through. Most are thankful for the extra attention that is focused on their issues, specifically in dealing with a youth with youth SED."

"For the staff here at YSB, it is a reaffirmation that in most circumstances parents do not fail their children, but more often it is inadequate or inappropriate child- and family-serving systems that fail to identify, understand or effectively meet families' needs. Services, particularly those to children and families, must be accessible at the time when they are most needed. As funding resources change at state and federal levels, more creativity and further collaboration will be needed at the local level to develop ways to respond to such changing conditions so that families have true access to a community of care that can meet their respective needs."

The support that the sector coordinators and resource developers provide to our families enhances the way mental health services are delivered to child, youth, and families experiencing the daily struggles of mental health disorders. Parents helped identify problems and service gaps, and are now in a position to inform the system and provide side by side support with service providers.

As we near the end of the first year of employment for these new positions, our partners are asking for time to brainstorm to look for ideas and strategies to increase their participation in the design and implementation of roles for parents, not just as sector coordinators and resource developers, but in other roles as well, in the hopes of expanding their outreach to families. The partnering that is occurring between our providers and families has gone from reserved and hesitant to accepting, excited and looking for more possibilities.

While the implementation of these two positions in our community is relatively new, we are always learning from the experience. We have started to reflect on the continuum of development for parents new to this work and identify potential triggers that might interfere with the way they interact with some professionals. As those moments of clarity surface, we can begin to strategize how to move through the emotions that occur during those times.

Many of the parents who work in the system share the same feelings of accomplishment and hope. The partnerships that have been developed so far include a diverse group of professionals and parents without whom this work would not be possible. It has not come without challenges, but the commitment of the partners has allowed each participant to learn and grow from the others.

Finally, as we look to the future, we are challenged not only with the idea of sustaining these positions, but how to put into practice family-driven principles throughout our community of care. We are posing questions to our partners to challenge them to think about strategies to sustain their effort. Those questions are: In four years, how do you see your agency including parents on advisory boards and committees, as well as paid support staff? If the money were gone tomorrow, would you still employ School Sector Coordinators and Family Resource Developers? How are we assuring the sector coordinators and resource developers remain healthy and avoid burnout?

After years of navigating the system as a parent I know I wouldn't trade my son for anything. I have grown as a person, and developed as a professional because of what I have learned from him, other parents, and professionals who chose to work with us. I am a completely different person than I was when I became a mom and he was placed in my arms that first day of his life.

I have developed more patience and understanding of differences, and more compassion than I would have if I had never traveled this journey with him. I know my feelings are shared by many parents working in this field. It is the perspective the parent professionals bring to this work that rounds out the continuum of care, and completes the circle of support for families.

Author

As a result of her experiences as a parent, **Beth Berndt** has learned about the special challenges and barriers to services that children with emotional and behavioral issues and their parents confront. Beth is a strong advocate for System of Care values. She is part of a team of parents and professionals working in concert to develop a system that offers hope and support to families, helping them move from feeling overwhelmed and isolated to becoming engaged in various ways as members of the behavioral healthcare workforce. Beth has been married for 32 years to David and is the mom of three young men.

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Supporting Wraparound Implementation: Overview

Janet Walker, Co-Director, National Wraparound Initiative, and Research Associate Professor, Portland State University School of Social Work

Achieving broad scale, high quality implementation of wraparound has proven to be challenging for a number of reasons. Many of these challenges occur at the practice level, where teams have difficulty implementing the wraparound process in a way that reflects the principles of wraparound. However, experience has also shown that the successful implementation of creative, individualized wraparound plans at the team level requires extensive support from the larger organizational and system contexts within which the teams operate. Achieving the necessary level of collaboration and support can be very challenging, given entrenched agency cultures and ways of doing business, a lack of local expertise in providing wraparound, inter-agency barriers, funding exigencies, and skepticism regarding the effectiveness of family-driven, strengths-based practice.

A wraparound project usually operates as a collaboration between agencies that contribute resources for implementation. To make wraparound work, these agencies and organizations must collectively develop numerous formal and informal policies, addressing, for example, questions about:

- who oversees the project,
- who makes decisions about what,
- which children and families are eligible for wraparound,
- how the referral process works,
- how decisions will be made about which children and families will be accepted into wraparound,

- how information will be shared,
- how wraparound families will access services and supports from the community's array,
- how staff time will be made available for the activities that are part of wraparound,
- who will pay for particular services and supports,
- how information will be stored and documented,
- what kind of training will be provided and for whom, and so on.

Because wraparound essentially operates between agencies, rather than within a single agency, answers to these questions must be arrived at collaboratively, creating a highly complex implementation context. A study undertaken at the Research and Training Center on Family Support and Children's Mental Health (Walker, Koroloff & Schutte, 2003, included as Appendix 6f in this guide) used qualitative methods to describe the implementation context for wraparound and to develop a framework of "necessary conditions" that must be met in the implementation context to support wraparound. Based on interviews and feedback from more than 75 experts from communities around the nation, the authors proposed a matrix of conditions that must be met for wraparound to be successfully implemented and sustained. The framework grouped the necessary conditions into a set of themes at the system level.

The *Community Supports for Wraparound Inventory*

Building on this conceptual framework of necessary conditions, members of the National Wraparound Initiative worked to develop the *Community Supports for Wraparound Inventory* (CSWI), a survey tool that assesses the adequacy of the implementation context for wraparound. The CSWI was designed to be used by researchers—to determine the impact of contextual features on fidelity and outcomes of the wraparound process—and community evaluators—to provide information about system support that can be used as an input to strategic planning for sustainable wraparound implementation.

A community that chooses to use the CSWI begins the process by designating a local coordinator who will inform the community about the CSWI, build enthusiasm for participation, and create a list of potential respondents for the assessment. The coordinator is instructed to include on the list members of various stakeholder groups who typically have knowledge about implementation, including: members of the project's community team (i.e., the group that oversees and guides the collaboration); people directly employed by the project (e.g., facilitators of wraparound teams or care coordinators, supervisors, family partners, etc.); current or former recipients of services; staff and administrators from public and private agencies who are part of the collaboration (e.g., child welfare, school systems, mental health provider agencies); and representatives of other stakeholder groups. Research staff from the Wraparound Research and Evaluation Team (a partner of the NWI) then create an online CSWI survey for that particular community, and invite participation from each of the stakeholders included on the coordinator's list. Participants receive their invitation by email, and simply click on a link to respond to the CSWI.

The CSWI includes items grouped into six themes: *community partnership, collaborative activity, fiscal policies and sustainability, access to supports and services, human resource development and support, and accountability*. Descriptions of each theme, and sample items from each theme, are presented in Table 1. Each item offers two "anchor" descriptions, one for "least developed system support" and one for "fully developed system support." Respondents rate their community on a 0-4 scale where 0 corresponds to "least developed," 2 to "midway," and 4 to "fully developed." When data collection is finished, research staff prepare a report for the community describing how the community scored on each theme and item, and listing areas of particular strength and challenge. A pilot test of the CSWI with seven communities around the country showed that the assessment had excellent internal reliability (both for the themes and for the measure as a whole) and that there was very good inter-rater reliabil-

Table 1. Themes and Sample Items from the Community Supports for Wraparound Inventory

Item	Fully Developed System Support	Least Developed System Support
***Theme 1: Community Partnership**. Collective community ownership of and responsibility for wraparound is built through collaborations among key stakeholder groups. (7 items)*		
Item 1.3: Influential Family Voice	Families are influential members of the community team and other decision-making entities, and they take active roles in wraparound program planning, implementation oversight, and evaluation. Families are provided with support and training so that they can participate fully and comfortably in these roles.	Family members are not actively involved in decision-making, or are uninfluential or "token" components of the community team, boards, and other collaborative bodies that plan programs and guide implementation and evaluation.
***Theme 2: Collaborative Action**. Stakeholders involved in the wraparound effort take concrete steps to translate the wraparound philosophy into concrete policies, practices and achievements. (8 items)*		
Item 2.3: Proactive Planning	The wraparound effort is guided by a plan for joint action that describes the goals of the wraparound effort, the strategies that will be used to achieve the goals, and the roles of specific stakeholders in carrying out the strategies.	There is no plan for joint action that describes goals of the wraparound effort, strategies for achieving the goals, or roles of specific stakeholders.
***Theme 3: Fiscal Policies and Sustainability**. The community has developed fiscal strategies to meet the needs of children participating in wraparound and methods to collect & use data on expenditures for wraparound-eligible children. (6 items)*		
Item 3.3: Collective Fiscal Responsibility	Key decision-makers and relevant agencies assume collective fiscal responsibility for children and families participating in wraparound and do not attempt to shift costs to each other or to entities outside of the wraparound effort.	Each agency has its own cost controls and agencies do not collaborate to reduce cost shifting, either to each other or to entities outside of the wraparound effort.
***Theme 4: Access to Needed Supports & Services**. The community has developed mechanisms for ensuring access to the wraparound process and the services and supports that teams need to fully implement their plans. (8 items)*		
Item 4.6: Crisis Response	Necessary support for managing crises and fully implementing teams' safety/crisis plans is available around the clock. The community's crisis response is integrated with and supportive of wraparound crisis and safety plans.	Support for managing crises is insufficient, inconsistently available, or uncoordinated with wraparound teams' crisis and safety plans.
***Theme 5: Human Resource Development & Support**. The community supports wraparound and partner agency staff to work in a manner that allows full implementation of the wraparound model. (6 items)*		
Item 5.5: Supervision	People with primary roles for carrying out wraparound (e.g., wraparound facilitators, parent partners) receive regular individual and group supervision, and periodic "in-vivo" (observation) supervision from supervisors who are knowledgeable about wraparound and proficient in the skills needed to carry out the wraparound process.	People with primary roles for carrying out wraparound receive little or no regular individual, group, or observational supervision AND/OR supervisors are inexperienced with wraparound or unable to effectively teach needed skills.
***Theme 6: Accountability**. The community has implemented mechanisms to monitor wraparound fidelity, service quality, and outcomes, and to assess the quality and development of the overall wraparound effort. (7 items)*		
Item 6.1: Outcomes Monitoring	There is centralized monitoring of relevant outcomes for children, youth, and families in wraparound. This information is used as the basis for funding, policy discussions and strategic planning	There is no tracking of relevant outcomes for children and youth in wraparound, or different agencies and systems involved maintain separate tracking systems.

ity within each community.

Other Resources Described in this Section of the *Guide*

Subsequent chapters in this section of the *Guide* focus in more detail on some of the key areas of support that a community must provide if wraparound is to be implemented and sustained. Chapters focus on training, coaching and supervision; financing; community collaborative teams; and data, particularly data for ongoing quality assurance processes.

Author

Janet Walker is Research Associate Professor in the School of Social Work at Portland State University and co-Director of the Research and Training Center on Pathways to Positive Futures. Her current research focuses on 1) exploring how individuals and organizations acquire capacity to implement and sustain high quality practice in human service settings, 2) describing key implementation factors that affect the ability of organizations and individuals to provide high quality services and treatment, and 3) developing and evaluating interventions to increase the extent to which youth with emotional or mental health difficulties are meaningfully involved in care and treatment planning. Together with Dr. Eric Bruns, Dr. Walker co-directs the National Wraparound Initiative.

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The Wraparound Process: An Overview of Implementation Essentials

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I. Overview

The wraparound process is an intensive, individualized care planning and management process for children and adolescents[1] with complex mental health and/or other needs. Wraparound is often implemented for young people who have involvement in multiple child-serving agencies and whose families would thus benefit from coordination of effort across these systems. Wraparound is also often aimed at young people in a community who, regardless of the system(s) in which they are involved, are at risk of placement in out-of-home or out-of-community settings, or who are transitioning back to the community from such placements.

Wraparound is not a treatment *per se*. The wraparound *process* aims to achieve positive outcomes for these young people through several mechanisms. For example, well-implemented wraparound provides a structured, creative and individualized team planning process that, compared to traditional treatment planning, can result in plans that are more effective and more relevant to the family. Additionally, wraparound plans are more holistic than traditional care plans in that they are designed to meet the identified needs of caregivers and siblings and address a range of life areas. Through the team-based planning and implementation process that takes place, wraparound also aims to develop the problem-solving skills, coping skills, and self-efficacy of the

1 While the wraparound planning process has primarily been used with young people and their families, it has also been used with transition-age youth, adults, and older adults in multiple service systems.

Primary Mechanisms of Change in Wraparound

- *Being family and youth determined*
- *Using a collaborative team process*
- *Being grounded in a strengths perspective*
- *Identifying and mobilizing natural and community supports*
- *Being driven by accountability and results*

young people and family members. Finally, there is an emphasis on integrating the youth into the community and building the family's social support network.

During the wraparound process, a team of individuals who are relevant to the life of the child or youth (e.g., family members, members of the family's social support network, service providers, and agency representatives) collaboratively develop an individualized plan of care, implement this plan, monitor the efficacy of the plan and work towards success over time. A hallmark of the wraparound process is that it is driven by the perspective of the family and the child or youth. The plan should reflect their goals and their ideas about what sorts of service and support strategies are most likely to be helpful to them in reaching their goals. The wraparound plan typically includes formal services and interventions, together with community services and interpersonal support and assistance provided by friends, kin, and other people drawn from the family's social networks. After the initial plan is developed, the team continues to meet often enough to monitor progress, which it does by measuring the plan's components against the indictors of success selected by the team. Plan components, interventions and strategies are revised when the team determines that they are not working, i.e., when the relevant indicators of success are not being achieved.

The wraparound process—engaging the family, convening the team, developing and implementing the plan, and transitioning the youth out of formal wraparound—is typically facilitated by a trained care coordinator or "wraparound facilitator," often in collaboration with family support workers and, increasingly, youth support workers (i.e., peers and "near peers"). The wraparound process, like the wraparound plan itself, is designed to be culturally competent, strengths based, and organized around family members' own perceptions of needs, goals, and likelihood of success of specific strategies.

The wraparound process has four phases: ***Engagement and team preparation*, *Initial plan development*, *Plan implementation*, *and Transition*.** Each phase has several core activities. Wraparound is also frequently described in terms of the ten principles or values to which practice must adhere. A full description of the principles of wraparound, and of the activities that take place in the four phases, can be found in articles published in the *Resource Guide to Wraparound*, which can be accessed through the web portal of the National Wraparound Initiative at www.wrapinfo.org.

II. Implementation Essentials

System- and Community-Level Support

The wraparound process is intended to ensure that youth with the most complex needs in a system or community benefit from a coordinated care planning process that is responsive to their needs and the needs of their families. The wraparound process produces a single, comprehensive plan of care that integrates the efforts of multiple agencies and providers on behalf of a youth and his or her family. The wraparound plan is designed to ensure that the young person and family receive the support needed to live successfully in the community, and at home or in the most home-like setting possible. To achieve this, wraparound plans and wraparound teams require access to flexible resources and a well-developed array of services and supports in the community.

Providing comprehensive care through the wraparound process thus requires a high degree of collaboration and coordination among the child- and family-serving agencies and organizations in a community. These agencies and organizations need to work together to provide the essential community- or system-level supports that are necessary for wraparound to be successfully implemented and sustained. Research on wraparound imple-

mentation has defined these essential community and system supports for wraparound, and grouped them into six themes:

- ***Community partnership:*** Representatives of key stakeholder groups, including families, young people, agencies, providers, and community representatives have joined together in a collaborative effort to plan, implement and oversee wraparound as a community process.
- ***Collaborative action:*** Stakeholders involved in the wraparound effort work together to take steps to translate the wraparound philosophy into concrete policies, practices and achievements that work across systems.
- ***Fiscal policies and sustainability:*** The community has developed fiscal strategies to support and sustain wraparound and to better meet the needs of children and youth participating in wraparound.
- ***Access to needed supports and services:*** The community has developed mechanisms for ensuring access to the wraparound process as well as to the services and supports that wraparound teams need to fully implement their plans.
- *Human resource development and support:* The system supports wraparound staff and partner agency staff to fully implement the wraparound model and to provide relevant and transparent information to families and their extended networks about effective participation in wraparound.
- ***Accountability:*** The community implements mechanisms to monitor wraparound fidelity, service quality, and outcomes, and to oversee the quality and development of the overall wraparound effort.

The Resource Guide to Wraparound includes a large number of chapters focusing on system- or community-level supports for wraparound. These chapters provide detail on areas from finance to information systems to accountability systems.

Organizational Support

In addition to these system-level supports, the wraparound process requires that people in key wraparound roles—facilitators, family support partners, peer partners, etc.—have the right skills and the right working conditions to do their jobs. This means that the lead agency or agencies responsible for providing wraparound to families must also provide organizational supports for wraparound, including maintaining right-sized workloads (typically 6 – 15 youth/families per coordinator dependent upon paperwork expectations and other duties); empowering teams to make timely decisions regarding funding needed for individualized strategies to meet families' unique needs; and ensuring that primary staff receive comprehensive training, support and skill development.

Many of the biggest challenges faced by organizations providing wraparound have to do with human resource issues: having the right people, with the right skills, available with sufficient time to complete a high quality wraparound process with each child and family. Several of the key types of issues that organizations face include the following:

Role Definition. Wraparound initiatives often are implemented using a wide range of staff roles (e.g., facilitators, family partners, clinicians, youth partners, paraprofessional support workers, supervisors, coaches, and others). Expectations for each role must be clearly defined before professional development strategies for each can be implemented.

Training and Skill Development. Wraparound is a complex process involving many different skill sets. People with key roles for carrying out the wraparound process therefore require substantial training, as well as ongoing coaching and supervision, to ensure that they have the knowledge and skills they need. Most wraparound projects, at least in their early stages of development, rely to some extent on outside people for training and for consultation on how to set up ongoing procedures for staff development and quality assurance. Finding a consultant or trainer is not always easy, however, since wraparound is not a proprietary model. Thus, there is no single purveyor organization or consultant group that is recognized as the single entity with which a community or local initiative must contract for training, skill development, or other type of human resource development and support. The National Wraparound Initiative has created a tip sheet for selecting trainers and con-

sultants. In addition, the Resource Guide to Wraparound contains an entire section focusing on wraparound practice, as well as a series of chapters in the section on implementation that describe how to create and implement a comprehensive training plan.

A comprehensive approach to training and skill development has several important components, all of which must be in place to ensure that people have the knowledge and skills they need.

Development of Core Knowledge and Skills. Training and other professional development activities should focus on basic knowledge and a set of core skills that will lead to high-quality performance by people key roles. Some skills will be universal (e.g., understanding and communicating about the wraparound model, conceiving youth and families' stories in terms of needs and strengths) and may be presented in training to the full cadre of individuals serving key roles for wraparound implementation. Other skills will be specific to certain roles (e.g., facilitator, family partner, supervisor, clinician, child welfare case worker). Finally, trainings should be available on skill sets that may be critical to wraparound as well as other components of a system of care. For example:

- Developing strengths-based understanding
- Building family- and youth-driven collaboration
- Effective team, meeting and plan facilitation
- Crisis and safety planning
- Mobilizing community resources and support
- Interacting with the service system and its context

The National Wraparound Initiative recommends that trainees' knowledge be assessed post-training. In addition, the NWI recommends follow-up evaluation at a later date to determine the extent to which training is having an impact on work-related behavior or productivity. Local and state wraparound initiatives are encouraged to engage in their own learning about what training methods are working best.

Supervision and/or Coaching. A comprehensive approach to workforce development and support will include a well-defined approach to supervising and/or coaching key staff. Supervision and coaching should be consistent with, and clearly linked to the training that is provided, and supervision and coaching processes should be based at least in part on objective data. Such data can be gathered through observation, individual or collective inquiry with teams and families, document review, and other methods. The data should be used to create tailored training and performance improvement plans for individual staff. In addition to data, supervisors need access to up-to-date materials about the evolving practices within wraparound; families and team members who can provide feedback based on direct first person experience of the process; and organizational back-up that allows personnel actions to follow performance.

Comprehensive Performance Monitoring. In addition to data used to support supervision and coaching, the organization should support and integrate collection of satisfaction, fidelity, outcomes, and costs data into its ongoing quality assurance processes. Funders of wraparound initiatives should be able to create contracts that require organizations to engage in data-driven quality assurance. Wraparound Contract managers need to move away from a prescriptive model that defines minimal compliance elements (i.e. productivity, minimal contacts etc.) to a management system that supports continuous quality and practice improvement.

Wraparound Outcomes

Significant outcomes found for wraparound compared to control or comparison groups:

- *Maintenance in less restrictive, community based placements*
- *Improvement in behavior and functioning*
- *Juvenile justice recidivism*
- *School achievement and attendance*

(Suter & Bruns, 2009)

III. Outcomes Research

The wraparound process has been implemented widely across the United States and internationally for several reasons, including its documented success in promoting shifts from residential treatment and inpatient options to community-based care (and associated cost savings); its alignment with the value base for systems of care; and its resonance with families and family advocates. Wraparound has been included in Surgeon General's reports on both Children's Mental Health and Youth Violence, mandated for use in several federal grant programs, and presented by leading researchers as a mechanism for improving the uptake of evidence-based practices.

Continued expansion of the wraparound research base has provided additional support for ongoing investment in wraparound. To date, results of 8-10 (depending on criteria used) controlled (experimental and quasi-experimental) studies have been published in the peer-reviewed literature. A meta-analysis of seven of these studies has recently been published showing consistent and significant outcomes in favor of the wraparound group compared to control groups across a wide range of outcomes domains, including residential placement, mental health outcomes, school success, and juvenile justice recidivism (Suter & Bruns, 2009). The overall effect size in this meta-analysis was found to be between .33 - .40, about the same as was found in a recent meta-analysis of children's mental health evidence-based treatments.

Thus, though wraparound has typically been described as a "promising" intervention, there has been consistent documentation of the model's ability to impact residential placement and other outcomes for youth with complex needs. The research base for wraparound continues to expand and, as a result, wraparound is likely to be more consistently referenced as an "evidence-based" model in the years to come.

For More Information

The Resource Guide to Wraparound, an online volume of over 50 articles about the practice model for wraparound, implementation supports, theory and research, and other resources, is available at www.wrapinfo.org.

Reference

Suter, J.C. & Bruns, E.J. (2009). Effects of wraparound from a meta-analysis of controlled studies. *Clinical Child and Family Psychology Review, 12,* 336-351.

Authors

Eric Bruns is a clinical psychologist and Associate Professor at the University of Washington School of Medicine in Seattle. He spends much of his professional life conducting research on innovative community-based models for helping youth and families with complex needs, including family treatment drug courts, treatment foster care, parent support programs, and the wraparound process. He is a lead developer of the Wraparound Fidelity Assessment System and, with Janet Walker, co-directs the National Wraparound Initiative.

Janet Walker is Research Associate Professor in the School of Social Work at Portland State University and co-Director of the Research and Training Center on Pathways to Positive Futures. Her current research focuses on 1) exploring how individuals and organizations acquire capacity to implement and sustain high quality practice in human service settings, 2) describing key implementation factors that affect the ability of organizations and individuals to provide high quality services and treatment, and 3) developing and evaluating interventions to increase the extent to which youth with emotional or mental health difficulties are meaningfully involved in care and treatment planning. Together with Dr. Eric Bruns, Dr. Walker co-directs the National Wraparound Initiative.

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Supporting Wraparound Implementation: Chapter 5a.3

Choosing a Consultant to Support Your Wraparound Project

Patricia Miles, Consultant
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National Wraparound Initiative

Implementing wraparound in a community is complex and difficult. At the service level, successful implementation of wraparound requires that key team members—team facilitators, parent partners, resource developers, and others—acquire skills and expertise that will enable them to collaborate with families to build plans that are individualized, culturally competent, and community- and strengths-based. Successful implementation also requires changes in the wider organizational and systems context within which wraparound teams operate. The agencies and organizations that participate in wraparound must learn new ways to work together, sharing authority, responsibility, and resources.

Because wraparound implementation is so complex, sponsors, managers, project staff, and collaborative partners often seek advice and assistance from experienced colleagues and other consultants. Opportunities to network with peers have never been greater, with a wide range of supports available including web-based resources, state-level information and technical assistance, and local, state, and national conferences. This peer interaction offers many advantages including the opportunity for sharing new insights, techniques, or implementation strategies, and the opportunity for mutual sharing about fresh lessons learned.

At the same time, it is not unusual for leaders in Wraparound projects to find that they need professional consultation as they move toward full implementation. In the past, Wraparound projects had to rely on word of mouth in order to find consultants with high levels of expertise. However, as Wraparound has become more widely implemented, the availability of consultants, experts, and helpers with direct

Wraparound experience has grown significantly, making it easier for projects to select the right mix of experience, skills, and talent to meet their unique implementation needs.

But how exactly should stakeholders proceed once they have decided to seek consultation for their Wraparound project? What steps can they take to ensure that they are investing wisely and getting the type of information and support they need?

Perhaps the most important thing to keep in mind is that a consultant will not solve your problems or fix your system. Do not expect or allow the consultant to manage your staff for you. You must provide leadership for your project, and there must be a committed group of active stakeholders within your own project who are continually expanding their own knowledge and expertise. Thus, these people are in a position to make best use of the knowledge the consultant brings, and to help structure the kinds of learning experiences that are needed by other people involved in the local implementation.

Steps for Choosing a Wraparound Consultant

- **Step One: Identify Your Objectives.** The first step in developing a successful relationship with a consultant is for the project to identify its aims or goals. A common mistake for projects experiencing significant implementation challenges is to skip this step and assume the consultant will be able to "fix" the problems they are experiencing. The consultant should not be the only voice in articulating the project problems but instead project leadership should be clear about the desired results of the consultation.
- **Step Two: Identify Your Audience.** Wraparound projects, by definition, involve a range of people with a range of roles getting together to design and develop imaginative and creative plans. The range of people and roles who may be involved in Wraparound implementation include project staff; project supervisors; family members; community members; people in existing staff roles such as clinicians, child welfare workers, probation officers, and teachers; and children or youth involved in the project. It is important for project staff to identify primary audience(s) that the Wraparound consultant should reach. Efforts should be made to find a consultant who is a likely match for the target audience of terms of expertise, style, and personality.
- **Step Three: Identify Your Preferred Consulting Method.** Consultants have a variety of approaches to offer a Wraparound project. It is important that the project identify what type of approach is best suited to their needs. Listed below are four methods that consultants often use in working with a local project to achieve their goals.
    - » *Information Consultation.* This method involves using a consultant to provide expertise, information, and professional advice designed to help the project. Typically, if your need is for information, activities will primarily center on formal training activities or the development of materials that can be disseminated to various stakeholders. When seeking an information consultant the project should consider the following areas:
        - What is the consultant's expertise in the area of need?
        - How much credibility will the consultant have in this area with your local audience? What can project personnel and/or the consultant do to assure credibility?
        - What is the best method for us to communicate this information? Training sessions? Written materials?
        - Does the consultant understand the need to provide information in a variety of modes, so that people with different learning styles can benefit from consultation?

- Does the consultant have a well-developed sense of the structures and strategies that are likely to be helpful to adult learners?
- Are there any barriers in the project that keep us from developing or sharing this information now?
- How long is this expected to take? Are our expectations realistic?

» *Coaching.* When a project feels a need to help people in key roles develop their skill and expertise in particular aspects of Wraparound, they may employ a consultant to serve as a coach. Coaching is usually fairly intensive, and involves an opportunity for the coach to observe, as closely as possible, the current skill level of the person being coached. The coach offers techniques, tools, strategies, and other supports that will help the person achieve a higher level of expertise. A coach will often demonstrate new skills and techniques in "real life" situations. Coaches often work with a project over time, offering new supports and insights appropriate to people's increasing level of skill and experience. Coaches may also work with supervisors to help expand local coaching capacity. When seeking coaching, the project may want to consider:

- Does the coach have a high level of expertise in the skills needed by our identified key project personnel?
- Does the coach have a well-developed sense of the structures and strategies that are likely to be helpful to adult learners?
- Is the coach able to relate to adult learners in ways that inspire them and increase their confidence?
- Does the coach have a variety of tools and resources to offer as supports to the coaching process?

» *Process Consultation.* If a project seems to have access to the right information but still seems to have difficulty making headway, a process-based consultant can be helpful. Projects that need a process consultant usually have a good sense of what they want to accomplish, but experience difficulty actually doing it. They may have a need for someone who has some distance from their local project and who can provide information and insight they need to get "unstuck". When selecting a process consultant, the project should consider the following areas:

- Is the consultant able to consider a range of implementation strategies?
- Can the consultant articulate a variety of strategies for implementation?
- Is the consultant able to grasp major themes or the "big picture" by analyzing the details of our implementation, local system, and local community?
- Will this consultant be able to summarize these themes to us in a way that moves the project towards its goals?
- How long will this take? Are we being realistic with expectations?

» *Relationship-based Consultation.* Some projects find their needs are best met by hiring an outsider to work with their project over time. A consultant in this role will work with a project over time providing feedback, strategic problem solving, and situation-specific advice and strategies as needs arise. A project that elects to use a relationship-based consulting process is typically looking for someone who can sustain a longer-term relationship with the project. When selecting a relationship-based consultant the project should consider the following areas:

- Is this person someone whom we could imagine working with over time?
- Is the consultant able to review our local implementation and make suggestions that are appropriate to our local situation?
- Do we feel comfortable with the consultant's base of knowledge?
- Do we feel comfortable that the con-

sultant is able to gather information about our process?

- How long do we expect this to take? Are we being realistic with our expectations?

Wraparound projects that are interested in pursuing consultation may consider what methods would most fit their local needs and strengths. Some projects may find individuals that will fit all three of the methods described above while other projects may find that they want to use different individuals to fit each of these methods. Projects may also find it useful to use several consultants with expertise in different aspects of implementation.

- **Step Four: Begin the Consultation Process.** When your project has matched the target audience with the consulting method, it is time to begin a consultation process. In some cases, this might entail trying a range of individuals before making a longer-term commitment. In other cases, initial interviews and getting references is enough to get started with consultation. In hiring a consultant, it is important that the project identify, in writing, the results they are hoping for from each consultation session. This allows the consultant and the project to continually evaluate the effectiveness of the consultation. Feedback on the consultant's activities should also be systematically sought from those who participated.
- **Step Five: Modify & Adjust: Hiring the consultant is only the beginning.** The successful consultation process involves an interchange between the client and consultant. Objectives should be outlined and agreed upon by both parties. Over time accomplishment of those outcomes should be reviewed to determine whether the strategies used should be adjusted, maintained, or simply stopped.

Some Tips for Selecting A Consultant

- *Beware the Expert View:* If you search for the ultimate answer you are likely to find that it won't work in your community anyway.
- *Relationships Count:* It is important to find someone who can make you feel comfortable in the consultation process.
- *Get References:* Don't be afraid to ask others for their view of the consultant's approach. Ask whether the consultant has delivered promised services and materials, and delivered on schedule. It is often a good idea to ask those people on the consultant's reference list if they can suggest anyone else for you to contact. Be sure to find out if the reference has current knowledge about the consultant.
- *Solicit Samples:* Ask the consultant to provide sample of other work and review it to determine compatibility with your project's needs. Samples can include published materials, reports, or training materials. Ask the consultant who wrote the materials—inexperienced trainers may be using materials developed by other with a higher level of expertise.
- *Follow Your Instincts:* Sometimes the final decision to selecting a consultant comes down to trusting your basic feelings about the person and their skills, personality, and attributes.
- *Be Clear About Expectations:* Establish a contract with clear expectations for the work you expect your consultant. This should explicitly describe the activities to be carried out, the materials to be produced, the timeline to be followed, and the outcomes by which the consultant's efforts will be evaluated.
- *Create Your Back Door:* It is important to identify strategies for the consultation to end even as the consultation begins. This will increase the likelihood that your project will use consultation in the right way, for the right purpose, for the right duration, and for the right price.
- *Find Someone Who is Interested in You:* Consultation is an interactive process that occurs between at least two parties. This is what makes it different than simply identifying a training event. The consultant should take the time to learn about you, your project, and your local community. The consultant should not only listen to you, but also reflect back to you that he or she has heard and understands what you are saying. You should be confident that the consultant is capable of modifying or adapting the consultation to fit your local situation and needs.

- *Strive for Consistency:* If you use multiple consultants, work with them to ensure that they are not sending mixed or contradictory messages to program staff and stakeholders. The same values and approaches can be conveyed in different formats and people can become confused or even conflicted about which approach to use.
- *Level with Your Consultant:* A successful relationship between a Consultant and their client will be based on candor and mutual honesty.
- *Remember It's an Equal Partnership:* Successful consulting is as much the responsibility of the client as the consultant.
- *Set Your Benchmarks:* Productive consultation will identify mileposts for accomplishment and review progress towards outcomes regularly. This allows the client and consultant to adjust strategies for greater effectiveness.
- *Plan for Follow-up:* Work with the consultant to decide how your program should follow up from consulting sessions, and whether the consultant will provide follow-up technical assistance or other forms of support.
- *Modify Your Plan:* As you begin the consultation process you are apt to find new insights, opportunities, and challenges. It is important that you continually review your implementation to determine where mid-course adjustments should be made.

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Supporting Wraparound Implementation: Chapter 5b

Planning for and Implementing System Change Using the Wraparound Process

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Introduction

Wraparound is increasingly being recognized as both a systems-level and child- and family-level intervention. When implemented effectively, wraparound facilitates changes in a community's mental health, substance abuse, child welfare and juvenile justice systems that reduce barriers to engagement, increase youth and family participation, and achieve positive child and family outcomes.

However, system change is tough to do. First, systems have a strong tendency to keep operating they the way they always have. Second, because systems are complex collections of many parts that interact in a variety of ways, attempting to change what's happening in one area of the system can have unforeseen consequences in other places. Third, since it takes as much effort to change a system as it does to operate it, keeping a system running while you are changing it requires twice as much work.

Because staff at most community agencies are hard-pressed to keep up with the existing demand for services, when wraparound is being installed, communities often find the means to hire a *project coordinator* to manage the change process. This might be through a new hire, or by backfilling an existing position to allow an experienced employee to flex out into the coordinator role.

However, a project coordinator can't change a system by her or himself. A team of leaders and stakeholders committed to improving the way that help is provided in the community is also necessary. This implementation team is made up of the people who will not only design the new system, but also put its various elements into action in the

areas they represent. Ultimately it will evolve into the *community team* that forms the foundation for wraparound's integrated services. Part of the budget for implementing wraparound should cover the cost of convening the implementation/ community team and supporting participation by stakeholders who might not otherwise be able to attend—such as parent and consumer representatives.

A third element that wraparound brings to a community's system of care is *flexible resources* for children and families that cannot be obtained anywhere else. As the wraparound values of strength-based, family-focused practice are implemented, it often happens that non-standard assistance is needed to pull together an effective plan of care for a child and family. Ad hoc support through the participating agencies can help fill these gaps while more sustainable alternatives for flexible and creative service responses are being established.

When communities implement the wraparound process, they develop a cohort of people who are trained to *facilitate teams, provide direct social support* and stabilization while the teams are forming, and act as *family partners* with enrolled families. Provisions should be made for training and technical assistance for the people filling these three positions. The initiative should also ensure there is peer consultation for these individuals, available practice and training materials, and resources to allow them to attend state and national training opportunities.

Facilitating Proactive Change

The adoption of the wraparound process for serving families with complex needs is an example of a *proactive change process*. Reactive system change happens all the time because of the rapidly shifting environment in which human services are delivered, but proactive change is rare. Effective change efforts should be intentional, reflective, well informed and meaningful. While each community has its own set of strengths and needs, its own culture and ways of getting things done, and its own context of political, funding and communication networks in which change must occur, certain core insights, skills and strategies can be used to facilitate a proactive change process even as it follows the unique pathways appropriate to a given community.

While a variety of articles have described the values and process steps of wraparound, this one will examine the process of change that communities go through as they adopt a new way of providing services. It will discuss the reasons why change is necessary in our child and family services, review the keys to successful change, describe some of the theories that can help us understand and guide change efforts, outline the basic steps of a system change process and discuss the role of leaders and community teams in helping make change happen.

Why Change?

This is an important question to ask because system change can be troublesome and disruptive. The answer is that because the challenges our human service systems must respond to have changed, as have the tools for addressing these challenges and the outcomes our systems are expected to produce, our systems must change to keep up.

It is often stated that communities always ask our agencies to provide more services for less money. But it might be more productive to say that what people want is better services at a reasonable cost. And it is the system's job not only to make these services available, but also to provide the most efficient and effective way of connecting people needing assistance with the services most likely to produce good results.

Patricia Miles, a leading national human services consultant, puts it this way: "The central task of an effective system of care is to get the right help to the right people at the right time for the right price, so we can produce the outcomes desired by the community and deserved by our system's customers."

This is no easy task. Which are the best services? How can we be sure which kind of help will be most effective with a given person or family? What should good services cost? How can we tell whether we are doing what we said we would do and whether it is helping? How do we deal with funding sources that require actions that may no longer be clinically sound or operationally efficient?

Despite these challenges, the demands, expectations and needs are there and must be dealt with: in the changing social and cultural environment in our communities, in the regulatory, political, legal and economic requirements, in the rise of research-informed service approaches, and in the continuing evolution of the consumer movement.

As a result, change is needed to accomplish a wide range of goals. Rebecca Proehl (2001) lists seven reasons why change in human service systems is essential:

1. To increase quality and client value,
2. To decrease the cost of internal coordination and management,
3. To introduce innovations more efficiently and effectively,
4. To reduce response time when clients present with acute needs,
5. To motivate staff to contribute wholeheartedly to the effort to assist children and families with complex and enduring needs,
6. To manage change at a faster rate as our agencies adapt to continually changing community needs; and
7. To demonstrate worth and effectiveness so that the public will value and support the work that we do.

Keys to Effective Change

After examining studies of system change efforts in several contexts, Nicole Allen and her colleagues found that to be successful, the staff expected to implement an innovation in human services need to know how the innovation works, understand why it works that way, and be taught the core skills required to use the innovation in daily practice.

To make that happen, Allen's group identified five key management inputs that are required for the successful introduction of an innovation into a human service system:

1. Incentives for implementation
2. Disincentives for failure to implement
3. Removal of barriers to implementation
4. Provision of resources to support the use of the innovation, and
5. Meaningful support from leadership.

Even when staff agree that an innovation is important and needed, the natural resistance to change in human service agencies (and most other organizations as well) will impede adoption, unless this full range of elements is present.

These principles help to illustrate the depth and range of change necessary to fully implement wraparound. Since wraparound includes a cluster of innovations that operate at not only the practice level, but also at the levels of program management, inter-agency coordination and community involvement, adopting this approach over the course of a change process implies a commitment to a large-scale transformation of the entire human services network.

At the *practice level* line staff in all participating agencies need to know how to use a strengths-based and family-centered approach in their overall work, so that enrollment in wraparound is not considered an aberration, but rather a specialized aspect of how services are delivered generally. The first challenge is for each agency to define this practice approach with enough clarity that line staff, supervisors and managers can tell when it is occurring and when it isn't, and figure out how to help it happen more often. Only then can realistic incentives, disincentives, and sup-

port be offered.

Spanning the *practice, program, interagency and community levels*, a key skill in the wraparound approach is convening and coordinating the family team planning process. Not only do the people who are designated as family team facilitators need to know how to coordinate teams and help those teams develop and implement integrated plans of care, but people from the various systems who may be asked to join family teams must know enough about the process to be effective participants. Only then can supervisors and managers provide the guidance and reinforcement needed to ensure consistent and effective adoption of the wraparound approach. Parallel skills for encouraging family involvement and voice have to be gained by the people who are selected to be family partners.

Wraparound recognizes that no service system can be effective unless it is grounded in, reflective of, and has the full participation of the community it is designed to serve.

At the *program level*, using wraparound means redefining the role of the various agencies that participate in the integrated services. This is a more abstract innovation, but important. Staff should know how the work their agency does fits into the overall pattern of effort of the community's system of care, and should have the skills and understanding needed to insure a balanced and effective response, regardless of the portal through which a child and family come to a given agency's attention. From the management perspective, the question becomes, How do we help staff acquire this knowledge and understanding, reward those who gain and use a more integrated approach to their work, and remove barriers to collaboration that line staff may not have the leverage to overcome?

At the *interagency level*, wraparound requires the development of explicit collaborative protocols to guide the operation of the integrated system of care, the maintenance of ongoing communication and quality improvement to insure the effectiveness of the assistance being offered to children and families with complex needs, and the development of a boundary-spanning infrastructure to support large-scale implementation, funding and data-tracking for the system of care. The managers and administrators participating in the various interagency teams and committees required for wraparound to operate effectively must have the knowledge, understanding and skills needed to recognize and resolve the complex political, economic and technical issues that will confound efforts at integration; and they must have the support of their boards and leaders needed to push through these barriers.

At the *community level*, wraparound recognizes that no service system can be effective unless it is grounded in, reflective of, and has the full participation of the community it is designed to serve. Implementing this principle is more difficult than stating it. The community team, which is the anchor of wraparound, requires structure, support and purpose if it is to have the energy needed to make the system of care a reality. The project coordinator selected to guide the wraparound implementation process plays an important role here, and must have the knowledge, skills and understanding needed to bring a diverse group together, motivate their participation, facilitate their agreement on common goals, and help them manage the conflicts that are natural to a collaborative process. But the coordinator isn't the only one who needs administrative support. Every agency representative who sits on the community team, and every consumer advocate and community stakeholder who is named to the community team, must understand the team's purpose and operations, and have the necessary backing and authority to participate wholeheartedly in the process.

Combining these elements, the accompanying box (next page) presents 10 questions for a steering committee or community team overseeing wraparound implementation to consider.

Ten Questions: Implementing Systems Change via Wraparound

1. *How well has the mission for the wraparound effort been clarified?*
2. *What are the specific outcomes that you hope to accomplish by implementing the wraparound approach?*
3. *What are the core values on which you hope to build your integrated system of care?*
4. *In what ways have you incorporated the perspectives of the various types and levels of agencies and stakeholders who will be a part of the wraparound process?*
5. *How has top management's understanding, support and guidance for the project been elicited?*
6. *How central is line staff empowerment to the change process?*
7. *How has family voice and participation been maintained as a focus in the planning process?*
8. *Have all necessary agencies and stakeholders been included in the process?*
9. *How have the information technology requirements of the new model been addressed?*
10. *Who are the leaders for the project, and do they represent the agencies and stakeholders who are needed for successful implementation?*

Adapted from Proehl,(2001) p. 25

Theories of System Change

There are many theories of system change, but they all have two common components: explaining why bringing about structured change is so hard, and what to do about it. The core framework for analyzing the change process was developed by Kurt Lewin in the late 1940's and was expanded and built upon by later theorists such as Edgar Schein. Organizations (or systems) go through three stages in any change process: *unfreezing* the current state, which leaves the organization open to change; *transition*, in which the organization develops and begins to incorporate new processes, structures and beliefs; and *refreezing*, in which the organization internalizes the changes and returns to a stable state.

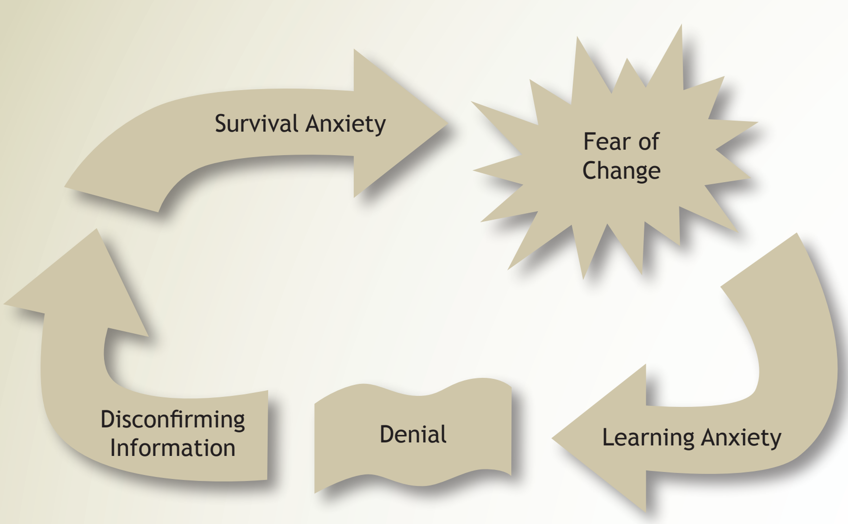
The driving force behind the change process is "disconfirming information"—data from any of a variety of formal and informal sources that indicates that the organization as currently configured is not well adapted to the challenges and opportunities in the environment in which it is located. Strongly disconfirming information will imply that there is a risk to the survival of the organization.

In the case of changes in systems of care for children and families, disconfirming information might take the form of a growing number of children placed out of the home for extended periods of time without resolution of the issues of permanency, safety and well-being. In some cases, disconfirming information comes in the form of lawsuits for failure to take adequate care of children under the custody or supervision of one or more of the agencies. Disconfirming information can be presented through headline cases that overwhelm the rest of what the system is accomplishing, or through an ongoing accumulation of smaller items that gradually convey the sense that the system should be going in a better direction.

The receipt of disconfirming information cues survival anxiety, which motivates change: "If we don't do something different, we may go out of business." However, as the members of the organization begin to think through the challenges involved in doing things differently, the thought of change makes them more and more nervous and resistant: "But doing it differently will be hard, and might not work anyway." The stronger the threat contained in the disconfirming information, the greater the survival anxiety. But the greater the survival anxiety, the greater need for change and so the greater the learning anxiety. This produces a further increase in resistance, which causes the operations of the organization to further deteriorate, and results in more disconfirming information. (See Figure 1.)

The answer is not to eliminate disconfirming information—because then there will be no motivation to change. Instead leaders and change agents must create a situation in which survival

Figure 1. Negative Reinforcement Cycle Created by Disconfirming Information



anxiety exceeds learning anxiety. Simply increasing survival anxiety won't work because learning anxiety will rise along with it. Instead, successful strategies maintain an appropriate level of survival anxiety while using a variety of techniques to lower learning anxiety.

Schein identifies eight options for creating enough psychological safety to open organizations to change. This list is an adaptation of the eight options:

1. Creating a compelling positive vision,
2. Providing useful and functional formal training,
3. Encouraging ongoing involvement of the people who are expected to change,
4. Providing opportunities for the whole group to practice doing things differently,
5. Creating practice fields, coaches and feedback that encourage staff to develop the skills needed for the change process,
6. Providing positive role models so that staff can see how it looks to use the proposed innovations,
7. Establishing structured support groups that help staff work through the stress of change, and
8. Designing consistent systems and structures that support the use of the new approach.

Having observed many unsuccessful attempts at organizational change, Schein counsels leaders and change agents to avoid sending double messages. Frequently, overt change efforts are undermined by covert messages that discourage change. Staff members are sent to workshops where they are instructed on methods for doing things differently, but when they return to the office the negative responses of managers and administrators to their attempts to implement these innovations quickly convey the message that that is not the way things will be done. He states the problem this way:

> What often goes wrong in organizational change programs is that we manipulate some assumptions while leaving others untouched. We create tasks that are group tasks, but leave the reward system, the control system, the accountability system and the career system alone. If these other systems are built on individualistic assumptions, leaders should not be surprised to discover that teamwork is undermined and subverted. (p. 141-142)

Planning for Change

These theories of organizational change help to inform the efforts of leaders and change agents, but generally operate in the background. The overt aspect of the change process is the development of a *strategic plan* to get from the way things are to the way things should be.

System change plans usually have three basic elements:

- A description of the *base state* of the system—how things stand now, what's working and what's needed;
- A description of the *end state*—how the change team wants things to be, what the system will look like when it is operating the way it should; and,

- A description of the *transition state*—what will be going on as the agencies and people involved help move things from the base state to the end state.

Although system change planning processes are usually laid out as linear steps, in reality this planning is highly circular with each of the parts informed by, and informing the others. Schein uses the accompanying figure to express this more complex relationship. (See Figure 2.)

When members of a community's system of care decide to use a wraparound grant as a way to improve the help they are providing for children and families, the RFP issued by the state, while requiring detailed information, still provides a template that can be completed relatively easily. The danger is focusing too narrowly on producing a good grant proposal, while exploring insufficiently the underlying need for change that is the driving force behind the decision to seek this type of support, the nature of the change that is desired, and the means by which the wraparound grant will help to bring about this transformation.

There is no magic to conducting this planning process. The right people need to be at the table, they need accurate data describing the current state of the system of care, they must have the motivation and freedom to creatively examine a variety of potential future states, and a sufficient number of the participants have to be willing to push the group to accomplish meaningful change.

Instilling and maintaining this pressure for transformation is not a mechanical operation. There is a tendency to think of system change planning as a highly strategic and structured process, but good plans for real change are built on passion and vision. Without this inspiration the process quickly becomes stale and predictable.

Kotter and Cohen (2002) put it this way:

> Changing behavior is less a matter of giving people analysis to influence their thoughts than helping them to see a truth to influence their feelings. Both thinking and feeling are essential, both are found in successful organizations, but the heart of change is in our emotions. The flow of see-feel-change is more powerful than that of analysis-think-change. These distinctions between seeing and analysis, between feeling and thinking, are critical because, for the most part, we use the latter much more frequently, competently, and comfortably than the "former." (p. 3)

Figure 2. A Planning Framework

Why change things?
(Determining the need for change; determining the options for change)

Define desired future state

Describe the present state

Getting from here to there: Assessing the present in terms of the future to develop an action plan

How to manage the transition?

Stepping-Stones to Change

Assuming you have a vision for how you want to make things better, and the passion to make your vision a reality, what should you do?

Proehl (2001) describes eight elements for a successful change process in a human services system. The following list is an adaptation of Proehl's:

1. ***Create a sense of urgency.*** Nothing will happen unless a sufficient number of people feel that change must happen to insure survival. What are the internal and external drivers for change? What choices exist regarding the decision to change? What are the political constraints affecting this change project? What steps will be taken to create the urgency?
2. ***Build a coalition for change.*** Nothing will happen unless a group of motivated and empowered people works together to produce change. Who are the system members who have the credibility, power, and interest to support the change? What steps must be taken to build a team to guide the effort? What strategies will be taken to build broad-based support?
3. ***Clarify the change imperative.*** Nothing will happen unless it's clear not only why change is necessary, but also what that change should look like. What are the problems being addressed? What is the vision for the change and outcomes anticipated? What resources will be needed? How will legitimacy be established for the coalition team? How will the vision be communicated?
4. ***Assess the present.*** Reliable and sustainable change to a future state will not occur unless it is built on a thorough understanding of the present state. What are the present obstacles to change? What are the strengths? What data exist regarding the proposed change? How ready is the system for change?
5. ***Develop a plan for change.*** We need to know who's going to do what, when its going to happen, how they're going to get it done, and how we're going to know whether or not it's happened and whether or not it's helped. What level of planning is appropriate? What strategies must be taken to help the organization achieve the vision? What activities will be taken to accomplish the strategies? What short-term gains will be generated?
6. ***Deal with the human factors.*** The best plan in the world is likely to collapse unless the folks who are supposed to carry out the plan are on board and ready to go. What actions will be taken to deal with communication, resistance, and involvement? What new skills, knowledge and attitudes are needed to make the change? What incentives have been created to encourage system members to change?
7. ***Act quickly and revise frequently.*** The window for creating and anchoring change is often a short one. What immediate actions can be taken? What is the timetable for the change? Who will be involved in the change activities? How will the change be monitored? How will the change be institutionalized?
8. ***Evaluate and celebrate the change.*** If you get this far, bask in the moment. How will organization members know if the goals have been achieved? How will they celebrate their accomplishments? What rewards, if any, will there be?

Each of these eight steps can be applied to the process of implementing wraparound. The next series of sections presents some ideas and examples of how.

1. Create Urgency

Urgency is created by an effective combination of bad news and good news. For example, the bad news might be disconfirming information that the county human services department did poorly on its quality service review (QSR). The good news would be that many communities that have adopted wraparound on a large scale have seen a significant improvement in their QSR results. The urgency behind the change effort must be clearly and consistently communicated to agency mem-

Five Elements for Successful Change in Teams

1. *The team must consist of members who have functional representation across departments, who are open-minded and highly motivated, and who represent the end users.* They also need position power, and expertise in their areas and credibility.
2. *A skilled team leader in a position of authority is key.* Although the team needs performance goals to have the direction and drive to get things done, it also needs someone at the helm who is skilled at group facilitation and who understands the nature and needs of the team.
3. *The team must have both the authority and the accountability to accomplish its task.* Many teams with good ideas flounder because no one on the team has the power to put those ideas into action.
4. *There must be upper-level management and support and involvement as well as adequate resources for the team.* Examples of resources for the team might include providing adequate release time, including direct supervisors of team members, identifying sponsors in upper-management ranks who are committed to the change effort, and providing budgetary and operational support for the team.
5. *Adequate internal and external communication systems must exist.* The team members have to be able to quickly share information with one another, and to get their message out to everyone else who will be affected by the change process.

Adapted from Proehl (2001), p. 129

bers and community stakeholders to build sufficient motivation for action. Why is it important to improve our county's QSR? Why is this more important than many of the other issues that are pressing upon our community? What dire consequences will ensue if the change doesn't happen? What wonderful opportunities will emerge if it does?

2. Build Coalitions

System change is a team sport. Successful change teams need the right personnel, equipment and skills. Teams are not just groups of people working at a shared task. To be a real team, Katzenbach and Smith (2003) have posited that it must be:

> A small number of people with complementary skills who are committed to a common purpose, performance goals and approach for which they are mutually accountable." (p. 268)

When asked what was the most important determinant of team performance, Katzenbach and Smith stated that while the role of the leader is important, "having a specific performance goal that is clear and compelling to all team members" is critical to successful team efforts.

The performance challenge and goal is different from the disconfirming information and positive vision that inspires urgency. It must be outcome-based and measurable. For example, disconfirming information might show an alarming increase in the number of families opened for formal child welfare services and a lack of any alternative response options. An outcome based goal might be "reducing the number of families being opened for formal child welfare services by 50% within 12 months, without an increase in the number of children reported as having been abused or neglected following initial system contact." Process-based goals can be measurable, but lack the same connection to the motivation for change. For example, "a minimum of 50 families will have family teams within 12 months." Having family teams may be a means, but keeping kids safe and at home is the end.

Proehl elaborates on the foundation established by Katzenbach and Smith by identifying five elements for successful change teams in human service systems (see accompanying box on this page).

After the change team develops and imple-

ments the plan for system change, the group (or at least some of its members) will evolve into the wraparound community team, charged with ongoing management of the integrated system of services and support. The community team is likely to have a larger membership in order to have sufficient representation and diversity. However, it is critical that the change team convey its sense of urgency, vision and performance goals to the new members of the ongoing community team.

3. Clarify the Change Imperative

In order to convey its message to other people, every member of the change team must understand and be able to explain to others what the team is doing, why it's doing it, its authority for undertaking the project and the outcomes that the team is seeking. When the change team becomes the community team this statement of purpose will be documented in the interagency agreement that is described in detail in other portions of this chapter.

The critical point here is that the interagency agreement must reflect the passion and decisions of the change team and community team, and not be created simply because a grant's RFP or a state statute requires one.

4. Assess the Present

It's hard to get to where you want to go if you don't know from where you're starting. The disconfirming information that contributes to the sense of urgency is not the same as developing a clear understanding of the system's current context, strengths and needs. The change team should use data-gathering tools appropriate to the size and needs of its particular community (i.e., individual interviews, focus groups, record reviews and surveys) to paint a holistic picture of how the system is working at present. This assessment should provide both quantitative (Who's served, how long are they in the system, how are they helped, what happens to them?) and qualitative information (What do staff, stakeholders and consumers like about the current system, what would they like to see different, where do staff and families feel empowered, where do they feel frustrated?) for the baseline.

This assessment should also convey a sense of the system's culture (How do things get done most effectively: formally, informally, collegially, or hierarchically?) and readiness (Who's on board, who has the flexibility and capability to start doing things differently?).

No system is going to be perfectly ready, willing and able to start a change process—if it were, the process wouldn't be needed. Therefore, the assessment of the present isn't about what's wrong, or what's right, but simply what is. That way a realistic plan for change can be constructed.

5. Develop a Plan

At this point you should know why you want things to be different and who will be working together to make change happen, and you should have clarified the change imperative and gained a better idea of what you have to work with. Now it's time to figure out what you're going to do and how you're going to get it done.

One of the characteristics of most system change plans is that they themselves change frequently. Teams almost never do everything they have in their plans just the way that the plans say it should be done. So why plan? Because having a good plan gives you the foundation and flexibility to adapt to changing circumstances and continually incorporate what you are learning as you put the existing plan into effect.

Once the plan is implemented, one major key to success is tracking and celebrating the short term wins. A family team comes up with a delightful innovation that helps a child return home; a

provider agency restructures its personnel roster so that staff have greater freedom to respond creatively to individual family needs; two crusty managers who never got along before suddenly find a point of common ground and their two systems take a major step forward; an unexpected stakeholder joins the community team and brings new life and ideas to the effort. This is the nature of change, and every time something like this happens, the change plan will evolve.

Despite its likelihood of changing frequently, the change plan should be as specific as possible about what sorts of changes are being proposed and where the changes will take place. The domains of change are not infinite. Essentially the change team should look at potential changes in several areas. This list is adapted from Grailer (1996):

- The way the integrated system of care will be governed, including the mandate and authority of the Community Team;
- The way the services and supports delivered through the wraparound process will be staffed and funded;
- The nature and extent of interagency collaboration that will occur in the system of care (for example, will the system of care use parallel planning among the participating agencies, shared planning or integrated planning?);
- How the day-to-day operations of the system of care will be managed and tracked, and how accountability for achieving process and outcome goals will be insured;
- How plans of care for enrolled families will be developed, implemented and how the outcomes achieved will be monitored;
- How child and family access, voice and ownership in both individual plans of care and in the overall operations of the system of care will be insured;
- How outcomes will be measured and the tools that will be used to support ongoing quality improvement;
- What training and support will be provided for family members, family team facilitators, service providers, community stakeholders, supervisors and managers, and community team members?[1]

6. Deal with the Human Factors

Having a well-constructed change plan is good. Having folks willing to implement the plan is priceless.

Earlier in this chapter we looked at the how disconfirming information generates resistance by creating secondary learning anxiety. In the same way, just because the change team comes up with a great plan doesn't mean that everyone will be excited about putting it into action. Timothy Galpin wrote a book on this issue and what do about it.[10] He broke the kind of resistance change teams experience when they introduce an innovation into three categories: (1) people who don't know about the innovation, (2) people who know about it, but aren't able to implement it, and (3) people who know about it and are able to implement it, but don't want to.

Analyzing the reasons for resistance this way helps the change team develop appropriate strategies for supporting adoption of the innovation. People in the first category (not knowing) can be brought on board by communicating the basic elements of the change plan to them, including the reason for the sense of urgency and the strategies for dealing with the problem that the team has come up with so far. In addition, these folks may become hidden resources once they hear about the change process and get involved in the effort. Many people in this first category aren't resistant—they just feel left out.

Folks in the second category (not able) can be helped with formal training, but usually they pick up needed skills best by watching other people. Get them on some family teams so they can see how wraparound works. When any of us are faced with doing something we don't feel we are competent to do, we get anxious. Provide some support

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1.The organizational domains used in this framework are adapted from an unpublished protocol for assessing systems of care developed by Community Care Systems, Inc, One Sherman Terrace, Madison, WI 53704, and shared with the author by Jodee Grailer. For more information on Community Care Systems, please visit their website at http://communitycaresys.com.

and encouragement to help them progress. This is the spot where Schein's eight tools for overcoming learning anxiety are put into action.

Individuals in the third category (not willing), present both a challenge and an opportunity. As knowing and able resisters, they may have a different perspective about what the change team is trying to accomplish that will help make the plan better. The key is to take the time to get to know them so you can understand why they are opposed to the change plan. The reasons can be personal: ("I'm 62 years old and have been through more organizational changes than I can count and I just don't have the energy to go through this one more time.") They can be practical: ("I know you think you have a good plan for integrating services, but I don't think you've looked closely enough at the needs of schools under all the federal and state mandates.") They can be based on principle: ("Yeah, collaboration is all the rage, but in my experience it just means that service providers spend even more time talking with one another and filling out paperwork, and even less time with the children and families who need help.")

Don't take on the most difficult component of change first. As many consultants counsel, pick the low hanging fruit.

Of course they may also just be ornery and negative and not want to cooperate, but most of the time, third category resisters have important stories to tell. Once they have a chance to be heard, and see themselves as being understood, they may be more willing to talk through the issues that concern them and in this way help you either improve the plan itself, or the way in which you are communicating the elements of the plan.

7. Act Quickly and Revise Frequently

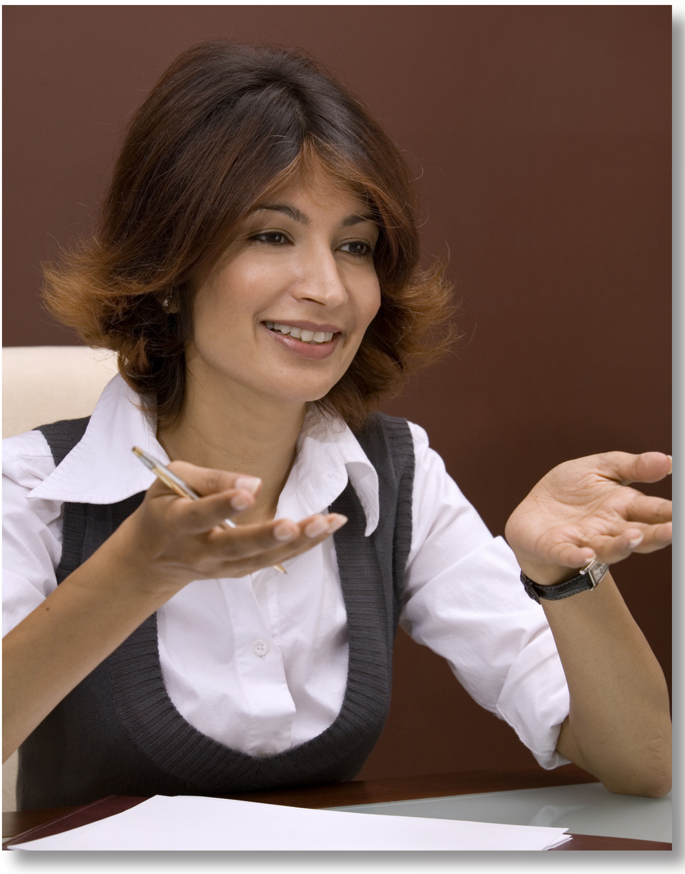
Change teams and community teams are at risk of planning to infinity. This is a subtle form of internal resistance. The way to overcome it is to get out and start doing something. In human services, incremental change is often the best way to make progress. This means that the plan should have manageable segments. Don't take on the most difficult component of change first. As many consultants counsel, pick the low hanging fruit. Also since all the parts of a system are interconnected, you are likely to find that when you make a change in one element, the configuration of the other elements will change, thus requiring an adjustment in the overall plan.

At a minimum, try to spend more time doing than planning. So, if you set a one-year timeline for your rollout, shoot for five months planning and seven months of early implementation.

The following hypothetical scenario is presented to illustrate how a systems change effort in the context of rolling out wraparound might look. It is not intended to demonstrate a typical wraparound model. Instead some unusual aspects are added to let local change teams know that while the principles of wraparound are a constant, there are many ways to put them into practice. After a short overview to provide a background for the scenario, the nature of the system changes the team came up with are broken down into the operational domains listed above.

Kenyon County decided to implement wraparound as an alternative response to support families at risk of disruption and keep them out of formal child welfare or juvenile justice services, or at least reduce their formal involvement to the shortest time possible. An analysis of the families currently open to those two systems revealed at least 50 who probably wouldn't have needed petitions if a family team and flexible resources had been available. About half of the children in those families presented with emotional or behavioral challenges sufficient to obtain a DSM diagnosis. Five of the children had severe emotional or behavioral disorders, and about 60% were in special education. Thirty percent of the parents or primary caregivers were receiving adult services through county mental health, substance abuse, W-2, or developmental disabilities. ten of the children were placed outside the home by court order, either with relatives who were not candidates to become primary caregivers, or in foster care.

A small workgroup was assembled to develop the wraparound implementation plan and Apollina Smith, the retired former DHS director, agreed to chair it. The workgroup included managers from child welfare, juvenile justice mental health, substance abuse and developmental disabilities, the executive directors of two of the main private providers serving the county, the special ed director from the largest district, two parents whose children had been served through the county's intensive in-home treatment program, an attorney who often served as a guardian ad litem, and the juvenile court judge's intake worker.



The group decided to develop a short, universal screening tool that could be used at the gateways of any of the agencies or school offices that might be points of first contact for families at risk of disruption. When the results indicated that the families might benefit from enrolling in wraparound, first contact personnel would be trained to explain the wraparound system and offer to have the wraparound project coordinator and the lead family partner contact the family to explain it further.

If the family chose to enroll after meeting with the two wraparound representatives, the family partner and coordinator would help them complete the necessary paperwork, arrange to address any immediate needs and assign a person to begin facilitating the family team process. The plans of care developed by the teams would include budgets for both formal and informal services, and indicate the appropriate funding streams for supporting the formal services. The budget for informal services would capture the in-kind and voluntary assistance included in the plan. The workgroup decided to have all the participating county agencies contribute a monthly micro-tithe (1% of their current out-of-home care budgets) to form a risk pool to cover services and supports that could not be paid for through other means. In addition the participating agencies agreed to share the cost of developing a network of family team facilitators and family partners who would be available as needed to support wraparound families.

A Community Team would be formed to develop and support the network, manage the funding stream for paying them, track process and outcome data, and review the requests for flexible funding when the amounts were more than $50 per month for a given family. When family team facilitators were already full time employees in county or private agency positions, some of the funding would be used to pay for their release time from their regular job. When facilitators came from other backgrounds, and for family partners, the funding would provide a stipend for their efforts.

The workgroup decided that since their long-term goal was to have the majority of enrolled families not be open to the formal services systems, they would not develop a single plan of care linking the family team's plan with the dispositional plans in child welfare and juvenile justice. Until families were able to step out of formal services, the wraparound plan would run parallel to the formal service plans. Similarly, the schools didn't want to combine their IEPs with the wraparound plans because they didn't want to be obligated to pay for anything contained in them. However, they were willing to try to schedule IEP meetings immediately after or before wraparound meetings whenever possible to improve

coordination of planning.

With this overview of their vision in mind, here are some of the system change elements they began putting into action:

Governance. *Formerly, any in-home teams operated as resources to either child welfare or juvenile justice. The new system would create a shared network of family team facilitators and family partners managed by the community team who could serve families that were not open to any system, as well as those open to any of the formal systems.*

Funding. *Formerly, the only flexible funding was in the intensive in-home program, which only served children with severe emotional disorders who were at risk of placement in residential treatment centers. The new system would build a relatively small pool of flex funds but also create mechanisms that would make it easier to access existing funding streams for formal services without having to file a petition in juvenile court.*

Interagency Collaboration. *Formerly, interagency collaboration only focused on deep-end children, everything else was ad hoc. Under the new system, collaboration would be moved to the front-end through the use of common screening criteria, equal access to the family team network, and shared supervision of the network and the flex funds.*

System management and accountability. *Formerly, system management remained in each of the county service silos. Under the new system, a project coordinator and lead family partner hired and supervised by the community team would manage the family team network for the use of all participating agencies.*

Care planning and service delivery. *Formerly, care planning for all children and families open to the formal systems was the responsibility of case managers in those systems. Even in the intensive in-home program, the care coordinator's function was often subordinate to the responsibilities of the assigned case manager. Care planning was primarily focused on fitting children and families into available service slots. Under the new system, families enrolled in wraparound would have strength-based, family-centered planning, and the workgroup also decided to roll out a consistent model of family-centered planning in the formal service systems on a parallel change track. Service access for wraparound would be plan driven and the emphasis would be on fitting services to the family, rather than the other way around.*

Child and family advocacy. *Formerly, child and family voice was provided either through self-advocacy or through formal advocates such as defense counsel, guardians ad litem and CASAs (court-appointed special advocates). Only families in wraparound had access to family partners. Under the new system, the network of family partners would be joined with the new network of volunteer family team facilitators to insure that voice and advocacy were intrinsic to the design.*

Information management, outcome measurement and quality improvement. *Formerly, the various public agencies collected voluminous data, but had little meaningful and accessible information about what they were doing and the progress their families were making. No feedback system was in place that would allow line staff and supervisors rapid access to performance indicators so they could adjust their plans of care accordingly. No child or family satisfaction data was collected, except in the intensive in-home program. Under the new system, a few key points would be sampled out of the data stream for quick feedback, all tied to the primary goal of helping families live together safely and positively. Family partners would use a combination of 1:1 interviews, focus groups and surveys to get information about satisfaction. The community team would meet every other month as a quality circle to review the process and outcome information and brainstorm options for improvement. The information management system for the network*

would be built on a simple and straightforward, password protected, web-based data management application.

Training and support. *Formerly, ongoing training on family team facilitation was limited to the staff that worked full time as intensive in-home care coordinators. They received supervision, training and support through their manager and supervisor at the contract agency providing this service.*

Since the new system was going to use a large cohort of facilitators and family partners, each of whom might only be supporting one or at most two families, and who might be working at any of a number of jobs throughout the community, a new training and support system was needed. The work group decided to operate the same way as a CASA program. People volunteering to become facilitators and partners would first go through a 40-hour curriculum. They would start with two days of training on wraparound, and then receive additional instruction through a combination of on-line courses and 2-3 hour workshops by a variety of instructors. Upon successful completion of the curriculum they would be certified in the role they had chosen and go on the list for appointment. Monthly social gatherings would be arranged by the project coordinator and would be open to all of the network members. An annual refresher curriculum would be required to remain in the network. The project coordinator and lead parent partner would be available for 1:1 support at any time.

Implementation timeline. *The hypothesis underlying the workgroup's vision was that by teaching a large group of people how to be facilitators and family partners, they would accomplish several goal. First, the concepts of strength-based, family-centered support would be dispersed throughout the community. Second, enrolled families would be more open to participation since the teams weren't managed by people who had power over them because of their position. Third, bringing the community in would provide a fresh perspectives both to the service agencies and to the community.*

But that was a long-term vision. After receiving the okay from the county board and hiring the project coordinator, they started by recruiting a small cohort of four volunteer facilitators and four people who wanted to be family partners. They tried out a variety of training materials with them in weekly sessions. The new facilitators and family partners shadowed the care coordinators and partners in the wraparound unit. At the same time the implementation team was testing out the screening tool and training the front-end contact staff on how to use it. For their first enrolled families they doubled up the facilitators and family partners. Only after they learned what worked and didn't work with this group did they develop a more structured curriculum and recruit a second cohort. That group began working both with families new to the system (and served informally from the start) and families that were open to child welfare and juvenile justice at the time of referral (with a goal of closing formal supervision as quickly as possible).

It took the work group four months to come up with their design. Startup took another four months after the project coordinator was hired. The first two families were enrolled a month later. The second group of families started with the project four months after that. After 18 months nine families were enrolled and four more had transitioned out. With that foundation, the larger effort was ready to go.

8. Evaluate and Celebrate the Change

To endure, change not only has to produce positive results, the participants in the change process also have to feel like they've done something valuable and worthwhile. Collecting good

data about process and outcomes takes care of the first part, having events and rewards to acknowledge accomplishments as they occur deals with the second.

Three kinds of information help document results: quantitative, qualitative and narrative.

Quantitative data consists of the hard numbers that measure what you're doing, who you're helping, what's happening with them and what you're spending in the process. Using the Kenyon County example, quantitative data would tell you when the screening tool was put in place, how many families were screened, where the screenings occurred, how many families were identified as ones who might be helped through wraparound, how many choose to enroll, how many facilitators and partners completed their training, how long the families were enrolled, the nature and cost of the formal and informal support they received, the percentage of children who stayed with their parents or primary caregivers, how they did in school, how many subsequent abuse reports occurred, and so forth.

Qualitative data would describe how the families and children felt about the help they were getting, their suggestions for making it better, how the new facilitators and family partners felt about it and their suggestions, likewise for the schools and agencies that served as enrollment portals for the families, and other stakeholders.

Narrative data would include stories about how things got started with the project, about what some of the big needs of the enrolled families were and how the teams developed plans for addressing those needs, how the community team was formed and its ups and downs and achievements.

You need hard data to demonstrate your project's effectiveness, qualitative data to show that it is valued, and narrative data so that people will understand and remember what you've accomplished.

Celebrations don't have to be big occasions with cakes, decorated rooms and door prizes. They can be ad hoc recognitions, spontaneous happy dances, unexpected gifts, and meeting for a cold drink and hot wings after work. The important thing is to mark each milestone and pay attention to each positive step.

Leading Change

Successful change in human services requires both good leadership and good management. Leadership brings hope, direction, passion and cohesion to group efforts. Leaders help their teams dream the future and choose to make it real. Management takes care of nuts and bolts like budgets, staffing, planning, organizing and problem solving. Managers make the future work.

Most people have a little bit of leader and a little bit of manager in them. The trick is to know when to use which characteristic, and how to balance leadership and management skills in a collaborative team. Most of the concepts that are discussed in this chapter are framed in a manager's rather than a leader's vocabulary. Bullet points, work plans, measurable objectives, preliminary assessments and interagency agreements are the tools managers use to keep the project rolling along. It's harder to describe the tools leaders use.

Leadership brings hope, direction, passion and cohesion to group efforts. Leaders help their teams dream the future and choose to make it real.

Craig Hickman, in his book *Mind of a Manager, Soul of a Leader* (1992) tries to capture the distinction. Managers, he says, like to use MBO (management by objectives) by setting goals and measuring progress toward them. Leaders like to use MBWA (management by walking around). They prefer to "establish a common purpose or philosophy and then stay in touch with people throughout the organization to make sure they work in sync with that guiding purpose."

His point is that good organizations combine both elements. If everyone tries to be the leader, not much work is going to get done. If everyone tries to be a manager, the organization will stagnate.

However, as they are managing by walking around, leaders can have a profound influence on the change process through the use of a variety of subtle tools (adapted from Schein, 1992)

- Language
- Reaction to crises
- Attention and recognition
- Shared learning experiences
- Allocation of rewards
- Consistency and repetition
- Framing
- Criteria for selection and dismissal

Language

The words leaders use to talk about proposed innovations, even the nonverbals that accompany discussions of those innovations, will tell staff what the leader really thinks about it. Language undermining an innovation can be overt: “They’ve come up with another stupid idea to make our lives miserable, but if we want to keep our jobs we’ve got to give it a try.” But it can also be covert: “Okay, I need some volunteers for this team thing.”

Reaction to Crises

Crises occur when the existing operational strategies of an agency don’t match well with a challenge that has been presented. When innovations are being introduced, they won’t have the large number of associated “what-if” options that are gradually attached to more long-standing procedures through extended use in varying situations. So, when a crisis occurs in the context of an innovation like wraparound, the way the leader responds will tell a lot about the leader’s commitment to change. In the Kenyon County example wraparound was used as an alternative to opening formal child welfare or juvenile justice cases. What happens when one of the enrolled families does something that must be reported as potential abuse or neglect? If the leader abandons or blames the innovation, that will be game-over for the staff.

On the other hand, if the leader acts coherently with the agency’s values but looks for ways to continue to use the innovation effectively, staff will be more likely to stick with it. “Safety is our number one objective, but it seems like we should have a better conversation with the family about our reporting requirements during the engagement phase. Let them know what the rules are, but also give them some control. When something is going on that they think we would be concerned about, let them make their own report or do one with us, and show them what will happen next and that the team will stick with them. We also have to look at our training. Facilitators and family partners shouldn’t be surprised if a family that’s been referred because of a risk for disruption has something like this go on.”

Attention and Recognition

This is the leader’s corollary to the last step in Proehl’s organizational change process (evaluate and celebrate). If staff see that the leaders are paying attention to their attempts to use the new innovation and recognize the positive steps that are occurring, they will be more likely to keep trying. Recognition doesn’t take a lot. “Jim, I heard that you and Carrie found a way to engage with that family out in Roxbury. That couldn’t have been easy, but it’s our first step forward with them in a long time. Good job. Let me know how it goes.” One of the characteristics of wraparound is its emphasis on teamwork. This means that leaders should pay attention to and recognize as a group folks who have worked well together as teams, and not undermine them by giving recognition only to one team member.

Shared Learning Experiences

Innovations don’t come out of the box fully developed and usable in any circumstance. They are basic ideas that have to be adjusted and adapted and filled out to make sense in a variety of circumstances. Leaders who sit down with staff, roll up their sleeves and say, “Let’s figure out how we can make this work,” instead of telling people what to do, or worse, abandoning the innovation, are sending multiple positive messages. First, we are an agency that values figuring things out and coming up with new ideas. Second, it’s okay to not know what to do, but it’s not okay to give up. Third, you are as likely or more likely than I am to come up with a good idea.

Allocation of Rewards

Rewards are a notch past recognition and include substantive tangible responses like promotions, bonuses and positively valued staffing assignments. In public agencies, leaders have limited ability to allocate tangible rewards, so when the opportunity does occur it is important to make sure that the decision is aligned with the values of the innovation that is being adopted.

Framing

Framing is how the leader conveys the meaning of a given event or situation. Is a crisis a learning opportunity or another example of the hopelessness of our efforts? Does our struggle with this family present a search to find the hidden unmet need, or demonstrate that there are some families you just can't help?

When a comprehensive innovation like wraparound is being introduced, it's important that leaders use wraparound principles to frame their examination of challenging situations. For example, a facilitator might come to the project coordinator and say, "I'm really having a tough time with the Jones family. Can you help me?" The leader might begin the response with a wraparound frame: "Sure. Could you start by filling me in a little? Where are you in the process, engagement, planning, implementation or transition?" (As opposed to a deficit-based frame: "What's wrong with those Joneses now? I swear that mother has more mental health problems than her daughter.")

Criteria for Selection and Dismissal

One might think that you could tell when the values and perspective of an innovation have moved to the core of an agency's culture when tag words for the innovation start appearing in the agency's job announcements. However, the real test is who actually gets hired, promoted and fired. The ad may say, "We are looking for social workers who emphasize a strength-based, family-centered approach in their practice," only because that's the current jargon the agency has adopted. What counts are the conversations in the hiring interviews, the hallway chats after someone's joined the staff, and the supervisory reviews during the probationary period.

Refreezing

The change process is complete when it disappears because the new innovation has been so thoroughly embedded in the cultures of the agencies in the system of care that it no longer stands out as anything special anyone is doing. It is just the way things are done.

In some ways implementing a new innovation is like planting a tree. You buy a healthy specimen, make sure the root ball is well wrapped, dig the right size hole, put good stuff in the hole to nurture the tree, fill the hole in and water the tree regularly, and wait. If the tree survives at some point it stops being the tree that has been transplanted into this spot and is the tree that grows there. The transition point is almost invisible, but after it happens you know things are different.

Levine and Mohr (1998) make this point with regard to organizational change. Their model is called Whole System Design. They take Lewin and Schein's three stages of change and divide them into six steps to better capture the shift that occurs during refreezing.

In *step one*, the organization is at stasis—sufficiently well adapted to the existing environment to keep survival anxiety at a minimum.

At *step two*, disconfirming information has begun coming in and survival anxiety has risen to the point where a lot of the operational aspects of the organization are being questioned. People are starting to look for alternative ways of doing things.

At *step three*, concerns have gotten so high that leadership has decided to redesign the organization in some way. During this stage a vision of the new model begins to form, often through the use of small-scale pilot projects that don't threaten the overall structure and culture of the organization.

At *step four*, a model for redesign has been selected, and this cues a sharp spike in learning anxiety throughout the members of the organization. Suddenly people are asking, "Where will my desk be if we make these changes?" Or even, "Will I still have a job under this new system?"

Many organizations dedicate a great deal of money and staff time to reach step four and then… just stop. They lack the energy to make it to *step*

five. Instead of refreezing around the innovation, the organization falls back to the structure it had at the outset and either marginalizes or discards the innovation.

However, if the roots of the transplanted tree find sufficient footing in the ground of the organization, step five occurs. Levine and Mohr call it "crossing the transition threshold." Something happens and the organization shifts from being the way it was, to the new way it is. Then comes the refreezing.

Step six is identical to step one, except that the new point of stasis includes the adoption of the innovation that has helped the organization improve its fit with the environment in which it is operating. Disconfirming information drops. Sooner or later the environment is going to change again, and the organization will once again find itself in a step two situation. But for now it will thrive. And when the next external change happens, the organization should have learned enough from this transformation experience to go into the next one with more confidence.

Conclusion

Wraparound offers a great opportunity for systems of care to acquire new tools and approaches for helping families. It is not a panacea, but it does provide a structured model for delivering strength-based, family-centered and collaborative care in a wide range of situations. Adopting the wraparound process means managing significant changes in the system of care. Understanding the dynamics of these changes can help those who are guiding the process create better implementation plans and deal more effectively with the bumps, roadblocks and distractions they will experience as they work through the stages of transformation. However, for the changes to take root, for the system to make it through the transition threshold, the understanding that the implementation team has of the mechanics of change must be matched or exceeded by their passion for the objectives of the change process. We don't use wraparound to become a better system of care; we use it so that children and families can have better lives.

Author

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Supporting Wraparound Implementation: Chapter 5b.2

Family Voices Network of Erie County: One Community's Story of Implementing System Reform

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Our community has a rich tradition of providing resources to individuals and families in need. As our service infrastructure developed over the years, however, the service delivery model for families and children in need of behavioral health services resulted in restrictive and categorically funded programming. During the late 1990s and early 2000s, our county government went through a period of innovation, which, in hindsight, we consider the beginning of the implementation of a new way of doing business with youth and families requiring mental health services. Through collaboration with our system and community partners, we have implemented a culturally competent wraparound service delivery model within and across our county's child-serving systems of care for children by infusing values and principles of strength-based assessments, individualized service planning, increased use of natural supports, and partnerships with families and youth at all levels. The effective use of practice and outcome data has been a key ingredient in our system reform efforts.

This chapter describes our community's journey toward implementation of wraparound and system of care, and the role that the use of data has played in that journey. According to the National Implementation Research Network (NIRN), "Implementation is defined as a specified set of activities designed to put into practice an activity or program of known dimensions" (NIRN, 2009). Our community's experience in implementing system reform efforts can best be described using the six stages of implementation as described by NIRN. These are: 1. *Exploration and Adoption*, 2. *Program Installation*, 3. *Initial Implementation*, 4. *Full Operation*, 5. *Innovation*, and 6. *Sustainability*.

I. Exploration and Adoption

Erie County is a mixed urban, suburban and rural area in western New York State with a population of approximately 950,000. It includes Buffalo, the second largest city in the state, with a population of nearly 260,000. According to U.S. Census figures, Buffalo is the third largest poor city in the nation, behind Detroit and Cleveland. In 2007, 28.7% of the city population was living in poverty, including 39% of children. A number of factors set the stage for our community's development and expansion of reform efforts for our system of care for children with serious emotional or behavioral health conditions and their families.

A Blueprint for Change

A Blueprint for Change initiative by county government in 2000 changed the mindset of human services delivery. The county executive, elected on a mandate for change, sought to make organizational and service delivery improvements that would result in more cost-effective, integrated, and outcome-based services to children and families. As a result, joint demonstration projects across mental health, juvenile justice and child welfare services were implemented to provide limited flexible wraparound services to children at high risk for out-of-home placement. A pilot model that used blended funding through New York State Office of Mental Health for high-need children culminated in the creation of a "Single Point of Accountability" (SPOA), simplifying the referral process.

Systems Collaboration

A needs assessment conducted with 134 direct service providers, and 32 parents found that children with serious emotional or behavioral conditions who had similar needs and challenges were represented across all child-serving systems (Kernan, Griswold, & Wagner, 2003). Data was collected about youth receiving services from various systems including foster care, juvenile justice and mental health. This data included diagnosis, service history, needs, gaps, and barriers to services. Additionally, focus groups were held with families and youth in preparation for submission of a proposal for a grant funded by the Center for Mental Health Services (CMHS). Table 1 shows that youth in placement and at risk of placement had similar needs. Recommendations to the county were to integrate child-serving systems and expand community-based and individualized services for children, youth and families. The Departments of Social Services (SS), Juvenile Justice (JJ), and Mental Health (MH) collaborated with each other and with families, and this helped build the trust and relationships that were crucial to our request for federal funding through CMHS's Comprehensive Community Mental Health Services for Children and Their Families Program.

II. Program Installation and III. Initial Implementation

When federal funds were awarded in 2004 to Family Voices Network of Erie County, our goal of cross-system cultural change for children with serious emotional disturbance and their families could be realized. The initial management team had been known as the 'Implementation Team', and included representatives from the county's child-serving agencies, service providers, and the family organization who met bi-weekly. Once the CMHS funds were awarded in 2004 this team became the 'Management Team,' and expanded to include social marketing, evaluation, and the youth director. Within a year, we had a cultural competency consultant on board part time. Our cross-system governance structure began to build collaborative relationships with families, family court, Social Services, Juvenile Justice, and youth. Our Executive Committee, which includes representatives of family and youth, as well as city, state and county

Table 1. Needs Assessment Range of Services Needed

	Children in Placement Need Service (N=64)	Children at Risk of Placement Need Service (N=70)
After-school programs	48%	46%
Mentoring	48%	31%
Respite in-home/overnight	46%	34%
Respite (mental health)	19%	29%
Parent training and education	27%	39%
Skill building	28%	24%
Transitional case management	22%	13%
Intensive case management	18%	46%
Mental health advocacy	20%	14%
Sexual trauma treatment program	17%	13%
Integrated treatment and case management	22%	26%
Vocational education	20%	9%
Psychiatric evaluation	8%	23%
Medication management	6%	20%
Child and family recreation	11%	29%
Parent support group with family	20%	27%

commissioners, makes policy decisions which affect the Management Team, which is the working group that implements the decisions made by the Executive Committee. Because our Management Team is so large—with as many as 45 attendees representing all child-serving agencies, family members, care coordination supervisors, cultural competency, and youth—we have sub-committees making recommendations to the Management Team on specific issues. For example, the cultural competency committee will look at data broken out by race/ethnicity or socio-economic status, identify disparities, and make recommendations for improvements to the Management Team. The Management Team subsequently decides by consensus of the group to make changes in service delivery or training based on these recommendations.

Family-Run Organization and the Youth Coordinator Position

With the CMHS grant award in 2004, the family organization Families' Child Advocacy Network, was able to receive funding to hire family support partners and jump-start activities. Family members began to attend the Management Team meetings. They took part as full members, and were

compensated for their time on an hourly basis. Our Youth Director had input at each level of governance including the Executive Committee. There were monthly Roundtable meetings that allowed family members to become full participants in the evaluation design, data collection, data interpretation, and decisions made regarding presentation and use of the data.

There were monthly Roundtable meetings that allowed family members to become full participants in the evaluation design, data collection, data interpretation, and decisions made regarding presentation and use of the data.

An example of family input was the decision to track how many days it was taking from the referral date to the start of services. Families complained that weeks would pass before services started or they heard about their status regarding services. Another issue that was important to families was transition planning. Both of these family priorities became focused areas for improvement and are monitored regularly. (Relevant data collection is discussed later in this chapter.) A working committee of family members, youth, the social marketing director, and the evaluator began to meet monthly to work on the website, newsletter, and family-friendly reports. This working group became the social marketing and evaluation team (S.O.M.E.) and was recognized by SAMHSA with a Silver level award for 'Involving Family Members and Youth in Evaluation' in 2008.

Strategic Planning Process and Logic Model Development

Within the first year of grant funding, a core group of individuals from our community of stakeholders—the project director, evaluator, family director, youth coordinator, clinical director, and social marketer—met weekly over the course of four months to create a first draft of our logic model, which encapsulated our strategic plan to affect change in our system of care. Conference calls with consultants Mario Hernandez and Sharon Hodges at University of South Florida were instrumental in putting our ideas to paper. We used our grant to develop our understanding about our target population, challenges, assets, goals and outcomes. We provided regular feedback on our progress to our Management Team.

Our logic model has become our central strategic tool for planning, evaluation, and continuous quality improvement, with short- and long-term outcomes reviewed quarterly by the Management Team. By reviewing our logic model regularly, new team members become familiar with our goals and indicators of progress and more experienced members can bring up issues that need to be addressed. Changes to our logic model are made by consensus of the Management Team. For example, we recently agreed to an additional family, youth and child-level outcome, namely "increased family participation and empowerment." Our logic model is a living tool, reflecting the dynamic changes in our community with our families and partners. Our logic model is featured as an exemplary model on the University of South Florida's website (University of South Florida, 2009), and in the System of Care Handbook (Stroul & Blau, 2008).

Critical Data Dashboard and Fine-tuning the CQI Process

Data management and reporting was a priority for the early leaders of system reform efforts. The county invested in an online, web-based system and required all agencies serving youth enrolled in Family Voices Network (FVN) to utilize this system, CareManager ©, for documenting care coordination activities consistent with wraparound practice, and, eventually, billing and invoicing. As our system of care developed and the county placed appropriate priority on ensuring that the model was achieving the desired outcomes, it became clear that we needed to monitor not only fidelity to practice but also outcome performance. Earlier efforts found us chasing "fires" with little

ability to track the effects of corrective actions, or to truly gauge the size of the "fire."

Reporting at this time was somewhat unfocused and untargeted, difficult to sustain, and lacking in transparency. As a result, in 2007 the county developed a 'critical data dashboard' which reports key practice and outcome metrics. Table 2 shows this dashboard, which was designed to be visually simple, provide a snapshot assessment of critical performance indicators, and be readily accessible to each care coordination agency and the county. The report format was designed so each care coordination agency (currently there are six) would receive its own monthly and year-to-date (YTD) data, as well as data providing a comparison with the system as a whole. For example, Table 2 shows 'slot utilization' for the month of August 2009. 'Enrolled days' are the number of days that families are in services, while 'allocated days' are the number of days that the agency is contracted to provide services. In the example shown for ABC Agency, there was an average of 40.1 enrolled days in August, which was 91% of allocated days. For the year to date (YTD), there was an average of 42.4 enrolled days which was 96% of days allocated. Looking to the right at the 'overall Family Voices profile' for the current month, 79.4% of allocated days were used, down from the year-to-date figure of 84.8%. Hence, ABC Agency is performing better than the FVN overall average for slot utilization. This information can be used by the agencies as benchmarks and to measure themselves against the overall average.

The county established quarterly dashboard meetings with individual agencies to discuss and review performance. In addition, the Management Team regularly communicates and resolves dashboard issues which are broader in nature. From early on in this process, meetings were not focused solely on specific measures of agency performance but rather on practices that would support proactive management and supervisory techniques. As the dashboard meetings began to reveal that agency supervision and clinical practices and outcomes were improving, the quarterly dashboard meetings were moved to once every six months for all agencies.

During calendar year 2008, the county contracted with a local agency to provide technical assistance (TA) in developing effective and focused quality improvement (QI) plans for each care coordination agency. These plans utilized existing data to target areas of concern that, when addressed via the QI process, would improve specific performance outcomes that had previously been identified as being of concern.

Recently, after a review of the data trends over the past two and a half years, we were in a position to develop community outcome performance standards. It is important to note that this was done in collaboration with our community providers. Because of our rich database, our community was able to identify areas of concern and as a result we have successfully implemented practices to improve performance with respect to timely submission of progress notes, as well as timeliness of case assignment.

As a result of the successes experienced in utilizing the data dashboard, data informed practices, community learning tools, and quality improvement practices, the county has also begun to implement a data dashboard for other children's behavioral health services.

We have found the following factors critical to the success of data dashboard utilization:

- Limit the dashboard to key variables most important to your community (if you look at everything you look at nothing).
- Make reporting visually simple (at-a-glance concept).
- Involve your stakeholders, especially in choosing what outcomes are important to them.
- Make data readily available and real time.
- Operationalize data; have early reviews addressing data reliability and make amendments if necessary.
- Use strength-based approaches—avoid using data as a "club."
- Create buy-in across various levels of the organization.
- Share across all organizational levels including CEO and direct line staff.
- Make reports transparent as early on in the process as possible.
- Have regular monitoring and communicate expectations clearly.

Table 2. Critical Data Dashboard - Family Voices of Erie County Care Coordination ABC Agency *(Note: data is actual, agency name is not)*, August 2007

Critical Data Element	Agency Profile				Overall Family Voices Profile			
	Current Month		YTD		Current Month		YTD	
	#	%	#	%	#	%	#	%
Assignment *(# and % of referrals that the Single Point of Accountability assigns within 10 calendar days)*	-	-	-	-	34	94.44	260	78.08
Slot Utilization *(Enrolled days versus allocated days [monthly average])*	40.1	91.13	42.4	96.36	358.97	79.42	383.61	84.87
Staffing Utilization *(% allocated care coordination [CC] staff days filled by permanent CC staff [does not include days temporary coverage provided] [monthly average])*	-	100	-	100	-	96.67	-	99.12
Length of Stay Current Enrollees w/LOS > 14 Months *(# and % [monthly average])*	2	5.41	1.75	4.18	30	8.33	34.75	9.09
Engagement *(# and % assigned and closed but not opened)*	0	0	4	5.41	5	7.46	31	4.99
(# and % enrolled but discharged < 90 days)	1	12.5	2	4.76	2	5.88	14	4.13
Change in CAFAS® *(% of those enrolled with 10 point or greater change at 6 months)*	6	100	25	96.15	13	100	143	87.2
(% of those enrolled with 20 point or greater change at 12 months)	-	-	10	100	2	100	96	85.71
(% of those enrolled with 10 point or greater change from enrollment)	7	87.5	34	80.95	26	78.79	254	76.97
Successful Discharge *(minimum of 65% of enrolled will be discharged with "objectives met")*	6	75	30	71.43	24	70.59	233	68.73
Community Based Care *(% of enrolled youth who are discharged without having been placed in a Residential Treatment Center [RTC])*	8	100	41	97.62	34	100	299	88.2
(# and % being placed in an RTC > 90 days)	0	0	0	0	0	0	0	2.95
(# and % being placed in inpatient > 30 days)	0	0	1	2.38	0	0	17	5.01

- Implement a QI component and revise as necessary.
- Drill down to individual service providers to make necessary improvements in practice.

IV. Full Operation

About three years into our implementation, Family Voices Network (FVN) was fully operational and serving nearly 350 families a year; however, we were still in need of continuous quality improvement practices. At this point our system-wide data management system, CareManager ©, was fully operational and collected process, outcome, billing and accounting information for all services provided to children and families enrolled in FVN.

We received a SAMHSA CMHS supplemental award to support and bolster the essential vendor service delivery system that provided wraparound services to children enrolled in FVN and was expanded to the Family Services Team (FST) programs that operate in targeted neighborhoods in the City of Buffalo. This award was used to fund the creation of a new quality management organization, Community Connections of New York (CCNY).

As a grassroots non-profit, CCNY was created to provide evaluation, quality improvement, training, and technical assistance to care coordination and vendor agencies within the system of care. CCNY is also charged with expanding the vendor network to include new agencies responsive to the needs of families receiving services, while also enhancing the existing network with capacity-building projects such as human resource development and training for professionals. CCNY works to promote access to culturally competent services and ensure voice and choice to families and youth during service selection.

As part of their evaluation process, CCNY uses methods that are anchored in a blended paradigm approach of utilitarianism (Patton, 1997) and realism (Kazi, 2003), combining the tenets of iterative stakeholder involvement and utility focused evaluation tools with statistical processes that help determine underlying patterns related to change in outcomes. As use of evaluation data is paramount, heavy emphasis is placed on working supportively with agencies in application of quality improvement practices such as the DMAIC (Define, Measure, Analyze, Improve, Control) Model (University at Buffalo Center for Industrial Effectiveness, 2008). This tag-team approach of user-focused evaluation and quality improvement strategies resulted in a mental health community organized around practice and system change to achieve better services for youth and families.

To help build community capacity, CCNY offers trainings in various modalities that are customized to the learning style of the end user. The company delivers trainings in person and online. CCNY is the only authorized training provider for the Casey Life Skills Tools in the North East region, and in this role provides learners with knowledge and tools to perform life-skills assessments, create learning plans, and evaluate life goals for clients in their programs (Downs, Nollan, Bressani, et al., 2005). CCNY provides ongoing technical assistance to community partners in FVN by offering training on the quality improvement continuum and construction of the tools to help them implement the practices. The organization hosts various trainings on cultural competency, assisting attendees in learning the behaviors, attitudes and policies that facilitate cross-cultural work between individuals, organizations and systems.

Measuring Fidelity to the Wraparound Care Coordination Process

Measuring fidelity to the wraparound care coordination model was an early strategy outlined in our logic model. Our families wanted to participate in the quality improvement process and we needed youth and care coordination input to improve practice. The Wraparound Fidelity Index (WFI) was

chosen for use in monitoring fidelity because of its growing research base and support from the National Wraparound Initiative. Data for the WFI is gathered via a phone interview with the wraparound facilitator (or care coordinator), caregiver (usually the parent or legal guardian), and youth. The WFI assesses adherence to the wraparound principles and activities (Walker, Bruns, Adams et al., 2004). The WFI has been conducted annually for the past two years, yielding information to the system of care on areas in need of improvement. Additionally, results from the 2007 WFI study were reported to system administrators in fall of 2007, and showed undesirable scores in fidelity for the transition phase of wraparound. This sparked development of case transition training and education programs for care coordinators, and mandatory transition planning in monthly family team meetings. Results were disseminated to a group of families and youth who made suggestions for improvements to the system of care. The orientation workshop, conducted by the Families' Child Advocacy Network for newly enrolled families, now includes a discussion about the transition phase of the wraparound process.

The research team completed the WFI again during the summer of 2008 to determine the magnitude of change in fidelity scores from 2007 to 2008. The WFI results showed significant improvements in the wraparound process in 2008 as perceived by the care coordinators and caregivers. High fidelity scores, as measured by the WFI, indicating adherence to wraparound principles and activities were in the mid to high 80 percentile.. Table 3 shows that the overall mean scores improved significantly from 2007 to 2008 for all respondent types except youth. Total mean score increased from 80% in 2007 to 85% in 2008. Youth scores increased from 73% to 77%. The wraparound care coordination process had improved after quality improvements were made to training and service delivery. With lower mean scores given by the youth, youth engagement in the wraparound process became a targeted area for improvement in 2009-2010. The WFI will be conducted again in the Fall 2009 to measure these quality improvement efforts (Kernan & Pagkos, 2009).

Table 3. Wraparound Fidelity Index Results

WFI Total Mean Scores			
	2007	2008	P value
Total Mean Scores	80.5	85.2	.001
Care Coordinator	87.7	90.7	.006
Caregiver	75.7	80.8	.01
Youth	73.3	77.2	.38

V. Innovation

Having developed and maintained a well defined data base and a method for reviewing this data on a real time basis has provided us with the opportunity to utilize this data in ways we could not have possibly planned for only a couple years ago. After a review of the data trends over the past two and a half years, we were in position to develop, in collaboration with our community providers, community outcome performance standards. Table 4 shows the performance standards that each care coordination agency should meet or exceed in 2010. For example, each agency is contracted to provide services to a set number of families. The community standard for 2010 is that each agency will utilize 95% of its allocated slots. This is a critical metric in order to maintain timely access for families and youth. Likewise, staffing at each agency should be kept at 95% to ensure timely services to families. Another metric we follow is the percent of families discharged without having been placed in a residential treatment center. We aim for a minimum of 90% of families meeting this goal in 2010. By setting these performance standards we challenge ourselves to improve service delivery and outcomes for our children and families.

Moreover, the availability of our rich data base has given us the ability to identify areas of concern within our existing processes. We have made noteworthy progress in two critical areas, specifically 1) timely progress note submission, and 2) timeliness of case assignment. Data collected from January to July 2008 showed that only 36% of all referrals to FVN were assigned within 10 days. Families were made to wait for services at the point when

Table 4. Care Coordination Community Standards

2010 FVN Standards Performance Metric Summary	Minimum Community Standard
Slot utilization	≥ 95%
Staffing utilization	≥ 95%
Cases with length of stay > 14 months	≤ 9%
Cases assigned and closed but not opened	≤ 4%
Cases enrolled but discharged < 90 days	≤ 4%
Cases with 10-point or > change in CAFAS® @ 6 months	≥ 80%
Cases with 20 point or > change in CAFAS® @ 12 months	≥ 80%
Cases with 20 point or > change in CAFAS® from enrollment to discharge	≥ 75%
Cases with successful discharge	≥ 65%
Cases discharged without having been placed in a Residential Treatment Center	≥ 90%
Cases placed in Residential Treatment Center > 90 days	≤ 5%
Cases placed at inpatient psychiatric setting > 30 days	≤ 5%
Cases with first Face to Face visit < 10 days	≥ 85%

they most needed them. To correct this situation, intake process was reviewed, paperwork was redesigned, strategies were put into place and improvements were made. Data collected from January to July 2009 showed that 76% of all referrals were assigned within 10 days and most recently, July 2009 saw 97.7% of all referrals were assigned within 10 days. Further, we have also begun to examine the effectiveness of wraparound services across ethnic and racial groups. As we begin 2010 we will be contracting with a local agency that will assist us in identifying any practices that are contributing to racial disparities and implement QI practices to effectively address those issues.

VI. Sustainability

How do we know our system of care is sustainable? Does it mean the goals we set for our community have been met? Have we Achieved Cross-system Cultural Change, Enhanced the Existing Infrastructure of Care Coordination and Individualized Services and Natural Supports, and Achieved Fiscal Stability? Data is at the core of our plan, and by showing our partners that youth are more effectively served through our system of care, we can serve more youth as we reinvest savings from residential placements. Approximately 400-425 families are served at any one time, up from 200 families four years ago. Twenty-five percent of residential funding has been diverted to the system of care, resulting in more youth living at home in their communities. Table 5 shows community placement data, and illustrates that in June 2007 we had discharged 78% of youth without having placed them in a residential treatment center (RTC) while receiving services. By August 2009, this percent had increased to 88% of youth discharged without placement in an RTC. System-

Table 5. FVN Community Placement DataJune 2007 - August 2009

Month	Year	% Discharged without having been placed in a RTC
June	2007	78.72
December	2007	79.24
June	2008	85.34
December	2008	86.55
June	2009	87.35
August	2009	88.3

wide sustainability is and must continue to be an on-going collaborative effort with our community partners. While our planning efforts have paid off with increasing numbers of families served from across a broad spectrum, the human services arena faces increasing stressors from the poor economic outlook in our region and state. Ongoing relationship building, development of trust with our system partners, and sharing resources will be critical to our sustainability plan for our system of care.

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Supporting Wraparound Implementation: Chapter 5c.1

Training, Coaching and Beyond: Building Capacity in Your Wraparound Workforce

Pat Miles, Consultant

As wraparound has continued to grow and expand, so has the variation among wraparound projects. This variation may be driven by political circumstances as they play out in funding and organizational options. It also may be driven by bureaucratic and administrative issues such as those related to Medicaid funding or state licensing requirements. Variation can also be fueled by human resource concerns, such as what sort of workforce is available and/or required to staff wraparound projects. Variation also arises because projects are designed to fit different local contexts and priorities. As a result, projects vary in terms of whom the project is targeted to, what local conditions and sensibilities exist, and where the administrative host environment for the wraparound project is located. Finally, variation among wraparound projects is also driven by differences in the understanding and concerns of local leadership.

Projects choosing to implement wraparound have attempted to deal with this variation in different ways. Some projects respond by placing a heavy emphasis on ensuring that teams achieve the various separate steps or activities that make up the wraparound process. This separation of the wraparound process into an invariant series of specific, separate steps may result a certain uniformity of practice across families; however, many projects find that this focus on achieving the steps of the process must be balanced by the need to individualize the process for each family. These projects come to see that wraparound as a whole is more than the sum of the steps that are its parts. As a graceful waltz is more than the individual steps, so it is true with wraparound.

This line of thinking leads projects to seek out strategies for building a workforce that is able to accomplish the steps of the process while also being able to appropriately adapt those steps on behalf of an individual family. A range of tools are available for creating this capacity including training, coaching, mentoring and supervising.

The successful project uses several of these strategies rather than focusing on only one approach. The first step in designing a sensible approach to developing workforce capacity is to recognizing that wraparound is a complex, integrative approach that must adapt over time to the needs of families and communities in which it is placed. Options available for developing workforce capacity include:

Training. Focused on providing an overview and fixing definitions as they relate to the wraparound process, many projects get started with a training focus. Training is most useful for communicating a sense of the whole when it comes to the wraparound process and for introducing participants to the language of wraparound. Additionally, formal classroom-based training sessions can also communicate what not to do in wraparound, especially as it relates to changes in the ways that families are viewed within the system. Some tips for mounting a successful training approach include:

- **Be realistic about the power and limitations of training.** Training, even entertaining training, is not likely to cause behavior change in practitioners. Training sessions can, however, define certain elements of the wraparound process while communicating values. Wraparound training can be made very powerful by including individuals who haven't historically been included as participants in training and by creating an event that people go through together.
- **Partner with families in providing the training.** Many communities have partnered effectively with families in delivering wraparound training. This has ranged from having families tell their own stories to having families function as co-trainers. In some sites, families are engaged to participate in the training for trainees to practice with as they learn skills and activities that are part of the wraparound process. This kind of training experience also provides a supportive environment for trainees to have a meaningful dialogue with families who have first-person system experience.
- **Build your local training capacity as soon as possible.** Many local communities rely on outside experts to implement their initial training opportunities. This allows wraparound information to filter in from other places. On the other hand, projects that build their own training capacity find that their understanding of wraparound increases as they take over their own training efforts.
- **Use training as a way to create a sensible host environment.** Many wraparound projects focus their training efforts on those who will be hired by the project. Some communities have focused their ongoing training activities more broadly, including all individuals who are likely to participate on wraparound teams. This allows wraparound team members to get oriented in a training environment rather than on the individual team.
- **Tailor your training to your staffing pattern.** As wraparound grows in a variety of settings so does the range of staffing options. Some projects have wraparound facilitators while others use care coordina-

tors. Some projects have family partners housed within the project while others have them housed as adjunct to the facilitation process. Some have no parent or family partner within the project design. Still others hire clinical staff to function as community clinicians or some sort of community support paraprofessional to do direct interventions with the child. While all of these staff roles will benefit from an overall training about wraparound, good projects will also build in more skill-focused training sessions designed specifically for the staff roles in place with the project.

Coaching. Recognizing the limitations of a training-only strategy, many communities have begun to use a coaching process to build capacity. These coaching efforts focus on developing and elevating expert practitioners. Expert practitioners may have demonstrated skill in past wraparound implementations, but often the wraparound process has not been locally implemented long enough for local expertise to emerge. In those cases, the "expert" is someone who is skilled in the art of analysis, synthesizing and feedback. Some tips for effective implementation of a coaching strategy include:

- **Develop consensus on your expectations.** Wraparound is an expansive model that incorporates a number of process steps. A strict focus on these practice steps may result in a descent into excessive detail. Building consensus among a variety of community members about what steps, when taken together, constitute the entire wraparound "dance" is likely to do several things. These include securing buy-in, creating agreement about your target and remembering why doing wraparound is important rather than focusing on strictly the "how" of wraparound.
- **Create a formal feedback loop.** Tools to summarize feedback to both the practitioner and their supervisor can make coaching much more effective. If coaching involves dialogue only there is a great possibility that much of the learning will be lost. Additionally, if a community is well resourced enough to have a coach who is separate from the supervisors, then good tools will make it easier for coaches to summarize information for supervisors as well.
- **Define your coaching process.** Projects that are able to make good use of coaches have defined how the interactive aspects of coaching should happen. This includes introducing and defining coaching process steps to employees as well as providing direct, honest and fair feedback to employees who are not performing in a way that's compatible with the way you have defined your project. Standardizing the feedback process using adult learning and social learning theories can increase the ability of staff to incorporate feedback from the coaching process.

Mentoring. Some sites that don't have the ability to have a full-time coaching capacity will use a mentoring approach. Creating a mentoring capacity often occurs after the project has had enough time to develop true expert practitioners. These individuals have demonstrated the ability to not only do the process according to the agreed-upon steps, but also to adapt the process to meet the needs of individual families. When sites employ a mentoring strategy, mentees are assigned to a primary mentor who checks in from time to time and serves as a role model. Less directed than the coaching approach, this approach creates the capacity for troubleshooting and assumes that the mentee will take responsibility to seek out feedback from the designated mentor. Tips for successful implementation of the mentoring strategy include:

- **Avoid making mentoring status a rung on the career ladder.** Mentors should be individuals who are seen as very skilled in implementing the process. In sites that struggle with a career ladder there is a tendency to name someone as a mentor because the person has been there for a long period and this is thought of as a way to recognize their service. This can cause confusion among staff members.

- **Be clear about mentoring parameters.** Some sites are able to reduce mentors' other duties to free up time for them to work with mentees. Other sites do not have this flexibility. The mentoring model expects the mentee to seek out the mentor for feedback more than the mentor is expected to seek out the employee. The mentor should stay focused on process rather than getting into personnel issues.
- **Mentor to the job role.** While wraparound implementation is important, it is also important to recognize that different staff roles will interact with the process in different ways. If a project pursues a mentoring approach and has multiple staff roles such as family partner, facilitator, clinician or others, then mentors in each role should be assigned.

Supervision. Supervising wraparound can often feel as complex as the process itself. One strategy for creating a strongly resourced workforce involves strengthening wraparound supervision. Good wraparound supervision is multi-dimensional in nature and focuses on personnel and on the process and the context in which it operates. Supervision should be clear, values based and rooted in real-time information about practice. (See chapter 5b.6 in this guide for a more detailed discussion of supervision in wraparound.)

Summary

Wraparound projects succeed and thrive based on the ability of managers and leaders to adapt capacity-building strategies to assure that staff have an understanding of what is expected and are able to demonstrate what is expected. Local wraparound leaders often find that they have to define and adapt their strategies for assuring the right skills based on local conditions. An effective workforce development strategy will adapt based on local conditions, incorporate families who are receiving wraparound support into employee development strategies, and frequently remind staff and partners that wraparound is never more important than the families it was designed to help.

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Supporting Wraparound Implementation: Chapter 5c.2

An Overview of Training for Key Wraparound Roles: The California Experience

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You Have to Start at the Top: Administrators and Directors

A community that wishes to introduce wraparound into its continuum of care for high-need youth and their families has many issues to consider and many decisions to make. These choices are best made when they are based on sound information gleaned from the experiences of others who have made the journey and when they are arrived at collectively by the leadership of the departments and agencies that will need to collaborate in the implementation process.

This "top" level of leadership includes heads of the departments, agencies, and community-based organizations (CBOs) that will be involved in the collaboration to implement wraparound. These leaders need to have the opportunity to acquire a foundation of knowledge about what wraparound is and what makes it successful. At a minimum, leaders need training, technical assistance, and/or coaching that covers the following topics.

A basic understanding of the philosophy, process, target population, and intended outcomes of wraparound

In order to make informed decisions regarding wraparound implementation, people in key leadership positions must be provided with information about wraparound's underlying philosophy as a strength-based, family-driven planning process intended to support high-need youth in the context of their home, school, and community. These people need

to know how wraparound works, which youth and families it will serve, how much it costs, and what they can expect in terms of results. They need to know that wraparound may have an impact on their other programs and services.

A recognition and appreciation of the need for teamwork at all levels to create shared ownership of the program, including its successes, its challenges, its risks, and its rewards

The words "team" and "teamwork" have special meaning and importance in the context of wraparound. At the child and family level, a unique team is constructed to support the work with that particular child and family. At the program level, staff at the supervisory and management levels must work collaboratively across agencies and systems. And, at the administrative level, agency

directors, including community-based provider agencies, must work together to support the underlying principles, to share resources, and to provide leadership in their respective agencies. Leaders should understand that they will likely be asked to sign on to various policies—such as protocols for shared planning, decision making, conflict management, and crisis response—and to commit resources and/or staff time to support initial and ongoing implementation.

An understanding of the variety of structures or models that communities have employed in order to implement wraparound

Wraparound has been implemented successfully through a variety of structures and models. Some communities choose to bring together staff from several governmental agencies to do the direct work with families. Some contract with community-based organizations to take on the implementation of wraparound. And some have devised networked combinations of these to bring a variety of agencies and perspectives together on behalf of youth and families. Each model has its particular advantages to be considered.

An understanding of the various funding sources that have been "blended" and "braided" across the nation in order to achieve both adequate and flexible financial and staffing resources to provide sufficient support for this approach

Various communities have succeeded in bringing together a wide range of financial resources and structures in order to yield sufficient funding to provide adequate staffing and flexible funds for wraparound. These sources have included:

- Federal foster care funds
- State foster care funds
- Local/County foster care funds
- Mental Health funds via Medicaid
- State mental health funds
- Local/County mental health funds
- Governmental grants
- Foundation grants
- Private donations

Section 5d of this *Resource Guide* provides chapters that discuss financing options in greater detail.

An understanding of the initial and ongoing training and coaching needs for managers, supervisors, and direct service staff to support wraparound implementation

While it is essential that direct service staff are provided adequate training and coaching on the knowledge and skill sets needed for their

jobs, it is equally essential that adequate training be provided for managers and supervisors in order to support the Wraparound core values and principles on a continuous basis. Supervisors in particular need to be able to model these principles in parallel process for their supervisees as well as monitor staff performance in the field.

You Have to Count on the Middle: Managers and Supervisors

Once the fundamental decisions have been made by the leadership, it's the middle managers and supervisors that make any program work. And, keep it working. Or not. These are key roles that are often overlooked by communities anxious to get something up and running. There is great danger in forging ahead without taking the time to build a strong infrastructure of support and commitment throughout the various departments and agencies that must work together effectively in order to implement and sustain wraparound.

The following are areas of essential understandings for which training, technical assistance, and coaching for managers and supervisors need to be considered.

A basic understanding of the philosophy, process, target population, and intended outcomes of wraparound, and how this plays out within and across different systems

The management infrastructure must support the concept that key decisions will be made at the child and family team level, driven by the strengths and needs of the family in the context of the community. Collaborative decisions must be made regarding the target population(s), referral and enrollment protocols, and outcome measures to assure both model fidelity and family goal attainment. The fiscal departments of all involved agencies must be made aware of the funding mechanisms provided as well as the expectation of the use of "flexible" funding to support family needs.

An understanding of the staffing patterns and caseload ratios needed to provide effective support for youth with high levels of need and their families

The wraparound planning process requires skillful and sensitive facilitation. Family Partners have proven to be effective in bridging the relationship between parents and professionals. Direct in-home work with the youth in the context of the school, neighborhood, community, and culture has been essential. Establishing effective caseload standards for each of these roles must be based on the needs of the youth and families, on the challenges of the target population, and on the availability of other supportive resources in the community. The Human Resources departments of involved agencies will need assistance in understanding the recruitment and training needs for each of the key roles of wraparound staff.

Communication across agencies and programs at the management and supervisory levels is essential for successful wraparound implementation.

A recognition and appreciation of the need for teamwork within and across agencies and departments

Communication across agencies and programs at the management and supervisory levels is essential for successful wraparound implementation. Youth and families who are referred to wraparound frequently have experienced involvement in more than one system and coordination of effort will be needed. Good teamwork at this level can avoid interagency misunderstandings and can respond effectively to complex situations.

An understanding of the stressors and benefits that this work will give to their staff, so that managers and supervisors can provide necessary individual and collective support

Managers and supervisors must work proactively to avoid burnout and unnecessary turnover

of staff by supporting the underlying philosophy of strength-based, family-driven practice. Focusing on staff strengths, identifying what is working well, celebrating successes, and acknowledging the hard work and dedication of their direct service staff can build and maintain an environment of optimism and hope to sustain wraparound over the long term. Periodic training can keep their skills up to date, and team-building activities can keep them inspired.

You Have to Support the Work: Direct Service Staff

While wraparound has proven to be both effective for youth and families and rewarding for staff and their agencies, it has also proven to be challenging, complex, and difficult to maintain.

Table 1 outlines areas of essential understandings for which training, technical assistance, and coaching for key direct-service wraparound staff need to be provided.

Challenges, Strategies, and the California Experience

Starting At the Top: Administrators and Directors

Challenges: How do you get the key individuals to sit down together; how do you help them understand what it is about the wraparound model that makes it so effective with high-need youth and families; and how do you get them to work collaboratively to make the necessary decisions and resource commitments to accomplish and sustain implementation?

Strategies: Three approaches are typically utilized. From a financial standpoint, it must be

Table 1. Essential Training Areas for Direct Service Staff

County/State Agency Referral Staff: child welfare workers, probation officers, mental health workers, and others who might serve on child and family teams	Facilitators of the Wraparound Process (government or private agency)	Child & Family Specialists who do direct in-home work with youth and parents	Family Partners who have personal experience as parents of high-need youth and who build bridges between family and professionals and provide direct support to parents
Basic information about wraparound philosophy and planning process	Basic information about wraparound philosophy and planning process	Basic information about wraparound philosophy and planning process	Basic information about wraparound philosophy and planning process
Referral criteria, knowledge of the roles of other members of the child and family team	Specific facilitation skills: planning and conducting meetings, conflict management, engaging participation, etc.	Specific skills for engaging and working with children and youth and their families.	Skill development in utilizing their life experience and success in coping with human service systems to support the team process
Knowledge of the resources and requirements of their respective agencies in the wraparound process	Knowledge of child development, group dynamics, family dynamics, and family culture	Knowledge of child development and behavioral management strategies	Knowledge of family culture, family dynamics, and parenting strategies for high-need children and youth

demonstrated that wraparound will either increase revenues or reduce costs (and the promise future cost savings is rarely effective). From the perspective of meeting external mandates or requirements, it must be shown that wraparound will be more effective than current practices. And from the perspective of meeting the social responsibility of improving the health and well-being of their respective communities, it must be shown that wraparound will yield better life outcomes for their high-need youth and families.

The California Experience: Following the very successful implementation of a pilot wraparound program by EMQ Children & Family Services in Santa Clara County, Senate Bill 163 was enacted to encourage replication of similar programs across the state. It should be noted that in California the social services, mental health, and juvenile probation programs are implemented at the county, not state, level. The primary funding mechanism was to allow counties to use the state and county shares of foster care dollars to provide intensive in-home services called wraparound. Some services could also be claimed to Medicaid where all eligibility requirements were met. No new funds were made available, and both state and county expenditures were to remain "cost neutral." California is comprised of 58 counties with widely differing populations, economies, and cultures. Populations range from 1,200 (Alpine County) to 10,000,000 (Los Angeles County).

The California Department of Social Services (CDSS) quickly enacted a process for county participation, a planning template, and Standards for Wraparound implementation. (http://www.dss.cahwnet.gov/getinfo/acin99/I-28_99.pdf). In addition, they executed contracts to provide technical assistance and training to the counties and provider agencies at no cost to them.

In order to manage the challenges identified above, several approaches were developed:

- In order to access state funds, the counties had to bring the key administrators and directors together to engage in collaborative planning processes and had to submit written plans demonstrating their understanding of the standards and how the standards would be met. A planning template was devised to identify key areas to be addressed (http://www.childsworld.ca.gov/res/pdf/Acr299.pdf).
- Technical assistance and training was provided at no cost to assist the counties through their planning processes to support their acquisition of essential understandings.
- Detailed information about the funding mechanisms and the experiences of existing successful programs in the state was provided: reduced costs, reduced lengths of stay, and improved social and behavioral outcomes for youth.
- Following acceptance by the state, formal Memoranda of Understanding were executed between the state and the counties.

Counting on the Middle: Managers and Supervisors

Challenges: How do you assure that management infrastructures will facilitate the identification and referral of appropriate youth and families; how do you make sure that appropriate staff and appropriate caseloads are provided; how do you inspire teamwork among the departments and agencies; and, how do you instill an understanding of the need for on-going support of direct-service staff?

Strategies: The primary strategies for managing these challenges have been to provide technical assistance regarding infrastructure and program design, information regarding existing successful implementations, and training for supervisors on coaching and supporting wraparound implementation. Where programs are provided via contracts with community-based organizations, they must be managed as true partners, not merely as vendors. Supervisory support, appreciation, and recognition of staff work are essential.

The California Experience: Through its state staff as well as its training and technical assistance contracts, CDSS has provided the following supports:

- Technical assistance throughout the planning and implementation of wraparound programs, whether provided by county staff or by community-based provider

agencies (This has included work with managers and supervisors related to designing infrastructures for youth identification, referral protocols, and interagency oversight of individual child and family wraparound plans.)

- Training for wraparound facilitators that has included supervisors and managers as well as direct service staff from across all participating agencies and departments
- Training for wraparound trainers to support local self-sufficiency in meeting ongoing training needs
- Specific technical assistance for supervisors in coaching, supporting, and nurturing direct service staff to sustain model fidelity as well as to reduce burnout and unnecessary turnover
- Ongoing technical assistance to revisit existing programs to review adherence to the standards and to identify needs for additional technical assistance and/or training
- Modeling the establishment of a "partnership" relationship with counties and provider agencies

Supporting the Work: Direct Service Staff

Challenges: How do you assure that every individual involved in implementing wraparound has the necessary knowledge, abilities, and attitude to carry out his or her role effectively; how do you inspire collaborative teamwork among individuals with widely divergent needs, strengths, and perspectives; how do you recruit, select, welcome, and retain key staff?

Strategies: Several strategies have emerged as potent means to manage these challenges.

- Training on the key knowledge and skills as identified above is, of course, of foremost importance.
- However, as Wraparound programs have matured across the state, more and more emphasis has been placed on the need to provide supervisors of all key staff (governmental as well as private) with the knowledge and skills to support wraparound implementation by their direct service staff. This includes coaching, field observation, and supervising to the process itself.
- Clarity of the various roles is essential, and requires accurate job descriptions, appropriate expectations, and understanding the essential interplay of each key function.
- Staff recruitment and selection must recognize the actual roles people will play. Not all therapists make good facilitators (but understanding group and family dynamics is necessary). Not all parents or caregivers make good family partners (but understanding the real life challenges of parenting a high-need youth is essential).
- Finally, appreciating staff performance, celebrating successes, and building on staff strengths are ways to support staff retention in a manner parallel to the wraparound process itself.

The California Experience: To support the work in California, CDSS has made available to county staff and the staff of CBOs who are implementing wraparound the following resources.

- Ongoing training, consultation, and technical assistance to direct service staff and their supervisors on a wide range of topics from Facilitation Skills, to Medicaid Billing, to Managing Compassion Fatigue
- Regional workshops across the state covering common implementation issues and specific concerns of various counties
- Consultation to administrators, managers, supervisors, and direct service staff by telephone and email
- Access to Wraparound information at the state website (http://www.childsworld.ca.gov/Family-Cen_318.htm) and their TA contractor's website (http://www.emq-fpi.org)
- Bi-annual statewide wraparound Institutes with presentations and workshops on numerous related subjects

- Twice-annual training for wraparound trainers

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Supporting Wraparound Implementation: Chapter 5c.3

The Evolution of Wraparound Training: Lessons Learned

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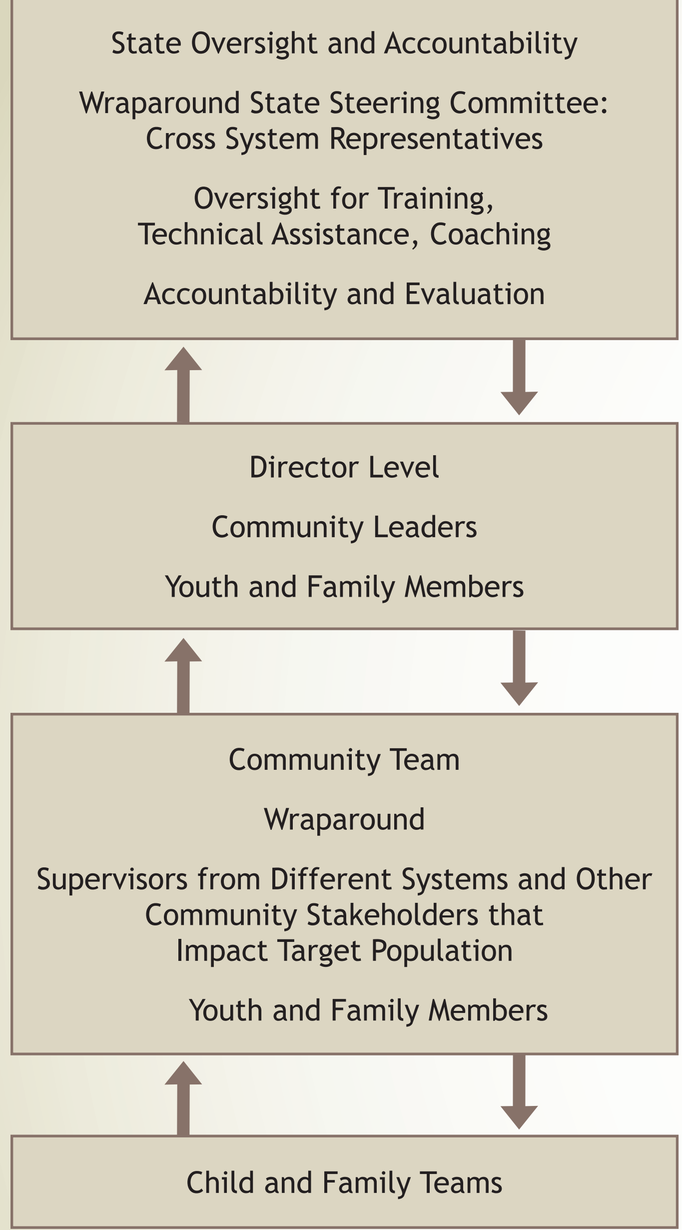
Infrastructure

Training for wraparound is a very complex venture that warrants careful attention. In wraparound, as in most evidence-based and promising practices, there is an increased emphasis on training, coaching and technical assistance, and this typically requires a significant commitment of financial resources. This article will focus on the need for training strategies to evolve as wraparound capacity develops and expands within and/or across a local area, region, or state. The article will outline different levels or phases of training, and it will briefly discuss how to tailor training for staff with different levels of expertise. It will show the importance of committing training resources and of developing an infrastructure that holds people and communities accountable for fidelity to the wraparound model. Furthermore, training needs to be seen as an evolving, ongoing process instead of as a single event or contract to get things started. The developing training and related infrastructure must be seen as a long-term process, otherwise wraparound may not evolve beyond being a good but unrealized idea about how to work with children and families.

It should be noted that this article is based on my personal experiences over 15 years in a variety of wraparound-related roles in Michigan, first as a team facilitator, and then as a supervisor for wraparound and as the wraparound/system reform coordinator in charge of coordinating training and technical assistance statewide.

One of the lessons I learned from observing the growth of wraparound is that it probably would not have happened

Figure 1.1. *Flow of Accountability*



without state and local leaders working closely together. In Michigan, state leadership provided a fiscal opportunity or "seed money" while local leaders took this opportunity and "made it grow." There was major concern at the state and local levels over the number of children in out-of-home placement and the need to try something new that could result in more effective community-based options that also preserved child and community safety. All of the local and state systems had this common vision and were motivated to achieve it.

From the very beginning, it was necessary to bring in outside experts that had been involved in wraparound in other parts of the country. They had experienced success and could speak to this common vision. The state provided the leadership and funding for this training and identified and funded local communities that were motivated and eager to take on this new challenge. One requirement to receive this funding was that the communities develop an infrastructure that provided for the flow of accountability and information between the top director level, the supervisor level, and those who worked with children and families (Figure 1.1). This infrastructure helped the wraparound facilitators address system challenges more easily because they had support from the top down. It quickly became apparent that for this arrangement to work, training needed to be offered to people at each of these levels, from the "top" directors on down. Once you have the executive level committed to the wraparound mission and have the roles and expectations defined at all levels of the system, training can be tailored to each level and role. If you skip the executive level and your target population is high-risk multi-system children and their families, there is a high probability that your wraparound efforts will fall short. There needs to be cross-system training that identifies some inherent conflicts in system language and mandates. For example, a probation officer is charged with the community safety mandate. So the wraparound team must find ways to meet this mandate while preserving the child and family's needs and voice in the wraparound process. In order to maximize impact, training for wraparound should rarely be done in a vacuum of one agency, but should instead be provided to people who need it, regardless of their "home" system or agency. This will help establish the sense of shared commitment and responsibility for the children and families to be served. Establishing a learning environment that supports the opportunity to discuss the similarities—as well as the potential conflicts—makes resolving differences more likely. Sometimes this resolution takes place at the child and family team or supervisor level, but other times, this resolution may need to occur at the executive/director level. Which leads to a central truth: "Wraparound is only as strong as the community that supports it."

Figure 1.2.
Evolution of Training

PLANNING IN
HOPES OF ACHIEVING
OUTCOMES

Foundation Training

- **Input:** Inspire to values
- **Outcome:** Buy-in to wraparound
- **Trainers:** Primarily outside experts
- **Training Technique:** Storytelling

- **Facilitator:** Inspired and creative with low confidence

Model Implementation

- **Input:** Solidify Model steps
- **Outcome:** Mechanical planning with expectations
- **Trainers:** Outside experts with some state and local trainers
- **Training Technique:** Experimental learning and some coaching

- **Facilitator:** Compulsive planning, mechanical and awkward at times

DANGER ZONE:
NEVER MOVING BEYOND
MODEL IMPLEMENTATION

Skill Set Development

- **Input:** Coaching to skill sets
- **Outcome:** Increased effectiveness—more team accountability
- **Trainers:** State, local and some outside experts
- **Training Technique:** Doing and coaching

- **Facilitator:** More focused planning on strengths, needs and Outcomes: steps of the process comes together to create a plan that makes sense

OUTCOME BASED
PLANNING MEETINGS OR
PLANNING TO SOMETHING

New Technology

- **Input:** New tools and techniques
- **Outcome:** More creative planning: high fidelity
- **Trainers:** Mostly state and local: strategic use of Outside experts
- **Training Technique:** Refine critical thinking and problem solving skill—facilitate learning

- **Facilitator:** Strategic planning: information gathered used as data for high effective planning: high confidence that allows flexibility to individual style

Foundation Training

As wraparound expands, training efforts must evolve. (See Figure 1.2, previous page). In its evolution, training must move beyond foundation training, which consists of inspiring the community and promoting commitment to wraparound values, and which results in initial buy-in to the wraparound process. Unfortunately, sometimes facilitators and teams get stuck in the value-based process and the result is planning that is more lecture-based than action-based. The result of this type of planning is that in the attempt to bring people together to plan, you create an atmosphere of debate and judgment of what you should do, while little actually gets done. This may occur when some team members buy into the values of wraparound, but other team members do not, or when some team members do not understand the planning process. The facilitator may not have the skills to move the team beyond the debate of values which can result in team conflict. This is why it is important not only for the facilitator to be trained but also for all team members to be oriented to the wraparound model and expectations. Once people know the rules of a game, they are more likely to participate based on the structure provided. The missing piece typically is that the facilitator knows what he or she is supposed to do but the other team members do not. Some facilitators have the personality that inspires a high level of trust, and they can use this to move teams to planning. However, this tends to be the exception rather than the rule. If the orientation step is missed, the result can be that the plan gets very comprehensive across several life domain areas to ensure that it is holistic, but the needs change so quickly that the plan soon becomes irrelevant to the child, family and team ("too much process and not enough production").

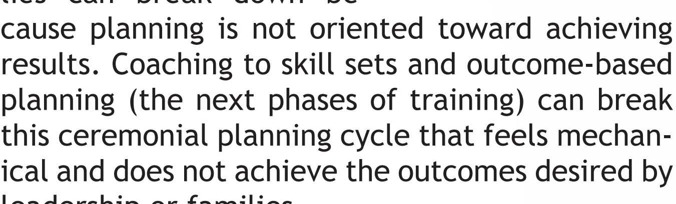
Sometimes facilitators and teams get stuck in the value-based process and the result is planning that is more lecture-based than action-based.

In this early phase of implementation, wraparound is new to supervisors, and they are largely dependent on outside experts. This reliance on outside sources of expertise can lead some people to think that the training isn't working, when really it is a necessary step to developing local expertise and just part of the learning curve. It is important to involve supervisors at the beginning stages of training and to offer them hands-on coaching and technical assistance so that they can effectively transmit the model to facilitators. Because wraparound is a different model than what people are used to, facilitators are tempted to fall back into their "comfort zone" of planning (case management, therapy, etc), and supervisors are likely to supervise to their "comfort zone" as well. That is why training alone cannot ensure model fidelity or the evolution of wraparound. Technical assistance and coaching to the steps of the process is necessary before skill refinement is ever possible.

Model Implementation

This next level or phase of training may be referred to as Model Implementation. Model implementation is the phase in training when facilitators are learning how to do the steps of the process, even though at times they may feel that this more ceremonial than connected to anything. The major pitfall of this phase is that facilitators will develop a "planning compulsion." This is what happens when they create wraparound plan after wraparound plan for a family in hopes that one will produce outcomes, instead of first identifying needs and outcomes and planning to meet them. Facilitators do need to learn the "ceremony" or the steps of the wraparound process before they are ready to refine their skills. However, allowing facilitators to create plans that fail is not a good way for them to learn and has a negative impact on families. Further, having facilitators fail can result in significant staff turnover. To avoid this pitfall, coaching and support should be provided to the supervisors and the community team, so that they help move the facilitator toward more effective wraparound. Unfortunately, if this sup-

port and coaching is not there, many projects do not move beyond this ceremonial aspect of wraparound, with teams mechanically following the prescribed steps of the practice model. Teams may come together in the spirit of wraparound, and families may feel supported, but the possibilities to achieve high impact outcomes are limited by overly ritualized ceremonial planning and lack of plan implementation. These are the times when facilitators complain that nobody will come to meetings and agreements between systems and families can break down because planning is not oriented toward achieving results. Coaching to skill sets and outcome-based planning (the next phases of training) can break this ceremonial planning cycle that feels mechanical and does not achieve the outcomes desired by leadership or families.



Getting Wraparound Past the "Danger Zone"

Just like anything else, before you can move forward you have to experience some painful lessons. The true danger of allowing a facilitator or project to stay in the ceremonial or value-based approach too long is that the risk to children and families is high and they need more immediate strategic planning. In addition to this, it will be easy for your facilitators to fall into the role of the "hero" who does too much individually and has difficulty motivating anyone else to change their practice. Another concern is that the initial plans that are developed can appear to meet the needs when, upon closer observation, they are based on superficial guesswork.

Another predictor of moving beyond ceremonial wraparound is the expectations defined by the funding sources and the state leadership. Does the training support growth and accountability? Are there contract expectations or quality assurance measures and evaluation? Does the training or technical assistance match the expectations? If you do not have the structure of accountability as wraparound grows, wraparound practice will evolve into something that is unrecognizable. Terms like warp-around, run-around, stand-around have been heard from people when wraparound morphs into something else entirely due to some of the factors cited.

In the fast food world, we are all about immediate gratification. In reality, people are complex and have to learn at their own pace, in their own way. General value-based training can inspire learning but it does not create a strong skill set that is easily applicable. Adult learning principles (i.e., hands-on, visual, participatory training) should be incorporated at all training phases, but it is especially important in the two later levels/phases. There are always some people that go through training, assimilate the information and then create expectations and accountability to practice. This is more rare than common. Training needs to evolve to more technical assistance and coaching which creates a learning environment that is a balance of expectation and accountability. If you do not take the time to build a strong community infrastructure or state accountability for wraparound, it will be by sheer will that a project evolves beyond ceremonial or value-based wraparound. Unfortunately, sheer will comes from exceptional individuals and thus is not sustainable. Some facilitators will strive to move beyond the ceremony of wraparound but the policies, procedures or lack of supervisory or community team support will limit their best efforts. Some will come to a training session and leave inspired, but then within days, they are back to status quo planning and providing case management because there is not the support to be creative or actually do wraparound. Once again, this highlights the need to have supervisory support across systems if wraparound is to be effective. At this point in the development of wraparound training, supervisors should be the primary "coach" of wraparound versus utilizing outside experts. The

national, state or local experts should funnel their knowledge and expertise through supervisors versus in the presence of supervisors. Supervisors are charged with monitoring the day-to-day operations and need to be skilled in coaching facilitators in how to address safety risks and other issues that arise in the team meetings. Coaching facilitators in the absence of their supervisor sets up an interesting dynamic. Who will the facilitator listen to if the supervisor is not in agreement? Most will chose the one who directly impacts their livelihood, which is the supervisor.

The first two training levels or phases that have been discussed are important for the evolution of a wraparound project, but there is a true danger to remain stuck or stalling out at either of these training phases. A dynamic of these two training levels or phases is focused more on the facilitator's ability to run an effective planning meeting. The unfortunate part of this is that sometimes the planning is more facilitated in hopes something will change versus planning to create change. Good meetings are fleeting and hard to measure. The best way to measure the effectiveness of a meeting is how the team interacts outside of that meeting. Is a therapist's practice driven toward the needs and outcomes of the child, youth and family in their therapy sessions? Does the principal/teacher incorporate the child's strengths during the school day? Does the child's grandmother change how she interacts with the child/parent outside of the meeting? Good meetings that produce best practice outside of meetings are optimal and what a wraparound project must evolve towards. Which brings us to the next phase: skill set development.

Skill Set Development

The next level or phase of training is when the focus should be on skill set development/refinement. Some effective ways to improve the skill sets of facilitators are to provide guided roundtables or "tailored learning environments". Most of these involve both the supervisor and facilitator since there is more accountability when they hear the information together. The other important aspect of moving to skill set training is the utilization of multiple trainers and teachers. It is important to incorporate different experts who can build different skill sets. Facilitators need to learn from facilitators and from other systems, as well as from family members. Another important aspect in preparing to train staff at this level is the need to review team plans and observe team meetings. The wraparound plan can provide the key to training or coaching needs of the facilitator and supervisor. Facilitators will gravitate to a part of the process they feel most confident and that will be evident in the plan. For example, some facilitators' plans will tend to have great strategies, but needs statements that don't sound like something a real family would create. Others may be fabulous at helping teams create missions but weaker at getting teams to specify and commit to specific actions steps. There will also be evidence if parts of a plan are missing or if there are parts that are in need of attention. As a trainer, coach or supervisor, it is important to pull all aspects together and connect the steps of the process. Skill sets need to be broken down into manageable parts. Some areas that may need attention are:

- Developing strengths and culture discovery: moving beyond positive labels
- Conflict resolution
- Understanding the needs of children, youth and their families
- Creative planning beyond service-oriented planning
- Developing individualized outcomes that are embraced by the family and system
- Assessing risk and safety factors
- Bringing children/youth home from placement
- Understanding the needs/mandates of the systems

New Technology

The last level or phase is the development of new technology. This can happen when facilitators are experienced and skilled, and are ready to move toward more sophisticated, flexible, and refined practice. For facilitators in this phase the other more "basic" or "core" type training becomes a frustrating experience. They are ready to

learn approaches/techniques that they can apply quickly and that are applicable to their job. Many core types of training cannot offer that level of individualized learning to increase the skill set of the facilitator.

As the confidence of the facilitators increase with acceptance of the values, commitment to the model and increased skills to facilitate an outcome-based plan, they are more prepared to accept new tools and technologies that fit with their individual styles and help them refine their skills. These training experiences need to be more focused on the enhancement of critical thinking and problem-solving skills. There need to be more opportunities to think carefully about the steps of the process and flexibility to plan creatively without limitations. One way a facilitator can learn to lead teams to creative planning is by being provided with the learning environment and supervisory support that allow them to go there. The trainer is in the role of facilitator of learning versus a stand-up teacher. This is where training and coaching need to be less about the model and more about the skill of creative problem solving and critical thinking. At this point, the facilitator should be able to balance the need to have the structure of the model with having the process as a whole come together for each team. Learning styles and creative ways of gathering information need to be created and supported by the facilitator. Training needs to be less about providing information and tools and more about creating an atmosphere that challenges facilitators to create their own tools and respond to the uniqueness of individual teams. Learning environments and roundtable discussions that allow facilitators to analyze and problem solve situations are effective training techniques.

Training Considerations

All of these levels or phases of training are fluid and different technology should always be incorporated to improve the learning or teaching opportunities for facilitators, families and systems. All trainers need to be prepared to do an assessment of what level the target audience is on. There are pitfalls in trying to start at the skill set level when the facilitators or systems do not have a strong foundation or commitment to the values or understand the connection of wraparound as a model. That pitfall can be very damaging to high fidelity wraparound: the facilitator may not understand wraparound as a model because of the need to perform the skills too quickly. There is also the potential to focus too much on the facilitator and too little on the roles of the community and systems, which can make or break any wraparound project. The biggest impact from my perspective is to inspire facilitators, families, communities and systems to want to learn different skills that produce different outcomes and wraparound can be one mechanism to do that.

It was my experience that in the beginning, wraparound was more of a movement to push people and systems to think carefully about decisions they made with regard to placement, services and how to develop partnerships with families. In the attempt to respond to the push toward evidence-based practice and fidelity to the wraparound model, it is important to remember the lessons learned. You cannot build without the foundation and the commitment on all levels of the state, system and communities are critical to build ongoing capacity. Training, technical assistance and coaching should always follow, because in the absence of the foundation, wraparound is no different than any other model.

Family members are instrumental in pushing wraparound toward the highest fidelity; as such it is imperative they are an integral part of all training experiences.

Family and youth trainers or consultants should have a role at every level of this journey. This involvement should evolve over time as well. It has been our experience that family members are instrumental in pushing wraparound toward the highest fidelity; as such it is imperative they are an integral part of all training experiences.

Outside experts are also important in starting

any wraparound project, but their involvement should change over time as wraparound evolves. Utilizing and building your state and local experts as trainers by offering training of trainer opportunities helps decrease over-reliance on outside experts and increases local capacity to meet the training and coaching demands. It is important when starting to develop training teams that you consider geography, diversity, parent and youth involvement, and variety of other system and life domain areas. Wraparound training should provide topical training that address potential themes, issues or needs that are facing the youth and families that are involved in wraparound. Outside experts may continue to be a valuable resource but their training needs to be tailored to the expertise, skill sets and what outcomes you want to achieve.

I remember hearing in my fifteen years of wraparound that "wraparound is a process not a program" and, in theory, I believe this. But I also know that viewing wraparound only as a process can be damaging. So I suggest that wraparound is a model. It is a model for strategically organizing systems, people, services, supports and interventions that allow the child and family to experience different results that are meaningful in their everyday lives. It is a model that provides new opportunities based on strengths, capacities, interests while being respectful to their culture, values, preferences and attitudes. It supports teams by allowing them the opportunity to critically think through with children, youth and families and problem solve more creative and effective ways to meet needs and produce outcomes. It is a model that acknowledges the mandates and expertise of the various systems and people within those systems and community while holding the family system as the most influential toward outcome achievement.

Acknowledgement:

I would like to express special appreciation to my colleagues and to youth and families in the state of Michigan, as well as outside experts who inspired this article.

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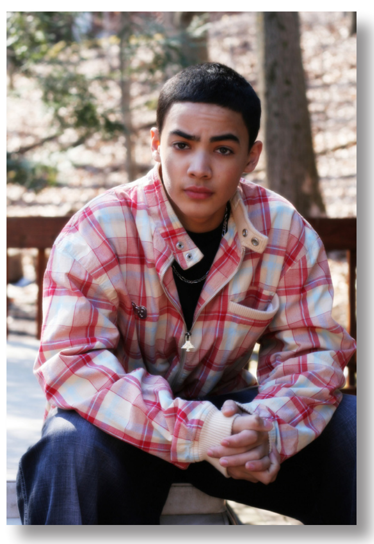
Supporting Wraparound Implementation: Chapter 5c.4

Supporting Workforce Development: Lessons Learned from Wraparound Milwaukee

Mary Jo Meyers, Deputy Director
Wraparound Milwaukee



Wraparound Milwaukee began its system of care development back in September of 1994 after receiving a five-year federal system of care grant from the Center for Mental Health Services. The main focus at the time was to develop a new and better service delivery system for children and families who were using deep-end services such as residential care. Many of these children were using these services for many years, costing Milwaukee County millions of dollars each year and resulting in poor outcomes for these children. As the name implies, Wraparound Milwaukee embraced the values and principles of the wraparound process described in this guide, and utilized these values and concepts to build a new system of care for youth and families with complex needs involved in multiple systems.

Wraparound Milwaukee is funded under the umbrella of Children's Mental Health for Milwaukee County. Therefore, to be considered successful in the eyes of our stakeholders, who were unhappy with the costs incurred by previous long-term residential stays, it was imperative that we focus on financial sustainability very early on in the life of the five-year grant. This push, as well as the strong commitment and belief in the wraparound process, encouraged us to become creative about what it would take to build a lasting system of care that would support and maintain a high quality workforce over the long haul.

Over 80% of the staff we had in 1994, including the facilitators involved in our now widely known and recognized 25 Kid Pilot, are still with Wraparound Milwaukee today in either a management, consultant, trainer, or supervisory role. The 25 Kid Pilot was a study of Milwaukee youth who

received wraparound facilitation and were successfully brought back to their homes and community from residential care. Of Wraparound Milwaukee's current workforce of care coordinators, lead workers and supervisors, 50% have been with us for over 2 years and almost 30% for over 5 years, with some having been employed for as

long as 10 years. In reviewing the past 3 years of existence, there are several key lessons or strategies which have helped Wraparound Milwaukee to maintain a quality workforce over the long haul: 1) Hiring the right people, 2) Providing continuous training, 3) Providing a career ladder, 4) Promoting leadership skills and opportunities for further education, 5) Promoting and maintaining close ties and communication between care coordination agencies and management, 6) Providing structures that encourage mutual support by coworkers, 7) Building healthy competition among the workforce, and, lastly, 8) Creating methods for positive recognition and ongoing support. Each of these eight strategies is important in and of itself, yet combined they create an atmosphere that sustains our workforce of quality facilitators of the wraparound process. Each of these strategies is discussed in the sections that follow.

1. Hiring the Right People

When we interviewed our supervisors about what qualities they look for in hiring facilitators/care coordinators they responded with:

- Likes kids and believes in families
- Is open minded and creative
- Is receptive to the values that form the wraparound philosophy
- Demonstrates good insight and judgment
- Is well organized
- Has an engaging and enthusiastic personality
- Is comfortable speaking in front of a group of people
- Knows when to be flexible and when to take control
- Has good writing skills
- Can speak to past experiences of team work

When hiring care coordinators, most of our supervisors use a combination that includes in-person interview by the supervisor and lead worker, written exercises, and role-play. For serious candidates, many supervisors will follow this with a group interview by the team of fellow care coordinators/facilitators with whom the candidate would work. The supervisors find the group interview to be one of their most successful tools in recognizing a "best fit" for the team they will be working with. This is particularly important since we have built a system of pairing facilitators to provide coverage for each other's families for evenings, weekends, holidays, vacation and/or sick time to avoid the possibility of burn out due to our policy of 24-hour-per-day, 7-days-a-week availability to the families we serve.

2. Providing Continuous Training and Coaching

All new facilitators receive 54 hours of training to become certified as Care Coordinators/Facilitators for Wraparound Milwaukee within the first six months of their employment. This training is broken up into 10 modules, including many of the topics that are included in this guide, as well as topics specific to working with Wraparound Milwaukee. All training is followed by coaching by either supervisors, lead workers, program coordinators, or wraparound consultants in specific skill sets such as running team meetings, writing plans of care, presenting in court, etc. Because Wraparound Milwaukee utilized a train-the-trainer approach early on in its development, we have been

able to “grow” our own trainers continuously.

By virtue of the initial five-year grant, Wraparound Milwaukee had the opportunity to utilize many nationally recognized trainers such as Vera Pina, Pat Miles, John Franz, John VanDenBerg, Karl Dennis, Mary Grealish, and Naomi Tannen in the first two years of our development. We used this opportunity to get everyone firmly grounded in the wraparound process. We then began cultivating our own trainers by hand-picking facilitators from the 25 Kid Pilot who were exceptional care coordinators and team facilitators and also demonstrated the potential to teach others. Pat Miles continued on as our consultant, encouraging us to begin including families in trainings to teach us how to engage and talk to families as well as accept feedback on our facilitation skills. This practice continues today and no training is done for Wraparound Milwaukee with fewer than six family members present, and often as many as fifteen. We also partner with our family organization, Families United, to co-train for the majority of trainings.

As of 2007, Wraparound Milwaukee is proud to say we have helped develop two nationally known and recognized trainer/coaches and at least eight co-trainer/coachers who have worked in other states. Of our current workforce of about 90 (supervisors, lead workers and care coordinators), at least 20% are engaged in providing ongoing local training and coaching in the wraparound process. Wraparound Milwaukee has also hired two of our own original care coordinators/facilitators to work for our system of care as coaches who are available to assist any team in need and to complete quality assurance activities in the area of child and family team development and ongoing team facilitation process.

While every supervisor, lead worker, and consultant is expected to assist with training, care coordinators are also encouraged and recognized for taking roles in trainings. There are four to eight opportunities a year in which care coordinators assist in training. At times, they are entirely responsible for creating and presenting on topics such as putting values into action, team development, and finding community resources. For the past two years, the supervisors and lead workers have designed and conducted our yearly two-day re-certification training. Feedback for improvement is provided by consultants who observe and critique the trainings, as well as from participant evaluations.

3. Providing a Career Ladder

Since many of the current managers of Wraparound Milwaukee worked as facilitators of teams during the original 25 Kid Pilot, we have an ingrained appreciation for keeping caseload size down and career opportunities up (see Figure 1). In 1996, as the number of enrolled families rapidly increased, a decision was made to build into our

Figure 1. Career Ladder

Other Possibilities:

- Provider Network:
- Agency Supervisor/ Program Lead
- Mobile Urgent
- Treatment Team
- Assessment/ Screening Team

care coordination contracts a requirement for a "lead worker." A supervisor and a lead worker—essentially an assistant supervisor—are responsible for the performance of eight to ten care coordinators. A lead worker is not allowed to carry more than four families on their caseload, while care coordinators are expected to carry eight to nine. Other responsibilities may include training new staff, providing coaching for facilitation of team meetings, providing mentorship to care coordinators in court, and reviewing plans of care.

As identified in many studies of what keeps people at their jobs, care coordinators will often tell you it is the support they feel from the team that they work with.

While care coordination is considered to be the backbone of our system design, there are other potential career and promotional opportunities provided through our extensive provider network, our mobile urgent treatment team, and our screening and assessment team. As noted earlier, many of our original care coordinators are still with Wraparound Milwaukee today in a variety of roles including management, supervision, and program development.

4. Promoting Leadership Skills and Opportunities for Further Education

In 1997, Wraparound Milwaukee partnered with Trinity College of Vermont (now Southern New Hampshire University) by supporting their satellite weekend educational program. The program allows working students to obtain a Masters in Community Mental Health in two and a half years. Wraparound Milwaukee provided staff who enrolled in the program one third of their tuition costs, and provided as much flexibility as possible with work hours so that students could work and fulfill their internship requirements. Of the first graduating class in 2000, eight of the nine Wraparound-employed students went on to be promoted to at least a supervisory position within the next year. Wraparound Milwaukee now partners with both the University of Wisconsin-Milwaukee and Southern New Hampshire University to promote further education for all of our care coordinators. Some of our care coordination agencies also provide tuition reimbursement as part of their benefit packages.

There are multiple opportunities presented and encouraged in the area of leadership for facilitators, including training, coaching, committee work, sponsoring family events, attending workshops or seminars, and more. To assist our supervisors in recognizing their leadership skills, we begin our monthly supervisory meetings with each supervisor sharing an example of his or her leadership for that week. We also recognize leadership by highlighting a success story in our monthly newsletter.

5. Maintaining Close Ties and Communication Between Agencies and Management

An interesting phenomenon pointed out to us by an outside consultant is that the Care Coordinators introduce themselves as working for Wraparound Milwaukee despite the fact they are employed by nine different agencies who have contracts with Wraparound Milwaukee. They were never asked to do this. It has just evolved on its own. I have come to believe it is a direct result of how closely the care coordinators identify themselves with the process of wraparound as well as how often we communicate, meet, provide assistance, problem solve, or do oversight for the work they do. Wraparound Milwaukee administrators formally meet with supervisors and lead workers on a biweekly basis but informally see or talk with them every day. All managers maintain a true open door policy, and when it comes to any one needing help, all management team members make themselves available. It is not unusual to see our chief financial officer serving food at a family event or our management information consultant assisting our Youth Council. Family members are encouraged as well to stop by or call whenever they would like.

6. Feeling Supported by Co-Workers

At an agency level, the supervisors have embraced creating a flexible atmosphere that allows care coordinators to get the work done and feel supported by one another. Many agencies offer flexible schedules and office time as long as care coordinators meet their work expectations. As mentioned earlier, care coordinators often share their workloads and provide coverage for one another. As identified in many studies of what keeps people at their jobs, care coordinators will often tell you it is the support they feel from the team that they work with. Agencies also participate in a variety of fun activities both with and without the families they serve. Despite the fact that agencies compete with one another for contracts, care coordinators themselves have formed strong bonds with each other. They are often asked to work together on committees, trainings, and family activities, where they share their ideas and support. Wraparound Milwaukee brings all care coordinators, lead workers, and supervisors together on a monthly basis for training on a topic of their choice. We also sponsor a yearly summer picnic and holiday luncheon for everyone to gather together. This also allows Wraparound Milwaukee to express our appreciation for our staff's hard work and dedication to the families we serve.

7. Building Healthy Competition/Incentives

As part of our data collection and quality assurance, Wraparound Milwaukee created a tool called the Agency Performance Report. This report contains a number of indicators built on the principles of wraparound. Individual care coordinators and agencies are measured on their ability to meet standards of holding monthly team meetings, increasing the number of natural and informal supports on teams, maintaining youth in home and community settings, etc. While at times this tool can create anxiety for the agencies, the majority of the time the tool has created a healthy competition among them and encourages staff development. Wraparound Milwaukee has provided financial incentives for some of the standards—such as successful disenrollments from the program—that then translates down to small bonuses for the care coordinators. Some of the agencies have instituted their own pay-for-performance and incentive programs, which have also helped with staff retention.

8. Creating Methods for Recognition and Ongoing Support

In addition to receiving financial incentives, care coordinators benefit from frequent reminders of a job well done. We have created a simple one-page form called a Positive Recognition Form, that anyone can use to recognize anyone else for a positive accomplishment. The Quality Assurance Department for Wraparound Milwaukee is responsible for processing the forms which are copied with one copy to the recipient, one copy to his or her supervisor, and then multiple copies to the wraparound management team. With permission from the writer and the recipient, all positive recognitions are printed in our monthly newsletter, which has both a local and national distribution. In addition, each recipient who is a care coordinator, lead worker or supervisor receives a call from management to acknowledge their accomplishment and thank them for their great work. Individual agencies have also set up ways to recognize their employees by establishing employee of the month programs and providing gift certificates and other small tokens of appreciation.

Support for care coordinators is available in a number of ways, both formally and informally. First and foremost, care coordinators are taught from day one that building child and family teams and writing good crisis plans are the best things they can do for the families they serve as well as for themselves. One of the common denominators of care coordinators who have been with us a long time is that they excel in both building teams and creating effective crisis/safety plans. Wraparound Milwaukee supports these efforts by maintaining a pool of people with special skills who can be added to teams when needed. These people include staff from Families United (our family organization) and our mobile urgent treatment team (a group of care managers, social workers, nurses or psychologists trained in crisis response), as well as Wraparound Milwaukee coaches and consultants

trained in a variety of specialty areas. Beyond the support of child and family team members, care coordinators also have access to support from their lead workers, supervisors, and wraparound management. In training, a large emphasis is placed on how to utilize team members and how to ask for help when needed. The last training module of the certification for care coordinators teaches skills around taking care of oneself and promoting health and well-being. Agencies are encouraged to hold activities for their staff to promote teamwork and focus on adding fun to the work place.

While I am certain there are additional strategies that can be used to develop, enhance and maintain a cadre of quality facilitators, the eight described here capture what we have found to be essential for the care coordinators of Wraparound Milwaukee. As with all things in life, workforce development is a continuous journey of examining what works, what doesn't, and why. Most of the managers of Wraparound Milwaukee have been together for over 15 years, and as the "old folk" reflect on years of system of care development, many of us ask the questions: Have the workforce values changed over the years? Are the families we serve more complex? Is the community we live in getting more challenged by poverty and violence? And of course the answer to all three is yes. But what has remained consistent is our belief in the values of the wraparound process and our desire to help children and families reach their visions for a better life.

And with those thoughts we continue…

Author

Mary Jo Meyers is the Deputy Director for Wraparound Milwaukee, a nationally recognized program for children and families involved in multiple systems, and is responsible for daily operations and work force development. Mary Jo also provides consultation, training and coaching to other states developing systems of care utilizing the concepts and principles of the wraparound process.

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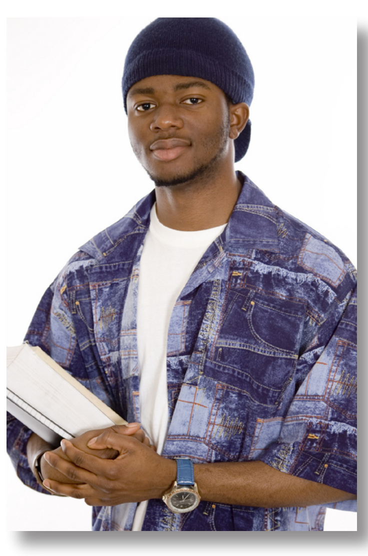
Supporting Wraparound Implementation: Chapter 5c.5

My Career Journey with Wraparound Milwaukee

Kenyetta Matthews
Wraparound Milwaukee



My career with wraparound began on August 31, 1998. My first day of work was one of the most challenging days of my entire career because I didn't know what to expect. I had no training in adolescent mental health except for one course in Life Span Psychology. Despite my lack of training in the field, I found my niche and fell in love. I fell in love with the process; I fell in love with the families; and I fell in love with social service as a profession. During my two-year tenure as a Care Coordinator, I learned so much about people and what's needed to be successful. I also learned that every family involved in the system is just like mine. They are running the same race that my family has run over the years; running a race to make sure the next generation can succeed.

Fast forward two years to 2000, and I found myself at a crossroads. It was time for me to do something different but I still had passion for the work I did with wraparound. During this time period, Wraparound Milwaukee made changes to the contracts with the Care Coordination agencies, so that now there were opportunities for Care Coordinators to "grow" their careers. The Lead Care Coordinator position was just what I was looking for at the time. The Lead Care Coordinator position would provide me with leadership experience while at the same time allowing me to continue working with the children and families that had captured my heart. I held this position for just over a year and learned even more about the wraparound process. I also developed leadership skills that would give my career some direction. I decided during my time as a Lead Care Coordinator that I was ready to take my career to the next level and I needed

an advanced degree to accomplish that. I enrolled in graduate school to better prepare for my chosen career in Human Services Administration.

While in graduate school, I took another position within wraparound that would keep me connected to the work that I had so much passion for. I became a Facilitation Specialist, providing care coordination to families in which a parent was struggling with alcohol and drug issues. Another component to this position was to provide Wraparound training to providers of services to treat drug and alcohol abuse, so that they could implement the process within their respective agencies. I thoroughly enjoyed this position as well. I enjoyed being able to educate others about the wraparound process.

After being employed as a Facilitation Specialist for just over a year, I was given the opportunity to supervise a care coordination unit at Children's Service Society of Wisconsin. I have been in this job for just under four years and this position within wraparound has been my favorite to date. Not only do I have the opportunity to continue working with families, but I also have the opportunity to cultivate the skills of the Care Coordinators that I supervise. I've been very privileged over the last eight and a half years to have worked with a fine group of administrators who have consistently advocated for the mental health needs of the children and families in Milwaukee. I've been equally as privileged to work with the children and families in Milwaukee who need a little help to run life's race.

I recently attended a conference where I learned that an African village determines its prosperity by the children of the village. A common question in this village is "How are the children?" The desired response is "The children are well." I believe that the work we do as Wraparound Milwaukee works to ensure that the children and families of Milwaukee are well.

Author

Kenyatta Matthews' nine-year experience with Wraparound Milwaukee has been very educational. She has worked with wraparound in several different capacities, and this has provided her with the skills necessary to continue to effectively advocate for children and families.

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Wraparound Supervision and Management

Patricia Miles, Consultant

Managing wraparound requires a multi-dimensional approach to management, supervision and leadership. Figure 1 on the next page defines three levels of focus for any wraparound supervisor. These three areas include:

1. Working with the Practice Model

Wraparound is an integrative model of responding to people who are suffering. Over the past several years the wraparound process has continued to evolve as practitioners and families have worked together to develop and refine those practices that seem to be most comforting. Because wraparound is a model that borrows from a variety of movements and approaches it is often difficult to describe. Recent developments have included an increased focus on "high fidelity wraparound" in an effort to increase reliability of wraparound practices. A single-minded focus on fidelity, however, can undermine the quality and flexibility of the wraparound process, by encouraging reductionist thinking, promoting an overemphasis on the rituals of wraparound (and an underemphasis on understanding the meaning of the approach), and discouraging innovation to meet family needs. Supervisors play a key role in helping staff accomplish the necessary activities of the wraparound process without sacrificing flexibility and innovation. Key competencies for wraparound supervisors who are trying to be effective within the practice model sphere are described below.

Knowing What Good Wraparound Practice Is

Since wraparound is an integrative model that borrows from and resembles many other practices, it can become very confusing for those involved in delivering it. Supervisors generally have to demonstrate the ability to define core activities that need to occur for quality practice. This means supervisors should be able to define not only what they want done but also how they want it done while tying this to the values inherent in wraparound.

Communicating Good Wraparound Practices

Knowing core practices is different than effectively communicating those practices. The effective supervisor is able to communicate to their employees and other stakeholders what is expected in a manner that is clear and transparent. This means the skilled wraparound supervisor will need to define not only what needs to happen but how it should happen and why it should happen in this way. The effective wraparound supervisor is able to identify phases or steps as described in a training manual or program brochure and define in detail on how they want these phases to be completed.

Recognizing Good Wraparound Practice

When wraparound is accomplished effectively it can often look like an accident of good social work. Wraparound supervisors often find they have a great deal of information about individu-

Figure 1. Three Levels of Focus for Wraparound Supervisors

al families who are participating in the process. This can lead to a model of staffing and expert consultation to staff who are struggling to master a process while meeting the needs of a family. The effective wraparound supervisor is able to move conversations in working with their staff from how the family behaves with the process to how staff follow the process with families. This allows wraparound supervisors to recognize good practice when they see it while coaching to reliable delivery of the steps they've defined in the process.

Adapting the Process for the Benefit of Individual Families

Good wraparound supervisors recognize that the point of wraparound is not just to do wraparound. Rather, the point is to do wraparound so as to help people find ways to meet their needs. Ultimately, as each family joins the process, good facilitators are able to adapt certain elements of wraparound to best fit the family and its situation at that time. Good supervisors create the capacity for that adaptation while still maintaining the basic integrity of process. Wraparound fidelity should not be about everyone delivering wraparound uniformly. Instead it should be about the workforce delivering wraparound reliably.

2. Working with Staff

The second dimension of wraparound involves working with staff. This includes not only communicating the mechanical and implementation aspects of the practice model, but also managing all aspects of what is often a very diverse workforce. Some wraparound projects have a range of staff assigned including wraparound facilitators, wraparound clinicians, parent partners, peer youth partners and, in some locations, youth specialists who provide direct interventions between team meetings. Some wraparound projects operate with facilitators only while others may have one or two of the roles listed above. What is clear is that wraparound supervisors are often faced with a workforce whose members may be more different than alike. This may range from parent partners who have first-person experience within the system to facilitators who are starting their career in Social Services. Wraparound supervisors who lead a diverse workforce should be prepared demonstrate a variety of skills, described below:

Conflict Resolution

The more diverse the workforce the greater the likelihood that there were be multiple perspectives. The wraparound supervisor should manage conflict creatively in assuring that all of those perspectives are blending into a holistic experience for families.

Coaching Staff

As the range of staff roles grow within the wraparound project, the wraparound supervisor has to develop a capacity to provide proactive, behavioral, field- and office-based coaching and instruction to staff. Coaching and supervising staff is different than maintaining fidelity to the practice model. Instead this is the process by which staff are given clear directives defining how they should perform their duties in a way that adds value to the comprehensive wraparound package.

> *Wraparound supervisors are often faced with a workforce whose members may be more different than alike.*

Correcting Staff

No matter how much proactive coaching has occurred, supervisors will find it necessary to correct staff behavior and practice patterns. Wraparound supervisors have to translate staff behaviors back to the values base that is articulated in a wraparound model and assure those behaviors are being demonstrated in everyday interactions with families and communities. When there is not a fit, wraparound supervisors should provide clear, consis-

Wraparound Staff Roles

Developing a wraparound workforce has become more complicated as wraparound has matured. Initial projects essentially required hiring someone in a facilitator or care coordinator role with basic educational skills. As differences in positions have developed within wraparound, developing an effective workforce has become more challenging. A range of positions exist within wraparound projects across sites. Typical positions include:

Wraparound Facilitator/Care Coordinator:

This position is typically responsible for organizing the steps of the wraparound process, documenting the plan, hosting and facilitating team meetings, and troubleshooting and organizing support, interventions and services to achieve outcomes.

Parent Partner/Family Partner/ Family Support Partner:

This position is typically filled by someone who has first-person experience within the service system on behalf of their child or loved one. The role of this person varies somewhat from site to site but typically those in this role provides peer-to-peer support for family members and consultation about family perspective to the organization and team,. The parent partner also participates in activities within the wraparound-implementing agency, including utilization and quality review meetings.

Child & Family Specialist/Community Support Specialist/Intervention Specialists:

Some sites have found it helpful to have direct, hands-one practitioners who are available to provide specific interventions as agreed on in the wraparound plan. These individuals will work flexible hours in various locations to provide support and interventions, especially to young people who are participating in wraparound. Support activities can include recreational activities, transportation, and socialization, while more structured interventions might include crisis response, skills building and intensive behavioral intervention.

Wraparound Clinicians:

Some projects integrate a clinical perspective by creating unique roles for clinicians within the wraparound project itself. That does not mean that all families get clinical services from that project clinician. Instead the person in that role may do a variety of things including providing clinical consultation to the wraparound staff and team, providing direct clinical interventions as requested by the team, providing crisis support and intervention as needed, and translating wraparound plans into reimbursable Medicaid plans.

Resource Developers/Resource Brokers/ Community Development Specialists:

Some projects have found that their ability to practice quality wraparound is enhanced by developing capacity to systematically connect with community resources. Those in this role do more than manage community resource manuals. Instead they are responsible for developing connections among community options and the wraparound project, communicating about options for wraparound staff, negotiating for access for wraparound families within the identified resource, and assisting community resources to maintain a welcoming stance for families involved in wraparound.

tent and direct feedback about not only what has happened but why it's a problem for the project and what needs to happen instead. The effective wraparound supervisor takes responsibility for fostering an environment in which staff seek to continuously improve their skills while assuring pride in their development as wraparound practitioners.

Developing Staff

As staff become proficient in demonstrating the wraparound process steps, they will undoubtedly want new challenges. This may mean that they are interested in advancing within the wraparound project or may want to move into other departments that have a philosophy that is compatible with the wraparound philosophy. Effective supervisors are able to champion the growth of their workforce by sponsoring and supporting employee talent and continued growth, through formal education/training, lateral transfers, promotions and/or restructuring jobs to enhance growth. Wraparound supervisors walk a fine line when making these adjustments and need to be sure that they are making accommodations that really enhance the employee's strengths, thus improving the overall program performance. Accommodations must be balanced with accountability to ensure that individuals are still producing good outcomes while consistently following practice pathways. (See Sidebar on page 6 for methods of developing staff).

3. Working with Systems & Organizations

Quality wraparound implementation takes the combined efforts of practitioners, managers, and partners on the inside who can tame

the bureaucracy and organization, as well as family and community members. Many wraparound projects are initiated as an alternative to other services specifically targeted for those situations that can't be resolved effectively with what's already available. This alternative approach often

makes wraparound programs very political within the host environments in which they are housed. Those involved in trying to serve the family prior to the referral to the wraparound project may feel defensive that the wraparound project will be able to achieve what they couldn't accomplish. This can set up an "us-them" mentality within the organization whether it is housed in a non-profit, public sector or other type of service agency. Some wraparound projects fail because of the inability of the host environment to change. Effective wraparound supervisors must demonstrate the following capacities in working with systems and organizations:

Lateral Alliance Building

Effective supervisors have the ability to work across departments with peers and others to assure that all employees within an organization or service system feel a sense of ownership and participation in the wraparound project. This means the effective supervisor has to stay away from taking on the role of "hero" within the organization and ultimately realize that a right-size host environment is fully participatory.

Manage Up

Effective supervisors are those who are able to produce the right type of practice model within the organization. This requires creating capacity within the organization to tolerate responsible risk taking, realigning rules and policies for individual situations, and working cooperatively with administrative leadership to assure that wraparound is well-placed within the organization. Smart organizational thinkers avoid the trap of developing their wraparound project as a subculture within the larger organization. Instead, they work cooperatively within the organization to increase compatibility between the operations within the wraparound project and those within the larger organization.

Build Out

Wraparound is a process that we use when we don't know what to do. It's also a process that you can't do alone. Wraparound supervisors find they spend a great deal of their time building connections in addition to those they need to build within their organizational environment. Many wraparound supervisors find they need to develop effective alliances with public systems such as child welfare, juvenile justice or mental health, so that they continue to make referrals to the project. Once the referral is made, wraparound supervisors must manage to assure continued participation by individuals in those systems. This can be a challenge for the individual who is used to referring "to" a service rather than joining with that project. Wraparound supervisors spend a great deal of their time assuring that their staff and project don't end up "going it alone" but instead, bring on everyone together.

Make Over

Wraparound supervisors should be prepared to partner with others in creating new opportunities within their primary host environment and the within larger service system. The wraparound project is often seen as a laboratory for innovative ideas or strategies and effective wraparound supervisors find ways to work with the organization to apply those strategies across more widely. One example is an organization that has hired parent partners within their wraparound project, and after experimenting in that setting, discovers that the rest of their programs could be enhanced by

Tips for Developing the Wraparound Workforce

Developing the right workforce can be a challenge for wraparound supervisors, especially if the project is new and designed to be richly staffed with a diversity of roles. These tips can be helpful for individuals who are developing new projects or realigning their staff patterns.

1. Recruiting

a. *Use the values base to publicize the staff needs in wraparound to attract individuals who are compatible with the philosophy.*

b. *Family/Parent/Support Partners can be recruited from client lists. Cast a wide net by sending out job announcements to all people who have received services in the past year.*

c. *Post job announcements in waiting rooms and encourage front desk personnel to distribute.*

d. *Direct contact counts. Go to practitioners to get names of potential applicants.*

e. *Define your expectations specifically. If you're recruiting for family members who are parents, say so. If you are expecting lots of on-call hours, state that the schedule will be irregular.*

2. Hiring

a. *Involve parents and young people in interviews from the first contact. This allows the workforce to know you are serious about working with families.*

b. *There are two HR Department responses when asked whether you can ask potential family partners about whether they have first-person experience of the system. One answer is "No, that information is privileged." The other answer is "Yes, first-person experience is a fundamental job requirement." Work cooperatively with your HR department to find ways to work through the first stance. One example to work around this includes conducting group interviews in which material is shared with a group of potential applicants and then they are required to respond to each other while the employer observes. In that circumstance, those with first-person experience will often self-disclose while those who haven't had that experience will become very obvious.*

c. *Use situations to get at the values. Most applicants will indicate they are "strength based, culturally competent, needs driven, community based, committed…" during an interview. Use behavioral examples to get at the values rather than simply asking if they believe.*

3. Training

a. *Use the values to build a foundation but don't stay there too long. If your training doesn't capture how to do something in addition to why to do it, your staff will not be able to demonstrate the skills you need.*

b. *Recognize the limits of training. Training will help you define terms but won't necessarily translate to action or good practice.*

c. *Involve families receiving services in all aspects of your training. The more your customers know about what's supposed to happen the more they will be able to help you produce it.*

d. *Avoid a before and after, us and them paradigm in training. When wraparound began it was clearly an alternative to other frameworks. As services within the larger system have continued to evolve to use more family-centered, strength-based models there is more in common between wraparound and basic practices then before. Materials that speak about moving from one assumption to another (for example a deficit model to a strengths model) may create a context for competition rather than cooperation.*

e. *Define what wraparound is in training rather than focusing on what it's not. Use positive, proactive examples that paint a picture of wraparound practice rather than defining wraparound in contrast to more traditional models.*

4. Supervising

a. *Describe wraparound practices behaviorally and specifically.*

b. *Define how you want the values to be delivered in specific, behavioral terms. For example, don't say to staff "be strength based," but instead describe for staff what you want them to do and use the values terminology to tie behaviors to the overall concept.*

c. *Actively supervise to the practices you have described and defined.*

d. *Recognize that as the supervisor you are responsible for assuring consistency across the breadth of the project.*

e. *Share your defined practice model with families*

f. *Solicit family feedback about whether you are following your own guidelines.*

g. *Seek feedback from a variety of sources and in a variety of settings including attending team meetings and accompanying staff.*

5. Transitioning

a. *Build vertical and lateral career ladders for the wraparound workforce to advance.*

b. *Working within a wraparound environment is not for everyone. Help those that are poorly matched move on quickly.*

c. *Establish your limits and communicate those to staff.*

d. *Reward demonstrated competence through promotions and opportunities either inside or outside of the wraparound environment.*

hiring those with "first person experience of the system." In this case, the organization has parent partners hired within their foster care, residential, day treatment and outpatient programs. Another example is the wraparound project that involved family members in hiring new staff. Over time, the organization has institutionalized that process in its human resource department by assuring that all new staff, including administrative staff, are screened by family members who are currently receiving services.

Summary

Wraparound supervision requires a multi-dimensional approach to practice, people, programs and policies. Effective supervisors are often faced with the need to define the practice model, build support for the practice model, and tame policies that may be in conflict with the practice model, while also creating procedures that are compatible with the spirit and intent of wraparound. Very few wraparound supervisors find themselves in situations that don't require some retrofitting of the host environment. The effective supervisor strikes a balance between the need to work on the larger environmental issues, the need to nurture the work force and the need to continually improve and adapt the process for the benefit of families.

When communities start new wraparound projects, supervisors may find themselves managing a project they have never done before. Staff or others may sometimes raise this as an issue in questioning the capacity of the supervisor to supervise. Some supervisors have elected to take on the role of facilitator for at least one family to assure they have a good understanding of the process. Others have elected to educate themselves by working closely with staff and being available within a variety of meetings and settings so they can gather information in that manner. Others find themselves networking with peers from other wraparound settings in order to get feedback and information. Some will also use consultants and trainers as a way to build their own confidence and knowledge base. It is important to remember that the skill set for supervising wraparound is different than the skill set for implementing wraparound. Those projects that are maturing and can create promotional opportunities for wraparound staff will do well to remember this. Effective projects invest in building supervisory skills at the same time they are developing strong wraparound capacities.

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Supporting Wraparound Implementation: Chapter 5d.1

Developing, Financing, and Sustaining Wraparound: Models for Implementation

Patricia Miles, Consultant

Introduction

Sustainable, effective wraparound practice takes more than good intentions and values. Leaders involved in developing wraparound capacity must consider not only what is happening on the direct practice level as it relates to the capacity to implement high-fidelity wraparound, but must also attend to the organizational and system levels to assure that wraparound efforts are robust, relevant and resilient. For many communities, some of the biggest implementation challenges revolve around funding for the wraparound effort. For example, there is the need to fund key roles that are required for high quality wraparound and the need for funding that is flexible enough so that the service and support strategies identified in wraparound plans can be put into place.

While every community develops a unique set of strategies for responding to the challenges of wraparound implementation, their overall approaches often resemble one another. In this section, three of the more typical overall approaches or models for implementing and funding wraparound are described from three different communities and states. The models described include:

- **Provider-Implemented Model: Catholic Community Services of Western Washington in Pierce County, Washington.** This article describes an effort to build flexibility at the provider level that has been more than fifteen years in the making. This provider works collaboratively with several state and county funders in order to assure that families have access to the wraparound process. This description details

the dance between direct funder, provider and policy levels to assure that families' needs are met with maximum flexibility.

- **Public Sector-Implemented Model: Butler County, Ohio**. This description details the efforts of one county in Ohio to develop capacity for wraparound implementation. In this model, local leadership created the organizational capacity to implement wraparound by working across systems. In reviewing this implementation model it is important to remember that context counts. Ohio is a home-rule state that has a long history of projects jointly managed through intersystem collaboration.
- **Network-Driven Model: Orange County, California.** This description identifies a public-private partnership for implementing wraparound. This model allows the county to contract for care coordination and direct services. In its large urban setting in Southern California, this model has worked effectively to assure that families have access to wraparound.

Context counts when designing a wraparound project. Local leadership should consider the community context in which the project is operating. Several important contextual features that will impact implementation include:

- What is the **population** you are worried about? Each leader involved in wraparound has to start somewhere. Identifying the highest priority population among potentially eligible families will allow leaders to make the right organizational decisions about where to start.
- What is the **urgency** for action? Timing matters with wraparound implementation. Leaders have to identify how quickly they must produce results in order for those families in the target population to get the help they need soon enough. At the same time, leaders have only so much time to demonstrate to the community stakeholders that the project is able to produce desired outcomes. Implementors should consider what organizational model will result in a "right timed" response.
- What is the nature of the **host environment** in which you are operating? Leaders have to consider the larger community and system settings for operations. A provider model is often shielded from larger system challenges which may allow faster implementation in the early days. On the other hand, a critique of the provider model is that it can get so protected from the larger environment that it becomes irrelevant to larger system practices. When this happens, the wraparound project can serve to function like a subculture within the larger system culture. This can be a problem for those families who can't find their way to the wraparound provider.

In reviewing these models, the reader is encouraged to consider population, host environment and urgency in identifying their first implementation options. Each model is summarized on the table on the following three pages along with key features and advantages and disadvantages of each. Additionally, each model is highlighted in the following community stories. What is true about each of these stories is that each model has experienced—and continues to experience—mid-course corrections based on local, state and national context. Consider these changes:

- *Catholic Community Services* started their wraparound journey in an environment in which local child welfare and mental health leadership blended funds. Today, they are operating with a braided model in which each system holds a separate contract with the same principles and values. The agency takes on the responsibility to create an experience of integration for those practitioners who get to work directly with families.
- *Butler County, Ohio*, a public implemented model, began with a wide change effort based on the notion that they could train many practitioners across multiple systems in hopes that families would have minimal barriers in finding their way to a wraparound process. Concerns about quality assurance and reliability caused leadership to rethink this strategy and build a centralized unit that is held in the local

Type of Implementation	Defined	Key Features	Some Advantages	Some Disadvantages
Provider-Implemented Model Catholic Community Services of Western Washington, Pierce County, Washington	Funding that is typically pooled (although this is not required) is passed on to a provider that is usually a private, non-profit. The provider takes responsibility for hiring staff roles assigned to implement the wraparound process including wraparound facilitators, parent/family partners and, in some cases, direct service supports such as behavioral support workers, clinicians or others. In this model, the provider assumes a certain amount of risk and rewards. Usually, some agreement occurs so that the provider can maintain a certain amount of savings from the per-month rate. In recent years, sharing strategies between funder and provider have been developed during initial days of implementation.	• Funding typically passes to provider with a monthly, per family rate. In some settings, providers are encouraged to use additional funding streams, including Medicaid. • Provider assumes some level of risk for implementation. • Active hands-on oversight from the public sector (typically a Community Team) • Funder/public sector selects referral source while provider is positioned to "just say yes."	• Builds trust between funder and provider • Creates a role for provider • Often the quickest to implement since private provider is not hampered by public sector rules • Allows funders to develop a stable funding base with a per-family rate for wraparound. • Often creates an impetus for change within private provider community. • Creates flexibility in funding that builds incentives for providers to work with those situations considered hardest to serve.	• Can create a proprietary feeling on part of the provider • Referring sources (public sector) may get resentful, feeling the provider has all of the flexibility. • Over time, perception the provider is getting "rich" from savings can cause resentment. • How relevant is the provider practice to the larger system practice? • Enclaves of wraparound capacity can result in isolation of the project.
County- or Public Sector-Operated Model Butler County, Ohio	This model requires the county or public sector system directly develop staff roles for wraparound implementation. In intersystem efforts, a unit is often configured that houses those public sector workers who are being assigned to the wraparound project. Examples might include a county that dedicates a Child Welfare worker, a county Probation Officer, a Mental Health clinician and a Special Education consultant to one unit that is specifically configured to operate wraparound. Other staff roles such as a parent/family partner or paraprofessional direct service roles may be developed through contractual arrangements with individuals or an organization to supplement public sector capacity.	• Public sector leadership (county, city or municipality) has to be able to develop some flexibility. • Flexibility in public sector workers being able/willing to take on new roles • Ability to "backfill" public sector workers' existing work load	• Close to public sector essential services, i.e., creates a way for long-term public sector workers to directly experience wraparound practice • Increased potential to transfer practice change to essential public functions • Opportunities for staff development • Close relationship to funders increases likelihood of long term buy-in. • Keeping funders directly involved in child and family teams may result in increased flexibility in funding overall.	• Public bureaucracies are not known for their flexibility • Loss of potential donation base, i.e., private non-profits can do fund-raisers, harder for government • High sensitivity to flexible funds since government is directly involved in writing checks • Potential for intersystem turmoil as public sector systems may lobby for control based on priorities or community pressures

Type of Implementation	Defined	Key Features	Some Advantages	Some Disadvantages
Network Model Orange County, California	This model creates a separation between wraparound staff roles that are part of the organizing process and direct service, intervention and support roles. In this model, wraparound facilitation/care coordination agencies are identified to hire staff to implement the wraparound process. Simultaneously, direct service providers are developed to provide direct services as called for by the child and family team in the wraparound plan of care. This second group is often referred to as the "provider network." These two groups intersect around individual families when the wraparound facilitation staff lead teams in developing a plans of care. A plan of care includes services from the provider network, the larger community and any other systems.	• Separates facilitation from service provision • Allows a wide range of participants, with providers being part of the provider network or one of the care coordination agencies • Creates "bottom up" budgeting in that providers receive no promises for funding, i.e., care coordinator funding levels driven by enrollment and provider network reimbursements driven by individual plans of care	• Fixes costs for wraparound implementation • Allows costs for individual plans of care to be driven by need rather than funding caps • Requires partnership and communication between funder, providers and wraparound implementors • Public sector can assume the risk and reward • Allows multiple ways for providers to participate in wraparound implementation, i.e,. if you aren't be good at wraparound coordination you can still be in the provider network	• Requires dual development, i.e., providers to do direct support work and facilitation/care coordination agencies to do wraparound work • Takes time to develop a flexible, broad based and robust provider network • Pricing for direct supports can be a challenge • Requires a management infrastructure to make sure contracts are changing and adapting to community context

education agency, overseen by public systems and viewed as organic and continually evolving.

- *Orange County, California*, elected to pursue a hybrid network that required an ongoing dance between providers and funders. In their model, county systems invested heavily in creating a management capacity while freeing up providers either to develop a wraparound facilitation capacity or to join a provider network. Their approach began with a series of experiments or exceptions to policy and, over time, developed into a system.

None of these models is the single, right one for wraparound implementation in every setting. Each community story has lessons that can be relevant to other communities implementing Wraparound. Readers should pay attention to their own concerns about target population, urgency and host environment in deciding what organizational model to pursue first. Readers should also remember that where they start is not necessarily where they will end up in terms of creating options.

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Supporting Wraparound Implementation: Chapter 5d.2

Private Provider & Wraparound Flexibility

Doug Crandall, COO
(provider in Washington State)

Catholic Community Service Family Preservation System

Family Preservation is a system within Catholic Community Services of Western Washington (CCS), a private non-profit agency that provides a range of social services including mental health, housing, long term care for older adults, child care, and other treatment and supportive services. The Family Preservation System provides services through contracts with mental health and child welfare authorities, is licensed as both a community mental health agency and a child placing agency, and is accredited by the Council on Accreditation.

Catholic Community Service's Family Preservation System operates from an unwavering belief that children need their families and families need their children. Since 1974, with the inception of the original "Homebuilders" program in their Tacoma, Washington (Pierce County) location, Family Preservation has continued to explore and develop innovative approaches that promote safety, stabilization, child and family well being, and permanency. As the Family Preservation System evolved, incorporation of Wraparound principles and approaches was very natural and exciting.

Early Wraparound Efforts and Experiments (1990 – 1993)

Wraparound efforts in Washington State and in Pierce County really got under way in the early 1990s when several initiatives came together. Washington State was implementing the Child and Adolescent Service System Program

(CASSP) initiative; the state Legislature mandated that local mental health authorities develop an integrated plan for mental health services to children, including those administered by other child serving systems; and the state level Mental Health Division had staff in the children's unit who had climbed on board the wraparound wagon and were bringing experts in the field to Washington to help whip up excitement. On a local level, Pierce County had just finished a broad community planning process to assume local administrative control of the publicly-funded mental heath system, and had just lost control of unrestricted access to one of the state's children's long term psychiatric facilities. This moved local leadership in mental health and other child serving systems into a closer partnership. Pierce County's child serving systems (mental health, child welfare, developmental disabilities, juvenile justice, public health and education) came together in the spirit of shared responsibility for children and began experimenting with the Wraparound framework by serving a few select children and their families. An interagency administrative team was formed for the purposes of planning and oversight of this initial wraparound effort.

Quickly, CCS became the primary provider of mental health treatment and support, while other mental health agencies struggled to create responsive, immediate and flexible services.

Catholic Community Services first became involved through a contract with the local mental health authority (under the oversight of the interagency team) to hire the first wraparound facilitator for a pilot project for ten children and their families. This individual was to facilitate child-and-family-team development, planning and implementation. Individual plans were to be funded with each system contributing staff resources, services or payment. CCS was the fiduciary/administrative agent. Services were expected to be available from existing community providers, including CCS, through categorical funding streams. Flexible funds were available to assist with any needs that could not be funded with categorical dollars. There was no dollar limit established or allocated for flex funds and expenses were paid on a cost reimbursement basis by the mental health authority.

Child and family teams were convened with much care given to educating team members about the principles of this novel approach and the process that would be employed. Systems began behaving differently – with more flexibility and creativity. For example, a child on probation for fire-setting behavior performed her community service hours washing trucks at a fire station. Sex offender treatment specialists began writing reports that contained statements of hope for youth, balancing the warnings of risk. This creativity was in part due to the newness and excitement of the approach, measured with a challenge to come up with the most innovative strategies possible. Systems were also beginning to trust each other and recognize the shared benefits of success.

Successes were immediate and exceptional. "Angie" was a 16 year-old with an extensive history of self harm and assault, often self-mutilating to the point that she required surgeries to repair the damage. She had received outpatient treatment for nine years, had experienced multiple psychiatric hospitalizations as well as nearly two years in a long term psychiatric facility. Due to past arson and assault charges, she was involved with juvenile court and probation. Each of the schools she had attended since 6th grade reported multiple behavioral issues and were quite reluctant to accept her back, citing concerns for student safety. She was released from a long-term psychiatric facility to her mother and siblings. In order to get a fresh start they moved to a rural community where staff accompanied the mother and daughter as they introduced themselves to neighbors. Work with the school resulted in Angie's attending on a limited basis while she attained her GED, and she participated on the school swim team. She was also assisted in getting an afternoon job with

a children's party planning business. Self-harm and assaultive behavior was essentially eliminated, being replaced with a sense of belonging and purpose. At the system level, administrators were astounded at the relative ease with which children and families experienced success.

Mental health was by far the largest provider of services, with child welfare a distant second. Other systems provided direct treatment or support services minimally and only occasionally. This was mainly due to the population of children being selected for this pilot, which tended to have extensive outpatient and institutional mental health histories.

Catholic Community Services proved to be both a highly capable administrative entity and direct mental health service provider. They were extremely flexible and creative in both capacities, developing supports and resources to meet needs and simplifying administrative issues such as immediate payment for goods and services. Quickly, CCS became the primary provider of mental health treatment and support, while other mental health agencies struggled to create responsive, immediate and flexible services. CCS also had the benefit of being a licensed child placing agency, and therefore had the capacity to utilize specialized foster homes for brief respite stays.

Second Generation Wraparound Efforts (1993-2000)

In the early to mid 1990s, the community context changed. The state mental health system was granted a 1915 (b) waiver to Title XIX of the Social Security Act, allowing implementation of managed care through capitated arrangements with local mental health authorities (called Regional Support Networks or RSNs in Washington). The mental health benefit design, under the rehabilitation option, was fairly broad and included a treatment modality for High Intensity Treatment. This modality included the full range of mental health services available in the Medicaid State Plan, and twenty-four-hour-per-day and seven-day-per-week access provided through a multi-disciplinary team in the community. Shortly thereafter, child welfare initiated a behavioral rehabilitation service (BRS) option utilizing Title XIX funds for those children who lived in group care or therapeutic foster care settings. Funding for this service included coverage for routine mental health care. Both the state mental health and child welfare authorities indicated that Medicaid mental health funding could not supplement this service since it would be viewed as "double dipping." The end result was that while mental health had achieved greater flexibility in funding, child welfare had created a categorical funding stream that inhibited blended funding.

When child welfare put out a bid for BRS services, CCS responded as the lead agency for an alliance of providers and was awarded the contract. This forced mental health and child welfare to evaluate how they would continue to partner in response to high needs children and families in the community. In evaluating the children identified as meeting criteria for either wraparound or high-end BRS (essentially the same criteria as wraparound), the number was about the same from each system. Given this, a decision was made to have mental health fund their share through wraparound and child welfare through BRS. The systems had abandoned the "it's your kid' mentality and were motivated to demonstrate such through collaborative funding arrangements, yet this solution seemed the most streamlined and administratively simple. They agreed to jointly monitor service utilization and expenditures with the expectation that things would change if the data presented the need.

During this time, a majority of the services and supports provided to "wraparound" children and families was being delivered directly by CCS. They had developed a cadre of skilled facilitators, clinical professional staff, psychiatric services, paraprofessional support, respite homes and parent partners. The function of the facilitator was

integrated into the role of the lead clinician from the agency. This was in part a financial decision. Since clinical work at CCS was always delivered nontraditionally, absorbing this role into that of the primary clinician seemed less confusing to both the family and staff.

At this point, the local mental health authority and CCS were invested in moving from a fee-for-service model to a case rate payment. An initial analysis of aggregate costs showed that a surprising percentage of expenditures fell into the clinical indirect category, which would not be considered reimbursable under a fee-for-service arrangement. These costs included higher levels of supervision, coordination between CCS staff, two-to-one staffing and travel. This was also a new way of doing business for CCS and the agency had not fully explored how to account for all activities to maximize direct billing. This was somewhat alarming to senior county mental health administrators and further analysis was requested.

Rather than pursue a retrospective study, it was decided to build a case rate based on the actual cost of plans. Catholic Community Services facilitators developed individual plans of care for each child/family served. Local mental health and CCS administrators "negotiated" the type and frequency of services, including flex funds, and established a cost per plan. Services were costed on a fee-for-service basis with hourly rates established by staff position and service type (e.g., therapist at $82/hr; parent professional staff at $11/hr; parent partners at $9/hr; etc.). Plans were funded for three months with a monthly reconciliation of actual expenditures to the budgeted amount. CCS could request additional reimbursement after the fact up to an established maximum consideration. Individual monthly plan amounts varied greatly, ranging from around $1,000 up to $14,000.

This process proved a real test of the strength of the relationship between the funder and provider. Arguments occurred, accusations of micromanagement abounded, and a few tears were shed. After 15 months, the RSN and CCS agreed to a monthly flat rate ($3,200). Funding came from a combination of state/federal Medicaid and state-only dollars administered by the local mental health authority. This rate would be authorized for up to one year, with decisions about authorization and re-authorization falling to the local mental health authority.

CCS had established itself as a niche provider for children and families presenting with the most challenging behaviors and complex needs. They helped the RSN achieve the lowest utilization of children's long-term inpatient care in the state. They also contributed greatly to the local child welfare system's success in keeping children in their own community and out of institutional and group care settings.

It was a period of rapid growth, and while service provision was sailing along smoothly, there was a need to convey clinical and administrative issues to two different funders.

This was an exciting as well as challenging time for CCS. It was a period of rapid growth, and while service provision was sailing along smoothly, there was a need to convey clinical and administrative issues to two different funders. It was necessary to shield staff and practice from bureaucratic and funding rules so they could focus on being creative, flexible and responsive. Fortunately, the relationship with funders continued to be strong, nurtured through participation in regular staff meetings, trainings and celebrations.

Present Arrangements

The current structure for providing wraparound within CCS has matured and been integrated into all aspects of the agency. Services have expanded throughout southwestern Washington and into Oregon replicating results experienced in Pierce County. Funding in Pierce County continues through a contract with mental health, with the all-inclusive flat rate and an expected "target" number of individuals served per month determining the contract's upper payment limit. Services are reported to the RSN through the use

of a per diem "wraparound" code, with CCS maintaining individual encounter data for management purposes.

Services are provided through a team of CCS staff in concert with the child and family, staff from other systems involved with the family and natural supports. Decision making is driven by families within a team context, with resources readily available when and where they are needed. Lead clinicians have the authority to bring other CCS staff resources (paraprofessional support, parent partners, psychiatric services and respite) to the team and authorize the use of flexible funds (up to $250) with only front-line supervisory authorization. Authorization for expenditures above that amount are made by managers and directors who are available on a 24/7 basis. Specially designated client needs checking accounts and agency credit cards are readily available to cover costs whenever and wherever they occur. Expenditures are tracked by client and fund source through an integrated clinical and fiscal management information system. Resource utilization is managed carefully by supervisors and managers through a host of management reports that include flex fund use, resource utilization, staff productivity and client outcomes.

Maintaining a competitive pricing structure has allowed CCS to stay in business even as some communities have reduced capacity. This reduction in capacity has been in large part due to a move to what is basically a Medicaid-only service delivery system in Washington State. Previously, up to twenty-five percent of children and families served did not have Medicaid and were covered with state-only funding. Economy of scale is another factor that has allowed CCS to maintain a fairly priced capacity.

Challenges

- *Conflicting Interpretation of Federal and State Financial Rules.* Federal and state communications often present contradictory viewpoints about what is allowable under Medicaid. At the federal level there is support for medical model care under a fee-for-service arrangement. Although Washington's Medicaid state plan modality does not mention wraparound by name, it includes an intensive treatment service allowing for a team-based flexible approach. However, state structures make implementation a challenge. For example, when the state was revising their coding rules, they took the position that two-to-one staffing was allowable only when there is a risk of safety to staff in a crisis situation. Wraparound relies on a team approach and may include two staff working with a family in a variety of other situations, including team meetings, family outings, and for the safety of the client or others. Under our per diem reporting structure, this is not a problem; however, questions abound as to whether this "bundling" of services will continue to be permitted.
- *Managing To the Practice Model: Keeping Fresh.* There is an inherent challenge in balancing creativity and flexibility with

adherence to process. While these are not mutually exclusive, they can cause friction, and when process takes priority over innovation and responsiveness, families may be left behind. This also includes attention to fit, so that the right response is truly tailored to specific needs. The danger is that without logical decision making it may be more expedient to just plug in the same thing or follow the same procedures in the name of fidelity.
- *Managing Perceptions of "Entitlements."* This may originate within systems and be-

tween families. It may interfere with the planning process when a specific direct service or flexible funds are viewed as a need instead of a planned strategy in response to one. For example, one family may be stretched and exhausted and receive frequent respite care. Other families may hear of this and feel they should receive the same. Referring staff in other systems may also communicate to the family or team the need for a particular response prior to the planning process. This sets families up for disappointment and makes the process of engagement and trust building more difficult.

- *Balance Between Planning and Doing*. The wraparound process, by its nature, is a balance between providing interventions and facilitating teams. Staff must be skilled, flexible and comfortable with this dual role. A challenge for any provider is creating the ability to implement "just in time" interventions, services or supports while maintaining a capacity to lead an ecological team in reaching agreement.

Lessons Learned for Providers and Funders

1. *Ensure that Mission and Values Drive Practice*. This may sound simple but should be the significant driving message of leadership of the provider agency. This requires constant self-reflection as well as organizational sophistication in reviewing the desirable characteristics of all staff and how decisions are made and how services are delivered and evaluated. Likewise, the funder has to be tolerant and supportive of a mission focused provider.
2. *Balance Provider and Larger System Issues. Providers have to accept that they can't change the whole system*. A provider becomes an option within the system. Funders have to continually manage the system change issues within the larger system. Funders should avoid making the provider responsible for system change.
3. *Regularly Re-evaluate your Commitments*. In Pierce County, the system-level outcomes have been so successful that there is a risk is that the provider is taken for granted. What were previously seen as monumental successes are now commonplace. As the bar rises from year to year, the provider runs the risk of no longer being seen as essential. It's a good idea to formally build in commitments at regular intervals over the years.
4. *Build Continuous Partnerships with Funders*. Providers have to partner with funders continually. Don't take supportive funders for granted. Leadership changes and as a provider one must to be prepared to continually demonstrate worthiness. Funders have a right to this. Strategies for identifying value and worth include identifying outcomes and results for the right price.
5. *Take the Broad and Deep, Long and Short View*. Providers must pay attention to all things at all times. The skilled administrator of a private agency has to attend to practice issues to ensure the work force stays innovative. The administrator must consider local, state and federal funding issues as well as legislative issues. Funders who are attempting to be supportive of a private, non-profit that is operating wraparound must attend to the possibility of mixed messages from other sources of the bureaucracy including contract management, accounting and certification. Housing wraparound in a private non-profit doesn't mean the funder only has to execute a contract, but must also be prepared to create supports and structures to insure the contract stays fresh, flexible and innovative.

Author

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agency delivering Wraparound services in Washington and Oregon. Doug has been involved in all aspects of wraparound development in Washington, including standards, rate setting and outcome monitoring.

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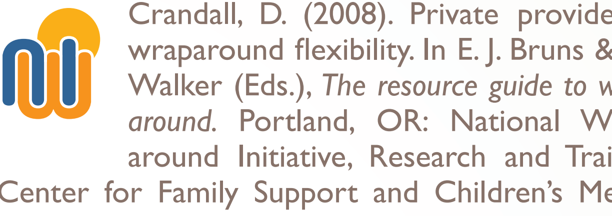

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The Wraparound Orange County Model

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Orange County Children and Family Services

Background

Orange County is located between Los Angeles and San Diego counties in Southern California. The county is populated by 3 million residents, of whom 53% are Caucasian, 32% are Hispanic, and 13% are Asian. In this urban county, the median family income is about $84,000 per year. The Social Services Agency (SSA) is the child welfare agency in Orange County. SSA chose to implement Wraparound Orange County for several reasons: a disproportionately high reliance on group home placements, a recognition that many emancipating adolescents return to their families of origin after dependency terminates, and an appreciation of the enhanced value of services provided through a strengths-based, multidisciplinary approach. The SSA has a positive, effective working relationship with the Orange County Health Care Agency (HCA), the behavioral/mental health agency in Orange County, and in fact already had integrated behavioral health staff into many components of child welfare work. SSA also has a positive working relationship with the Orange County Probation Department, which shares a common interest in developing better solutions for youth with severe emotional or behavioral difficulties.

Wraparound Orange County was implemented in July 2001. It is administered by the SSA, in partnership with HCA and the Probation Department. As of April 2007, Wraparound Orange County was serving 330 youth each month.

Target Population

To be eligible, a youth must have severe emotional or behavioral difficulties, and be currently placed in, or be at-risk of being placed in, a group home (which includes residential treatment centers and correctional placements), and be either:

- a dependent from child welfare, or
- a ward from probation, or
- referred by mental health and identified by special education.

Child Welfare dependents are youth who are declared to be abused or neglected, and who are under the jurisdiction and supervision of the Juvenile Dependency Courts. During court dependency, youth may reside with their birth parents, relatives or in foster homes. Similarly, probation wards are youth who have committed a crime, are adjudicated, and under the jurisdiction and supervision of the Juvenile Probation Courts. The Juvenile Courts will terminate dependency or wardship when the conditions that brought the youth to the formal system have been resolved, i.e., youth are living in a safe and permanent home, or they are no longer determined to be a safety risk to the community.

The Wraparound OC Model

Wraparound OC is administered by the SSA. Administrative tasks for Wraparound OC include contract management, payment of placement costs, quality assurance, training and technical assistance, and coordination of services with county staff and the Juvenile Court. Liaisons (supervisor level staff) from the HCA and Probation Department participate with SSA staff in these tasks. The SSA contracts with five community-based organizations to provide direct and support services. Four agencies have extensive experience in the residential treatment field, and are certified Medi-Cal providers. Medi-Cal is California's version of Medicaid, which is available to all foster care dependents and probation wards while under the jurisdiction of the Juvenile Court. Additionally, families may qualify for Medi-Cal to meet their physical and mental health needs, depending on their financial situation.

These agencies employ Care Coordinators (facilitators), Parent Partners (peer parents), and Youth Partners (mentors) to work with wraparound families. A fifth agency, Family Support Network, developed the Parent Institute to recruit, train, and support the Parent Partners, who are employed by the four direct service provider agencies. The Parent Institute represents the collective voice of parents in the development, administration and oversight of Wraparound OC, and it participates in a variety of meetings, trainings and organizational planning sessions.

Senate Bill 163 was established in California to allow counties with approved wraparound plans to access the state and county foster care funds that

would have gone to fund the youth's placement and treatment costs in a group home facility, and instead allow counties to use the funds to support and maintain the youth in a family setting. In compliance with California Department of Social Services (CDSS) SB 163 Wraparound standards, the four wraparound provider agencies bill Medi-Cal for allowable services to eligible families. The Orange County Health Care Agency (HCA) administers the Medi-Cal contracts and meets each month with the providers and SSA to ensure coordination of services and fiscal accountability.

After some early experience managing the complex fiscal and bureaucratic tasks for new wraparound referrals, a system was established. The referring social worker, probation officer or therapist consults with a wraparound supervisor to determine whether the youth meets the eligibility criteria for Wraparound OC. Once consultation is approved, the referring worker obtains

the consents of the family members and prepares the referral packet. The Wraparound Review and Intake Team (WRIT), composed of administrators from child welfare, probation and mental health, together with parent representation, reviews referral packets each Wednesday and assigns eligible youth to a contracted wraparound provider, and engagement work with the family begins. This is the pre-enrollment stage. The referral remains in this pre-enrollment phase until the youth's transition from group care has occurred. Once the youth resides in the family home (birth home, relative home, or foster home), then official enrollment into a wraparound slot occurs, which triggers the funds to flow into the wraparound fund from the state and county, and remains until dependency or ward status terminates. Upon termination, official enrollment ends, and the youth can enter post-enrollment for up to 90 days of transition from wraparound. Each month, the county SSA submits statistical documentation to the California Department of Social Services in order to claim funds for youth enrolled in SB 163 slots. When youth are not enrolled in an official SB 163 slot, they are documented as pre- and post-enrolled, which is funded through Wraparound Orange County's savings and reinvestment fund. The Reinvestment Fund includes any savings from the Wraparound OC program, and is used to reinvest into services and programs to support children and families. In Orange County, reinvestment funds have been used to provide Wraparound to families who would otherwise not qualify, due to the fact that their behaviors do not rise to the level of group home care. In addition, a Provider Network has been developed to fund services and interventions that were otherwise not known or developed in Orange County, including crisis services, additional youth mentor services, sexual behavior treatment programs for families who could not afford it. Additional fee-for-service contracts are funded with reinvestment funds including tutoring, after-school programs, in-home safety aides, monitored visitation, and housing location services.

Within the initial month of referral, the Care Coordinator and Parent Partner are responsible for meeting with the family, holding an initial family team meeting and developing an initial Plan of Care, Family Budget and Safety Plan for the first three months of service. The Family Budget is authorized by having the Care Coordinator submit monthly Individual Service Reports (ISRs) to the County Administrator for reimbursement of flex fund and non-Medi-Cal allowable costs incurred to support the family. The most common types of costs are related to basic needs (housing, food, utilities, childcare) and individual activities for youth in the community (dance lessons, sports, music lessons). On average, the use of flex funds averages about $300 per family, per month. A separate Medi-Cal report is submitted to HCA for Medi-Cal allowable costs. In Orange County, direct therapeutic intervention is not provided by the wraparound staff. Instead, the wraparound staff will facilitate the family team in a planning and documenting decisions to access various services and interventions. This is considered "case management" according to Medi-Cal definitions. Additionally, the wraparound staff may directly assist the youth in the development of skills or engagement in activities. This is considered "rehabilitation." In addition, Medi-Cal allows staff to bill for the time it takes to document these activities, as "documentation." In addition to flex fund expenditures that are reported each month on the ISR, wraparound providers invoice SSA for their monthly operating and staffing expenses, per the approved contract budget.

Each contracted wraparound agency has a flex fund budget for each fiscal year, based upon the total number of youth the agency could serve each month. The provider expends funds to meet immediate needs of the families they serve, and then the agency is reimbursed for these flex fund expenditures. The contract requires that each wraparound agency has the capacity and resources for family teams to access funds the same day, as needed. The actual check writer remains within each wraparound agency. Once the family team decides what interventions could meet the family's need, there are a variety of interventions that can be paid for through the use of flex funds. Common interventions in Orange County include housing assistance, basic needs, respite, transportation and youth activities (sports, music lessons, tutoring).

The Social Services Agency, as the fiscal agent for Wraparound Orange County, maintains fiscal management of the reinvestment and savings pool

for Wraparound Orange County. The Wraparound Oversight Group (WOG) includes executive administrative management from Social Services Agency, Health Care Agency and Probation Department. Wraparound Orange County is in our 6th year of providing wraparound. Over that time, we have been able to save costs over what residential or other out-of-home placement costs would have been. Our wraparound plan, approved by California State Social Services and our County Board of Supervisors, states that any savings are to be reinvested into our system of care for services to children and families. WOG, in consultation with representatives on the countywide Children's Services Coordination Committee (CSCC), reviews and approves recommendations for reinvestment of the savings into various services for children and families. Reinvestment into services promotes system change within both community and formal service systems. By expanding the target population for referral to Wraparound Orange County, additional families and staff have had the opportunity to participate in this family-centered, team driven, strength-based decision making process.

Reinvestment into services promotes system change within both community and formal service systems.

Some may question how the formal systems know when costs are really important for the family. In the early years, WRIT provided additional oversight for flex fund spending. A written request was required, which outlined the rationale for justification of flex fund use for individual interventions. The request was intended to remind wraparound staff to consider various options when developing interventions for individual needs, and to plan for the family's ability to sustain the investment over time, if needed. However, over time, this review of flex fund spending has transferred to the supervisors within each contracted wraparound agency. Wraparound teams are to develop a Plan of Care, which includes how each intervention will be funded. Since each wraparound agency has a flex fund pool, the agency can determine whether to approve individual requests or not, based on the family team's recommendations.

Public/Private: Cost-Reimbursement Model

In this model, the public system (child welfare, probation, and mental health) has identified the child welfare system (Orange County Social Services Agency) as the primary program and fiscal administrator to manage the wraparound fund, which is composed of both state and county funds. This county agency is responsible for provider network development, training and quality assurance of private, non-profit contracted providers, as well as outcome and fiscal management. In this model, Care Coordinators (facilitators) and Parent Partners (peer parents) are assigned to each family served. Care Coordinators function in the lead role of developing family teams, plans of care and safety plans, and authorizing purchase of services. The actual check writer remains with the contracted provider who employs and supervises the Care Coordinators, Parent Partners and Youth Partners (mentors). As a result of a Request for Proposal (RFP), several private, non-profit agencies have applied to contract with Orange County Social Services Agency to be an approved wraparound provider. Contracts are structured so providers can maintain a certain number of staff to serve a maximum number of youth. For example, a provider contracted to serve up to 120 youth could employ 12 teams of staff. Each team could serve up to 8-10 youth and would consist of one Care Coordinator, one Parent Partner, and, potentially, one Youth Partner. The Provider is authorized to begin the contract year with a certain number of staff, and may increase their staffing to the maximum allowed through their contract, based upon authorization from the County, who maintains referral authority as youth are referred to wraparound. In this model, the County fiduciary would reimburse the contracted provider for all program costs regardless of the number of youth and families served or the level of services provided. However, since providers hire staff based

on the flow of referrals from the County, there is rarely an instance when providers have more capacity than youth to serve.

What is needed to implement this system?

- County oversight, quality assurance, fiscal organization and blending of funds, training, data and trend reports
- Request for Proposal (RFP) process for wraparound agencies to provide Care Coordinator, Parent Partner and Youth Partner capacity
- Ability to hire and manage paraprofessionals and parent support staff
- Core Values – strength based, family driven, community based, team driven, culturally responsive
- Parent Partner component – assigned to each family
- On-call capacity for staff within the wraparound agencies availability 24 hours/day, 7 days/week
- Check writing for flex funds within same day of a request

What are the advantages of this organizational option?

- Unlimited capacity for Care Coordinators, Parent Partners and Youth Partners, based upon referral demand
- Contract-based, which is outcome driven rather than limiting families to a predetermined timeframe for their involvement in wraparound
- Allows savings to be managed in the public sector for reimbursement into services for children and families
- Allows for practice change within the entire wraparound agency, as staff interact with other departments and programs and continue to practice in family-centered, strength-based ways
- Service providers can be hired and deployed more quickly than county staff

What are the disadvantages of this organizational option?

- Doesn't lead to as much practice change within the existing formal service system as it does within the community contracted wraparound agencies because the county staff are not the direct service providers.
- Developing a provider network to offer different types of services can take time
- Need to find a way for county system to include private providers in a meaningful way as the county system enhances service delivery policies and practices
- Some confusion between the formal system representatives about their role in wraparound (SSA, HCA, Probation)
- Increased formal service system oversight and government fiscal lead can make some community stakeholders nervous about flex fund spending to directly support families, if the county doesn't follow through with their plan to reinvest savings back into services for children and families

Author

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Supporting Wraparound Implementation: Chapter 5d.4

Developing, Financing and Sustaining County-Driven Wraparound in Butler County, Ohio

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Over the last four years, Butler County has undertaken a process to develop, finance, and sustain a successful, visible wraparound initiative. Butler County is located in the southwest corner of Ohio, just outside of Cincinnati. In 2000, the population of the county was 323,807 (91% White, 5% black or African American, 1.6% Asian, and 1.4% Hispanic). The median household income was $47,885.00. The county has experienced rapid growth in the last decade and its social service delivery capacity has been stressed as a result.

Ohio has a history of collaborative cross-system practice stretching back several decades. One of the forms that this work has taken has been the creation of county-based "clusters," groups of cross-system representatives who work together to arrange services and plans for families whose needs are not met in typical service delivery. Growing frustration with this "cluster" process led to the decisions that premised Butler County's development of an effective wraparound capacity. In Butler, and many other Ohio counties, there had been a history of having collaborative fixed teams of system staff meet on a regular basis to review plans for families who were in need of additional or different responses to their needs than the typical service processes were able to deliver.

Over four years, Butler County has planned and implemented a series of strategies related to the development of an effective wraparound capacity. One significant feature of this effort has been the high trust level present between the Family and Children First Council (FCFC) and its host, the Educational Service Center, and amongst the partici-

pating systems from across the community. Trust has fostered the support and flexibility, as well as patience, needed to see through the development of this effort.

The Context

Local counties operate all key child/youth- and family-serving agencies in Ohio. This means that all employees providing for the care and support of youth and families are employees of the county government with the exception of the Mental

Health (providers of service are hired at private companies and non-profit organizations) and Education systems (hiring of school personnel is based in districts that have different geographic boundaries than the counties they are located in). Over the years, each county has evolved a network of contract agencies that provide the direct care and management of behavioral health services. Most Ohio counties also have multiple school districts within their geographic regions. Special Education services are district based and supported by regional educational service centers that provide training, consultation, and specialized services that districts do not maintain individually.

In each of the 88 counties in Ohio there is a body called the Family and Children First Council (FCFC). This is a mandated collaborative structure that brings together child- and family-serving system representatives and parent representation, to oversee and manage services and supports for families that are multi-system involved. These councils are supported by a state level council that is made up of the leadership of for each individual system. FCFCs are also charged with the oversight of collaborative service efforts and planning for community needs for youth and families. The FCFCs have grown out of a long history of collaboration at the cross system level that was first implemented in the state over 30 years ago.

Ohio is a home rule state. As a result, many state initiatives take on a flavor that is shaped by a county context. Wraparound has been no exception. Each county is required to submit to the state a "Service Coordination Plan." This plan describes the county's arrangements for meeting the needs of families whose lives touch more than one or two of the county's child and family serving systems. In Ohio, the wraparound process is one of many options that counties can pursue to improve services and outcomes for children, youth and families who bump up against multiple systems. Butler County elected to pursue the wraparound process because local leadership felt this approach could yield improved outcomes for youth and families served collaboratively across systems. Specifically the county leadership sought to serve multi-need youth within the county borders as opposed to utilizing out-of-county placements

The History of Implementation

Plan A: Once leadership in Butler County decided to develop wraparound capacity, their next decision was to build a design. After spending a year in design conversations, their original design involved creating wraparound facilitation capacity across local systems rather than through a centralized team or unit. This design called for training system staff from all child and family serving systems and for their "home" systems to allow and support the staff to facilitate wraparound teams for families identified through the FCFCs. The original designed called for wraparound facilitators to facilitate across systems. For example, a child welfare worker would facilitate for a probation-involved family while a probation worker would facilitate for a mental health involved family and so on.

It soon became obvious that this strategy was difficult to implement for the following reasons:

1. Capacity and Expertise: It was difficult for

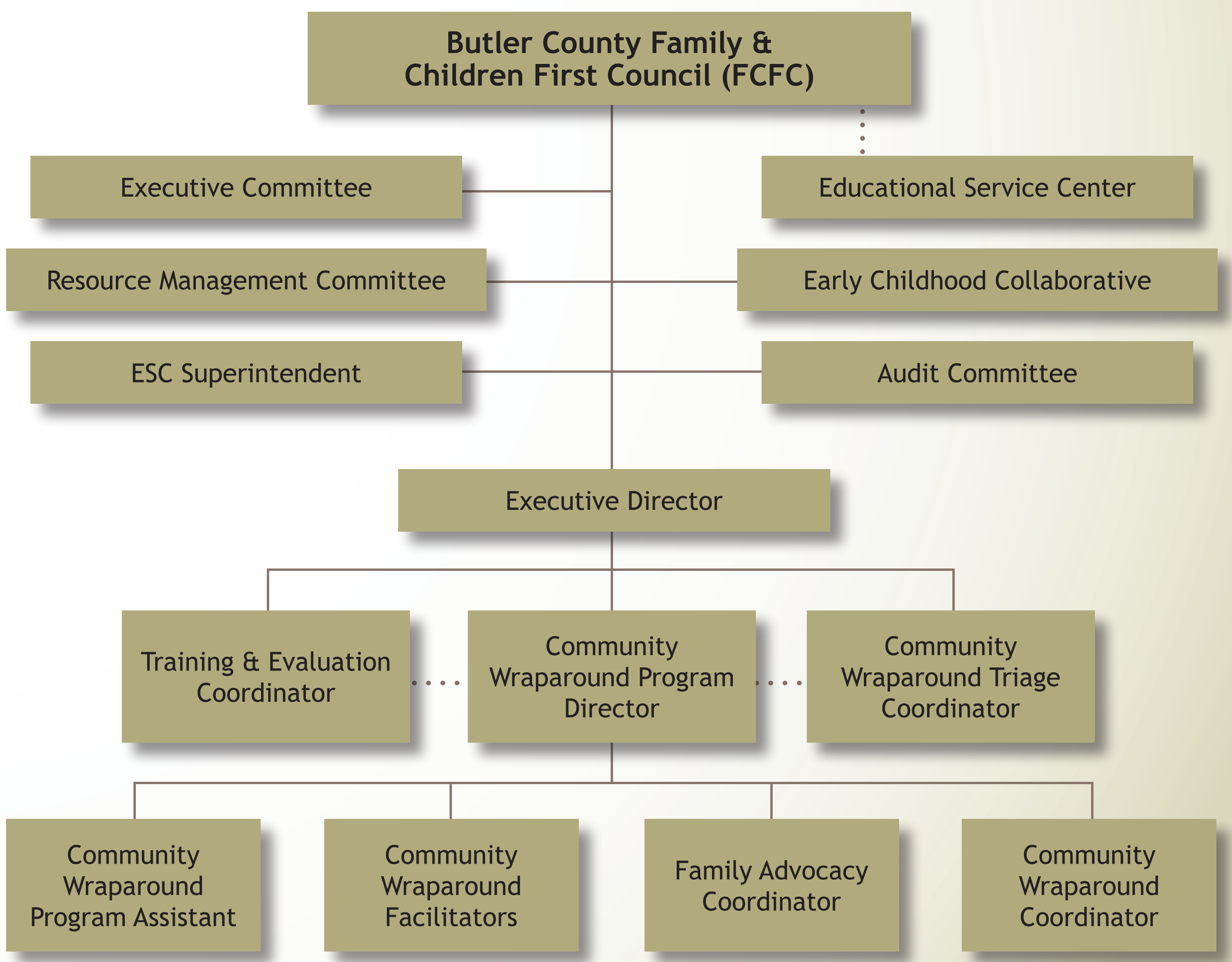
facilitators to learn facilitation skills while at the same time still performing the core tasks of their "real" job in the organization they worked for.

2. Diffuse Supervision: Since there was no centralized wraparound supervision, there was not enough consistency to assure quality in the process as it happened across multiple sites within the county.
3. Agency boundaries: Agencies required that staff from key systems only facilitate for families involved in the worker's home system.

Plan B: Butler County leadership, through the FCFC, developed a second strategy, which was to build a pool of Community wraparound facilitators. The FCFC recruited community members and interested system staff to be trained to serve as facilitators. These community facilitators received contract rates per family when they facilitated a wraparound team and plan. Payment was delivered in increments, when key benchmarks in the process were reached. These benchmarks included the completion of a Strengths, Needs, and Culture Discovery document, the initial wraparound plan, and the crisis/safety plan.

This strategy provided enough momentum, in

Figure 1. Butler County Family & Children First Council Organizational Chart



> *"The stars aligned and we were able to develop wraparound for families in our county"*
>
> *- Butler County Wraparound Program Staff Member who has watched the growth from the very beginning through the current status*

terms of developing community support for wraparound, that the next step was taken. Two local systems, Child Welfare, and the Department of Job and Family Services (DJFS, Ohio's evolution of the adult welfare system, responsible for welfare in the era of post welfare reform) created contracts that currently fund the positions described below. The adult system's funding position for the wraparound initiative came to pass because of the DJFS participation and history in the local collaborative infrastructure as well as it understanding of the role it plays in supporting families in the community care system.

The Butler County Wraparound Program currently operates as a staffed unit of the county's collaborative structure. The development of the Wraparound Program is unique as it was not funded as a discrete program but rather "grown" through several different strategies that resulted in the formalization of the county's commitment to the approach. The FCFC, through its executive committee and staff leadership, has built a structure that now provides wraparound to 100 families or more a year.

The Elements of the Process

Overview

The wraparound unit in Butler County is housed at and managed through the FCFC. In turn, the FCFC is housed at the Educational Service Center (ESC), the multi-district special education support center for the county. The ESC serves as the fiscal agent for all activities related to the program components. Oversight of the activities of the FCFC staff is conducted by the Executive Director of the FCFC who reports to the Executive Committee of the Council. The organizational chart (see Figure 1 on previous page) reflects the current structure and staffing for the Wraparound Program in Butler County.

The wraparound initiative is currently composed of eight FTEs and the services of the Executive Director of the council. Positions within the structure include:

- Facilitators (4 FTEs): There are four full-time facilitators who implement the wraparound process. These positions are employed by the ESC. The family load for these staff varies across the year but averages about 15 families at a time.
- Family Advocacy Coordinator (1 FTE). This position is responsible for developing volunteer parent-to-parent connections for families in the wraparound process. There is limited capacity for funding through stipends to some parent to parent supporters. Thus there are both paid and volunteer "advocates" supported by this position.
- Community Wraparound Coordinator (.5 FTE): This position supports community wraparound facilitators through individualized coaching and field-based support.
- Program Assistant (1 FTE): The person in this position provides support to the project, including data entry for tracking outcomes and process.
- Community Wraparound Program Director (1 FTE). This position supports and supervises all project staff.
- Community Wraparound Triage Coordinator (1 FTE). This position assists families through the intake process to access the wraparound process. The Triage Coordinator also provides support for and to families who may not be eligible for the program. Additionally, the Wraparound Triage Coordinator is available to help families who aren't able to immediately enter into the wraparound project but are in a crisis

based on an immediate lack of options or service responses.

County Wraparound Facilitation Capacity

Team facilitation is provided primarily by the four county staff who are managed under the auspices of the county collaborative structure. Additionally, there are six Community Wraparound Facilitators, including people who are not county employees but who are trained and supported to serve as wraparound facilitators for a small number of families. Additionally, a small number of system employees, not employed by FCFC, who work in other county organizations, are viewed as "community facilitators" who provide facilitation to typically no more than one family at a time.

Parent Advocacy and Partnership

All families involved in wraparound in Butler County are offered access to a Parent Advocate. In Butler County advocates typically work with a small number of families at a time—one to three or four families depending on the role of the advocate (paid or unpaid) and the amount of effort the advocate has available to devote to the work. Butler County Parent Advocates partner with a parent throughout the team planning and support the service delivery process in order to assist families in:

- Engaging in the wraparound team development and planning process;
- Assisting teams, providers, and other supports to clearly hear and understand the family's unique perspective and voice; and
- Providing support to families as they participate in various meetings throughout the community and system.

Butler County has developed several avenues to assure the presence of parent advocates in their wraparound initiative. In addition to funded positions there is a cadre of "volunteer" parent advocates who can provide peer-to-peer support. These efforts are supported by a Family Advocacy Coordinator who is responsible for;

- Linking local volunteer advocates to the state-wide efforts
- Recruiting and supporting parent advocates as they work with families

Enhancement Efforts

Triage: Over the course of the year, the Butler County Wraparound Project may maintain a waiting list. Additionally, some families face imminent risk of out-of-home placement, with no immediately available wraparound response. The county has a commitment to addressing the needs of all families referred, including those who wouldn't necessarily meet eligibility requirements for the formal wraparound process. In order to meet this commitment, Butler County has recently added a Community Wraparound Triage Coordinator. This person is responsible for:

- Assisting families entering the Wraparound Program with any immediate needs that must be met in order for them to make benefit of the wraparound process;
- Assisting families whose children are at immediate risk of an out-of-home placement or whose children are being discharged from a placement without a plan for services by providing supports through rapid clinical assessment and coordinated service response across systems; and
- Assisting families who were referred but not eligible for the wraparound project in linking to improved categorical, programmatic, and community resources through short-term service coordination activity.

Training: Butler County uses training in wraparound as a means to build community support for the process. A community-operated training team, led by FCFC, provides regular training on a variety of topics throughout the year. The training team is made up of representatives from the key child- and family-serving organizations in the county. In the first full year of operations, training sessions were conducted to inform providers, funders, and families about wraparound and local implementation plans. A total of 349 people attended these trainings. The training team also trained 43 people

in methods for team facilitation. Several of these became the Community Facilitators. Training capacity is currently maintained in order to improve the quality and efficacy of wraparound as well to continue building community support.

Tracking and evaluation: The collaborative structure is developing a mechanism for tracking wraparound process by family and facilitator to ensure adherence to key steps in the process. This information will be used in supervision of staff and community facilitators. The Ohio Scales, a tool designed to track status and outcomes of youth receiving behavioral health services across the state, is also maintained and analyzed by the Butler County Wraparound Program.

How the Funding Works

Staffing & Infrastructure

Staff positions for the Butler County Wraparound Program are funded by agreements across the FCFC executive leaders. Specifically, the Butler County Department of Job and Family Services provides funding that supports six of the staff positions. The local Child Welfare agency funds the remaining facilitator positions. By agreement, funds are moved to the Educational Service Center (ESC), the fiscal agent for all FCFC programs. The ESC hires the staff and provides office space and other support for the Butler County Wraparound Program.

Funding for Family Plans

The Butler County service system includes an array of services for youth and families that is comparable to that available in many other communities. Butler County has worked to expand the number of intensive in-home and in-community resources available to families to assure a range of options is available to them. These services are traditionally funded and can be found in individual wraparound plans.

When family teams develop care plans that require activities and supports that are not funded

Table 1. Butler County FAST Expenditures by Category 2006*

Category	Amount
Bed	$167.97
In-Home Services/Supports	$15,192.00
Respite	$640.00
Safety Devices/ Alarms	$312.20
Service Coordination/Facilitation	$5,154.37
Social Recreational	$8,311.54
Utility Assistance	$314.59
Administrative Fee (Partially Funds Admin. Position)	$7,333.00
Grand Total:	**$34,415.67**

** From the Butler County 2006 Annual Wraparound Report*

Table 2. Butler County Pooled Fund Expenditures by Category 2006*

Category	Amount
Car Repair	$1.023.41
Child Care	$372.25
Homemaking Services	$1,204.60
Housing Assistance	$3,800.00
In-Home Therapeutic Supports	$24,101.91
Outpatient Therapy	$9,207.00
Utility Assistance	$2,626.95
Grand Total:	**$43,336.12**

** From the Butler County 2006 Annual Wraparound Report*

in the local array of services, they turn to two discrete resource pools. The first is a state funding stream called FAST, while the second is referred to as Pooled Funds.

- FAST dollars are Ohio Department of Mental Health funds allocated on a formula basis to each county. These funds are used to for families who are receiving behavioral health care services through the local mental health system. Eligibility requires enrollment in the mental health system and the completion of tools used to track the impact and efficacy of these dollars across the state. These tools include a Caregiver Wants and Needs Scale, the Ohio Scales, and an inventory of needed and accessible services. FAST dollars are managed by the local mental health authority but decision making about their use in a family plan resides in a committee of the Butler FCFC called the Community Resource Team (CRT). See Table 1 for FAST Expenditures in 2006.
- Pooled Funds are local dollars that system managers have contributed to a shared pool of dollars. These dollars are managed by the collaborative county structure. This pool of funds has been created to meet the needs of families participating in the wraparound process who are ineligible for other funding sources. Pooled funds were originally created in Butler County in 2002. County leadership agreed to pool dollars equal to what they were already spending on their most expensive out-of-county placements. Alternative plans were developed for those youth in care and their families. This effort resulted in improvement in functioning and system outcomes on 11 out of 13 measures they tracked. It also resulted in a savings of 60% of the original investment. These pooled dollars were committed to meeting the needs of families using the Butler County Wraparound Program. These dollars are also managed by the CRT. See Table 2 for pooled fund expenditures in 2006.

The CRT is made up of mid-level managers from across the systems and provider agencies in the community. When a family plan needs resources not otherwise available in the community system, the team and facilitator prepare a budget request that describes what dollars are needed, what activities they will fund in the broader plan for the family, and what outcomes the request will support. The CRT meets, reviewing the plan and the wraparound process for the individual family. The committee's role is threefold:

- To identify different or additional community resources already funded that could be adapted to support the planned request,
- To authorize the use of flexible dollars as fits a given family, and
- To support the implementation of high fidelity wraparound by providing suggestions and access to services and supports.

When these funding streams are used, individual budgets tracking flexible expenses are created and utilized within the system. They are used to track expenses and aggregate information for reporting. This information is reported to the broader FCFC committees as a tool for anticipating new developmental needs for the cross-system service environment in Butler County.

Many plans developed by child and family teams do not require flexible funding. In 2006 in Butler County, $34,415.67 from the state FAST funds available to the county were assigned to support individual plans for families receiving behavioral health services and using wraparound teams as a planning and support mechanism. Teams supporting families not enrolled in the behavioral health system accessed $42,336.12 from the local Pooled Funds resource. A description of the population served, outcomes attained, and other details of the effort are available in the Butler County 2006 Annual Wraparound Report. (See Appendix x.4 of this *Resource Guide*.)

Summary

Butler County has developed a "right sized" wraparound capacity for its community and families. Key ingredients in getting to this point include:

- ***Self-reflection & self-analysis:*** Having a level of frustration with current system functioning is often a necessary catalyst to a willingness to change and adapt structures: Butler County had to self-analyze their existing structures, systems and assumptions in developing a wraparound capacity. A significant decision included taking a risk by pooling funds and maintaining a focus on those children in out-of-home care. This ability to self-analyze continued as Butler County adapted its original design of a diffuse facilitator model.
- ***Don't stop until you get it right:*** Self-analysis is part of the equation. Doing something about your assessment is as important as accurately assessing your implementation. Assuring that the first implementation plan can be changed and corrected based on county and state realities is a critical capacity. The shift from a vision for diffuse cross-system facilitation to the current FCFC-based wraparound unit is the reflection of this ingredient for Butler County. The FCFC staff are also aware that future changes may be necessary to continue to assure quality implementation in their setting
- ***Training should have a point:*** Butler County has used training opportunities strategically. All training has had a focus in terms of payoffs. Developing and maintaining a training capacity helps build support for the process across the community. Training assisted in developing a pool of interested parties that comprise the Community Facilitator pool. Training can also serve to build a framework for continuous skill enhancement. The Butler County Community Wraparound Coordinator is responsible for identifying and planning for the developmental training needs of staff. This focus on skill enhancement and the capacity to address those needs in a planful way is an important component of the Butler County implementation.
- ***Program for fiscal flexibility:*** Building wraparound requires multiple funding streams and agreements if it is to be sus-

tained over time. Within the Ohio environment, where there are no funding streams directed specifically at staffing wraparound initiatives, the ability to blend resources from multiple streams into a cohesive program effort has required on-going flexibility and negotiation across the funding systems. Building flexibility in public systems tends to be a challenging task. In the Butler County implementation efforts, the presence of a cross-system collaborative organization (FCFC) at the county level has been a critical ingredient in carving out the flexibility to provide effective wraparound to families. It has allowed county systems to expand the array of care available to families, and it has exposed their staff to a changed framework for care planning without having to mandate changed practice across all staff roles. The FCFC has offered a shelter within which it has been possible to foster innovation within the framework of a county-operated model.

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Funding Wraparound is Much More than Money

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Introduction to Funding as a Collaborative Process

Many wraparound projects start with seed money but can expand and evolve—and be sustained—when potential funding sources are explored and tapped. Wraparound can be funded by many different sources, depending on which system takes the lead in implementation. In Michigan, state leadership has identified various options for funding sources and worked with local communities to create their own funding structures for wraparound.

The good news about funding wraparound is that there may be several potential funding sources. The bad news about funding wraparound is that these funding sources can be interpreted as inflexible due to how they have been categorized. There also may be historical myths about funding flexibility. So, an important step to establishing wraparound funding is to investigate potential funding sources and examine the realities and myths that have grown out of the historical use of these funding sources. Engaging state leaders across agencies who understand the complexities of funding sources can help reduce unnecessary debate locally because the state is often the intermediary of most of these funds. This means they allocate these funds then monitor the implementation, eligibility, and evaluation. Another strategy to avoid unnecessary debate about funding sources is to explore fiscal models that have been successful in other communities or states around the nation. Some can be replicated, but they typically cannot be completely

implemented in a new community or state in exactly the same way. As with services, sometimes these models can be replicated and still be effective, and sometimes an individualized approach is what is needed. This article provides guidance on how a community and state can create a strategy for funding wraparound.

One common error wraparound projects make is failing to implement wraparound in a collaborative way. Many wraparound projects target children and families involved in multiple systems. As a result, wraparound should be a collaborative process. Nevertheless, it seems to be common in wraparound projects for one system to rely on its own internal funding to implement wraparound, without exploring partnerships with other systems at the state and local level. This type of funding arrangement tends to be reactive or impulsive by one system even though the population served may cross many systems. One danger of this kind of strategy is that, while it may work in the short run, it may be a problem later on, when the first system recognizes the need to partner with other systems. The necessary collaborative infrastructure is harder to develop retroactively. For wraparound to be effective, the systems have to agree that it is the model they will commit to even if it is not through a collaborative funding mechanism. The commitment to wraparound and joint funding is easier to manage on the front end, so first put the collaborative infrastructure together to create a common vision and mission that identifies shared responsibility and accountability. Below are some of the questions collaborative leadership should be prepared to answer as a means of creating a common mission and vision.

Collaborative Community Planning

1. Identify who should be part of the discussion (gathering of the stakeholders including family members, youth).
2. What is our mission/ vision?
3. What are our guiding values and principles?
4. What are the major assumptions of why we work together?
5. Whom do we want to serve? (What is the target population?)
6. Who is mandated to serve this target population?
7. What outcomes (results) do we want to achieve?
8. What model or intervention will accomplish this task?
9. What commitments are we willing to make with resources (funding, staffing, participation on teams, etc.)?
10. What are we currently doing (outpatient treatment, home based treatment, residential, detention, foster care, etc) with children and families in the target population?
11. What funding sources are we using?
12. Can we redirect some of the resources to jointly fund wraparound?
13. Are there other funding sources (grants, foundations, United Way, etc.) that exist that can be used in ways that support our values and outcomes?
14. Can we create a collaborative plan with our commitments in writing and get all stakeholders to sign it? (If you take this proactive step, you are prepared for any new funding sources that may arise instead of doing reactive planning that tends to be more superficial and less sustainable.)
15. What community infrastructure (executive level, community team, fiduciary agency, supervisor, staff, etc.) do we have in place or do we need to develop if we choose to do wraparound? Are their others we need to engage in this conversation?

Critical Analysis of Funding Sources

The next step is to identify existing funding sources that serve the target population and maximize those funding sources first. One reason to do this is that existing funding sources are probably going to be more sustainable than time-limited grants. Another reason to do this is that there is probably more than one funding source that exists across systems that has potential to meet your vision, mission and outcomes. Depending on the trust between agencies and various regulations—and sometimes the politics of funding sources—agencies may chose to assess these funding sources independently before discussing them together.

Typically, funding sources come with child and family eligibility criteria identified. You will need to explore each funding source and separate reality from myth. Many system partners may say, "We can't use that funding for that;" "It has never been done;" "There are policies that prohibit the use of those funds for that;" "This will just be too hard to track and it makes me exhausted just thinking about it;" "I don't trust that you will use my funds wisely." Some of these statements are less likely to occur if you have jointly identified your vision, values and models before trying to access funding sources. Working through each fund source will be a time consuming but necessary process. You wouldn't go to a bank and expect to get a loan without a business plan, so why would you expect our human service system to be any different?

For wraparound to be effective, the systems have to agree that it is the model they will commit to even if it is not through a collaborative funding mechanism.

If you know you want to serve "community children"—in other words, children and families that cross eligibility criteria from our various systems—then a variety of funding sources across systems should be explored. Communities need to think about federal, state, and local funding sources creatively. It is also important to think about funding sources in terms of how flexible they are. It is okay to have less flexible options as long as you have some highly flexible options. Figure 1.1 is a framework that can help you think about funding sources in new ways. Using this framework can help to critically analyze how you spend your funds and reallocate them into a joint project that may allow you more benefit for your investment. There may be some funding sources (e.g., county funds) that exist where you can actually draw down 50% from the state or federal government for community-based alternatives to out-of-home care. With this funding source, if you provide a community-based service as an alternative to out-of-home care, and the state will reimburse communities 50% of the cost after the service is delivered.

Identification of the Possibilities and Limitations of Funding Sources

Another important consideration is that each new funding source brings regulations, reporting requirements, contractual obligations, and evaluation considerations. That is why it is important for communities to analyze each funding source based on these considerations as well as the others outlined in figure 1.1. Each funding source should be analyzed for the potential to complement the wraparound model because there are many unintended consequences of pursuing funding sources that may not complement high fidelity wraparound. There are many reasons that wraparound has not faded in Michigan, but one major reason is that there are several funding sources that communities can chose to access to fund their projects. For example, there are primarily four potential funding sources that exist in child welfare (family preservation funding, local funds), three that exist in mental health (federal block grant, Medicaid, and general funds), at least one that exists in Juvenile Justice (Court) and others that exist in local communities (United Way, Local Foundations, education, etc.) These funding sources are not specifically identified as "wrap-

around funding" but can be used to fund wraparound as well as other community based services. This helps during difficult budget times. When one funding source gets cut, programs can shift to other funding sources. Communities in Michigan have historically rallied to continue the efforts due to positive outcomes they experienced with wraparound.

Limitations of Single Source Funding

Wraparound funded by one funding source, especially Medicaid, may be limited in terms of its possibilities to serve the children and families that your community identifies. Medicaid is a unique funding source with multiple regulatory issues. It can be helpful when serving Medicaid-eligible children and youth, as communities always need to remember to maximize entitlement funding first. Medicaid is a key funding source your community should pursue, but it is for a very limited population and may not complement other system partners. Community stakeholders need to fully understand the eligibility, regulations and the priority population mandates with Medicaid. For example, not all Medicaid-eligible beneficiaries from other systems (child welfare, juvenile justice, schools, etc) will meet the mental health eligibility criteria for wraparound.

One lesson that we have learned regarding Medicaid and wraparound is that it may push the facilitator into a case manager role versus a facilitator role due to the service eligibility orientation of Medicaid. For example, Medicaid funding is typically designed to fund certain services and wraparound planning is more needs driven (educational needs, recreational, social, etc.) versus service driven. This can be overcome if the supervisor and the community team are holding the community, facilitators and teams accountable to meet needs and achieve outcomes versus just coordinating services. So other agencies will need to identify other funding sources to fill that gap in funding. There are other funding sources (mental health block grant, county funds, family preservation funds, etc.) that will fit the profile of non-Medicaid eligible children, youth and families, if you work closely to identify them with your system partners.

Once your community has analyzed the avail-

Considering a Funding Source

1. Identify the funding source.
2. Identify the type of funding (federal, state, local, grant, foundation, etc.).
3. Does it have a target population identified?
4. How flexible is the funding source? (SED, open child welfare case, multi-system children, risk level, etc.)
5. What are the regulations and potential contractual obligations?
6. What is the long term potential of this funding source? (For example, is this an entitlement, or other federal, state or local funds that have been stable?)
7. What are the evaluation and reporting requirements?
8. Is there a model or intervention that must be implemented or can any approach be used?
9. If we choose to do wraparound, will this funding source allow or assist us to implement it with high fidelity and collaboratively?
10. If this funding source is accessed, what type of training is required and/or available?
11. Does this funding source allow flexibility to serve a diverse population? (e.g., is it restricted to a single agency, age group, diagnosis, etc.)
12. Does it allow or have the flexibility to blend or braid with other funding sources?
13. Is there a fiduciary agency requirement? For example, for Medicaid and Medicaid waivers the funds may have to filter through mental health versus directly to another provider.
14. Will this funding result in multiple providers in our community and if yes, how will we monitor for outcomes, fidelity to the model, ensure overall community collaboration, etc.? How do we bring it all together to ensure consistency across providers?
15. Does this funding source complement our vision, values and outcomes?
16. Should we pursue this funding source? (Yes, No, Maybe)
17. If yes, develop a memorandum of understanding outlining agreements, commitments, oversight and accountability.
18. If no, move to the next one.
19. If maybe, generate a list of questions and pursue getting the answers.

able funding sources, you need to define your collaborative infrastructure. This consists of clarifying expectations and roles at a state and local level. See the Michigan Wraparound Communiqué (box on opposite page), which outlines some of the things communities need to consider. This Communiqué was developed by the Michigan State Wraparound Steering Committee to help communities create some common expectations regardless of the funding sources. These expectations are outlined in the contract language for wraparound on a state level for the Department of Human Services (Child Welfare) as well as the Department of Community Health (Mental Health). The importance of having this state leadership has been that regardless of the funding source or provider agency, expectations for wraparound are the same. The training requirements, quality assurance and evaluation of wraparound are the same across systems, and the contract language is very similar despite some unique system requirements that vary.

One of the biggest lessons that I have learned about funding is that most of the complexities of funding can be broken down and simplified. It is important that there are state and community leaders willing to read between the lines of funding regulations and requirements and expose the possibilities. It can be exhausting to challenge the myths regarding funding but persistence can be rewarding in the end. Blending funds with your partners can sustain your efforts and lead to other joint projects and planning. In our current economic climate, we need each other more than ever to serve these children at high risk and their families. It has been our experience that if we did not have multiple funding sources, despite positive outcomes, wraparound would have been one more fad that went away over time. Wraparound has been in Michigan for fifteen years and has expanded from one single-source-funded project in two counties to being almost statewide. There are multiple funding sources through the various systems that many communities are utilizing.

There have also been other unintended benefits from partnering across systems to work more closely on projects and having various levels of your systems talking together. Directors, supervisors, staff and family members are constantly detecting unmet needs and gaps in the community services and supports and identifying ways to meet these overwhelming needs together. Wraparound has also expanded to other high-risk target populations (e.g., homeless children and families, high-risk adults with dementia and Alzheimer's, etc.). The sense of helplessness that systems are limited with regard to funding may still exist, but they may have more options if they look to each other to fill a need.

One of the best things we can do is to stop our impulsive and reactive tendencies that have us searching for the perfect program or model but instead, expand the existing possibilities. An aspect of funding that needs to be considered when trying to jointly fund wraparound projects is the need to be able to pay for the "right" services and supports to serve wraparound youth and families. Those services and supports need to cross life domain areas from housing, school, recreational, social, mental health, health, etc., because good planning that identifies needs and outcomes with no way to meet them will sink most wraparound projects. The best wraparound is not about coordinating services but organizing the system, services, interventions and strategies to meet needs and achieve the outcomes that the family and system need collectively. Some of this is about funding; however most of this is about how we utilize our resources strategically and in a fiscally responsible way. In addition, states and communities need to analyze interventions that are not shown to be effective in producing outcomes. Yet it is also important not to pursue evidence-based or promising practices that may not fit your target

population.

The conversation about vision, values and outcomes must occur before funding or resources are ever discussed. It is important to remember this may turn out differently depending on the culture of the community. In order to insure that you are having the right conversation and making the right decisions, you should be sure to have family and youth involved at all levels of the infrastructure. Their voices, advocacy and support of each other and system change cannot be underestimated. It has been our experience that youth and family voices push the conversation from impulsive or reactive funding decision making to more creative funding decision making which both lends itself to better outcomes and tends to be more cost effective.

Conclusion

When I became a social worker, I never envisioned that I would spend so much of my time discussing funding, contracts, accounting and auditing.I have grown to realize how important all of this truly is if we are ever going to push our system reform efforts in a way that makes sense to all children, youth and families regardless of which system door they open or is open to them. As budgets decrease and risk increases, systems need to be able to respond flexibly and creatively, and not fall back into thinking that placing children and youth in institutions is a good answer. We need to hold each other accountable to not give up the community-based alternatives that we know are effective in producing positive outcomes and building resilience. Blended funding and joint purchasing projects are ways to ensure that we are more proactive and less reactive to the pressures that face us.

Creating shared financial commitments may be the best way to actualize the "unconditional commitment" or "never give up" philosophy because when you are accountable together it is easier to not give up. The sense of helplessness that develops when you feel alone can be replaced with energy when we work together. Who would have thought that thinking carefully about funding would have resulted in feeling more empowered?

Acknowledgement

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Author

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EMQ Children & Family Services: Transformation from Residential Services to Wraparound

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EMQ Children & Family Services

Introduction

EMQ Children & Family Services (aka Eastfield Ming Quong) is a private, not-for-profit community-based organization that provides a wide range of services, from addiction prevention to wraparound and Rate Classification Level (RCL) 14 group home care (aka residential treatment services), in four major counties throughout California: (a) Santa Clara, (b) Sacramento, (c) San Bernardino, and (d) Los Angeles. It also provides foster care services in 20 other counties. The agency is over a century old, founded in 1867 with roots as an orphanage (Home of Benevolence, later known as Eastfield's Children Center) and a rescue mission for Chinese girls (the Presbyterian Mission Home later known as Ming Quong) founded in 1874.

In 1970, Jerry Doyle became Executive Director of Eastfield Children's Center. At that time, the agency had an annual budget of approximately $300,000 to provide residential treatment. In 1987, Eastfield and Ming Quong merged to become Eastfield Ming Quong. Prior to becoming the first wraparound provider in California in 1994, EMQ operated 130 RCL 14 residential treatment beds, at a cost of $95,000 per year per child. The most common primary diagnosis was related to disruptive behaviors (47%), with some type of depressive disorder as the second most common. The outcomes for these youth, after an average of 18 months of service, reflected the general "treatment as usual" outcomes.

Today, residential treatment revenue represents 5% of a $55 million annual revenue stream, as compared to 72% of a $12 million annual revenue stream prior to the implementation of wraparound. The purpose of this article is twofold:

1) to present a case study of how a child-serving organization transformed itself from residential to innovative, community-based services; and 2) to share issues revealed in the process of implementing wraparound. The article contains three major sections including Introduction, Current Operations, and Tips to Implement Wraparound, as well as a final section that includes Lesson Learned. Throughout this article, we will reflect on the significant systems change required to implement wraparound.

Part 1: From Residential to Community Based Care

Attempt to Grow Residential Treatment

Initial County Partnership. In the course of the 1987 merger, EMQ collaborated with the Santa Clara County Executive and local Social Service, Juvenile Probation and Mental Health Agencies to assess their need for residential treatment beds and arrived at an agreement that would make EMQ's 130-bed residential treatment program available exclusively to referrals from Santa Clara County. EMQ accepted any child the County referred to the residential program. In return, the County provided additional funding to meet the mental health needs of all the children in the program, as the basic residential or group home rate structure covered only the care and supervision of the children. Initially, the agreement met the respective parties' needs. However, review of the program's outcomes revealed that while some children seemed to benefit from the residential program, for many others, the gains were short-lived once they returned home. Often, this was due to the complex family needs that were left unaddressed by the residential stay, including siblings with significant emotional and behavioral challenges.

Private Insurance. For a brief period in the early 1990's EMQ explored the possibility of serving children whose treatment could be covered by private insurance. As the trends suggested that the managed care environment was likely to impact both the public and private sectors in California, the organization realized that it was on an unsustainable course. With the confluence of events, EMQ underwent a fundamental reinvention, or what is referred to by Nadler and Tushman (1995), as a reorientation, "a fundamental redefinition of the enterprise—its identity, vision, strategy and even its values" (p. 26). In a reorientation, the organization must change the definition of its work, the attitudes of its people, its formal structures and processes, and its culture.

Embarking on a New Path. Under the leadership of Jerry Doyle and Rick Williams (Chief Operating Officer during the most tumultuous period of the process), the agency consulted with Michael Doyle, a nationally prominent expert in the change management and consensus building process, to lead a visioning process which would result in the fundamental reinvention of the then-123-year-old organization. Existing assumptions about the business were set aside so as to start a visioning process from a blank slate (see Doyle, 1986). The change and renewal process began with a self-assessment of strengths and weaknesses.

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The second step was an environmental scanning process which included dialoguing with all customers, conducting market research, reviewing trends in the children's mental health and child welfare fields, and benchmarking services in an effort to find more effective approaches to serving children with serious behavioral and emotional disturbances and their families. Through this benchmarking process EMQ learned about wraparound from some of the early pioneers of the wraparound movement including Karl Dennis (Kaleidoscope Program, Chicago), John Vandenberg, Ph.D. who led the Alaska Initiative wraparound program (see Burchard, Burchard, Sewell, & VanDenBerg, 1993), and John Burchard, Ph.D.,

who had developed a wraparound program in Vermont (see VanDenBerg, Bruns, & Burchard, 2003), and with whom Richard Clarke, EMQ's Research Director at the time, had worked. Simultaneously, EMQ also codified its values and beliefs with an end product of an organizational Values Constitution, which would guide the work and behavior of the organization and its employees. This process involved staff at all levels of the organization.

The next step in the change process was to create a vision of the desired future which was congruent with the result of the self assessment, environmental scan, and Values Constitution. It was proposed that a visioning approach be utilized, emphasizing a future ideal state, and then creating a plan to reach that state. A growth and renewal strategy was then developed and a change architecture was designed to move the organization to be more wraparound focused and less dependent on residential services.

Transformation from Residential Services to Wraparound

Creating a wraparound Funding Source. In 1991, there was no funding structure for wraparound in California. The County agreed to continue to pay EMQ the same 60% share of the group home rate that it would otherwise fund to have the same children in the residential program. In addition, EMQ worked in partnership with the county in an ultimately successful four-year effort to secure passage of legislation (AB2297) providing that the state's 40% share of the group home rate was made available to help fund wraparound, and to leverage potentially available federal funding streams including Title XIX (Medicaid federal mental health funding; known as Medi-Cal in California) and Title IV-E dollars (federal reimbursement to states for the board, care, and supervision costs of children placed in foster homes or other types of out-of-home care under a court order or voluntary placement agreement). To ensure cost neutrality to the County, EMQ was paid the appropriate share of the group home rate less any concurrent out-of-home placement costs to the County for children in wraparound. Although each county varies in application of the 60-40% share, this continues to be the primary financial structure to fund wraparound in California.

Persistence in Creating Systemic Change. Implementation of wraparound is more than simply starting a new program. Successful implementation requires a major systems change effort that affects and is affected by all levels of the services system. In any social system, 2.5% of the individuals are innovators and 13.5% of the individuals are early adapters to change (Rogers, 1995). Moreover, if a heterogeneous 5% of a social system fundamentally shifts its culture, fundamental change will occur in other areas of the system (Rogers, 1995).

With EMQ's experience, it took four years to create significant systems change. Initial efforts

concentrated on identifying and working with innovators and early adapters that would support the change. This included the presiding judge of the dependency court at the time, the Honorable Len Edwards, who became an early champion of the wraparound process.

As change is dynamic, it is important to address local, state, and national levels concurrently. This includes extensive wraparound training for all employees within the organization, management and line staff of the Social Services Agency, and the Mental Health Department, the District Attorneys, Public Defenders, and County Counsel. Through this process, additional champions for the change process will emerge. Partnerships with national wraparound experts may help generate support for the major systems changes necessary to provide training.

Policy and Legislation: The Four-Year Struggle for Funding. Having an agency reserve helped in the period of financial crisis. While promoting wraparound on all systems levels, EMQ closed 100 residential beds over an 18-month period, resulting in a precipitous drop in annual revenue from $12 million a year to $8 million a year. EMQ had fixed overhead costs including bond payment obligations which could not be eliminated, and for the first time in over 20 years, EMQ had serious and growing budget deficits.

Meanwhile, EMQ worked with the California Department of Social Services (CDSS) and elected officials on statewide wraparound legislative proposals to allow for funding of wraparound as an alternative to group home care. However, there was enormous resistance to the legislation from the group home industry. Ultimately, the first two attempts at legislation failed, but EMQ persisted in working with various legislators (e.g., Senator John Vasconcellos, Assemblymember Cunneen) and state and county leaders (Eloise Anderson, Director of CDSS) that eventually resulted in successful legislation (AB2297, SB163) that provided state and county funding for wraparound.

Wraparound Growth in California

Wraparound in California has increased rapidly since 1994. By 2000, seven other counties were providing services through some version of the wraparound process. Five years later, 29 counties were providing wraparound. In FY2007, Proposition 63 is projected to generate $1.6 billion in new funding for mental health services for children, adults, and older adults through a 1% tax on personal income above $1 million a year. Within three years of the passage of Proposition 63 in November 2004, the Mental Health Services Act (MHSA) requires every county to implement an SB163 wraparound program for youth and their families, unless the county provides "substantial evidence that it is not feasible to establish a wraparound program in that county." (See http://www.dmh.cahwnet.gov/MHSA/docs/meeting/12-17-2004/Mental_Health_Services_Act_Full_Text.pdf.) In effect, wraparound will be available as an alternative to group home care throughout California. Furthermore, these programs will have access to the state and county foster care share of the group home rate for each wraparound slot.

In response to a class action lawsuit filed in 2002 that challenged California's practice of confining at-risk youth to hospitals and large group homes instead of providing services to enable them to remain in their homes and communities, Judge A. Howard Matz ordered the state to provide wraparound and therapeutic foster care to any child in or risk of entering California's foster care system. The *Katie A. vs. Bonta* litigation (Katie A. et al., v. Diana Bonta et al., 2006) provides another avenue through which wraparound should proliferate across California.

Part 2: EMQ Wraparound Operations Today

Today EMQ serves approximately 6,000 youth and families on an annual basis. Approximately 350 of those youth receive wraparound and another 250 receive services from programs based on system of care and wraparound principles. Although the agency has over ten years of experience as a wraparound provider, the local system of care in which it operates vary significantly and have made implementation of services a challenge. Accordingly, it is critical to continually engage in positive systems change efforts focused on each of the counties served, and on the state as a whole.

All of EMQ's wraparound programs serve an ethnically diverse group of children between 5 and 18 years of age who meet Medi-Cal criteria for services. Prior to referral to wraparound, many of these youth received traditional mental health services, such as residential treatment, day treatment or intensive outpatient. The current average length of stay is 16 months, with a range of 9 to 24 months.

In the rest of this section, we present some tips for wraparound implementation based on EMQ's experiences reconfiguring itself to support service provision via the wraparound model.

Tips to Implement Wraparound

Tip #1: Commit to Being a Continual Learning Organization. EMQ uses several tools to support continual improvement:

1. Formal change management techniques to

enhance the success of an implementation that will impact large systems or the culture of an organization. Such tools (e.g., Business Case for Action, sponsorship contracts, etc.) are widely applied in corporate organizations and can also be applied in social service organizations.

2. Consistent data collection via various outcomes measures and an electronic health record system. It is critical to have an infrastructure that includes identified staffing with specific responsibilities to coordinate outcomes and evaluation efforts.
3. A Research Advisory Council composed of renowned subject experts. The purpose of the council is to provide an objective review of current outcomes evaluation and recommend research based on their cutting edge information from the field. Such a relationship provides a vehicle for collaboration between universities and local agencies that provide direct services.

Tip #2: Management Infrastructure Needs to Support Wraparound Implementation. A Licensed Clinical Program Manager (CPM) is responsible for both clinical and administrative supervision of services provided by the Masters-level family facilitators (FF), family specialists (FS), and family partners (FP), all of whom serve a number of families. Facilitators conduct the child and family teams (CFT) while family specialists work directly with the children and Family Partners provide the support for parents. Under the supervision of the CPM, this group of facilitators, family specialists, and a family partner comprise a *pod*.

Child and Family Team (CFT). The pod and CPM are the two basic organizational structures that support the CFT. The CFT is the primary unit involved in implementing the wraparound process. The team is comprised of the child, caregivers, other family members, clinical professionals, and any "natural" (non-clinical professional) members and is responsible for identifying, facilitating, and monitoring services for the child.

Pod Meetings. The teams of clinical professionals work in a group to provide and manage the wraparound process. Pod meetings have two major aims: building staff morale and providing a forum for the pod members to exchange ideas to better meet the needs of children and families. The structure of the pod meeting reinforces the needs-driven approach of the wraparound program and thus differs from most traditional clinical team or staff meetings.

Tip #3: Provide On-Going Training and Mentoring for Staff. Successful CPMs have sophisticated facilitation skills. They are responsible for training Pod members in wraparound philosophy and practices. As mainstream graduate schools tend to emphasize traditional clinical practices that focus on the medical model as opposed to a strength based, family-centered practice, training is a crucial component of the CPM's responsibility. In general, training and coaching is an on-going process that should encompass all aspects of one's responsibility. Table 1 (see following page) provides a sample of current training topics.

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Tip #4: Continually Improve Wraparound Implementation. In the effort to continually provide best practices, the following components are included to enhance the wraparound process and subsequently enhance outcomes for children and families.

Functional Behavior Assessments (FBA). As described by O'Neill, et al. (1997), the purpose of a functional assessment is to improve the effectiveness and efficiency of behavioral interventions by serving as a data-collection tool. The processes employed provide an analysis that may reveal the children's patterns of behavior, iden-

tifying specific triggers for undesirable behaviors (antecedents) and the needs that the behaviors fill (consequences). Using this information, the staff, particularly the family specialists, create a behavioral support plan whereby an intervention is proposed based on the hypothesized function of the behavior, and youth are taught alternatives to the target behavior that fulfill the same need. This intervention takes the form of a proactive behavioral support plan that contains the educative components and means of communication with the child, and lays the groundwork for evaluating the outcomes of the plan (Ingram, Lewis-Palmer, & Sugai, 2005).

Conograms. A conogram is a pictorial illustration of relationships in an individual's life. (See

Table 1. Wraparound Program Sample Training Topics

General Category	Topic	Description
Orientation	Job Expectations	Introduce staff to performance- and outcomes-based work, and review job responsibilities for each position to support wraparound and program goals
	On-Call	How to respond to family emergencies using wraparound values and the safety plan
Legal and Ethical	Confidentiality and Abuse Reporting/ HIPAA	Responsibilities and procedures for confidentiality and mandated reporting, and how these issues are handled in the wraparound process and community setting
Financial	Documentation (Progress notes)	How to bill and document billable services for wraparound
	Flex Funding	Appropriate ways to utilize a funding stream to enhance services
Wraparound	Wraparound Overview (day 1)	Historical overview of wraparound and exploration of wraparound values
	Wraparound Overview (day 2)	How to implement the 10-step domain planning process, and the roles and responsibilities of CFT members
	Community Access	How to implement timely, relationship-based resources to meet needs in multiple life domains
	Safety Planning	How to facilitate the development and design of dynamic and responsive safety plans and how to implement them in the family, home and community
Interventions	Connectedness Mapping	How to visually map out primary connections for children in CFTs
	Family Finding	The importance of permanency and durable connections for children over time; tools and skills for implementing family finding
Outcomes	Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, 2000)	CAFAS ratings and integration of the CAFAS into the wraparound plan

Figure 1. Sample Conogram

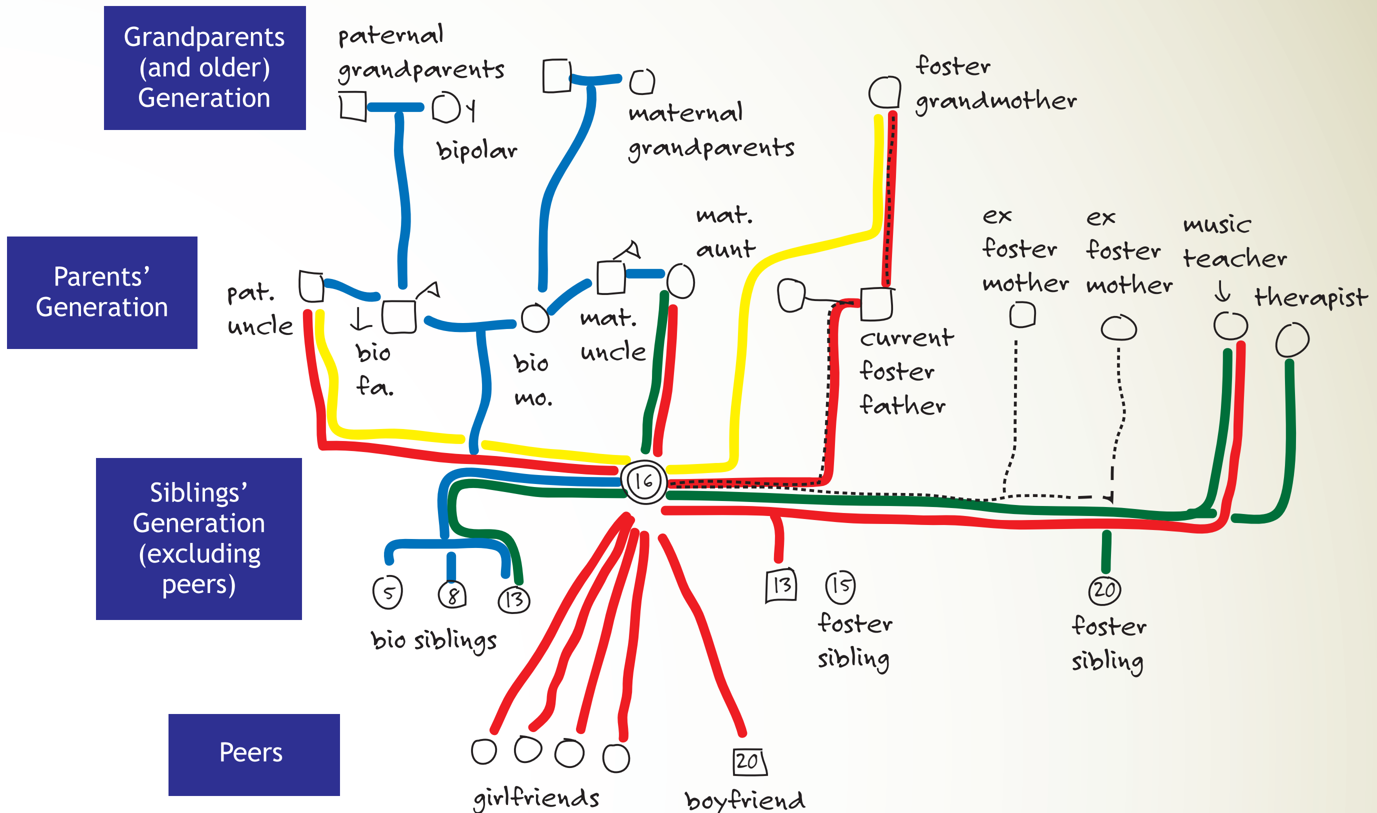

Figure 1.) Red lines of connection indicate who loves whom, blue lines indicate blood relations, green lines indicate who is teaching whom, and yellow lines indicate spiritual connections while purple lines capture cultural connections. The EMQ connectedness diagramming process is designed to be used collaboratively with children and families to explore various relationships that might not otherwise be discovered. This process attempts to capture the various types of relationships in a manner that fosters engagement, empowerment, genuine inquiry, and the desire to truly understand the intimate lives of children and families. This connectedness map provides the basis of ongoing work for the team that supports the child.

Family Finding. Family finding, pioneered by Catholic Community Services of Western Washington (CCSWW) in Tacoma, WA, is a process to identify or locate a dependent child's biological family members who have lost connection with the child for various reasons. The process is a combination of conversations, chart reviews, internet searches and travel, all in the interest of re-establishing broken connections and developing potential permanency for these children.

Professional Parenting. A professional parent is someone, often a foster parent with specialized training, who will support the youth through the planning and transition process and help them move on to their permanent home. The professional parent provides a stable, caring and structured environment for the youth while meeting all community care licensing foster care requirements.

Independent Living Skills (ILS). Family specialists provide individual and group ILS training (e.g., money management, household chores, employment training, community safety, etc.) for

the youth as needed to meet their goals to better prepare them for adult life.

Tip #5: Wraparound Can Be Used to Meet Different Target Population Needs. Although wraparound in California was designed as an alternative to high level residential care, the wraparound principles can be applied to various target populations. For example, in 2001 EMQ adopted the wraparound principles as the basis for service re-design and provision in two other clinical services: System of Care (SOC) and Matrix, as neither program was achieving desired outcomes such as those being demonstrated by the agency's wraparound program. Despite its name, "System of Care" (which reflected a particular mental health funding stream in California prior to 2003), the SOC program was serving fewer than 35 children in a traditional, clinic-based therapeutic model. The Matrix program was originally designed in 2001 as an alternative to residential placement for older adolescents in the Santa Clara County Children's Shelter. Some youth were living in congregate care residential treatment while others were living in the community with therapeutic support. The residential component was fraught with the usual difficulties inherent in congregate care for this population of high-risk, older, street-savvy adolescents.

Table 2 illustrates the positive impact of wraparound on different target populations in an organization. Prior to the implementation of the wraparound philosophy (e.g., strengths based) and practices (e.g., services in the community), both programs were well below the program census with lengths of stay longer than anticipated. Furthermore, staff attrition reflected that of similar settings in the nation (Ben-Dror, 1994), and productivity was half of the expected target. Since the implementation of the wraparound philosophy and practices, both programs now meet, if not exceed, the program census with lengths of stay half that of pre-implementation. Furthermore, staff attrition is well below the 15% target, and productivity has doubled.

Because these three levels of care are available within a single agency, recipients of services have the benefit of a seamless transition between appropriate levels of care, decreasing or increasing service intensity given the child's behavior and/or level of functioning and their caregivers' ability to address the challenges. Families in this program to do not have to be concerned about being referred elsewhere to have their needs met.

Tip #6: Continually Evaluate Treatment Outcomes and Process Outcomes. In addition to analyzing treatment outcomes, EMQ developed the wraparound Supervisor Adherence Measure (W-SAM; Castillo & Padilla, 2007). Developed on the same premise as the Multisystemic Therapy Supervisor Adherence Measure (SAM; Henggeler,

Table 2. SOC and Matrix Process Outcomes

Indicators	SOC		Matrix	
	Pre-Wrap	Post-Wrap	Pre-Wrap	Post-Wrap
Average Census/ Capacity	35/50	145/160	13/20	27/24
Length of Stay	18 months	10 months	22 months	11 months
Intensity of Service	1 hr/wk	3-5 hr/wk	3 hrs/wk	5-10 hrs/wk
Staff Attrition Rate	50%/yr	5%/year	60%/yr	5%/year
Staff Productivity	50 hrs/mth	100 hrs/mth	43 hrs/mth	100 hrs/mth

Schoenwald, Liao, Letourneau, & Edwards, 2002), in that the supervisor plays a critical role in maintaining fidelity, the Wraparound Supervisor Adherence Measure (W-SAM; Castillo & Padilla, 2007) is a 40-item questionnaire that rates the supervisor's fidelity to the wraparound principles and practices from the facilitator's perspective on a 5-point Likert scale (1- Never to 5- Almost Always). Currently, the tool is in its infancy stage and further analyses are necessary. However, there appears to be a trend in the relationship between the supervisor fidelity scores and positive process and treatment outcomes. For example, the trend suggests that higher fidelity scores tend to be correlated with planned discharges.

Part 3: Lessons Learned

Operational Lessons. Below are only a few operational lessons learned over a decade of wraparound implementation in California.

Lesson #1: Systems Practices Impact Service Provisions. When implementing wraparound, there needs to be an effective system in place for addressing systems issues, particularly as they manifest at the direct care level. Without objective data, much less a forum to address these concerns, sometimes idiosyncratic events or issues are inappropriately generalized to the program rather than viewed as a symptom of a larger systems issue. With no formal forum to address the system's issues, the problem is likely to continue to rear itself in direct service situations. Regular convening of a local community collaborative, and/or quarterly meetings of managers for each referring department is recommended. This forum may address such topics as: (a) review and discussion of program outcomes (including trends over time); (b) identification and resolution of department concerns or needs; and (c) strategizing and planning. This proactive approach to resolving systemic concerns may also serve as an interdepartmental collaboration to identify current training needs for program and referring department social workers, probation officers, and mental health clinicians.

Lesson #2: Management of Flexible Funding is Important. Having a formal flex fund stewardship plan from the onset will establish clear guidelines on appropriate use of flex dollars for all stakeholders. The stewardship plan should include: (a) specific flexible funding training for staff; (b) a "Stewardship of Flexible Funding" protocol to be shared with each new family and referring workers; and (c) job performance expectations for the direct care staff that families are provided with a viable transition plan from the use of these flex funds to accessible community resources.

Lesson #3: Need for an "In-Vivo" Coaching/Supervision Model as opposed to a traditional office based supervision model. The wraparound service delivery model and underlying principles require staff to work in the community, and to provide very specific, individualized care. The traditional supervision approach of meeting with staff in the office during the typical work week hours is not sufficient to support staff in providing high quality wraparound. In a coaching/support model of community-based services supervision, supervisors are required to go out into the community to observe the provision of the wraparound process and be available 24/7.

Lesson #4: Need for Evidence Based Practices (EBP) to Support the Overall Effectiveness of the Wraparound Process. Promising and evidence-based practices can enhance the wraparound process. For example, when the family specialists are trained to utilize Functional Behavioral Assessments and Positive Behavior Support plans, the amount of time they need to spend with the children decreases as their work is more effective in a shorter period of time. Furthermore, given that the majority of our youth have been traumatized as they have been removed from home and experienced some type of trauma, Trauma Focused-Cognitive Behavior Therapy (TF-CBT; Cohen, Mannarino, & Deblinger, 2006) has been used to help achieve more positive outcomes in a shorter period of time.

Lesson #5: Documentation of Wraparound that Emphasizes a Strengths-Based, Youth- and Family-Driven Service within a "Medical Model" that Focuses on Medical Necessity for EPSDT Reimbursement. Continual training is necessary for staff as they integrate a service delivery model that emphasizes different aspects of treatment from the revenue streams' emphasis. Initially staff may struggle to integrate a strengths-based,

needs-driven philosophy in a system whose funding stream is pathology based (e.g., Medi-Cal). For example, documentation may focus on support activities and capturing the child's and family's strengths, rather than articulating the extensive interventions utilized to intervene with the child's behaviors. Training is essential to illustrate how mental health concerns of the child and family are components of the "behavioral and psychological domains" of a comprehensive wraparound plan that addresses the various aspects of youth and families' lives.

Lesson #6: The Need for a Significant Investment in Training and Supervision Can Not Be Overemphasized. While values that are core to wraparound are gaining increasing acceptance nationally, it is still not a core practice. Assuring families' voice, choice, and ownership of their treatment plan and focusing on strengths as the building blocks for the creation of that plan often flies in stark contrast to the pathology-based, expert-centric medical models that still exist in many communities and university curriculums today. Subsequently, new and seasoned clinicians alike require significant education, training and supervision to support this practice change.

Lesson #7: Celebrate Successes and Provide Consistent Reinforcement. It is important to consistently reinforce staff for positive outcomes. Having a formal forum for such recognition is powerful reinforcement for all stakeholders. Graduation celebrations are a formal means of celebrating success. When families share their journey with the entire wraparound team and referring system staff, it can be an incredibly rewarding and rejuvenating experience for both the families and staff.

Macro-Level Lessons

Lesson #1: The Power of the Visioning Process. EMQ has learned from experience that a well-executed visioning process to fundamentally transform an organization is extremely powerful. Allowing people to imagine what could be, rather than simply trying to fix what's broken, involves engagement of people's hearts and minds.

Lesson #2: Systems Thinking. The introduction and dissemination of wraparound is best understood and executed as a major systems change effort, and not simply as the introduction of a new program. Many of the fundamental principles and values of wraparound will directly challenge and confront existing assumptions that are prevalent in many children's services systems. Fundamental cognitive, attitude, and cultural changes toward parents and about the appropriate roles of various players in the system are imperative at the individual clinician level and various systems levels.

Lesson #3: The Value of Partnerships. Real and effective partnerships, rather than mere "purchaser/vendor" relationships between government entities and non-profit organizations, can have enormous benefits to both parties, as well as to children, families and the community as a whole. Many leading private sector companies who have made a commitment to an emphasis on total quality and continuous quality improvement have learned that it is much more cost effective to build long-term partnerships with high quality suppliers, rather than to continuously subject "vendors" to competitive bidding based primarily on cost. The same is true of relationships between government entities and non-profit provider organizations.

Lesson #4: Change Management. It is very helpful for organizations to consciously think of themselves as being in the change management business, rather than as in the child welfare or mental health business. Equipping its management and key staff with state-of-the-art change management methodologies and knowledge will greatly increase the effectiveness of the organization, no matter what environmental challenges it may face. Perseverance and tenacity are criti-

cal, as major systems change is often long and difficult. Establish a culture that embraces change as an opportunity for personal and professional growth.

Lesson #5: It's All about Outcomes. Focus on outcomes, not on cost. Agencies' commitment to improve the outcomes for children and families should be the fundamental driver of systems change efforts. It is true that timing is everything. It is much better to initiate the introduction and diffusion of wraparound at a time when government funding is relatively stable, rather than in the middle of a major budget reduction. Otherwise, there is a very great risk that the primary emphasis will be on cost saving, rather than on achieving positive outcomes for children and families. On the other hand, if agencies implementing wraparound are allowed to keep any savings that may be achieved, and to reinvest those savings in the provision of new prevention or early intervention services, their motivation to make the change will be greatly enhanced, and the long term savings will be maximized.

Conclusion

The dissemination of wraparound requires a systems change effort as the very nature of wraparound requires significant systems review, and perhaps systems overhaul. The process not only impacts an agency, but all systems (child welfare, education, juvenile probation, mental health, substance abuse, etc.) involved in the lives of participating youth and families' lives. Accordingly, implementation of wraparound requires the development of effective and collaborative relationships with elected officials, public agency leaders at the state and local levels, and key leaders in the private and non-profit sectors.

The shift in cognitive schema about mental health services cannot be overemphasized. Wraparound should not be viewed as a money saver in the context of limited resources. Rather, it should be viewed as a service to produce better outcomes for the youth and families who have often times been through a system that may have inadvertently hindered quality of life. Organizations and all systems should consider the tremendous advantage of building real partnerships between government agencies and leading non-profit agencies rather than mere purchaser/vendor relationships. Most non-profit agencies really want to help children and families. Many agencies, with the proper training and support will willingly and perhaps eagerly make the shift from a residential focus to a wraparound focus if they are given the opportunity to retain any savings achieved and to reinvest those savings to provide additional services for children and families.

In the 15th century, Niccolo Machiavelli wrote, "There is nothing more perilous to undertake, nor more uncertain of its outcome, than to create a new order of things." The historical failure of the foster care and mental health systems to effectively meet the needs of children has been well documented. We owe it to the children and families we serve, and we owe it to ourselves, "to create a new order of things." Although the birthing of wraparound in California has been long and at times very painful, the results have been worth the effort.

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Dedication

To my great friend, my spiritual brother, and my mentor, Michael Doyle, December 21, 1942 - January 29, 2007.

-Jerry Doyle

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Supporting Wraparound Implementation: Chapter 5e.1

Measuring Wraparound Fidelity

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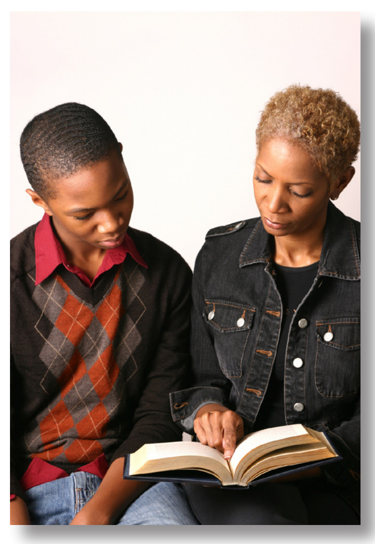


During the early years, it is unlikely that the pioneers of wraparound were concerned about "implementation fidelity." Wraparound captured the attention of child- and family-serving systems during an exciting era when the field of children's mental health was being challenged by families, advocates, forward-thinking administrators, and even a few researchers to do things that were fairly radical. For example, actively partner with youth and families and honor their voices in decision-making. Engage their natural supports and create individualized plans based on their specific needs. Build new service arrays that can meet these needs. De-emphasize treatment outside the home and community.

Within this exciting context, individuals in Chicago, Alaska, Vermont, and other places extended these ideas to new extremes in order to maintain their most challenging children and youth in their homes. These leaders found ways to "do whatever it takes" to keep these young people home and started using teams, facilitated by paid wraparound coordinators, to brainstorm more creative plans. To ensure these individualized plans were carried out, they developed networks of community resources (including churches, businesses, and mentoring after-school programs), and flexible funding pools to pay for strategies that were not free or reimbursable. Other innovators created procedures for doing strengths-based assessments that tied strategies in plans to youth and family strengths. Still others focused on how best to engage the family to express their needs and goals, and ways to track progress toward meeting these needs and goals.

Eventually, a set of basic methods began to coalesce

into something people called "wraparound." Referred to by various names (e.g., wraparound services, the wraparound approach, individualized and tailored care, child and family teams), the "model" was not yet fully specified or well-understood, but by the mid-1990s there was nonetheless a loose community of practice nationally and

internationally that shared these ideas, and more and more wraparound programs began to emerge. Dismissed as a fad by some and critiqued by others as not supported by research, wraparound as an idea and as a model has showed great endurance, with the number of wraparound programs seems to be holding steady or even increasing, and over 100,000 youth now estimated to participate in wraparound nationally (see Bruns, Sather, & Stambaugh, 2008, Chapter 3.4 of this *Resource Guide*).

Wraparound has continued to be embraced by communities because its principles make sense to families, and its procedures are supported by basic research (see Walker, 2008a, Chapter 3.1). In addition, wraparound has provided many compelling community success stories (see, for example, Anderson et al., 2003; Kamradt, 2001). As described in other articles in this *Resource Guide*, wraparound seems to succeed when it is implemented well *and when* it is implemented for populations for which it is suited. These populations tend to be youth with serious and complex needs for whom intensive, coordinated support helps to keep them in the community, avoiding costly and unnecessary placements, or disruptions in placement.

Unfortunately, however, neither of these conditions is guaranteed to be met. As its popularity has grown, wraparound has often been attempted by only one child-serving system in the absence of partnerships with other systems. In other communities, wraparound is attempted for populations for which a clear "pay-off" and recouping of investments in the intensity of the process does not occur. These experiences can lead to quick de-funding of an existing wraparound initiative, and general dismissal of wraparound as "too expensive." (For more information about setting up and funding wraparound, see articles in Section 5d elsewhere in this *Resource Guide.)*

The other major implementation question that arises with wraparound is whether it is, in fact, being implemented well, or, in other words, "implemented as intended." This is the very definition of implementation *fidelity* (Bond, et al., 2000). The rest of this article will focus on this issue. In doing so, we will consider several questions:

1. How do we know we have a "fidelity problem" in wraparound?
2. When applied to wraparound, what does "fidelity" mean?
3. What are methods to measure fidelity to the wraparound model?
4. Does fidelity even matter?

The Fidelity Problem in Wraparound

Since its inception in 2003, the National Wraparound Initiative (NWI) has functioned somewhat like a wraparound team looking to meet the priority needs of the model itself. In its first meeting, the model's strengths and needs were reviewed. One priority need that was identified was better communication of what "real" wraparound consists of, so that communities could serve families better, and program leaders and policy makers could understand what they needed to do. Another priority need that was identified was better development of the research base on wraparound, so that its benefits could be understood and communicated. Basically, the advisors who gathered at these first meetings were concerned that wraparound was a wonderful idea that was nonetheless at risk of being discredited due to too many poor

attempts at implementation and not enough emphasis on documenting its positive impact on the lives of children and families.

Research that was being conducted supported these concerns. As detailed in other articles in this *Resource Guide* (e.g., Bruns, 2008, Chapter 3.2), studies of wraparound implementation were revealing that many programs that called themselves "wraparound" did not even have plans of care with goals, let alone a strengths-based approach or natural supports on teams. In addition, researchers at Portland State's Research and Training Center were demonstrating just how important community and system supports were to wraparound (Walker, Koroloff, & Schutte, 2003). These studies showed that even when a community understands wraparound and attempts to do it in a way that reflects its core principles, actually *doing* high quality wraparound is tremendously difficult. The list of challenges is extensive and includes the following:

- Implementing wraparound requires providers who are well-versed in its value system. Yet most higher education programs do not teach family-driven, community-based principles and strategies.
- Wraparound requires intensive and ongoing training, supervision, and administrative support. Yet many wraparound programs do not provide such supports to the staff that are asked to implement the process.
- Implementing wraparound requires adoption of new ways of funding and organizing services, such as the availability of flexible funds for teams, strong collaborative relations, and single plans across multiple agencies. Yet wraparound initiatives remain vexed by agencies that operate in isolation and traditional reimbursement procedures.

Thus, the "fidelity problem" in wraparound, as was described around the turn of the millennium, could be summed up in this way:

1. Wraparound had evolved through the efforts of many innovators, not a single developer. Thus, no one "invented" wraparound, and there was no clear source document that said what a new wraparound community should do to implement it.
2. Doing wraparound means implementing a *youth- and family-level intervention* that is individualized to each youth or family as well as a *system-level intervention* (e.g., around collaboration, fiscal arrangements, and so forth). Needless to say, this is a very complicated model, difficult to describe and even harder to pull off.
3. Research—as well as stories from frustrated families and providers—describing poor implementation was becoming more and more common.

Thus, in 2003, family members and family leaders, pioneers in wraparound implementation and training, national researchers, and others, agreed that a necessary first step was to develop some materials presenting the fundamentals of the wraparound model. Having taken this first step, it was reasoned, wraparound could be more clearly communicated to families and to the field. Such descriptions could also provide a template for provider staff to understand the required practice guidelines. The materials in this *Resource Guide* represent a major result of these efforts.

Having defined what it means to implement wraparound "as intended," additional steps could be taken to further address the fidelity problem. For example, tools could be created to support high quality implementation. As the field of human service delivery focuses more on implementation, it has become increasingly common to use results of rating scales, checklists, logs, or clinical records to inform areas in which service delivery is not adequately conforming to a program model (Bond, et al., 2000; Fixsen et al., 2005). In addition, with an understanding of what "fidelity" means in wraparound, better research could be conducted on the model. For example, in research using wraparound groups and comparison groups, fidelity measures are necessary to examine the differences in implementation for the different groups. Without such information, interpretation of between-group differences can be difficult or impossible. Using fidelity measures also can help with research that aims to identify critical ingredients of program models, as well as help to

synthesize findings from multiple research studies (Bond et al., 2000; Moncher & Prinz, 1991).

Defining What "Fidelity" Means in Wraparound

Before developing fidelity or implementation measures, it was obviously necessary to first define what it means to do high quality wraparound. Initial guidance in this area was provided by training manuals (e.g., VanDenBerg & Grealish, 1998) as well as a description of the core elements and practice principles of wraparound, defined in 1998 and published in a federally-funded monograph (Burns & Goldman, 1999). Elements presented in these documents provided frameworks of minimum expectations for labeling a process "wraparound," and guidance for the first fidelity measures for wraparound (Bruns, Burchard, Suter, & Force, 2004). Among the more widely used measures were the Wraparound Fidelity Index (WFI; Bruns et al., 2004), which collected data via interviews with parents, youth, and wraparound facilitators; and the Wraparound Observation Form (WOF; Epstein et al., 1998), which measured adherence to wraparound principles as observed during team meetings.

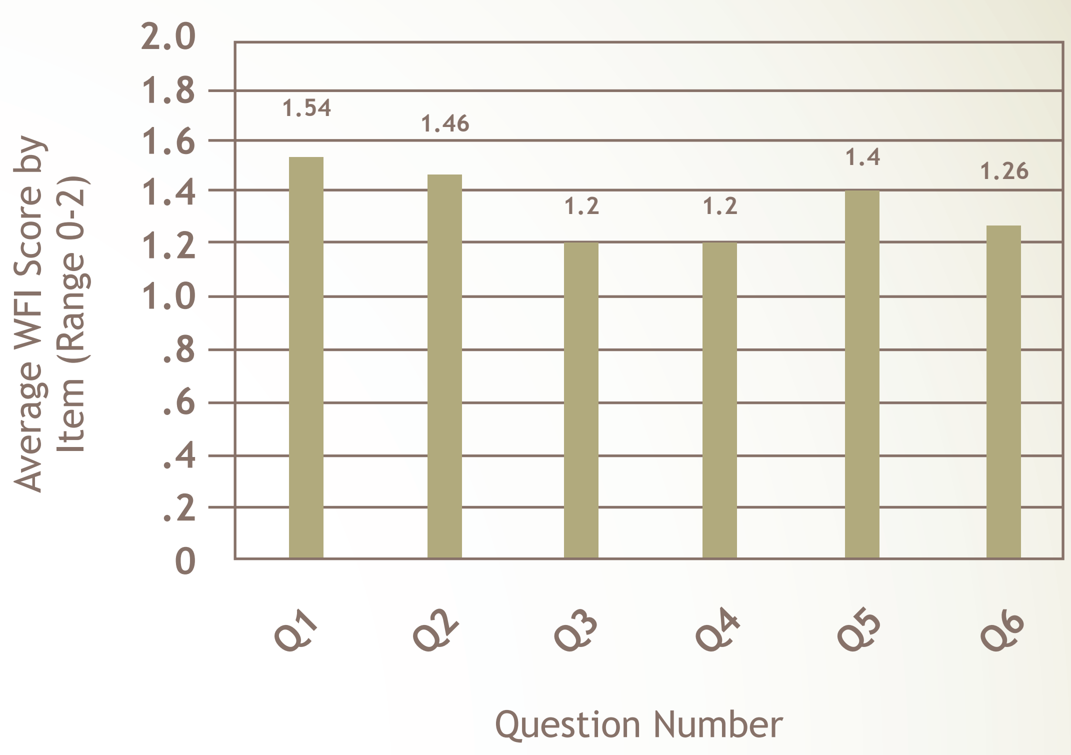
Thus, there was clear precedence for and obvious interest in using the wraparound elements or principles as a basis for assessing fidelity. One of the first activities of the advisors of the NWI was to more clearly define these principles at the child and family level. This was done in order to aid in their clarity, make them more useful in training staff and setting expectations, and more amenable to measuring whether they were happening in practice. (For a description of the principles of wraparound, see Bruns et al., 2008, Chapter 2.1 of this *Resource Guide.)*

To take this philosophical description of wraparound further, and provide greater clarity on what wraparound consists of, the NWI also conducted a research- and consensus-based process to define the basic activities of wraparound. Unlike the wraparound principles, such a description of the "practice model" for wraparound had never been created for wide dissemination, and thus was seen as a critical need to help explicate what it means to implement the wraparound process for a youth and/or family. The basic activities of wraparound were defined by reviewing dozens of source documents, including manuals, articles, monographs, and training materials. A core group of prominent trainers (such as Pat Miles, John VanDenBerg, John Franz, and others) and program directors contributed to the process and reviewed initial drafts, which were then submitted to the NWI advisors for review and comment. The procedure ultimately organized 31 basic types of activities into four phases of implementation that are now adopted by many programs and initiatives: Engagement, Planning, Implementation, and Transition (see Walker & Bruns, 2006).

The final piece of the wraparound program model was provided by the monograph developed by Walker, Koroloff, & Schutte (2003) that explicated the conditions that are necessary at the program and system level to support high-quality wraparound implementation (See Figure 1). As described in this monograph, key people in a wraparound initiative may be well-versed in the principles of wraparound and may even be trained and coached to implement it very well. But without a hospitable environment for implementing the model, attempts to maintain adherence to the principles and implement the activities will be very difficult. Ultimately, six key types of supports were identified, again, through a combination of research by Walker and colleagues and collective work by NWI advisors: Community Partnership, Collaborative Action, Fiscal Policies and Sustainability, Access to Needed Supports & Services, Human Resource Development & Support, and Accountability (see Walker, 2008b, Chapter 5a.1 in this *Resource Guide).*

In sum, answering the question "What is wraparound fidelity?" is fittingly complex for a model as complex as wraparound. First off, researchers on human service implementation typically define fidelity as "the degree to which programs are implemented as intended *by the program developers*" (Dusenbury, Brannigan, Falco, & Hansen, 2003). But wraparound was not invented by any one developer or team of developers. So the first bit of complexity was presented by the need for some consensus on what wraparound practice consists of. Second, since the model started as a philosophy, its philosophical principles necessarily constitute at least some of what is considered wraparound fidelity. Third, wraparound requires

Figure 1. Sample Report from the Wraparound Fidelity Index



Parent/Caregiver Responses by Item			
Q1. Were you given time to talk about your family's strengths, beliefs, and traditions?	True - 10;	Partly True - 3;	Not True - 2
Q2. Did your facilitator fully explain wraparound & the choices you could make?	True - 9;	Partly True - 4;	Not True - 2
Q3. Did you have a chance to tell your wraparound facilitator what has worked in the past for your child and family?	True - 7;	Partly True - 4;	Not True - 4
Q4. Did you select the people who would be on your wraparound team?	True - 7;	Partly True - 4;	Not True – 4
Q5. Is it difficult to get team members to meetings when they are needed?	True – 9;	Partly True – 3;	Not True - 3
Q6. Did you go through a process of identifying what leads to crises for your family?	True – 8;	Partly True – 3;	Not True - 4

Sample report from the Wraparound Fidelity Index, showing results from six items from the Engagement Phase of the WFI. The scores represent the responses of 15 caregivers and parents who completed WFI interviews in one community.

both family-level as well as program- and system-level effort to implement well; meaning that adherence to its practice model should also consist of measurement of *both* whether its core activities are being completed as well as whether necessary support conditions are in place. Finally, to be true to its principles, any wraparound fidelity measurement approach should allow for the individualization of the model for families as well as communities. All these factors make assessment of wraparound fidelity fairly complicated.

Measuring Adherence to the Wraparound Model

As described in the previous section, measuring whether wraparound is being implemented "as intended" will require, at a minimum, assessing (1) adherence to the principles of wraparound, (2) whether the basic activities of facilitating a wraparound process are occurring, and (3) supports at the organizational and system level. As such, the NWI has focused a good deal of its effort on presenting descriptions of these three concepts. Like any wraparound team, there has been debate and compromise among NWI advisors about the best way to present these descriptions. But there is also some consensus that these three basic descriptions get at the basics, while still allowing for individualization. Having created these documents on wraparound, the next question is: How do we measure its integrity?

Measuring treatment fidelity can take many forms. Some methods (e.g., counting pills through electronic monitoring of medication containers) will not be appropriate to psychosocial models such as wraparound. But most approaches used in the human services world are candidates, including:

- Reviewing manuals and program descriptions,
- Reviewing staffing and budget data,
- Reviewing case file data on treatment plans and meeting notes,
- Compiling data from management information systems data on procedure or reimbursement codes,
- Observing service processes,
- Staff completing checklists of activities conducted, and
- Interviewing the individuals involved, including youth, family, and provider.

Early attempts to measure fidelity to the wraparound process primarily rested within programs' quality assurance procedures (Bruns et al., 2004). For example, supervisors trained in the wraparound approach met with wraparound care coordinators to assess the fidelity of their performance per the wraparound principles and to problem solve around difficulties. Programs also conducted open-ended interviews with providers, youth, and families to determine whether services delivered were drawing upon child and family strengths, utilizing non-professional services and supports in the community, being responsive to family's opinions, preferences, and stated needs, and so forth.

Later, rating-scale surveys, including initial versions of the WFI, became more common. Youth and families were queried about their satisfaction with services in general and specific providers and some asked parents and youth whether services adhered to basic wraparound principles, such as whether they felt providers listened to them, or whether they perceived their services would be provided "no matter what" (Rosen, Heckman, Carro, & Burchard, 1994). As described above, measures that allow for recording of the adherence to wraparound principles during the course of team meetings were developed, as were methods to review documentation found in case files (such as wraparound plans, crisis plans,

> *Without a hospitable environment for implementing the model, attempts to maintain adherence to the principles and implement the activities will be very difficult.*

and meeting notes). Finally, since publication of the monograph by Walker et al. (2003), measures of organizational and community support have been developed that ask community stakeholders to rate the degree of development of the critical implementation supports for wraparound presented above. (For more on the Community Supports for Wraparound Inventory, see Walker, 2008b, Chapter 5a.1 in this *Resource Guide*).

There are subtle variations in methodology across these tools, usually depending on how the information is intended to be used. For example, the Wraparound Integrity Tool assesses wraparound fidelity as part of Illinois's statewide evaluation of school-based wraparound. The WIT is intended to contribute to a repository of data on the quality and effectiveness of services for students with intensive needs, as well as drive decision-making on behalf of individual students and teams. As such, the 47 items of the WIT are completed by the by the wraparound facilitator and team members (including student and family when applicable) collectively. The data that is generated is intended to be used both for high-level evaluation as well as to facilitate problem-solving around improving the process for that particular student and team.

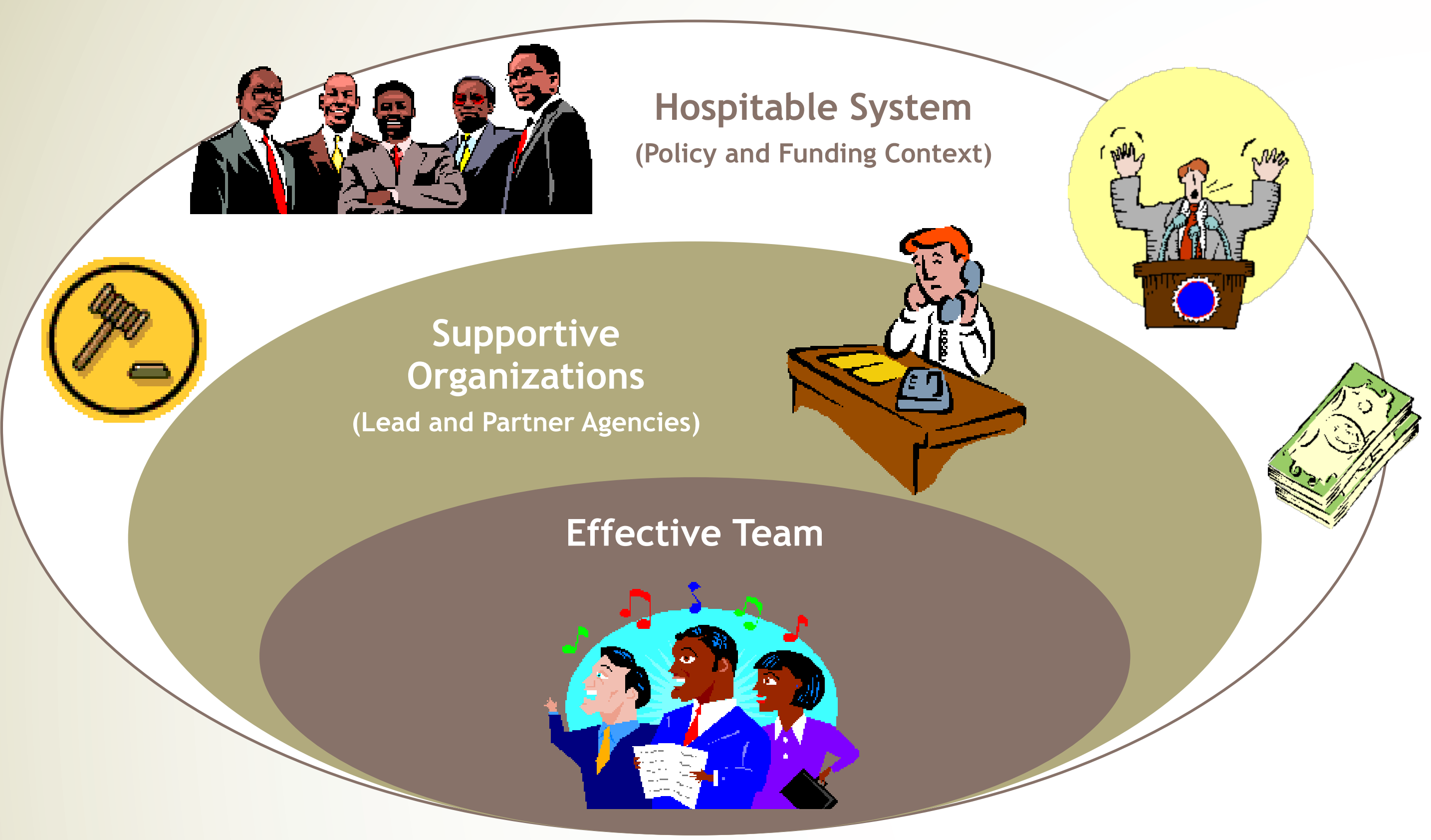
The measures of the **Wraparound Fidelity Assessment System (WFAS)** are somewhat different in that they are intended to be used to conduct an external assessment of fidelity to the principles, phases, and activities of the wraparound process as described by the NWI. To serve this purpose, measures of the WFAS (which include the WFI interviews, team observation, document review, and the CSWI) are administered by individuals who are not directly involved in services with the family. Like the WIT and most fidelity instruments, the measures of the WFAS are intended to serve both quality assurance and research and evaluation purposes. A brief description of each of the tools of the WFAS is presented below. (More can be found on the measures at www.wrapinfo.org, or the website for the Wraparound Evaluation and Research Team: http://depts.washington.edu/wrapeval.)

Wraparound Fidelity Index, version 4. The Wraparound Fidelity Index, version 4 (WFI-4) is a set of four interviews that measures the nature of the wraparound process that an individual family receives. The WFI-4 is completed through brief, confidential telephone or face-to-face interviews with four types of respondents, in order to gain a complete picture of wraparound implementation: caregivers or parents, youth (11 years of age or older), wraparound facilitators, and team members. A demographic form is also part of the WFI-4. The WFI-4 interviews are organized by the four phases of the wraparound process. In addition, the 40 items of the WFI interview are keyed to the 10 principles of the wraparound process, with 4 items dedicated to each principle. In this way, the WFI-4 interviews are intended to assess both adherence to the basic wraparound practice model as well as fidelity to the principles of wraparound.

WFI data can be used to assess the overall fidelity of an organization or wraparound initiative. Data can also be analyzed by phase, principle, or item to help a program or supervisor make mid-course corrections. (See Figure 2, next page.) The Wraparound Evaluation and Research Team (WERT) is currently developing an on-line data entry and report generation system to help programs use the measure in these ways.

Team Observation Measure. The Team Observation Measure (TOM) assesses adherence to standards of high-quality wraparound during team meeting sessions. It was originally developed to be used by external evaluators, but has also been used by supervisors to help support coaching and supervision of wraparound staff. The TOM consists of 20 items, with two items dedicated to each of the 10 principles of wraparound. Each item consists of 3-5 indicators of high-quality wraparound practice as expressed during a child and family team meeting. Working alone or in pairs, trained

Figure 2. Effective Wraparound Teams Require Support at the Organizational and System Levels



raters indicate whether or not each indicator was in evidence during the wraparound team meeting session. These ratings are translated into a score for each item as well as a total fidelity score for the session overall.

Document Review Measure. The Document Review Measure (DRM) is a 30-item instrument that is used to assess wraparound fidelity through review of documentation typically used in wraparound implementation. The DRM is used by a trained evaluator who uses the tool to rate conformance to the principles of wraparound in materials such as the child and family's wraparound plan, crisis and safety plans, transition plan, and meeting notes. Like the other WFAS fidelity tools, items on the DRM link to the 10 principles of the wraparound process, and result in scores for individual items, the 10 principles of wraparound, and a total score for the instrument overall. As of this writing, the DRM has been pilot tested and is being revised.

Community Supports for Wraparound Inventory. As described above, and elsewhere in this *Resource Guide,* the CSWI is a research and quality improvement tool intended to measure how well a local system supports the implementation of the wraparound process. The CSWI is based on the framework of Necessary Conditions described by Walker, Koroloff and Schutte (2003), and presents 42 community or system variables that ideally are in place in communities that aim to implement the wraparound process. The CSWI is somewhat

unique from the other WFAS instruments in that it assesses the system context for wraparound as opposed to the fidelity to the practice model for an individual child and family.

The CSWI results in a quantified assessment of community supports for wraparound across multiple domains, so that researchers can determine the impact of these conditions on fidelity and outcomes of the wraparound process. It also presents the level of support across the six domains listed above (e.g., finance, collaboration, and accountability) so that evaluators and stakeholders can understand the full context for wraparound implementation as part of their local evaluation projects. Third, items and domains are structured so that local groups can assess local supports for wraparound, respond to areas of strength and weakness, and monitor improvements over time. (For more on the CSWI, see Walker, 2008b, Chapter 5a.1 in this *Resource Guide*.)

Psychometrics. The measures of the WFAS all have basic psychometric data that support their reliability, but the measure that has been best tested is the WFI. Different versions of the WFI have demonstrated adequate test-retest reliability, internal consistency, and inter-rater reliability (Bruns et al., 2006). Validity studies have found that fidelity scores correlate with the ratings of an external wraparound expert, while other studies have found significant associations with child and family outcomes (Bruns et al., 2005) as well as the level of community and system supports for wraparound (Bruns, Leverentz-Brady, & Suter, 2006). Recent studies using the WFI-4 have shown that total scores have been found to discriminate between wraparound and non-wraparound programs, and to show higher scores for sites with more extensive quality assurance plans (e.g., training, coaching, and directive supervision) than for sites without these supports. Studies are currently underway to determine the validity of the TOM and DRM.

Why Should We Be So Concerned about Wraparound Fidelity?

The new emphasis on measuring quality of implementation is hardly restricted to the wraparound process. Until the last decade, the program evaluation field focused almost exclusively on whether or not programs worked (Rosenblatt & Woolridge, 2003). But in recent years, there has been a realization that "evidence-based practices" that have been shown by research to work in one setting often do not translate into success somewhere else (Weisz, Donenberg, Han, & Weiss, 1995). What happens? Caseloads are allowed to rise and models get diluted. Core principles (such as engaging natural supports or letting families take the lead in planning) are de-emphasized in supervision. Training and professional development budgets get cut, and staff persons are not consistently taught how to do the work "as intended."

As the issue of implementation has grown more important, research has borne out the hypothesized relationship between treatment fidelity and improved client outcomes. Within adult mental health, fidelity to assertive community treatment (McHugo, et al., 1999) and integrated dual disorders protocols (Drake, et al., 2001) have been found to be associated with outcomes. Within children's mental health services, this relationship has been found for multisystemic therapy (Henggeler, et al., 2002), school mental health programs (Greenberg, et al., 1999), and many other models. Meanwhile, in wraparound, research has shown that individual families' WFI data helps predict their outcomes (Bruns et al., 2005), that the fidelity with which staff implement wraparound is associated with outcomes for the children they serve (Bruns, Rast, et al., 2006), and that system supports are indeed related to implementation fidelity as assessed by the WFI.

Added to this body of research are the real concerns of families and their advocates. One parent from Kansas expressed that "they were promised wraparound and got the runaround." And, as described in the beginning of this article, it was not that long ago that key pioneers of the wraparound model were afraid wraparound was going to soon be dismissed, since it was ill-defined and researchers were finding poor outcomes (often in the absence of good implementation). With all these arguments, the case for understanding and supporting wraparound fidelity is not hard to make. Nor is it hard to support the cause of reliable and valid fidelity measurement—after all, as the old saying goes, "what gets measured gets done."

Conclusion: A New Fidelity Problem in Wraparound?

In sum, there are a lot of points in favor of defining, supporting, and measuring wraparound integrity. Doing these things is viewed as a critical step in advancing the research base on wraparound, and establishing evidence on its effectiveness. Collecting and feeding back performance and outcomes data is critical to ongoing improvement of human services (Fixsen et al., 2005). Family members and youth can collect quality and fidelity data and play a role in reviewing and interpreting the results, providing them with a clear and active partnership role. Finally, though they are far from perfect, fidelity measures for wraparound have advanced considerably, and feature better supports to train data collectors and facilitate data entry and reporting than in previous years.

Along with the promise, however, comes potential trade-offs. The wealth of new methods to measure wraparound quality can be overwhelming to small programs and initiatives, and investing in fidelity data collection can lead some to make sacrifices elsewhere, such as in outcomes monitoring or even investments in the service system. Moreover, many jurisdictions have swallowed the "fidelity" argument whole and have attempted to write requirements for fidelity into provider contracts and standards. This can only be done very carefully – such requirements must be backed with resources for objectively collecting data as well as a clear data use plan. Such an approach must also be done in a way that encourages a climate of collaboration and quality improvement rather than punitiveness.

Finally, some have critiqued the emphasis on wraparound fidelity at a more fundamental level. Wraparound is a complex process, much less amenable to standardization than, for example, a 12-session parent training course, or a cognitive behavioral intervention for anxiety. In addition, it is individualized to each youth and family. As such, fidelity measurement is necessarily less precise because there is a greater range of activities in which each family may take part. Attempts to make measurement of wraparound implementation more precise (or to standardize the process to make it more amenable to consistent training and supervision) makes it vulnerable to losing something considered critical to wraparound – the idea that communities and teams may need to color way outside the lines to do "whatever it takes" to support a youth and his or her family.

Ultimately, this is the balancing act facing those of us who have been engaged in the process of defining wraparound and developing implementation measures. We must recognize that both poor quality *and* over-specification are dangers to the wraparound philosophy. To interact with this tension, the NWI has attempted to create a skeleton of a practice model that can be "fleshed out" through local adaptation and innovation (Walker & Bruns, 2006). The items of the WFAS instruments are based on this model, and focus on basic wraparound principles and non-negotiable activities that are central to the wraparound logic model. Through continued research and experience, we will endeavor to find the right balance that leads to the best outcomes for children and families.

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Supporting Wraparound Implementation: Chapter 5e.2

Building Databases and MIS to Support Wraparound Implementation

Aggie Hale, MIS Consultant
Wraparound Milwaukee

In Wraparound Milwaukee, the development of our current MIS system began after a number of years of using numerous stand-alone databases to support the project. These included, for example, a separate database for maintaining demographic and enrollment information, a leased software program for service authorizations and payments, and Milwaukee County's mainframe for check writing. None of these data were integrated, nor did the majority of our stakeholders have any access to the data. Most of the information was entered by a very large finance staff from paper documents faxed, mailed, or hand-delivered by care coordination staff. In all, thousands of pieces of paper were processed every month. The data were purely maintained to support business functioning—enrollment, demographic, and financial. There was no technology to support our real focus—serving families and providing care coordination services. In 1999, we decided that we needed to develop a system to integrate our existing business data as well as to support families and care coordinators.

Our first step in undertaking this was to identify our consumers. The primary consumer of data in a wraparound model should always be the families. Whether or not families directly enter or edit data, the information available must be able to be presented in a family-friendly manner, and should be used to enhance the quality of care for families. Care coordinators will likely be the primary users entering data into the system, so ease of use, integration of data and system support will be important to them. Supervisory and program management staff need to use the data to support day-to-day functioning and monitoring of outcomes.

For these users, the reporting capability of the system is their primary need. Funding sources and evaluation staff also need access to the data, and their concerns will be the reliability of the data and timeliness of information. Meeting the needs of this disparate group of users can be a difficult balancing act.

After identifying who our consumers would be, we contracted with a software development firm, Stratagem, Inc., and began development in June of 1999. By December of that year, we had a working system. How was this possible? First and foremost, we had clearly-identified business processes in existence already. Second, we clearly outlined the scope of the project at the outset and stayed within those boundaries during initial development. Also, two individuals were identified—one from the development team and one from Wraparound Milwaukee's management team—to serve as liaisons between development and program staff, and we empowered those individuals to make independent decisions.

The Synthesis System

The software that Wraparound Milwaukee developed is called Synthesis. As our user base is geographically dispersed, we developed Synthesis as an internet-based software. Initial development focused on integrating three main areas: enrollment and demographic data; contract and service data; and the plan of care process. All three areas were developed simultaneously, and released in December, 1999. Since that time, development has continued. We have revised the plan of care module several times, incorporated progress notes, an on-line resource guide for both paid and community supports, evaluation tools and juvenile justice information.

The main components of Synthesis, and their primary uses, are outlined in the following sections.

1. Demographic / Enrollment Data

- Basic demographic information—including DSM diagnostic information—allows us to report on our population to the community.
- Placement data helps us monitor youth in out-of-home care, and provides a mechanism to evaluate how well the program is doing to meet its goal of maintaining children in the community.
- Financial components to each enrollment allow us to track Medicaid eligibility, payor source (child welfare and/or juvenile justice) and outstanding payments from these entities, ensuring that we are properly reimbursed.
- Satisfaction survey data is used to enhance quality of care for families and quickly identify potential areas of concern.
- An on-line child and family team list allows us to monitor the inclusion of formal and informal supports on teams, and track how they are being used by families.

Figure 1. Demographic Data

Address | Notes | Label Addresses | Update

Client Demographics

Field	Value	Field	Value
* Required Fields		ClientNumber:	3499
SSN (No Dashes)	123456789	Program*	Wraparound
M.A. Number		SACWIS Number	
Client Name* (First, MI, Last)	John / / Anderson		
Date of Birth* (mm/dd/yyyy)	2/5/1988	Gender	M
Ethnicity	Asian	Primary Language	Chinese
Emp Status	Student	Case Number	
Family Role	Child	Marital Status	Single
Care Coordinator*	HALE, AGGIE - Aggie's Case Managment and Therapy		
Legal Guardian	Greg Jones (GrandFather)		

Figure 2. Vendor Data

Vendor Demographics [Update] [Options]

Vendor Number:	80037		
Name:	Aggie's Case Managment and Therapy		
Mailing Address:	2345 Any Street		
	Milwaukee, WI 53222		
Appear in Resource Guide?	(•) Yes ( ) No	Minority Vendor:	( ) Yes (•) No
Vendor Billing Type:	Paid	Faith Based?	(•) Yes ( ) No
If client-specific vendor, client name:		Medicaid Eligible:	( ) Yes (•) No
Active:	(•) Yes ( ) No	M.A. Number:	
Suspend New Referrals?	( ) Yes (•) No	Tax ID Number:	5
Termination Date:		Fiscal Year End:	
Termination Reason:		Civil Rights Plan Rec'd?	(•) Yes ( ) No
Reinstatement Date:		Type of C.R. Plan:	Type A
Suspension Date:		Date Rec'd:	3/10/2006
Suspension Reason:		Type of Corporation:	
Reactivation Date:			

- Juvenile justice data received from the court is entered, and is used for research purposes and as one of our outcome measures. (See Figure 1.)

2. Vendor Data

A comprehensive vendor database allows us to store and report on vendor activity.

- Vendor licenses and insurance coverage are monitored to ensure compliance with state guidelines.
- Providers serving our families, along with their credentials and specialties, are tracked to allow us to monitor care at the individual provider level as well as the vendor level.
- Data from this area can be accessed by care coordinators and families through an on-line resource guide, which includes both paid and unpaid providers.
- Satisfaction surveys and complaint data are stored in the software, allowing provider network and quality assurance staff to monitor family satisfaction and respond to any concerns. (See Figure 2.)

3. Service Data

As a capitated health management organization (HMO), Wraparound Milwaukee authorizes and pays for all of the mental health care for our enrollees. Based on services authorized through the plan of care, care coordinators enter services, which are approved by supervisors.

- Vendors have access to view authorizations on line, allowing them to independently confirm authorization prior to service delivery.
- Invoices are entered directly by the vendors, and adjudicated and paid weekly.
- Real-time reports are available allowing management staff to monitor service costs, look for trends and outliers, and analyze service utilization across different populations. (See Figure 3.)

4. Plan of Care

In keeping with wraparound training the care coordinators receive, the plan of care process has three distinct elements:

1. Strengths / Culture Discovery

Figure 3. Service Data

December 2006 SARs for Ola Anderson [Show Detail] [Delete SARS] [Done]

Approved Services Value: $675.00

Paid Services
Approved: $675.00
Paid: $90.00
Requested: $0.00

PAID SERVICES

Status	Service/ *Recipient*	Vendor/ *Provider*	Req/App Units	Req/App Amount	Paid Units	Paid Amount	Pmt/ *Check*
Inv	Care Coordination-Daily - 5500A *Anderson, Ola*	Alyssa's Home Therapy *Strong, Alyssa*	30 Days	675.00	4	90.00	

Figure 4. Plan of Care

Main | Secondary | DSM Diagnoses | Family Vision | Statistics | Family Narrative | Needs
Comment | Past POCs

Plan of Care Needs — Add Need(s)

Need	Domain(s)	Need Start Date	Current Note Date	Need Ended	Open
Ola and her mother want to learn how to get along better	Family	2/1/2007	5/9/2007		
Ola needs to feel safe in her current school setting.	Safety/Crisis	3/1/2007	None		

2. Crisis / Safety Planning
3. Needs Identification and Service Planning

The majority of the plan of care is entered as free-form text to promote individualized care for youth and families. However, areas where we have a need to report on or analyze data are standardized:

- Families assign a numeric value for each identified need at time the need is developed, for each update, and when the need is closed. This allows us to look at a numeric "needs met" score as perceived by families.
- As care coordinators build child and family teams, each member of the team is identified as either a formal (i.e., paid) or informal support (family members, neighbors, community organizations, etc.). When creating plans of care, the team member(s) responsible for each strategy are selected, allowing us to pull information from the plans of care to verify use of sustaining supports on the teams.
- School attendance, special education placements, substance use history, and medication data are among the other areas that are standardized to allow for analysis and reporting of data. (See Figure 4.)

5. Evaluation Data

Wraparound Milwaukee is currently using the Child Behavior Checklist and Youth Self Report, administered at enrollment, six months, one year (and yearly thereafter) and disenrollment. Scores from each scale are entered and can be reported for distinct populations. In addition, family-friendly reports for use by the teams can be generated. (See Figure 5.)

6. Progress Notes

Progress notes are entered by care coordinators and data from those notes are used extensively by supervisors and management to monitor service hours, contacts with families, and child and family team meeting compliance. (See Figure 6.)

Data Access and Reporting

Users should have direct access to all of the data they need to do their day-to-day functions. No one user will need access to all of the information, but each user should be able to retrieve any information that is relevant to their job. Real time access to information from a variety of sources greatly promotes 'buy in' from the users of the software.

The reporting area should be the most robust component of the system. Supervisors and managers should have tools to help them monitor provi-

Figure 5. Evaluation Data

Evaluation Tools Test - CBCL — Enter | Cancel

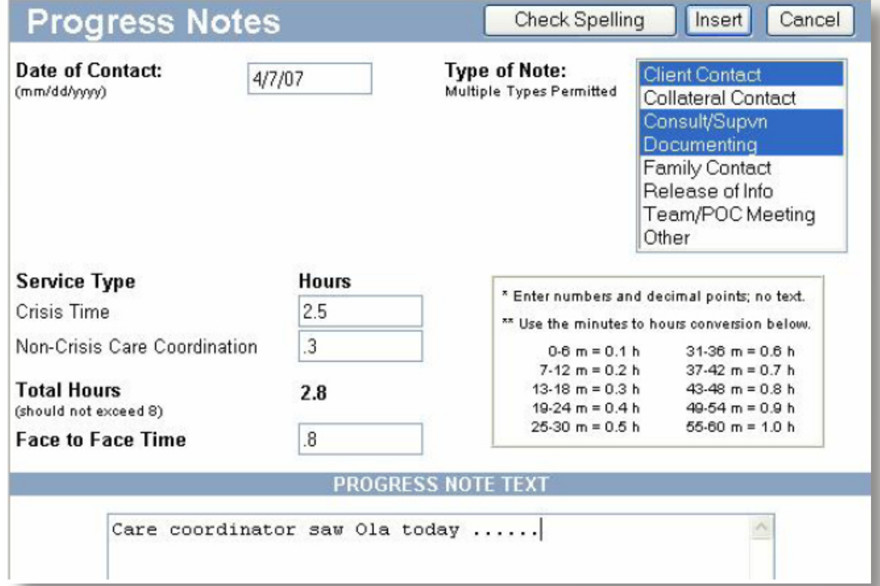
Enrollment Date: 6/1/2006 Test Interval: Intake

Test Date: (press 'Enter' to mark this test as received)

Check this box to indicate test is not required:

	T Score	Percentile
Activities		
Social		
School		
Total Competence		
Anxious/Depressed		
Withdrawn/Depressed		

Figure 6. Progress Notes



sion of services to families. Fiscal staff will need real-time reporting of revenues and expenditures. Vendors should be able to track their authorizations and invoicing. Each stakeholder in the system of care should have access to reports that are relevant to them. Having in-house I.T. staff who are accessible and who can quickly create these reports greatly enhances user satisfaction with the software.

What We Measure

Synthesis data is used extensively in measuring outcomes for our families, and evaluating performance of organizations that work with our families. Wraparound Milwaukee contracts with nine outside agencies for care coordination services, and evaluates each agency's performance on a semi-annual basis, using a number of indicators:

- Level of family satisfaction by care coordination agency is assessed using survey data entered in Synthesis. Families rank their satisfaction level on a scale of 1 to 5 in areas such care coordinator follow through and responsiveness, crisis/safety planning and family choice in providers.
- The percentage of days in community-based settings is assessed using data from the placement screens.
- The percentage of school days attended is calculated from data entered in the Plan of Care screens.
- Care coordinator service hours, weekly face-to-face contacts, and compliance with monthly team meeting requirements is gathered from data entered in progress notes.
- The balance of formal vs. informal supports on teams is gathered from the plan of care by looking at who is responsible for each of the strategies developed.
- Each disenrollment is given a "level of success" based on three weighted criteria:

» The level of 'needs met.' This can be calculated from the ranking given to each need by family members. The final Plan of Care, then, has an overall "needs met" score, which becomes part of the total disenrollment score.

» Level of permanency achieved, data for which is taken from the placement screens. Each category of placement (such as independent living, relative placement, home, group home, etc.) has a numeric value that is part of the total disenrollment score.

» Every disenrollment is also coded into categories such as Needs Met, Correctional Placement, Services No Longer Wanted, etc., and those codes also have numeric values that are part of the disenrollment score.

Where We Are Now

In the years since we have been using Synthesis, our business processes have changed greatly. Most dramatic has been the shift in staff allocations across departments. Since we began using Synthesis, the number of data entry staff in the fiscal department has decreased by two-thirds. None of these positions were lost, however. These

staff were re-allocated to quality assurance and other administrative functions as their jobs shifted from simply entering data to assisting with monitoring and evaluation of the data. The processing time from invoice submission to payment has decreased from 6-8 weeks to one week or less. Care coordinators have technology to support them in their work with families, and supervisors have tools to allow them to focus more supervision time on quality-of-care issues instead of paperwork compliance. Families receive monthly benefit statements which serve as a crucial component of our auditing of service provision. Families and their teams also have access to the resource guide, empowering them to make informed choices when selecting service providers.

Lessons Learned

From our experience developing and using our software, it is clear that several key components have led to our success:

1. We had a clearly-defined business process in existence already. That allowed us to focus strictly on automating a process we knew well and that worked for us already.
2. After a series of initial meetings with managers, support staff and other end-users, we defined what our initial goals for software development would be. From that time until the initial release of the software, we were very careful to avoid “scope creep” as users identified new areas they wanted to automate. We committed to a second phase of development to commence after the initial release of the software.
3. Although we developed a fairly robust online ‘Help’ component to the software, we quickly decided that a key component to success would be the development of a Help Desk function.
4. We only collect and maintain information that is used. Programs and initiatives should be willing to identify why they are collecting information and how it is used, and be ready to cease collection of data that is no longer relevant to the business process.
5. Too much information can be overwhelming. We instituted monthly ‘business meetings’ with our care coordination agencies during which we review key information and/or highlight areas of concern.

Author

Aggie Hale is the information technologies consultant to Wraparound Milwaukee, one of the initial system-of-care grantees. She directed the development of their Synthesis software, which is used both in-house and by other wraparound initiatives, and provides technical assistance and training to these other sites during implementation of new IT systems.

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Supporting Wraparound Implementation: Chapter 5e.3

Wraparound: A Key Component of School-Wide Systems of Positive Behavior Supports

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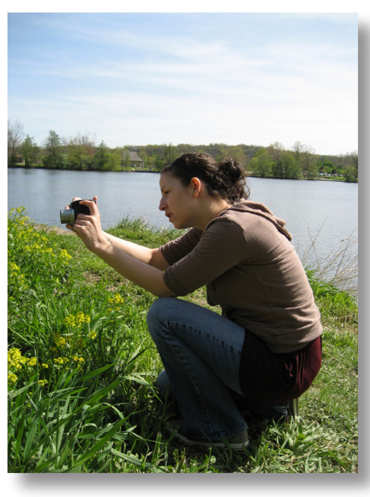
IL Positive Behavioral Interventions and Supports Network



Most of the articles and resources in the *Resource Guide to Wraparound* present examples of wraparound implemented in the context of community mental health, child welfare, and juvenile justice systems. Though school systems play an important role in wraparound initiatives led by these systems, schools also are increasingly leading wraparound efforts. A prime example is when school systems incorporate the principles and practices of wraparound into their continuum of supports and services for all students, including those with or at risk of emotional/behavioral disabilities (EBD). This allows the benefits of wraparound to be experienced by a greater number of youth and can prevent schools from resorting to restrictive educational settings and out-of-home placements.

More recently the wraparound process is being integrated into systems of school-wide positive behavior support (SWPBS) to ensure that all students, including those with EBD or other serious disabilities and challenges, experience success at school (which is also a significant contributor to a youth achieving success at home and in the community). This paper describes: (1) how the wraparound process can be integrated into schools through SWPBS, (2) differences between wraparound and typical school-based practices, including special education, and (3) how SWPBS systems can support and strengthen the wraparound process and its ability to improve quality of life for youth with unique emotional/behavioral needs, and for their families and teachers.

Wraparound and PBS: What’s the Connection?

Positive Behavior Support (PBS) is based on the core belief

that all children can learn and succeed and that schools, in partnership with families and communities, are responsible for identifying and arranging the physical, social, and educational conditions that ensure learning (see www.apbs.org; Eber et. al., in press). In the past 10-15 years, school-wide applications of PBS have emerged with the intent to build capacity for schools to provide effective behavior supports to all students, including those with complex behavioral needs, through a comprehensive prevention-based approach. SW-PBS applies the science of behavioral techniques school wide, using systems change structures that include a representative leadership team, ongoing self-assessment of the fidelity of the process, and rigorous application of data-based decision-making. Consistent with the public health model, SWPBS is a systemic approach that focuses on large units of analysis (e.g., school buildings and classrooms) and incorporates a three-tiered framework (Horner & Walker, 1996):

1. **Universal prevention** addresses the entire school population via evidence-based instructional practices, pre-correction, and adjustment of the environment to foster pro-social behavior;
2. **Secondary or selected prevention** delivers higher level, more specialized interventions to 10-15% of students whose lack of response to universal prevention places them at risk for problem behaviors; and
3. **Tertiary or indicated prevention** delivers specific interventions to the 1-5% of students with the highest needs due to a disproportionately high level of risk relative to protective factors.

The wraparound process is an essential component of school-wide positive behavior support if schools are to ensure success for students with complex needs across home, school and community settings (Eber et al., in press). Experience implementing wraparound through interagency system-of-care initiatives has shown that families (including the youth) need to be positioned as key informants and decision makers in prioritizing desired outcomes and strength-based strategies. The wraparound process provides a structure for schools to establish proactive partnerships between families and community supports, a necessary component for arranging successful environments around students with complex emotional/behavioral needs.

In addition to incorporating natural supports and interagency services, wraparound plans organize and blend positive behavior support and academic interventions as needed to ensure success at school. Differentiating itself from traditional service delivery in schools, wraparound focuses on connecting families, schools and community partners in effective problem-solving relationships. There are several features of wraparound that distinguish it from typical school-based practices. First, family and youth voice guide the design and actions of the team. Second, team composition and strategies reflect unique youth and family strengths and needs. Third, the team establishes the commitment and capacity to design and implement a comprehensive plan over time. Finally, the plan addresses outcomes across home, school and community through one comprehensive plan.

Connecting Families and Teachers through Wraparound

A hallmark component of the wraparound process is that it includes specific steps to establish ownership by, and therefore investment of, the family. These same engagement techniques need to be applied to teachers who also may become frustrated and discouraged with "expert-focused" intervention plans that often don't work in the context of their classrooms. Engagement and collaborative problem solving creates an environ-

ment in which a range of interventions, including behavioral supports, are more likely to be executed with integrity.

Just as wraparound teams support families, they can also tailor supports for teachers who may be challenged with meeting the unique needs of a student. For example, a plan to change problem behavior at school may be more likely to succeed if the teacher has a trusted colleague of her choice who models the instruction of the replacement behavior or how to naturally deliver the reinforcement in the classroom context. This may feel more helpful than simply being told to "provide more reinforcement" by the behavior experts at an IEP meeting. Participating in the design of successful interventions for the most challenging youth can provide a sense of both competency and relief for teachers, as the wraparound team frequently acts as a support to the teacher. The emphasis on the cooperative planning and data-based decision making—consistent with wraparound and implemented within SWPBS—reduces the feelings of isolation and sense of failure that teachers may experience in the traditional child study model. This model, typically used in special education, tends to focus more on eligibility and placement than brainstorming, monitoring, and refinement of specific and individualized interventions.

The School-Based Wraparound Facilitator

Differing from IEPs and other typical school-based team processes, the wraparound process delineates specific roles for team members, including natural support persons, and detailed conditions for interventions, including specifying roles each person will play in different circumstances. The role of a designated team facilitator is critical to adhering to the steps of the process and to upholding the principles of the strength-based, person/family-centered approach. The school-based wraparound facilitator, often a school social worker, counselor, or school psychologist, guides the team through the phases of wraparound, ensuring a commitment to "remain at the table," despite challenges and setbacks, until the needs of the youth and family are met and can be sustained without the wraparound team.

Individuals who perform the function of team facilitation should ideally possess certain skill sets and dispositions, including the ability to translate the experiences and stories of the family, youth and teacher(s) into strengths and needs data that can be used to guide the team. Another crucial facilitator skill is the ability to respectfully articulate the family's vision without judgment. This includes helping teams clarify the "big needs" that, if met, will improve the quality of life for the youth and family. Examples of "big need" statements to guide wraparound teams include: "José needs to feel respected by teachers;" or "Tracy needs to feel accepted by other students and teachers." The identified facilitator also must have the ability to facilitate problem solving and decision making in a consensual manner. Potential wraparound facilitators, readily available in school systems, include personnel who already lead intervention planning and meetings for students with or at-risk of EBD. Typical persons who are trained and coached to facilitate strength and needs-based wraparound meetings include school social workers, school psychologists, counselors, special education specialists, administrators, and others (Eber, 2003).

Engagement and collaborative problem solving creates an environment in which a range of interventions, including behavioral supports, are more likely to be executed with integrity.

How is Wraparound Different than Typical School-Based Approaches?

On the surface, wraparound can be seen as similar to the typical special education or mental health treatment planning process. It actually goes much further, however, as it dedicates considerable effort to building constructive relation-

ships and support networks among the youth and their family (Burchard, Bruns & Burchard, 2002; Eber, 2005). This is accomplished by establishing a unique team with each student and his family that is invested in achieving agreed-upon quality of life indicators. Key questions asked of youth and their families and teachers during team development (Phase I) of wraparound often include: “What would a good school day for your child look like to you?” Or, “How would you define success for your child five years from now?”

The identified team facilitator initiates wraparound using individualized engagement strategies with the family and youth, teacher and other potential team members. Assuming lower level interventions (e.g., universal and secondary PBS, parent conferences, function-based behavioral intervention plans) have not resulted in enough positive change, families may be understandably cautious about engaging in yet another meeting about their child. School-based wraparound team facilitators are trained to approach a family carefully to ensure that the family doesn’t feel judged and/or blamed. Families who have had a lot of contact with school but little success may need to be reassured that *they* are not expected to change the problem behavior of their child at school. For example, facilitators may use a statement such as “At school, we feel we are not being successful enough or positive enough with your child so we are going to change our approach to make sure he is going to have success.” This may be a different message than what the parent is used to hearing from the school and can set the stage for a different type of process that is intensive, yet positive.

How Does SWPBS Support Wraparound?

Program evaluation data in Illinois suggests that schools that implement SWPBS with measured fidelity at the universal level are more likely (than schools not yet reaching fidelity at the universal level of SWPBS) to implement individualized interventions, including wraparound. This suggests that SWPBS practices create school environments in which successful wraparound plans are more easily developed and implemented. The benefits that SWPBS offer to the highest level of support on the continuum (achieved via the wraparound process) include experience with a problem-solving approach and using data to guide decisions. Also, full implementation of SWPBS at the universal level provides a solid base of lower level interventions (e.g. primary and secondary) to build upon, as well as more effective and supportive environments in which to implement wraparound plans.

Within a three-tiered system of behavioral support, students who need tertiary level supports also have access to and can benefit from universal and secondary supports. Each level of support in SWPBS is thus “in addition to” the previous level. In other words, no student only needs wraparound—the wraparound plan, with its multiple-life-domain and multiple-perspective focus, makes the universal and secondary supports available in the school effective for the student. (For more information on SWPBS, see www.pbisillinois.org and www.pbis.org.)

Youth who need wraparound usually respond best in environments that are predictable (setting behavioral expectations), clear (direct teaching of behavioral expectations), strength-based (acknowledgment systems) safe (school-wide discipline policies and practices), and that have high levels of prompts (re-teaching). SWPBS supports these youth by providing these components across all school settings and creates climates where all youth in the building are supported, and are therefore calmer and better behaved. Peers can help support or prompt one another because the expectations are positively stated and well understood. Teacher and administrative time isn’t taken up by responding to multiple low-level problems throughout the building, giving the time necessary to provide the extra support to those students who need more comprehensive planning time.

Proactive use of data to drive instructional decisions within a problem-solving model is a hallmark principle and practice of SWPBS (Lewis-Palmer, Sugai, & Larson, 1999; Sugai & Horner, 1999; Nakasoto, 2000). Participating schools not only gather, report and use data related to students’ social and academic behavior, but are also encouraged to self-assess SWPBS implementation fidelity (e.g, using the School-wide Evaluation Tool or SET) and effectiveness of school-wide practices (Horner et al, 2004). Tertiary level SWPBS prac-

tices, including wraparound, also require the use of data to facilitate positive change for students. Most critical for this purpose is the use of data by individual family and youth teams for purposes of making decisions about effective interventions. In turn, the systems surrounding the child and family teams can make changes that support and sustain effective practices as evidenced by positive student outcomes (Eber et al., in press).

Future Directions

Schools need to expedite efforts to build competency and capacity for supporting students with complex emotional and behavioral needs. The wraparound process, with its focus on linking families, schools, and community partners on behalf of individual students should be an integral part of a multi-tiered, prevention-based system to support the emotional/behavioral needs of all students. To ensure optimal outcomes, the critical features of SWPBS, including data-based decision-making, ongoing self-assessment of fidelity, and rigorous progress monitoring, need to become routine within the wraparound process.

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Supporting Wraparound Implementation: Chapter 5e.4

Wraparound is Worth Doing Well: An Evidence-Based Statement

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"Anything worth doing is worth doing well." At some point, a parent, teacher, coach, or supervisor probably has given you this sage advice. Did you ever ask (maybe to yourself) whether there was evidence to support it?

In fact there is. Research tells us we should heed this guidance when delivering our children's behavioral health services. Meta-analyses of interventions delivered in "real world" systems have shown that "services as usual" are often no more effective than no service at all. Services based on evidence for effectiveness have a better chance of succeeding, but they must be delivered with quality and model fidelity if they are to produce positive effects.

Wraparound care coordination is no exception. Over 20 years, findings from controlled, peer-reviewed research articles (see Suter & Bruns, 2009; Bruns & Suter, 2010; Bruns, Walker, et al., 2014 for reviews) and federal evaluation reports (e.g., Urdapilleta et al., 2011) have consistently found wraparound to be associated with positive residential, functioning, and cost outcomes. Most of these studies were small pilot projects, however, in which implementation was tightly overseen and staff were well-trained and supervised (e.g., Bruns, Rast, Walker, Peterson, & Bosworth, 2006; Pullmann et al., 2006).

In 2014, two studies were published that provide cautionary notes to policymakers and providers involved in the increasingly common enterprise of taking wraparound programs to scale in real world public systems. The first study, funded by the National Institute of Mental Health, randomly assigned 93 youths with complex emotional and behavioral

needs and involved in the Nevada child welfare system to wraparound care coordination (N=47) versus more traditional intensive case management (N=46). The wraparound group received more mean hours of care management and services and demonstrated initially better residential outcomes. By 12 months, however, there were no group differences in functioning or emotional and behavioral symptoms (Bruns, Pullmann, Sather, Brinson, & Ramey, 2014).

The second study evaluated whether the addition of a wraparound facilitator to regular child protection services (CPS) in Ontario, Canada, improved child and family functioning over 20 months. While both groups improved significantly in child functioning, caregiver psychological distress, and family resources, addition of a facilitator did not improve outcomes above regular CPS (Browne, Puente-Dura, Shlonsky, Thabane, & Verticchio, 2014).

In addition to rigorously examining wraparound outcomes at some level of scale in “real world” systems, these two studies also shared another thing in common—both found Wraparound implementation quality to be poor.[1] In the Ontario study, fidelity as assessed by the Wraparound Fidelity Index (WFI) was found to be in the “below average” or “not wraparound” ranges for six of the scale’s 10 subscales, per standards disseminated by the NWI (Bruns, Leverentz-Brady, & Suter, 2008). The authors concluded that “some of the major components of wraparound may not have been sufficiently provided in order to promote optimal support and care for families” and that “a little bit of wraparound fidelity may not be enough for optimal treatment success.”

In the Nevada study, fidelity as assessed by the WFI was worse than 80% of sites nationally for parent reports and worse than 90% of sites nationally per a team observation measure. Parents and caregiver responses on the WFI and observation of team meetings suggested that the program did not consistently do things associated with high-quality implementation, such as:

- Involve youths and family members in the development of the wraparound team
- Actively engage and integrate the family’s natural supports
- Develop proactive crisis plans based on functional assessments
- Link caregivers to social supports
- Involve youths in community activities
- Develop statements of team mission or family priority needs
- Brainstorming individualized strategies to meet needs
- Ensure team members followed through on tasks
- Develop effective transition plans

In contrast, earlier studies of smaller-scale wraparound initiatives in the same system with only 4-5 WSM facilitators and extensive training and coaching showed high levels of fidelity and far better residential and functional outcomes for wraparound than for a comparison group of similar youths (Bruns, Rast, et al., 2006; Mears, Yaffe, & Harris, 2009). To put the differences in perspective, youths enrolled in the pilot project improved by an average of 35 points on the Child and Adolescent Functional Assessment Scale (CAFAS), compared to only 13 points in the study of wraparound taken to scale.

Looking at the big picture, these two studies bring the total number of controlled (experimental or quasi-experimental) wraparound studies in peer reviewed journals to 12. Among these, only one other study (Bickman, Smith, Lambert, & Andrade, 2003) found uniformly null effects for the wraparound condition. Perhaps not surprisingly, this is also the one other study among the 12 that documented a lack of adherence to the prescribed wraparound model. In this study, the authors concluded, “many elements of the practice model of wraparound were not present” and that the wraparound condition “was not meaningfully different

1. *Notably, both studies also applied wraparound facilitation to youth involved in child welfare. It is possible that this also played a factor in the finding of no significant effects over services as usual.*

from the comparison condition."

Thus, many may initially interpret the results of these studies as evidence against the growing movement by states and large jurisdictions to invest in care coordination using the intensive procedures recommended by the National Wraparound Initiative (Walker & Bruns, 2006) for youths at risk for costly and disruptive out of community placement. Closer examination of the studies, however, suggests their findings may simply be an extension of hard lessons learned about implementation of evidence-based practices in general. *Not only is it worth doing these practices well, outcomes for youth and families probably depend on it*.

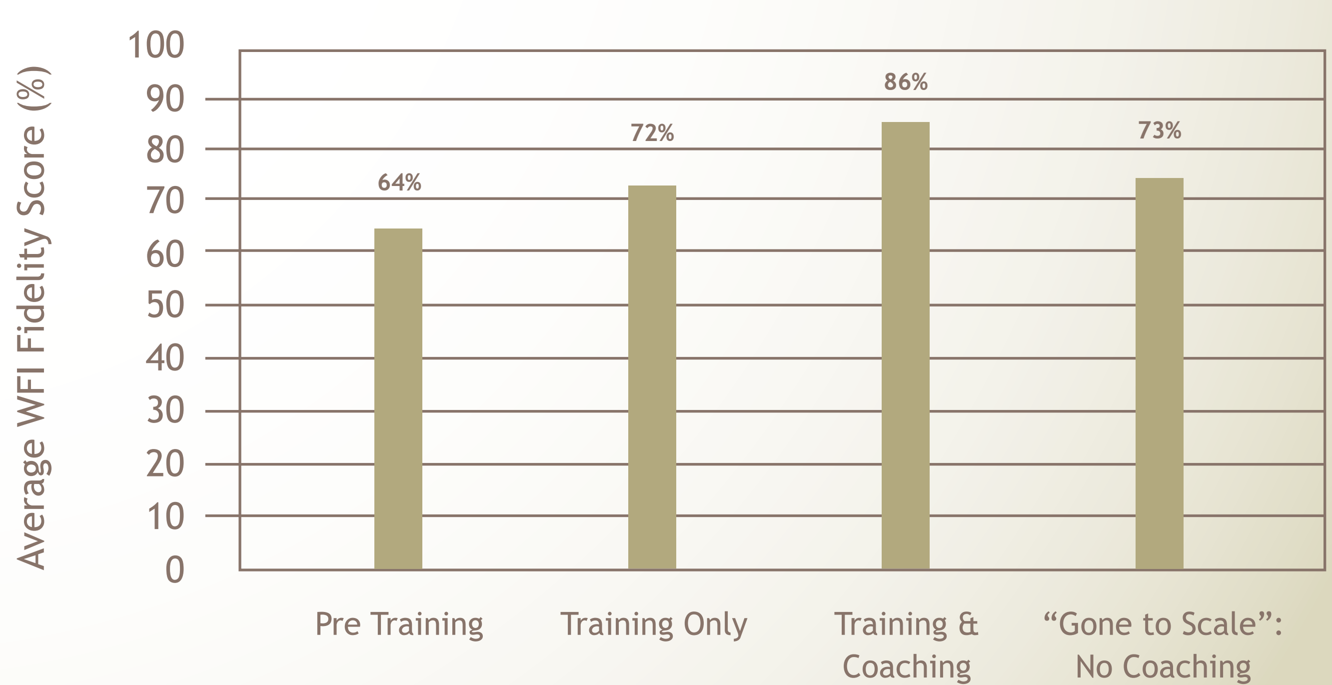
Doing Wraparound Well

So, what does it mean to "do wraparound well"? Obviously, the research summarized above suggests that implementation with fidelity to the prescribed practice model is critical. As has been described in multiple research articles and program descriptions (e.g., Walker & Bruns, 2006; Walker & Matarese, 2011), these practice-level elements must be in place for wraparound to live up to its theory of change and represent the well-coordinated, youth- and family-driven, multisystemic strategy that it is intended to be.

To achieve high-quality practice, system and program supports must be accounted for into the initiative. According to implementation science, the three big implementation drivers to keep in mind are Leadership, Workforce Development, and Program and System Support. Obviously, it would be ideal to do this from the beginning, but many wraparound projects have also successfully developed these "implementation drivers" over time.

Training, Coaching and Supervision. Wraparound projects require a thoughtful and deliberate approach to building staff and personnel capacity. This includes effective training, coaching, and supervision as well as other types of human resource decisions such as appropriate job descriptions, hiring practices, caseload sizes, performance systems, and staff support, including compensation.

Figure 1. Wraparound Fidelity in a System of Care with Variable Workforce Development Over Time



When it comes to training, coaching, and supervision, the evidence is growing crystal clear in human services that the "train and hope" model is destined to fail to achieve high-quality implementation. In the Nevada study cited above, for example, the drop off in fidelity and outcomes coincided with the withdrawal of resources for staff training and coaching that accompanied the national recession of 2007 that hit that states particularly hard (See Figure 1).

To help ensure states and systems understand what is important to attend to in workforce development, the National Wraparound Initiative (NWI) worked with its community of practice to develop

Figure 2. Workforce Development in Wraparound, from Orientation to Innovation

	PHASE 1	PHASE 2	PHASE 3
	Phase 1: Orientation	Phase 2: Apprenticeship	Phase 3: Ongoing coaching and supervision
Main components	• Basic history and overview of wraparound • Introduction to skills/ competencies • Intensive review of the process	• Observation by the apprentice • Observation of the apprentice	• Ongoing coaching, informed by data • Periodic observation • Document review
Key features	• "Tell, show, practice, feedback" process	• Experienced coaches • Structured process • Use of reliable assessments	• Quarterly observations (minimum) • Intensity increased if data indicate challenges • Superior facilitators become innovators
Ends when...	• Training completed	• Observations completed • Score exceeds threshold • Apprentice passes knowledge test	• Ongoing

Throughout, training, coaching and supervision is provided in a way that is consistent with wraparound

2. See http://www.nwi.pdx.edu/pdf/wrap-training-guidelines-2013.pdf

guidelines for training, coaching and supervision for Wraparound Facilitators.[2] As shown in Figure 2, this guidance describes the types of content and practice activities to which facilitators should be exposed in initial training and orientation before they start to work with families. It goes on to describe the all-too-often neglected "apprentice" period, during which facilitators work in tandem with an experienced facilitator—a "coach"—who uses a structured process to help them gradually develop the ability to work independently with families. In a third phase of skill development, ongoing coaching and supervision should be provided to ensure that facilitators continually develop their skills and expertise. In each of the phases, the learning experience should be characterized by a "tell, show, practice, feedback" process, whereby training and coaching shifts gradually from imitation of skillful performance to production of skillful performance.

Program and System Supports. Critical though it may be, training and coaching alone is unlikely to ensure skillful practice and successful implementation. Over a decade ago, Walker, Koroloff, & Schutte (2003) showed that "doing wraparound well" is a complex undertaking that requires a focus on an array of systems-level structures, policies, and supports necessary to ensure quality practice-level implementation and positive outcomes. These "necessary support conditions" have since been codified by the NWI in the form of six themes, shown in Table 1.

Table 1. Necessary Support Conditions for Wraparound

Theme	Description
Theme 1: Community Partnership	Collective community ownership of and responsibility for wraparound is built through collaborations among key stakeholder groups.
Theme 2: Collaborative Action	Stakeholders involved in the wraparound effort translate the wraparound philosophy into concrete policies, practices and achievements.
Theme 3: Fiscal Policies and Sustainability	The community has developed fiscal strategies to meet the needs of children participating in wraparound and methods to collect and use data on expenditures for wraparound-eligible youth.
Theme 4: Access to Needed Supports and Services	The community has developed mechanisms for ensuring access to the wraparound process and the services and supports that teams need to fully implement their plans, including evidence-based practices.
Theme 5: Human Resource Development & Support	Wraparound and partner agency staff support practitioners to work in a manner that allows full implementation of the wraparound model, including provision of high-quality training, coaching, and supervision.
Theme 6: Accountability	The community has implemented mechanisms to monitor wraparound fidelity, service quality, and outcomes, and to assess the quality and development of the overall wraparound effort.

Subsequent research has shown that these conditions can be measured and that they are associated with positive implementation on the ground level (Bruns, Leverentz-Brady, & Suter, 2006; Walker & Sanders, 2011). In the "real world" of wraparound implementation, the following are examples of topics that will require careful attention:

- *System structures for governance and management,* including consideration of options such as care management entities[3] and health homes[4];
- Investment in *quality assurance and accountability*[5] structures;
- *Sustainable financing* of high quality Wraparound, including the use of Medicaid and other federal financing mechanisms[6];
- Developing *centers of excellence* for ongoing implementation, quality assurance, policy, financing, and evaluation support;
- Building, enhancing, and/or implementing *workforce development initiatives* outside of the Wraparound practice model, including shifting providers from residential services to quality home- and-community-based services; and
- Implementation of Wraparound in the context of other systems of care efforts, including developing and implementing other *evidence-based and promising practices*.

Conclusion

In the late 1990s and early 2000s, many feared that the exciting innovations in family- and youth-driven, team based "wraparound" care would become a passing fad. Instead, wraparound has become a touchstone for children's mental health, recommended as a strategy in federal guidance documents,[7] and available in nearly every one of the United States. While it is encouraging that wraparound has gone to scale in this way, wraparound applied inappropriately or implemented "in name only" may represent a waste of our increasingly scarce behavioral health dollars.

Though it is no longer radical, wraparound has the potential to be quite powerful. To make the most of their investment in wraparound, however, states and communities must heed the lessons learned from recent research, lest they be doomed to repeat them.

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Supporting Wraparound Implementation: Chapter 5f

A Best Practice Model for a Community Mobilization Team

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Hamilton and Brantford, Ontario

A wraparound community mobilization team (hereafter referred to as a CMT) supports the work of wraparound teams and wraparound facilitators working with families in the local community.[1] This description is based on work developed by the innovators of community-based wraparound in Ontario, Canada starting in 2002.

As we started to develop wraparound initiatives that were driven and supported by local Community Mobilization Teams, we found that the concepts and description of the community team of the 1990s were insufficient to describe the rich community development and mobilization effort that was occurring in many communities across Ontario. The concept and description of a community resource team seemed to suit the evolving function of this entity. John VanDenBerg subsequently shared with us his use of the term community mobilization team and we found that this term best suited the structure and function of this community group and renamed it accordingly.

Community Mobilization Team Overview

As described above, a CMT is a community-level entity intended to support wraparound implementation for individual teams and families. The CMT is made up of people

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1. A local community as referred to here is a group of people that live, play and potentially work in proximity to each other and care for each other. It may also be defined by culture, such as an Aboriginal community or reserve, a Polish community, or an Asian community.

who are "community connectors." John McKnight, Professor of Education and Social Policy and Co-Director of the Asset-Based Community Development Institute at Northwestern University, has identified the primary characteristics of good "community connectors" as follows:

1. They are gift centered in their nature.
2. They are well connected in their community.
3. They are trusted—this is important because they are asking people to help families with children and youth with complex needs who are often marginalized and have become isolated from positive social networks.
4. They believe that their community is a welcoming and supportive community.

Community connectors come from all walks of life. Frequently, they are community leaders, representatives from natural or informal community support entities (such as recreation, faith, business, or service clubs), or representatives of formal child and family services in the community. The important role they play is to help the families served through the local initiative to get connected to volunteer support people and in-kind resources they require to have their needs addressed on a daily basis.

The chair of a CMT is often a locally recognized community leader and/or champion for children and families. The CMT functions in a manner similar to but distinct from a steering or advisory committee or a board of directors. Lead agencies take care of all the programmatic and administrative aspects of the functioning of the CMT.

There are several main purposes of the CMT:

- To educate the local community about wraparound and the children, youth, and families who participate;
- To mobilize the community and its resources and volunteers to provide effective community support to each family with children and youth with complex needs involved in wraparound that live in that community; and
- To support the work of wraparound facilitators by connecting the children, youth, and families served to the in-kind resources and volunteers they require to meet their needs on a daily basis

Here are a few examples of how effective community supports may be facilitated by a CMT:

1. *A young mother in her late teens with two children got her life back together with the help of wraparound. She had bounced from foster home to foster home and then group home to group home from ages 4 to 16 when she left her last group home. All together, she had been in 23 different placements. She believed that parenting was instinct as she had not experienced a positive parenting experience herself. As a young mother of two children she was an open case to child welfare because they were concerned about her low level of parenting skills. When she had completed a very successful year in wraparound that saw child welfare close her file, she was asked what about wraparound had made the biggest difference. To her, it was the volunteer mentor who helped her develop her parenting skills. The mentor was recruited for her early in her wraparound process by the CMT.*
2. *A man and a woman with three children had been on disability for the last 12 years. Upon doing the strengths discovery,*

the wraparound facilitator identified that the father had grown up in a family and town where it was important for him to learn to fix his own car. The father had only worked in food services at minimum wage before being put on disability. With the help of the local CMT, the father was sponsored to get his mechanics certificate. A person on the CMT used their connections at a local garage to get them to give the father a shot at being an apprentice. Not only did he complete his apprenticeship, but he was also hired on as a mechanic by the garage once he was finished his apprenticeship.

3. *A teenage boy of 14 just about to be released from secure custody was referred to wraparound. Upon meeting him, his wraparound facilitator discovered that despite exhibiting extreme acting-out behavior in the custody facility, he was enthusiastic about all outdoor sports and some indoor sports and could quote stats for the last five years about sports such as hockey, biking, and skiing. With the help of the local CMT, he was placed for his court-ordered restitution at an outdoor sporting goods store that a CMT member frequented. Initially, the manager of the store requested a one-to-one worker to be with the 14-year-old all the time. Within a week, the manager phoned the probation officer and said that the one-to-one worker was not needed. He said that the youth's passion for outdoor sports was such that he had switched the young man from doing odd jobs to selling sports equipment. The manager predicted that he would be a great salesman for him.*

A Vision and Mission for Developing CMTs

Our vision is a vibrant network of localized community mobilization teams, linked together across the country, providing effective community support for local families with children, youth, or adults with multiple, complex problems involved in wraparound.

Our mission is to continue to develop and launch a number of localized CMTs across Canada over the coming years. Each of these CMTs will mobilize their local community by securing the necessary financial and in-kind resources and support so that families with children, youth, or adults with complex needs involved with wraparound can receive effective community support.

Engaging Potential Members of a CMT

People we approach to be on the CMT often ask us how this community group we are asking them to join (and possibly lead) helps children, youth and adults and their families dealing with complex needs, and how wraparound is different from other services. To answer these questions, we first try to explain wraparound in a community-friendly way, providing an example of how it works.

For example, a referred family with children, youth or adults with complex needs is assigned a wraparound facilitator whose role is to work in partnership with the family to help them pull together their wraparound team. This team will be made up of the family themselves, their friends, community support people, and the service providers involved with the family that they find helpful. This is the family's team. They decide who will be on their team. The facilitator works with the family to help them identify their strengths, their culture and their priority needs. The facilitator and the family then bring together the family's wraparound team and together they review the strengths, culture and needs with the team and get them to add to each.

The facilitator then helps the family and their team to work through a highly structured, intense planning process. The product of this planning is the development of a comprehensive plan that addresses the top one or two needs that the family has chosen. This is accomplished by the facilitator helping the team brainstorm strategies that build on the strengths of the family, their team, and the community in which they live. The family then chooses the strategies that they think will work best. In essence, this team "wraps" services and supports around the family, based on their description of what is needed and what might work.

The potential CMT member is told that their

role will be to participate on a team that mobilizes the community to acquire necessary resources for participating families and teams. Such needs are communicated (in a non identifying way to the family) to the members of the local CMT through formal and informal channels. Resources may include volunteer and/or in-kind donations that are beyond the resources of the family and their team.

What makes wraparound so different? In response to questions about how wraparound is different from other service models, we typically present these four examples:

1. The family's wraparound team brings together the family's friends and relatives, community support people and the service providers that the family finds helpful. The wraparound planning process integrates all of their efforts to help create a single plan for the family, focusing on one or two priorities identified by the family. While safety issues are non-negotiable, families usually identify safety issues as their top priority.
2. Part of the role of the wraparound facilitator is to teach the youth and family to build their capacity to do this kind of planning for themselves wherever possible. Many families graduate from the wraparound process and are able to carry on their own wraparound planning.
3. The CMT is able to help find the in-kind resources and volunteers that the family and their wraparound team need, but are not able to immediately obtain.
4. The family's wraparound team and the local community mobilization team are connected to help the family rebuild its safety net, develop connections to positive social networks, and develop positive relationships over time with people in their local community.

Youth and parents who have been involved with the wraparound process talk about wraparound as being different and providing them with real hope that life could be better on a daily basis.

The Structure and Functioning of a Community Mobilization Team

John McKnight strongly recommended to us that the relationship or partnership between child and family services and our CMTs be structured such that the child and family service providers *support* local community leaders and citizens in that community to be in charge of the CMT.

All members of the CMT sign a partnership agreement that clearly outlines the role and functioning of a CMT and what is expected of each member. Agreements signed by sponsoring agencies also address due diligence issues, such as volunteer clearance and supervision and liability insurance.

So, is the structure and functioning of a CMT like a board of directors, an advisory or steering committee, or a community service club? A CMT functions a little like each one of these types of entities. Like a board of directors, it oversees the acquisition and use of in-kind resources and volunteers. The CMT also has an executive like a board of directors, though typically not with staff *per se*. A CMT also functions a little like an advisory or steering committee in that it provides feedback to the local wraparound initiative. However, the members of the CMT have actual duties linked to the functions of a CMT described in the preceding section.

Finally, a CMT functions like a community service club in that it attracts people to a group that strongly believes in the power of the local community to do good things for those in need in their community. However, while similar, the focus on mobilizing the community into a state of readiness or preparedness to help address the individual needs of families with children, youth or adults with multiple, complex problems involved in wraparound is more like a board of directors.

Expectations for Members of a Community Mobilization Team

1. Members are passionate about helping families with children, youth and adults in their community, especially when their needs are complex and hard to address.
2. Members are oriented to and willing to support what wraparound is and how it

helps families with children, youth and adults with complex needs have a better life. They are also asked to commit to the vision and mission described above.

3. Members are oriented to and willing to support what a CMT is and how it helps, as well as committed to work in accordance with the personal values and the community principles that underpin how wraparound is provided to people and families in need in the local community.
4. Members are asked to give what they can in the way of their own gifts, strengths and resources to support the function of the CMT and the people and families in wraparound that live in that local community.
5. Members are asked to act as "community connectors" to other individuals and social networks that have in kind resources and volunteers that could potentially help or be needed by people and families involved in wraparound that live in that local community.

We suggest to people that minimally it will involve one 2-3 hour meeting per month. They also will be asked to use their "connections" to help find in kind resources and potential volunteers, which they should be able to do in the course of their regular activities through the week. In addition, members may chose to get more involved and join a particular subcommittee (e.g. public education or fundraising) which would add another two hours to what they do in a month for about five hours at most. Or, they may choose to run for a position on the Executive next time there is an opening, which would potentially add another two hours monthly.

The Structure of a CMT

As shown in Figure 1 (see page 6), the CMT is conceived as supporting individual families and their wraparound teams. This support is provided in partnership with sponsoring agencies who implement wraparound. These agencies also provide administrative support to the CMT. Below we provide a description of the key roles in the functioning of a CMT.

Executive Team. Each CMT has an executive team as well as a chair or multiple co-chairs who direct the executive team and provide leadership and management of a local CMT. The executive team administers the CMT partnership agreement with both the membership of the CMT and with the sponsoring agencies that provide administrative support for the CMT and provide wraparound facilitators to work with families. An executive team may also have subcommittees such as public relations, fundraising and membership recruitment for the CMT. The executive team takes a lead role in community mobilization of in kind resources and volunteers (e.g. drivers, tutors, coaches, mentors, etc.)

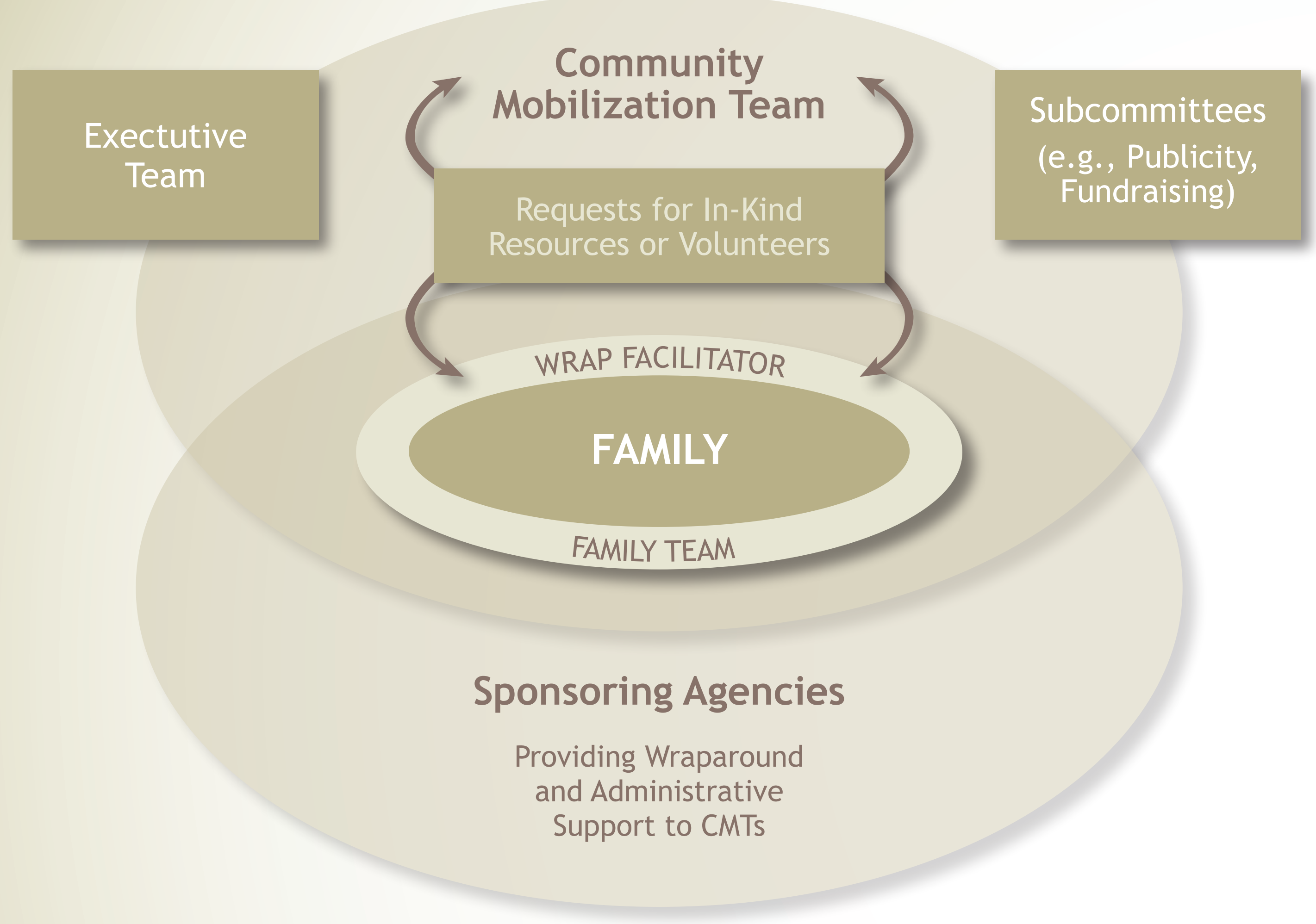
Youth and parents who have been involved with the wraparound process talk about wraparound as being different and providing them with real hope that life could be better on a daily basis.

Chair or Co Chairs of the CMT. As described above, ideally the CMT chair or co-chairs are people who are already viewed as community champions. The chair(s) are critical to success of the CMT and the wraparound initiative. The chair(s) work with the support of the sponsoring agencies to ensure that all people, including those on the CMT and others involved with the local wraparound initiative, work together to ensure the smooth functioning of the initiative.

Wraparound Teams. As described in more detail above and in this *Resource Guide*, wraparound teams consist of people supporting individual families with whom wraparound is being implemented. A facilitator helps the family to identify potential team members and then uses the following guidelines to select the people to be on their team:

- Is the person willing to help?
- Does the family generally trust their advice?

Figure 1. The Role of a Community Mobilization Team in Supporting Wraparound Implementation



- Is the person generally a positive influence with the family?
- Will the person keep the family's business private and confidential?

Sponsoring Agencies. In addition to overseeing implementation of wraparound and supervision of staff such as the wraparound facilitators, sponsoring agencies support local CMTs by taking care of programmatic and legal functions, financial administration (hold and audit raised funds), and risk management (volunteer screening, liability insurance). They also provide meeting and office space, and provide charitable receipts as necessary.

Typical Agenda Items and Related Discussion for a Meeting of the CMT

Logistics. The meeting of the CMT is held at a time that is convenient for all members of the CMT. Supper meetings or meetings from 7-9 pm are popular times, as are lunchtime meetings. The location of the meeting is meant to be welcoming. Typically it might be held at the chair's house or some other place such as a local restaurant or meeting room that is warm and inviting. The chair

acts as host welcoming people and engaging them in conversation and easing them into the meeting. The chair always make sure that everybody knows each other or gets to know each other. This part of the meeting may take up to 10 or 15 minutes or until the chair decides that everybody is comfortable.

Celebrating Success. Typically the chair eases the group into the meeting by describing themselves or getting the appropriate members to talk about key areas of success since the last meeting. This is a time to celebrate and thank people for their efforts. Often this will include the announcement of the successful result of a search for a key in kind resource or volunteer needed for a family in wraparound. It is important that non identifying information about the family be used to also talk about how the receipt of the resource or the help of a volunteer is making a difference in the lives of the family in wraparound. Sometimes a facilitator attends to share success that the family has achieved, especially with respect to the resources and volunteers found by the CMT.

Requests for Support. The chair then moves the meeting into reviewing the requests for needed resources and volunteers by families involved in wraparound. Again, care is taken to keep the identity of the family confidential. If members think that they can address the request themselves, then no further planning is required. However, if the request is beyond the resources immediately available to the members of the CMT, brainstorming a “fan out” strategy among everybody’s “community connections” may be called for. Once the ideas are all out on the table, the top two or three are chosen. Action plans are then developed and people volunteer to follow up on them so as to acquire the necessary resource or volunteer.

It is important that the chair try to ensure that everybody gets involved in both the brainstorming as well as the development of action plans. If a member goes to meeting after meeting without getting or being involved in the work of the CMT, they often drop out of the CMT. In this respect we have found that members who join the CMT want to do things, not just talk about it. Members of the CMT say that they stay involved because they feel that their gifts and strengths are being valued and used.

Planning Educational and Fundraising Events. The chair then asks people in charge of educational and fundraising events to review where the planning is at, again trying to invite others to get involved as they choose.

Closing and Setting the Next Meeting. The chair then wraps up the meeting, summarizing any key points that should be repeated before people leave, and ensuring that everybody is aware of the date and location of the next meeting. Usually there is a social period at the end of the meeting for those that don’t need to rush off to other obligations.

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This material is taken from training modules written by Andrew Debicki as an external partner of and for Vroon VanDenBerg LLP. The work in this module builds on original work done and written up by Andrew Debicki with Anne Bain.

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Supporting Wraparound Implementation: Chapter 5g

Family Driven, Individualized, *and* Outcomes Based:

Improving Wraparound Teamwork and Outcomes Using the Managing and Adapting Practice (MAP) System

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The wraparound team process has established itself as a standard of care for children and youth with complex needs and their families who require coordination of care and for whom a single intervention is unlikely to suffice. The wraparound practice model operationalizes critical system of care principles such as family driven and youth guided, community based, and collaborative; it is extremely popular with families; and the process is locally adaptive in that it can be flexibly applied in a range of public service systems. Moreover, evidence continues to accumulate for its effectiveness (Bruns, et al., 2010; Suter & Bruns, 2009).

Research results indicate that wraparound's strongest evidence for positive effects are in the residential, family, and cost domains. In these areas, significant, medium-sized effects have been found across a range of studies. Positive clinical and youth functioning outcomes, on the other hand, have been less consistently found. Where significant, effects on these outcomes have been found to be small (Suter & Bruns, 2009).

It is perhaps not surprising that more positive results are found for residential, family, and cost outcomes. Wraparound's primary innovation is to focus on teamwork that yields individualized strategies to keep children in their home communities with their families. Wraparound teams actively consider the multiple levels of a child's social ecology (family, friends and neighbors, providers, systems, com-

munity) and identify service and support strategies that fit within the family's contexts and culture (Bruns, et al., 2010; Walker & Matarese, 2011; Walker, Bruns, & Penn, 2008). The result is that youths are maintained in their homes—or in "home like" community settings—and are more likely to avoid costly out-of-home placements (Bruns, 2008; Bruns & Suter, 2010; Bruns, et al., 2010). As evidence, a recently completed 10-state Medicaid demonstration project found wraparound cost to be substantially less than institutional and other alternatives, with an average per capita saving of $20,000 to $40,000 (Urdapilleta, et al., 2011).

Manualized EBPs often do not represent a good fit with either family's expressed needs or the philosophy embedded in the wraparound process.

This is highly encouraging news, but what about the clinical and functional outcomes? As described above, effects in these areas are smaller, and we often hear families, system partners, and researchers alike express concerns about whether wraparound can be as successful at reducing problematic behaviors and improving emotional functioning as it is at supporting families and stabilizing placements. Individual therapy (for children) and family therapy are the most common services included on wraparound plans, yet wraparound teams often find themselves frustrated by the lack of high quality clinical services available in their communities. In short, research and experience has inspired many wraparound and system of care advocates to ask how better clinical and functional progress in youths might be promoted through thoughtful application of evidence-based practices (EBPs) within wraparound.

Applying a Relevant EBP Paradigm to Wraparound

Communities have become aware of the fact that EBPs have the potential to produce better outcomes than treatment as usual (Weisz, et al., 2012; Weisz & Kazdin, 2010). However, manualized EBPs are not available for all child disorders, and, when a child has complex challenges that might suggest the use of multiple EBPs, there is usually no mechanism to ensure coordination. Moreover, many manualized EBPs are expensive to implement, requiring training and retraining by the treatment developer.

Finally, manualized EBPs often do not represent a good fit with either family's expressed needs or the philosophy embedded in the wraparound process. The service and support strategies provided through wraparound are intended to be highly flexible and individualized, so that they match family needs, preferences, and perceptions of utility as described above. In contrast, manualized EBPs usually emphasize strict adherence to specific protocols. Thus the wraparound team (and by extension, the family and youth) lose the power to individualize and optimize the treatment.

Recognizing the difficulties that have arisen in attempts to reconcile wraparound and EBP, researchers have been searching for a way to combine the strengths of the two approaches in a synergistic manner (Weisz, Sandler, Durlak, & Anton, 2006). On the surface, this would seem to be simple: Wraparound is flexible and individualized and has substantial "real-world" credibility and adaptability (but less evidence for clinical and functional effects). EBPs show extensive support for their clinical efficacy but less clarity regarding their "real world" effectiveness, feasibility, and cost/benefit ratio (Chorpita, et al., 2011). Thus, the complementary nature of the limitations of wraparound and EBPs seemingly points to an opportunity to leverage the strengths of both. The question is: How?

Applying a Knowledge Management Approach to EBP

Some applications of EBP have taken a more individualized approach that aligns with the wrap-

around philosophy. Instead of strict implementation of one or more manualized treatments, these applications are based on quality improvement models and flexible application of the evidence for "what works" in child and family treatments. Such ***knowledge management approaches*** to EBP flexibly inform practice by generating options based on research studies and tracking practice and progress for each youth (Daleiden & Chorpita, 2005). Thus, treatment is coordinated based on evidence for effects of psychosocial interventions while also being flexible, modularized, and capable of mid-course corrections when the youth needs demand a more individualized and tailored approach.

The **Managing and Adapting Practice (MAP)** system provides an approach and an array of tools to support coordinated knowledge management in services delivery and application of EBP resources (PracticeWise, 2010; see also CIMH, 2012). The most relevant and visible of these tools are the ***PracticeWise Evidence Based Services (PWEBS) Database***, codified clinical supports called ***Practitioner Guides***, and a feedback tool to monitor practices used and youth progress called the ***Clinical Dashboard***. All these tools are supported by an online resource library and user interface maintained by PracticeWise (www.practicewise.com).

The PWEBS provides a method for a practitioner to use a database of treatment components, or elements, that have been found to be effective at addressing common child and youth problem areas. Among the many hundreds of *interventions* that exist for youth problems, there are a relatively small number of treatment *components*. These components—sometimes referred to as "common elements" of EBP (Barth, et al., 2011; Chorpita, Delaiden, & Weisz, 2005a)—are essentially the smaller pieces that make up interventions. Chorpita and Daleiden (2009) reviewed 322 randomized trials of treatments for the most common problem areas of youth, including depression, anxiety, and disruptive behaviors. Coding of the components of these studies found that 41 common practice elements could be "distilled" from the 615 manualized protocols reviewed.

PWEBS assists a practitioner to match a youth and his or her problem areas to the most relevant, research-supported, treatment elements. After input of youth (e.g., age, race, gender) and treatment (e.g., setting, format) characteristics, PWEBS returns a review of treatment elements with evidence for effectiveness from controlled studies for that type of youth and setting. With tools to help review the applicability of the components to the youth, the clinician or wraparound team may select from among these components and implement them, while monitoring how the child responds. If desired outcomes are not being achieved, systematic adaptations may be attempted, such as implementing different components (Chorpita, Bernstein, Daleiden, & the Research Network on Youth Mental Health, 2008). Thus, in addition to a resource for clinicians, the PWEBS provides a potential tool for wraparound facilitators and teams to improve brainstorming of strategies and the effectiveness of strategies.

The Practitioner Guides present two-page reviews of the steps to implement the common treatment practices and processes, in a way that reflects the research literature. (See an example in Figure 1.) The Practitioner Guides can be used flexibly by a range of practitioners to enhance their skills (if they are well versed in the treatment) or structure the care they provide (if they are relatively unfamiliar). These guides may also be used to help a wraparound facilitator understand the nature of treatment that is expected from a clinician to whom the team has referred a youth, or to help a natural support, mentor, behavioral aide, or family member support a treatment (e.g., rehearse cognitive or behavioral strategies in the community).

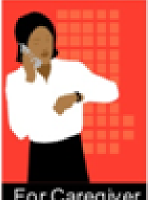
Figure 1. Example of Practice Guide from the Managing and Adapting Practice (MAP) System

Practice Guide

Commands or Effective Instructions

Use This When:

To increase child's compliance with caregiver instructions.



Objectives:

- to provide the caregiver with strategies to clearly and consistently communicate instructions to the child
- to provide the caregiver with strategies to demonstrate to the child that caregiver will see the task through to its completion
- to minimize discord between the child and caregiver regarding directives

Steps:

☐	**Provide rationale**	Increasing a child's compliance with instructions involves managing what happens before the command (antecedents), addressing the form and content of commands, and managing what happens after the command (consequences).
☐	**Set the stage for success**	Instruct the caregiver to optimize the likelihood of compliance by managing certain setting events, including: • minimizing distractions (e.g., turning off television), • getting the child's attention by saying the child's name, making eye contact, and standing near the child, and • providing a transition warning when appropriate (e.g., "In two minutes it will be time to put the toys away").
☐	**Example: Tone of voice**	Instruct the caregiver to use a firm, but calm, tone of voice. A critical tone or one that conveys frustration may increase the likelihood of noncompliance.
☐	**Example: One at a time**	• Instruct the caregiver to provide commands one at a time. • This helps increase compliance by minimizing the number of things the child has to remember to do and by providing caregiver with opportunities to praise compliance after each task is successfully completed. • Example: "Brush your teeth." [Wait for compliance.] "I like how you brushed your teeth when I asked. Now wash your face."
☐	**Example: Simple is better**	• Provide simple, clear instructions (e.g., "Put on your coat."). • Avoid vague requests (e.g., "Get ready to go."), or general criticisms (e.g., "We're leaving soon and you are not ready!").
☐	**Example: Tell, don't ask**	• Instruct the caregiver to provide commands in statement form ("Put away your toy truck") • Avoid question form (e.g., "Would you put away your truck?" "Would you do me a favor and put away your truck?) • Avoid using the word "Let's" if the caregiver does not intend to participate (e.g., "Let's put away the toys now.")
☐	**Example: Tell child what to do**	The caregiver should instruct the child about what to do (e.g., "Walk in the hallway"), rather than what to stop doing ("Don't run!"). Telling the child what to do is more positive and informative than telling the child to stop doing something.

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The Clinical Dashboard monitors practices delivered and how the child is responding, so that strategies can be adjusted as needed by monitoring of youth progress and process. The MAP Dashboard presents progress (such as toward a goal or as assessed by a standardized measure) in one pane, and practice (e.g., the treatment components that were implemented) in another pane, both along the same axis of time. (See Figure 2.) In wraparound, the principle of *outcomes based* demands that needs be prioritized and progress toward meeting needs and achieving outcomes be measured and reviewed by the team so that service and supports can be adjusted as necessary. However, such efforts are often not undertaken by wraparound teams or staff (Bruns, Suter, Burchard, Leverentz-Brady, & Force, 2004; Bruns, et al., 2010). A standardized means for doing so, such as via a consistent yet individualized clinical dashboard, would be likely to promote positive teamwork and outcomes in wraparound.

Discussion

For all its strengths, application of wraparound practice in real world settings often does not provide explicit guidance for how best to incorporate evidence-based clinical content into plans of care. Though the research is not well-developed, this shortcoming may reduce wraparound's effectiveness, especially on symptom outcomes. An obvious alternative is to use and train on manualized EBPs instead of wraparound. The benefit of this approach is that EBPs have evidence for efficacy in addressing symptom-level outcomes. However, as discussed above, this option does not provide clear guidance on how to manage multi-component plans of care. Moreover, EBPs may be incompatible with family preferences and/or not provide the holistic support necessary to maintain a youth with complex needs in his or her community. Another potential solution to this problem would be to promote use of manualized EBPs along with wraparound in systems of care. However, installing multiple EBPs along with wraparound will likely result in a great deal of complexity, and differences in the practices and value systems of EBPs and wraparound may be hard to reconcile at a system and practice level.

The alternative, proposed in this article, is to introduce a clinical model that incorporates knowledge of all EBPs in an individualized manner and that does not just align with the wraparound principles but actually reinforces them. A weakness of this "Wrap and MAP" approach is that there is limited evidence from controlled research that it works: Only one randomized trial (Weisz, et al., 2012) and a statewide open trial (Daleiden, et al., 2006). The potential strengths of this option, however, are greater provider buy-in (Borntrager, et al., 2009), better fit with real world systems (Palinkas, et al., 2009), and greater likelihood of aligning with critical aspects of the wraparound process, such as team-based planning, creative brainstorming, and purposeful use of natural and community supports (Chorpita, et al., 2008; Chorpita, et al., 2011; Daleiden & Chorpita, 2005). Most important, a system may get the best of all worlds with respect to outcomes: youth symptoms and functioning as well as family resilience and maintenance in the community.

At this point, a range of options for how to combine the mutually reinforcing models of "Wrap and MAP" remain to be developed and tested. As one option, the MAP approach could simply be used by clinicians who will therefore become more effective at treating children and youth as well as more effective members of wraparound teams. Or, "Wrap PLUS MAP" could be administered in a coordinated way, whereby wraparound staff and teams are themselves trained to use the MAP concepts and tools to better use research evidence to generate more and better options for the plan of care. The PracticeWise system supports training, coaching, and certification of a range of roles, including therapists, agency supervisors, and professionals who can train others in their agency or system on use of the system (PracticeWise, 2010). Training, coaching, and certification on MAP for wraparound-specific roles is now being developed.

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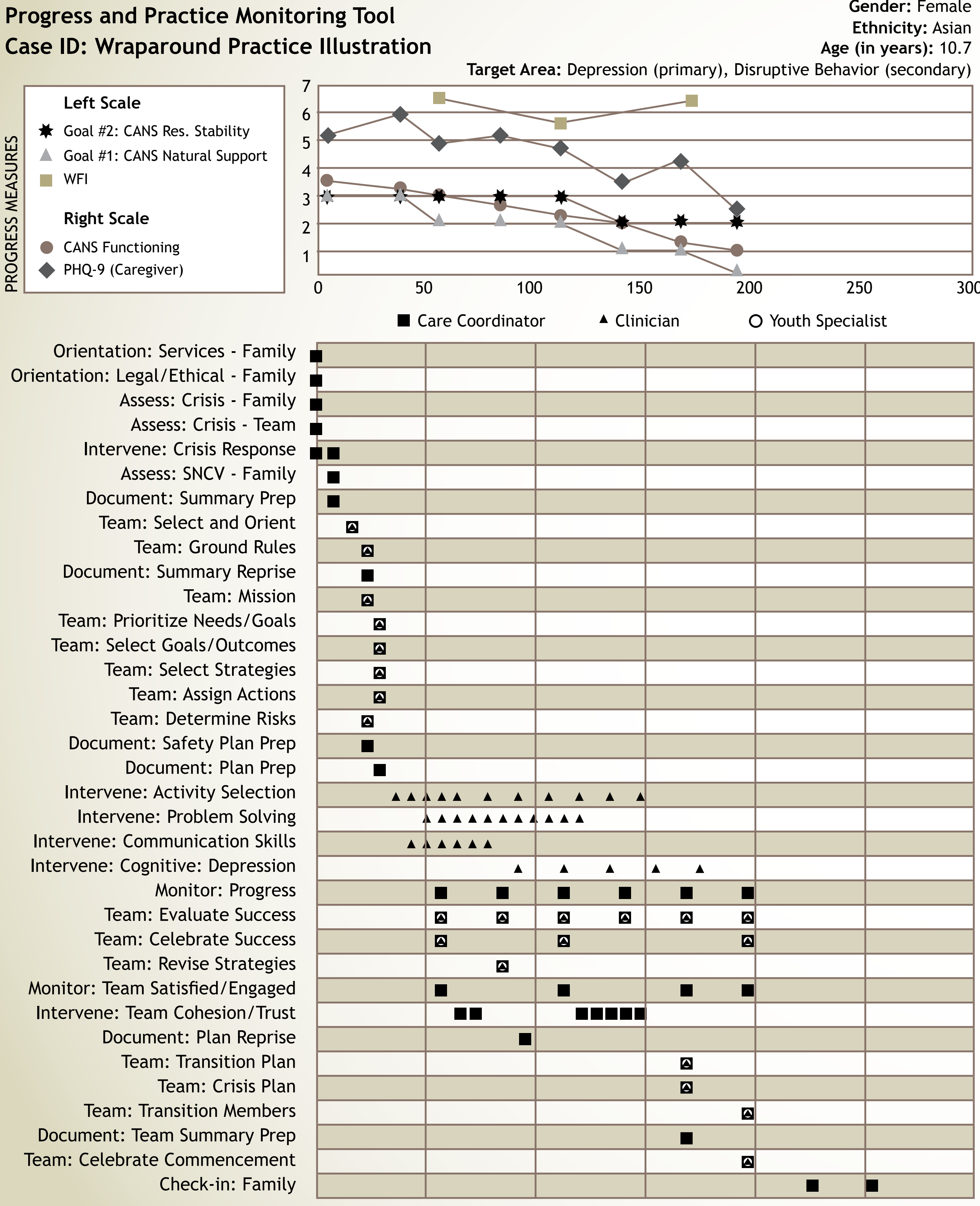
Figure 2. Example of a Wraparound-Specific Dashboard from the MAP System



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Bruce Chorpita is Professor of Psychology at the University of California, Los Angeles. He is one of the co-developers of the Managing and Adapting Practice (MAP) system. Dr. Chorpita's work is dedicated to improving the effectiveness of mental health services delivered to all children, through innovation in mental health treatment design, clinical decision-making and information-delivery models, and mental health system architecture and processes.

Eric Daleiden is the Chief Operating Officer of PracticeWise, LLC and is one of the chief architects of the PracticeWise products and services. Dr. Daleiden's recent efforts focus on the application of behavioral and information technologies to develop tools and processes for compiling, delivering, monitoring, and managing the products of scientific discovery in behavioral health systems.

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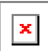
Overview



Overview

The Community Supports for Wraparound Inventory (CSWI) is a research and quality improvement tool that assesses how well a local community or system supports the implementation of high quality wraparound. The CSWI can be used in several ways:

· To help communities evaluate to what extent the supports that are needed for wraparound are (or are not) in place in their community. Using this information, the community partners can make changes and track improvements in community supports over time.

· To help researchers determine how much these community support conditions affect fidelity and outcomes of wraparound.

· To help evaluators understand the system context for wraparound as part of their local evaluation projects.

In general, the information that you and others in your community provide on the CSWI will be used to improve implementation of community based services for children, youth, and families.

The CSWI typically takes up to 45 minutes to complete.

CSWI responses will be kept confidential

Thank you for agreeing to complete the CSWI.

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Instructions

Instructions

Please check off each of the boxes below to confirm that you have covered that part of the instructions.

The CSWI is organized into six themes, with six to eight items per theme. Each item has one "anchor" statement that describes what a fully developed system would look like relevant to that item, and another anchor statement that describes what the least developed system, or a system at the beginning of its development might look like related to that item.

For *each* item, you should consider the conditions in your community or system relevant to that item. Next, you should select a rating on the five-point scale that is provided.

On this scale, a score of 4 is the highest and indicates that your community resembles the description of the fully developed system for that item. In other words, your community shows the greatest level of system support.

On the other end of the scale, a score of 0 is the lowest and would indicate that your community resembles the description of the least developed system for that item.

Often, your community will not resemble either extreme of the scale. In this case, you should choose a score elsewhere on the 4-to-0 scale that best approximates where you feel your community lies on the continuum from the description of the fully developed system to the least developed.

Check each of the boxes below:

- ☐ A 4 rating means you believe your community fits the description of fully developed system for this item.
- ☐ A 3 means your community is fairly close to achieving the fully developed system. It has made substantial progress, but is not all the way there yet.
- ☐ A 2 means midway between the two end points, indicating that you believe your community or system is about midway between "fully" and "least" developed system support.
- ☐ A 1 means that a small amount of progress has been made, but that your system still resembles the least developed description.
- ☐ A 0 means that the description for least developed system support is accurate for your community.

If you do not feel adequately informed or knowledgeable about your community's system choose"DK" for "Don't Know".

- ☐ I should choose "Don't know" for any item that I don't know enough about to rate

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How to stop the survey and finish it later

If you don't have enough time to complete the survey in one sitting, you may leave the survey and then resume it later. In order to do this, SurveyMonkey needs to place a cookie on your web browser. You will need to use the same original computer to resume the survey. For this feature to work, you will also need to have your browser settings configured so as to allow cookies.

When you want to leave the survey, click on the white "exit this survey" link in the upper right-hand corner of the page. When you are ready to access the survey again, just click on the link you received in the original invitation e-mail. The link remembers where respondents left off based on the last completed page. As you click on the "next" button in the survey, the survey page saves.

jn If I want to stop the survey and finish later, I just have to click on the "exit this survey" link to leave, and then using the *same original computer* click on the link in the invitation e-mail I received to resume from the point where I left off.

Click "Next" to proceed to the CSWI Survey.

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Respondent Information

Please enter the identification number from your email invitation. If you do not have the email invitation, please contact April Sather at sathea@u.washington.edu.

How many TOTAL years have you been involved in wraparound in ANY role?

How many years have you participated in the following roles? (Please provide an answer in each row. Choose 0 if you have never had this role.)

	0 or N/A	less than 1 year	between 1 and 2 years	between 2 and 4 years	between 4 and 7 years	between 7 and 10 years	10 years or more
Family member/youth on a wrap team or involved in wrap implementation							
Natural support on teams other than your family's own							
Family partner/other wraparound family support role							
Wraparound facilitator or care coordinator							
Wraparound team member who is a professional							
Wraparound supervisor or coach							
Program manager/agency administrator involved with wraparound							
Higher-level (e.g., county or state) administrator or policy maker involved with wrap							
Evaluator or researcher on wraparound							

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Primary Role

Describe your primary role within the wraparound project that you will be referencing as you fill out this form. (Choose one answer.)

- Facilitator/care coordinator in this wraparound project
- Parent/family partner or other formal parent support role in this wraparound project
- Other provider or supervisor of direct wraparound practice employed in this wraparound project
- Family member or natural support on teams
- Youth
- Service provider not primarily employed in wraparound (therapist, parole officer, teacher, respite provider)
- Administrator of wraparound program
- Administrator of some other service program
- Other (please specify)

How long have you been involved with this wraparound program?

In terms of your ethnic or racial background, which of these best describes you?

- African American
- Latino/Hispanic
- Native American/American Indian
- Asian American
- Pacific Islander
- Caucasian/European American
- Other (please specify)

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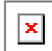
Theme 1: Community Partnership (7 items)



If you are unable to make a rating, please click "Don't know." There is space for comments at the end of this survey.

THEME 1-- Community Partnership: Collective community ownership of and responsibility for wraparound is built through collaborations among key stakeholder groups.

**In this theme, "community team" means a group of people who have formally organized themselves into a collaborative structure to take collective responsibility for the wraparound effort. Your community may have a different name for this group of people. Also, the "team" can take many forms, and may be composed of several smaller committees or forums that work together in a coordinated manner to set policies and make decisions, etc.

Item 1.1 Community Team

Fully developed system

There is a formal collaborative structure (e.g., a "community team" or other body) for joint planning and decision making through which community partners take collective responsibility for development and implementation of wraparound.

Least developed system

The wraparound effort is not supported by any collaborative system-level decision-making entity to oversee wraparound implementation, bust barriers and solve system-level problems.

- 4 - Fully developed
- 3 - Almost there
- 2 - Midway
- 1 - Beginning
- 0 - Least developed
- Don't know

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Item 1.2 Empowered Community Team

Fully developed system

The community team includes leaders who are empowered to make decisions and commit resources on behalf of their organizations to support the development and implementation of wraparound.

Least developed system

People who represent their agencies and organizations in planning and overseeing the wraparound effort do not have the power to make decisions or commit resources for wraparound on behalf of their organizations.

- 4 - Fully developed
- 3 - Almost there
- 2 - Midway
- 1 - Beginning
- 0 - Least developed
- Don't know

Item 1.3 Influential Family Voice

Fully developed system

Families are influential members of the community team and other community level decision-making entities, and they take active roles in wraparound program planning, implementation oversight, and evaluation. Families are provided with support and training so that they can participate fully and comfortably in these roles.

Least developed system

Family members are not actively involved in decision-making, or are uninfluential or "token" components of the community team, boards, and other collaborative bodies that plan programs and guide implementation and evaluation.

- 4 - Fully developed
- 3 - Almost there
- 2 - Midway
- 1 - Beginning
- 0 - Least developed
- Don't know

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Item 1.4 Influential Youth Voice

Fully developed system	Least developed system
Youth and young adults are influential members of the community team and other community level decision-making entities, and they take active roles in wraparound program planning, implementation oversight, and evaluation. Young people are provided with support and training so that they can participate fully and comfortably in these roles.	Young people are not actively involved in decision-making, or are uninfluential or "token" components of the community team, boards, and other collaborative bodies that plan programs, oversee implementation, and conduct evaluation.

- 4 - Fully developed
- 3 - Almost there
- 2 - Midway
- 1 - Beginning
- 0 - Least developed
- Don't know

Item 1.5 Full Agency Support

Fully developed system	Least developed system
Relevant public agencies (e.g., mental health, child welfare, schools, courts) and major provider organizations all collaborate with and participate actively and productively on the community team. These agencies and organizations fully "buy in" to the wraparound effort.	Relevant child-serving agencies and major provider organizations do not participate actively and constructively on the community team. The organizations or agencies that provide wraparound do so in the absence of "buy-in" from these other agencies and their staff.

- 4 - Fully developed
- 3 - Almost there
- 2 - Midway
- 1 - Beginning
- 0 - Least developed
- Don't know

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Item 1.6 Community Stakeholders

Fully developed system	Least developed system
The community team includes leaders from the business, service, faith and other sectors, who partner in system design, implementation oversight, and evaluation, and provide tangible resources (including human resources such as volunteers).	Few if any representatives of the business, service, faith or other sectors participate actively in the wraparound effort or provide tangible resources.

- 4 - Fully developed
- 3 - Almost there
- 2 - Midway
- 1 - Beginning
- 0 - Least developed
- Don't know

Item 1.7 Community Representativeness

Fully developed system	Least developed system
The membership of the community team reflects the social, cultural, and economic diversity of the community and the families served by wraparound.	Members on the community team and/or other collaborative bodies do not reflect the social, cultural, and economic diversity of the community and the families served by wraparound.

- 4 - Fully developed
- 3 - Almost there
- 2 - Midway
- 1 - Beginning
- 0 - Least developed
- Don't know

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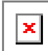
Theme 2: Collaborative Action.



If you are unable to make a rating, please click "Don't know." There is space for comments at the end of this survey.

THEME 2 Collaborative Action: Stakeholders involved in the wraparound effort take specific steps to translate the wraparound philosophy into concrete policies, practices and achievements.

Item 2.1 Community Principles & Values

Fully developed system

Key stakeholders in the wraparound effort have collectively developed and formally ratified statements of mission, principles, and desired outcomes that provide a clear direction for planning, implementation, and joint action.

Least developed system

Statements of mission, principles, and/or outcomes have not been developed. Each agency and organization has its own mission and values and there is no common vision or set of values or desired outcomes shared across agencies.

jn 4 - Fully developed jn 3 - Almost there jn 2 - Midway jn 1 - Beginning jn 0 - Least developed jn Don't know

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Item 2.2 High-Level Leadership

Fully developed system

The system has multiple high level leaders (e.g., senior agency administrators, elected officials, and other influential stakeholders) who understand wraparound and who actively support wraparound development by forging partnerships among agencies and organizations, changing policies, inspiring individual stakeholders, and creating effective fiscal strategies.

Least developed system

There are few if any high-level leaders in the system who truly understand or actively support wraparound development. Leaders are unable or unwilling to forge partnerships, integrate systems, or create effective fiscal strategies to support the wraparound effort.

- 4 - Fully developed
- 3 - Almost there
- 2 - Midway
- 1 - Beginning
- 0 - Least developed
- Don't know

Item 2.3 Proactive Planning

Fully developed system

The wraparound effort is guided by a plan for joint action that describes the goals of the wraparound effort, the strategies that will be used to achieve the goals, and the roles of specific stakeholders in carrying out the strategies.

Least developed system

There is no plan for joint action that describes goals of the wraparound effort, strategies for achieving the goals, or roles of specific stakeholders.

- 4 - Fully developed
- 3 - Almost there
- 2 - Midway
- 1 - Beginning
- 0 - Least developed
- Don't know

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Item 2.4 Joint Action Steps

Fully developed system

Collaborative and individual agency plans demonstrate specific and tangible collaborative steps (e.g., developing MOUs, contributing resources, revising agency regulations, participating in planning activities) toward achieving joint goals that are central to the wraparound effort.

Least developed system

Though there may be a stated commitment to the wraparound effort, agencies and other key stakeholders have NOT taken specific and tangible steps toward achieving central goals of the wraparound effort (such as developing MOUs, revising policies and regulations, etc).

- 4 - Fully developed
- 3 - Almost there
- 2 - Midway
- 1 - Beginning
- 0 - Least developed
- Don't know

Item 2.5 Partner Agency Staff Preparation

Fully developed system

The collaborating agencies take concrete steps to ensure that their staff members are informed about wraparound values and practice. All staff who participate directly in the wraparound effort do so in a manner that is in keeping with wraparound principles, such as collaborative, strengths-based, and respectful of families and youth.

Least developed system

Providers and agency personnel are not informed about the wraparound philosophy, and staff who participate in the wraparound effort are unable or unwilling to do so in a manner that is in keeping with wraparound principles.

- 4 - Fully developed
- 3 - Almost there
- 2 - Midway
- 1 - Beginning
- 0 - Least developed
- Don't know

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Item 2.6 Information Sharing

Fully developed system

Information is shared efficiently across systems (or is maintained centrally for the wraparound program) so as to provide the data needed to monitor wraparound quality, plan implementation, costs, and outcomes.

Least developed system

Agencies have not resolved legal issues and/or developed mechanisms for efficiently sharing the information that is required to monitor wraparound quality, plan implementation, costs, and outcomes.

- 4 - Fully developed
- 3 - Almost there
- 2 - Midway
- 1 - Beginning
- 0 - Least developed
- Don't know

Item 2.7 Single Plan

Fully developed system

The wraparound plan is the plan of care that structures and coordinates all partner agencies' work with a given child and family. The format and structure for documenting the plan reinforces relevant wraparound principles such as strengths-based, family-driven, and individualized.

Least developed system

Different agencies and systems that serve a child and family develop and maintain separate, uncoordinated plans of care; and/or the wraparound plan or other agency plans are recorded in ways that are not in keeping with wraparound principles (e.g., plans reflect deficit-based, family-blaming, or expert-driven perspectives).

- 4 - Fully developed
- 3 - Almost there
- 2 - Midway
- 1 - Beginning
- 0 - Least developed
- Don't know

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Item 2.8 State Interface

Fully developed system

The wraparound effort has an active and productive partnership with state agencies. This partnership has been successful in motivating policy and funding changes that support wraparound programs and practice.

Least developed system

There is no organized interface between the community and state agencies around children's services and supports. State level policies, regulations, and funding are in conflict with the community’s wraparound effort and different stakeholder groups are competing for different types of changes to rules, regulations, and laws.

- 4 - Fully developed
- 3 - Almost there
- 2 - Midway
- 1 - Beginning
- 0 - Least developed
- Don't know

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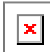
Theme 3: Fiscal Policies and Sustainability.



If you are unable to make a rating, please click "Don't know." There is space for comments at the end of this survey.

THEME 3 Fiscal Policies and Sustainability: The community has developed fiscal strategies to meet the needs of children participating in wraparound and methods to collect and use data on expenditures for wraparound-eligible children.

Item 3.1 Fiscal Understanding

Fully developed system

Agencies and decision makers have access to accurate information about the types and magnitudes of expenditures from all funding streams (e.g., mental health, special education, juvenile justice, developmental disabilities) for services and supports for all children with serious and complex needs (regardless of whether or not they are actually enrolled in wraparound).

Least developed system

Information about expenditures for services and supports is fragmented across different information systems/sources such that decision makers cannot determine the use and costs of services and supports for children with serious and complex needs (regardless of whether or not they are actually enrolled in wraparound).

- 4 - Fully developed
- 3 - Almost there
- 2 - Midway
- 1 - Beginning
- 0 - Least developed
- Don't know

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Item 3.2 Removing Fiscal Barriers

Fully developed system	Least developed system
The community collaborative has a formalized process for identifying and acting to remedy fiscal policies that impede the implementation of the wraparound program or the fulfillment of wraparound plans. Important changes to fiscal policies have been made.	The community collaborative lacks formal understanding of the ways in which fiscal policies act as barriers to the implementation of the wraparound program or the fulfillment of wraparound plans; and/or, where awareness exists, no action is taken to change policy.

- 4 - Fully developed
- 3 - Almost there
- 2 - Midway
- 1 - Beginning
- 0 - Least developed
- Don't know

Item 3.3 Collective Fiscal Responsibility

Fully developed system	Least developed system
Key decision-makers and relevant agencies assume collective fiscal responsibility for children and families participating in wraparound and do not attempt to shift costs to each other or to entities outside of the wraparound effort.	Each agency has its own cost controls and agencies do not collaborate to reduce cost shifting, either to each other or to entities outside of the wraparound effort.

- 4 - Fully developed
- 3 - Almost there
- 2 - Midway
- 1 - Beginning
- 0 - Least developed
- Don't know

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Item 3.4 Fiscal Monitoring

Fully developed system	Least developed system
There is a formalized mechanism for reviewing the costs of implementing the wraparound program and wraparound plans. This information is used to clarify/streamline spending policies and to seek ways to become more efficient at providing high-quality wraparound.	There is little or no information available about the costs of implementing the wraparound program or wraparound plans and/or what information is available is not used to streamline spending policies or improve efficiency.

- 4 - Fully developed
- 3 - Almost there
- 2 - Midway
- 1 - Beginning
- 0 - Least developed
- Don't know

Item 3.5 Fiscal Flexibility

Fully developed system	Least developed system
Funds are available to pay for services and supports, and funds are flexible, so that teams can fully implement the strategies included in individual wraparound plans and safety/crisis plans.	Financing policies are rigid and are largely or entirely designed to facilitate payment for categorical services. There is little latitude for flexibility to provide creative, individualized care for children, youth, and families.

- 4 - Fully developed
- 3 - Almost there
- 2 - Midway
- 1 - Beginning
- 0 - Least developed
- Don't know

Item 3.6 Sustained Funding

Fully developed system	Least developed system
There is a clear and feasible plan for sustaining fiscal support for the wraparound effort over the long term, and this plan is being fully implemented.	There is no clear and feasible plan for sustaining fiscal support for the wraparound effort.

- 4 - Fully developed
- 3 - Almost there
- 2 - Midway
- 1 - Beginning
- 0 - Least developed
- Don't know

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The Wraparound Process User's Guide

A Handbook for Families

ENGAGEMENT

PLANNING

IMPLEMENTATION

TRANSITION

A PRODUCT

of the

National Wraparound Initiative

The Wraparound Process User's Guide

Acknowledgments:

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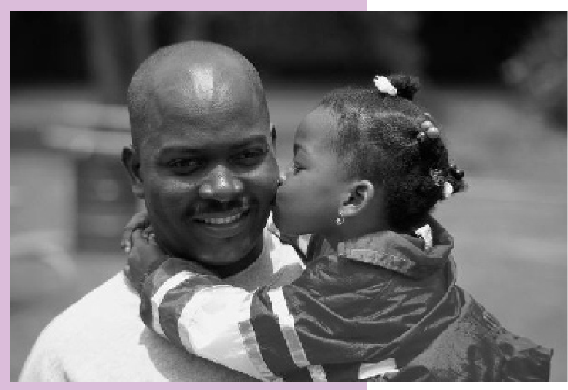
Welcome to Wraparound

Congratulations on your decision to consider the **wraparound process** as a way to plan and implement services and supports for your child or youth and family.

About the Process

Wraparound is a planning **process** that follows a series of steps to help children and their families realize their hopes and dreams. The wraparound process also helps make sure children and youth grow up in their homes and communities. It is a planning process that brings people together from different parts of the whole family's life. With help from one or more **facilitators**, people from the family's life work together, coordinate their activities, and blend their perspectives of the family's situation.



Wraparound may look different from one community to another. There also may be different types of facilitators. Though it may look different across communities, wraparound should always be driven by the same **principles**. In addition, wraparound should always follow the same basic **phases and activities**. This handbook will describe each of these phases and activities. The wraparound principles and a summary of the phases are listed on pages 22-23 of this handbook.

About this Guide

This **User's Guide** was created to serve as a "road map" for family members. You can use it to help make sure your family is on the right path, and make sure the process follows closely to the principles and activities of wraparound.

In the following pages, you will first see some basic summaries of the wraparound process, including a quick guide to wraparound and a list of common wraparound terms. In later sections, you will see more details on the wraparound process, including descriptions of each of the four phases of wraparound and notes on "troubleshooting" common problems that occur in each phase. You will also find checklists of things that should happen during wraparound, and documents and forms you should see along the way.

Before You Get Started: Wraparound Set-Up

The wraparound process is a team-based activity that helps groups of people involved in your family's life work together toward a common goal. For some wraparound teams, the goal is a **team mission**; for others, it is the family's **vision** of how things will look in the future. The process is organized and delivered by someone who is trained to facilitate the team. The team creates a plan that includes ways to assure that children/youth and their families can experience success in their communities, homes, and schools. Parts of the process will seem familiar to you while other parts of it will not. Before you get started you should consider these areas:

What do I need to know?

- You will be asked to help develop a **team** and make decisions with that team.
- You will be asked to identify your family's **strengths** and **needs.**
- You and your team will consider a variety of **actions** to meet needs.
- Your wraparound **plan** will change regularly.
- You and your team will get an opportunity to evaluate whether your plan is getting to the **results or outcomes** you want.

What can I expect?

- You can expect a **facilitator** to contact you to get to know you and your family.
- You can expect regular **team meetings.**
- You can expect to get **copies of all plans** and reports including your wraparound plan and your strengths inventory.
- You can expect your first youth/child and family team meeting to occur within three weeks of your initial conversation with your facilitator.
- You can expect that the wraparound facilitator may ask you to sign papers so that he or she can talk to other people in preparing for your first team meeting.
- Throughout the process, **you can expect to be respected and your voice to be heard.**

Before You Get Started: Wraparound Set-Up

What can I do to get started?

There is no requirement that the family has to do anything to get started with wraparound but if you want to be prepared, here are some suggestions:

- Make an initial **strengths list** of what each member of your family does well, what they like and what their best features are.
- Make a list of **who has been helpful** to you or your family as well as who cares about what happens to you.
- Think about **your goals** and what you would like your family life to be like in the future.

Where can I get more information?

Local contacts

- Ask your wraparound contact or representative to help you talk with another **family member** who has been through the process.
- Ask your wraparound contact or representative to connect you to a local **family organization** that can help you and give you information.

National Sources:

- National Federation of Families for Children's Mental Health www.ffcmh.org (240) 403-1901
- The National Wraparound Initiative – www.rtc.pdx.edu/nwi
- Systems of Care - The U.S. Substance Abuse and Mental Health Services Administration – www.systemsofcare.samhsa.gov

The Wraparound Process Quick Guide

Phase One: Engagement & Team Preparation

A **facilitator** or program representative meets with us to discuss the wraparound process and listen to our family's story. We discuss our concerns, needs hopes, dreams, and **strengths**. We describe our **vision** for the future. We identify people who care about us as a family as well as people we have found helpful for each family member. We reach agreement with the facilitator about who will come to a meeting to develop a plan and where we should have that meeting.

This phase takes several meetings over 1-2 weeks.

Phase Two: Initial Plan Development

We attend our first **Wraparound Team** meeting with people who are providing services to our family as well as people who are connected to us in a supportive role. The team will:

- Come up with a **Mission Statement** about what we all will be working on together
- Look at our family's **needs**
- Come up with several different **ways to meet those needs** that match up with our strengths
- Different team members will take on different tasks that we've agreed on.

When the meeting is over everyone will leave knowing what they have to do and how to contact other team members.

This phase takes 1-2 team meetings within 1-2 weeks.

Phase Three: Plan Implementation

Based on our planning meetings, our team has created a written **plan of care.** We have committed to some action steps, team members are committed to do the work, and our team comes together regularly. When our team meets we do four things:

- Review our **A***ccomplishments* (what we have done and what's been going well);
- **A***ssess* whether our plan has been working to achieve our goals;
- **A***djust* things that aren't working within the plan;
- **A***ssign* new tasks to team members.

This phase requires regular team meetings. Team members also complete assigned action steps. The Phase continues until we get the result we need.

Phase Four: Transition

Even though **transitions** happen throughout the process, there is a point when we will no longer need to meet regularly with the team. **Completion** may involve a final meeting of the whole team, a small celebration, or simply saying we are ready to move on. As a family we will get a record of what we did as well as list of what worked. We will also make a plan for the future, including who we can call on if we need help or if we need to re-convene our team.

Transitions happen throughout the process.

Completion may be done in one meeting or take several weeks.

A Quick List of Wraparound Terms

Action steps

Statements in a wraparound plan that describe specific activities that will be undertaken, including who will do them and within what time frame.

Facilitator

A person who is trained to coordinate the wraparound process for an individual family. This person may also be called Care Coordinator, Navigator, Wraparound Specialist, Resource Facilitator or some other term. The person in the facilitator role may change over time, depending on what the family thinks is working best. For example, a parent, caregiver, or other team member may take over facilitating team meetings after a period of time.

Formal supports

Services and supports provided by professionals (or other individuals who are "paid to care") under a structure of requirements for which there is oversight by state or federal agencies, national professional associations, or the general public arena.

Life domains

Areas of daily activity critical to healthy growth and development of a child or successful functioning of a family. Life domains include such areas as safety, school/work, health, social/fun, a place to live, legal issues, culture, behaviors, emotions, transportation, and finances.

Mission Statement

A statement crafted by the wraparound team that provides a one to two sentence summary of what the team is working toward with the youth and family.

Natural supports

Individuals or organizations in the family's own community, kinship, social, or spiritual networks, such as friends, extended family members, ministers, neighbors, and so forth.

Outcomes

Child, family, or team goals stated in a way that can be observed & measured.

A Quick List of Wraparound Terms

Plan of care or Wraparound plan

A dynamic document that describes the family, the team, and the work to be undertaken to meet the family's needs and achieve the family's long-term vision.

Strengths

Strengths are the assets, skills, capacities, actions, talents, potential and gifts in each family member, each team member, the family as a whole, and the community. In wraparound, strengths help family members and others to successfully navigate life situations; thus, a goal for the wraparound process is to promote these strengths and to use them to accomplish the goals in the team's plan of care.

Vision

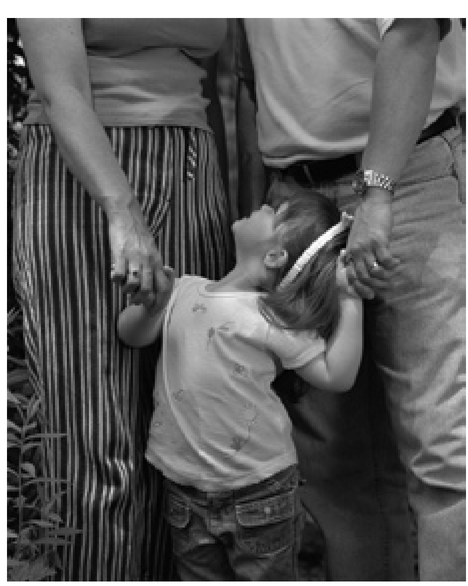
A statement constructed by the youth and family (with help from their facilitator and possibly the wraparound team) that describes how they wish things to be in the future, individually and as a family.

Wraparound Principles

A set of 10 statements that defines the wraparound philosophy and guides the activities of the wraparound process (see inside back cover).

Wraparound team

A group of people – chosen with the family and connected to them through natural, community, and formal support relationships – who develop and implement the family's plan, address unmet needs, and work toward the family's vision.



Description of the Wraparound Process

Phase One: Engagement & Team Preparation

The Engagement and Team Preparation phase should last for no more than three weeks.

You and your family will meet your **wraparound facilitator**. This initial meeting will be held at a location that you find most comfortable. It should seem more like a conversation than a formal meeting or intake appointment.

The wraparound facilitator will give you an opportunity to describe, from your perspective, what things have worked in the past to help your family and what you would like to see happen in the wraparound process. You will talk about people who care about your child/youth and family as well as who has been helpful for each family member.

The facilitator will listen closely as you describe your child and family. You will describe your family's beliefs and traditions as well as family members' **strengths** – things that they are good at and that help them to succeed. You and your child or youth will describe what you believe family members most need help with – what their **needs** are.

This initial meeting should last from one to three hours and will occur with you and your facilitator. Depending on your preference, the facilitator can meet first with you and then your child or youth, or you can all meet with the facilitator at the same time.

After this initial meeting, the facilitator will talk with other people in your life to get their commitment to participate on your **wraparound team**. You will then work with your facilitator to contact team members to invite them to your first **wraparound team meeting**.

A Note about Crisis Planning:

Throughout the wraparound process, crisis response will occur. In the first phase of the wraparound process, before the team even meets, immediate crises must be addressed and an initial crisis plan should be developed. During later phases, you and your team will work together to develop an effective crisis plan.

Good wraparound plans identify what could go wrong and how people should respond if they do. Good crisis planning assures the family and team an opportunity to practice the crisis response in much the same way that schools practice fire drills or law enforcement does disaster drills. Good crisis plans should also include who will notify who and when. Finally, good crisis plans should be portable – all team members should have a copy they can easily carry and refer to when they're needed.

Description of the Wraparound Process

Phase Two: Initial Plan Development

During the Plan Development phase, the wraparound team will meet once or twice to develop an overall wraparound plan.

The wraparound plan of care (or "wraparound plan") is like a continually updated agenda for your family as it goes through the process.

During the first planning meeting, your team members will introduce themselves and then will review the **strengths list** that was developed from talking with you and other team members. All team members will get a chance to add to that strengths list.

The facilitator will lead the team in creating a **team mission statement** that describes what you hope to accomplish through this process. To do this, you and your family will describe what you would like to see happen as a result of your team's effort. Then, other team members will add to your statement.

Eventually, those statements will be boiled down to one simple **mission statement** that you can all agree to and remember. This statement will serve to guide the team's work.

Next, **needs statements** for individual family members will be identified and recorded. Then you and your team will select up to five **needs** that will get you closer to realizing your team's mission and/or your family's vision.

The facilitator will lead the team in brainstorming **strategies** to meet the chosen needs. These strategies should be creative and individualized to your family's needs. When several strategies have been listed for each need, strategies that best match your strengths list and that you and your family think will be most effective will be chosen.

Action steps to implement these strategies will then be brainstormed. Volunteers will be selected from all team members to follow through on the action steps for the chosen strategies.

For each strategy, you and your child will also work with the team to identify **outcomes** that will let you know when the strategy has succeeded.

Results of this plan development phase should include the mission, strengths list, needs statements, strategies, outcomes, and action steps. These will be summarized in a **plan of care** or **wraparound plan** and distributed to team members.

This meeting should take no longer than 90 minutes. It may take two meetings to complete the wraparound plan. If it does take two meetings your team should plan the meetings to take place within a week to ten days of one another.

The Implementation Phase is characterized by regular team meetings that occur formally and regularly over many months. It is also the phase during which people follow through outside of team meetings to do what they committed to do.

Description of the Wraparound Process

Phase Three: Plan Implementation

Now that the initial **plan of care** has been developed, you and your **team members** are responsible for actually implementing it.

Ongoing team meetings

Ongoing team meetings follow a regular agenda that starts with **Accomplishments**. The facilitator asks team members to share accomplishments since the last meeting. This keeps the team focused in a positive way.

Second, you and your team members will **Assess whether the plan is working.** This involves looking at whether people did what they said they were going to do. This is a first check for follow through. It also involves identifying whether the **action step** actually helped to get the **strategy** accomplished. In addition, the team will review **outcomes** the family and team identified. As a family member, your input will be actively sought to check whether outcomes were accomplished, and whether your family's needs are being met.

When reviewing is done, the facilitator will lead the team in identifying any changes to the plan. **Adjustments** will happen by changing some action steps, stopping some actions, or adding some new ones. During this part of the team meeting, the group will do new brainstorming to come up with new strategies to meet old needs that have not been successfully met, or to address newly identified needs.

Finally, when the team has selected the next set of actions designed to meet needs, the team members will **Assign** and take responsibility for specific actions. After each meeting, the facilitator should update the plan of care to reflect the adjustments and assignments made by your team.

In initial stages of plan implementation, meetings are likely to occur at least every 2-4 weeks until the team identifies that they are making fewer and fewer adjustments. At that point, team meetings may only occur every 1-2 months.

Between team meetings:

Formal team meetings aren't the only way that work gets done in Wraparound. Between wraparound team meetings, you and your team members communicate as needed to complete the tasks listed in the plan. Team members have developed your plan together and everyone should have the same document describing the plan. In addition, the facilitator should be actively following up with team members about the success of action steps in between meetings. This should reduce the possibility of misunderstandings and result in a better situation for your family.

Description of the Wraparound Process

Phase Four: Transition

Sooner or later, you and your wraparound team will come up with the right mix of strategies and interventions, delivered in the right way at the right time. Your team will find that outcomes are being accomplished, and the team's mission has been met or is close to being met. Things will be going well for you and your family. At this point, **transition** is negotiated among all team members.

Transition planning should occur throughout the wraparound process.

The facilitator should have conversations with you and your child and family members to discuss transition regularly. Eventually, you and your facilitator will raise the issue and begins to have team members voice any ideas they may have.

The team then brainstorms follow-up options that will help and support your family to succeed outside of the formal wraparound structure. Team members also identify what type of follow-up support they can personally provide to the family. The facilitator and the team should also determine how to regularly check in with you and your youth/child and family.

The facilitator typically takes this information and puts it into a **transition plan** and returns it to the next team meeting for review. Once the team has reworked the transition plan the entire team negotiates a schedule for transition.

Finally, if its agreeable to you and your child or youth, the team figures out some sort of final **celebration** of the team's accomplishments and work well done.

Once this celebration or ritual is completed, the facilitator completes a **formal discharge letter** (which should be no more than 2-3 pages) identifying the family strengths as well as accomplishments of the team and interventions that were helpful.

All team members including the family get a copy of this final discharge summary in electronic or paper version so they can use it if they need to reenter a formal system for help in the future.

As the team negotiates and agrees on an ending, plans for follow-up care and response should be developed. The facilitator will lead the team in identifying who will introduce your family and the team's accomplishments to follow-up providers. This might include drafting a letter of introduction you can keep in their records or meeting with other service providers to describe what is going to be helpful or not. Sometimes this is most efficiently done in team meetings and other times it occurs outside of a team setting.

Wraparound Troubleshooting

Phase 1: Engagement and Team Preparation

Question:

This wraparound team process sounds good but things aren't going well for us right now. I'm afraid I can't wait for three weeks for some help for my son or daughter. Does this mean we shouldn't do wraparound?

Answer:

During the initial conversation with your facilitator, he or she will be prepared to help you make sure that things are safe and stable enough to move ahead with the team process. If you have concerns about safety bring them up right away and work on coming up with a temporary plan until you can have your first team meeting.

Question:

Things have been so bad for so long that I've decided that my son or daughter needs to go away from home to get help. Doesn't that mean we shouldn't do wraparound? Besides, other professionals who have worked with us have said that my child or youth needs this kind of treatment.

Answer:

Some families will end up considering out of home placement as an option. There are several things to remember about this. First, eventually your son or daughter will return home so it will be helpful to consider ways to plan for that day. Second, if you can identify your family's most pressing needs and start to look at ways to meet those needs, that may help other service providers do a better job of helping. Finally, there is a possibility that by using a team approach, we can come up with new ideas that might work and haven't been tried before.

Question:

The facilitator will be asking about friends and family as well as people who have provided services like counseling or education to join our Child and Family Team. What if I don't feel comfortable having our family issues discussed with family and friends?

Answer:

Wraparound planning brings people together to figure out what to do and how to help. The wraparound team process is not a place to discuss family issues but is a place for all of those on the team to look at your needs and decide what to do to meet those needs. Your privacy is important and should be protected even during a child and family team process. You can and should work with your facilitator to make sure that you are comfortable with who you have on your team, what's being said, and how it's being said during the team process.

Wraparound Troubleshooting

Phase 1: Engagement and Team Preparation

Question:	Answer:
How do I know that this just won't be more of the same?	You can't be sure. It is important to talk with your facilitator about what has worked for your family in the past as well as what hasn't worked. You might find it helpful to speak with other families who have been through the wraparound process in your community, to see how it worked for them. In addition, consider what you need to see happen to convince you that wraparound is working. The wraparound process should always be focused on looking for this kind evidence of success (sometimes called "outcomes"). If needs identified by you and your family are not being met, or goals set by you and your family are not being reached, the wraparound process should change.

Question:	Answer:
My son or daughter has been in so many meetings with so many adults who tell her or him what they've done wrong. I can't imagine that I can get him or her to even go to one of these meetings. What if they refuse to attend?	You can work with your facilitator to make sure your son or daughter feels welcome and comfortable. Be sure to give him or her time on the agenda to speak up and be heard. Sometimes the focus on strengths can also help reassure the young person. If your son or daughter isn't comfortable attending, you and the facilitator can come up with ways to make sure his or her voice is heard.

Question:	Answer:
The facilitator will be looking for my child and family's strengths. Does this mean that our problems will not be addressed?	The facilitator will be looking for strengths for several reasons. First, often we forget to look for strengths when confronted with challenges. Second, all services or actions should build on strengths. Your concerns will be addressed but solutions that build on strengths will be the way they are addressed.

Wraparound Troubleshooting

Phase 2: Initial Plan Development

Question:

Going over the strengths makes me feel a little uncomfortable or embarrassed. We know what we're good at. Does this have to happen?

Answer:

A key element of wraparound planning is the idea of shared responsibility. Posting strengths can help team members become willing to share responsibility. It is not unusual to have the strengths review feel a little unsettling. However, some families report that seeing their strengths posted makes them feel confident they can get where they need to go.

Question:

I'm worried that with all of this process we will never get down to business. Doesn't this take too long?

Answer:

An effective wraparound process that follows the steps outlined in this guide should not take too long. Remember that any goal worth reaching should take some time. Figuring out how to achieve challenging outcomes requires identifying underlying needs, identifying several ways to meet these needs, and coming up with a good plan.

Question:

With some reluctance, I agreed to have someone attend the wraparound team meeting. But I am afraid that this person will behave rudely or abusively toward me or just be hard to handle in the meeting.

Answer:

As the family, you "own" the content of the wraparound process because it's your story. The facilitator "owns" responsibility for the process itself. If you have concerns about people behaving disrespectfully during the team meeting, discuss them with the facilitator before the meeting and tell him or her what you would need to feel comfortable. If someone behaves rudely or negatively during the meeting, you should feel free to tell the facilitator that you're uncomfortable. A wraparound team can also work together to set ground rules for meetings that all members must agree to follow.

Wraparound Troubleshooting

Phase 3: Plan Implementation

Question:	Answer:
Things seemed to be going well until right after our wraparound team meeting. Now, I'm worried about how things are working and we're not scheduled for another wraparound team meeting for a long time. What can I do now?	When the team has moved to less frequent meetings because the plan of care seems to be working, a way to call an emergency meeting should be in place. This usually involves a telephone tree of all team members to make sure that no single person is responsible for pulling everyone together. You can call the facilitator or follow your emergency team meeting protocol.

Question:	Answer:
Sometimes I don't feel comfortable talking about needs in front of certain team members For example, I have some co-workers on my team who have been great. But I would like my son or daughter to participate in some activities that would require flexible funding help. I don't feel comfortable disussing this at a team meeting in front of my co-workers. Does this mean that they need to leave the team or that I just can't have these issues addressed?	Throughout the wraparound process, areas can arise that families would prefer not to have discussed in the presence of all of the team members. In a situation about flexible funding, the team may help identify the need and strategies to address the need. However, that action step can involve a meeting between you and the facilitator.

Question:	Answer:
We agreed to do something in our team meeting but I know one person isn't following through. What do I do now?	The ongoing planning process holds all team members accountable for follow through. When a team member can't follow through, the team should meet and can choose to try again or come up with a new strategy to meet the need. In addition, your facilitator may work with you and other team members to try to address these issues of follow through between meetings.

Wraparound Troubleshooting

Phase 3: Plan Implementation

Question:

We've been working with one service provider but it doesn't feel right. I'm not really on the same page as this person and I can't say that it's done any good. I would like to try another service provider but I don't want to hurt this person's feelings. How do I go about that?

Answer:

When you go through the wraparound process you get to rate whether outcomes for each strategy are being achieved, and whether your needs are getting met. If needs are not being met, the team brainstorms other solutions. One solution could be to try a new person. If you are concerned about hurt feelings, feel free to speak with your facilitator or another team member for ideas about how to handle this.

Question:

We had a great team this year but now it's the end of the school year and we're looking at a new teacher next year. I'm worried about how it will be with a new person who wasn't here for this initial planning. Are we going to have to start the team process all over again?

Answer:

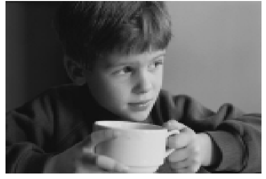
During this phase, team members will often come and go as the plan is adjusted. The facilitator is responsible for orienting new team members to wraparound and assisting them to become part of the process. New team members may include new service providers or educators, family members who were not initially involved, friends of the family, clergy, or others who have reconnected with you or connected with you for the first time.

Wraparound Troubleshooting

Phase 4: Transition

Question:	Answer:
The issues that we were facing are still issues even though we are completing the wraparound process. Some families who go through this process are dealing with lifetime challenges like mental illness or addiction, or chronic illness. Since the old issues still remain, if things get bad again will we need to start wraparound again?	Part of transitioning is for a family to locate services and supports in the community for possible future use. You should work with team members and the facilitator to make sure you feel confident about accessing future services, and even reconvening your team, if necessary.

Question:	Answer:
The best thing that wraparound did for me and my family was to get all of us on the same page. I can't imagine that this is going to happen without a wraparound team. Won't I just go back to where we started with lots of people failing to understand us?	You should work with your facilitator and team members to make sure you get copies of your strengths summaries, the discharge summary and other documents so you can use those to introduce your family to others. You may look to your local family organization for help and support. Finally, your transition plan should include good strategies generated by your team about how to stay connected to important team members and other who will support you in the future.

Question:	Answer:
I enjoyed the wraparound process and feel like I just got used to it. I worry that I'll be all alone without these connections. What do I do next? 	Families often find that they want to maintain the relationships with individual team members, but they don't necessarily want to continue the formal structure. You also might consider volunteering to be available to speak to new families about the wraparound process. Your facilitator should also have a way to follow-up with you, so that if you need to have another formal team meeting, that can happen.

Question:	Answer:
Our family really felt good about the strengths and accomplishment activities. Going through a formal review of strengths regularly helped us remember good news and be a little easier on each other. How can I keep from sinking back into our old patterns?	Many families find elements of the wraparound ritual helpful and implement them on an informal basis. For example, some families hold regular family meetings within the household to consider strengths and accomplishments while others talk about needs as a way to understand behavior.

Documents and Forms families are likely to see during each phase

Technical Notes

Engagement & Team Preparation Phase

Documents:

- ❒ Strength Summary or Discovery
- ❒ Strength list or inventory
- ❒ List of Potential Youth/Child & Family Team members

Forms:

- ❒ Form providing initial permission to provide services
- ❒ Release(s) allowing Facilitator to speak with other team members

Initial Plan Development Phase

Documents:

- ❒ Plan of Care that includes Team Mission, most important needs, actions that detail who is responsible to follow through when.
- ❒ Written crisis plan that includes who will do what when things go wrong and who should be called in what order
- ❒ Schedule of future team meetings

Forms:

- ❒ Permission(s) and release(s) if new service providers are called.

Plan Implementation Phase

Documents:

- ❒ Team minutes that detail team accomplishments, changes to the plan and schedule of meetings.
- ❒ Regular progress reports that reflect progress made from the original plan.

Forms:

- ❒ Updated releases for team members especially if new ones are added.

Transition Phase

Documents:

- ❒ Transition plan that describes how ongoing services will be accessed if necessary
- ❒ Crisis plans that includes communication protocols for those who will be contacted in the event of an emergency
- ❒ Follow-up phone numbers for all team members who might be contacted
- ❒ Formal discharge plan that describes strengths of the family, the interventions that were successful and those that weren't

Forms:

- ❒ Discharge summary

Wraparound Checklist

Engagement & Team Preparation Phase

- ❐ Met with **facilitator** and explained our story
- ❐ Addressed immediate needs and crises and put together an initial **crisis plan**
- ❐ Generated a **strengths** list
- ❐ Generated a **team member** list
- ❐ Agreed on first **meeting**
- ❐ Agreed on who will contact potential **team members**
- ❐ Got more **information** about this process

Initial Plan Development Phase

- ❐ Participated in one or two youth/family **team meetings**
- ❐ Our **strengths** were listed and reviewed
- ❐ Developed a **Team Mission Statement** that reflects what we and other team members hope to get out of this
- ❐ Reviewed **needs** that reflect our concerns and worries
- ❐ Picked a few **needs** to keep us and the team from becoming overwhelmed
- ❐ Brainstormed a variety of **strategies** to meet those needs
- ❐ Chose **strategies** to meet those needs which matched to our strengths
- ❐ All team members are reflected as doing something in the plan
- ❐ The wraparound **plan of care** has been distributed to all team members

Plan Implementation & Refinement Phase

- ❐ **Activities** promised are being provided
- ❐ **Accomplishments** are reviewed and recorded
- ❐ **Assessment** of the plan is occurring
  - ❐ Team is meeting often enough to check on follow through
  - ❐ We're being asked if actions are meeting our needs
- ❐ **Adjustment** of the plan is occurring based on our feedback
- ❐ **Assignments** are being made and recorded at each team meeting
- ❐ Copies of the minutes and updated plan of care is sent to all team members
- ❐ Regular progress reports are written and sent out
- ❐ We practice what to do if a crisis occurs with our family and the team

Transition

- ❐ We have held **practice crisis drills** and are confident we know what to do if things go wrong
- ❐ We have a way to **access services** in the future
- ❐ We have a way to **connect with other families** who have been through the process
- ❐ Our concerns have been considered
- ❐ We have a list of **team member** phone numbers who we can contact if needed
- ❐ Leaving Wraparound has been discussed with the whole team
- ❐ We have **written documents** that describe our strengths and accomplishments

Helpful Hint:

Use this checklist to keep track of how your wraparound process is going.

The Wraparound Road Map: An Overview

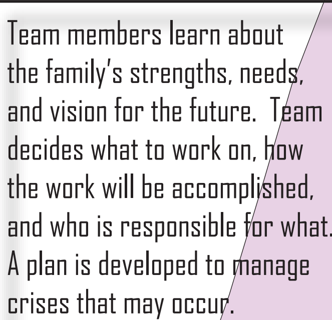
As the team nears its goals, preparations are made for the family to transition out of formal wraparound. Family and team decide how family will continue to get support when needed, and how wraparound can be "re-started" if necessary.

Transition

[Ongoing]

Plan Implementation

[9-18 months]



Family and Team members meet regularly. Team reviews accomplishments and progress toward goals, and makes adjustments. Family and team members work together to implement the plan.

Team members learn about the family's strengths, needs, and vision for the future. Team decides what to work on, how the work will be accomplished, and who is responsible for what. A plan is developed to manage crises that may occur.

Planning Phase

[1-2 weeks]

Family meets facilitator. Together they explore the family's strengths, needs and culture. They talk about what has worked in the past, and what to expect from wraparound. Facilitator engages other team members, and prepares for first meeting.

Engagement Phase

[2-3 weeks]

10 Principles of the Wraparound Process

1. **Family voice and choice.** Family and youth/child perspectives are intentionally elicited and prioritized during all phases of the wraparound process. Planning is grounded in family members' perspectives, and the team strives to provide options and choices such that the plan reflects family values and preferences.

2. **Team based.** The wraparound team consists of individuals agreed upon by the family and committed to them through informal, formal, and community support and service relationships.

3. **Natural supports.** The team actively seeks out and encourages the full participation of team members drawn from family members' networks of interpersonal and community relationships. The wraparound plan reflects activities and interventions that draw on sources of natural support.

4. **Collaboration.** Team members work cooperatively and share responsibility for developing, implementing, monitoring, and evaluating a single wraparound plan. The plan reflects a blending of team members' perspectives, mandates, and resources. The plan guides and coordinates each team member's work towards meeting the team's goals.

5. **Community-based.** The wraparound team implements service and support strategies that take place in the most inclusive, most responsive, most accessible, and least restrictive settings possible; and that safely promote child and family integration into home and community life.

6. **Culturally competent.** The wraparound process demonstrates respect for and builds on the values, preferences, beliefs, culture, and identity of the child/youth and family, and their community.

7. **Individualized.** To achieve the goals laid out in the wraparound plan, the team develops and implements a customized set of strategies, supports, and services.

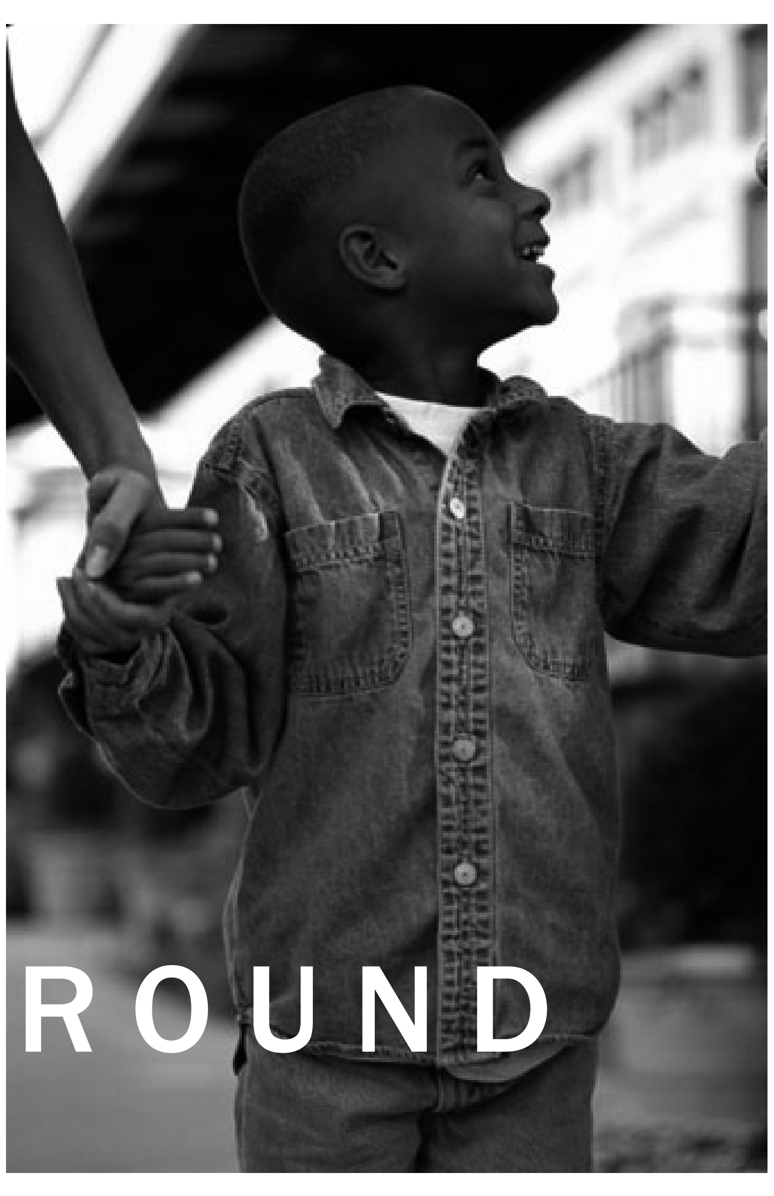
8. **Strengths based.** The wraparound process and the wraparound plan identify, build on, and enhance the capabilities, knowledge, skills, and assets of the child and family, their community, and other team members.

9. **Persistence.** Despite challenges, the team persists in working toward the goals included in the wraparound plan until the team reaches agreement that a formal wraparound process is no longer required.

10. **Outcome based.** The team ties the goals and strategies of the wraparound plan to observable or measurable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly.

THE WRAPAROUND PROCESS USER'S GUIDE

Helping children and families realize their hopes and dreams.



WRAPAROUND

The Wraparound Process User's Guide is a product of the National Wraparound Initiative, a project that includes over 100 advisors from across the country and from all walks of life. The NWI is an attempt to engage experts nationally in a process of defining standards for high-quality wraparound, and disseminating supports to communities to implement the wraparound process. In addition to this *Handbook for Families*, you can find many additional documents about wraparound on the Initiative's website at www.rtc.pdx.edu/nwi.

Manual de Usuario del Proceso del Wraparound (Asistencia Integral)

Una Guía para Familias

COMPROMISO

PLANIFICACIÓN

IMPLEMENTACIÓN

TRANSICIÓN

UN PRODUCTO

de la

National Wraparound Initiative

La producción de esta Guía fue respaldada por la Organización de Asistencia Técnica para la Salud Mental del Niño y la Familia

El Proceso del Wraparound (Asistencia Integral) Guía del Usuario

Reconocimientos:

El trabajo de la National Wraparound Initiative (Iniciativa Nacional del Wraparound) ha recibido el apoyo de diversas fuentes, incluyendo la Rama del Niño, Adolescente y Familia del Centro para Servicios de Salud Mental, la Administración de Servicios de Salud Mental y Abuso de Sustancias de los EE.UU.; el Centro para Servicios de Medicare y Medicaid Services (no. de subvención 11-P-92001/3-01); el Departamento de Maryland de Servicios Juveniles; y la Oficina del Gobernador de Maryland para el Control y la Prevención del Crimen.

La producción de esta Guía fue respaldada por la Organización de Asistencia Técnica para la Salud Mental del Niño y la Familia. Visite el sitio web de la Sociedad de Asistencia Técnica en www.tapartnership.org para mayor información.

www.systemsofcare.samhsa.gov

Esta Guía del Usuario fue preparada por Patricia Miles. Pat recibió la ayuda de Trina W. Osher de la Federación Nacional de Familias para la Salud Mental de los Niños y de Eric Bruns y Janet Walker de la Iniciativa Nacional del Wraparound. Alice Galloway del Wraparound Oregon y April Sather de la Universidad de Washington estuvieron a cargo de la disposición de las páginas y el diseño.

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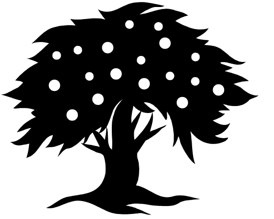
Bibliografía Sugerida: Miles, P., Bruns, E.J., Osher, T.W., Walker, J.S., & National Wraparound Initiative Advisory Group (2006). The Wraparound Process User's Guide: A Handbook for Families. Portland, OR: National Wraparound Initiative, Research and Training Center on Family Support and Children's Mental Health, Portland State University.



UN PRODUCTO de la **National Wraparound Initiative**

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Bienvenido al Wraparound

Felicitaciones por su decisión de considerar el **proceso del Wraparound** como una manera de planear e implementar servicios y apoyo para su hijo o joven y familia.

Acerca del Proceso

El **Wraparound** es un **proceso** de planificación que sigue una serie de pasos para ayudar a los niños y sus familias a realizar sus sueños y esperanzas. El proceso del Wraparound también ayuda a asegurar que los niños y jóvenes crezcan dentro de sus hogares y comunidades. Es un proceso de planificación que une a las personas de distintas partes de la vida familiar. Con la ayuda de uno o más **facilitadores**, las personas de la vida familiar trabajan juntas, coordinan sus actividades, y comparten sus perspectivas sobre la situación familiar.

El Wraparound puede verse diferente entre una comunidad y otra. También pueden haber distintos tipos de facilitadores. Aunque pueda verse diferente en las diversas comunidades, El Wraparound siempre debe seguir los mismos **principios**. El Wraparound también debe seguir siempre las mismas **fases y actividades básicas**. Esta guía describirá cada una de estas fases y actividades. Los principios del Wraparound y un resumen de las fases aparecen en las páginas 22-23 de esta guía.

Acerca de Esta Guía

Esta **Guía del Usuario** fue creada para que funcionara como "hoja de ruta" para los miembros de la familia. Usted puede usarla para asegurarse que su familia vaya por el buen camino, y para asegurar que el proceso siga de cerca los principios y actividades del Wraparound.

En las páginas siguientes, primero verá algunos de los resúmenes básicos del proceso del Wraparound, incluyendo una guía rápida al Wraparound y una lista de términos comunes sobre el Wraparound. En secciones posteriores, verá más detalles sobre el proceso del Wraparound, incluyendo descripciones de cada una de las cuatro fases del Wraparound y notas sobre cómo solucionar problemas comunes que ocurren en cada fase. También encontrará listas de control de cosas que deben suceder durante el Wraparound, y documentos y formularios que encontrará en el camino.

Antes de Empezar: Organización del Wraparound

El proceso del Wraparound es una actividad basada en equipos, que ayuda a grupos de personas involucradas en su vida familiar, a trabajar en conjunto para lograr una meta en común. Para algunos equipos del Wraparound, la meta es una **misión de equipo;** para otros, es la **visión** de la familia, de cómo se verán las cosas en el futuro. El proceso lo organiza y provee alguien capacitado para facilitar el equipo. El equipo crea un plan que incluye maneras de asegurar que los niños/jóvenes y sus familias puedan experimentar el éxito en sus comunidades, hogares y escuelas. Ciertas partes del proceso le parecerán familiares, mientras que otras, no. Antes de empezar, debería tomar en cuenta estas áreas:

¿Qué necesito saber?

- Se le pedirá que ayude a desarrollar un **equipo** y que tome decisiones con ese equipo.
- Se le pedirá que identifique las **fortalezas** y **necesidades** de su familia.
- Usted y su equipo tendrán que considerar una variedad de **acciones** para satisfacer las necesidades.
- Su **plan** del Wraparound cambiará de manera regular.
- Usted y su equipo tendrán la oportunidad de evaluar si su plan está obteniendo los **resultados** o **efectos** que desea.

¿Qué puedo esperar?

- Puede esperar a que un **facilitador** se comunique para conocerlo a usted y a su familia.
- Puede esperar **reuniones del equipo** de una manera consistente.
- Puede esperar obtener **copias de todos los planes** e informes incluyendo su plan del Wraparound y su inventario de fortalezas.
- Puede esperar que su primera reunión de su equipo del Wraparound ocurra dentro de las tres semanas posteriores a su conversación con el facilitador.
- Puede esperar que el facilitador del Wraparound le solicite firmar unos documentos para que él/ella pueda hablar con otras personas que lo prepararán para su primera reunión con el equipo.
- A lo largo del proceso, **puede esperar ser respetado y que su voz sea escuchada.**

Antes de Empezar: Organización del Wraparound

¿Qué puedo hacer para empezar?

No hay ningún requisito que la familia deba cumplir para empezar con el Wraparound, pero si desea estar preparado, he aquí algunas sugerencias:

- Prepare una **lista de fortalezas** inicial sobre lo que cada miembro de su familia puede hacer bien, lo que a cada miembro le gusta y cuáles son sus mejores cualidades.
- Prepare una lista sobre **quién lo ha ayudado** a usted o a su familia, así como quién se preocupa por lo que le pase a usted.
- Piense en **sus metas** y también en cómo le gustaría que fuese su vida familiar en el futuro.

¿Dónde puedo conseguir más información?

Contactos Locales

- Solicite a su contacto o representante del Wraparound que le ayude a hablar con otro **miembro de otra familia** que haya pasado por el mismo proceso.
- Solicite a su contacto o representante del Wraparound que lo relacione con una **organización de apoyo familiar** local que lo ayude y le brinde información.

Fuentes Nacionales:

- Federación de Familias para la Salud Mental de los Niños (National Federation of Families for Children's Mental Health) www.ffcmh.org (240) 403-1901
- Iniciativa Nacional del Wraparound (National Wraparound Initiative) – www.rtc.pdx.edu/nwi
- Sistemas de Cuidado (Systems of Care) - Administración de Servicios de Abuso de Substancias y Salud Mental de Estados Unidos (U.S. Substance Abuse and Mental Health Services Administration) www.systemsofcare.samhsa.gov

La Guía Rápida del Proceso del Wraparound

Fase Uno: Compromiso y Preparación del Equipo

Un **facilitador** o representante del programa se reúne con nosotros para discutir el proceso del Wraparound y escuchar nuestra historia familiar. Hablamos sobre nuestras inquietudes, necesidades, esperanzas, sueños y **fortalezas**. Describimos nuestra **visión** del futuro. Identificamos a las personas que se interesan por nosotros como familia, así como a las personas que cada miembro de la familia considera que las han ayudado. Llegamos a un acuerdo con el facilitador sobre quién vendrá a la reunión para desarrollar un plan y dónde debemos llevar a cabo esa reunión.

Esta fase requiere de diversas reuniones en el lapso de 1-2 semanas.

Fase Dos: Desarrollo del Plan Inicial

Asistimos a nuestra primera reunión con el **Equipo del Wraparound** con las personas que están ofreciendo servicios a nuestra familia, así como con las personas que nos dan apoyo interpersonal. El Equipo:

- Se presentará con una **Declaración de la Misión** acerca de lo que todos estaremos haciendo juntos
- Observará las **necesidades** de nuestra familia
- Se presentará con diversas **maneras diferentes de satisfacer todas aquellas necesidades** que coinciden con nuestras fortalezas
- Los diferentes miembros del equipo asumirán diversas tareas previamente acordadas.

Cuando termine la reunión, todos nos iremos sabiendo lo que hay que hacer y cómo contactarse con otros miembros del equipo.

Esta fase requiere de 1-2 reuniones del equipo en el lapso de 1-2 semanas.

Fase Tres: Implementación del Plan

En base a nuestras reuniones de planificación, nuestro equipo ha creado un **plan de cuidado** por escrito. Nosotros nos hemos comprometido con algunos pasos a seguir, los miembros del equipo están comprometidos a hacer el trabajo, y nuestro equipo se reúne frecuentemente. Cuando nuestro equipo se reúne, hacemos cuatro cosas:

- Revisamos nuestros **L***ogros* (lo que hemos hecho y lo que ha estado funcionando bien);
- **E***valuamos* si nuestro plan ha estado funcionando para alcanzar nuestras metas;
- **A***justamos* las cosas que no están funcionando según el plan;
- **A***signamos* nuevas tareas a los miembros del equipo.

Esta fase requiere reuniones del equipo de manera regular. Los miembros del equipo también completan los pasos a seguir asignados. La Fase continúa hasta que obtenemos el resultado que necesitamos.

Fase Cuatro: Transición

Aunque las **transiciones** ocurren a lo largo del proceso, existe un punto en que ya no necesitaremos reuniones de manera regular con el equipo. La **Culminación** puede incluir una reunión final del equipo completo, una pequeña celebración, o simplemente anunciar que estamos listos para seguir adelante. Como familia, tendremos un registro de lo que hicimos y una lista de lo que sí funcionó. También haremos un plan para el futuro, incluyendo a quién se puede llamar en caso de ayuda o si necesitamos volver a reunirnos con nuestro equipo.

Las transiciones ocurren en todo el proceso.

La culminación puede llevarse a cabo en una reunión o durar varias semanas.

Una Lista Rápida de Términos del Wraparound

Pasos a seguir

Las declaraciones de un plan del Wraparound que describen las actividades específicas que se llevarán a cabo, incluyendo quiénes las van a hacer y dentro de qué lapso de tiempo.

Facilitador

Una persona capacitada para coordinar el Wraparound de una familia individual. Esta persona también puede llamarse Coordinador de Cuidados, Navegante, Especialista en Wraparound, Facilitador de Recursos o cualquier otro término. La persona bajo el rol de facilitador puede cambiar con el tiempo, según lo que la familia considere que es mejor. Por ejemplo, un padre, tutor, u otro miembro del equipo puede asumir las reuniones del equipo luego de un período de tiempo.

Apoyo formal

Los servicios y apoyo proporcionados por profesionales (u otras personas a quienes se les "paga por asistencia") bajo una estructura de requerimientos, sobre quienes se ejerce supervisión por parte de agencias estatales o federales, asociaciones profesionales nacionales, o público en general.

Aspectos de la vida

Las áreas de actividad diaria importantes para el crecimiento y desarrollo saludables de un niño o funcionamiento exitoso de una familia. Los aspectos de la vida incluyen áreas tales como: seguridad, escuela/trabajo, salud, sociabilidad/diversión, un lugar para vivir, aspectos legales, cultura, comportamiento, emociones, transporte y finanzas.

Declaración de la Misión

Una declaración elaborada por el equipo del Wraparound que ofrece un resumen de entre una y dos oraciones sobre el trabajo del equipo con respecto a los jóvenes y la familia.

Apoyo natural

Personas u organizaciones en la propia comunidad de la familia, o en sus redes sociales o espirituales, como: amigos, parientes, ministros, vecinos, etc.

Resultados

Metas de los niños, la familia o el equipo, determinadas de una manera en que pueden ser observadas y cuantificadas.

Una Lista Rápida de Términos del Wraparound

Plan de cuidados o plan del Wraparound

Un documento dinámico que describe a la familia, el equipo, y el trabajo que se llevará a cabo para satisfacer las necesidades de la familia y alcanzar la visión de la familia a largo plazo.

Fortalezas

Las fortalezas son los activos, habilidades, capacidades, acciones, talentos, potencial y dones de cada miembro de la familia, cada miembro del equipo, la familia como un todo, y la comunidad. En el Wraparound, las fortalezas ayudan a los miembros de la familia y otros a conducir con éxito las situaciones de la vida; por tanto, una meta del proceso del Wraparound es la de promover estas fortalezas y utilizarlas para lograr las metas del plan de cuidados del equipo.

Visión

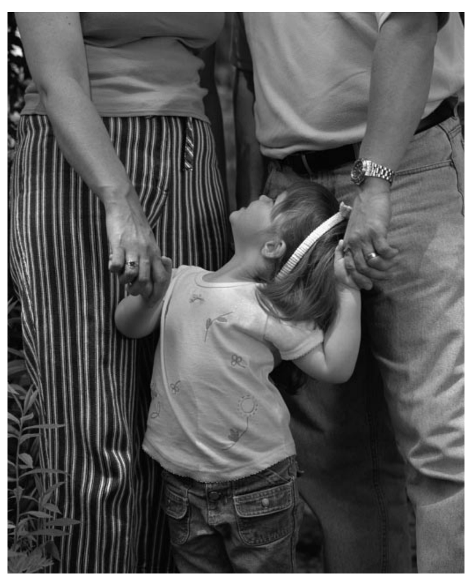
Una declaración elaborada por los jóvenes y la familia (con la ayuda de su facilitador y posiblemente del equipo del Wraparound) que describe cómo desean que sean las cosas en el futuro, de manera individual y como familia.

Principios del Wraparound

Un conjunto de 10 declaraciones que define la filosofía del Wraparound y guía las actividades del proceso del Wraparound (ver dentro de la contratapa).

Equipo del Wraparound

Un grupo de personas—elegidas con la familia y conectados a ella a través de relacionaes de apoyo naturales, comunitarias y formales—que desarrollan e implementan el plan de la familia, tratan las necesidades no satisfechas, y trabajan hacia la visión de la familia.



Descripción del Proceso del Wraparound

Fase Uno: Compromiso y Preparación del Equipo

La fase de Compromiso y Preparación del Equipo no debe tomar más de tres semanas.

Usted y su familia conocerán a su **facilitador del Wraparound**. Esta reunión inicial se llevará a cabo en el lugar que le parezca más cómodo. Deberá considerarla como una conversación más que una reunión formal o una cita de admisión.

El facilitador del Wraparound le dará la oportunidad de describir, desde su propia perspectiva, qué cosas han funcionado bien en el pasado para ayudar a su familia y qué le gustaría que ocurriera en el proceso del Wraparound. Hablará sobre las personas que cuidan a su niño/joven y a la familia, así como a las personas que cada miembro de la familia considera que las han ayudado.

El facilitador escuchará de cerca a medida que usted describe a su hijo y a su familia. Describirá las creencias y las tradiciones de su familia, al igual que las **fortalezas** de los miembros de la familia -las cosas en las que son buenos y que los ayuda a alcanzar el éxito. Usted y su niño o joven describirán lo que consideran en qué necesitan más ayuda los miembros de la familia -cuáles son sus **necesidades**.

Esta reunión incial debe durar entre una y tres horas y se llevará a cabo con usted y su facilitador. Según su preferencias, el facilitador podrá reunirse primero con usted y luego con su niño o joven, o sino todos juntos pueden conocer al facilitador a la vez.

Luego de esta reunión incial, el facilitador hablará con otras personas en su vida para obtener su compromiso de participar en su **Equipo del Wraparound**.
Luego trabajará con su facilitador para contactar a los miembros del equipo e invitarlos a su primera **reunión con el equipo del Wraparound**.

Una Nota sobre la Planificación de la Crisis:

A lo largo del proceso del Wraparound, ocurrirán reacciones a la crisis. En la primera fase del proceso del Wraparound, incluso antes que el equipo se reúna, deberán tratarse las crisis inmediatas y desarrollarse un plan de crisis inicial. Durante las fases posteriores, usted y su equipo trabajarán juntos para desarrollar un plan de crisis efectivo.

Los planes buenos del Wraparound identifican qué podría ir mal y cómo deberían responder a eso las personas, si lo desean. Una buena planificación de la crisis asegura una oportunidad de practicar la reacción a la crisis para la familia y el equipo de manera muy similar a la práctica de simulacros de incendios en las escuelas o de simulacros de desastres en seguridad pública. Los buenos planes de crisis también deben incluir quién notificará a quién y cuándo. Finalmente, los buenos planes de crisis deben poder llevarse con uno mismo -todos los miembros del equipo deben tener una copia que puedan cargar fácilmente y revisarla cuando sea necesario.

Descripción del Proceso del Wraparound

Fase Dos: Desarrollo del Plan Inicial

Durante la fase del Desarrollo del Plan, el equipo del Wraparound se reunirá una o dos veces para desarrollar un plan general del Wraparound.

El plan de cuidados del Wraparound (o "plan del Wraparound") es como una agenda que se actualiza constantemente para su familia a medida que pasa a través del proceso.

Durante la primera reunión planeada, los miembros de su equipo se presentarán y luego revisarán la **lista de fortalezas** que fue desarrollada cuando hablaron con usted y los otros miembros del equipo. Todos los miembros del equipo tendrán la oportunidad de añadir cosas a aquella lista de fortalezas.

El facilitador guiará al equipo en la creación de una **delacración de la misión del equipo** que describa lo que espera lograr a través de este proceso. Para hacerlo, usted y su familia describirán lo que desean que ocurra como resultado del esfuerzo de su equipo. Luego, otros miembros del equipo aportarán ideas a su declaración.

Eventualmente, esas declaraciones se reducirán a una **declaración de misión** única que todos puedan aceptar y recordar. Esta declaración servirá para guiar el trabajo del equipo.

Luego, se identificarán y registrarán **las declaraciones de necesidades** para miembros individuales de la familia. Posteriormente, usted y su equipo seleccionarán hasta cinco **necesidades** que lo acercarán a entender la misión de su equipo y/o la visión de su familia.

El facilitador guiará al equipo para sugerir **estrategias** y cumplir con las necesidades elegidas. Estas estrategias deben ser creativas e individualizadas para las necesidades de su familia. Cuando se hayan mencionado diversas estrategias para cada necesidad, se elegirán aquellas que mejor coincidan con su lista de fortalezas, y que usted y su familia piensan que serán las más efectivas.

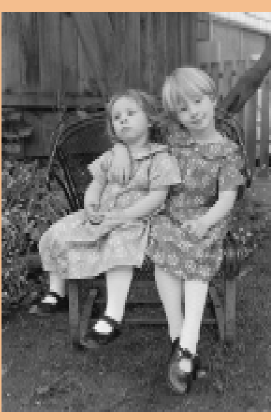
Los pasos de acción a tomar para implementar estas estrategias se sugerirán luego. Se elegirán voluntarios de todos los miembros del equipo para llevar a cabo los pasos de acción a tomar para las estrategias elegidas.

Para cada estrategia, usted y su hijo también trabajarán con el equipo para identificar los **resultados** que le indicarán que la estrategia ha tenido éxito.

Los resultados de esta fase de desarrollo del plan deben incluir la misión, la lista de fortalezas, las declaraciones de necesidades, las estrategias, los resultados y los pasos de acción a tomar. Estas se resumirán en un **plan de cuidados** o **plan del Wraparound** y se distribuirán a los miembros del equipo.

Esta reunión no tomará más de 90 minutos. Podrá tomar dos reuniones para completar el plan del Wraparound. Si toma dos reuniones, su equipo deberá planear las reuniones para que se lleven a cabo dentro de una semana a diez días de la otra.

La Fase de Implementación se caracteriza por reuniones regulares del equipo que ocurren de manera formal y regular durante muchos meses. También es la fase durante la cual las personas continúan el seguimiento fuera de las reuniones del equipo para llevar a cabo lo que se comprometieron a hacer.



Descripción del Proceso del Wraparound

Fase Tres: Implementación del Plan

Ahora que se ha desarrollado el **plan de cuidados** inicial, usted y los **miembros de su equipo** son responsables de implementarlo.

Reuniones continuas del equipo

Las reuniones continuas del equipo siguen una agenda regular que empieza con **Logros**. El facilitador pide a los miembros del equipo que compartan sus logros desde la última reunión. Esto hace que el equipo se mantenga enfocado de una manera positiva.

En segundo lugar, usted y los miembros de su equipo **Evaluarán si su plan está funcionando.** Esto incluye observar si las personas están haciendo lo que dijeron que iban a hacer. Esta es una primera revisión para el seguimiento. También incluye identificar si los **pasos de acción a tomar** realmente ayudaron a lograr la estrategia. Adicionalmente, el equipo revisará los **resultados** identificados por la familia y el equipo. Como miembro de la familia, se esprará su participación activa para revisar si se lograron los resultados, y si se están satisfaciendo las necesidades de su familia.

Cuando la revisión esté lista, el facilitador guiará al equipo para identificar cualquier cambio en el plan. Se efectuarán **Ajustes** cambiando algunos pasos de la acción a tomar, o añadiendo otros nuevos. Durante esta parte de la reunión del equipo, el grupo hará una nueva lluvia de ideas a fin de obtener nuevas estrategias para satisfacer antiguas necesidades que no se hayan satisfecho adecuadamente, o para tratar nuevas necesidades identificadas.

Finalmente, cuando el equipo haya seleccionado el siguiente conjunto de acciones designadas para satisfacer las necesidades, los miembros del equipo **Asignarán** y serán responsables de acciones específicas. Después de cada reunión, el facilitador debe actualizar el plan de cuidados para reflejar los ajustes y asignaciones realizadas por su equipo.

En etapas iniciales de la implementación del plan, es posible que las reuniones se lleven a cabo al menos cada 2-4 semanas hasta que el equipo identifique que están haciendo cada vez menos ajustes. En ese momento, las reuniones del equipo sólo tendrán lugar cada 1-2 meses.

Entre reuniones del equipo:

Las reuniones formales del equipo no son la única forma de realizar el trabajo en el Wraparound. Entre reuniones del equipo del Wraparound, usted y los miembros de su equipo se comunican como sea necesario para completar las tareas mencionadas en el plan. Los miembros del equipo han desarrollado juntos su plan y todos deben tener el mismo documento que lo describe. Además, el facilitador debe hacer un seguimiento activo con los miembros del equipo sobre el éxito de los pasos de acción a tomar entre reuniones. Esto debe reduicr la posibilidad de malentendidos y dar como resultado una mejor situación para su familia.

Descripción del Proceso del Wraparound

Fase Cuatro: Transición

Tarde o temprano, usted y su equipo del Wraparound tendrán la mezcla perfecta de estrategias e intervenciones, entregada de la manera correcta y en el momento correcto. Su equipo descubrirá que se han logrado resultados y que se ha satisfecho, o casi satisfecho, la misión del equipo. Las cosas irán bien para usted y su familia. En este punto, se negocia la **transición** entre todos los miembros del equipo.

La planificación de la transición deberá ocurrir a lo largo de todo el proceso del Wraparound.

El facilitador debe tener conversaciones con usted, su hijo y los miembros de la familia para discutir acerca de la transición de manera regular. Eventualmente, usted y su facilitador hablarán sobre el asunto y empezarán a hablar con los miembros del equipo sobre cualquier idea que tengan.

El equipo luego sugiere opciones de seguimiento que ayudarán y apoyarán a su familia para lograr el éxito fuera de la estructura formal del Wraparound. Los miembros del equipo también identifican qué tipo de apoyo de seguimiento pueden suministrar personalmente a la familia. El facilitador y el equipo también deben determinar cómo deben presentarse ante usted y su joven/niño y familia.

El facilitador normalmente toma esta información y la pone en un **plan de transición** y la regresa a la próxima reunión para su revisión. Una vez que el equipo ha corregido el plan de transición, el equipo entero negocia un programa de transición.

Finalmente, si usted y su niño o joven aceptan, el equipo pensará en alguna forma de **celebración** final de los logros y trabajo del equipo bien hechos.

Una vez que esta celebración se ha completado, el facilitador completa una **carta formal de culminación** (que no debe pasar las 2-3 páginas) identificando las fortalezas de la familia, así como los logros del equipo y las intervenciones que fueron útiles.

Todos los miembros del equipo incluyendo la familia obtienen una copia de este resumen final de culminación en versión electrónica o impresa para que puedan usarla si necesitan reingresar a un sistema formal de ayuda en el futuro.

A medida que el equipo negocia y se pone de acuerdo con la culiminación, deberán desarrollarse planes para la respuesta y el cuidado del seguimiento. El facilitador guiará al equipo e identificará a la persona que presentará a su familia y los logros del equipo a los proveedores de seguimiento. Esto puede incluir la redacción del borrador de una carta de presentación que pueda guardar en sus registros o la reunión con otros proveedores de servicios para describir lo que será útil o no. A veces esto se hace de manera más eficiente en las reuniones del equipo y otras veces ocurre fuera del ambiente del equipo.

Solución de Problemas del Wraparound

Fase 1: Compromiso y Preparación del Equipo

Pregunta:

Este proceso del equipo del Wraparound suena bien, pero las cosas no están yendo bien con nosotros por el momento. Me temo que no voy a poder esperar tres semanas para recibir ayuda para mi hijo o hija. ¿Esto significa que no debemos obtener el Wraparound?

Respuesta:

Durante la conversación inicial con su facilitador, él o ella estará preparado para ayudarlo a asegurarse de que las cosas estén lo suficientemente seguras o estables para continuar con el proceso del equipo. Si tiene inquietudes sobre seguridad, menciónelas inmediatamente y elabore un plan temporal hasta que pueda tener su primera reunión de equipo.

Pregunta:

Las cosas han ido tan mal por tanto tiempo, que he decidido que mi hijo o hija se vaya de casa en busca de ayuda. ¿Esto significa que no debemos obtener el Wraparound? Además, otros profesionales que han trabajado con nosotros dicen que mi hijo o joven necesita este tipo de tratamiento.

Respuesta:

Algunas familias terminarán considerando la ubicación fuera de casa como una opción. Hay muchas cosas que recordar al respecto. Primero, eventualmente su hijo o hija volverá a casa así que sería útil considerar maneras de planear para ese día. Segundo, si puede identificar las necesidades más apremiantes de su familia y empezar a examinar maneras de satisfacer aquellas necesidades, eso podría ayudar a que otros proveedores de servicios hagan un mejor trabajo de ayuda. Finalmente, existe la posibilidad que usando un enfoque de equipo, podamos aparecer con nuevas ideas que puedan funcionar y que no hayamos tratado antes.

Pregunta:

El facilitador estará pidiendo a amigos y familia, así como a personas que han suministrado servicios de consejería o educación, que se unan a nuestro Equipo de Hijo y Familia. ¿Qué pasa si no me siento cómodo con el hecho de que mis asuntos familiares se estén discutiendo entre familiares y amigos?

Respuesta:

La planificación del Wraparound junta a las personas para ver qué se puede hacer y cómo ayudar. El proceso del equipo del Wraparound no es un lugar para discutir asuntos familiares, sino un lugar para que todos aquellos en el equipo observen sus necesidades y decidan qué se puede hacer para satisfacer dichas necesidades. Su privacidad es importante y debe protegerse aún durante un proceso del equipo de hijo y familia. Usted puede y debe trabajar con su facilitador para asegurarse que esté cómodo con las personas que se encuentran en su equipo, con lo que se dice y cómo se dice durante el proceso del equipo.

Solución de Problemas del Wraparound

Fase 1: Compromiso y Preparación del Equipo

Pregunta:	Respuesta:

¿Cómo sé que esto no será más de lo mismo?

No puede estar seguro. Es importante hablar con su facilitador acerca de lo que ha funcionado para su familia en el pasado, así como acerca de lo que no ha funcionado. Puede serle útil hablar con otras familias que han pasado por el proceso del Wraparound en su comunidad, para ver de qué manera funcionó con ellos. Además, tome en cuenta que necesita verlo suceder para convencerse de que el Wraparound está funcionando. El proceso del Wraparound siempre debe enfocarse en buscar esta clase de éxito (a veces llamado "resultados"). Si las necesidades identificadas por usted y su familia no se satisfacen, o las metas establecidas por usted y su familia no se están alcanzando, el proceso del Wraparound debe cambiar.

Pregunta:	Respuesta:

Mi hijo o hija ha estado en demasiadas reuniones con demasiados adultos que les dicen lo que han hecho mal. No puedo imaginarme a mí mismo convenciéndolo de que vaya ni siquiera a una de esas reuniones. ¿Qué tal si se rehúsa a asistir?

Puede trabajar con su facilitador para asegurarse de que su hijo o hija se sienta bienvenido y cómodo. Asegúrese de darle tiempo en la agenda para hablar y ser escuchado. A veces el enfoque en las fortalezas también puede ayudar a reasegurar a la persona joven. Si su hijo o hija no se siente cómodo asistiendo a las reuniones, usted y el facilitador pueden idear maneras de asegurarse que su voz sea escuchada.

Pregunta:	Respuesta:

El facilitador estará observando las fortalezas de mi hijo y familia. ¿Esto quiere decir que nuestros problemas no serán tratados?

El facilitador estará observando las fortalezas por diversos motivos. En primer lugar, muchas veces nos olvidamos de buscar fortalezas cuando estamos confrontados con desafíos. En segundo lugar, todos los servicios y acciones se basan en fortalezas. Sus inquietudes serán tratadas, pero las soluciones que se basan en fortalezas será la manera en que se traten.

Solución de Problemas del Wraparound

Fase 2: Desarrollo del Plan Inicial

Pregunta:

Repasar las fortalezas me hace sentir un poco incómodo o avergonzado. Sabemos en qué somos buenos. ¿Tenemos que hacer esta parte?

Respuesta:

Un elemento clave de la planificación del Wraparound es la idea de responsabilidad compartida. Anunciar las fortalezas puede ayudar a los miembros del equipo a querer compartir responsabilidades. No es inusual que las personas se sientan un poco perturbadas con el repaso de fortalezas. Sin embargo, algunas familias informan que ver anunciadas sus fortalezas las hace sentirse seguras de que pueden lograr lo que desean.

Pregunta:

Me preocupa que con todo este proceso, nunca logremos nada. ¿No tomará demasiado tiempo?

Respuesta:

Un proceso efectivo del Wraparound que sigue los pasos detallados en esta guía no debe tomar demasiado tiempo. Recuerde que cualquier meta que valga la pena alcanzar deberá tomar algo de tiempo. Averiguar cómo lograr resultados desafiantes requiere identificar las necesidades subyacentes, identificar diversas maneras de satisfacer dichas necesidades, y formular un buen plan.

Pregunta:

Con algo de renuencia, acepté que una persona asistiera a la reunión del equipo del Wraparound. Pero tengo miedo que esta persona se comporte de manera ruda o abusiva conmigo o que simplemente sea difícil de manejar en la reunión.

Respuesta:

Como familia, usted "es dueño" del contenido del proceso del Wraparound porque es su historia. El facilitador "es dueño" de la responsabilidad del proceso mismo. Si tiene inquietudes acerca de las personas que se comportan irrespetuosamente durante la reunión del equipo, discútalas con el facilitador antes de la reunión y dígale lo que necesitará para sentirse cómodo. Si alguien se comporta de manera ruda o negativa durante la reunión, debe avisar libremente al facilitador que no se siente cómodo. Un equipo del Wraparound también puede trabajar junto para establecer reglas básicas para las reuniones que todos los miembros se comprometan a seguir.

Fase 3: Implementación del Plan

Pregunta:	Respuesta:
Las cosas parecían ir bien justo hasta después de nuestra reunión del equipo del Wraparound. En estos momentos me preocupa cómo están funcionando las cosas y no hemos programado otra reunión del equipo del Wraparound por un largo período de tiempo. ¿Qué puedo hacer ahora?	Cuando el equipo haya pasado a reuniones menos frecuentes porque el plan de cuidado parece estar funcionando, debe existir la posibilidad de llevar a cabo una reunión de emergencia. Esto a menudo incluye una red telefónica de llamadas para asegurarse de que no sólo una persona sea la responsable de agrupar a todos. Puede decirle al facilitador o seguir su protocolo de reunión de emergencia del equipo.

Pregunta:	Respuesta:
A veces no me siento cómodo hablando sobre necesidades frente a ciertos miembros del equipo. Por ejemplo, algunos colegas de mi equipo han sido excelentes personas. Pero quisiera que mi hijo o hija participara en algunas actividades que requerirían una ayuda con fondos flexibles. No me siento a gusto discutiendo este tema frente a mis colegas. ¿Esto significa que deben salir del equipo o que simplemente no podremos tratar estos asuntos?	A lo largo del proceso del Wraparound, pueden surgir temas que las familias prefieren no discutir en presencia de todos los miembros del equipo. En una situación sobre fondos flexibles, el equipo puede ayudar a identificar la necesidad y las estrategias para tratar la necesidad. No obstante, el paso de acción a tomar puede incluir una reunión entre usted y el facilitador.

Pregunta:	Respuesta:
Acordamos hacer algo en nuestra reunión del equipo, pero sé que una persona no nos está siguiendo. ¿Qué puedo hacer ahora?	El proceso de planificación continua hace que todos los miembros sean responsables del seguimiento. Cuando un miembro del equipo no puede seguir, el equipo debe reunirse y puede escoger intentarlo otra vez o encontrar una nueva estrategia para satisfacer la necesidad. Además, su facilitador puede trabajar con usted y otros miembros del equipo para intentar tratar estos asuntos de seguimiento entre reuniones.

EL PROCESO DEL
WRAPAROUND
GUÍA DEL USUARIO

Solución de Problemas del Wraparound

Fase 3: Implementación del Plan

Pregunta:

Hemos estado trabajando con un proveedor de servicios, pero no me siento a gusto. No nos ponemos de acuerdo con esta persona y no puedo decir que me ha ido bien. Quisiera intentarlo con otro proveedor de servicios, pero no quiero herir los sentimientos de esta persona. ¿Cómo soluciono esto?

Respuesta:

Cuando atraviesa el proceso del Wraparound, usted debe calificar si los resultados para cada estrategia se están logrando, y si sus necesidades se están satisfaciendo, el equipo sugiere otras soluciones. Una solución puede ser intentar con una persona nueva Si le preocupa no herir los sentimientos de una persona, hable libremente con su facilitador u otro miembro del equipo en busca de ideas sobre cómo manejar esto.

o excelente este año,
del año escolar y
vea maestra el próximo
saber cómo será con
que no estaba aquí para
nicial. ¿Tendremos que
nte con todo el proceso

Respuesta:

Durante esta fase, los miembros del equipo llegarán y se irán a medida que el plan se va ajustando. El facilitador es responsable de orientar a los nuevos miembros del equipo del Wraparound y ayudarlos a ser parte del proceso. Los nuevos miembros del equipo pueden incluir proveedores de servicios o educadores nuevos, miembros de la familia que inicialmente no estaban involucrados, amigos de la familia, miembros del clero, u otros que se hayan vuelto a poner en contacto con usted o que se hayan puesto en contacto con usted por primera vez.

Solución de Problemas del Wraparound

Fase 4: Transición

Pregunta:	Respuesta:
Los temas que estamos discutiendo son solamente temas, a pesar que estamos completando el proceso del Wraparound. Algunas familias que pasan por este proceso están enfrentándose a desafíos de por vida como enfermedades mentales o adicción, o enfermedades crónicas. Ya que los temas antiguos aún permanecen y las cosas vuelven a empeorar, ¿necesitaremos iniciar nuevamente el Wraparound?	Parte de la transición para una familia consiste en ubicar servicios y apoyos en la comunidad para posible uso futuro. Debe trabajar con los miembros del equipo y el facilitador para asegurarse que se siente confiado acerca de acceder a servicios futuros, e incluso de volverse a reunir con su equipo, de ser necesario.

Pregunta:	Respuesta:
Lo mejor que hizo el Wraparound por mí y mi familia fue ponernos a todos de acuerdo. No puedo imaginarme que esto pueda ocurrir sin el equipo del Wraparound. ¿No retrocederá al punto de inicio con muchas personas sin llegar a comprendernos?	Debe trabajar con su facilitador y los miembros del equipo para asegurarse que obtenga las copias del resumen de sus fortalezas, el resumen de culminación y otros documentos para que pueda presentar a su familia ante otras personas. Podrá buscar ayuda y apoyo en su organización de familia local. Finalmente, su plan de transición deberá incluir buenas estrategias generadas por su equipo sobre cómo permanecer conectado a los miembros importantes del equipo y a otro que lo apoyará en el futuro.

Pregunta:	Respuesta:
Disfruté el proceso del Wraparound y siento que ya me acostumbré a él. Me preocupa quedarme solo sin estas conexiones. ¿Qué puedo hacer ahora?	Las familias a menudo se dan cuenta que desean mantener las relaciones con miembros individuales del equipo, pero no desean necesariamente continuar con la estructura formal. Quizás también desee ayudar como voluntario para estar disponible para hablar con nuevas familias sobre el proceso del Wraparound. Su facilitador también deberá tener una manera de hacer un seguimiento con usted, para que si necesita tener otra reunión formal del equipo, ésta pueda realizarse.

Pregunta:	Respuesta:
Nuestra familia realmente se siente bien con las actividades de fortalezas y logros. Un repaso de una revisión formal de fortalezas nos ayudó regularmente a recordar las buenas noticias y ser menos duros con los demás. ¿Cómo puedo evitar hundirme en nuestros antiguos patrones?	Muchas familias encuentran útiles los elementos del ritual del Wraparound y los implementan de manera informal. Por ejemplo, algunas familias tienen reuniones familiares regulares dentro del hogar para considerar las fortalezas y logros mientras otras hablan sobre necesidades como una forma de comprender el comportamiento.

Documento y Formularios que verán las familias durante cada fase

Notas Técnicas

Fase de Compromiso y Preparación del Equipo

Documentos:

- ❒ Resumen o Descubrimiento de Fortalezas
- ❒ Lista o inventario de fortalezas
- ❒ Lista de miembros potenciales del Equipo del Joven/Niño y Familia

Formularios:

- ❒ Formulario con permiso inicial para proveer servicios
- ❒ Autorizaión(es) permitiendo al Facilitador hablar con otros miembros del equipo

Fase de Desarrollo del Plan Inicial

Documentos:

- ❒ Plan de Cuidados que incluye la Misión del Equipo, las necesidades más importantes, las acciones que detallan al responsable de hacer el seguimiento y cuándo
- ❒ Plan de crisis por escrito que incluye quién hará qué cuando las cosas salgan mal y a quién debe llamarse y en qué orden
- ❒ Programa de reuniones futuras del equipo

Formularios:

- ❒ Permiso(s) y entrega(s) si se llaman a los nuevos proveedores de servicios.

Fase de Implementación del Plan

Documentos:

- ❒ Actas del equipo detallando los logros del equipo, los cambios del plan y el programa de reuniones
- ❒ Informes regulares del progreso que reflejen el progreso realizado a partir del plan original

Formularios:

- ❒ Entregas actualizadas para los miembros del equipo especialmente si se añaden nuevas

Fase de Transición

Documentos:

- ❒ Plan de transición describiendo cómo se tendrá acceso a servicios continuos, de ser necesario
- ❒ Planes de crisis que incluyen protocolos de comunicación para aquéllos que serán contactados en caso de emergencia
- ❒ Números telefónicos de seguimiento para todos los miembros del equipo que pueden ser contactados
- ❒ Plan de culminación formal describiendo las fortalezas de la familia, las intervenciones que fueron exitosas y las que no lo fueron

Formularios:

- ❒ Resumen de culminación

Lista de Control del Wraparound

Fase del Compromiso y de la Preparación del Equipo

- ❒ Conocimos al **facilitador** y le explicamos nuestra historia
- ❒ Tratamos las necesidades y crisis inmediatas y elaboramos juntos un **plan de crisis** inicial
- ❒ Generamos una lista de **fortalezas**
- ❒ Generamos una lista de **miembros del equipo**
- ❒ Acordamos la primera **reunión**
- ❒ Nos pusimos de acuerdo sobre quién contactaría a **miembros del equipo** potenciales
- ❒ Obtuvimos más **información** acerca de este proceso

Fase del Desarrollo del Plan Inicial

- ❒ Participamos en una o dos **reuniones del equipo** con los jóvenes/la familia
- ❒ Nuestras **fortalezas** fueron enumeradas y revisadas
- ❒ Desarrollamos una **Declaración de la Misión del Equipo** que refleja lo que nosotros y otros miembros del equipo esperamos lograr
- ❒ Revisamos las **necesidades** que reflejan nuestra inquietudes y preocupaciones
- ❒ Escogimos unas cuantas **necesidades** para evitar que nosotros mismos y el equipo nos veamos agobiados
- ❒ Sugerimos una variedad de **estrategias** para satisfacer dichas necesidades
- ❒ Escogimos **estrategias** para satisfacer aquellas necesidades que coincidían con nuestras fortalezas
- ❒ Todos los miembros del equipo se reflejan haciendo algo en el plan
- ❒ El **plan de cuidados** del Wraparound ha sido distribuido a todos los miembros del equipo

Consejo Útil:

Use esta lista de control para hacer seguimiento de cómo está avanzando su proceso del Wraparound .

Fase de la Implementación del Plan y las Modificaciones

- ❒ Se están suministrando las **actividades** prometidas
- ❒ Los **logros** se revisan y registran
- ❒ Ocurre la **evaluación** del plan
    - ❒ El equipo se reúne a menudo para revisar el seguimiento
    - ❒ Nos preguntan si las acciones están satisfaciendo a nuestra necesidades
- ❒ Ocurre el **ajuste** del plan en base a nuestros comentarios
- ❒ Se realizan y registran **asignaciones** en cada reunión del equipo
- ❒ Se envían copias de las actas y del plan de cuidados actualizado a todos los miembros del equipo
- ❒ Se redactan y envían informes regulares del progreso
- ❒ Practicamos lo que hay que hacer si ocuree una crisis con nuestra familia y el equipo

Transición

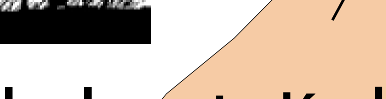
- ❒ Hemos realizado **simulacros de práctica de crisis** y estamos seguros que sabemos lo que hay que hacer si las cosas van mal
- ❒ Tenemos una manera de **acceder a los servicios** en el futuro
- ❒ Tenemos una manera de **conectarnos con otras familias** que ya han pasado por el proceso
- ❒ Han tomado en cuenta nuestras inquietudes
- ❒ Tenemos una lista de números telefónicos de **miembros del equipo** a quienes podemos contactar de ser necesario
- ❒ Hemos discutido con todo el equipo el hecho de culminar el Wraparound
- ❒ Tenemos documentos escritos que describen nuestras fortalezas y logros.

Hoja de Ruta del Wraparound: Una Visión General

A medida que el equipo se acerca a sus metas, se realizan preparativos para que la familia haga una transición fuera del Wraparound formal. La familia y el equipo deciden cómo continuará la familia teniendo apoyo cuando lo necesite, y cómo puede "reiniciarse" el Wraparound de ser necesario.

Transición

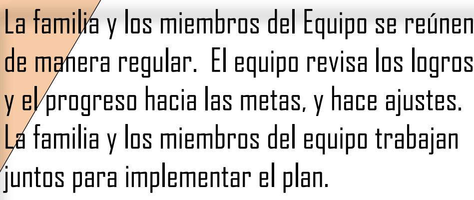
[Continua]



Implementación del Plan

[9-18 meses]

La familia y los miembros del Equipo se reúnen de manera regular. El equipo revisa los logros y el progreso hacia las metas, y hace ajustes. La familia y los miembros del equipo trabajan juntos para implementar el plan.



Los miembros del equipo aprenden acerca de las fortalezas, necesidades y visión del futuro de la familia. El equipo decide en qué trabajar, cómo se logrará el trabajo y quién es responsable de qué. Un plan se desarrolla para manejar las crisis que pudieran ocurrir.

Fase de Planificación

[1-2 semanas]

La familia conoce al facilitador. Juntos exploran las fortalezas, necesidades y cultura de la familia. Hablan sobre lo que ha funcionado en el pasado, y sobre qué pueden esperar del Wraparound. El facilitador compromete a otros miembros del equipo, y los prepara para la primera reunión.

Fase de Compromiso

[2-3 semanas]

10 Principios del Proceso del Wraparound

1. **Voz y elección familiar.** Las perspectivas de la familia y joven/niño son intencionalmente sacadas a la luz y priorizadas durante todas las fases del proceso del Wraparound. La planificación se basa en las perspectivas de los miembros de la familia, y el equipo lucha por proporcionar opciones y elecciones como que el plan refleje los valores y preferencias de la familia.

2. **Basado en el Equipo.** El equipo del Wraparound consiste en individuos acordados por la familia y comprometidos con ella a través de apoyo informal, formal, y comunitario y relaciones de servicio.

3. **Apoyos naturales.** El equipo busca y alienta activamente la participación completa de los miembros del equipo convocados a partir de redes de miembros de la familia de relaciones interpersonales y comunitarias. El plan del Wraparound refleja las actividades e intervenciones que se inspiran en fuentes de apoyo natural.

4. **Colaboración.** Los miembros del equipo trabajan en cooperación y comparten responsabilidades de desarrollo, implementación, monitoreo y evaluación de un único plan del Wraparound. El plan refleja una mezcla de perspectivas, mandatos y recursos de los miembros del equipo. El plan guía y coordina el trabajo de cada miembro del equipo hacia la satisfacción de las metas del equipo.

5. **Basado en la Comunidad.** El equipo del Wraparound implementa estrategias de servicio y apoyo que ocurren en los escenarios más inclusivos, más receptivos, más accesibles, y menos restringidos posibles; y que promueven con seguridad la integración del niño y la familia en la vida del hogar y la comunidad.

6. **Culturalmente competente.** El proceso del Wraparound demuestra respeto y se basa en valores, preferencias, creencias, cultura, e identidad del niño/joven y la familia, y su comunidad.

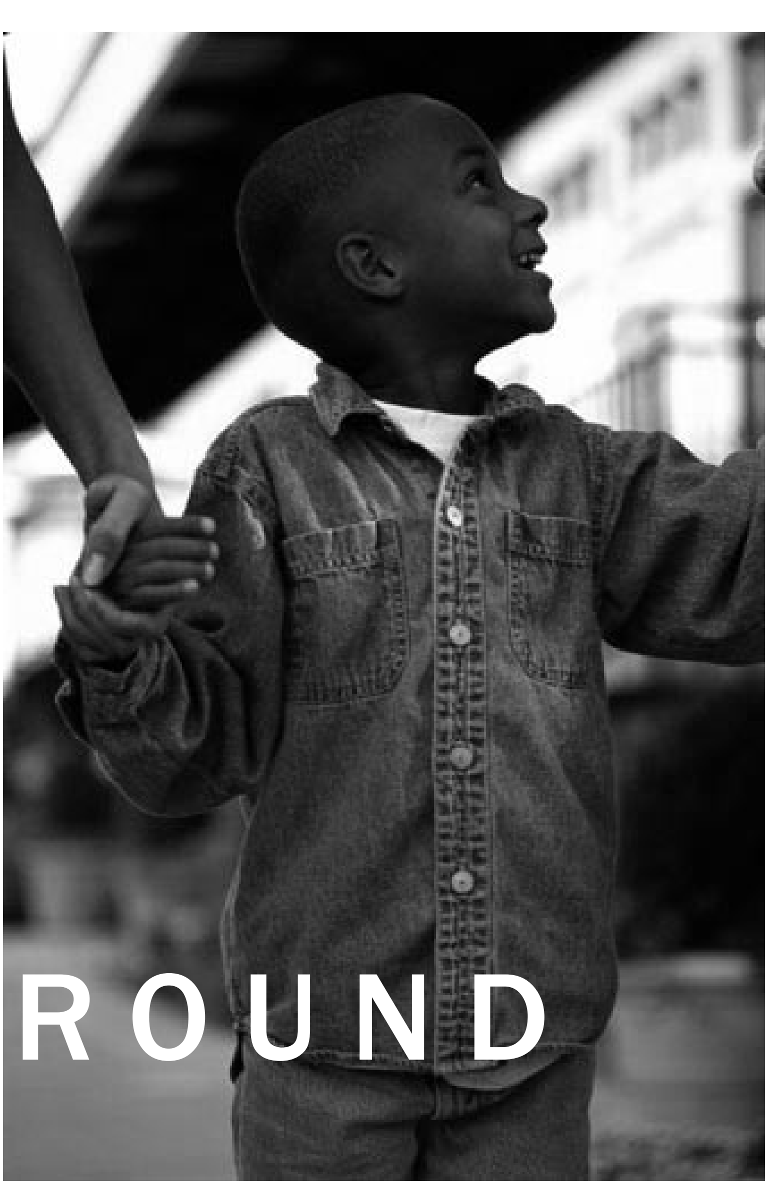
7. **Individualizado.** Para alcanzar las metas trazadas en el plan del Wraparound, el equipo desarrolla e implementa un serie de estrategias, apoyos y servicios personalizados.

8. **Basado en Fortalezas.** El proceso del Wraparound y el plan del Wraparound mismo, identifica, se basa en y realza las capacidades, los conocimientos, las habilidades y los activos del niño y la familia, su comunidad y otros miembros del equipo.

9. **Persistencia.** A pesar de los desafíos, el equipo persiste en trabajar hacia las metas incluidas en el plan del Wraparound hasta que el equipo alcance un acuerdo de que ya no se necesita más un proceso formal del Wraparound.

10. **Basado en Resultados.** El equipo asocia las metas y estrategias del plan del Wraparound con indicadores observables o mensurables de éxito, monitorea el progreso en términos de estos indicadores, y revisa el plan consecuentemente.

Ayudando a niños y familias a realizar sus sueños y esperanzas.



WRAPAROUND

La Guía de Usuario del Proceso del Wraparound es un producto de la National Wraparound Initiative (Iniciativa Nacional del Wraparound o NWI, por sus siglas en inglés), proyecto que incluye a más de 100 consejeros de todo el país y de todas las clases sociales. El NWI es un intento por comprometer a expertos a nivel nacional, a un proceso de definición de estándares para Wraparound de alta calidad, y de difusión de apoyo a comunidades para implementar el proceso del Wraparound. Además de esta *Guía para Familias*, podrá encontrar muchos documentos adicionales sobre el Wraparound en el sitio web de la Iniciativa: www.rtc.pdx.edu/nwi.

Involving Youth in Planning for Their Education, Treatment and Services:

Research Tells Us We Should Be Doing Better

Youth Empowerment

AMPlifying Youth Voice in Planning

www.rtc.pdx.edu

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Introduction

Human service and educational agencies often convene teams to work collaboratively on plans for serving children or youth. This happens most often for children and youth who are involved with multiple systems or who are felt to be in need of intensive support. Often, these are children and adolescents with cognitive, emotional, behavioral, physical, or learning challenges.

The teams that create plans for these young people include IEP (Individualized Education Plan) teams, wraparound teams, foster care Independent Living Program teams, transition planning teams, youth/family decision teams, and other teams that create service, care, or treatment plans. Unfortunately, it is often true that these plans are created *for* youth, with little input or buy-in from the young people themselves.

Many adults support the idea of increasing youth participation in planning and decision making about their own care, treatment, and preparation for the future. Other adults just think this is a bad idea. Most adults are probably somewhere in between, however. They think it's a good idea in general, but maybe not for youth who have emotional problems (participating in meetings is too stressful), youth who have behavioral problems (they will act out and cause planning meetings to be unproductive), youth with cognitive challenges (their level of functioning is too low for them to really participate), or youth who have difficult personal circumstances (hearing the truth about their lives will upset them).

While there is not as much published research on this topic as there should be, the research that is available indicates that involving youth meaningfully—and successfully—in planning for their own treatment and care is quite possible. This research also indicates that involving youth meaningfully in planning provides benefits for the youth and his or her caregivers and providers.

Following are some common questions that people might have about youth participation in education, care, treatment, or service planning. Information from published research is summarized to help answer each question. We provide references so that if you are interested, you can get more details from the original sources.

Question: Before we get into these other questions, what do you mean by "meaningful" participation in education, care, service or treatment planning?

Answer: *First of all, if a youth is going to participate in planning, he or she must be present when plans are made. But merely having the youth present doesn't mean that his or her participation will be meaningful. Participation isn't meaningful unless a young person is able to have an impact on the decisions that become part of the plan. So even a youth who talks a lot during a meeting may not really have an impact on what is decided.*

Detail: By "meaningful participation," we mean that a young person has the opportunity to make real choices for the plan and to influence decision making. To participate meaningfully, the young person must also have access to information that enables him or her to make informed choices and decisions. He or she also has the opportunity to help set and monitor the goals that become part of the plan. Finally, the young person has the encouragement and support needed to take an active role in planning.

Question: Aren't young people already involved in their education, care, and treatment planning?

Answer (part 1): *This is a long answer, so let's take it step by step. First of all, it appears that few students participate meaningfully in creating their Individualized Education Plans (IEPs).*

Detail: Much of the research that helps answer this question comes from examining student participation in creating their Individualized Education Plans (IEPs). Federal legislation requires that high-school-aged children participate in the IEP process as part of planning for transition to adulthood. Despite this mandate, it seems that most students do not participate meaningfully in the IEP/transition planning process. Many do not even have a transition plan, and many students who attend their IEP meetings do not participate at all.

The largest study to examine this issue was done by Wagner[1], who analyzed data on a nationally representative sample of 1,077 students, aged 13-16 years old. All the students were receiving special education services and had been given the label of "emotional disturbance." (This is the label that applies to children with emotional or behavioral disorders.) Between 15% and 35% of eligible children

did not even have transition plans at all. Among those who did, 16% had not attended their last transition planning meeting, and another 27% had attended but not participated at all. Only about one in ten youth in the study had participated "substantially" in their most recent transition planning meeting.

Powers and her colleagues[2] analyzed 400 IEPs and transition plans of students in Oregon and California. About a quarter of the time, students were not present at the planning meeting. Students were often assigned responsibility for carrying out the goals on their plans, even if they had not been at the meetings when the plans had been made. Only about one fifth of the goals on the plans appeared to be rooted in a student's interest or preferences.

Lovitt and Cushing[3] interviewed students with IEPs at two high schools in Washington state. They found that most students were unfamiliar with the IEP process and felt no ownership of their plans. Among students who had attended their IEP meetings, most students said they "just sat there." The researchers also examined the students' IEP plans. While the documents were well prepared and met federal guidelines, "a lack of individualization was obvious." Many of the plans had exactly the same goals.

Answer (part 2): *It also seems that youth with emotional or behavioral disorders do not usually participate meaningfully in creating their own care, treatment, or service plans.*

Detail: Gyamfi[4] conducted research on federally funded projects to create "systems of care" for children and adolescents with complex mental health and related needs. One of the hallmarks of a system of care approach is that youth are to be involved in decisions at all levels of the system, from their own plans to making policy. The study found that youth involvement was limited and that "only in some cases were they involved in planning their services or providing feedback on the services they receive." In fact, the study also found perceptions that some administrators were actively trying to prevent youth from finding out about their rights and their opportunities to be involved in planning.

Walker and Schutte[5] observed wraparound planning meetings around the country and found that the youth who was the focus of planning was present (for more than half of the meeting) just over a third of the time (39%).

Answer (part 3): *Professionals who participate in this kind of planning are also dissatisfied with the level of youth participation.*

Detail: Analyzing post-meeting surveys from the wraparound meetings they observed, Walker and Schutte[5] found that the most common dissatisfaction with the meeting was with the level and/or nature of youth participation. In a study of IEP meetings, Mason found only 34% of school personnel were satisfied with the level of student involvement.[6] Adults are often uncertain about how to involve youth productively in the planning process.[3, 5, 7, 8]

Question: You said before that participating meaningfully in planning means that young people have to take part in making decisions and setting and monitoring goals. Can youth who have significant mental health, learning, and/or cognitive difficulties really be expected to master the skills needed to do this?

Answer: *Yes. Children and youth of all ages and with a variety of disabilities and challenges have successfully learned skills and participated in planning.*

Detail: This is an area where a lot of research has taken place. A large number of curricula have been developed for teaching young people skills that are important for meaningful participation in planning, including skills for self-advocacy, self-determination, problem solving, choice making, and goal setting and monitoring. These skills have been successfully learned and used by children as young as five years old, and by students with a variety of disabilities and disorders including mild and moderate cognitive disabilities, emotional and behavioral disorders, learning disabilities, and physical disabilities. There are a lot of these studies, so if you want to know more about them, the easiest place to begin is with published articles that review the existing evidence.[9-12]

There is also quite a bit of evidence that children who are taught these kinds of skills participate more, and more meaningfully, in planning. Again, this has been shown for children and youth with cognitive disabilities, learning disorders, emotional and behavioral disorders, and physical disabilities.[7, 8,]

Question: Why do you think it's so important to include young people in planning for their education, treatment or care? What's to be gained?

Answer (part 1): *There are a lot of potential benefits to increasing youth participation in planning, so let's think about different kinds of benefits one at a time. First of all, when people feel they are doing something because they want to, they tend to be happier and more engaged, and do a better job, than when they don't feel they have a choice.*

Detail: There is a wealth of research that compares the experiences of people who feel they are acting autonomously—by their own choice—and those who are externally controlled. People acting autonomously tend to have more interest, excitement and confidence about what they are doing. In turn, this leads to enhanced performance, persistence, and cre-

ativity.[16]

There's also a whole lot of research that looks at this issue specifically in relation to people's work on teams—usually this means teams created in the workplace. Not surprisingly, this research shows clearly that team members are much more likely to be invested in team goals and to follow through with team tasks if they feel that they participated meaningfully in selecting the goals and making decisions about how to achieve the goals. Likewise, when the members of a team all agree on the goals, the team is more likely to achieve the goals.[17, 18]

A main task of later childhood and adolescence is to develop autonomy. There is quite a bit of research showing that an adolescent's ability to make choices about the activities he or she is involved in has a direct impact on mood and well-being.[19] Adolescents also perform better on activities they choose themselves.[19] In a small study focusing specifically on students with emotional and behavioral disorders, making choices increased task engagement and reduced disruptive behavior.[20]

In short, it makes sense to think that if youth feel they are making choices for their plans, they will be happier, try harder, and do better when they are involved in activities that are part of the plan.

Answer (part 2): *Learning to make plans and achieve goals is an important part of growing up for any young person. People who are confident that they can solve problems in their lives and reach the goals they set for themselves experience many positive outcomes—including positive emotional and behavioral outcomes.*

Detail: There are a large number of studies that examine the positive outcomes that are associated with *self-efficacy*. Self-efficacy is the confidence that people have about their ability to overcome obstacles in their lives and to reach goals they set for themselves. People develop self-efficacy in large part because of having successful experiences using their own skills and resources to achieve personally meaningful goals. Similar outcomes have been found in studies that examine optimism and hopefulness, which also have a lot to do with people's beliefs that they can achieve the goals they set for themselves.

Because there are so many studies that affirm these kinds of findings, we'll mention some that are particularly relevant, but mostly we'll refer to reviews that summarize findings from multiple studies. People with higher self-efficacy tend to be more optimistic and hopeful, and they persist and try harder in the face of obstacles.[21-23] People who believe they can solve problems in their lives have better general mental health and well-being, and they are more likely to avoid depression.[21, 23-26] In general, people with higher self-efficacy cope better with stressful life circumstances. They are also more likely to take action to protect their health; to adopt new, healthy habits; and to maintain behavior change.[21, 25] Adolescents who are optimistic tend to do better in school and college, abuse drugs less, and have less anger, better health, and fewer social problems.[27] Children and adolescents who are trained in problem-solving have more

optimism and avoid depression.[28]

There is also some relevant research looking at *self-determination* among adolescents with various kinds of disabilities. (Self-determination involves taking action to make decisions and exert some control over one's life.) In one study, adolescents with cognitive and/or learning disabilities who were higher in self-determination had better post-school outcomes, including being more likely to live independently, have a bank account and pay for their own groceries.[29] In another similar study, students higher in self-determination also had better post-school outcomes. They were more likely to be employed and earned more per hour than peers who were low on self-determination.[30] Other studies are described in the review by Chambers.[12]

Finally, there are studies that have shown that it is possible to increase self-determination among youth with disabilities—including youth with emotional and behavioral disorders. For example, youth with disabilities who participated in an intervention called *Take Charge*, which taught self-determination skills and provided mentoring for youth, showed higher self-determination and increased goal achievement.[31] Wehmeyer developed the Self-Determination Model of Instruction and found that it was effective in promoting self-determination and enabling students to attain educationally valued goals.[32] In a study by Zhang, a group of ninth graders with learning disabilities completed a curriculum on self-determination. These students gained significantly more on measures of self-determination skills than students in a control group.[33]

Taken together, these studies tell us that it makes a lot of sense to try to increase self-determination and self-efficacy among youth who are involved in collaborative team planning. We know that young people can learn the skills for solving problems, making decisions, and creating and monitoring plans, and that this contributes to their self-determination and self-efficacy. It also seems very reasonable to think that self-determination and self-efficacy would increase when youth play an important role in helping the team successfully achieve goals on the plan. Furthermore, the most powerful source of self-efficacy is the experience of success in reaching self-defined goals.[21] When participation on teams helps youth have these experiences, it is likely to increase their self-efficacy.

Answer (part 3): *Developing self-efficacy would seem particularly important for youth who face high levels of challenge in life. However, it appears that children with disabilities and children who are involved with the child welfare or mental health systems have far fewer opportunities than their peers to experience self-efficacy.*

Detail: As we said before, the most powerful source of feelings of self-efficacy is the experience of success in reaching self-defined goals.[21] Children and youth who experience challenges in their lives—either from difficult personal circumstances or from having disorders or disabilities—often do not have many opportunities to experience this kind of success.[34-37]

In a qualitative study with boys in the child welfare system in England, Leeson[38] found that the boys had "overwhelming feelings of helplessness experienced as a consequence of not being involved in decision-making…. The boys were all scared of making decisions [and] did not know how to make them." One boy described the anxiety he had about making wrong decisions, and felt that he could not rely on his own thought processes.

In another study of young people's perceptions of mental health services, young people emphasized the lack of control they had, and how that made them resist help that was offered: "I'll get mad if a social worker turned round to me and says: 'You've got to do this, you've got to do that. They'll wind me up and I'll get mad and then I'll just flip on 'em.' "[39]

So it should be particularly important to help youth who experience challenges in life have successful experiences of planning and achieving valued goals.

Answer (part 4): *In addition to all these reasons, perhaps the most important reason for including youth meaningfully in planning is because it's the right thing to do.*

Detail: Virtually any declaration of human rights is based in the idea that people have the right to make choices about their own lives, and that the only time that it is reasonable to restrict that right is if one person's choices are likely to lead to harm. As human beings, we acknowledge we have a moral duty to promote this essential aspect of freedom.

Additionally, we owe it to our young people to do our best to help them become successful, autonomous adults who are capable and confident in making good decisions for their lives. Research like that described here provides clear guidance about how we can fulfill this duty to our children and youth.

Conclusion: Ok, let me see if I have this right. What you're saying is that it's possible to teach youth to participate meaningfully in their education, treatment, or care planning. Doing that helps youth achieve better outcomes, and probably also helps the adults who work with the youth get better results as well. So we should do what we can to help youth participate meaningfully because it gets good results. And above all, it's the right thing to do.

Answer: *I couldn't have said it better myself.*

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ACHIEVE MY PLAN

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Best Practices for Increasing Meaningful

Youth Participation

In Collaborative Team Planning

ACHIEVE **M**Y **P**LAN

AMPlifying
Youth Voice in Planning

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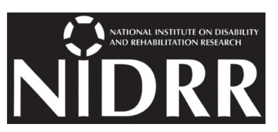

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Human service and educational agencies and systems often convene teams to work collaboratively on plans for serving children or youth. This is particularly true for children and youth who are involved with multiple systems or who are felt to be in need of intensive intervention. These kinds of planning teams include IEP (Individualized Education Plan) teams, wraparound teams, foster care Independent Living Program teams, transition planning teams, youth/family decision teams, and other teams that create service or treatment plans. Unfortunately, it is often true that these plans are created *for* youth, with little input or buy-in from the young people themselves.

In previous research on team planning, we found that adults who participated on teams were eager to involve youth in planning in a more meaningful way, but were unsure how to feasibly accomplish this goal. In response, we began work on AMP. AMP—Achieve My Plan—is a five-year project that is developing and testing ways to increase the meaningful participation of youth in collaborative team planning meetings. Here, we share some of what we have learned about how to create plans with youth, so that youth will see the plans as a means to help them move towards important life goals.

These best practices are based on a combination of research findings and input from AMP advisors and other youth and adults who are part of planning teams around the nation. Some of these practices require time and resources, and many require that teams organize their work in ways that are different than usual. But this is to be expected—getting a higher level of youth participation than you are used to will require you to invest in making some changes.

Organizational Support for Participation

Promote an organizational culture that sees youth participation as valuable and feasible. Agency staff are more likely to support youth participation if they see that it is a priority within the agency, and if the agency provides resources—like time and training—so that staff can gain the skills they need to carry out activities that encourage youth participation. Staff, families, and youth themselves will be more open to youth participation if they are given information that demonstrates increasing youth participation is both desirable and possible.

Ensure youth are present when decisions that impact the plan are made: "Nothing about me without me." Youth won't be participating meaningfully in the planning process unless they are present when decisions are made, and their input is invited. The agency and the team should be clear about their commitment to youth participation in decision-making and the process for making decisions. Make a record of the decisions. Don't change these decisions later or make "real" decisions outside the team meeting. Invite youth to participate in the entire meeting, and don't make decisions or share important information when youth are absent.

Before the Meeting: Help the Youth Prepare

In consultation with the youth, formulate an agenda before the meeting. A young person will be more comfortable and willing to participate if he can trust that the team will not become a public discussion of uncomfortable topics. The youth should have a chance to review agenda items before the meeting. If there are topics that he feels should not be discussed in front of the whole team, work with him to figure out how to manage sensitive topics outside of the team setting.

Provide adequate preparation so that youth have a real opportunity to think about what and how they want to contribute to the topics on the agenda. Youth are likely to draw a blank or feel put on the spot when asked to spontaneously contribute to a discussion in a room full of adults. Youth should have an opportunity to prep for the meeting with a "coach" who reviews the meeting structure and the items on the agenda. This can be done individually, or with youth in groups. During this prep session, the youth is supported to decide what points she wants to make about each topic on the agenda and how she will communicate these points. She should also be coached to think about times during the meeting when she may need some kind of support, and who would be the best person to offer that support.

Make sure that the youth has the opportunity to formulate goals that will be part of the plan. It's essential for young people to learn about setting and reaching their own goals—after all, this is what becoming more mature is all about. What's more, a young person is more likely to feel ownership and buy-in for the plan when it includes activities and goals that she finds personally meaningful. Part of prepping for initial planning meetings should include an opportunity for the youth to be coached through a process of thinking about her goals for the future, and how activities consistent with those goals can become part of the team plan.

Help the youth plan to contribute to the meeting in whatever manner feels comfortable to him. With preparation, many youth will feel comfortable talking to the team during the meeting. Some youth prefer to use notes; some prefer to read prepared comments. Some youth may prefer to have someone else speak for them. Some youth feel comfortable talking during parts of the meeting (for instance, welcoming everyone and doing introductions); however, the youth may want more support to talk when it comes to commenting on topics others bring up during the meeting. Even youth who are usually shy may feel comfortable speaking in the meeting if they know that there is a back-up plan in place in case this becomes too difficult. (For example, if the youth gets too anxious to speak, the support person can speak from the youth's notes.)

Help the youth think about things he might do during the meeting to help stay calm and/or focused. Youth will be able to participate more effectively in the meeting if they feel comfortable using strategies to manage their attention, emotions and/or behavior. A youth may prefer to stand or walk around during part of the meeting. Another may be able to pay more attention if he is doodling or chewing gum. Another youth may need to take a cigarette break mid-way through the meeting. Help the youth identify strategies that will work for him and support the youth for using those strategies during the meeting.

Work with the youth to figure out who can support her during the meeting and prepare that "support person" for his role. Encourage the participation of one or more "support people" recognized by the youth. A support person is someone that, in the youth's eyes...

...can be trusted,

...believes in the youth's capacities to make decisions and set goals,

...understands what meetings are and can interact well with others in a meeting, and

...can help the youth communicate productively during the meeting.

A support person will likely need orientation prior to the meeting so that he can understand his role. He should also have the opportunity to be "prepped" together with the youth prior to the meeting so he knows how and when the youth might need support and how to offer support in the team context.

During the Meeting: Create a Safe Environment

Ensure that the team environment feels safe for the youth. Young people report that, during team meetings, they are often ignored, lectured at, and/or harshly criticized. To help the meeting feel safe, the team should agree to a set of ground rules, and the facilitator should be able to control the meeting in a way that ensures that people follow the rules. Ground rules should include the following:

1. All team members treat each other respectfully, the youth no less than others. This means that people in the meeting …

…talk directly to the youth, not about the youth as if she is not there.

…do not assume or assert that they know why the youth said or did something. No one knows for sure what's in another person's mind.

…speak to the group one at a time, and avoid side conversations or distractions like answering phones during the meeting.

…treat everyone's ideas and contributions respectfully.

2. Remain strengths-based and solution-focused. Youth feel that adults often spend too much time stuck thinking about the past, particularly about problems the youth might have had or bad "incidents." Avoid telling long stories about the youth. Do not take this as an opportunity to lecture the youth about how she should act. Do not get into arguments with the youth about what she "really" did or why she "really" did it. This is unproductive and alienating. Instead, focus on strengths, problem solving, and building opportunities that help the youth act in ways that the whole team can support. Communicate that you believe the youth can set new directions for herself and that you want to help.

3. During the meeting, stick to the agenda that the youth has helped create. There should be no last-minute additions to the agenda; off-topic discussion that arises during the meeting should be tabled for later discussion. Team members can make a list of these items and be sure that, by the end of the meeting, they have worked out a strategy for addressing them.

4. Make sure that everyone can understand what is going on. Invite everyone on the team to ask questions if they don't understand something or if unfamiliar terminology or acronyms come

up during discussion. Be supportive when people ask for this kind of clarification.

5. Learn how to talk in ways that don't alienate or hurt the youth. Professionals often say that they don't want to include youth in important decisions because hearing certain truths will hurt the youth's feelings. Professionals may feel uncomfortable or even cruel using labels or speaking about the results of tests or assessments in front of a youth. But rather than using this as an excuse to exclude the youth, use it as an opportunity to reflect on why "helping" feels so cruel that it has to be done when youth are not around. It is possible to speak the truth and to get business done without being cruel. Explain that discussion of diagnoses and problems are often required by the system in order to get services, but the most important purpose of the team is to recognize the youth's strengths and support her in moving toward a positive future.

During the Meeting: Ensure the Youth is Part of the Team

Structure discussion in ways that provide multiple opportunities for the youth to express his ideas or offer comments, even if he doesn't want to say a lot at any one time. Make space for the youth to contribute to discussions, and check in with him from time to time. A youth may not want to say a lot each time, but will feel more included anyway.

Ensure that what the youth says matters and has an impact on discussions and decisions. While this does not mean that the youth should solely dictate the plan, it does mean that people on the team should be willing to truly listen to what the youth has to say and incorporate the youth's interests into the plan. Of course, helping the youth formulate goals for the plan and prepare to speak to topics on the agenda are important ways to help ensure that he or she will have an impact.

Beyond this, it is also important to structure decision-making in ways that support collaboration. Some key ways to do this are:

1. Don't decide the solution before you have a chance to think about what the goal, "problem," or need really is. Sometimes a goal, problem, or need is defined so narrowly that there is no room to collaborate in creating a solution or strategy. A team member may say that the problem is that the youth needs anger management classes. If the team accepts this as the real problem, then there is only one (predetermined) way to solve it: with anger management classes. In this way, the person that defines the problem gets to define the solution as well. There is no chance for the youth—or anyone else—to have meaningful input. While this example is a bit of a caricature, this type of situation occurs frequently in group settings. A more collaborative (and often more effective) way to think about a problem is to work as a group to think about deeper needs. What purpose would anger management classes serve? In general, a problem or need should be defined in such a way that a variety of strategies could be used to solve it. Then you can…

2. Consider several different strategies to solve a problem or meet a need before picking one to use. If only one strategy is considered, it is often not a very creative strategy, and usually it is the "pet" strategy of someone with a higher level of power at the meeting. Everyone in a group

or team is empowered when the team considers options before making decisions, but this is particularly true for youth, who haven't had a whole professional career to think about some of these things.

Ensure that the youth's strengths, assets, talents, and achievements are a focus of the meeting and a part of the plan. Youth report that what they do well is rarely discussed in meetings. They also feel that what they accomplish from week to week or month to month is consistently overshadowed during meetings by talk about problems and deficits. Goals and activities that are written into plans usually focus on remedies for problems rather than on developing skills, talents, and assets. A strengths focus helps to counteract these tendencies by engaging youth and other team members in recognizing, reinforcing, and building on a youth's positive actions and capacities. Maintaining a strengths focus is not something that naturally happens in most team meetings, so meetings should be structured and facilitated in ways that support it.

Specific portions of the meeting and steps in the planning process should be explicitly structured to bring in a strengths focus. For example, every meeting can begin with a group discussion of what's going well. Initial steps in planning should include some form of strengths inventory or list, and this list should be used when the team is deciding how best to reach goals or meet needs. The strengths list or inventory should appear in formal team documentation and can be reviewed or added to at a specific point during each meeting.

Be sure that everyone, including the youth, understands the decisions made and the next steps after the meeting. At the end of the meeting or before shifting from one agenda item to the next, review any decisions made and follow-up responsibilities and deadlines. Write this information down and give the plan to each participant, including the youth. When a youth has offered to take on a follow-up task, be sure to ask if he needs any support to do it. Help the youth think through what accomplishing the task will require and offer support ideas.

Measuring Participation and Empowerment

It is important to gather some sort of data or feedback from youth to assess whether they feel involved in planning and confident about their ability to make decisions about services. The AMP project has created and validated two measures for exactly this purpose. One assesses youth participation in team planning, and the other assesses youth empowerment. Both measures are youth-friendly and brief. The two together can be completed by most youth in 5 to 8 minutes. The youth participation measure assesses whether or not the team environment is one that encourages meaningful youth participation in the planning process. The empowerment measure assesses the extent to which a youth feels confident in managing his or her condition, interacting with service providers, and helping change service systems. These measures are available from the Research and Training Center on Family Support and Children's Mental Health. Contact rtcpubs@pdx.edu. **AMP**

MY

PLAN

AMP

This document was created by staff and advisors of the AMP (Achieve My Plan) project at the Research and Training Center on Family Support and Children's Mental Health, Portland State University, Portland, Oregon.

Youth Involvement in Systems of Care:

A Guide to Empowerment

Reflections

From the Field

Youth Involvement in Systems of Care:

A Guide to Empowerment

January 2005

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Reflections from the Field are technical assistance products inspired by stories, questions, and needs of system of care communities. Each document in the series aims to educate the reader on a specific topic, providing insights, answers, and resources.

Reflections from the Field have been created in part by the Technical Assistance Partnership. To the extent possible, family members, youth, and professionals from system of care communities have reviewed each product.

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Disclaimer:

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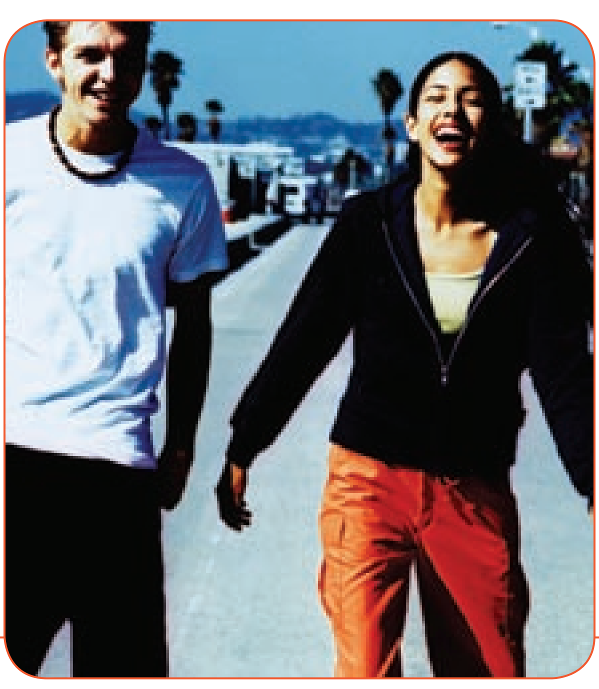
The names and stories of the young people in this guide are real and the individuals gave us permission to print their stories and quotations with their names.



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Youth Involvement in Systems of Care: A Guide to Empowerment

Lorrin's Story—The Power to Make a Difference

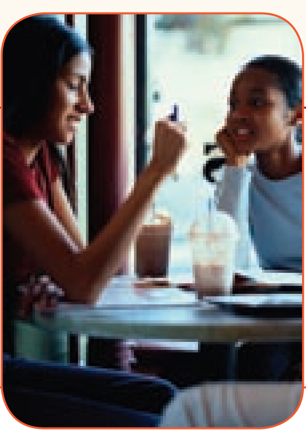
On November 7, 1999, two days before my 15th birthday, I was almost successful in taking my life. It was not the first time I had attempted suicide, nor was it the first time that I had harmed myself. What makes this date so significant is that it was my last suicide attempt. My name is Lorrin McGinnis and I am 19 years old. I am also bipolar.

At the age of 12, I was institutionalized for self-harm. Upon being released from the hospital, I quickly turned to anything that would alter my painful reality, including alcohol and a variety of prescription pills. When I returned to school, classmates who had discovered my whereabouts during my month's absence ridiculed me. I was laughed at and made fun of. Some people thought it was a joke; others were afraid of me and treated me like a plague. There were even a few kids who were morbidly fascinated and wanted to know how I hurt myself, what I used, and what it felt like. I was a 'star.' Yet all I wanted was to be left alone. I became obsessed with suicide and began cutting myself on a regular basis.

When I was 15, I joined a youth advocacy group called Health N' Action (HNA). Before joining I had been through different systems of care and had seen different care providers, but nothing worked for me. I never felt like I was being listened to; I just felt like I was being talked at. By the time I discovered HNA I had pretty much given up on the system, and I was positive that it had given up on me. Joining HNA gave me hope and it gave me a voice. It taught me that I can take what I viewed as my biggest weakness—being bipolar—and turn it into one of my greatest strengths by using my experiences to help other people. Discovering this made every hard time worth it and gave every tear a purpose. For me, it gave my feelings validation, and in many ways, helped me to discover that my life had worth. By sharing my negative and positive experiences in the mental health system, I was able to truly make a difference with the people that I talked with. For the first time, I was able to see value in the feelings that I experienced. As Emily Dickinson so eloquently put it:

If I can stop one heart from breaking,
I shall not live in vain;
If I can ease one life the aching,
Or cool one pain,
Or help one fainting robin Unto his nest again,
I shall not live in vain.

Creating partnerships with youth and giving them a voice works. I know because it saved my life. November 7, 1999, was the last time I attempted suicide because after that, I learned that all the pain I felt didn't have to be in vain. I was shown that people do care about the experiences that I have had and that they want to help. Most importantly, it taught me that because of everything I have been through, I too have the power to make a difference and to help other people.



Preface

Youth Involvement in Systems of Care: A Guide to Empowerment has been developed in partnership with two young people who are currently involved in local systems of care[1] as well as a team of youth and youth coordinator reviewers from across the country. The guide was also vetted to multiple reviewers including internal staff from the American Institutes for Research as well as Gary Blau, Ph.D. from the Center for Mental Health Services, Child, Adolescent, and Family Branch.

The lead authors, Lorrin McGinnis, Martha Mora and Marlene Matarese each have extensive experience within systems of care. The Technical Assistance Partnership for Child and Family Mental Health (TA Partnership) conducted interviews with over 40 youth from across the country and Lorrin and Martha each had exceptional skills and expertise to be hired as the youth consultants on this project.

Lorrin McGinnis is a 20-year-old youth coordinator for Allies With Families in Salt Lake City, UT. Prior to her work in Utah, Lorrin was a youth leader for the King County, Washington youth group Health 'N Action. Her experience as a consumer in the mental health system since the age of 12 is illustrated throughout this guide. Martha Mora's experiences with system involvement are also illustrated throughout the guide. Martha is a 17-year-old youth leader for Sacramento Advocates for Family Empowerment in Sacramento, CA. She is bilingual in Spanish and facilitates five different support groups for teens in her area. Marlene Matarese began her work in the Burlington County, NJ system of care community as a care manager, lead care manager, and trainer on the wraparound process. She worked closely with the youth who were involved in the Youth Movement and the Youth Partnership in New Jersey before beginning her position as the Youth Resource Specialist for the TA Partnership.

Lorrin and Martha guided the development process, authored multiple sections, researched content areas, and interviewed community members on their work around youth involvement. Martha and Lorrin also co-led the focus groups with youth and youth coordinators during one of the vetting meetings. They are exceptional people who were the guiding force behind this project. Together, the three authors were able to gather information and convey the work around youth involvement and the Youth Movement from local and national perspectives.

[1] System of care is defined as "a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and challenging needs of children and their families" (Pires, 2002, p.4).

Purpose of the Guide

The goal for *Youth Involvement in Systems of Care: A Guide to Empowerment* is to provide a resource to youth, youth coordinators, family members, professionals, and other adults working with young people. This guide is a starting point for understanding youth involvement and engagement in order to develop and fully integrate a youth-directed movement within local systems of care.

The mission of *Youth Involvement in Systems of Care: A Guide to Empowerment* is to educate all professionals and adults who work with young people on the importance of engaging and empowering youth. This guide will serve in building the foundation and framework for the Youth Movement in order to enhance opportunities for young people and to utilize their expertise in system change.

A Walk Through the Guide

This Guide is organized in ten primary sections:

I. **Youth Involvement: Moving From a Good Idea to a Necessary Solution**
Youth involvement is a necessary solution to meet the needs of youth and families in systems of care. This chapter will provide you with the rationale for involving youth, including literature on the positive youth development approach and additional information providing support for youth involvement. Readers will understand how the power of youth participation helps to rebuild the community, fosters resiliency, and combats stigma around mental illness.

II. **Who Benefits From Youth Involvement?**
Everyone does. This chapter informs readers of the key benefits from authentically involving youth in systems of care. It addresses benefits for youth, families, programs, organizations, planners, policymakers, and the community as a whole.

III. **History of the System of Care Youth Movement**
The history of youth involvement has followed a path similar to that of the Family Movement. This chapter highlights critical milestones of the Youth Movement.

IV. **Advancing the Youth Movement: Establishing the Value Base**
Advancing the movement requires an understanding and commitment to the values around youth involvement. This chapter will inform readers about these values and how to utilize them in climbing the ladder towards authentic youth involvement.

V. **Getting Started: Hiring the Coordinator and Forming the Group**
This chapter provides the blueprint for the steps necessary to develop a youth-directed group in systems of care. It will guide readers through the steps of hiring a youth coordinator and developing the youth group.

VI. **Cultivating the Environment for Growing Leaders**
Leadership development requires an environment of support and training. Youth and adults need to build partnership and understanding in order to foster a youth-guided system. This chapter will enhance the readers' understanding of what it takes to cultivate this type of environment and build partnership.

VII. Youth Involvement in Systems of Care: Making It Happen
How do you make it happen? Readers will be guided through examples of involving youth in every level of system of care development from developing a communitywide event to meaningful engagement on boards, to evaluation and social marketing, and working towards sustainability.

VIII. On the Horizon
Youth involvement is continuously evolving within systems of care. On the Horizon informs readers about upcoming developments, including the development of the National Youth Development Board as well as focus group studies conducted by ORC Macro on youth involvement in system of care communities.

IX. Resources for Youth Involvement
This final chapter provides readers with a resource list that focuses on various components of youth involvement.

X. References

We encourage you to use this guide as a key learning tool on your journey to develop a youth movement and youth-guided system of care.

Section I

Youth Involvement: Moving From a Good Idea to a Necessary Solution

Building the Rationale: Why We Do It

Positive Youth Development Approach

I. Youth Involvement: Moving From a Good Idea to a Necessary Solution

This chapter provides readers with the reasons why we involve and engage young people in every level of system of care development from policy and planning and systems management to service provision and quality assurance. It informs readers about the positive youth development approach and additional research findings that support the emerging argument for youth engagement.

Building the Rationale: Why We Do It

The population of young people in the United States continues to increase annually. According to the 2000 U.S. Census, there are almost 100 million young adults between the ages of 0 and 24 years, making them the largest generation today at approximately 36% of the total population (United States Census Bureau, 2000). In understanding the mental health issues of this generation, we can differentiate between mental health problems and serious emotional disturbances. According to the 1999 U.S. Department of Health and Human Services (HHS) report, *Mental Health: A Report of the Surgeon General,* "serious emotional disturbances" refer to the range of diagnosable emotional, behavioral, and mental disorders that severely disrupt daily functioning in home, school, or community (U.S. Department of Health and Human Services [HHS], 1999). Serious emotional disturbances effect approximately 5–9% (between 5 and 9 million) of children and youth in the United States in any given year (President's New Freedom Commission on Mental Health, 2003). In order to best support the growing populations of young people, the systems that serve youth are beginning to realize is that they must involve youth fully in the process, much as families have been for the past 15 years.

Youth and family involvement is a necessary component in all levels of systems work. It is imperative that as consumers of services, youth and families play a directing role in their own recovery and feel committed to their own well-being. According to research by Burns, Hoagwood, and Mrazek (1999, p.238), "…the effectiveness of services, no matter what they are, may hinge less on the particular type of service than on how, when and why families or caregivers are engaged in the delivery of care…it is becoming increasingly clear that family engagement is a key component not only to participation in care, but also in the effective implementation of it." Additional research has emerged to support family involvement as a vital component to effective interventions. In fact, "Not all the studies show that improvements resulted from the intervention specifically. Family engagement may play a stronger role in the outcomes than the actual intervention program" (Thomlison, 2003, p.584). In addition, consumers and families told the Presidents New Freedom Commission on Mental Health Transformation that, "having hope and the opportunity to regain control of their lives was vital to their recovery. Indeed, emerging research has validated that hope and self-determination are important factors contributing to recovery" (p.27). These findings coincide with the experiences of many young people.

"having hope and the opportunity to regain control of their lives was vital to their recovery"

Though we are only in the initial steps in evaluating the effectiveness of involving youth, we do know the benefits of youth involvement from youth, family, and providers' anecdotal stories; the personal stories and quotes throughout this guide illustrate this. The attention to youth involvement continues to dramatically increase as young people, professionals, and other adult supporters see that it works. Youth involvement opportunities help young people achieve positive development, assist in their successful transition to adulthood, and develop deeper connections to their communities and their peers. Engaging youth helps to enhance the effectiveness of programs and youth-serving agencies. Research findings have shown that young people feel more able to control their own lives in a positive way, strengthen their connection to the community, engage in their education, and avoid risky behavior when

they are able to improve the lives of others (Lewis, 2003). Research has also revealed that effective adolescent programming tends to involve peer leaders who assist in program delivery (Fischhoff, Crowell, & Kipke, 1999). Youth involvement not only enhances the positive development of young people, but it also reaches throughout the community and system of care. These are the kind of opportunities for youth that we need to begin developing, cultivating, and sustaining within systems of care. Some communities have already begun the work. Westchester Community Network in New York is an example of the benefits of involving young people within systems transformation.

The first step in comprehending youth involvement is gaining a deeper understanding of the positive youth development approach.

Youth Forum is a Success!

Youth Forum is a peer run, peer-to-peer support group for adolescents and young adults transitioning from children services to adult services. It was developed with the support of Westchester County's Department of Community Mental Health and Westchester's family support organization, Family Ties. The members are ages 16–23 and are heavily involved with mental health, special education, juvenile justice, and social services. The group began in 1993 with a few members who considered themselves to be veterans of the system. Family Ties recognized the gaps in services and wanted to hear from older youth and young adults who had been in multiple mental health services and child serving systems. Family Ties asked the young people to participate in a focus group about their experiences with children's mental health services. Six youth agreed and met once a month for 6 months. The young people described various services, placements, and experiences that differed from each other; however, all the youth could identify with feelings of isolation and loneliness. At the end of the 6 months, the youth created a document called What Helps—What Harms. This document outlines what helped the youth and what hurt them in inpatient psychiatric hospitalization, residential placements, school (special education), therapy and treatment, family, and in their home communities. In 1994, the youth presented the document at the first Westchester Wraparound System of Care conference for 300 providers and families. This was an empowering process for the young people. Families, professionals, and providers listened to their experiences and recommendations and took the document seriously.

The group recognized the bond that had formed and they wanted to continue meeting in a safe place once a month and discuss youth-relevant issues. The youth requested funds from the county to continue meeting and to cover costs for food and transportation. The county and Family Ties agreed and provided a small amount of money, and the young people formally established Youth Forum.

Westchester Community Network contracted with the Health Services Research Unit, Department of Child Psychiatry, College of Physicians and Surgeons, Columbia University to evaluate the group. The study revealed that 100% of Youth Forum members believed they are listened to in the group and that their opinions count. The young people were also found to be more empowered and have higher self-esteem: 84% stated that Youth Forum changed the way they felt about themselves. The findings also showed that 75% of young people indicated that they would call another Youth Forum member if they needed peer support.. Of the active members interviewed, 50% were employed and 75% were in school or attending college. Most of the youth (75%) were currently involved in treatment and believed that it was necessary and helpful for success and transition into adulthood. Youth Forum members acknowledged that for many youth who have a mental illness or who are involved in the youth-serving systems, stigma silences them. Youth Forum works to stop the silence and to provide opportunities for young people to communicate their system-related experiences as well as their strengths and abilities.

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(Youth Forum is a Success!...continued)

Youth Forum members present at local and national conferences. They are peer and self- advocates and continue to work toward enhancing the youth-serving systems. Youth Forum creates opportunities for young people to be successfully heard, to bond and create friendships, and to assume leadership positions. They believe that involving youth and providing a forum where young people can speak out and support each other will help to reduce stigma for all youth involved in the system of care.

Positive Youth Development Approach

"Youth groups give you a sense of belonging. If you're young, sometimes you feel like you have no place to go. Youth groups help you to move on, start to feel OK; your morale goes up, so does your self-esteem."

—Daniel Toone, Youth Leader. Youth Forum, Westchester, New York

The positive youth development (PYD) approach is a way of thinking, living, and acting as individuals and as a community. As adults and youth, we should expect more from young people and provide them with opportunities to give more and become more. It is important to remember that even though youth involvement promotes positive youth development, involving youth is not only a way to help them to develop positively, but also to utilize their expertise in enhancing systems transformation. The youth development movement was created to emphasize the positive outcomes that youth can create, rather than the negative outcomes that society hopes to prevent.

This concept of developing opportunities for young people to create change is not a new one. The PYD approach has been a relevant concept in adolescent development literature for the past 20 years. During this time, youth development has shifted from prevention (programs created to combat the problems of high-risk youth) to preparation (developing skills and encouraging broader development for all young people) to participation and empowerment (utilizing young people as partners in decision making). The Youth Development and Delinquency Prevention Administration (YDDPA) describes the four components of positive youth development as having a sense of competence, usefulness, belonging, and power (National Clearinghouse on Families and Youth [NCFY], 1996).

These components comprise a comprehensive and inclusive approach to youth development:

- Young people and families need to be viewed as partners rather than clients of the system. They need to be involved in creating and implementing programs and services.
- Youth need to be given opportunities to participate in programs and services that will meet their developmental needs.
- Youth need opportunities to develop supportive and trusting relationships with adults.
- Adolescence is an important stage in the developmental process of young people and a valuable opportunity for communities to encourage youth to move in positive directions.
- Youth development is a natural and complex evolution.

(NCFY, 1996)

Why Is Positive Youth Development Important?

Young people need to be given opportunities that will meet their intellectual, social, physical, psychological, ethical, and moral developmental needs. Youth benefit from hands-on experiences, from belonging to a group while keeping their individuality, and from the support of and interest from adults. Youth also need to develop critical thinking skills whereby they learn to clearly express their opinions, challenge the assumptions of adults, and make sound decisions (NCFY, 1996). When young people are not given opportunities to grow and develop in a positive way, they are more likely to find harmful alternatives. For example, some youth may consider gangs as a way to belong, to find support, and to make decisions. When young people have access to appropriate supports and opportunities, they avoid self-destructive lifestyles, such as that of a gang member, and achieve a healthy sense of identity and the competencies necessary to become successful adults (Zeldin, 1995). The development of youth groups in system of care communities, in addition to involving youth in each level of systems transformation, creates opportunities for positive youth development.

Fostering a PYD approach in the community often requires a shift in beliefs relating to young people. Youth leaders and adult supporters must have an understanding of both the benefits and challenges of changing the community perceptions. It is the responsibility of these change agents to show practitioners, policymakers, and community members the importance of regarding young people as economic and cultural resources. Youth, families, and professionals need to be valued as equal partners in creating systemic change. In order to achieve authentic youth involvement, community and professional partners must accept that they need more than just youth input, and that young people must be actively engaged.

Rebuilding Communities With Youth

Young people should grow up in communities, not programs. An important factor in utilizing a youth development approach is the connection of the youth to the community (NCFY, 1996). It is through the connection with the community and youth development opportunities that young people gain a sense of personal power. All young people need to feel a connection and a sense of belonging and will seek out ways in which they can meet their basic physical and social needs, as well as build competencies that they feel are necessary to participate in society.

Often young people who are involved in systems of care are disconnected from their community due to out-of-home placements and isolation as a result of stigma. Young people who have a mental illness may be faced with reintegrating back into the community after stays in psychiatric hospitals, juvenile detention centers, foster homes, group homes, or residential facilities. Young people who are currently dealing with poverty, school failure, family crisis, and challenging behaviors are the least involved in youth development opportunities (Roach, Cao Yu, & Lewis-Charp, 2001). For these young people, socialization and discrimination have profound effects on their positive development. Youth and adults often react to a loss of belonging by engaging in high-risk behaviors to lessen feelings of seclusion and isolation (Kirshner, O'Donoghue, & McLaughlin, 2002). As healthy relationships between people dissipate, communities begin to fall apart resulting in a greater chance of violence and crime. One way to rebuild communities is to support youth, families, and community resources simultaneously so that the core problem, and not just its symptoms of the problem, can be treated.

The development of youth groups for young people in systems of care that are grounded in the community will foster a sense of connectedness. Allowing opportunities for youth to communicate about the barriers they have faced often helps them to move forward in positive ways. These groups may also help young people deal with issues of race, gender, sexuality, and religious differences in order to better understand each other's experiences. Talking openly and honestly about power, identity, adultism, control, and experiences within the system will help change attitudes relating to youth, youth perceptions of adults, and youth serving systems (Mohamed & Wheeler, 2001).

In order to rebuild a community, all community members must be seen as equal partners in the rebuilding process. The "community as partners" approach empowers members of the community – youth, families, and community supporters – to become active in making positive changes

in their neighborhoods (Kirshner et al., 2002). When an empowered community creates change, the community becomes a safe and supportive environment for youth to learn and develop new skills. These new skills can be developed through positive participation in community-building activities, which in turn create appreciation and public awareness of youth contribution.

The PYD approach requires that the community view youth contribution and partnering as an important investment in the future of the community. The youth development-community empowerment approach engages youth in activities that give them the opportunity to learn new skills and grow while simultaneously encouraging positive relationships that root them in the community (NCFY, 1996). Youth involvement and engagement is the foundation for rebuilding the community.

PYD Framework Fits in Systems of Care

- ➜ Youth development requires partnership.
- ➜ Youth and the community must share a common vision in order to implement a youth development approach.
- ➜ Organizational changes may be necessary when implementing a youth development approach.
- ➜ Youth groups need to partner with adults in creating evaluation indicators for youth development.
- ➜ Youth groups need to promote a positive image of youth in the community.
- ➜ Youth groups need to educate policymakers, providers, communities, and families.

The goal of system of care communities is to create transformation within the children's mental health system. Authentic transformation creates structural and philosophical change. Youth leaders, consumers, coordinators, and adult supports are all a part of system reform. The role of youth and youth coordinators is to foster youth development and involvement within their own group as well as throughout the community. However, given these fundamental principles, each youth organization is going to use a different model. The PYD approach emphasizes the importance of addressing the strengths, needs, and resources of individual communities in order to build the most appropriate framework. Family support, individual personality, socioeconomic status, access to education and opportunities, gender, physical capacity, and racial or ethnic background contribute to the development of young people and affect the types of contributions that youth are able to bring to their communities (NCFY, 1996). For example, while one young person may be able to advocate for youth through public speaking, another may express him or herself more effectively through art or writing. Thus, different youth development approaches are more effective for different youth. It is important to remember that youth development is contextual, not linear.

PYD Approach and Resiliency

Resiliency is also an important component in the positive development of young people. Why do some youth "make it" and become successful? Care and support, high expectations, and opportunities to participate help young people to become more resilient when faced with challenging life experiences. Young people who develop problem-solving skills, have positive relationships with adults, and have a sense of social competence, safety, identity, autonomy, purpose, respect, and future often have the ability to bounce back from adversity (Bernard, 1991). Resilience is a product of trusting relationships, internal strengths, skills in interpersonal relationships, and the ability to problem solve. Faith and self-esteem are also crucial in building resiliency in young people (Institute for Mental Health Initiatives, 1999). Having a sense of belonging and purpose, as well as resiliency, often allows young people to overcome the barriers that they face due to the stigma of having a mental illness.

Cloteal Norman is a youth advocate from the Youth Task Force in San Francisco, CA. This 20-year-old African American leader survived the murders of four of her siblings, drugs and violence on the streets, and experienced

over 10 years of therapy. She is a shining example of the resiliency of the young people involved in systems of care. Below is a poem written and presented by Cloteal at the Federal National Partnership for the Transformation of Children's Mental Health Care Meeting on November 22, 2004 to key leadership in the Federal government and national organizations.

My Ghetto, My Community

By Cloteal Norman

The ghetto…
Look at it rise
Listen to our cries
Look at the streets
They think they got us beat
Mind games played
People hanging around in a daze
Bagging up rocks
And hustling on street blocks
Hey, watch out here come the cops
Who really cares…
Who's really there?
You look at our clothes
But you should really look at our souls
Hurt
Sorrow
Stuck thinking there is no tomorrow
Anger one of our most common pains
Police knowing us one by one
Each by name
WHAT A SHAME!
What about the different systems
Juvenile justice
But what is really justified
How our lives compare to books
Mental health
Ha!
Most therapists seem to be crooks
Special education
What's really changing
Foster Care/Group homes
Yeah right,
You end up feeling all alone
Let's flip it
Let me tell you what the media doesn't see
I'm a representative of the class of
Two double O three (2003)
Graduated on May 21st with a 3.95 (GPA)
Now check me out and say that GPA isn't high
Three siblings dead
I've been raped
Molested
Abused
Misused
Remember being scared
From mama being sick
Thinking
Somebody help us now
Praying to God
Never being lost
But always found
Working everyday
Knowing the Lord always makes a way
Thinking no matter if people discriminate against
Or hate me
Because it doesn't make or break me
I quit selling dope
I quit hanging out
I quit fighting
I quit playing church
So now I am more real
I'm working
Towards telling people
Exactly how I feel
But all in all
Look at me
I'm no longer a statistic of society
Look at my ghetto so frequently talked about
Society talks about us
People pass by
Instead of helping us
But I rose above
I think beyond these earthly things
Like heaven
A place where I want to be
Look at me and my community
I'm a product of this "ghetto society"
Only because the Lord always looks out for me
He's the reason for my success in this ghetto society
So remember
That something good
Can come from the hood.

Countering Stigma With the PYD Approach

Lorrin's Story—The Sting of Stigma

Growing up, I experienced a great deal of stigma because of my mental illness. When I was institutionalized for the first time in sixth grade, I had to deal with my peers calling me crazy and taunting me about my failed suicide attempt when I returned to school. Many people were afraid of me and no longer cared to associate with me. There were others who simply chose to avoid me because they didn't know what to say. As I grew older, the stigma I endured in my life continued to increase along with the labels placed on me. I had people call me crazy and selfish. Some people accused me of being weak and encouraged me to "toughen up." I can't even count how many times I was told to "just snap out of it." I once had a boyfriend ask one of his friends, "What do you think it would be like to date somebody who is bipolar?" His curiosity stemmed from the stigma he had been taught about mental illness; the stigma that says that we are completely different from everybody else—a separate species even. And often I felt just like that. My involvement in the youth advocacy group I joined helped me to understand where the stigma I had felt all my life came from and how I could combat it.

A component of authentic youth involvement and engagement is understanding and combating stigma in the lives of young people. Many people deal with some type of stigma whether it is private, social, or even academic, but most do not face this on a regular basis. Unfortunately, this is not true for many youth who have a mental illness. Being a teenager is difficult enough, but having to deal with the stereotypes and stigma of having a mental illness makes it that much more challenging. In addition to adjusting to adolescence and trying to maintain stability and personal safety, young people with a serious emotional disorder are faced with the task of proving that they are people of worth, intelligence, and strength.

The stigma of mental health is closely associated with young people's feelings of isolation and being marginalized. The final report of the President's New Freedom Commission on Mental Health describes stigma as "a pervasive barrier to understanding the gravity of mental illness and the importance of mental health" (President's New Freedom Commission on Mental Health, 2003, p.20). Often, individuals do not recognize their own symptoms of mental illness, and when they do, the stigma prevents them from seeking treatment. The stigma against mental illness has become so pervasive that many young people would rather be labeled as substance abusers or juvenile delinquents than as being mentally ill, according to Lorrin McGinnis' experience. Being labeled as either a substance abuser or juvenile delinquent gives the illusion of control, whereas having a mental illness is not a choice but a medical illness. Many people do not recognize mental illness as a true illness; it is often perceived to be a personal weakness or a choice rather than a physiological disease. This stigma continues to effect youth within the education system.

Schools are supposed to be safe institutions where young people go to receive an education free from discrimination and stigma. However, many youth with a mental illness receive the "bad kid" label at school. When a young person is perceived to be struggling, the teacher will often increase discipline, focusing on the youth's negative behaviors rather than providing praise for his or her positive behaviors. This can lead to the reinforcement of a negative self-image, increased insecurities, and amplify feelings that the young person may already be experiencing in his or her life. Eventually, many youth are expelled or drop out because the school systems are not trained to reach out and to understand how mental illness affects young people. Of children with serious emotional/behavioral disorders, 50% drop out of high school, compared to 30% of students with other disabilities (U.S. Department of Education, 2001).

Without individualized, tailored care, many youth are unable to be successful in completing their education. This is not a reflection of their intelligence. Partnering with youth to establish an individualized plan of care that would include

setting realistic goals and adjusting assignments or time limits to comply with individual youth's emotional needs is an important way to help them be successful in completing their school work and attending classes.

The most painful form of stigma that youth deal with is social stigma. The media and entertainment industries continually endorse stereotypes of mental illness. People with mental illness have been portrayed as being crazy, dangerous, stupid, slow, dependent, selfish, and unable to positively contribute to society. These labels reinforce the insecurities that many youth may already have, often leading to isolation and a further disconnection from society. Young people may refuse to seek support because they fear being judged. Thus, it is important for adults, professionals, and youth to use a strength-based approach in working with young people rather than a deficit-based focus. All too often, young people are criticized for their weaknesses rather than being praised for their strengths and potential. These criticisms are given at a time when young people feel unattached to society and feel that they no longer belong to it.

The development of youth groups and youth involvement is a step toward decreasing stigma. Young people are the professionals when it comes to their lives. Adults may have a degree in psychology or social work and have read about the subject, but young people live it. They know what it is like to be depressed and suicidal; to be living on the streets; to be dealing and using drugs; to drop out of school; to be locked up, institutionalized, and hospitalized; to lose friends through suicide and acts of violence; to be laughed at, patronized, and tokenized; and to have survived. Youth involvement and engagement is a way of acknowledging that young people are able to positively contribute to society. Youth groups create a partnership with young people that shows them that their illness is a strength, which helps youth create change. Encouraging young people to share their stories and advocate for themselves and other people will simultaneously empower them while decreasing the stigma and isolation that surrounds them.

Martha's Story—Overcoming Challenges and Creating Change

My name is Martha. I'm 17 years old and I'm from Sacramento, California. I moved to Sacramento about 5 years ago from the Bay Area. I started my first year of high school in Sacramento, that's when all my problems started. I was the new girl, so I had no friends. Everyone already had their little crews and didn't want to be friendly with the new Latina girl. The school I attended was mostly upper-class White kids. As time went by I slowly made friends, but the only people who would accept me were the kids who did drugs and skipped school. After awhile, I just stopped going to school and I started doing drugs. Once my parents found out, I ran away from home. I ran away because I was so upset with myself—I couldn't believe what I was doing to myself. I felt like I had to leave home for awhile because I was lost. I didn't know who I was anymore. I was feeling lost and hopeless. There was so much I was feeling and I didn't know why I was feeling like it. I was so scared. Finally after a week away from home, my mom found me.

When my mom found me, the police told my mom to take me to a place called The Neighborhood Alternative Center, where all the runaways go. On the way there my mom was yelling at me. I was so frustrated because it made me feel like she didn't even care that I was gone, so I tried to jump out the car while she was driving. She called the police and they took me to a local mental health hospital. Going to that hospital is what made my whole family wake up and realize that I had a problem and I needed help. At the time I was 14 years old. I didn't know that they had a mental health hospital. It was all new to me. When I finally saw the doctor and he went over with me and my family about me being depressed, I had no clue what he was talking about. I knew nothing about mental health. I just thought

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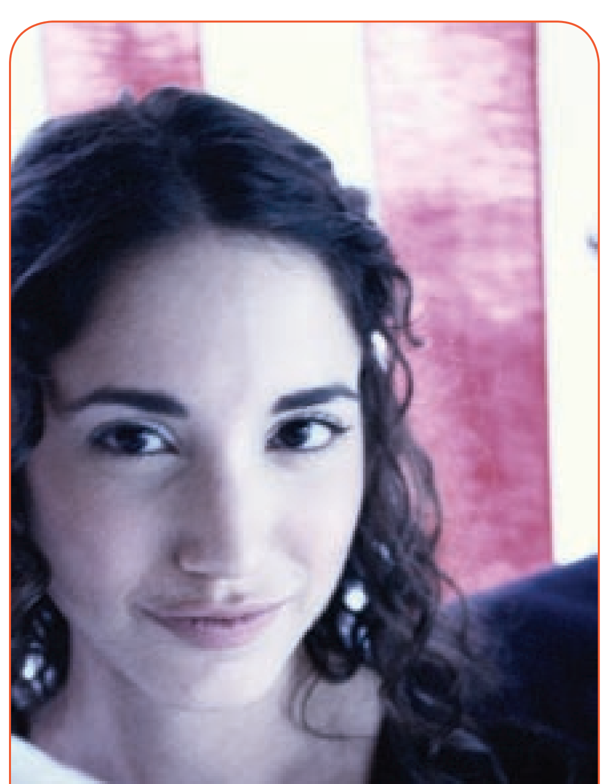
(Martha's Story—Overcoming Challenges and Creating Change...continued)

it was normal to feel the way I did. Soon after I was released from the hospital, I was connected with a youth advocate named Shannon. She was an advocate for the Sacramento Advocates for Family Empowerment (SAFE) program. Once I met Shannon, I decided to make a change in my life. Shannon helped me get back on track with school and my family life. She also helped my family and me understand more about mental health and the whole system overall.

After a few months went by I was tired of going to the same youth group every Tuesday, so I had asked Shannon how we could have other groups with different kids. So that's what we did. After a year went by, we had started two groups—a girls' discussion group at the probation center and a boys' activity group at the family court house. Once I turned 16, Shannon finally turned the job over to me because she started medical school. I've been working with the SAFE program for a year now and we have five youth groups that are running right now and are very successful and so many youth who have come a long way. The other groups that we have are a Gay, Lesbian, Bisexual, Transgender, Questioning; Anger Management; and Teen Support, and the Youth Advisory Council.

If it wasn't for the SAFE Program, I don't know where I would be right now. In March of 2004 my boyfriend committed suicide. At the time, I was working with the SAFE program and also with the Sacramento system of care, the OASIS Project. If I didn't have all this work to keep me busy and all the great people to help me get through this, I don't know where I would be right now. I think that youth today just need that one person to make a difference in their life.



Section II

Who Benefits From Youth Involvement?

Benefits for Youth

Benefits for Families

Benefits for Adults

Benefits for Organizations

Benefits for Planners and Policymakers

Benefits for the Community

II. Who Benefits From Youth Involvement?

Everyone does! Youth, families, adults, organizations, policymakers, and communities as a whole benefit when young people have a voice that is listened to, respected, and utilized within systems of care. Youth engagement can assist in a successful transition to adulthood by providing training and opportunities such as budgeting, public speaking, program development, and peer advocacy. Young people are able to learn and enhance their skill sets in supportive environments. The entire system of care community benefits from the knowledge and abilities of these young people.

Benefits for Youth

Involvement helps youth to:

- Understand the community in a different way
- Make friends
- Have a support group of people who "get them"
- Create a positive change in their community
- Develop new skills and knowledge
- Reframe their personal identities from an "SED kid" to a leader and change agent
- See themselves reflected from peers and family members in a positive light
- Develop confidence and strengthen their sense of pride, identity, and self-esteem
- Create a better system that will help themselves and others
- Have their voice heard and utilized

Benefits for Families

Youth engagement helps families to:

- See their sibling or child evolve into a leader with competencies and a sense of belonging, self-advocacy, and independence skills
- See that their children are resilient
- View the youth as a model for the family for utilizing mental illness as a strength
- Become more strength-based as they see the youth growing and becoming change agents
- Gain relief and respite from caregiving
- See that the youth has the ability to connect with peers and have sustained relationships

Benefits for Adults

Youth engagement helps adults to:

- Experience young people's competence
- View youth as legitimate and essential contributors to the organizational decision-making process
- Feel more effective, confident, and competent in their work with youth and the work of youth
- Gain a stronger sense of community connectedness

Benefits for Organizations

Organizations and staff also benefit from involving young people in decision-making opportunities. In a study conducted by the National 4-H Council (Zeldin, McDaniel, Topitzes, & Calvert, 2000), researchers found that youth involvement in organizational decisions helps in a variety of ways. Youth engagement helps organizations:

- Bring clarity to their mission
- Improve adult staff involvement
- Enhance their responsiveness to the community
- Strengthen their commitment to the work
- Raise funds

(Benefits for Organizations...continued)

- Better meet the needs of young people when they understand youth
- Enhance the commitment and energy of adults
- Embed youth involvement principles in the organization practices
- View the importance and benefits of involving a diverse community in decision making
- Generate increased creativity
- Bring underrepresented groups into organizational decision making

Benefits for Planners and Policymakers

Planners and policymakers benefit from youth involvement and can utilize the expertise of young people to enhance youth-serving systems.

Youth involvement helps planners and policymakers:

- Develop a better understanding of the needs and issues of the youth population they serve
- Gain a different perspective of youth experiences with multisystem involvement
- Develop systems that are more creative and better meet the needs of children and families
- Know what works and does not work based on real-world youth experience

Benefits for the Community

Youth involvement helps the community:

- Interact with youth to overcome youth culture stereotypes
- Increase its understanding of how young people view the world
- Identify ways to enhance their community
- Generate fresh and innovative ideas of young people
- Increase community relations
- Increase youth ability to make positive contributions to the community

Involving young people enhances systems from the lives of individuals and families to organizations, programs, and the community. Authentic youth involvement means that young people are engaged and have opportunities to have their voices heard and utilized, and adults and youth share power in decision-making.

Section III

History of the System of Care Youth Movement

Families Paving the Way

Youth Gain Momentum

Surgeon General's Conference on Child Mental Health

System of Care Community Meeting in Atlanta

System of Care Community Meeting in Puerto Rico

Rosalynn Carter 17th Annual Symposium

New Freedom Commission Youth Presentation in Chicago

Youth Involvement Today

III. History of the System of Care Youth Movement

Today, the Comprehensive Community Mental Health Services for Children and Their Families Program requires that young people with a serious emotional disturbance who have systematically been denied the opportunity to share in their home, community, and educational life have a "voice" in each system that serves them. However, this has not always been the case.

Families Paving the Way

Over the past 15 years, the family movement has led the way for positive change in children's mental health services. Their work has clearly paved the way for the youth movement. Families have been involved in systems of care in various roles since the authorization of the Comprehensive Community Mental Health Services Program for Children and Their Families in 1992. The language and values around the family movement have evolved through the years from being primarily child- and family-centered, to encompassing family friendly, family support and, now, family driven efforts. Families remain advocates at the individual level and have developed into a national movement and network of families. The movement gained momentum with the establishment of the Federation of Families for Children's Mental Health (FFCMH) organization by Barbara Huff and other family activists in 1988. In addition, the National Alliance for the Mentally Ill and the National Mental Health Association developed advocacy movements and linked adult mental health consumers, their families, friends, concerned citizens, and professionals for decades (Cheney & Osher, 1997). Family members continued to become actively involved in policymaking at the local, state, and national levels. Families have also consistently provided peer-to-peer support individually as well as through support groups. Local family organizations, many affiliated with FFCMH, are located throughout the United States as 501(c)(3) organizations and are often connected with local system of care communities.

Youth Gain Momentum

The youth movement is following a path similar to that of the family movement. Youth are viewed as valuable partners and experts on their own needs. Youth involvement in policymaking has steadily risen. Some of the organizations that have helped spread the word are the Federation of Families for Children's Mental Health, the Children's Defense Fund, and the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS). Their willingness to have youth involvement at their annual conferences has helped youth to educate more young people, families, and professionals on the value of youth involvement, engagement, and empowerment.

Surgeon General's Conference on Child Mental Health

The Surgeon General's Conference on Child Mental Health was held on September 18 and 19, 2000. This was a pioneering conference where young people were invited to "sit at the tables" with families and professionals to discuss the Surgeon General's focus on children's mental health. Although the adults at the tables were well intentioned, the youth voice was lost in the jargon, competition for time, and other variables that made the youth feel unwelcome and tokenized. That day, the youth made a decision that would change the shape of youth voice in public policy; they unanimously decided to not attend the conference the

second day due to what they felt was a lack of respect. Their absence was noticed. In fact, it left a void. The youth rejoined the group after writing a manifesto asking the parents and professionals to treat them with respect and dignity. Among the requests were to:

- Not use acronyms without explanations that youth would understand
- Not use acronyms, labels and diagnoses to describe youth in meetings (e.g. SED kid)
- Fund and support youth organizations at the same level as family organizations
- Make room for youth to participate when they are asked to sit at policy tables

After this presentation the entire conference became more youth-friendly. At the end of the meeting, Cecilia Nation from Alaska delivered to the Surgeon General, Dr. Satcher, an impassioned plea that was written by all the youth attending the conference. The plea was simple: Nothing About Us, Without Us, which was first echoed within the family movement. Ms. Nation received a standing ovation, and the youth movement has rapidly moved forward for the past 4 years.

System of Care Community Meeting in Atlanta

Following the Surgeon General's Conference on Children's Mental Health, the biannual Fall 2000 System of Care Community (SOCC) meeting in Atlanta, GA, had a team-building, conflict resolution skills workshop for youth, youth coordinators, and advocates attending the meeting. During this conference, youth also participated in panel presentations during the workshop sessions. This was a well-received and empowering experience, and young people wanted to have more youth workshops at all conferences.

System of Care Community Meeting in Puerto Rico

For the Spring 2001 SOCC meeting in Puerto Rico, youth were invited for the first time to present at both the opening and closing plenary sessions of the conference. Youth also presented at various workshops with their communities and facilitated a collaborative workshop on the various youth groups and their activities in their communities. During the planning process for this conference, the youth expressed a need to have their own meeting room for the duration of the conference where they could socialize, connect with other youth, and prepare for their presentations. The youth and youth coordinators planned a two-day youth track workshop in which more than 20 youth from Puerto Rico and more than 25 youth from the various grant-funded communities attended. During these two days, youth learned conflict resolution skills and team building and developed their personal mission statements and goals. Young people facilitated a powerful discussion on the needs of youth in the system of care across the nation and developed a list of recommendations for their communities and national policymakers.

Some of the most important recommendations suggested were:

- Involving youth in all policymaking and governing bodies
- Providing access to resources and skills to make youth effective advocates
- Promoting collaboration between youth and family organizations
- Building a mutual relationship between consumers and professionals, with a goal of shared power
- Hearing and utilizing youth voice
- Developing a youth curriculum for professionals and youth coordinators
- Developing a national, recipient-run youth organization
- Coordinating an annual youth/young adult conference
- Hiring of a youth coordinator at a national level who has been a recipient of services
- CMHS Request for Applicants should require:
    - Youth involvement
    - Youth participation in all conferences
    - Hiring local youth coordinators

Rosalynn Carter 17th Annual Symposium

The youth's reputation for being experts led to their participation in the Rosalynn Carter 17th Annual Symposium in November of 2001, which focused on children's mental health. The youth participated in a panel discussion with four professionals in which they discussed their experiences and the different things that worked and did not work in the children's mental health system. The youth also had the opportunity to have lunch with Mrs. Carter and to discuss their issues and concerns. During the conference, young people further addressed the importance of having a national, full-time youth coordinator with officials at SAMHSA. The youth also participated in work groups where they brainstormed ideas with the professionals and other symposium participants on solving the issues put forth in the Surgeon General's report. The Carter Center printed a report of the symposium's outcomes shortly thereafter.

New Freedom Commission Youth Presentation in Chicago

On September 11, 2002, the Metropolitan Child and Adolescent Network's Teen Advisory Council in Chicago presented research findings to the President's New Freedom Commission. This committee was comprised of 10 adolescents, ranging in age from 14 to 19, all of whom had been primary consumers of community mental health services. The youth presented a strong voice to the commission and contributed to the commissioner's viewpoint that services need to be consumer and family driven.

Youth Involvement Today

Young people continue to be engaged at the national level in conference planning, youth track development, policymaking, and advocacy. The 2002 Request for Applicants in the Child Mental Health Initiative now requires youth involvement with the hiring of local youth coordinators and ensures youth involvement in every level of system of care development. To respond to this new requirement, the Technical Assistance Partnership for Child and Family Mental Health has hired a full-time national youth resource specialist dedicated to supporting the various youth groups and system of care communities across the nation. There are currently more than 40 youth groups dedicated to youth voice in public policy. The movement continues to gain momentum with new and exciting advances on the horizon discussed in the final section of this guide.

Section IV

Advancing the Youth Movement: Establishing the Value Base

How Do You View Youth Involvement?

Ladder of Youth Involvement

Values of the Youth Movement

Keep It Positive: Be Strength-based

Participation = Shared Power & Empowerment

Recognizing and Avoiding Adultism

Cultural and Linguistic Competency: Valuing Diversity

Valuing Youth Culture

IV. Advancing the Youth Movement: Establishing the Value Base

"Youth are a major part of what forms the system of care so therefore we should and need to be included in decisions and meetings concerning anything with the system of care. Our voices can be very powerful if we are heard by the right people. I believe very strongly that youth can make a humungous difference if we're given the chance. So let us!"

—Sarah Oram, Youth Leader, Burlington Youth Partnership, Burlington County, New Jersey

What does it mean to truly value youth involvement in a meaningful way? Individuals may be at varying levels in this process. This chapter will guide readers through the progression of developing and understanding the philosophies and values around youth involvement. To begin with, you should ask…

How Do You View Youth Involvement?

Building a partnership with young people requires an understanding of personal views of young people and a willingness to change those perceptions if necessary. Adults may view young people as objects, recipients, or partners (Innovation Center For Community and Youth Development, 1996). The Ladder of Youth Involvement, pictured below, illustrates the different relationships adults can choose to engage in with youth. Each rung of the ladder fits into one of the above-mentioned roles. As one moves closer towards the top, maximum youth involvement is approached, and a youth-adult partnership becomes a reality.

Ladder of Youth Involvement

Step 9. Youth Initiated and Directed

Step 8. Youth Initiated, Shared Decisions with Adults

Step 7. Youth and Adult Initiated and Directed

Step 6. Adult Initiated, Shared Decisions with Youth

Step 5. Consulted and Informed

Step 4. Assigned and Informed

Step 3. Tokenism

Step 2. Decoration

Step 1. Manipulation

Maximum Youth Participation

Minimum Youth Participation

(Adapted from "Hart's Ladder" from "Youth Participation in Community Planning," a report of the American Planning Association Innovative Centre for Community and Youth Development. Available at: www.theinnovationcentre.org)

View of Youth Involvement	Outcome	Steps of the Ladder
Youth as Objects Adults know what is best for young people.	Involves youth in adult-controlled situations at the discretion of adults. Young people's contributions are insignificant and underutilized. Young people maintain a powerless position.	1. Manipulation 2. Decoration 3. Tokenism
Youth as Recipients Adults view youth participation as an experience that will be good for them.	Creates an opportunity for young people to learn from the adult experts, which will help them when they become adult contributors.	4. Assigned and informed 5. Consulted and informed 6. Adult initiated, shared decisions with youth
Youth as Partners Adults view youth as important contributors	Encourages youth to become involved in all aspects of the organization, group, or project. Youth and adults share power and are equal partners in decision-making, Both bring strengths, abilities, and expertise to the table. The system of care is youth-guided.	7. Youth and adult initiated and directed 8. Youth initiated, shared decisions with adults 9. Youth initiated and directed

Understanding how adults view young people will help adults refrain from tokenizing youth. Young people can be involved in many ways within systems of care, but how they are involved and the level of authentic partnership makes the difference. Involvement can range from manipulation as the lowest level of participation to youth initiated and directed involvement, the highest level of participation. Youth and youth coordinators strive for youth initiated and directed involvement. At this level, youth are making decisions, setting goals, and developing action strategies with the youth coordinator who is serving as the coach to encourage and empower youth, not to lead them.

In system of care work, communities vary in their level of youth involvement. The primary goal is to move beyond stages 1–5. Shifting youth involvement to stages 6–9 can be challenging, but it is necessary in achieving authentic youth involvement and becoming a youth-guided system of care. As youth involvement is maximized, adults' roles in working with youth are also evolving, from being mentors to becoming partners and coaches. It is essential for adults to eliminate traditional youth–adult relationships that are based on power imbalances. Young people and adults must overcome stereotypes about each other before this partnership can fully occur. Youth and adults should have a mutual understanding of what the partnership will entail; roles and shared responsibility must be clear (Drake, Ling, Fitch, & Hughes, 2000). Adults, allies, and youth coordinators must be passionate supports to young people. It takes dedication and drive to support a youth-led movement and to instill or revive that passion in each other and in the community.

Values of the Youth Movement

Similar to the family movement, the youth movement is constantly evolving. Youth involvement has recently shifted to youth-guided systems of care. Young people now are not simply involved in a token way, but are actively engaged and supported in guiding their own service and support planning as well as the planning for the system of care. Young people are in the process of developing a working definition of "youth guided" as well as the principles and values of the youth movement.

The five primary values in partnering with youth include cultivating and maintaining a strength-based focus, sharing power and empowering young people, recognizing and avoiding adultism, valuing cultural and linguistic competence, and valuing youth culture.

Initial discussions around the values of the Youth Movement and youth-guided systems of care include:

- ➜ Youth involvement is offered as proof that individuals with mental illness can function and be contributing members of society.
- ➜ Youth have rights.
- ➜ Youth are utilized as resources and part of the solutions in the development of themselves, their communities, and youth-serving systems.
- ➜ Youth have an equal voice and are engaged in developing and sustaining the policies and systems that serve and support them in every level of system of care development.
- ➜ Youth are active partners in creating their individual treatment and support plans.
- ➜ Youth have access to information that is pertinent to their treatment and lives.
- ➜ Youth are valued as experts in creating systems transformation and in their own lives based on their personal experiences.
- ➜ Youth's strengths and interests are focused on and utilized.
- ➜ Families, professionals, and other adults share power with youth.
- ➜ Adults and youth respect and value youth culture and all forms of diversity.
- ➜ Youth are supported in a way that is developmentally targeted to their individual needs.

Keep It Positive: Be Strength-based

In general, adolescents are looked down at by society. For more than 20 years, the HHS has focused on the strengths of young people as the fundamental principle in youth development rather than their weaknesses in their youth-related programs (NCFY, 1996). Continual recognition of individuals and the work of the entire group will help to build a strength-based environment, as will laughter and having fun. Using the energy of youth makes life more exciting and enjoyable. Youth expression and creativity must be fostered within any meeting involving young people.

Identifying and acknowledging strengths will steer the youth group in the right direction. Everyone in the group has something amazing to bring to the table. It is important to take time to figure out what the youth group's strengths are and how they can be used to the group's benefit. Conducting a strengths assessment should occur throughout the lifetime of the group. Some questions to ask as part of the strengths assessment are:

- What are each of your individual strengths?
- What do each of you bring to the table?
- What are the group's strengths?
- What are the strengths of your community?

A strengths assessment can be incorporated into a youth group meeting as an agenda item. It can be as simple as going around in a circle and having each individual say what he or she believes is his or her greatest strength that can be shared with and utilized by the youth group. Taking it one step further, one group member can write down the strengths as they are shared and hang up the list so the group can actually see, and be reminded of, the myriad strengths that empower the group. Identifying the strengths

of young people who are participating in board meetings and committees will also help youth select roles that match their expertise and interests.

Participation = Shared Power & Empowerment

Authentic youth involvement creates opportunities for young people to actively engage in decision making. Youth involvement means that youth voices should be heard, valued, and utilized in all decisions that affect their lives and the lives of their peers and families. Young people have the ability to create significant change and to cause others to make change. Participation can be defined around three general areas: contact with the political, economic, and social spheres of society; decision making in arenas that will influence one's well-being; and involvement and planning in the community (Youth Council for Northern Ireland, 1993).

Youth participation is key in the development of a social conscience and social responsibility. Youth involvement in policymaking occurs when youth have direct decision-making authority in making public policy decisions. This happens when youth are board members, committee members, or voting members of commissions (Mullahey, Susskind, & Checkoway, 1999). Young people should develop youth support and advocacy groups, should be involved in every level of system of care development from the planning stages to service delivery, and positions for young people on governing boards and other decision-making bodies should be created.

The Youth Leadership Institute (YLI) conducted a study in 2000 on the effects of young people who participated on boards and committees. They found that youth benefited from participation on governing boards in numerous ways. Youth board members reported that they learned how to make better decisions about issues facing their peers. They believed they were better at planning and facilitating meetings. Young people reported that they were more comfortable sharing ideas in a group, having leadership roles, and giving presentations. Youth board members reported being more committed to helping the community, and involvement helped them develop positive relationships with adults. Young people were also found to be more prepared and interested in higher education (YLI, 2000). Young people are the present and future agents of change and need support from the adults in their community to be successful. Developing an authentic youth involvement movement in system of care communities requires that young people are given opportunities, and adult and professional power is shared with youth.

Adults innately want to "fix" and "save" children and defend their rights. Young people are often represented in the media as violent, irresponsible, drug addicted, pregnant, school drop outs, homeless, and many other images that create stereotypical images of youth. As stereotypes continue to be reinforced, young people become more alienated from adults and their communities (see chart below). How can we help youth? The question should be reframed—how can we help youth help themselves and their communities? We do this by providing tools, training, and opportunities.

Young people can accept responsibility for creating social change and often want to develop the competencies and skills to make this happen. Young people can identify social concerns and develop methods to address those concerns. Young people can develop, initiate, and organize projects that respond to personal needs as well as the needs of their peers and their community. Youth development and youth involvement are interlinking concepts. Young people need youth development opportunities in order to transition successfully into adulthood and to enhance the quality of services they receive.

Adults sometimes make generalizations about "today's youth." The following examples are from conversations and discussion groups with youth and youth coordinators.

Generalizations	Realities
They are disrespectful.	They are respectful, especially when treated with respect.
They don't act and dress appropriately in meetings.	Youth have a culture of their own which should be as equally respected as adult culture.
They don't know what's good for them and they're unreliable.	Youth are resources. They do know what's good for them and what works in many circumstances. They have valid life experience.
They can't see the long-term consequences of their actions.	Being involved will help youth see the consequences of using their voices in creating change.
They are always acting out.	Being involved will help youth see the consequences of using their voices in creating change.
Youth don't want to contribute to society.	Youth need to be given opportunities.
They are too young to have anything to offer to the community.	Young people need the chance to make important decisions without adults doing it for them.

Empowerment

Positive youth development requires that young people have access to youth-empowering environments. These environments should enable youth to do the following (NCFY, 1996):

- Feel a sense of belonging in a community
- Learn and master skills and tasks
- Feel invested in the outcomes of their lives
- Give back to the community
- Utilize their expertise from their personal experiences within the child serving systems to create change
- Have a voice and choice in their life planning

Recognizing and Avoiding Adultism

In bridging the gap between young people and adults, adults must be aware of adultism. What is adultism? It can be defined as the assumption that adults are better than youth and can therefore act on behalf of young people without their agreement because youth lack life experience and are inferior to adults (Stoneman, 1988). Comments such as "You're so driven for 16," foster the type of attitude that can lead to undervaluing youth and can be oppressive and counterproductive.

Adultism may enter into the work of youth development, but there are ways to counteract this. Adults should listen to and partner with young people by supporting them, not controlling them. Adults need to avoid parenting youth and should be patient, reliable, and respectful. They must also validate young people by welcoming all ideas and helping young people form their ideas into realistic possibilities. Adults are not alone in leading the youth movement; they are there to provide resources and support to the young people with whom they partner. This is not an easy task for some adults. Often, we place an importance on training young people to become stronger advocates but lose sight of the value of preparing adults to better partner with youth. The youth coordinator is responsible for partnering with young people in fostering an empowering environment for all youth involved within the local system of care. This process includes a focus on the value of diversity.

Cultural and Linguistic Competency: Valuing Diversity

Youth come to the table with experiences similar to those of their peers as well as their own unique life experiences; both should be celebrated. The youth group should respect, reflect upon, and embrace diversity such as race, ethnicity, gender, class, sexual orientation, religious beliefs, talents, and interests within the youth group. Diversity should be recognized and appreciated and assumed to be necessary and beneficial to the functioning of the group. This is all part of fostering a culturally competent environment for young people.

Cultural competency is accepting and respecting diversity and difference in a continuous process of self-assessment and reflection on one's personal perceptions of the dynamics of culture. Reaching towards cultural competency requires engagement in the ongoing development and integration of cultural knowledge (Center For Mental Health Services [CMHS], 2000). The term culture defines more than one's ethnicity or race—it also embraces beliefs, practices, and values. Culture helps one understand the historical events and the current contextual factors that impact a group's political, economic, and social status in society. This is especially important in the field of mental health, where a young person's psychological well-being can be directly affected by the socioeconomic and political circumstances of his or her cultural group.

A lack of cultural competence can contribute to the development of stigmas associated with mental illness. Minority populations are underserved in the current mental health system where the history, traditions, beliefs, languages, and value systems of diverse populations are often not incorporated (President's New Freedom Commission on Mental Health, 2003). People from minority groups are less likely to have access to available mental health services and to receive mental health care. Further, minority populations often receive poorer quality of care and are underrepresented in mental health research. As America continues to grow in numbers and diversity, mental health providers have begun to recognize cultural competence as a critical component in offering effective mental health services. It is equally as important for youth groups and youth leaders to understand the role that cultural competency plays in youth development and participation.

Valuing Youth Culture

The gap that occurs in youth–adult relationships is often rooted in one thing: understanding. To say it is difficult to understand another culture is an understatement. Fully understanding a different culture may be a bit too ambitious, but respecting it is something we can all do. All diverse groups have a unique culture that makes up who they are, and all diverse groups deserve to be to valued and respected. Youth culture is no exception.

Young people today are not the same young people of 10 years ago, nor will they be 10 years from now. Youth culture is ever-changing, forcing a constant adjustment by those trying to understand it. One can try to define youth culture by clothing, appearance, or music, but an image of a boy in baggy pants and a jersey with his tongue pierced rapping along with Eminem or 50 Cent is no less accurate a picture of youth culture than a girl in a short plaid skirt and hoop earrings with blonde highlights singing to Britney Spears. All of these characteristics define youth culture, though not all are applicable to every young person. To understand youth culture is to accept that there is no one definition of youth culture, but the diversity that is youth today.

Youth culture is a form of expression. Young people use their appearance, their choice in music, even their language, to express themselves. For example, slang is often overheard in conversations between young people. Slang has been a significant part of youth culture for decades and is a way of connecting, bonding, and identifying with other youth. As a "native tongue" for youth, slang is what they grew up hearing on the playground, around the neighborhood, and perhaps even in their own homes. When young people use words such as "dawg," "tight," or "fo' shizzle," it is no different than their parents using the words "groovy" or "right on." It is important that adults recognize slang as a way youth communicate with each other and respect it as such. Young people do not expect adults to learn slang, nor do they expect adults to bleach their hair or tune their radios to hip hop or

alternative music. What they do expect is for adults to accept these things as part of who they are, but not all that they are. Self-expression does not limit one's potential, and it should not be used as an excuse to lower expectations.

Mutual respect must exist between young people and adults. Each must respect the other for both their similarities and differences. It should not come as a surprise when young people and adults butt heads because they see things differently. Growing up in different times and having different experiences will cause people to view things in varying perspectives. When this happens, it is important to embrace these differences rather than shoot them down as wrong. Allowing both sides to explain their reasoning will enlighten the group, perhaps bringing a new understanding and respect for the other's point of view.

Part of understanding youth culture is supporting the limitations of young people. For example, a young person attending a board meeting may find him or herself unfamiliar with abbreviations and acronyms and need the group to take the time to explain them so he or she can fully participate in all agenda items. On the same note, holding meetings after school hours or helping youth find accessible transportation are ways adults can show youth how important they are to the group.

For some young people, having multisystem involvement becomes part of their culture. This is why adults need to listen to the experiences of young people and work on building relationships together. Youth and adults can partner by focusing on similarities such as wanting to see young people succeed. Both youth and adults bring valuable expertise and experiences to the table, and in bridging the two cultures both will need to listen, share, and acknowledge that both generations care, want to create change, and need to work together to make it happen.

Culture, in any form, needs to be respected, valued, and embraced in a partnership between young people and adults. Building on a deeper understanding of difference will begin the work of involving young people and developing a youth group.

Section V

Getting Started: Hiring the Coordinator and Forming the Group

Involving Youth: The Role of the Youth Coordinator

Developing the Youth Group

V. Getting Started: Hiring the Coordinator and Forming the Group

This is the "getting started" section of this guide. This chapter will lead you through the steps for hiring a youth coordinator and developing a youth-led youth group in your system of care community. This is a blueprint that should be customized to fit the specific needs of individual communities. Initiating youth-based initiatives for social change allows young people to choose their focal issues, lead the organization, and select the strategies to reach their goals. Often, young people use strategies such as advocacy, social action, education, and community and program development to achieve their goals for social change.

Involving Youth: The Role of the Youth Coordinator

"This program has been just as therapeutic for me as it has for the youth we serve. As the Youth Coordinator, I've been given the opportunity to take the most negative things in my life and turn them into something positive for other youth. While battling severe mental illness, I used to sit around and wonder what I should do with my time and with my life. Now I don't have the time to sit and wonder. I have purpose in my life, I finally feel alive again."

—Melanie Green, Youth Coordinator, Clark County Options Program, Vancouver, Washington

The role of the youth coordinator is to be a coach for youth. When we conceptualize the word coach, we think of words such as encouragement, support, guidance, energizing, empowering, and supportive. The coach is someone who is a part of the team as a supportive resource but is not the person playing the game.

Activities of Effective Youth Coordinators

The youth coordinator should be a coach in all aspects of forming and maintaining the youth group. Although it is important to let the youth lead, the youth coordinator should still be present as a support person. He or she should be involved as the youth develop ground rules. The youth coordinator should head off any discussions that violate the group's rules. The youth coordinator should not be a director or disciplinarian. Young people do not need another authoritarian figure to exert control and manage their behaviors. Rather, they need support and encouragement in their activities and guidance from an experienced individual. Youth coordinators need to ensure that all contributions are valued and to emphasize that there are no right or wrong answers. They should be careful not to dominate the discussion or step in as the "expert." Instead, they should be present as a resource, a support, and a coach. The youth coordinator should be a model listener and encourage others to listen with open minds. Youth advisors should advocate for their youth, empowering them and enhancing their leadership skills. Youth should be involved in all steps of the process, including developing policies and guidelines for the group, designing the group logo, planning and implementing strategies, and selecting the time and location for meetings. Young people should know about and be part of developing the group budget and share in the decision-making process in allocating funds.

Characteristics of Effective Youth Coordinators

Youth coordinators who are hired within systems of care should have the following characteristics:

- Be flexible
- Be youth-focused
- Understand the various child-serving systems (ideally from personal experience)
- Respect youth culture

- Relate to young people
- Be strength-based
- Be able and willing to build partnerships
- Partner with youth
- Focus on a youth-driven and youth-run process
- Be willing to give up power and share power
- Understand the complexities in the lives of young people

The roles of the youth coordinator should include the following:

- Raise awareness of the importance of valuing youth voice and incorporating youth voice into policy development and service delivery
- Build a bridge between the youth and professional worlds
- Educate adults and professionals on the importance of youth involvement
- Advocate continually for increased authentic youth involvement within the system of care and the broader community
- Support youth and advocate for their participation on governance boards and other committees
- Coordinate the development of a youth-run group in the community for youth who are involved in the mental health system
- Provide training to youth members to enhance their leadership skills
- Attend trainings to enhance their personal skill sets
- Serve as a representative on relevant committees at the state and local levels
- Connect youth with community-based resources
- Reconnect youth with the community

Developing the Youth Group

In the development of the youth group, the youth coordinator may begin by identifying youth. Once young people are involved, they should develop a mission statement, goals, objectives, and strategies that will guide the group through its work.

Identifying Youth

Many youth coordinators get started without youth partners. Identifying youth in the beginning stages can be challenging. Youth can be found in family organizations and schools or through other youth, care coordinators, teachers, therapists, and child welfare workers. A youth coordinator need not worry if he or she can identify only one or two interested young people, because those youth often become links to others. A small number of youth is all that is necessary to move to the next stage in developing the group.

It is important to begin with the development of the youth group because it provides the support and foundation for youth involvement in other areas within systems of care. Young people need to feel supported by their peers when participating on boards and committees and need to know that they can turn to a group of individuals who are all facing challenges associated with creating change. Isolated positions within the community will often continue to foster feelings of isolation within the young person.

Youth will be more motivated to participate in a group that is unfamiliar to them if they are able to see the group as meaningful. From the beginning, it is important to explain to young people that this is an opportunity for them to reclaim their identity and to become empowered to create systems change and improve their lives and the lives of their families and peers.

Identifying Place and Space Really Matters!

The place where youth meet is a critical component in developing and maintaining a youth group. This should be a place where young people feel welcome, respected, and comfortable, and opportunities exist for youth development and relationships to foster between peers and adults (Pittman & Cahill, 1992). This includes a physical space that is accessible to youth that they can consistently count on as their own. It is not, for example, a room next to a CEO's office or the room in the basement of a building. Location is key to ensuring that youth will be able to access the space and that it is centrally located in the community. Giving youth their own space will help to instill a sense of value and

importance in the group. This space is a youth-friendly zone where youth want to be, feel comfortable being, and are not hesitant to express themselves. It is a space that the young people take a sense of ownership in, have a sense of pride in, and consider to be their own.

Creating a Mission Statement—Why Are We Doing This?

It is important that the youth group have a unified vision that is shared by its members. Developing the mission statement can be a challenging task. Youth members are going to be responsible for carrying out this mission, so it is important that this be a group endeavor. This effort is most effective in the beginning stages of the youth group when the core group is small so that the youth can work intimately together to fully develop the statement. It is important for the mission statement to be short and jargon-free.

In developing the mission statement, ask the following questions:

- What is the purpose of your youth group? What do you hope will be the result of the work you will do?
- What need(s) is your youth group trying to address?
- What are the values or beliefs of your youth group (e.g., teamwork, creativity, youth empowerment, a need for mental health systems reform, an end to the stigma associated with mental health)?
- Who will be affected by the work of your youth group?
- What makes this youth group unique?

Sample Mission Statement

To educate professionals, families, and peers on mental health issues and reduce stigma within our communities in Region III; to support other youth with mental health disorders; and to provide a youth voice within our local systems of care.

—Youth Encouraging Support (YES), Kearny, Nebraska

Developing Goals and Objectives—What Do We Want to Do?

Youth should establish goals and objectives that are specific and realistic and related to the mission statement. Goals can be both short- and long-term. An objective is a statement of an outcome you want to achieve that is specific, measurable, attainable, relevant and timely.

In developing goals and objectives for the group, consider these questions:

- What opportunities for your youth group will come from your mission?
- What are the barriers to reaching your goals?
- What would help you reach the goals of the group?
- What short- and long-term goals, based on your group's mission, do you hope to achieve?

Planning Strategies and Activities—How Are We Going to Do It?

The group needs to brainstorm strategies to figure out how to reach their established goals and outcomes. They need to develop activities that are linked to their goals. In addition to this process, certain "nuts and bolts" activities will help pull together the work of developing a youth movement. These components include time lines and budget development, funding identification, consent forms and confidentiality, community mapping and stakeholder partnership development.

Establishing a Time Line

It is important to review the notes from your prior discussion, prioritize aspects of the project, and establish a time line. This will ensure that everyone is accountable and that the set goals are met within a reasonable amount of time. You may even want to assign different youth group members as leads on different parts.

Developing a Realistic Budget

Youth groups cannot function at their optimal potential without funding and a budget. It is crucial to develop a realistic budget early in the process. Develop the budget before reaching out to the stakeholders who may be willing to support your effort. Potential funding sources

are the system of care, charitable foundations, corporate sponsors, community members, provider organizations, and government departments. An organization may not be able to give your group monetary donations but may be able to donate in-kind supplies such as pens, paper, and other materials or office space.

Identifying Funding Sources

Identifying funding sources is necessary. Youth should know how their group is funded and should be part of both raising funds and deciding how to use the funds. A significant portion of the youth group budget should come from the system of care funding, especially for communities with cooperative agreements. Youth groups should not rely on this funding source for longer-term sustainability, which is discussed further at the end of this chapter. In many instances, youth groups are part of the local family organization that is connected with the system of care and are part of their overall budget. Creative fundraising is a way to both raise funds and awareness of the group within in the community. Youth groups may also want to ask for in-kind donations of meeting space, office supplies, volunteers, food, and other materials.

Using Consent Forms and Ensuring Confidentiality: Trips and Other Liabilities

Once young people are identified, they should partner with the youth coordinator to create updated, youth-friendly consent forms for participation in meetings and trips. These forms should include emergency contact information, medications the young people take, allergies, and other relevant information. Some groups may choose to include consent for youth to be photographed. Many youth groups have a lawyer who reviews the consent forms to ensure the youth and family's safety and rights and the agency's protection.

The youth should also determine what information will be confidential within the group. This discussion should be revisited frequently as the group develops and changes. The group may choose to create an environment in which all discussions stay within the group whereas other groups may not. The important thing to remember is to allow the young people to make that decision. The youth coordinator can present the confidentiality form as a covenant between the individual and the group and remind the youth of the promise they are making when they sign it. Once the issues of liability and confidentiality are taken care of, the next step is often to map the community.

Mapping the Community

Many youth groups choose mapping the community as the first group activity. The mapping process can lead to opportunities that expand support to another group of young people; identify gaps in resources in the community; or lead to partnering with other groups to create events, projects, or programs. Young people canvass their community to identify and document each resource that they find. Examples of resources are the local community center, mental health centers, or other local youth groups. Youth may already know some resources from their personal experience or from that of their peers. They can expand the process by calling programs they find in the yellow pages or other listings. Youth groups may choose to create "We've Been Mapped" posters that foster community awareness and eagerness to participate. They also may develop a fact sheet of what community mapping is and why they are doing it. The Academy for Educational Development (AED) Center for Youth Development and Policy Research, Community Youth Mapping (www.communityyouthmapping.org) offers more in-depth information on this topic.

The group should begin the mapping process by developing a budget that includes cost of food, transportation, telephone calls, printing, technology, and office supplies. The group may also want to reach out to local provider agencies for financial support if this process would help the agencies identify needs for additional community programming. The group will also need to decide how it will disseminate the information it gathers and should choose action steps to address any issues that arise, such as gaps in services. However, before choosing any action plan, the youth group will need to identify community supports such as stakeholders.

Collaborating With Stakeholders

Youth involvement should be a community value that is embedded in the work of your system of care. To this end, the

youth coordinator, in partnership with young people, should work to create a system-wide “attitude change.” Part of this process is identifying key stakeholders in the development of a youth movement. Stakeholders may include community program staff, local provider organizations, elected officials, community- and faith-based organizations, educators, civic and service clubs, and business owners. They should be community members who have knowledge and expertise that can be incorporated into your program. The community mapping activity will often identify possible stakeholders. The group may choose to identify organizations that are serving youth in the community and discuss how those organizations could better provide those services. The youth group should think about how they will pique the organization’s interest in learning from youth to enhance the positive outcomes of the organization’s work.

It is important to engage a diverse group of stakeholders in order to increase the sustainability of the group efforts. Partnering with stakeholders will create formal and informal linkages throughout the community for collective growth with a base of shared values and vision for youth involvement. These stakeholders should be a support for the growth and sustainability of your youth group.

Identifying stakeholders requires asking five key questions:

1. Who in your community will be interested in the work of your youth group?
2. What are all the youth-related resources that you can find in your community?
3. Why is the development of your youth group important for your community members?
4. Who in your community has an investment in the mission and outcomes of your youth group?
5. Who in your community will support your efforts?

In addition to assisting in the growth and sustainability of the youth movement, stakeholders create partnerships where all parties can benefit. An example would be a partnership with the local school system. Stakeholders who support youth involvement will be more likely to invite youth in for presentations and staff training. Youth who participate in conferences during the school year may be able to use their conference experience for course credit or class assignments. This is just one example of an opportunity furthering a local youth movement; there are numerous opportunities for continual development.

Section VI

Cultivating the Environment for Growing Leaders

Leadership Development and Empowerment

Building and Sustaining Relationships Through Youth–Adult Partnership

Providing Training and Skill Development

Guiding Principles of Cultural and Linguistic Competency

Learn Essential Facilitation and Conflict Resolution Skills

VI. Cultivating the Environment for Growing Leaders

Throughout the evolution of youth involvement and engagement in communities, there are certain areas that are ongoing opportunities for growth. This section will discuss the need to continually address issues of leadership development and empowerment, building and sustaining youth and adult partnerships, and training and skill development with a focus on cultural and linguistic competency as a core value of the youth group.

"I've learned a lot of new things [from getting involved] and it's helping me push towards my goal more and I want to be a better person. They've [system of care professionals] taken time to hear me and help me on lots of different occasions. They have lots of trust in me and that makes me feel very important…they have nominated me for so many things and I love it 'cuz I'm learning and experiencing different things and it will help me through college."

—Crystal A. Henson, Youth Leader, CARE - New Hampshire

Leadership Development and Empowerment

Creating systemic change requires leadership. Youth leaders must continually create youth-focused activities, emphasizing young people's strengths and advocating for experiences that will bring them closer to the community. It is the role of youth leaders to create opportunities for new young leaders to further develop.

What Does It Take to Become a Leader?

- **Courage** • Most truly challenging situations require not only creative solutions, but also the determination to make them happen.
- **Action** • Leadership is challenging. However, the actions of a leader can make future changes happen easier and quicker.
- **Listening** • To have an open-mind, and to have respect for different ideas and beliefs.
- **Valuing** • Considering and valuing the ideas and beliefs of others, even if it means putting aside one's own biases or wishes.
- **Learning** • Decision-making, learning from the outcomes, sharing the credit, accepting the blame, and taking something valuable away from the experience.

(NCFY, 1996)

There are multiple leadership opportunities for young people within the system of care.

Youth can:

- Provide input to local mental health boards, commissions, and task forces in the youth-serving systems
- Reach out to local mental health directors and departments
- Establish youth development committees that are cross-system—including mental health, child welfare, juvenile justice, education, etc.
- Develop and facilitate support groups for youth with serious emotional disturbances
- Initiate peer counseling and mentoring programs that match young people with other youth with whom they can relate and establish healthy relationships
- Develop presentations for peers and professionals within youth-serving systems regarding mental health issues, treatment, and peer support
- Establish support groups in schools and other community settings

Building and Sustaining Relationships Through Youth–Adult Partnership

"[Authentically involving youth takes] stepping back, letting youth know that their voice is really being heard by implementing some of their ideas, by compromising when we don't agree or understand. We need to let youth educate us by listening and not be condescending. We need to be true partners with youth."

—Pat Mosby, Family and Youth Advocate and Care Coordinator

Building a youth–adult partnership is a building block to youth involvement. Partnership is demanding and requires commitment. Authentic partnerships provide opportunities for youth and adults to learn from each other, as well as plan and strategize together. Young people need a network of adults who are leading change agents and decision makers and are also willing to authentically involve and support youth. Both groups need to recognize the strengths, interests, experiences, and power the other group brings to the table.

Adults bring:

- Age and past experience, offering guidance and support to young people
- Connections to community resources
- Professional experience and connections with the youth-serving systems
- Access to resources such as financial status and legitimacy that young people may not have
- Authorized professional power

Youth bring:

- Uninhibited honesty; the lack of subtlety that may hold back adults allows some realities to be brought to the table
- Unauthorized power to challenge providers and organizations
- Connections to other youth
- Energy, fresh ideas, and creativity
- Personal experience with system involvement

Training Professionals

Professionals and other adults may provide additional support in partnering with young people. Adults should be trained (by young people in partnership with adults) to:

- Empower youth to be involved in their treatment plan and in creating system-wide change
- Knock down the walls of professionalism
- Build relationships and partnerships with young people
- Encourage and cultivate youth voice, ownership, and access
- Focus on youth needs, including culture-specific needs
- Not give up on young people!

Building Relationships

Building relationships with young people takes time. Creating a trusting relationship requires patience and may be tested over time to make sure that the adult is truly there to partner with the young person and will be a consistent source of support.

Open communication is key to a successful relationship between the youth coordinator and youth participants. Examples of some guiding questions you may want to ask to help build this relationship include:

- How do you know when someone cares about you?
- What makes you care for others?
- What would make you want to come back to the youth group?

The answers to some of these questions may assist the youth leader in developing a caring environment based on the needs and perceptions of the young people. Youth–adult partnership is built on the foundation of a caring environment.

Youth FAIR Shows that Friends Are Important Resources

Youth Friends Are Important Resources (FAIR) in West Palm Beach, Florida, is a youth group that is widely recognized for the group cohesiveness and genuine care of the youth for each other. Their members are comprised of young people under the age of 22 who have system involvement. In their mission statement, Youth FAIR members describe themselves as "The voice of hope, love, strength and unity." Youth FAIR members agreed to an interview to discuss their group culture.

Youth FAIR members attribute the group's caring environment to the food, resources that are available to them, the warm and caring people, and deep personal conversations in a safe and supportive space. The members believe that the safe space is the outcome of their mutual respect for peer established ground rules, a high level of confidentiality, and continual feedback. The members stated, "Members of Youth FAIR do not look at each other's weaknesses but their strengths and for who they are inside." New members are never singled out and all members express a dedication to the group, because they believe in the group mission. The members also are culturally sensitive to the diverse backgrounds of the members. The group always fosters an open line of communication and peer support; often the youth connect outside of Youth FAIR activities. All members present expressed that they genuinely care for each other.

The Youth FAIR members agreed that they need and value adult support in their youth group. They described their adult supporters as caring and respectable people who always communicate without yelling, screaming, or arguing. One youth member reported, "The adults teach and mentor with love, showing care by following up on youth needs and allowing them to vent their feelings."

Youth FAIR members described the necessary components to creating a safe, caring, and supportive environment for youth.

Youth groups can foster a caring environment by:

- Developing equal ground rules by members
- Ensuring a strong line of communication between the youth and the coordinator
- Creating a shared mission between youth members and the coordinator
- Encouraging and valuing feedback
- Identifying any challenges the group is facing and brainstorming possible solutions
- Hosting discussions based on youth interest
- Assisting with transportation
- Providing food at each meeting
- Creating opportunities for youth to explore and demonstrate their talents and skills
- Recognizing youth participation through stipends, celebrations, trips, newsletters, and awards
- Supporting and mentoring each other

Supporting and Mentoring

Peer-to-peer support and mentoring are key components of developing a youth movement. Young people need to have support from each other and a sense of belonging; these are essential for a functioning youth group. Young people gain a sense of validation when they can relate to others with similar challenges and life experiences. Participation in socialization and recreational activities often decreases loneliness and isolation, preventing further depression and mental health challenges. Spending time with peers provides an opportunity for normalization for young people who do not always feel "normal." Young people can help other youth know their rights and find necessary resources within the community. This support and knowledge builds advocacy networks for other youth to address their mental health needs.

The need for support also pertains to the youth coordinator. Youth coordinators can also feel isolated in their work. The work of change agents is exciting and rewarding, but can also be challenging and isolating. As a result, youth coordinators need a tremendous amount of support from administrators, supervisors, and peers. In addition, youth coordinators can connect to the national youth coordinator community for support to generate ideas and exchange resources. Both youth and adults who are working to create systems change need to be supported and reminded of the importance of their work and to have their achievements celebrated. In many ways, support comes in the form of training and skill development.

Providing Training and Skill Development

To be successful in their endeavors, young people need support and education in areas that are relevant to their lives and their work. Young people should have learning opportunities both locally and nationally. Youth groups may want to bring in speakers from the community to educate young people on various issues.

Conferences also give youth and youth coordinators an opportunity to collaborate with individuals from other youth groups. Conferences provide a time and space for young people to strategize on their challenges and share their successes. Additionally, conferences can provide youth with direct contacts to leaders in the government and other valuable resources, thus encouraging a dialogue that can benefit both youth and the government. Many conferences offer youth workshops to help young people develop the skills needed for effective youth participation, such as public speaking, knowledge of laws and regulations, and leadership training. Training and a deeper knowledge of the systems and other topic areas will help young people become stronger advocates and contributors. Training needs to be an ongoing support for young people throughout the growth of the group. Each new activity or group endeavor may also require additional training.

The need for training also pertains to youth coordinators. Youth coordinators bring tremendous strengths, experiences, and skills to their work, and they too need opportunities for growth. Training should include cultural and linguistic competency as a core value.

Guiding Principles of Cultural and Linguistic Competency

By becoming culturally competent, youth leaders and youth group members will acquire the knowledge and skills to work effectively with diverse populations. There are three guiding principles to effectively integrate cultural competency into the youth group setting: knowledge development, community bonding, and cultural inclusion and training (CMHS, 2000).

Youth development, involvement, and change are more likely to happen when youth leaders and young people have access to relevant information and develop attitudes that are culturally competent. This requires youth groups to make an extended effort to utilize existing resources and initiate contact with anyone who can provide additional knowledge to the group. Building their information base will give group members a general idea of the various cultures that comprise their community, and hopefully will initiate further curiosity into the practices and beliefs of their peers.

Cultural competence in a community-based system of care requires a personal understanding of the diverse cultures that make up the community. To have neighbors engage with each other in cultural activities is the next step in the process. For example, Family HOPE, the system of care community in West Palm Beach, FL, has formed a cultural exchange program where youth and families come together each month to learn about the different cultures in their community through traditional dances, food, and ceremonies. Such a program can work to unite a community as members are exposed to new and different cultural practices and gain an appreciation for the traditions of their neighbors.

A youth group cannot be culturally competent without the inclusion of members of various races and ethnicities, religions, genders, and sexual orientations that compose the community. There must be a constant effort to integrate all youth into the group. Extra effort needs to be made in reaching out to those in the community who may not feel comfortable participating in a group separate from their own

culture. One way to do this is to ensure access to bilingual leaders, volunteers, or youth so that all young people will have someone to communicate with in the group. An ongoing plan to train and develop the young people in each youth group on cultural competency is another way of going about this. Scheduling trainings will help all group members process the knowledge they have gained and the customs they have been exposed to, as well as really make sense of the values and behaviors of their peers. It is essential to foster a safe environment for open discussion where everyone can share and challenge their values and stereotypes.

Training Members of the Youth Group

Training on cultural competence should include the following activities:

- Discussing issues that define different racial/ethnic groups, gender identity, sexual orientation, religious beliefs, etc., including youth's diverse histories, values, traditions, belief systems, etc.
- Identifying how acculturation affected/affects individuals from the different racial/ethnic groups
- Recognizing how ethnicity, racism, class, social status, gender, and sexual orientation impact youth values, belief systems, attitudes, and mental health
- Understanding the different causes of mental illness (e.g., supernatural, religious, etc.) and the stigma concerns specific to each group and their subgroups
- Listening and communicating successfully across all cultures (CMHS, 2000)
- Developing relationships with youth and family members from the diverse populations through culturally appropriate community resources

Circle-of-care and tribal system of care communities have set examples on the importance of culture and tradition in partnering with youth. Each Native community is distinct in its approach to working with youth, however the message that most tribes strive for is to connect youth with their culture and elders. Choctaw Nation Cares and the Native American Health Center provide two tribal communities' perspectives.

Youth Involvement in Tribal Communities

Many tribal system of care communities and circle-of-care communities use the term temporary emotional disharmony rather than the label serious emotional disturbance when discussing the needs of their children and youth. Native communities also focus on a holistic approach in working with youth that includes the social, mental, physical, and spiritual areas of personal wellness. Within these communities, there is a particular focus on tradition and culture in working with Native young people.

Circle-of-care and tribal system of care communities are involving young people in various ways that reflect tribal culture and tradition. In Oklahoma, Choctaw Nation Cares system of care serves youth and families in 11,000 very rural square miles. Many of the native children and youth are extremely shy and Jack Austin, youth coordinator, has found that introducing cultural activities helps them open up and build trust. One of the youth activities is Healing Groups. The Healing Group process is based on the four medicine wheel quadrants and focuses on the four main areas of life: community, mind, spirit, and body. The first quadrant represents the community, and youth participate in activities to increase their self-esteem. The belief is that

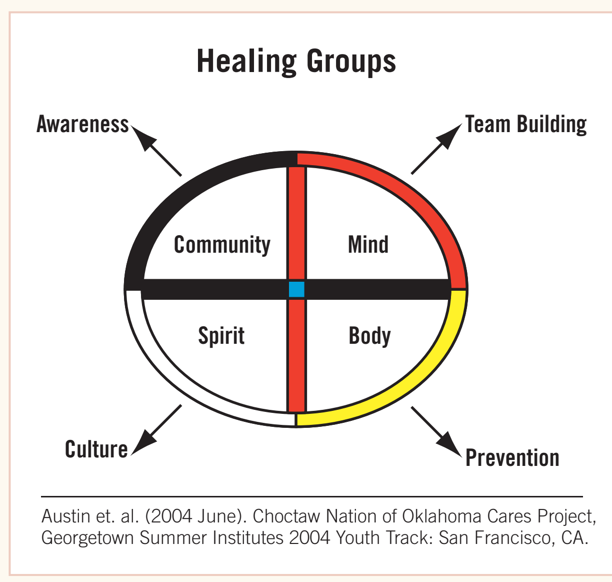
> *"Culture is so important because it brings youth back when they think something isn't going right or there are so many issues in their lives, it reminds you of what your ancestors have been through and it grounds you. Even traditional dance and art give youth a healthy cultural escape from their problems."*
>
> *—Tahnee Camacho, Youth Coordinator, Native American Health Center Circle of Care in Oakland, California*

(Youth Involvement in Tribal Communities...continued)

increased self-esteem leads to decreased disharmony in the family. The second quadrant represents the mind, and youth are guided through thought-provoking, team-building activities. The third quadrant represents the body, and youth participate in substance abuse prevention activities. The youth wear DUI goggles, which blur their vision, and then walk the line, or try to shoot basketballs. Youth are able to feel the effects of alcohol consumption without actually drinking and can see that substance use blurs a person's version of reality. The fourth quadrant represents the spirit, and youth participate in a talking circle. Youth are asked a question such as, "What would you change about your community?" Youth then pass an eagle feather or talking stick and everyone is able to share their thoughts when they have the feather or stick. Jack Austin commented, "One youth was so thankful because she said that was the only time her voice had been heard."

Another example of a youth activity is the Tribal Scavenger Hunt where youth explore the community in an attempt to get signatures from certain people. All of their directions are written in the Choctaw language and youth are given Choctaw dictionaries in order to find out whom they need to get a signature from without speaking English. The process helps them understand their ancestors' way of life. Some of the signatures that youth need in the scavenger hunt are from the tribal elders. The elders only speak Choctaw to the youth, which helps the youth further connect with their culture.

Similarly, Tahnee Camacho, Youth Coordinator, Native American Health Center in Oakland, California, is working to connect youth with the elders in their community. Tahnee found that many youth in the urban environment are not keeping tribal traditions and the youth group is a way to bring that back into their lives. The Native American Health Center is developing a mentoring program between youth and tribal elders. In addition, tribal youth in Oakland are connected to the monthly powwows where they participate in native dancing, crafts, and traditional foods. Both of these communities are examples of the importance of valuing and incorporating culture into work with youth in order to preserve and celebrate traditions.



Austin et. al. (2004 June). Choctaw Nation of Oklahoma Cares Project, Georgetown Summer Institutes 2004 Youth Track: San Francisco, CA.

Learn Essential Facilitation and Conflict Resolution Skills

Another important training area is around group facilitation and conflict resolution. Youth leaders usually need to teach the members of the youth group the skills that they will need to function effectively and successfully.

Using Effective Group Facilitation

Often, youth groups choose to create ground rules, which are peer developed and mutually agreed on. Some groups consider their ground rules to be their bylaws, which provide the group with a framework. These ground rules are often a good resource for resolving incidences of conflict within the group.

One of the challenges of any youth coordinator is to take a group of individuals and help them learn to function as a team. Although each group is a bit different, certain participant roles are likely to be found within any group. The key is being able to emphasize the positive contributions of each participant. A positive group dynamic will lead to equal, individualized participation, with all voices being heard in the group.

Even with a cohesive group in the most ideal circumstances, conflicts may arise. Active listening is the core competency needed to manage challenging group scenarios. Usually when someone is frustrated or angry, all he or she really wants is to be heard in a respectful manner. In this process, it is important that the youth coordinator bring the group back to the ground rules, which should include respecting and listening to one another. Although the initial role of the youth coordinator may be to manage conflict, the ultimate goal should be to help young people develop the skills they need to manage the conflict within the group without adult facilitation.

Resolving Conflicts

Each group needs to learn and understand the following five skills for effective conflict resolution.

1. Listen—Focus on the person speaking and encourage him or her to use "I statements." Recognize that there are differences of opinions. Ask questions for clarification. Summarize the situation as you understand it to ensure that everyone agrees on the facts. Avoid jumping to solutions. Affirm and acknowledge that a challenge is present and that feelings are involved, but recognize that this can be a win-win situation.
2. Keep It Positive—Create a win-win situation. Challenging behaviors are almost always a result of unmet needs. The win-win approach says, "I want to win and I want you to win, too." The person facilitating the situation will need to discuss the underlying needs in the situation. Often these needs will be very similar. Create opportunities for members to share power. Identify ways to meet all their needs.
3. Reframe—Transform problems into opportunities for creating change. The outcome can be another learning opportunity and lead to increased understanding. Be sure to facilitate a dialogue that will attack the problem, not the person, and continually provide feedback in a nonjudgmental way. Discuss the outcomes that both parties hope to achieve.
4. Negotiate—Focus on needs, not positions, and emphasize a common ground. Be creative about identifying options and solutions. Create opportunities for youth to back down without feeling humiliated or being perceived as "losing face." Help facilitate trade-offs that may be part of trial and error in finding a solution.
5. Focus on the Future—Discuss options for moving forward and identify the clear solutions that all parties have agreed on. Try to develop an agreement to move forward without focusing on the past. Remind the youth that this experience was a challenge from which everyone can learn and grow.

(The Conflict Resolution Network, 2004)

Identifying youth, developing a group mission statement, goals, objectives, strategies, and ground rules, and understanding how to manage conflict are all part of the core foundation of youth involvement.

Section VII

Youth Involvement in Systems of Care: Making It Happen

What Do Youth Groups Do?

Developing a Community Event

Getting Youth on Board

Creating Opportunities for Youth Roles in Evaluation

Social Marketing: Youth Getting the Word Out!

Sustaining Youth Involvement

Barriers and Solutions to Youth Involvement

What Makes Youth Involvement Successful?

VII. Youth Involvement in Systems of Care: Making It Happen

Authentic youth involvement in a system of care community permeates the community and is actualized through the meaningful involvement of young people in each level of system of care development. This chapter will guide you through this process. Young people are able to partner with a supportive adult and take the lead in all aspects of the youth movement. Young people in youth groups continually work to sustain youth involvement in their communities through outreach, stakeholder groups, activities, and projects in the community, as well as through evaluation and social marketing projects. Sustainability depends on commitment, dedication, and a willingness for a community to change and adapt. The youth movement within a system of care begins with the developed youth group.

What Do Youth Groups Do?

Currently, systems of care across the nation support more than 40 groups for young people. These groups have different looks, missions, and activities, but all share the common goal of supporting youth voice and involvement within the system of care.

Young people nationally have undertaken a variety of tasks:

- Developing presentations and products such as tips sheets for professionals
- Creating Web sites, chat rooms, and Internet-based bulletin boards
- Organizing fundraisers and community-wide events
- Participating on governing boards and committees
- Developing social marketing campaigns
- Engaging in research
- Providing peer support, advocacy, and bonding activities for other youth

Developing a Community Event

Many youth groups in systems of care develop community events to create change, decrease stigma, forge partnerships, and involve other young people. This process can be challenging if it is not thoroughly planned. It is important to ensure that the voice of young people is the center of the event.

Begin with a discussion of the purpose of the activity—is it to raise community awareness? Plan whom you will invite and how many people you can expect at the event. Make sure that the agenda of activities and the location and time of the event all take into account the target audience. Appropriate venues for advertising the event may be local organization bulletin boards, youth centers, or schools the targeted audience attends. The group will also need to plan the number of staff needed, the tasks each will be responsible for completing, and possible compensation. It is important for the group to seek out community support in each event or project to increase the visibility of the group in the community. Involving the community in all aspects of event planning and the events themselves will foster support and can affect sustainability. It is also essential that the youth group record every aspect of the project's development in case it needs to apply for future funding. Finally, it is important to have a follow-up meeting to allow the group to reflect on what went well and suggest changes for future events.

Many youth groups have successfully produced community events. In 2001, the King County, WA, Health 'N Action! youth group developed the first Teen Health Summit for the community.

2001 Health 'N Action Teen Health Summit

The mission of Health 'N Action! (HNA) is to bring youth issues to the attention of policymakers, professionals, youth-friendly adults, and other youth involved in the system of care in order to promote understanding and action by community leaders by using youth expertise. Following their mission, the youth of Health 'N Action! organized the first "For Youth, By Youth" teen health summit in King County, Washington. More than 350 youth, parents, and providers attended the event.

HNA started early and allowed a year for planning. The group focused on four components of event planning: goals, message, audience, and activities. HNA had to first agree on the goal of the Teen Health Summit and then make sure that its actions would lead to meeting this goal. The group decided that the goal for the event would be to start a dialogue about youth voice in public policy. With this goal in mind, the youth focused next on developing messages for the event. They divided into work groups to develop the messages they wanted to convey. They decided that each workshop would have a different message, but each would relate to the overall goal. After determining that the audience for this event would be youth, the group moved on to developing activities for the Summit. HNA determined that fun and informative activities would keep the audience engaged. The group decided that each workshop should have a number of youth-friendly activities and breaks. This approach would keep everyone's attention and break the long day into more manageable and memorable sessions.

During the Summit, youth and young adults learned about health and safety issues. They shared their concerns and priorities with the people in government, law enforcement, and social services who plan and provide these services. The young people developed workshops about HIV/AIDS and safety issues surrounding sexual activity, safe driving, teen health care plans at no or low cost, chemical dependency, and mental health issues that affect teens but often go undiagnosed or untreated. Policymakers, professionals, youth, youth-friendly businesses, and service providers came together to discuss issues that affect youth growing up in today's ever-changing world.

Although the King County Mental Health, Chemical Abuse & Dependency Services Division, the Children and Families in Federal Mental Health grant, and the Seattle Center collaborated in sponsoring the Teen Health Summit, Health 'N Action! coordinated the majority of the planning and organization of the event. Youth who stayed for the day received community service credit certificates and were eligible for raffle prizes that included a trip to Disneyland, donated by Alaska Airlines and Disneyland. Health 'N Action! reached out to numerous community partners to make this event happen. By following the four key components to event planning, HNA youth planned and executed a successful event.

Getting Youth on Board

"Youth involvement makes a difference in our community by bringing the policymakers and the youth that are directly affected by the policy together. This open communication allows youth to discuss what works for them and what doesn't and the policymakers get to realize that sometimes even the best of intentions can be harmful if the people that the policies will directly affect are not consulted. The very presence of youth in policy meeting breaks down the invisible 'us and them' barrier that develops when doing things for and to people instead of with them."

—Stephanie Lane M.S.W, Youth Coordinator, Health N'Action, King County, Washington

In addition to participating in youth groups, young people are taking on other roles within systems of care as voting members on governing boards and committees. Significant roles in the community must be given to youth to really engage them and develop their leadership skills. Involving young people can be a tremendous asset to the community and the organization if it is done well.

Challenges can occur in placing youth on governing boards when young people are filling a quota or are treated as observers. Youth involvement may not be successful if adult board member mentors are not selected carefully, do not have time to adequately support young people, or expect that everyone will immediately know how to work together (Hoover & Weisenbach, 1999). Solutions to some of these challenges include selecting mentors who have time and are dedicated to providing support and encouragement to interested youth. In addition, providing time and a comfortable environment for the mentor and the youth to get to know each other helps the process.

Both young people and adults will benefit from the relationships fostered through the training and youth board participation. Adults will need to make sure that youth have transportation to and from meetings and that they are held at a time that does not require young people to miss school. Mentors should also spend time with youth before and after meetings to answer questions and create a more supportive environment.

Generating Momentum

Organizations need to know why and how to involve young people in the decision-making process. Young people will often need support in being a part of this process. To involve young people successfully in decision-making roles in the community and to create a community-wide shift to involve young people, organizations need to take the following key steps (Hoover & Weisenbach, 1999):

- Promote local legislation to stipulate inclusion of youth on nonprofit boards and local governing bodies
- Train youth to be able to stand up and assert themselves
- Train adults so that they better understand youth involvement, the needs of youth, and ways to partner with youth for training on positive youth development
- Develop public relations and social marketing in the community

Adult Responsibilities for Involving Youth in Meetings: 5 Simple Strategies

There are a few simple strategies to use when adults ask youth to participate in meetings or conferences. Implementing these strategies will ensure that adults who are involving youth in meetings allow ample time and provide support for youth preparation for authentic participation.

1. **Identify youth and adult support**
   a. Involve more than one youth in meetings; adult supports should participate as coaches to the youth.
   b. Ensure that youth have the appropriate skill set for their role in a particular meeting. This may vary according to meeting type, i.e., governance board, committees, presentations, workshops, etc.
   c. Identify requirements for youth participation such as experience presenting, public speaking, advocacy, understanding of the system, personal experience within particular systems, etc.
   d. Facilitate introductory communication (written or verbal correspondence) once the youth is identified
   e. Involve youth in developing the content and setting the time and location (if possible) for the meeting
2. **Ensure preparatory support**
   a. Send official invitation 30 days in advance, which will include:
      i. Objectives for the meeting
      ii. Meeting agenda with youth listed on the agenda
      iii. Logistical information
   b. Coordinate a conference call with youth and adult support
   c. Identify and support cultural and linguistic needs (i.e. interpreters)

3. **Clarify roles and responsibilities**
   a. Facilitate conference call with youth and adult supports at a time that is convenient for both individuals
   b. Discuss specific responsibilities and youth role with youth and adult supports
   c. Review meeting objectives (specifics on topics and youth role in those topical discussion areas)
   d. Ensure that the adult support and youth have developed a coaching schedule to prepare for the meeting or presentation (should be weekly)
4. **Ensure logistical support**
   a. Identify, coordinate, and provide travel arrangements to and from the meeting
   b. Set protocol for stipends/honorariums for youth participation; youth should be compensated for their work
   c. Ensure that meals and expenses related to the meeting are covered in advance; advance the per diem if travel is involved
   d. Coordinate early arrival to ensure adjustment to the new environment
5. **Orient youth on location**
   a. Orient youth prior to the meeting at the meeting location. This will facilitate time for questions, familiarity with the meeting environment, and adjustment to the new environment. For presentations provide time for the youth to walk on stage, use the microphone, etc.

CARE New Hampshire is on Board

Care New Hampshire system of care community has applied these steps in generating a training program for young people to enhance their leadership skills. New Hampshire's Youth Leadership program is a training curriculum for youth who are interested in participating on boards, on committees, and in policy advocacy relating to child and youth mental health. The program has space for 12–18 youth from all regions of the state. The program comprises youth who have a history of personal mental illness or have family members with a mental illness. Their ages range from 16 to 24.

The Youth Leadership Series began with a teen group discussion. Youth were asked what would make them feel comfortable enough to participate in a board meeting with adults. The youth reported that they would need to know what the adults were talking about so that they would feel competent enough to contribute. This helped the adult coordinators better understand the training needs of youth so that they could develop the training curriculum. The Youth Leadership Series is now in its fourth year. The Youth Leadership Series began out of a model of positive youth development through funding from the Care New Hampshire grant and the Department of Behavioral Health. The funding allowed the group to bring in speakers to train young people on various aspects of board participation. In addition, the Youth Leadership Program was able to hire a young adult graduate from the program as the Youth Leadership Assistant.

The training consists of a series of seven sessions that train youth to be active participants in systems change. Training sessions include team building, cultural competency, peer relations and negotiations, spokesperson training, understanding mental health symptoms, legislative advocacy, board development, negotiation on boards, and an in-depth training on the mental health system and the Department of Child and Family Services. All sessions include guest speakers, expert presenters, onsite visits, and experiential learning opportunities centered on the best practices for each subject. During their first training, the youth choose a project to create change in their community. The youth then develop a public service announcement on the issue for the local radio station. For the final weekend of the series, youth participate in an overnight trip and a high ropes course. At the end of the series, graduates

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(CARE New Hampshire is on Board...continued)

are invited to a job fair where local providers come to recruit graduates for their boards and committees.

Initially, the Youth Leadership Program focused on training for young people, but it has since learned that adult providers also need training on youth–adult partnership and authentic youth involvement. Staff members now train providers on the Dignity of Expertise, which helps professionals partner with youth and helps families share power and value life experience as expertise. Both training components have shown to be necessary to authentically involve youth on boards and committees.

Creating Opportunities for Youth Roles in Evaluation

Involving youth in research is part of creating social change and improving their lives and the lives of their peers. In addition to board and committee participation, young people have been involved in evaluation (Sydlo et al., 2000). Young people should be involved from the beginning stages of defining the problem to collecting and evaluating information, making decisions and taking action. Youth involvement will give these young people opportunities to learn about research and evaluation (Checkoway & Richards-Schuster, 2003). Youth have been involved in evaluation as subjects, consultants, and partners. Young people have served as co-evaluators and directors and have organized their own research project to study a problem of their choice.

One example of this process comes out of the Federation of Families for Children's Mental Health (FFCMH). FFCMH partnered with youth to conduct a 2-year study on the experiences of youth with co-occurring mental health and substance abuse problems and their families. The purpose of the study was to provide opportunities for youth and families to share their experiences in these systems and to make recommendations for change. The youth guided the study and received research training in the process. Ten youth were trained to design the questions, facilitate the focus groups and interviews, and analyze the data. The youth came from all over the country and did most of their work via the telephone with the help of the researcher who was hired to train them. The youth core research team interviewed 150 youth and families and then formulated recommendations, which were published in *Blamed and Ashamed: The Treatment Experiences of Youth with Co-Occurring Substance Abuse and Mental Health Disorders and Their Families* (Federation of Families for Children's Mental Health, 2001).

Three Main Purposes of Involving Youth in Evaluation and Research (Smith, 2001)

- To help youth develop and to encourage their active involvement in the decisions that affect their lives and the lives of their peers
- To enable youth to contribute to the development of the organization or program
- To provide young people with the opportunity to create real community change

What Makes Youth Involvement in Research Successful?

- Readiness of the organization and community to support young people throughout the process
- Training and support for youth to help young people understand the project and gain a sense of competency in completing the work
- Training and support for adults partnering with youth to eliminate stereotypes of youth and to battle adultism
- Support for youth who may participate with different levels of intensity or at different times depending on their outside obligations
- Compensation for youth, transportation, and food for meetings held during meal times

Chicago's Metropolitan Child and Adolescent Network's Teen Advisory Council

In March 1999, the Metropolitan Child and Adolescent Network established the Teen Advisory Council (TAC), a subcommittee of its Network Advisory Council. This committee consisted of 10 adolescents, ranging in age from 14 to 19, all of whom had been primary consumers of community mental health services at agencies in the Metro C and A Network. The TAC's first evaluation project, the Adolescent Consumer Satisfaction Questionnaire, was initiated from a youth-led discussion about personal experiences in the mental health system. The young people in the TAC realized that they represented a small portion of the youth who receive counseling services, so they decided to develop a survey to find out whether other young people were satisfied with their mental health services. Funded by the Illinois Office of Mental Health, the project provided youth stipends, food, and materials. The young people worked in partnership with two adult supporters to develop the survey and write all the questions. The youth then distributed the survey to community mental health agencies and asked therapists to distribute the survey to their youth consumers. Because the TAC members believed that it was important for teen respondents to be able to participate autonomously and anonymously, they included self-addressed, stamped envelopes with the survey.

The results of their survey showed that 91.5% of adolescents responding to the survey found their counseling to be "worthwhile." However, they also found that some young people were not receiving the type of help they needed through counseling and did not always feel heard. As a result of the survey, the TAC developed a newsletter called Letz Talk About It. The newsletter discusses how youth use counseling. It is developed by, and targeted at, youth in counseling. The TAC has also presented its findings to the local consumer parents' group, the Network Advisory Council for the Office of Mental Health, and the Federation of Families for Children's Mental Health Annual conference. The young people of TAC used this project as a basis for amplifying their voice; the project gave them an evidence-based platform from which to talk.

After completing their work on the Adolescent Consumer Satisfaction Questionnaire, the youth developed an approach and wrote a proposal for developing and administering a survey addressing the incidence of violence within the teen mental health population. The Illinois Violence Prevention Authority received the group's proposal and gave them a $5,000 grant. Having gained more expertise in evaluation, the youth wrote and distributed the survey themselves, asking community mental health agencies to distribute it randomly. They had a very good response rate and compiled and entered the data into the computer. The youth also wrote the final report. A striking finding in the survey was that 40% of teens who had been victims of violence did not inform their therapist of this fact.

The second phase of this project involved producing a film discussion on teen violence, "Letz Talk About Violence." The TAC conducted a pretest, showed the film, had a focus group discussion on the content of the film, and then administered a posttest. The goal of this project was to raise awareness about the extent and effect of violence in the lives of young people. After completing the film project, the group used the remaining funding to hire a marketing consultant working with the system of care grant to design a poster on the results of the survey. The youth worked with the consultant and decided which statistics were important

"As adolescents and children, we have been asked for very little feedback, and we question whether our perspectives are taken seriously. We should be taken seriously because some of us will be in this (mental health) system for our whole lives."

—Quote from a survey respondent

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(Chicago's Metropolitan Child and Adolescent Network's Teen Advisory Council...continued)

to highlight as well as the design and overall content of the poster. The TAC youth printed the poster and provided it to community mental health agencies; the poster is currently posted in many mental health waiting rooms in Chicago.

The New Freedom Commission invited the TAC young people to present this project when the commission met in Chicago. The presentation is now posted on the commission's Web site. The TAC youth also presented their work to a consumer parent group and at the Building on Families Strengths Conference in Portland, Oregon. The work of the Chicago TAC is an exemplary example of the strengths, abilities, and successes of young people when they are involved in the evaluation process.

Social Marketing: Youth Getting the Word Out!

Social marketing is a valuable tool for changing behaviors among key audiences. At its core, social marketing is an application of marketing strategies that are effective in the commercial world. Instead of persuading people (your audience) to buy a certain brand of soap or see a new movie, social marketing encourages them to take actions that will lead to better health or some other social good. Or, as a youth who works on social marketing in Florida defines it, "Social marketing is how you get the word out."

How does it work? By offering benefits people want, reducing barriers people face, and using persuasion, not just information. By identifying and addressing the benefits and barriers, effective social marketing is also culturally and linguistically competent. The key is to get to know and involve your audience in your social marketing efforts.

Young people "get" other young people in ways that adults never will. Because of their personal experiences, young people know what works and what needs to change. Social marketing is an area in which young people can tap into their experience-based knowledge and develop campaigns that will best reach their peers. Traditionally, social marketing campaigns attempted to reach their target audience through gathering historical data, conducting market research, and developing cultural profiles. This process has been successful in numerous social marketing programs. However, there has been a recent endorsement for youth to step outside their traditional target audience roles. Young people are now assisting with program conceptualization and developing and executing strategies for program implementation. Youth can and should be involved in every aspect of social marketing.

The social marketing planning process uses the following steps (Caring for Every Child's Mental Health Campaign):

- Determine the goal of the project
- Identify and profile audiences
- Develop messages
- Select communication channels
- Choose activities and materials
- Develop and pre-test activities and materials
- Implement the plan
- Evaluate and make midcourse corrections

Youth can be involved in:

- ➜ Sponsoring a forum
- ➜ Hosting a community event
- ➜ Testifying before a legislative body
- ➜ Speaking in front of an assembly
- ➜ Conducting media outreach
- ➜ Creating newsletters, web sites, videos, songs, public service announcements

Burlington County Youth Partnership: Combating Stigma Through Social Marketing

The Burlington Partnership in New Jersey shows that youth are indeed the experts in developing relevant social marketing projects.

A significant element in the mission of the Burlington, New Jersey, Partnership system of care is to reduce the stigma associated with having a mental health illness. To combat stigma, the Burlington Partnership produced a 30-minute informational video. This video attacks stigma by presenting real people with mental health challenges and their families and by describing the care available in Burlington County.

The project began in 2003 when the Burlington Partnership asked the Youth Partnership to spearhead the project. The University of Medicine and Dentistry of New Jersey (UMDNJ) funded the project at close to $18,000 and provided the necessary technical assistance to complete it.

The Youth Partnership began by building its team with youth who were committed to the necessary hard work required to develop the video. Youth volunteered to help coordinate the project, and members from the Department of Human Services and families and children from the Burlington System of Care volunteered to participate in the interviews that would frame the video.

After pulling together four strong youth leaders, the team worked with UMDNJ to develop a storyboard and identify three key questions to ask the public to shape the video.

1. What is a system of care?
2. How does a system of care work?
3. Why is a system of care such a great idea?

To address issues of confidentiality, the team drafted a standard consent form designated for both adults and minors and consulted with an attorney to review the form and ensure that it was legally sound. All interview participants signed the form before the video went final production.

The youth interviewed more than 25 individuals ranging from directors and CEOs of provider organizations at the state level to families and children at the local level. They depicted the diversity of their community through the different genders, ages, experiences, and cultural backgrounds of the people they interviewed. The youth also showed a diversity of roles by including the voices of children and families alongside the voices of directors from the state level.

The group planned to incorporate the video into training packages for local communities, providers, family members, and systems partners. The goal of the project was to help viewers gain a more in-depth overview of the systemic reform that is occurring throughout New Jersey. The video premier was on August 3, 2004 and stakeholders including administrators, key staff, family members, youth, and providers attended the showing. The premier received glowing reviews from participants.

The Youth Partnership believed that once a potential family saw actual family members and youth on tape, the likelihood that they would enroll in the system of care would increase. The interviews on the video are genuine and reflect the experiences of real families and professionals who care about the well-being of children with serious emotional and behavioral disorders. The video reflects the intense dedication and hard work of four youth leaders from the Youth Partnership of Burlington County whose vision and creativity will help other youth receive the services and support that they need to succeed.

Sustaining Youth Involvement

Sustainability depends on both philosophical and fiscal support. Sustaining a youth group often comes down to the need for funding. As mentioned previously, youth should be actively engaged and driving the process of sustaining the group. In order to respond to most funding opportunities, the youth group must be under a nonprofit, 501(c)(3) organization. This has historically been under the local family organization. Youth groups that are well developed can complete the Application for Exempt Status Under Section 501(c)(3) of the Internal Revenue Code, which is a long process with strict requirements. Information on the process can be located on the Internal Revenue Services Web site at http://www.irs.ustreas.gov/charities/.

Identifying funding sources begins with research on local, state, and national resources that are available in supporting youth involvement. Youth groups need to consider national, community, and corporate foundations for funding opportunities. The youth group should ask for the foundation's annual report or funding guideline information to ensure that the funding requirements and their mission fits with the youth group mission and vision. The youth group should also know the geographic focus and area of interest before applying for funding from a foundation. Federal agencies may also be a possible funding source. They often issue Requests for Proposals that are located in the Federal Register. Local newspapers, state announcements, and even Internet searches are ways to identify funding opportunities. Youth groups may also want to investigate corporate giving programs in their area. Large companies and corporations often provide local programs with financial support based on a set of priorities established by the company (www.nydic.org/nydic/fundfact.html).

Fundraising is also important to build funds for the youth group as mentioned earlier in the chapter as well as in-kind donations. Building community partnerships where you can pool your resources and bring together diverse stakeholders who are committed to the group and to youth involvement are critical components to sustaining youth involvement.

Barriers and Solutions to Youth Involvement

Even in the best circumstances, there are often barriers to involving young people within the system of care. For many of these obstacles, there are solutions to make the possibility of youth involvement a reality. During the 2002 Georgetown University Training Institutes and the 2003 Spring System of Care Community Meeting, youth involved in the system of care verbalized their feelings and ideas about barriers and solutions to youth participation. The following list of barriers and solutions are examples of their thoughts and ideas.

Barriers to Youth Involvement	Solutions to Youth Involvement
Youth have ideas, but don't know how to implement them	Provide training opportunities for young people
Adults refuse to share power with young people	Educate about the power and benefits in involving youth
Adults plan projects without involving youth	Provide training for adults who will partner with young people
Adults view young people as problems rather than resources	Create opportunities for youth to train adults and providers
Youth don't view themselves as change agents	Listen to and value the suggestions of young people so they become more comfortable and competent when making suggestions
Youth are unwilling to get involved (because they have never been invited to the table before)	Use youth leaders to link with other youth in the community
Lack of support for young people when they come to the table	Identify an adult mentor for youth to help in understanding meeting processes and protocols
Distrust between youth and adults	Facilitate a discussion or activity where youth and adults can learn about each other

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Barriers to Youth Involvement	Solutions to Youth Involvement
Lack of transportation to meetings	Help youth decide how they will get to the meeting (e.g. Provide bus tokens if youth use public transportation or schedule a car pool)
Scheduling of meetings	Schedule meetings after school and provide dinner if the meeting is during a meal time
Financial Constraints	Provide compensation for youth involvement (cash, vouchers, credits, community service hours)
Cultural differences	Provide cultural competency training that includes youth

What Makes Youth Involvement Successful?

Involving youth in decision making will be a successful venture when young people have support and training opportunities and when the organizational leader is committed to youth partnership.

Effective youth participation happens when:

- Empowered youth voice is woven throughout your system of care
- Youth are valued for their experience and expertise
- Youth consumers are advocates and educators
- Youth members are on boards and committees
- Youth are decision-makers
- Youth on boards are treated the same as other members
- Youth are able to get to meetings (transportation and schedule)
- The group's efforts are sustainable
- Adults in the community are allies and support youth involvement
- Equal partnership and shared respect

Examples of what it takes to successfully involve youth:

- ➜ Youth provide pressure and support for increasing youth participation
- ➜ Decision-making body of an organization committed to forming a youth–adult partnership
- ➜ Increase opportunities for youth partnership and governance and changing organizational operations
- ➜ Older youth involvement initially helps to create adult support
- ➜ An adult visionary leader with institutional authority who advocates for youth involvement in decision-making
- ➜ Adults believe that there is a good reason to partner with youth
- ➜ Adults observe young people excelling in the boardroom or other places that are commonly adults' territory
- ➜ Adults view youth as competent decision makers

Section VIII

On the Horizon

Conclusion

VIII. On the Horizon

"Youth involvement is the next step towards effective and productive service. Youth need to be involved as equal partners in the planning of their lives. They will always know more about themselves than their providers will know about them"

—Victor Damian, Youth Coach, Youth Task Force, San Francisco, California

Youth involvement in system of care communities and the youth movement is ever evolving. There is national momentum keeping the force behind the movement with tremendous support from the CMHS Child, Adolescent, and Family Branch. Examples of upcoming developments around youth involvement and the youth movement include the creation of the National Youth Development Board and the focus groups conducted by ORC Macro.

Currently, the Technical Assistance Partnership for Child and Family Mental Health and the Child, Adolescent, and Family Branch are in the beginning stages of developing the first National Youth Development Board (NYDB). The NYDB is made up of a diverse group of young people from system of care communities. The purpose of the board is to unite the voices and causes of youth; act as consultants to youth, professionals, families, and other adults; and be more involved in the politics and legislation of mental health policies. In addition, the board will support a national youth movement; assist in developing the Youth Leadership Program at national conferences; create youth movement principles and policies; and develop training tools, guides, and other documents. This will be the first youth-driven advisory board at a national level in the history of the Comprehensive Community Mental Health Services Program for Children and Their Families.

As of 2002, all newly funded system of care communities are required to have a youth coordinator and youth involvement. At this time, communities are working to define the role and responsibilities of their youth coordinators and the nature of youth involvement in their systems. To help form an understanding of what is going on in the communities with respect to the role of youth coordinators, ways in which youth are involved, and barriers and facilitators to involvement, the national evaluator for CMHS-funded systems of care conducted focus groups with youth coordinators and youth from communities funded in 1999 through 2003. The information obtained from the focus groups will be disseminated to improve understanding of the status and issues related to youth involvement, and will aid in the development of a standardized interview to be administered to a sample of youth in all system of care communities as a component of the System of Care Assessment for the national evaluation.

Based on the initial focus groups, ORC Macro found that youth expressed feeling disempowered and disrespected when they are denied an opportunity to have a voice or get involved, which outweigh the benefits of being part of a system of care. In contrast, being active in their system of care communities gives them a sense of pride and accomplishment, an opportunity to help others, a place to go, and something to do. Findings such as this will generate increased momentum around issues of youth involvement and create a bright picture for the future of youth as change agents.

Conclusion

This guide has taken you on a journey toward authentically involving young people in systems of care. Youth involvement is key in developing and managing a system of care for many reasons; young people's skill sets and abilities are enhanced, and adults, organizations, policies, communities, and child-serving systems benefit. When young people are actively involved, stigma surrounding mental illness is reduced. Though there will be barriers during this journey, this guide has provided you with the necessary tools to find solutions in partnering with young people. In order to forge this partnership, adults and young people need to step outside of their comfort zones and begin taking risks and steps toward mutual understanding and respect. This involves fostering a respect for differences and similarities as well as respect for the experiences that young people and adults bring to the table. This guide has taken you through the process of initiating a youth group and identifying ways in which doors for youth involvement can be opened. Enjoy the journey!

Section IX

Resources for Youth Involvement

Youth Participation in Evaluation/Research

Youth–Adult Partnerships

Youth Participation on Boards and Committees

Youth Development Approach/Theory/Practice

Youth Development and Civic Engagement/Action

Youth Participation in Community Planning

Youth Group Experiences and Examples

Guides/Training/Tool Kits

Cultural and Linguistic Competency Resources

IX. Resources for Youth Involvement

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Section X

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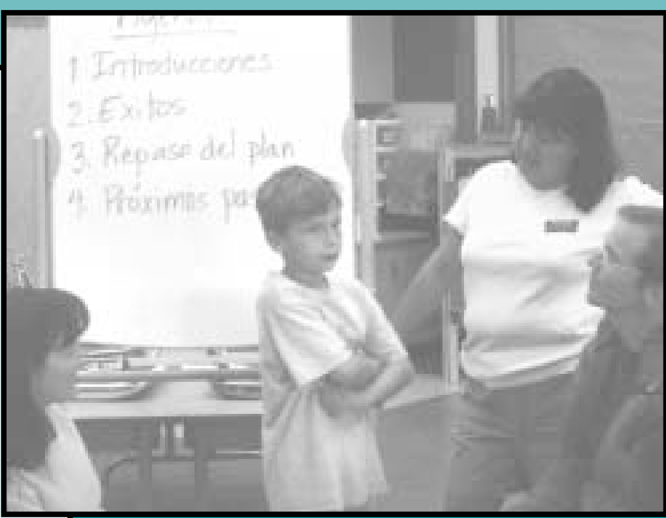
Implementing high-quality collaborative Individualized Service/Support Planning: Necessary conditions

Janet S. Walker, Ph.D., Nancy Koroloff, Ph.D., Kathryn Schutte, M.S.



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Research and Training Center on Family Support and Children's Mental Health

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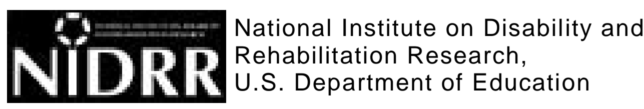

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Federation of Families For Children's Mental Health

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Chapter 1: Overview

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Chapter 1: Overview

In recent years, communities across the country have responded to the multifaceted needs of children with serious emotional and behavioral disorders by using a variety of creative approaches for coordinating, designing, and delivering services. One popular approach is the use of collaborative Individualized Service/Support Planning teams (ISP teams). The ISP team members—the identified child/youth, parents/caregivers and other family and community members, mental health professionals, educators, and others—meet regularly to design and monitor a plan to meet the unique needs of the child and family. The planning process itself, as well as the services and supports provided, are intended to be individualized, family centered, culturally competent, and community and strengths based. In different communities, ISP teams are known by a variety of different names, such as wraparound teams, family networking teams, child and family teams, and so on. In 1999, it was estimated that as many as 200,000 ISP teams were at work,[9] and it appears that numbers have been increasing since.

Among those who advocate and practice team-based ISP, there is a good deal of agreement about the definition of the team. There is also a consensus about the *value base* for ISP. Advocates and practitioners agree that the ISP process itself—as well as the plans produced through the process—should be individualized, family[*] driven, community and strengths based, and culturally competent.[4,14] This approach has been contrasted to traditional forms of service delivery, which have often been experienced by families as professional driven, family blaming, deficit based, and lacking in respect for the family's beliefs and values.[17,22]

Achieving quality implementation of team based ISP has proven to be challenging.[8,25] One set of challenges arises from the lack of a shared model of practice for ISP. Despite the consensus about the value base of ISP, there is little agreement regarding exactly how this value base should be translated into practice at the team level. As a result, there has been no formal definition of the techniques, behaviors, or procedures that make up the ISP process. This has led to a wide variety of practice models, many of which appear to be inconsistent with the original approach for ISP service delivery.[3]

Other challenges to high quality implementation arise from the larger context within which ISP teams work. Practical experience has shown that achieving meaningful change at the service delivery level requires extensive support from the *organizational level*, as well as from the *system level*[**] (or *policy and funding context).* [5,16,18,20] This required support

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[*] Throughout this document, we intend for the term "family" to refer to the adult(s) with primary, long-term caregiving responsibility for the identified child, together with other members of his/her household. Such a family may or may not include, in the role of primary caregiver, biological parents, kin, foster parents and/or other guardians. We consider a family-driven process to be one which accords significant weight not only to the perspectives of the caregivers, but also, to the greatest extent possible, to the perspective of the identified youth/child.

[**] We use these terms interchangeably in this report.

for the team ISP process can be hard to come by given that organizations and systems are often locked in their traditional ways of doing business by organizational cultures;[18,23] inter-agency barriers;[15,16] funding exigencies;[19] and skepticism regarding the effectiveness of family-centered, strengths-based practice. [26]

As the field has gained experience with the challenges associated with implementing ISP, practitioners and advocates of the process have responded by developing a wide variety of supporting tools, procedures, policies, and structures at the team, organizational and system levels. Because each ISP program is embedded in its own local context and subject to local policies, this set of supports tends to look somewhat different in each community. Our research suggests, however, that these different tools, policies, procedures, and structures represent strategies that share a common goal: to produce conditions that allow for quality implementation of the team ISP model. What we propose here is to enumerate the conditions—at the team, organization, and system level— which must be in place if an ISP program is to thrive.

In the pages that follow, we propose a conceptual framework that specifies these necessary conditions. The proposed conceptual framework was developed through a process of "backward mapping."[7,12] Backward mapping begins with a description of desired behavior at the lowest level of intervention—in this case the team level—and then proceeds to identify the resources and supports that are needed if the desired behaviors are to occur. In developing this framework, backward mapping began with the basic proposition that quality implementation of the team-based ISP process can be recognized when teams conduct their work using practices that simultaneously promote both effective planning and the value base of ISP. Teams employing such practices maximize the likelihood that they will set and reach appropriately ambitious goals as they create and implement plans that are individualized, family driven, community and strengths based, and culturally competent. If this is to happen, what are the conditions that must be in place at the team, organization, and system levels?

Team, organization, and system

Before beginning the discussion of the proposed necessary conditions, we would like to clarify what we mean by *team*, *organization*, and *system (or policy and funding context)*. As we mentioned above, there is general agreement in the academic and training literature that a team *should* include the primary caregiver; the child or youth (if he or she is willing and able to participate); other friends, family, or community members whom the family finds supportive; and service providers* who figure importantly in the plan. In practice, the actual constitution of teams can vary widely not just from team to team but also from one meeting to the next. For the purposes of this discussion, we define a team as the caregiver and youth and at least two or three other consistently attending core members from the list above who are charged with creating and implementing plans to meet the needs of the family and child with an emotional disorder. This core

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* Service providers include human service professionals (e.g. care coordinator, child therapist, school psychologist, teacher, child welfare worker, probation officer) as well as professionals and volunteers who provide services to the community (judo teacher, scout leader, pastor).

team may be supplemented as necessary by others who attend when their role in the plan is under consideration or when their input is invited.

At the organizational level, the picture becomes somewhat more complicated. We find it useful to distinguish between two roles that organizations or agencies can play relative to ISP teams. In the first role, an agency takes the *lead* in the ISP implementation, and is responsible for hiring, training, and supervising team facilitators. This agency may also provide training for other team members with specialized roles, such as family advocates or resource developers. In the second role, an agency acts as a *partner* to the team-based ISP process by contributing services, flexible funds and/or staff who serve as team members. Communities have developed a variety of strategies for distributing these roles across different agencies. In some systems, one agency may cover aspects of both functions (for example, when a therapist is also the team facilitator), whereas in other communities, the ISP model specifies that these roles should not merge. Furthermore, elements of the lead and partner roles may be divided up between different organizations or agencies in different ways. Our conceptual framework stresses the importance of the lead agency's role because we see facilitation as a key to the team-based ISP process. We view the training and supervision of facilitators as requiring a level of understanding of, and support for the team-based ISP process that is substantially greater than that required of agencies that act primarily in the partner roles.

We use *system level* or *policy and funding context* to denote the larger service policy and economic context that surrounds the teams and team members' agencies. The system level is made up of multiple organizations that may focus on a specific set of services (e.g. mental health), a geographic area (e.g. county), population (e.g. children), or a combination of these. The policy and funding context may also include multiple governmental entities at the county, region, or state, as well as other organizations that set policy, monitor or enforce policy, or interpret state or national policies to local service providers. The system level also includes any body that has been constructed to oversee the development of the service system or to manage funds that have been pooled. The policy and funding context varies from community to community but at the very least will include those individuals and bodies that make decisions regarding policies and procedures and the allocation of resources that affect the functioning of the lead agency (or agencies) and by extension, the teams.

Configurations of support

The conceptual framework described here proposes that the necessary conditions for the implementation of high quality ISP teams may be met even in the absence of a developing system of care. In fact, we have seen ISP teams function successfully in contexts offering very different levels organizational and system support. It appears, however, that different configurations of support have implications for the viability of individual teams, the stresses experienced by various stakeholders in the teams, and the sustainability of ISP programs over time. What is more, while some isolated *teams* may function well in the absence of organizational and system support that meets the proposed necessary conditions, we do not believe that high-quality ISP *programs* will be able to do so. Below, we discuss several different configurations of organization and system support for ISP: the *independent team* (low organizational and system support),

the *single agency program* (high organizational support, low system support), *newly developing system of care* (high or low organizational support, low to moderate system support) and *integrated system of care* (high organizational support, high system support).

At the level of least support from either organizations or systems, we have observed some teams that function for extended periods of time independently of any ISP program. These *independent teams* are unsupported by any formal arrangements at the organizational or system level. Such teams seem to emerge from the interests and efforts of highly motivated families and service providers who have learned of the ISP model but cannot access such services locally. As a result, team members have chosen to implement the model on their own, and in some cases have had a tremendous positive impact on the lives of the child and family for whom the team was formed. However, these independent teams tend to struggle, often unsuccessfully, to access and fund desired services and supports. Often they find they must either provide services/supports themselves or prevail upon sympathetic contacts in various agencies to make exceptions and bend rules. Team members on independent teams are often highly stressed by their continual efforts to work around existing policies and providers, as well as the need to negotiate multiple barriers to services and funds. Families also tend to be highly stressed due to continual uncertainty. Over time, these teams are not likely to have a significant impact on the agencies or systems with whom they interact, and so the stress experienced by team members does not decrease. Without any organizational or system support, independent teams have difficulty sustaining their work over time, and stimulating the creation of multiple independent teams does not seem like a viable means of systematically meeting the goals of children and families with high levels of need. We thus regard indifference on the part of organizations and systems—as is usually experienced by the independent teams—as insufficient to support high-quality ISP.

We did see evidence, however, of the potential for ISP programs to be successful within systems that are *almost* indifferent to their existence. Usually, such programs are operated using what we call a *single agency program* for ISP.* In this model, the ISP program exists within an established, well-regarded human service agency which is able to provide strong support as the lead agency for ISP. Outside of this strong lead agency, the necessary conditions for high quality ISP (i.e. the conditions fulfilled by partner organizations and the larger policy and funding context) are met in a minimal way, and often through informal agreements or special arrangements. Directors and supervisors at the lead agencies rely on relationships with various key allies both among their peers at partner agencies and at the county, regional, and/or state level. These key allies have enough influence to ensure that the necessary conditions described here are met—but usually only for that specific agency and often on an ad hoc basis. Thus for example, allies at the system level might write special contracts that permit the agency flexibility in managing funds or changing service categories and codes. Or county or regional-level allies might help the agency negotiate with other child serving agencies, such as child welfare, on issues such as developing unified documentation of plans. Similarly, when teams need services or arrangements that are somewhat unusual, agency supervisors or administrators often enlist the aid of peer allies in other agencies to negotiate exceptions or to creatively work around barriers to services or funding.

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* This is similar to the agency model described elsewhere. [10]

At the team level, there appears to be less stress on the families in the single-agency program model than in the independent team model; however, relatively greater stress generally falls on the care coordinators who are constantly negotiating exceptions with counterparts in other agencies and systems. The program may also experience setbacks and disruptions when key allies leave their jobs, and previous informal or special arrangements must be re-negotiated. What is more, single agency programs, while capable of having a significant positive impact on a small number of families, may be quite limited in terms of the number of teams they can support. For example, because there tends to be no restructuring of jobs in partner agencies to accommodate teamwork, team members from those agencies—or those in private practice—must donate their services to teams. As the number of teams in a community grows, it becomes increasingly difficult for the lead agency to find people who are willing to assume—on top of existing job responsibilities—the considerable efforts that can come with participation on ISP teams. A similar phenomenon exists with respect to community resources. A small number of creative teams may be very successful at linking to appropriate community resources to support team plans. In the absence of a larger community effort to build capacity, increasing the number of teams at a given agency may quickly exhaust community capacity to provide desired support.

Most teams and programs appear to exist in a context of somewhat higher levels of system support, particularly in the context of *newly developing systems of care*. Often, these nascent systems of care have developed formal interagency agreements recognizing teams and providing pools of funds that can be used flexibly, as well as interagency committees which meet to problem solve or to create policies supportive of ISP teamwork. Ironically this situation can at times be even more stressful for team members, and particularly for care coordinators and families, than the single agency model described above. This appears to be especially likely when the lead agency is also newly created and/or when the ISP program has been adopted as part of efforts at systems reform that have shaken up multiple agencies. In these cases, the care coordinators are subject to the same stresses as in the single-agency model, except that their power to elicit cooperation from partner agencies may be *decreased* (due to the agency's lack of well-established reputation and relationships with peer and system-level allies) while resistance to their efforts from partners may well *increase* (due to defensiveness on the part of peers in partner agencies which have also been swept up in the efforts to reform the system). Family members may experience high levels of stress due to uncertainties and difficulty in accessing services, supports, and funds to meet unique needs. Lead agencies in these circumstances may experience rapid turnover among care coordinators, and consequently the capacity for high quality ISP may never develop. On the other hand, strong, well-established agencies with clear models of ISP practice appear to be able to survive, and even thrive in conditions such as these. In general, however, ISP programs with tenuous, newly developing and/or only nominal system support appear to be quite vulnerable to turnover among system-level allies and to changes in funding arrangements. Such programs are often funded under pilot agreements or grant-based initiatives, and their support may wane quickly once the trial period ends.

Recognizing these vulnerabilities, advocates of ISP in many communities seek to ensure the longer-term viability and quality of ISP programs by institutionalizing supporting conditions and arrangements at the organization and system levels. In most cases, this

is envisioned as coming about as part of the process to develop a larger, fully *integrated system of care*,[11,22,24] and/or through the formation of a locally managed system of care focusing on subsets of children with high levels of need.[*] With the move towards a system of care, the stresses may decrease on the teams and care coordinators. They may find they have more legitimacy and leverage to work with partner agencies, more resources and more flexibility with funding and documentation, and a greater pool of like-minded peers who are willing and experienced participants on teams.

As systems of care continue to develop, advocates of ISP programs may find that the conditions for high quality implementation will be met in a more stable and profound way than under any other sorts of arrangements. However, making the transition to a system of care is a long process, and there may be a tendency for resistance among upper level managers and systems people to increase as they become more fully aware of the thoroughgoing changes required by a shift to the system of care approach. Whether these sorts of barriers can be overcome in many communities is a matter of some uncertainty at this point.[6] What is more, research on systems integration sends a strong caution against relying on system reform, in and of itself, as a route to improved outcomes for children and families. These studies argue that without attention to improving the quality of services [1,2,13] and to increasing the capacity of organizations,[13] there may be little reason to expect improved outcomes under systems of care.

Even in the absence of obvious movement toward a system of care, it would appear that the necessary conditions for stable system level support of high quality ISP can be met through arrangements that are institutionalized in rules, policies, and structures. We propose that when the conditions are met in this manner, ISP programs can sustain high quality implementation even where the various child- and family-serving systems are otherwise not well integrated. Sufficient institutionalized support will mean that ISP programs will not be excessively dependent on the good will and efforts of a few key allies and will not continually demand exceptional efforts from the team members themselves. Regardless of the level of system support, however, we do not believe that a high quality implementation of ISP can be achieved unless the lead agency is highly capable, and can provide a strong model of practice, high quality supervision, and the other conditions described in this report.

Overview of this report

The remainder of this report focuses on work undertaken as part of *The Context of Services* project at the Research and Training Center on Family Support and Children's Mental Health. The goal of this work was to develop a conceptual framework describing the conditions that are necessary to support high quality implementation of team-based ISP.

Chapter 2 of this report provides a description of the types of information that were used in building the conceptual framework. The chapter also describes the process by which the framework was further developed through several rounds of expert review.

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[*] See the descriptions of *local managed systems of care* in Pires. [21]

The next chapters describe the proposed necessary conditions for high quality implementation of ISP. We have grouped the conditions under five themes as outlined in Figure 1 (*see next page*). Each theme is discussed in a separate chapter, as follows:

Chapter 3: Practice model

Chapter 4: Collaboration/partnerships

Chapter 5: Capacity building/staffing

Chapter 6: Acquiring services/supports

Chapter 7: Accountability

Consistent with the idea of backward mapping, each chapter begins with a discussion of necessary conditions at the team level, and then goes on to discuss the organizational level and system level/policy and funding context (i.e. reading across the rows of Figure 1). Thus Chapter 3 begins with *support for a practice model* at the team level, and continues with the same theme at the organizational level and the policy and funding context (system level). Chapter 4 then returns to the team level to begin with the theme of *collaboration and partnerships*, and so on. The discussion of each condition includes evidence and argument supporting its inclusion among those necessary to ISP implementation. Additionally, we offer examples of specific techniques, processes, procedures, structures, or other mechanisms that different communities or teams have used to satisfy the condition.

Chapter 8 addresses the question of how this framework of necessary conditions can be put to practical use to improve the quality of ISP implementation. The chapter is built on the idea that quality can be improved when stakeholders 1) approach implementation with an agreement about conditions that must be in place at the team, organization, and system levels; and 2) use relevant data to guide ongoing discussions about the extent to which these conditions are currently in place. The chapter introduces a series of assessments that were developed alongside the conceptual framework. The assessments—for team practice and planning, organizational support, and policy and funding (system) context—are designed to provide stakeholders with a structured way of examining the extent to which the necessary conditions for ISP are present in their local implementation. The assessments are not designed to provide a rating or ranking of the implementation; rather, they are intended for use in discussions of the strengths of the implementation, as well as to help clarify and prioritize areas for further development.

The assessments were also designed with an eye towards issues of mutual accountability across the various levels of implementation of ISP. Traditionally, we think of people at the service delivery level as accountable for the quality of the services that they provide. When programs fail to deliver desired outcomes, the blame flows downward: to frontline service providers, and even to the families served. However, as our research has made abundantly clear, high quality work in ISP cannot succeed where support is lacking from organizations and from the policy and funding context. But how are people at these levels to be held accountable for providing an acceptable level of support? We believe that assessing the extent to which the necessary conditions are in place at the organizational and system levels provides a means for pushing accountability upward as well as downward. Used in the way that we envision, the assessment of organizational

FIGURE 1: NECESSARY CONDITIONS

TEAM LEVEL	ORGANIZATIONAL LEVEL	POLICY AND FUNDING CONTEXT (SYSTEM LEVEL)
Practice model i. Team adheres to a practice model that promotes effective planning *and* the value base of ISP. Sub-conditions of practice model 1-7	**Practice model** i. Lead agency provides training, supervision and support for a clearly defined practice model. ii. Lead agency demonstrates its commitment to the values of ISP. iii. Partner agencies support the core values underlying the team ISP process.	**Practice model** i. Leaders in the policy and funding context actively support the ISP practice model.
Collaboration/partnerships i. Appropriate people, prepared to make decisions and commitments, attend meetings and participate collaboratively.	**Collaboration/partnerships** i. Lead and partner agencies collaborate around the plan and the team. ii. Lead agency supports team efforts to get necessary members to attend meetings and participate collaboratively. iii. Partner agencies support their workers as team members and empower them to make decisions.	**Collaboration/partnerships** i. Policy and funding context encourages interagency cooperation around the team and the plan. ii. Leaders in the policy and funding context play a problem-solving role across service boundaries.
Capacity building/staffing i. Team members capably perform their roles on the team.	**Capacity building/staffing** i. Lead and partner agencies provide working conditions that enable high quality work and reduce burnout.	**Capacity building/staffing** i. Policy and funding context supports development of the special skills needed for key roles on ISP teams.
Acquiring services/supports i. Team is aware of a wide array of services and supports and their effectiveness. ii. Team identifies and develops family-specific natural supports. iii. Team designs and tailor services based on families' expressed needs.	**Acquiring services/supports** i. Lead agency has clear policies and makes timely decisions regarding funding for costs required to meet families' unique needs. ii. Lead agency encourages teams to develop plans based on child/family needs and strengths, rather than service fads or financial pressures. iii. Lead agency demonstrates its commitment to developing culturally competent community and natural services and supports. iv. Lead agency supports teams in effectively including community and natural supports. v. Lead agency demonstrates its commitment to developing an array of effective providers.	**Acquiring services/supports** i. Policy and funding context grants autonomy and incentives to develop effective services and supports consistent with ISP practice model. ii. Policy and funding context supports fiscal policies that allow the flexibility needed by ISP teams. iii. Policy and funding context actively supports family and youth involvement in decision making.
Accountability i. Team maintains documentation for continuous improvement and mutual accountability.	**Accountability** i. Lead agency monitors adherence to the practice model, implementation of plans, and cost and effectiveness.	**Accountability** i. Documentation requirements meet the needs of policy makers, funders, and other stakeholders.

support and the assessment of policy and funding context are tools for this sort of *upward accountability*. In contrast, the team level checklist can be seen as a more traditional sort of tool, of the type that is used for supervision in a more familiar form of *downward accountability*. The idea is that, rather than having two separate sorts of accountability, a balance of upward and downward accountability actually builds a culture of mutual accountability that encourages focused problem solving over defensive blaming.

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Chapter 2: Method

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Chapter 2: Method

The conceptual framework presented in this report is based on three main sources of information. First, project staff gathered relevant theory, research, and practice-oriented information available in published and unpublished literature. Second, we interviewed a number of stakeholders in the team-based ISP process, including parents, children/ youth, parent advocates, and other caregivers and team members; team facilitators and their supervisors; program and organization administrators; and county and state administrators. Finally, we gathered information during observations of ISP teams as they planned, implemented, and monitored services for children and families. Each of these sources of information is described in greater detail below.

At several points during the course of developing this framework, we asked experts in ISP to review our work and give us feedback. After each round of expert review, we synthesized the feedback and incorporated it into the subsequent version of the framework. Further information about the process of expert review is provided in the last section of this chapter.

Sources of information

Research literature

Project staff undertook a broad-based search for relevant literature at the team, organization, and systems levels. At the team level, one of our primary goals was to gather research on factors influencing the effectiveness of teams and groups that are similar to ISP teams in important ways. For example, we were particularly interested in locating information on teams that undertake a long-term planning process during which they define their own goals, devise strategies for meeting those goals, and monitor implementation and effectiveness of the strategies. We also sought information on the effectiveness of teams that have demographic, power, and/or status differences between team members, and teams whose members represent a diversity of experience and perspective. Our goal was to focus on team-level attributes shown to impact effectiveness in multiple studies across a variety of planning contexts. Thus, we paid special attention to locating relevant research reviews and meta-analyses. Much of the research we reviewed came from the fields of organizational behavior and applied social psychology; however, we also consulted literature on group facilitation, mediation, and the resolution of conflicts in groups, as well as research and theoretical literature directly related to the principles, practices and evaluation of ISP.

We also gathered and reviewed materials designed to guide the practice of ISP. Primarily, these materials were manuals for training team members in the ISP process. We gathered 13 different training manuals. Among these, 11 were developed for specific sites (in nine different states), while two were used by trainers who worked with a variety of sites around the nation. In addition to the full manuals, we collected a variety of practice-oriented guidelines, checklists, brochures, booklets, and descriptions of training activities.

In preparing the first draft of this framework, staff from the research project conducted semi-structured interviews with a total of 55 people with high levels of experience in ISP at the team, organization, and/or system levels. Included in this number were interviews conducted with 28 team members identified as experts who had worked with multiple teams. Among these experts, eight were caregivers. The expert team member interviews were part of a separate sub-study on supports and barriers for ISP teams. Since we will report some of the results of this study at various points in later chapters, we provide here some information about the method used to obtain and analyze the data.

Each expert team member had worked with multiple teams in roles that included facilitator, care coordinator, resource developer, and parent partner/advocate. About two-thirds of the interviewees were identified by asking site directors to nominate the team members they would recognize as being among the most effective and experienced at that site. Site directors contacted included those at seven sites recognized by the Center for Mental Health Services* as having implemented promising practices related to ISP. The remaining interviewees were identified as experts by national level trainers with experience at numerous sites. The interviews with expert team members lasted about an hour each, and focused on interviewee perceptions of factors that influenced the success or failure of ISP teams. The factors identified by the interviewees included both those that were mostly within the team's control (e.g. team process and structures), as well as those which were not (e.g. funding policies and supervisor support).

To analyze the data from the expert interviews, we developed a coding system that was designed to capture interviewees' perceptions regarding the essential elements of effective ISP teamwork, barriers to achieving effective teamwork, and strategies for overcoming these barriers. Records from six of the interviews were coded by two staff members, who achieved good agreement (mean inter-rater agreement >.85% over 62 ratings for each interview) on whether or not a given theme was or was not present. The remaining interview records were coded by one researcher.

In addition to these experts, we also interviewed a further seven experienced team members (including five caregivers and one youth); one trainer; twelve directors of ISP programs; five system-level administrators from the county, regional, or state level; and two researchers with a national perspective on ISP teams. Our interviewees at the team and organizational level included seven African Americans, two Latinos and three Native Americans (all but one from the expert group); however none of our system level interviewees was a person of color. The interviews were tailored somewhat for people at the team, organizational, and system levels, but each version focused on the eliciting information about supports for and barriers to successful ISP teamwork.

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* These sites are identified, and their promising practices described, in a series of monographs produced from the Promising Practices Initiative of the Comprehensive Community Mental Health Services for Children and Their Families Project. The series is published by the Center for Effective Collaboration and Practice, American Institutes for Research, in Washington, D.C.

In preparing later drafts of this framework, we also had additional interview data available to us, from the preliminary phases of our intensive study of videotaped team meetings. For this study, we videotaped meetings of ISP teams whose members had been working together for some time. Soon after the meeting, we met individually with key team members who watched a series of selected excerpts from the meeting. After viewing each portion of the meeting, the team member answered a series of scaled and open-ended questions about the teams interaction and productivity during that segment. We also had an expert family member* who worked with our project reviewing the meeting using the same debriefing procedure. We completed this process for a total of 11 teams and 52 debriefing participants. While we have not formally analyzed the data, the interview information has informed the preparation of this report.

Observations

As part of a separate study on ISP teamwork, research staff collected data during observations and follow-up of 72 meetings of 26 different collaborative family-provider ISP teams. Sixteen of the participating teams were observed during only one meeting, and four teams were observed during five or more meetings. Observations were made of teams whose members had been working together for some time.

The teams that were observed were diverse in a variety of ways. In terms of geographic diversity, participating teams represented 13 different communities in eight different states. Three of these communities were located in the core areas of large cities, two in smaller cities, three in established suburban areas, and eight in developing "edge" areas where farmland and newer suburbs were intermixed. Teams were also diverse in terms of the overall levels of organizational and system support they received. For example, nine of the teams were from programs recognized by the Center for Mental Health Services as having implemented promising practices related to ISP. An additional four teams were also drawn from communities which had received substantial federal grants to improve service coordination and to implement Systems of Care. Members of some of the observed teams received extensive training and support from the organizations and systems in which they were embedded, while other teams received almost no such support.

One or two members of our research staff attended each observed meeting. Research staff collected any materials created by the team for use during the meeting (e.g. agendas, lists of goals), and took notes during the meeting about the structural characteristics of the team and elements of team process and planning. Copies of minutes or other team records produced as a result of the meeting were also provided to the research staff. At the end of the meeting, team members were asked to fill out a post-meeting survey.

At a later date, after all meeting materials had been gathered, each staff member who had attended the meeting separately reviewed notes and team materials, and completed a checklist summarizing various attributes of the team and its activities during the

* This family member had participated on, and then facilitated her son's ISP team, and had participated on numerous other teams in a role of parent advocate/support. She had also received a good deal of high quality training on ISP values and practice.

meeting. Information collected included: sex, race, and role of each team member in attendance; portion of the meeting attended by each member; and location, time, and length of the meeting. Another section of the checklist was used to rate whether or not various indicators of team process and planning were evident during the meeting. The list of indicators was derived from theory and research on team effectiveness and ISP. It was created as a means of assessing the extent to which there was evidence, during the observed meeting, that the team had the ability to promote both effective planning and the value base of ISP (see also Chapter 3). Using the ratings of two observers over nine of the meetings that were attended by two staff members, a mean agreement greater than 85% was achieved over the 28 items.[*] A revised version of the team checklist is provided as the team level assessment in Chapter 8.

Expert review[**]

The first draft of this report was written based on the information in the interviews, the data from the study of expert team members, and the data from the first 54 observations. Results from additional observations were incorporated into later drafts as the information became available.

The first draft was circulated to members of the National Advisory Committee for the Research and Training Center for Family Support and Children's Mental Health. This committee includes caregivers, advocates, practitioners, youth consumers, and researchers with a high level of expertise in children's mental health. From this group, seven with the greatest level of expertise relevant to ISP participated in a feedback session, which was audiotaped. Remarks from the session were summarized from the tape, and the feedback was incorporated into the second draft.

The second draft was then circulated to a further 11 expert reviewers, who included two parents/caregivers, one case manager, one ISP program director, two researchers, three state-level administrators, and two consultants. Ten of the 11 reviewers provided detailed feedback during interviews lasting about an hour in length. In most cases, two members of the research staff took detailed notes on the feedback during the interviews. Seven of the reviewers also provided written comments. One reviewer provided only written comments. Once again, the feedback was incorporated into the

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[*] Three items had three disagreements each, representing agreement of 67%. For one such item, disagreement arose from the issue of whether a team could have shared goals in the absence of a team plan. We clarified this definition and were able to reach agreement. A second area of disagreement centered on whether natural support activities could count as team-related activities if the team as a whole had played no role in arranging the activity. Adjusting the definition of this item to reflect a team role in arranging the natural support led to acceptable agreement on this item. Finally, disagreement arose regarding the item coding whether or not teams had looked into providing community service. Clarifying the definition of community service allowed agreement on the item. Revised definitions were applied to all future work with the checklist.

[**] Of the total 45 expert reviews of the framework, twelve were given by parents, four by youth or young adult consumers, ten by researchers, eight by ISP facilitators or care coordinators, five by state level administrators, five system-level administrators, six ISP program administrators, and two consultants. (This total is greater than 45 due to reviewers in multiple roles relative to ISP teams and programs.) Among the 45 reviews, seven were provided by African Americans, three by Native Americans, and three by Latinos. The remainder of our reviewers were Caucasian, or their ethnicity was unknown.

subsequent (third) draft. This draft also became the basis for the assessment of organizational support and the assessment of the policy and funding (system) context.

Revised portions of the third draft, as well as the system and organizational assessments, were circulated to the National Advisory Committee, and again, the (ten) members with the highest levels of expertise in ISP participated in a group feedback session. Feedback, which focused primarily on the assessments, was incorporated into revisions of the assessments.

After these revisions, the organization and system assessments were circulated to two further groups of people who had considerable expertise in ISP and who were planning to attend a national conference on systems of care. One group received the assessment of organizational support. Included in this group were parents/caregivers who had been members of ISP teams, case managers/care coordinators, facilitators, and consultants. Members of this group came from four different states. The second group received the assessment of policy and funding context. This group included system or program administrators and consultants from seven different states. At the national conference, each group came together for an hour-long reaction session during which the participants discussed the appropriate assessment and provided feedback. Feedback sessions were taped. The assessments were revised based on a review of the tape, as well as on notes taken during the reaction sessions. A final draft of this report, including the assessments, was then prepared and sent out for final review. Final review included internal review, as well as review by a parent consultant to the research project. This parent has a high level of expertise with the ISP process, coming not only from her experience with her own ISP team, but also from her involvement with a parent advocacy group taking a strong role in system reform. The current version of each of these assessments is included in Chapter 8.

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Chapter 3: Necessary Conditions: Practice Model

This chapter begins the discussion of the proposed necessary conditions for high quality implementation of collaborative team-based Individualized Service/Support Planning (ISP). The conditions covered in this chapter are those found in the top row of figure 1, and are related to support for a practice model for ISP.

This chapter begins with a discussion of the need for teams to adhere to an ISP practice model that promotes effectiveness in reaching desired outcomes. The chapter goes on to discuss the conditions that need to be in place at the organizational level to support teams' adherence to the practice model. Finally, the chapter discusses the conditions that must be in place in the policy and funding context (system level) in order to support organizations and teams in these efforts.

Practice model: Team level

i. Team adheres to a practice model that promotes team cohesiveness and high quality planning in a manner consistent with the value base of ISP.

Individualized Service/Support Planning teams face a variety of challenges in accomplishing their work. Like other teams involved in complex long-term planning, ISP teams need to overcome numerous challenges related to the "generic" tasks of teamwork. If any team is to be successful, its members must be able to select appropriate goals, devise high quality solutions to problems, avoid destructive conflict, maintain confidence in the team's efforts, and so on.[21,44] In addition to these generic challenges of teamwork, ISP teams face a series of additional challenges that are more specific to the ISP process. These challenges arise because ISP specifies that team plans—as well as the planning process itself—should be individualized, family centered, and culturally competent. ISP teams are further required to create plans which build on the strengths and assets of the team, the family, and the community.

In this section, we describe the types of knowledge and skills that team members must possess if they are to overcome these challenges and work together effectively. The discussion throughout this section is based on the model of ISP team effectiveness outlined in figure 2 (*see following page*). In developing the model, we incorporated information from our interviews, as well as information from research and theory on teamwork and team effectiveness. (Much of this research and theory is cited in the chapter.) The resulting model is a variation on the type of model that is most commonly used in research and theory on team effectiveness.[92] The model shown in figure 2 is also consistent with the way that expert ISP team members talk about teamwork. In our study of expert team members, we asked our interviewees to describe challenges to effective ISP teamwork and strategies for overcoming those challenges. In order to classify the main themes that came up in their responses, we used a coding system that was derived from the same conceptual foundation as the model. The level of inter-rater reliability that we achieved in coding the interview material suggests that the conceptual foundation is a good fit for practical as well as theoretical understandings of ISP effectiveness.

FIGURE 2: A MODEL OF ISP TEAM EFFECTIVENESS

ISP Inputs

Team member background, knowledge, and skills

Organization and system support

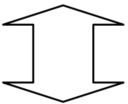
ISP Practices

Specific techniques and procedures for making decisions, defining goals, ensuring family centeredness, building on strengths, etc.

ISP Team Processes

Planning. The planning process prioritizes family/youth perspective and includes attention to

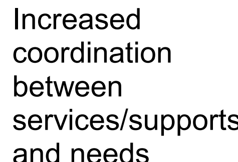
- Defining team mission* and goals* with associated strategies and performance criteria.*
- Exchanging information,* broadening perspectives,* and generating multiple options before making decisions.*
- Continually evaluating* and revising* goals and strategies.



Building cohesiveness. Team members build shared perceptions that

- Team members hold goals* and values* in common, including the values associated with ISP (cooperativeness).
- The team can be effective* and ISP is an effective intervention (efficacy).
- The team follows fair procedures during discussion and decision making* (equity).
- Team members are respected, even when they disagree or make mistakes* (psychological safety).

ISP Outcomes



Team achieves appropriately ambitious goals in a manner consistent with the ISP value base.

Increased coordination between services/supports and needs

Supportive and adaptive relationships

Increased family empowerment and quality of life

*These attributes of process have been linked to team effectiveness in studies across a variety of contexts.

In the model, the main route to effectiveness is from *inputs* through *practices* and *processes* to *outcomes*. ISP *inputs* include team member skills, knowledge, and background, as well as organizational and system support. ISP *practices* are specific techniques and procedures that team members intentionally employ as they work to develop the plan and operationalize the ISP value base. Practices include specific techniques and procedures for defining and prioritizing goals, stimulating the exchange of information, making decisions, obtaining feedback, building an appreciation of strengths, ensuring family-centeredness, and so on. Practices take place within a short time frame, though the same practice may occur on many occasions. ISP practices are translated into *outcomes* through their impact on two team-level *processes*: the planning process and the process of building team cohesiveness. On cohesive teams, team members have developed the shared belief that they are willing and able to work together to achieve goals held in common. Figure 2 describes the two processes in terms of a series of attributes that have been linked to effectiveness in numerous team studies across a variety of contexts. These attributes are marked with asterisks in the figure. Other attributes of the two processes reflect the special nature of ISP by incorporating elements of the value base. The two team-level processes are complex, and each is continually affected not only by team practices but also by feedback loops that operate both within each process and between the two.

The model of ISP effectiveness assumes that success in both processes is required if teams are to be effective in achieving desired ISP *outcomes* (e.g. improved fit between services/supports and needs, increased family empowerment, and improved quality of life). In turn, effective practice is based on a clear understanding of how a given technique or procedure can be expected to impact team-level processes. In addition to being knowledgeable about practices, team members must also have skills that will enable them to implement practices at the appropriate times. These types of skills and knowledge are contained in a *practice model* for ISP.

The overall condition for high quality implementation of ISP at the team level is that a team adheres to a practice model that promotes team cohesiveness and high quality planning in a manner consistent with the value base of ISP. This overall condition is quite complex, however, so we have organized the discussion around seven sub-conditions that provide more detail about the types of knowledge and skills that team members need to have in order to maximize the probability that their work will be effective. These sub-conditions are:

1. Team adheres to meeting structures, techniques, and procedures that support high quality planning,
2. Team considers multiple alternatives before making decisions,
3. Team adheres to procedures, techniques and/or structures that work to counteract power imbalances between and among providers and families,
4. Team uses structures and techniques that lead all members to feel that their input is valued,
5. Team builds agreement around plans despite differing priorities and diverging mandates,
6. Team builds an appreciation of strengths, and
7. Team planning reflects cultural competence.

Below, we describe each of these sub-conditions more fully. We should be clear that our intention is not to provide a full practice model. Instead, the sub-conditions summarize the *types* of information that should be included in a practice model. Regarding the first sub-condition, for example, we argue that the practice model should provide clear, detailed information about the structures, techniques, and procedures that teams should use to support their planning. And while in many cases we provide examples of the types of techniques, structures, or procedures that might meet a given sub-condition, we do not attempt to offer a complete or exhaustive list.

Extensive trainings in ISP already exist, and any given training or manual may provide sufficient information to guide teams about how to meet most or all of the sub-conditions. However, in many communities, the local practice model is built from many different sources, and training and/or the model itself may be extensively adapted to fit local needs. This list of sub-conditions can help communities judge whether or not their own practice model is sufficiently comprehensive and specific. The Checklist for Indicators of Practice and Planning (ChIPP, described in Chapter 8 and included as Appendix A) is an assessment that can also be used in efforts to assess the adequacy of a practice model. Communities can then focus on filling in any gaps or weaknesses that they identify.

Each of the following sections focuses on a single sub-condition, and includes a brief summary of research results that support the idea that the condition is necessary for effective ISP teamwork. The results cited are drawn both from our own work and from other published studies. The cited research also provides evidence for the relationships between practices, processes, and outcomes depicted in the model.

Ultimately, of course, it is up to the team to adhere to the practice model. As teams carry out their work, different people, with different roles, will take primary responsibility for ensuring that various sub-conditions are met. For example, the person acting as the facilitator often assumes much of the responsibility for seeing that the team implements the steps of an effective planning process. On different teams, facilitation may the responsibility of a parent, a care-coordinator, or someone who has no other role on the team. Similarly, on one team, a parent advocate may take on a good deal of responsibility for ensuring that teamwork is family centered and strengths based. Other teams will not have a parent advocate, and so those teams will need other strategies to ensure that these values are guiding the team's work. The practice model should provide sufficient guidance about how the various responsibilities are shared out among the various team members. Team members will, of course, require sufficient training to enable them to carry out their roles on the team.*

1. Team adheres to meeting structures, techniques, and procedures that support high quality planning.

At its heart, ISP is a planning process. Teams that are effective in complex, long-term planning use a structured process for creating and monitoring their plans. The process moves through successive cycles of setting goals, selecting and carrying out action

* The provision of training is considered the responsibility of the lead and partner agencies, and is discussed at the organizational level.

steps, assessing progress, and adjusting goals and strategies as needed. Such an approach requires that:

- A long-term goal or mission is agreed upon;[71,92]
- Intermediate goals and observable indicators of progress towards goals are clearly defined;[22,44]
- Tasks or action steps are linked to intermediate goals, and responsibility for performing each task is assigned;[69] and
- Progress on each action, goal and/or sub-goal is monitored and/or revisited in subsequent meetings, and strategies for achieving the goals are altered as needed.[31,34]

Adherence to these structures of good planning helps ISP teams access other avenues to increased effectiveness as well. Further along in this section, the discussion provides clarification of how adherence to these structures can lead to increased ISP team effectiveness by: helping teams turn conflict to constructive ends, providing opportunities to promote the family's perspective, and contributing to cultural competence and the individualization of plans. It is worth emphasizing that these benefits accrue only when the team is united behind a *team* plan. Among the ISP teams we observed, less than one third maintained a team plan with team goals. Thus, more than two thirds of the teams were not making use of the structures of teamwork that have been most consistently linked to team effectiveness in virtually any setting.[92] A practice model for ISP should provide clear guidance to teams about how to maintain the essential elements of an effective planning process.

Training materials for ISP, as well as a formal consensus reached by ISP researchers, advocates, and trainers[40] give the ISP team the additional responsibility for developing the crisis plan for the child and family. While a crisis plan is different in some ways from the larger team plan, it nevertheless seems likely that imposing appropriate structure on crisis planning can increase the potential for the plan's effectiveness. For example, the crisis plan can be developed to reflect a goal structure with action steps clearly defined. And even though the crisis plan may never be measured against indicators of success (because it may not be used), the strategies included in the crisis plan should be reviewed periodically and revised where necessary. The practice model should provide guidelines for what should be contained in the crisis plan, as well as explicit expectations about how it should be reviewed and maintained. In general, the types of skills, procedures, and techniques that the ISP practice model provides for teamwork in developing the overall plan would apply equally in the case of the crisis plan.

2. Team considers multiple alternatives before making decisions.

Teams are widely touted for their potential to reach creative solutions to complex problems. However, this potential is often unrealized, and teams may well be less creative and/or less productive than individuals working on the same task.[69] This loss of creative potential appears to come about because team members are often over-eager to commit to the first goal, strategy, or solution that comes up, rather than generating multiple options and then choosing among them. Generating multiple options while problem solving leads to superior solutions because first solutions tend to be of poorer quality than those generated later.[10,78] Teams in general appear to be reluctant to adhere to procedures—such as brainstorming—that have been shown to stimulate creative, open-ended thinking.[74,92]

These barriers to creativity appear to be present in ISP teams as well. In our observations, fewer than one in five teams considered multiple options for ways to meet a goal or carry out an action even one time during the meeting. Fewer teams still used a structured activity to stimulate creative thinking. This may be one of the reasons teams appear to have relatively little success in developing highly individualized plans that incorporate community and natural supports.[13,87] Among the 72 meetings we observed, there was only evidence during 11 meetings that teams were providing access to a regular community service or support (for example, by purchasing a membership in the YMCA). More strikingly, during only four meetings was there evidence that the teams were actually tailoring a community service or activity to meet the specific needs or goals of the child or family.

There are of course numerous barriers that limit ISP teams' ability to respond creatively to the challenges of planning. While many of these—particularly financial incentives and funding issues—are primarily organization- and system-level issues, there are also various barriers at the team level. Team members need to be keenly aware of a pitfall we heard about frequently in our interviews—relying on traditional, categorical services in a non-individualized manner. Team members often complained that the results of team planning all too often came down to the provision of the same kinds of services that had been happening before, albeit possibly in a more coordinated manner.

A practice model for ISP should provide clear guidance on the procedures and techniques that teams can employ to increase creativity. Teams will need to develop a mindset that will keep them from committing too quickly to the first solution—often a service solution—that comes up. Discipline in generating multiple options also has great potential to increase the extent to which the plan will be family driven and culturally competent. When teams generate multiple options, family members have a greater opportunity to select the option that fits with their own preferences and their own cultural values.

3. Team adheres to procedures, techniques and/or structures that work to counteract power imbalances between and among providers and families.

The value base of ISP specifies that the process is to be family centered,[40] with the work of the team being driven by the family's own sense of its strengths, needs, and priorities. The family's choice should also guide decision making regarding the services and supports that will be accessed or developed to serve the team's goals. Plans devised with genuine family input are more likely to have realistic goals, to include creative and flexible strategies, and to engender a sense of family ownership. What is more, when the process is family centered, it is more likely that the plan will be truly individualized, and that it will reflect cultural competence.

Available research indicates that it is likely very difficult to realize this vision of family-driven teamwork. Mental health professionals often demonstrate a reluctance or inability to hear the family's perspective, or to respect the knowledge which families bring to collaboration.[30,39,45,63,67,89] This may also reflect a more general dynamic that appears in teamwork. On any team, people of higher social status tend to talk more and have more influence over the decisions that are made.[68] Thus, for example, team meetings are likely to be dominated by men rather than women, by bosses rather than subordinates, or by people with more rather than less formal education.[7] It is very difficult for teams

to overcome this sort of imbalance, even when team members are making conscious efforts to equalize participation and influence. On ISP teams, it is not uncommon for family members (particularly youth) to possess relatively few markers of high status. Even where family members have relatively high status outside of meetings, their status within meetings is likely to be deflated because of team members' tendency to see the family in terms of its needs and deficits.[61] As noted above, professionals also tend to have high opinions of their own expertise relative to those of families of children who are experiencing emotional and behavioral difficulties.

If the practice model does not provide teams with specific, concrete guidance about how to redress the imbalances of power between the family/youth and professionals, it is unlikely that the family's perspective(s) will be adequately represented in the planning process. Simple process interventions to increase the number of contributions to discussion and decision making may be effective, but it is likely that teams will need to employ a variety of strategies for increasing family input and decision making at various stages during the planning process. Strategies we have seen in use include providing opportunities for family members to speak first and last during discussions, checking back in with families after any decision, or using a family advocate to reinforce the family perspective as elicited in interviews outside of full team meetings. It is particularly important that the team goals reflect the family's perspective. When the family's strengths, needs, and priorities are codified in the goals, the team's subsequent work by necessity builds from the family perspective. Obviously, this will not happen if the team has not selected goals, or if the goals are not clearly specified.

A number of our interviewees and several of the training manuals stressed that, beyond increasing family input into discussion and decision making, the planning process should also provide room for a qualitatively different sort of input from the family by providing opportunities for family members to "tell their stories." Potentially, providing such opportunities can be empowering for families by allowing them to provide a narrative explanation for how current situations have come to pass, and why.[64] The family's views of agency and causation thus become the frame for discussions of future steps. In addition to being inherently empowering, family storytelling can help the team access information that might otherwise be lost in more formal or abstract processes that are part of planning. A family's story can contain important information about hopes, goals, strategies, and resources. In some communities, the family is encouraged to add to their story at each ISP meeting by reflecting on how things are going, while in other communities the bulk of the story is elicited outside of meetings during interviews with a family advocate or care coordinator. Regardless of the specific techniques used, it appears that an ISP practice can be strengthened in important ways when opportunities are provided for family members to speak in an open-ended, narrative way about their experiences.

Beyond merely providing opportunities for the family to assert its perspective, our interviewees stressed the importance of creating a team atmosphere such that family members feel safe to speak openly and honestly about difficult topics, feel comfortable telling their stories, and feel engaged in the ISP process. Of course, it is desirable for *all* team members to feel psychologically safe and engaged in the ISP process. The discussion below—particularly that contained under the sub-conditions having to do with valuing input, building agreement, appreciating strengths, and reflecting cultural competence—

provides information about how the practice model should guide teams towards creating this sort of comfortable interpersonal environment. However, issues of psychological safety and engagement are of particular importance to the family, and the team needs to practice extra care to maintain the meeting as a safe and comfortable place where families feel valued and supported. Thus, for example, where team members might use techniques of active listening, such as reflecting and summarizing, to help demonstrate valuing of each team member's input, this might be done with greater frequency and deliberateness for input from the family.

4. Team uses structures and techniques that lead all members to feel that their input is valued.

Teams are more effective when team members feel that discussion and decision making processes are *equitable* or fair.[26,57,62,86] It is important to note that equity and equality are not the same. For example, teams may well feel that it is fair (equitable) for a mother to have more (*un*equal) opportunities than professional team members to speak and to make decisions. Team members are likely to feel that teamwork is equitable when they believe that they are respected, and that their input is valued.[21,25] When team members' participation is not perceived as equitable, the team's effectiveness tends to suffer due to decreases in creativity and information sharing, and due to increases in destructive conflict. When team members feel that decisions are reached through processes that are not equitable, they are unlikely to feel committed to the decisions and to follow through on tasks.[56]

As was noted previously, teams are often dominated by people with high status, and this can easily lead team members to feel that team process is not equitable. For example, a team's discussions may be dominated by a psychiatrist or clinical supervisor, and valuable input from a behavioral skills specialist may be lost. Once again, it is likely that these tendencies will continue unless the practice model provides specific information about how to increase equity in participation, and how to make people feel that their input is respected and valued by the team. Teams need explicit guidance from the practice model about techniques to increase team perceptions of equity, not just through counteracting status differences, but through other methods as well. Some examples of team process or techniques that can increase perceptions of equity include: providing opportunities for each team member to give input into decisions; reflecting, summarizing, and/or recording team member ideas or suggestions; and having the team set its own rules or guidelines for how to demonstrate interpersonal respect.

The practice model should also provide specific guidance about how to help ensure that youth team members will feel respected and valued. Existing research offers little information about collaborative teamwork between adults and youth; however there was a strong consensus among team members who participated in our studies that including the youth could be quite difficult. On the other hand, we observed teams that were successful in engaging children as young as nine years old in the planning process. Teams that include the youth in the planning process may well also confront challenges when the youth and other family members disagree.

5. Team builds agreement around plans despite differing priorities and diverging mandates.

On effective teams, members believe that their goals are cooperative.[21,82] This means that team members believe that the actions of each team member serve to advance the goals of all. This does not mean that team members will never be in conflict or have disagreements; on the contrary, controversy is an essential source of creativity and learning on successful teams.[51,82] Disagreement and controversy are particularly likely to occur on teams, like ISP teams, that have a high level of diversity in background and experience.[3,14] What is more, on ISP teams, different team members may be responsible for carrying out specific mandates that appear to be contradictory. Our interviewees reported that this can be a source of great conflict on some teams.

In teams and groups, conflicts are less likely to arise, and more likely to be resolved when the team has a clear sense of shared goals.[50,70] On ISP teams, conflict around the best ways to achieve goals may be decreased when the action steps are clearly linked to the goals. Furthermore, team members—especially those who may be skeptical about a particular goal or action step—need to be able to trust that the team will be pragmatic in evaluating the success of strategies or action steps, and discarding those which are not helping the team reach its goals.

A practice model must provide teams, particularly facilitators, with a variety of specific strategies for dealing productively with conflict and controversy. For example, facilitators should be able to recognize and intervene quickly in "negative process,"[9] cycles of blaming and attacking behaviors which are detrimental to group functioning. Many strategies for harnessing controversy depend on consistently reminding the team of shared goals, and building from there. Where skills in conflict management are lacking, there is a high probability that the team's effectiveness will suffer.

6. Team builds an appreciation of strengths.

The ISP value base stresses that the process should be strengths based. In particular, the strengths of the family and youth are to be built upon. Additionally, the assets of other team members, and of the community, are to be drawn on in the plan. Research has little to say about whether a strengths orientation impacts team effectiveness; however, there is evidence that the affirmation of strengths can empower low status team members and increase their confidence and participation.[7,19,20] Furthermore, since acting in a strengths-based way is one of the requirements for ISP teamwork, it is important for team members to be able to recognize when they are being successful in practicing the value.

In our observations, we saw teams using several strategies to focus on strengths, especially those of the family. During interviews, a number of team members pointed out that child and family strengths are affirmed when the family is trusted and empowered to drive the ISP process. This is concrete evidence of a team's conviction that the family has a fundamental strength in knowing what to do to take care of itself. Research in other settings has shown that the participation of low status team members increases during teamwork when the team acknowledges specific contributions that the low status members have made to achieving team goals. Despite the strengths activities we observed,

and the comments we heard, team members in our studies consistently expressed concern because they were unsure about how to build a strengths perspective into the ISP process. Team members pointed out that it is not easy to design a plan that simultaneously addresses needs and builds on strengths. They also expressed some confusion about the differences between "real" and "fake" or superficial strengths, a distinction that appears in many training materials. Clearly, a practice model for ISP should specify the procedures and techniques that teams can use to assist them in maintaining a strengths perspective.

7. Team planning reflects cultural competence.

Each of the sub-conditions mentioned so far is potentially impacted by cultural values and norms. People from different cultural backgrounds may hold different values and make different judgments about, for example:

- what sorts of team procedures and rules will be acceptable,
- what sorts of interactions communicate respect,
- how strengths are defined and how they are talked about,
- how needs are defined and how they are talked about,
- how conflict is expressed and managed, and
- the most important types of goals for a child and family.

Team members who hold different beliefs in these areas may have great difficulty working collaboratively together. What is more, cultural differences in values and norms can arise from many sources, and not just from differences in racial, ethnic, or religious background. For example, individual families have their own norms and values; and mental health, juvenile justice, and child welfare workers are imbedded in organizations and work-based interpersonal networks which reinforce their own norms and values. Indeed, the cultural gap between the perspective of professionals and the perspective of families is one that appears regularly in teams, regardless of the degree of the racial, ethnic or religious similarity among team members.

The practice model should provide some specific information about how to increase the cultural competence of teamwork. It is likely that this guidance will need to be formulated with the culture of specific communities in mind. Agencies will need to adjust and elaborate practice models to provide clearer support for cultural competence on teams. Other agency efforts to support cultural competence are discussed in sections on organizational supports for ISP.

Beyond this, it is clear that teams are likely to be more culturally competent when they adhere to the other elements of teamwork discussed above. For example, differences in norms and values often exacerbate the difficulty that teams encounter in hearing the family and following the family's lead in planning. This makes it even more important that the team adhere to structures, techniques, and procedures that support the family's values and the family's voice. Similarly, cultural competence is likely to be greater when the practice model specifies how the planning process can be structured to offer choices between options. This allows family members to review a variety of options, and select those that best reflect their values and priorities. A number of our interviewees believed that cultural competence would be increased when teams included larger numbers of community and natural supports. This is another area where the practice model could be expected to provide concrete guidance, by specifying what teams can do to recruit and retain community and natural supports (see Chapter 6).

Practice model: Organizational level

i. Lead agency provides training, supervision, and support for a clearly defined practice model.

This section discusses why it is necessary for the lead agency to clearly define a single, shared practice model that will guide ISP practice for all its teams. Successfully implementing the practice model at the team level requires considerable expertise from team members in key roles, and this section also focuses on the training and support that agencies will need to provide to key team members.

The ISP practice model defined and supported by the lead agency may be one that has been developed specifically within the agency, or it may be one that is agreed upon across multiple sites. Regardless, it is critical that the practice model be shared among the facilitators, parent advocates, trainers, and supervisors who work together. This means that they will understand ISP teamwork in terms of shared definitions for the essential elements of the practice model, including the required techniques, skills, and procedures. Having shared definition will make it easy to recognize if a facilitator is, say, using procedure X for generating multiple alternatives to reach a goal, or using skill Y for promoting team members' sense of equity in decision making. Having shared definitions for essential elements of the practice model also makes it easier for trainers, supervisors, and team members to have a shared standard for evaluating the quality of the performance of key team roles.

Various strands of research and theory support the idea that having this sort of shared understanding of a clearly defined practice model is crucial for implementing and maintaining high quality, complex interventions like ISP.* For example, results from research on training show that when a model for the practice of complex interpersonal interventions is clearly defined, trainees and supervisees are more likely to learn the skills and techniques more quickly, apply them in their practice, and be more effective than practitioners using more eclectic or less fully specified approaches.[8,28,36,48,58,94] In meta-analyses examining psychotherapeutic interventions** for children, the provision of a structured model for practice is one of the factors that has been associated with the apparent superiority of practice in research settings over practice in community settings.[91] Shared understandings and shared vocabulary also facilitate discussion of the skills in a way that is effective in helping people develop metacognitive† awareness about when to apply a particular skill or technique to a particular type of situation. The development of metacognition appears to be an essential part of expert approaches to

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*The various studies we cite have been selected focus either on training generally or on training in fields in which the skills to be acquired are similar to those which are used in facilitation—i.e. skills requiring the trainee/supervisee to facilitate or guide interactions in a complex interpersonal environment. Little high quality research exists specifically addressing the effectiveness of training and/or supervision in the context of social service organizations.[16,37,84]

**Our use of results from research in psychotherapy does not imply that we equate ISP with therapy. On the other hand, psychotherapy is like ISP in that practitioners need to learn and employ specific techniques or skills for managing complex interpersonal interactions.

†Metacognition is, literally, thinking about thinking. Metacognition is a higher order thinking process through which people evaluate their reasoning, thereby learning to improve judgment on future occasions.

a wide variety of complex cognitive tasks,[72,80] including the types of relational tasks that are central to teamwork. Having a clearly defined practice model is also essential for monitoring fidelity (the extent to which actual practice is "true" to recommended practice). If fidelity is not measured, or measurable, the chances of successful implementation of any intervention is greatly decreased, particularly if the intervention is complex.[77]

At the team level, it is the facilitator who will have the primary overall responsibility for ensuring that the team adheres to the practice model. For example, the facilitator must ensure that the family perspective is adequately represented in discussion and planning. The facilitator must also be able to help the team collaborate effectively despite differences of opinion and perspective. It is likely that it will take some time for facilitators to acquire the necessary expertise, and the lead agency must be prepared to offer support as effectively as possible. Beyond providing training, the lead agency must provide facilitators with sufficient, high-quality, ongoing support to ensure that training is transferred into practice. High-quality support will include supervision and/or coaching that

- incorporates information from observations, audio- and/or videotapes of facilitator performance; and
- focuses in a structured way on building knowledge about, and skills required for, the practice model.

Other team members with specialized roles, such as family advocates or resource developers, will also need training and support for their roles in the practice model, although this training may or may not be provided by the lead agency. Ongoing support for these team members should also encourage the transfer of training into practice by using a structured approach to coaching and/or supervision. The rationale for these recommendations is presented below.

It takes time to develop expertise in a complex task,[72] and research provides some clear guidance about the type of support that should be provided so that learning continues beyond the initial training episodes. Perhaps most important is the need for ongoing coaching. It is estimated that only about 10% of training is actually transferred into practice,[15,43] even when the trained skills are simple. For more complex interpersonal skills, transfer may be even less; however, when there is a clear practice model, *and* when ongoing coaching is provided, transfer can be dramatically increased.[55] Minimally, effective coaching for interpersonal skills involves observation of the trainee practicing the skill, followed by a discussion of the observation session. While supervisors and trainers can be used as coaches, peer coaching can also be very effective.[24,55] The literature on supervision suggests that ongoing support for skill acquisition will be more effective—as well as more satisfying to participants—when it is a *structured process*, based in a clear conceptual framework, and organized around the setting and monitoring of specific supervisee goals.[1,4,59,73,83] In meta-analyses examining psychotherapeutic interventions for children, supervisor monitoring of therapist practice (e.g. through review of videotapes) is another of the factors associated with the apparent superiority of practice in research settings over practice in community settings.[91]

Our own research confirmed others' assertions that many teams calling themselves ISP or wraparound teams do not appear to be working within the paradigm as it is defined,

and that this is at least partly due to a lack of specification of a practice model.[12,75] As noted previously, we found many teams operating in an essentially unstructured way, without a team plan or team goals. Other markers of ISP, such as attention to strengths or to the family perspective, were also absent in many meetings, including meetings from sites held up as national models. The team members we interviewed, *including those recognized as most expert*, were almost unanimous in saying that they felt overwhelmed by the complexity of the ISP process, and that they felt far from comfortable and competent in their roles. While many facilitators felt that the training they had received was useful in helping them to learn about the philosophy underlying the ISP process, they also said that they did not feel they had learned the specific procedures and skills that would help them to be strengths based, culturally competent, and family centered while also managing meetings effectively. Even when a training had focused on procedures, techniques, and skills, some facilitators reported feeling overwhelmed by the volume of information presented. Furthermore, while the extent of training varied from site to site, a substantial number of facilitators from "average" teams reported receiving no special training at all prior to starting to facilitate team meetings.

The supervision provided to team facilitators (as described by our interviewees) only rarely appeared to focus on the skills of team-based planning and facilitation *per se*. Furthermore, it was rare to encounter agencies that had developed clarity about how to recognize indicators of good practice, collected data on the extent to which these indicators appeared in teamwork, and then used the resulting data in supervision. In fact, there was no meeting, among the 72 that we observed, where there was a supervisor present to evaluate the performance of the facilitator or parent advocate (nor were any of these meetings audio- or videotaped for this purpose). Most facilitators reported receiving regular "clinical supervision"; however the supervisors were most frequently reported to be clinical psychologists who were not experienced or trained in facilitation of the ISP process. Most facilitators also reported that they had group supervision sessions with other facilitators.

Facilitators reported that they felt supported by their supervision; however for the most part they also reported that both group and individual supervision sessions were quite unstructured, and that there tended to be no formal goal setting or data gathering to assess facilitator skill or progress. Some sites have used, at least on occasion, reviews of service plans or surveys of team members as a means of providing feedback to facilitators and their supervisors, while other sites provided feedback based on observations of team meetings. It is not surprising that ISP supervisors do not follow recommended practices for supervision. Generally in the human services it appears that supervisors are rarely trained in supervision, and that most have no clear model for their practice of supervision.[52]

Just like facilitators, people with other special roles on ISP teams are likely to be more effective when the ISP program supports a single, clearly defined practice model, and when the roles for carrying out the practice model are also clearly defined. The agency providing training and support for these team members may or may not be the lead agency. For example, parent advocates may be trained and supervised by family advocacy organizations. Available research suggests that trained parent advocates can help increase family participation on collaborative planning teams,[11,95] and theories of parent empowerment are becoming increasingly specific regarding what skills are most helpful

in helping to empower parents.[49] Training curricula for parent advocates in the ISP process have been developed in several communities.[23,90] On the teams that we observed, parent advocates rarely appeared to take an active role unless they were also facilitating the meeting. In and of itself, this is not direct evidence that the non-facilitator parent advocates were ineffective; however, we were left with a sense that the parent advocates in many instances were not confident about the role they were to play on the team.

Finally, our interviewees suggested that all team members should receive orientation to the basic ISP model, and that family members in particular would benefit from such orientation. Many sites do, in fact, provide some form of orientation for teams. Often, portions of initial meetings are set aside for orientation and a discussion of procedures and ground rules. In other instances, orientation takes place apart from the planning process and can range from very simple (e.g. providing team members with introductory videos, booklets or pamphlets describing the ISP process) to quite elaborate (having teams come together to engage in structured team-building activities such as simulations, role plays or games). Some sites make a special effort to orient families to the purpose, values, and process of ISP, and available research suggests that that this is indeed helpful in increasing parent participation in collaborative planning.[41,93] Some evidence also suggests that when all members of a group or team are aware of how the group is structuring its work, they can all contribute to the facilitation of that process, thereby leading to more equitable participation.[18]

ii. Lead agency demonstrates its commitment to the values of ISP.

Many of our interviewees, as well as several of the trainers we spoke with, expressed the opinion that high quality team-based ISP could only happen when the entire lead agency demonstrated both:

- a conviction that ISP is an effective way to meet the needs of children and families, and
- a belief that the values of ISP should structure not just team interactions but also interactions between and among staff.

For example, there was agreement among the experienced facilitators, advocates, and administrators with whom we spoke that truly family-centered ISP practice could only take place within organizations which intentionally cultivates a parent/youth/consumer voice in organizational decision making around team issues. Similarly, a number of our interviewees expressed the belief that strengths-based practice can only take place within an organization that takes a strengths-based view of staff, and that culturally competent practice can only be sustained within culturally competent organizations. Relevant research reviews and results, as well as a growing consensus among proponents of systems of care, provide a measure of support for the idea that there should be consistency between the values *advocated* by an organization and the values *practiced* by the organization.

In the literature on organizational effectiveness, there is large body of research which generally supports the hypothesis that employees (and hence their organizations) perform better when organizational values and culture are clear and consistent and aligned with expectations for employee behavior.[6,32] There is also a smaller body of research which

supports the idea that teams are more effective when there is alignment between team and organizational goals (see the review and results reported by Cohen[22]).

Several of our research participants pointed out difficulties arising from a divergence between the values of ISP and the values practiced by managers and staff of the lead agency. A number of interviewees expressed the idea that lead agencies may be more willing to "talk the talk" than "walk the walk" of ISP values. In these cases, managers and other staff in agencies were seen as being generally supportive of the idea of ISP, but unable, or unwilling, to change their own attitudes or behaviors in significant ways to reflect the values of the model. The most commonly suggested remedy for this situation was increased ISP training for managers and other staff. Several interviewees recommended that job descriptions be rewritten to include demonstrated commitment to ISP values as a prerequisite for hiring.

Theory (and, to a lesser extent, research) on mental health services and systems of care also support our interviewees' claim that there should be consistency in values across different levels of the service delivery system. At the organizational level, the need for consistent values is seen primarily in discussions of the need for organizational level attention to cultural competence and collaboration with families. In the system of care literature, there is a general consensus in agreement with the proposition that cultural competence at the service level can only exist within organizations that are themselves working towards cultural competence.[27] Further, organizations are called upon to do more than "talk the talk" of cultural competence by engaging in a structured process which includes substantial participation by diverse stakeholders.[88] This process can be based in organizational cultural competence self-assessment,[42] or in other forms of structured discussion and planning.[29] Another strand in the literature focuses on the need to generate feedback about perceptions of cultural competence from consumers, using measures such as the Client Cultural Competence Inventory.[81]

Similarly, the theory and qualitative research on systems of care support our interviewees' contention that family-centered services will only be a reality when service-providing organizations also collaborate effectively with families in determining organizational policies and priorities.[47] Our interviewees stressed that it difficult for agencies to fully understand the importance of providing a means by which family perspectives can have a real impact on the organization. Even where agencies might endorse this value, many barriers stand in the way of realizing it. Given this difficulty, it appears necessary that agencies implement concrete strategies to ensure that the family voice has an impact on practices.[47] Examples of such strategies are: hiring family members as staff, including family members in setting practice/skill guidelines or in hiring or evaluating facilitators, providing seats for family and youth on boards of directors, including family members in training for all staff, and involving families in service delivery. Similar strategies, as well as others, have been designated as promising practices in children's mental health, and are more fully described elsewhere.[79,96]

Finally, several interviewees were adamant that facilitators and other team members could only truly learn to be strengths based within agencies that treated *them* in a strengths-based way, particularly with respect to supervision. Cohen makes a similar argument, supporting it with evidence from existing research.[17] Various other theories, with limited research support, have focused on the more general idea that interactions

between clinicians and clients will parallel interactions between those same clinicians and their supervisors.[35] While our interviewees did not volunteer specific ideas about how to increase the strengths focus at the agency level, other sources provide examples of structures and techniques for strengths-based supervision.[37,73]

iii. Partner agencies support the core values underlying the team ISP process.

During our observations and interviews, we were made aware of the importance of partner agency support for ISP values. A lack of support for such values was one of the barriers to effective team functioning that was most frequently cited by our expert team members. Our interviewees did describe examples of teams that functioned well despite the fact that some of their members came from organizations or agencies with values that were to some extent inconsistent with those underlying team-based ISP. In some cases, the individuals from those partner agencies were asked to join the teams precisely because their personal values were more in line with the philosophy of ISP; however this could also mean that their values ran somewhat counter to those in their "home" (partner) agency. In other cases, individuals from partner agencies described their values as changing as a result of their experiences with the team process.

Interviewees reported that being at odds with the values of their home (partner) agency could be quite stressful for team members, and could cause friction for them with their supervisors and/or co-workers. These team members might also have difficulty in securing funds to help support team plans. Even when teams successfully "enculturated" individual members from organizations with different values, this could take a long time and detract significantly from team effectiveness in the meantime. Furthermore, relying on particular individuals who had been enculturated in this manner left the team vulnerable in the case of turnover. Finally, interviewees reported that some team members from partner agencies never became supportive of the ISP values, and that lack of support could be very detrimental to the team's ability to function.

Each of these observations is supported to some extent by research in organization and team effectiveness. Just as consistency in organizational values and culture has been linked to positive outcomes for individual employees and for organizations (previous section), inconsistent demands from competing values is often associated with negative outcomes.[32] For example, there are a number of studies suggesting that, when a person works under inconsistent or divergent values or expectations, she is likely to experience conflict and stresses that detract from work satisfaction and performance (see reviews in Tubre[85] and Nygaard[66]). Studies of team effectiveness show that unresolved value discrepancies among team members can have a variety of negative impacts on team functioning, including increased conflict, restrictions on information sharing, and turf battles.[65]

Care coordinators and facilitators reported spending a great deal of time trying to educate team members from partner agencies about the values of ISP and the effectiveness of the ISP practice model. Unfortunately they also reported that they were frequently unsuccessful in getting "buy-in" from skeptical team members, particularly where their (partner) organizations' cultures did not resonate with the ISP philosophy. Similarly, they reported engaging in various efforts to educate supervisors and managers at partner agencies about ISP and its values. Several interviewees reported

that training in ISP for partner agency staff was an effective way of remedying their lack of support for ISP. Several other interviewees suggested that accessible materials summarizing objective evidence of the effectiveness of ISP would be helpful in building partner agency support. In cases where partner agency support was seen as high, interviewees reported that the agencies were willing to pay for their staff to attend training in the practice model and were willing to take agency time to orient administrators and supervisors to the theory and skills underlying ISP.

Practice model: Policy and funding context (system level)

i. Leaders in the policy and funding context actively support the ISP practice model.

ISP teams faced with the daily reality of the needs of families and youth may view the knowledge and commitment of leaders from the funding and policy context as generally irrelevant to team functioning and reflecting abstract political maneuvering.[24] Furthermore, team members may see the policy and funding context as responsible for excessive requirements for documentation and other bureaucratic demands.[63] Despite this rather pessimistic view, there are a number of well documented instances in which strong leadership from the policy and funding context have been instrumental in the implementation of system changes and service delivery innovations. For example, Armstrong, Evans and Wood[5] describe the important role played by the state of New York in the development of family involvement policies. Jordan and Hernandez[54] list the existence of a statewide goal as one of the enabling factors in the development of the Ventura project in the state of California.

During the era of Child and Adolescent Service System Program (CASSP) funding, many service innovations, including individualized planning, were identified and introduced by mental health staff at the state level. In the current funding and policy context, agency managers or line workers may champion innovations like ISP. Whatever the origin of idea, in order for team-based ISP to be effectively implemented at the practice and organization level, there must be at least some key leaders at the policy and funding levels who have a commitment to ISP, understand the basic components of the practice model, and are willing to actively advocate for the needs of ISP teams. A number of our interviewees referred to these key leaders as *systems champions* of ISP. Lourie[60] comments that a core of committed individuals who share a common vision are critical to the development of any effective service delivery effort. Hernandez and colleagues[46] identify strong leadership as a prerequisite for shaping services within the perspective of outcome-oriented accountability. In their study of factors associated with successful and unsuccessful collaborations, Johnson and colleagues[53] concluded that strong leadership from key decision makers was one of the three major variables related to successful collaboration.

Without the benefit of active leadership from champions at the funding and policy level, it seems unlikely that team-based ISP will be implemented in more than isolated teams or within single agencies. Rosencheck[76] reminds us of what he calls the "iron rule of hierarchy," the tradeoff between innovation initiated by the upper levels of an organization and innovations from the grass roots. If the innovation comes from higher in the hierarchy, more people will hear about it and it has the potential for a wider scope

of dissemination. However, "If the impetus for implementation comes from lower in the organization… it is more likely to succeed, because fewer stakeholders need to concur, but the impact is likely to be limited and locally restricted" (p. 1610). In order for ISP to thrive, support for ISP and goals consistent with ISP need to be articulated at upper levels of the system as well as within the organization and the team.

It is not necessary that all ISP stakeholders at the system level be active champions of ISP; however, it is important that leaders of participating agencies (e.g. upper level administrators in child welfare or juvenile justice) have some basic knowledge about the values and practice of ISP. This level of knowledge will help them understand how decisions they make at their own agency may impact the ISP process, and can help them avoid initiating new policies that will adversely impact teams. It is also important that these individuals are at least willing to adopt a pragmatic attitude towards ISP (i.e. they agree that it's a good idea for plans to be family driven and for children to be treated in the community if such services can be at least as effective and no more expensive than current practices). These leaders may well place philosophical concerns in second priority behind issues of efficiency and effectiveness, and they may predicate their long-term support on the extent to which ISP programs are able to produce evidence of their success. ISP champions at the system level also plan a critical regard in securing the ongoing good will (or pragmatic neutrality) of their less committed peers. It is essential that the champions engage in ongoing efforts to educate their peers about ISP values and practice, and that they also transmit evidence about the effectiveness of ISP wherever it is available.[2,38]

Successful implementation of supportive policies or funding processes that emanate from levels above the lead agencies is another important concern.[33] In several of our interviews, we heard about policies or legislation supportive of ISP that had been codified in some manner but never implemented. Our interviewees stressed that an important role for leaders of the policy and funding context is to actively work for implementation of policies that support ISP, as well as making or supporting decisions that have a direct positive impact on ISP teams. They also stressed the importance of having a forum for addressing difficulties that might arise due to differing interpretations of such policies or a reluctance to implement them (see Chapter 4, system level, condition ii).

It is of course helpful if supportive leaders in the policy and funding context remain in their positions long enough for the desired policies and practices to become institutionalized and thus able to survive turnover among systems champions. Amado and McBride found that the degree of long-term commitment and support for long-term change were instrumental in the implementation of person-centered planning in the five demonstration projects they studied.[2] Systems champions must also maintain—and help their peers to develop—realistic expectations regarding both the time it will take to achieve full implementation of ISP, and the outcomes that can be achieved.

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Chapter 4:
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Chapter 4: Necessary Conditions: Collaboration and Partnerships

This chapter continues the discussion of the proposed necessary conditions for high quality implementation of collaborative team-based Individualized Service/Support Planning (ISP). The conditions covered in this chapter are those found in the second row of figure 1, and are related the need for building the collaborative relationships that are required to carry out the ISP practice model.

The chapter begins with a discussion of the team-level need for collaboration. The chapter goes on to discuss the conditions that must be in place at the organizational level to support team members as they work together collaboratively. Finally, the chapter discusses the conditions that must be in place in the policy and funding context (system level) in order to support the collaboration of organizations and teams in the ISP process.

Collaboration/partnerships: Team level

i. Appropriate people, prepared to make decisions and commitments, attend meetings and participate collaboratively.

The ISP process requires that team members representing a wide variety of perspectives and mandates gather together and work in a spirit consistent with the values of ISP.* At the most basic level, interviewees reported that there is often difficulty getting the necessary team members to come to meetings at all. Hectic schedules and/or a lack of commitment to the process may mean that team members find themselves "too busy" to attend meetings. Without the key team members in attendance, important decisions may have to be delayed or made provisionally, and team planning can easily become uncertain and ineffective. At a minimum, the team needs to have the key members in attendance on a consistent basis. Our interviewees also stressed that it is important for ISP teams to maintain a stable membership over time. They provided numerous examples of ways that a team's work could be set back when there were changes in membership.

There are a number of strategies that teams can use to increase team member commitment and to encourage attendance. For example, team members are more highly committed to attending meetings and remaining as members of teams they perceive as cohesive and effective.[5] Cohesiveness and effectiveness perceptions are likely to be higher on teams that incorporate elements of effective planning as laid out in Chapter 3. For example, one of the most straightforward ways of building a sense of team efficacy is through documenting successes, even if these represent only "small wins."[7]

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* A closely related topic is discussed in Chapter 6, namely, how teams can encourage the inclusion and participation of natural support people on teams. This section focuses on attendance and collaboration more generally.

Teams that have a clear sense of their goals, and of the steps they are taking to reach these goals, will be able to document these small wins as they occur. What is more, increased perceptions of team efficacy lead to increased perceptions of team cohesiveness.[1,12] Perceptions of team cohesiveness can also be cultivated directly through attention to issues of equity and cooperativeness as outlined in the team level conditions in Chapter 3.

Teams may find it more difficult to ensure stability of membership over time. Personal commitment on the part of team members can go a long way towards decreasing team turnover; however, turnover among human service workers and disruptions in funding are frequent causes of discontinuity in team membership, and these are issues that are more appropriately addressed at the organizational and system levels (next sections). When team member turnover does occur, having a clear and well-documented plan can be a major asset in preserving a team's sense of purpose despite changes in membership. A clear plan can also help in getting new team members "up to speed" and "on the page" more efficiently.

It is of course not enough for team members to merely attend ISP meetings. Team members need to be able to participate flexibly and collaboratively as well. Often, collaboration will require making some degree of compromise regarding goals, priorities, and strategies. Our research participants tended to view team members from partner organizations as most likely to resist collaboration. Often the difficulty was attributed to a rigid interpretation of partner agency mandates, or to differences in levels of "buy in" to the values of ISP. For example, several interviewees reported difficulties in getting parole officers to act collaboratively. Interviewees said that while some parole officers were highly collaborative, other parole officers' focus on community protection could keep them from considering certain types of goals and options in an open-minded way.[*] We also heard about teams on which it was the natural support people who were sometimes most resistant to collaboration. Typically, this came about when extended family members had fixed ideas about what caregivers or youth "really" needed. Even where differences of perspective among team members are not ongoing or clear cut, teams may experience periodic difficulties in reconciling divergent perspectives and priorities.

Among our interviewees, the most commonly reported strategy for increasing team member commitment and collaborativeness was through facilitators' or care coordinators' efforts to build individual relationships with team members who were not collaborating well. Investing in these relationships helped to build interpersonal trust, which could in turn be parlayed into support for ISP and the planning process. Facilitators and care coordinators reported spending a great deal of time in these efforts, however, they also pointed out these time-consuming efforts were often unsuccessful. Interviewees pointed to a great need for increased "buy in" among partner agencies, as well as to a need for adequate support from the lead agency, as a remedy for this sort of difficulty (these issues are discussed in the organization and system level conditions later on in this chapter).

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[*]It should be noted that team members were not disagreeing with mandates per se; in fact, clearly delineated mandates were seen as potentially quite helpful in helping the team decide on appropriate goals and strategies.

Interviewees also believed there was great value in providing training to team members so that they would be more willing, and better able, to collaborate. Several sites offered extensive training in the ISP process to partner agency staff, while other sites offered workshops, pamphlets, or other forms of orientation. One site had developed an ambitious plan to provide collaborative problem solving training to interested individuals across various levels of all participating agencies. The idea was to make the training attractive by highlighting the importance of collaborative group process within, as well as between, agencies. At the same time, the training would have direct application to collaborative efforts on ISP teams.

Interviewees pointed out that it is also possible to increase collaborativeness through the planning process itself. One way this could be done, they said, was through skillful teamwork in resolving conflicts. Many of the same team members, however, pointed out that they felt insufficiently trained in techniques for doing so. Experienced facilitators also suggested that good plans—based on shared goals and documenting successes—can help overcome some degree of initial skepticism on the part of uncommitted team members. By demonstrating accountability (Chapter 7), teams encourage and support members to find creative ways of working within their mandates.

Research on effective teams provides a rationale for these recommendations. The discussion around necessary conditions for the practice model (Chapter 1) presented evidence that team member collaborativeness tends to increase when:

- Teams structure discussions and decision making such that each team member feels he has equitable input,
- Decisions are made using processes perceived as fair,
- Teams have skills that enable them to engage in productive discussion of differences of opinion while avoiding destructive conflict, and
- Teams are able to provide evidence of their effectiveness in reaching goals.

As mentioned above, it is not always easy for natural support people to act collaboratively on ISP teams. Teams must be prepared for the possibility that they will need to spend time securing collaboration and commitment from natural support people as well as from professionals. Teams should keep in mind that natural support people do not get institutional support for attending meetings—it is not part of their job, and they are not paid or given time off for attending meetings. Like other team members, natural support people's commitment to the team is likely to increase when they see that their contributions are valued, that their time is being spent in a worthwhile effort, and that their voices are being heard.

Collaboration/partnerships: Organizational level

i. Lead and partner agencies collaborate around the plan and the team.

Because ISP teams work across the boundaries of many agencies and service systems, they face special challenges with regard to collaboration.[8] Interviewees across stakeholder groups stressed the importance of having the team's work respected by staff in each of the participating agencies. When this does not happen, our interviewees told us, the team's work can easily be undermined or derailed. For example, in our observations, we followed a team whose different agency members maintained four separate plans of care for the family. Over the course of more than a year's worth of meetings, we never

observed team members sharing their separate plans with each other or with the family. Team meetings provided evidence of numerous occasions where the requirements of different plans were placing separate, and sometimes incompatible, sets of demands on the family. There was often also a good deal of confusion regarding exactly who had agreed to do what, and there was little team level awareness of whether the actions defined in the separate plans had actually been accomplished. The overall effect was one of extreme incoherence, and family members in particular expressed frustration with the lack of consistency across plans.

If the team plan does not serve as the case plan for each participating agency, team members need assurance that partner agencies will respect the goals and services/supports as decided by the team and will not develop separate goals and plans which are inconsistent with or undermine that of the ISP team. A further step in collaboration involves the development of a common format for case plans so that each team member is not required to translate the team plan into the language of their home agency—thus avoiding the temptation for goals and activities to drift away from the values and intent of the team. The development of a common format for plans also works to reduce inefficient and redundant paperwork thus giving team members more time to develop resources and pursue other team activities. Even where a common plan format is not fully in place, agencies must work together to minimize redundant documentation and effort.

ii. Lead agency supports team efforts to get necessary members to attend meetings and participate collaboratively.

As noted above, team level efforts to encourage key members to attend and collaborate during meetings are not always successful, especially where support for ISP varies across participating partner agencies. Teams will sometimes need support from the lead agency to supervisors and managers to encourage commitment and collaborativeness, especially where buy-in to values and process of ISP is uneven across participating agencies. When the ISP facilitator has used all of the personal authority and persuasiveness she can muster in her efforts to encourage collaborativeness, it is critical that she be able to appeal to management for backup and intercession. McGinty notes that the support of agency administrators is vital to the successful implementation of wraparound programs.[9] Although in our interviews it was viewed as a last line of defense by most, this level of commitment and support seemed critical to making teams effective. Lead agency supervisors and managers also need to work in a peer-to-peer manner to help their partner counterparts understand—and then communicate to their staff—the need for flexibility with regard to fulfilling mandates and the need for open-mindedness about what goals the team should pursue.

We were also told of occasions where attendance and/or collaborativeness were problematic even among certain team members from the lead agency. Under such circumstances, it may once again be necessary for supervisors or managers in the lead agency to support team efforts to help their coworkers develop a more supportive attitude. Interviewees also reported that lead agency policies were sometimes to blame for such problems, such as when two staff members from the agency were working with a family, but only one was allowed to attend team meetings, or only one was supported in following up with team tasks. Lead agency policies around access to funds

or services could also impede teamwork when staff were not empowered to make decisions about access or expenditure during team meetings. (This difficulty is more often encountered among partner agencies, and is discussed in more detail in condition iii, below.)

Often, supervisor or manager peer-to-peer interactions with partner organizations take the form of education about the team-based ISP process, its potential, and the need for some degree of creativity in satisfying competing mandates.[9] Our interviewees reported that these efforts can be enhanced when all involved have access to research demonstrating the efficacy of the team-based ISP process, and other materials that describe the process. Sometimes, partner agencies are not receptive to this sort of "education," and there may be a need to provide other incentives or to search out other means of encouraging collaboration. For example, we have seen situations in which the lead agency has funded training for administrators and potential team members from partner agencies. In other cases, where the lead agency has the authority to select and pay partners who most actively learn and practice the model, partner organizations have an added incentive to become collaborative team members.[4]

iii. Partner agencies support their workers as team members and empower them to make decisions.

This section focuses on the role of partner agencies in encouraging their workers to attend team meetings, to work collaboratively, and to make meaningful decisions during those meetings. Minimally, agencies whose professional workers participate on ISP teams must allow their workers to attend meetings on a regular and continuing basis. The continual cycling of new members replacing veteran members on a team is cited by many experienced team members as detrimental to team functioning. To more fully support team-based ISP, partner organizations permit workers to schedule their time flexibly so as to allow for their participation on teams and for team-assigned activities. The supportive partner recognizes that, for staff who participate on ISP teams, fulfilling team responsibilities takes time outside team meetings. Supportive partner organizations do not expect that the responsibilities that come with team membership will simply be added on to an already existing set of job responsibilities.

Another important aspect of the partner agency role is to support collaboration by allowing staff to make meaningful decisions during team meetings. One important way for partner agencies to support their workers in this area is to provide them with some flexibility around issues such as eligibility for services and how to meet agency mandates. Partner agencies further support collaboration by encouraging staff who participate on ISP teams to be open-minded in determining goals and seeking solutions. It is also important that partner agencies empower staff to make decisions *during* team meetings about access to funds and services at the partner agency. Our interviewees pointed out that when team members are not truly empowered to make decisions, they are often put in the position of having to go back to their home agency co-workers or supervisors to try to "sell" the team plan. If the team member is then unsuccessful in gaining approval from the home agency for the services or funds laid out in the plan, the activities of the whole team may be thrown into disarray. What is more, there may well be no efficient way to work out alternate solutions until the next team meeting. We were told of a number of instances in which a team member from a partner agency

failed to get approval for an expenditure which had been written into the ISP plan during a team meeting, even though the expenditure seemed like a fairly routine and legitimate use of agency resources. It is not hard to imagine the stresses that are placed on the team process if *multiple* members of the team can only provisionally agree to the activities and expenditures laid out in the plan.

Our interviewees suggested that partner agencies are more likely to support their staff in collaboration on ISP teams when the partner agency supervisors and managers understand and support ISP as an effective way to deliver services. Interviewees recommended increasing buy-in at partner agencies by educating managers both about the ISP process itself (see also Chapter 3) and about the mandates and work of other agencies that were partners in the ISP process. This education could proceed in a variety of ways. Minimally, managers and staff at partner agencies could be provided with orientation materials and information about partners. Several sites went further by having representatives from partner agencies (including management-level people) attend ISP workshops or even full trainings together. One site trained upper level managers as team facilitators or co-facilitators (at this site, facilitators did not have any other role on a given team). The idea was that the first-hand experience that these managers would have with the ISP process would help them better understand the need for collaboration, and that this would encourage them to work to build a more collaborative attitude in their home agencies. Other sites set up job shadowing opportunities during which supervisors or managers would spend some period of time observing the daily work of a peer at a partner agency. Often the experience was accompanied by activities that might include discussion or journaling. At still other sites, partner agency representatives, including supervisors and/or managers, participated on standing interagency committees that worked to resolve difficulties around funding, mandates, and other aspects of collaboration. Participation on such committees was seen by our interviewees as an effective way not only of resolving specific conflicts, but also of educating the committee members about what ISP teams do, and the need for improved coordination and collaboration. Finally, there was one site that made an effort to train people across all levels of partnering agencies in a generalized skill of collaborative problem solving.

Collaboration/ partnerships: Policy and funding context (system level)

i. Policy and funding context encourages interagency cooperation around the team and the plan.

The development of interagency cooperation and coordination around activities that are mutually conducted is an ongoing challenge for the mental health community and has suffered from a lack of research specific to children's services organizations.[3] Tuma,[11] in his study of mental health services to children, found that many children with multiple agency involvement were not receiving comprehensive services. Whetten, [13] in his seminal work on interorganizational relations, identifies two groups of variables that are preconditions to successful coordination. The first of these is perceptual conditions (such as a positive attitude toward coordination or a recognition of the need to collaborate), and the second is resource and structural adequacies. In order to encourage

partner organizations to cooperate with the team ISP process, perceptual conditions must be maximized so that the partner agencies understand the importance of collaboration to ISP, recognize the desirability of collaboration with the lead agency, and assess the costs of collaboration as being in their favor. Leaders in the funding and policy context can influence these perceptual conditions by education, active support, and/or pressure on organizations to work together. Administrators and supervisors in partner organizations must be encouraged to allow their employees to participate in team planning and to complete team tasks, even when these activities are different from their usual work.

Resource and structural adequacies[13] must also be taken into consideration as a part of the strategy to encourage interagency cooperation. Decision makers in the policy and funding context need to make rules that allow partner organizations to be flexible in terms of how their mandates are met, and that allow for creative means of meeting the mandates while also responding to the priorities as expressed by teams. Changes in information and reporting systems (particularly changes that enable the use of shared documentation and common formats across agencies) represent an important means of streamlining work and enabling greater interagency collaboration.

More generally, the policy and funding context should provide both pressures and incentives for the implementation of policies about interagency collaboration.[2] What is unclear at this point, however, is whether or not such collaboration for the benefit of a small number of children and families with multi-system involvement can be embedded in a system in which agencies on the whole do not collaborate much, and in which services do not tend to be individualized and/or coordinated. Some of our interviewees believed that collaboration in the team-based ISP process could not be sustained unless entire systems were reformed, such that coming together around the specific and individualized needs of particular children and families were the norm for all service delivery, not just the "200 kids with most needs." This is an intriguing research question, and one that is difficult to address as there are few examples of team-based ISP programs with long tenure or of systems in which collaborative activity and individualized services are the norm. However, as team-based ISP programs go on year by year within systems that are still largely organized into vertical "silos" (child welfare, mental health, juvenile justice, education) there is increasing reason to believe the idea that team-based ISP can be maintained within a policy and funding context that reflects the philosophy and values of ISP only to a limited extent.

During the course of our interviews, we became increasingly aware of the importance of a structure or mechanism that allows collaboration and coordination to occur. Three distinct structures for managing interdependency among agencies are identified by Whetten:[13] mutual adjustment (little or no structure), corporate (single authority structure), or alliance (a medium amount of structure with a single lead agency). Although the relationships between lead and partner agencies who collaborate around ISP teams might most effectively be supported by an alliance, most communities appear to work from a loosely structured form of mutual adjustment. Mutual adjustment approaches depend on good working relationships among line level staff and rarely involve decision makers from upper levels of the organization.

Our interviewees pointed out that the primary mechanisms for achieving interagency collaboration are meetings, and that there is often a direct trade-off between going to meetings to learn about how things work in partner agencies and organizations, and using that time to attend to other work. Administrators report a great deal of frustration associated with meeting-based efforts to increase interagency collaboration. Our interviewees suggested that in many cases the decision making capacity remains within the individual organizations and no real authority is vested in the interagency groups, typical of a mutual adjustment structure.[13] As a result, the meetings become an additional burden and serve no real coordinating or collaborative function. It was suggested that when interagency groups are truly empowered to collaborate and make decisions, the interagency body comes to replace decision making bodies within individual organizations. Unless this happens, not only will the interagency groups be ineffective, but participants in such groups will continue to feel overburdened by attendance at meetings with little impact on decisions.

ii. Leaders in the policy and funding context play a problem-solving role across service boundaries.

In order to identify and solve mutual problems, there needs to be a recognized mechanism at the state, county, or regional level for bringing groups together to address policy issues that cut across agencies and affect the ability of teams to function.[10] This niche can be filled either by key individuals acting informally or by an individual or group that is formally charged with this responsibility. The individual/group needs to be able to solve problems or challenges in two areas: 1) resolving conflict over which stream of resources will pay for what (unless most funds are blended), and 2) recognizing the challenges to team functioning and bringing others together for the purpose of addressing those challenges. Further, it is important that individuals from teams and agencies understand that this is the mechanism for solving conflicts, and feel comfortable bringing their concerns to this individual or group.

Johnson and colleagues[6] note that involving upper management in planning and problem solving was one of the frequently reported strategies used to address barriers to interagency collaboration. We found examples of this kind of problem solving body in the interagency or interdepartmental committees referred to in several of our interviews. In some instances, the interagency body is active in resolving conflict over which funding stream should be used. Once the problem-solving group has taken action or made a decision, it is critical that it stays actively involved to make sure that the plan is implemented. In some cases, the individual or group may make decisions supportive of ISP but there is less focus on serving as a strong advocate for the ISP philosophy. The interagency body will be most influential if it actively supports the philosophy behind team ISP and is able to assess potential decisions or policies with that philosophy in mind. Training opportunities, workload and caseload policies, personnel practices and contract language are all examples of policies or decisions made at a county, regional or state level that might effect the ability of teams to function. Additionally, in the course of ISP team planning, it is inevitable that specific difficulties, unique to that team, will arise.

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Chapter 5: Necessary Conditions: Capacity Building and Staffing

Capacity building/staffing: Team level

i. Team members capably perform their roles on the team 65

Capacity building/staffing: Organizational level

i. Lead and partner agencies provide working conditions that enable high quality work and reduce burnout 66

Capacity building/staffing: Policy and funding context (system level)

i. Policy and funding context supports development of the special skills needed for key roles on ISP teams 67

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Chapter 5: Necessary Conditions: Capacity Building and Staffing

This chapter continues the discussion of the proposed necessary conditions for high quality implementation of collaborative team-based Individualized Service/ Support Planning (ISP). The conditions covered in this chapter are those found in the third row of figure 1, and are related the need for building capacity in the specialized skills and knowledge that are required to carry out the ISP practice model.

The chapter begins with a discussion of the team-level need for specialized skills and knowledge. The chapter goes on to discuss the conditions that must be in place at the organizational level to support team members as they acquire these assets, and to retain them afterward. Finally, the chapter discusses the conditions that must be in place in the policy and funding context (system level) in order to support the development of the special skills needed for key roles on ISP teams.

Capacity building/staffing: Team level

i. Team members capably perform their roles on the team.

This conceptual framework stresses the importance of specialized skills and knowledge that will be required for ISP teams to function effectively. In particular, competent facilitation is seen as essential for creating and maintaining a high-quality team-based ISP process. Teams will also require various other types of skills and knowledge to carry out their work. For example, if teams are to create plans that are truly individualized and community based, they need skill and knowledge to develop individualized resources, particularly those based in the community. While the necessary knowledge (of what services and supports are available, how to access them, and so on) may be distributed across team members, a team may benefit from having at least one team member who specializes in community resources, and who has many connections and sources of information within the community. Beyond this, the team may well require that a member or members have skills in developing new community resources, or in tailoring existing resources to help ensure that children and families can have successful experiences when accessing them. Other skills and knowledge required for effective ISP teamwork will include, for example, those related to empowering the family in the planning process, building on strengths, and locating effective providers.

These sorts of skills and knowledge may be spread across different team members in different ways on different teams. For example, on one team, a parent advocate may facilitate the team and also work with the family around defining strengths. On another team, the parent advocate may be exclusively concerned with drawing out and supporting the family perspective during team meetings. On many teams, the facilitator is also the care coordinator; however, some teams use a model of planning that relies on a facilitator who specializes in that role, and fills no other role on teams. Some

agencies have designated resource developers, while in other agencies, case managers are expected to fulfill this function.

While teams can work to attract team members who have desired skills and knowledge, the lead organization will bear much of the responsibility for ensuring that these assets are present on teams. The primary mechanism for this will be through support for an adequately comprehensive practice model, which will provide guidance about the various responsibilities of team members with specialized roles. Lead and partner organizations must also provide working conditions that allow them to hire, train, and retain team members with needed skills and knowledge.

Capacity building/staffing: Organizational level

i. Lead and partner agencies provide working conditions that enable high quality work and reduce burnout.

The work climate created by the organization is known to be associated with positive service outcomes and service quality.[4,17] In particular, much research has been conducted about the relationship between job turnover, job satisfaction and burnout. The ability to keep workers who have attained the skills needed to perform effectively on ISP teams is directly related to the program's ability to achieve good outcomes. In our interviews, we heard much concern about the rapid turn over among ISP facilitators and others with special roles on the team. There is at least some evidence that burnout and subsequent turnover may be related to the intensity of the interaction with families and the number of crises the family experiences.[9,18] Corrigan and colleagues[2] report that mental health workers who are emotionally exhausted (one component of burnout) are also likely to report a lack of cooperation and collaboration on their teams. The positive experiences of working on effective teams is a buffer against the difficulties and challenges that inevitably arise, as is supportive supervision.[16] The lead agency that hires, trains, and supervises team facilitators plays a strong role in demonstrating that it values the special skills that team facilitators need. Providing effective supervision and support (Chapter 3) are important in increasing the skillfulness of facilitators and communicating this value. Rauktis[16] suggests that supportive supervision may be most effective when it is coupled with strategies at the organizational level that address other sources of job stress, such as high workload.

Research on the relationship between heavy work loads and burnout is mixed in its conclusions. Some authors have reported a direct connection between caseload size and burnout [10] while others have failed to find a correlation.[7,8] In describing more recent work, Rautkis concludes that "work stress had a mediating or intervening effect while support and accomplishment had a moderating or buffering impact on the relationship between work load and burnout" (p. 40). With regard to effective ISP, "teamloads" need to be kept to a level that does not overtax the facilitators. The exact number of teams that a facilitator might handle depends on a number of factors, most importantly the extent to which the facilitator carries out other roles beyond facilitation—e.g. record keeping, case management, meeting and team support, etc. In many cases, facilitators do all of these tasks, and the consensus of our interviewees is that in these instances facilitators should be handling a maximum of ten teams at a

time. Whether or not this is a fixed ceiling is an issue open to further exploration. What is helpful is for the lead agency to articulate a reasonable expectation regarding the number of teams a facilitator will lead at one time and then make decisions that adhere to that benchmark.

Adequate pay and opportunities for career development are also important to facilitator tenure and can be influenced by the organization.[15] In many lead agencies, facilitators are BA-level, often newly degreed, and they receive a salary that many described as "less than a living wage." Furthermore, there is no clear career path for facilitators, so building a career may mean moving to different positions with different skill sets, or leaving work with public sector clients for private practice or other private systems. Not surprisingly, job tenure for facilitators in most sites was reported to be relatively brief (averaging under two years). Sites with longer facilitator tenure seem to be quite successful in providing intangible benefits to workers—experiences of success and a culture of support and optimism were benefits most often cited. In other sites, the organization has managed to build a value and respect for the role of facilitation in a way that increases the intangible benefits associated with the job. In other instances, particularly one case in which ISP was facilitated by a person whose sole job with teams was facilitation, the pay for the facilitators was substantially higher than average for other staff.

All collaborating agencies must also find ways to reward and promote family members who serve regularly on multiple teams in the role of family advocate or parent partner.[15] Several studies [3,5,11] have reported that status differential among team members is a barrier to effective team functioning. Frequently, family members who occupy special team positions either volunteer or are paid on an hourly basis and do not receive benefits or experience promotional opportunities or a reasonable salary level.[13] Treating family members who occupy these roles equally with other team members with regard to training, supervision, compensation and promotion is a tangible way of demonstrating that the organization values their skills.

People from partner agencies also need support from their agencies if they are to do high quality work on ISP teams while avoiding burnout. The supportive partner agency will fully recognize the time commitment that is required for attendance at team meetings and for carrying out team-assigned tasks (Chapter 4). Additionally, supportive partner agencies recognize that staff who participate on ISP teams will acquire skills and knowledge as they gain competence in the collaborative ISP process, and that these represent assets that should be valued and rewarded.

Capacity building/staffing: Policy and funding context (system level)

i. Policy and funding context supports development of the special skills needed for key roles on ISP teams.

The skills needed by people in key roles on ISP teams (facilitator, parent advocate, resource developer, care coordinator) are in many ways different from the skills and training needed for the development and delivery of services in a more traditional service system.[12,15] State and local stakeholders have important roles to play with

regard to staff development and training concerns.[15] In a study of human resource issues in the southern region of the country, Pires[14] found that 69% of those surveyed considered workforce issues to be of equal importance to issues of adequate funding in children's mental health. Leaders from the policy and funding context have an important role to play in addressing the development of the special skills needed by staff on ISP teams. This can include providing leadership to efforts to coordinate training across a state or region as well as using policy venues and contractual language to encourage the development of ISP skills.

There are a number of documented examples of states who have employed creative methods for coordinating skill development opportunities, usually focusing on developing skills needed for implementation of a system of care philosophy. Illback and colleagues[6] describe a process in Kentucky in which a state level interagency council worked to "assess the scope and focus of current provider training, develop strategies for integrating and coordinating initiatives, and formulate a plan to demonstrate coordination and integration of training in pilot regions" (p. 148). In the early childhood arena, Cantrell[1] describes a method of cross training that includes bringing together administrators from various service components to educate each other about their activities.

Other ways that leaders in the policy and funding context can be supportive of skill development needed by ISP team members involve using their ability to make policy and control resources through contract language. The lead organization may have the responsibility to train and supervise people in these key roles; however, it is the policies and rules set at the system level that makes it feasible for this to happen. Leaders within the policy and funding context have the ability to develop contracts and administrative rules that reflect an understanding of the need to retain and continually upgrade the skills of people in specialized team roles. Further, policies and contracts can set the standard for compensation, promotion and workload levels. Without some conceptual support from the system level, it is very difficult for administrators in the lead agency to maintain a commitment to people in key roles on the ISP team, given competing demands and financial pressures.

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Chapter 6: Necessary Conditions: Acquiring Services and Supports

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Chapter 6: Necessary Conditions: Acquiring Services and Supports

This chapter continues the discussion of the proposed necessary conditions for high quality implementation of collaborative team-based Individualized Service/Support Planning (ISP). The conditions covered in this chapter are those found in the fourth row of figure 1, and are related the need for access to services and supports as called for in ISP plans.

The chapter begins with a discussion of the team-level need to identify, access, and/or tailor services and supports as called for in the ISP plan. The chapter goes on to discuss the conditions that need to be in place at the organizational level to support team members' efforts to acquire these services and supports. Finally, the chapter discusses the conditions that must be in place in the policy and funding context (system level) in order to support access to, and development of, effective services and supports consistent with the ISP practice model.

Acquiring services/supports: Team level

i. Team is aware of a wide array of services and supports and their effectiveness.

One of the main functions of the ISP team is to match the family's identified needs to available services and supports. In order to perform this sort of matching effectively, teams will need to know what services and supports are available and how to access them. Teams will also need to know something about the effectiveness of various types of services and supports, as well as the characteristics of providers who are most likely to be helpful in meeting an identified need.

Our interviewees often commented on how difficult it is to be aware of all possible services and supports, formal and community, that might be available to a team. Team members, of course, bring their own specific knowledge to bear on this issue, though a given team member's knowledge is usually most detailed with regard to the services or supports offered by his or her home organization or agency. Since teams tend to be numerically dominated by professional members, this means that teams have greatest knowledge about professional, agency-based resources. Teams are often not knowledgeable about publicly funded services provided by agencies or organizations not represented on the team, particularly school-based resources. Interviewees also pointed out that it can be very difficult to be up to date with information about community resources, and several said it could be of great benefit to teams to have a resource developer, or other expert in available services and supports, as a member. Many team members cited the need for additional organizational support in this area (See the next section of this chapter).

However, even where services or supports are available, there is no guarantee that they will be of high quality. The team's ability to achieve its goals is enhanced when the team can judge services or providers, using available information to decide which is most likely to contribute effectively to positive outcomes. For example, a number

of the teams we observed employed "mentors"; however a majority of these "mentoring" relationships appeared to be of short duration, and in several instances there was marked team dissatisfaction with the mentors' behavior. Research on mentoring has identified key attributes of effective mentors and successful mentoring relationships. One key element of a successful relationship is the length of time it endures, and in fact, short-term relationships may actually harm youth.[15] Best practices for selecting and training mentors have also been identified.[14] It seems likely that teams with information about the effectiveness of mentoring will be prepared to select from among available programs, or even individual mentors, to find one which is most likely to meet an identified need. Alternatively, learning that no qualified mentors or high-quality mentoring programs are available, the team might turn to an alternate strategy.

Virtually all the teams we observed purchased child psychotherapy services. Given the lack of evidence for the effectiveness of psychotherapy for children and adolescents in community settings,[38-40] teams are well advised to be critical consumers of such services, rather than continuing in an uncritical way with whatever provider or whatever approach is available. Teams that are aware of the evidence base for treatments for various disorders[6,36] will be better able to undertake such decisions, as will teams who are clear about the goals for therapy and the indicators for measuring progress towards those goals. A well-informed team might, for example, gather data on a youth's perception of therapeutic alliance, and use this information in decisions regarding whether or not to continue with the service and/or the provider. Another team might specify that the goal of therapy is to help the youth learn ways to decrease the number of conflicts he is involved in at home and school. The team would then monitor indicators of success related to that goal (perhaps by having family members and key teachers provide simple data). If therapy did not seem to be resulting in decreased conflict, the team could decide that a new therapist, or a new approach, might be needed.

ii. Team identifies and develops family-specific natural supports.

Including greater numbers of natural support people on ISP teams is an ongoing challenge. In trainings, and during interviews, we were often told that natural support people should outnumber professionals on the team, but this was almost never the case among the teams we observed. At the meetings we observed, there were no natural supports at all at just under sixty percent of the meetings, and only one natural support at 32% of the meetings. A total of seven meetings out of 72 had more than one natural support.* Natural supports were about equally likely to be extended family members or caregivers of other children with emotional or behavioral challenges;** and on only one occasion was there an attendee at a meeting who represented a

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* These figures represent unpaid natural support people. If paid parent advocates are included in the count, then 47% of team meetings had no natural supports in attendance, 32 % had one natural support, fifteen percent had two natural supports, and four teams had three or more.

** This heavy reliance on other caregivers to children with emotional and behavioral disorders as natural supports—often the sole natural support—on ISP teams is troubling, as these are often single-parent families that are already highly stressed.

community organization or institution (club, church, sports). We have heard anecdotally of communities where levels of natural support participation on ISP teams are higher, though we have not been able to verify this formally. Additionally, several people have suggested that participation of informal supports on teams is higher in rural areas.

Facilitators, administrators and families point to a variety of challenges in identifying, recruiting, and retaining natural supports on teams. Many of our interviewees pointed out that families whose children have emotional or behavioral disorders tend to be socially isolated. Families often feel that friends and even extended family members blame them for their children's difficulties, and that this blaming attitude causes rifts in relationships and decreases available support. Even in the absence of blaming, families said that they felt that their sources of support had been burned out due to the high level of family needs and frequent crises. Another key barrier is family reluctance to have potential natural supports at team meetings where many sensitive topics are discussed. Families do not necessarily want their neighbors or even extended family members to know details of their difficulties. Families also expressed reluctance to burden support people by asking them to meetings, and support people were often discouraged from attending meetings by work schedules and difficulties with child care and transportation. Finally, there were a number of family members who commented that teams that do attract natural supports may be at a loss as to how to use them effectively. Especially in teams that are dominated by professionals' perspectives and goals, family members and natural supports can be marginalized.

Some teams have had good success identifying natural supports, and usually this began with a structured process to help the family think about people that could be invited to join the team. Several sites have developed aids—interview prompts or charts, for example—to help in this process. Other sites use trained parent advocates to help families identify the people in the community who are most connected to the family, educate them about the team process, and invite them to the team meeting. This is done prior to the first team meeting so the natural supports are involved from the beginning of the ISP process. Teams can also schedule meetings at times and places most convenient for natural support people, and can be attentive to encouraging them to participate in team discussions and decision making. In many communities, teams can request funds to help natural support people get transportation and child care.

If the goal of 50% natural support membership on teams is to be realized, however, it is likely that a more comprehensive set of strategies will have to be developed to support team efforts in this area. The agency support for team efforts (next sections) is also crucial.

iii. Team designs and tailors services based on families' expressed needs.

A critical aspect of developing an ISP plan is listening carefully to the family's expressions of its needs and then individualizing a response by creating or modifying services traditional and/or community services that meet those needs. Our observational data suggest that teams are not very successful in individualizing plans to a significant extent. Teams did show a willingness to make small modifications—in

scheduling or meeting place, for example—to services if the family requested this. We saw services being "tweaked" in this way in 88% of the meetings we observed. In about a third of meetings, services were added or dropped as requested in the team plan. In these ways, teams did appear able to respond to family preference. Fifteen percent of teams purchased community services for the family (e.g. membership at the YMCA), but only 6% of teams tailored the community service or provided support to the family to help ensure that the community experience would be successful. For example, when supported by a paid or unpaid mentor, a child may be able to participate successfully in activities at a community center. Or when a martial arts teacher is aware of a child's particular behavior challenges, the teacher can help the child recognize inappropriate behavior and encourage him to use agreed-upon self-talk or self-calming procedures. At 14% of meetings we observed, there was evidence that the team was using flexible funds or other monies to purchase supplies or services to meet the family's unique needs.

Our observational data also showed that teams only very rarely spent time considering alternatives when deciding on strategies for meeting a need. Combined with the tendency to rely on "off the shelf" services, this strongly suggests that teams have a need for increased capacity for creativity in designing and tailoring services and supports. Team process that stresses creativity-enhancing strategies during decision making (Chapter 3) may be an essential ingredient in creating truly individualized plans. The apparent lack of individualization of plans may also be caused by insufficient support for the family's perspective during the planning process. This seems a reasonable hypothesis, given that: providers numerically dominate teams, there are few natural supports in attendance at meetings, and teams tend to lack a repertoire of concrete strategies for eliciting or reinforcing the family's input into discussion and decision making. A strong practice model may help to remedy some of these concerns (Chapter 3).

Acquiring services/supports: Organizational level

i. Lead agency has clear policies and makes timely decisions regarding the funding for costs required to meet families' unique needs.

In order to function effectively, teams need to quickly get the funding they need to pay for services or supports that are unique to the needs of an individual child or family.[5,8,21,26] These unique costs may include special equipment, non-traditional services, services or supports from a new provider, or services that are specific to the child's cultural heritage. Most frequently, these funds come from a pool of money designated as *flexible funds*. Given the increased emphasis placed on the availability of flexible funds, it is surprising that little has been written about the need for clear organizational polices and procedures regarding access to these funds.[10] Organizational procedures should encourage the purchase of the most effective services/supports and those preferred by families rather than any one categorical service.

Dollard and colleagues[10] noted three important factors in the successful use of flexible funds in the two programs they studied: 1) the ready availability of funds, 2) the dissemination of funds at the local team level, and 3) accountability for funds at the

local team level. In our interviews, facilitators reported that they are best supported when teams are trusted to make all but the most unusual purchases on their own authority. In one organization, facilitators were given an average amount of flexible funds that they could use per family in their caseload. They were free to use more for one family and less for another as long as the average was maintained. Team members also reported that it is helpful when organizational leadership has a clear philosophy about the use of flexible funds and there is a commonly shared understanding about what sorts of unique costs are legitimate to fund from this source. Dollard and colleagues[10] stated that an important policy for program managers to develop is "identifying the broad general uses for which money can be used" (p. 124). A number of our interviewees pointed out that it is also helpful if there is a shared understanding about the distinction between "enabling" and supporting families. Several administrators we talked to said that this distinction is not an easy one to articulate and is usually based more on experience and gut feeling than on a written policy.

To add further complexity, the organization's policies and procedures need to anticipate potential community concerns about certain types of expenditures. For example, in one setting, a limit was placed on the amount of flexible funds that could be used for recreational expenses per family. This was in direct response to administrative concerns over how the community might view use of flexible funds. In this case, organizational leadership was able to proactively anticipate public pressure and take steps to buffer team members from external criticism. In other cases, organizational leadership has been able to recognize the risk involved in using flexible funds to purchase unusual services and has prepared the community in advance for these uses.

ii. Lead agency encourages teams to develop plans based on child/family needs and strengths, rather than service fads or financial pressures.

The lead agency plays an important role in helping teams access services and supports called for in the ISP plan, and for helping to develop new services and supports when needed to meet the unique needs of a family and child.[5,27,34,37] Eber [11] notes the importance of monitoring how services and supports are developed so that "availability of specific services does not dictate wraparound planning" (p. 147). A support that works well for one or two children may inadvertently become a new categorical approach. Another threat to optimal team functioning is the normal pressures toward survival that exist within agencies and within service systems. An example of such a pressure is the subtle expectation to overpurchase certain formal services that are in plentiful supply. Sometimes team members have to face pressure from their own employer to make sure that certain programs are filled to capacity. Workers in this case may feel some need to refer children in order to make sure that the service continues to exist. Similar pressures can occur within the service system when a service provided by another agency is threatened with cuts. Pressure also occurs when a new service becomes available and workers and families see it as *the* solution to a variety of problems (e.g. mentoring). These pressures or incentives are often not recognized within the team even though they may exert a powerful influence over the shape of the ISP plan.

Team members need to be as free as possible from these pressures and incentives so that recommendations for services are based on the child and family's preferences

and needs, not organizational requirements. This buffer can be provided by a supervisor or agency administrator who is alert to the dampening effect that these pressures can have on team decisions.

The lead agency can also work in a more proactive manner to anticipate increased demands for types of services that ISP teams tend to favor. In the meetings we observed, mentoring and respite were two services most often desired by families and also often insufficiently available. In several cases, lead agencies were working with partner agencies (developmental disabilities or child welfare) to increase the supply of licensed respite homes. Lead agencies could also work with community and partner agencies to develop mentoring programs that mesh with the needs and goals of ISP.

iii. Lead agency demonstrates its commitment to developing culturally competent community and natural services and supports.

Given the diversity of the families served through ISP, it is important that the lead agency makes a commitment to cultural competence in the services and supports provided. In addition to having an overall plan to develop agency cultural competence, the lead agency needs to develop a specific plan for increasing the cultural competence of ISP teams, including opportunities for team facilitators and other team members to develop knowledge and understanding of the history and resources of the communities of color that exist within their geographic area.[19,31] The development of such a plan is most frequently done through an inclusive planning process that allows families from diverse backgrounds to participate in identifying services and supports appropriate to their situation. Community leaders, providers of culturally specific services, and representatives from resources that serve diverse communities should also be consulted in developing this plan.[3] In addition to a plan for supporting cultural competence in the ISP process, the lead agency can also demonstrate its commitment by hiring people connected to diverse communities to fill special roles on the team.[9] Roles such as family advocate or resource developer benefit from a history of living and working in the community, having strong ties with community leaders, and speaking the languages most often used by community members.

iv. Lead agency demonstrates supports teams in effectively including community and natural supports.

For the most part, community resources that are supportive of families and children with emotional disorders are hard to find, although Hernandez and colleagues[16] report that communities following system of care principals are more likely to have sources of informal support available. Team facilitators and the lead agency have to make a conscious effort to build capacity to develop needed community services and to make sure these services are connected to diverse cultural groups. Although still unusual, some organizations now employ staff to develop community supports that are appropriate for children with emotional or behavioral difficulties, while others assign this task to an existing staff member.[8] In one setting that we studied, the community resource developer worked closely with the parent advocates to identify needed resources. In another, the position of family resource developer integrated the functions of developing community resources with family support and advocacy. Examples of community supports that might be developed or modified include recreational opportunities, skill-building options related to employment, or supported peer activities

such as church youth groups or Boy Scouts/Girl Scouts. Such positions are tangible evidence of the organization's commitment to developing community opportunities and tailoring them so that the opportunities are truly available to teams.

In those service systems where community supports and natural networks are valued and nurtured, a greater degree of cultural competence can be achieved because of the input from community members and the influence of community norms.[3] The lead agency can support these efforts by encouraging team members to increase their knowledge of diverse resources within the community, particularly those that support children and families from diverse cultural backgrounds. Knowledge of resources in communities of color is particularly important for team members with specialized roles (e.g. family advocate, resource developer) because they often assume the role of cultural specialist and can apply the knowledge to the ISP process.

Supervisors should be knowledgeable about specific strategies for increasing the use of community resources and natural supports. Supervisors can help teams develop specific skills for inviting people from community organizations to ISP meetings, and for including them in decision making. Our interviewees often noted a lack of real local examples of the effective inclusion of community and natural supports on teams. Supervisors can provide opportunities for team members with special roles—parent advocates, resource developers, care coordinators—to meet and work collaboratively to share examples of novel ways to increase the availability of, or access to, supports in the surrounding community.

v. Lead agency demonstrates its commitment to developing an array of effective providers.

Effective providers are those who adhere to evidence-based approaches, who conform to best practices, or who demonstrate their impact on important outcomes through other means. Effective providers can provide formal services such as therapy or substance abuse treatment, or non-traditional supports such as tundra walking or sweat ceremonies, or community services such as mentoring or recreation. Although less research is available for non-traditional and community services, an evidence base has been established for many services and supports, [7,17,20,24] and best practices have been proposed for many others. While it is the responsibility of the team facilitators to know the array and quality of services available, it is the role of the ISP program manager and supervisor and other administrators of the lead agency to promote the development of high quality, evidence-based programs within the community.[31] The availability of services that are grounded in theory and have demonstrated an acceptable level of effectiveness is critical if teams are to be able to help families and youth think about what would be helpful in their situation. At the same time, it is important to avoid limiting the team's creativity in order to use only proven interventions.[33] While most communities cannot afford a vast array of services and providers, some amount of choice is important to the family's ability to feel that their needs are being considered. Teams that are limited to a few unproven approaches to treatment or one unsatisfactory provider will find it difficult to construct plans that are creative or responsive to family preference. Even the most effective provider may not appeal to all families because of differences in religion, culture or family lifestyle.

Acquiring services/supports: Policy and funding context (system level)

i. Policy and funding context grants autonomy and incentives to develop effective services and support consistent with the ISP practice model.

The ability to evolve a service system with a broad array of formal and informal services seems to depend on both support from the top (policy and funding context) as well as creativity and energy from the bottom (provider and team level). [25,31] It is apparent from our interviews that the leaders from the policy and funding context are in the best position to provide incentives (such as more resources) to develop the services that are consistent with the ISP practice model, especially services that are community based rather than those that employ out-of-community strategies. At the same time, many providers maintain that they could develop formal and informal services consistent with family and community needs and ISP philosophy if system level constraints were reduced and incentives increased.[27] For example, in one community, the lead agency developed a list of providers who showed the greatest willingness to collaborate with team ISP. Some providers proved to be more collaborative than others and because of this, more often received referrals. State and system level officials allowed the local community to shape its system of care in this manner.

The policy and funding context plays an important role in recognizing and rewarding effective services and those that are include evidence-based practices. Fiscal incentives can also be constructed so that programs and/or providers are rewarded for cooperating to meet a family's needs and for developing community and natural supports that achieve good outcomes. In a number of communities, the money saved by keeping children out of institutions is kept in the community and redirected to local services.[23,29] In other communities, managed care contracts are being written with specific requirements for elements like family involvement and the use of natural supports, thus making tangible the commitment to ISP.[32] Similarly, contracts can be written to take into account the costs associated with training and supervising providers in the ISP practice model.

ii. Policy and funding context supports fiscal policies that allow the flexibility needed by ISP teams.

ISP teams thrive in a funding context that supports flexible fiscal policies. Leaders in the funding and policy context are responding to this need by experimenting with a variety of strategies to increase flexibility. The two most commonly employed seem to be blended funding and flexible funding pools.[28] Dollard[10] proposes that the concept of flexible funds can be applied at both the macro (policy and funding context) and micro (individual team) levels. At the macro level, flexible fiscal policies suggest merging resources from several different sources into one funding stream. Blending funds across service areas often results in the removal of rigid eligibility criteria (e.g. income level), increases access to services and can be a major support to effective team functioning wherever it occurs. This may be facilitated by leaders within the

policy and funding context who give authority to provider agencies to blend funds as needed without excessive oversight. Supportive policy makers are active in encouraging and rewarding programs and policies that support non-categorical funding strategies. They may also advocate at the federal and state level for funding streams that can be blended. In addition to blending funds whenever possible, the policy and funding context can be instrumental in incorporating supports and services commonly used by ISP teams into the existing fee structures.[32] In some states, the work of parent advocates and other family support services has been incorporated into the fee structure. In other communities, team facilitation is recognized as a "medically necessary" service. In general, many of our interviewees felt that the advent of managed care had made the incorporation of these less traditional services into the fee system more difficult. The Health Care Reform Tracking Project partially confirms this perception, finding that managed care reforms resulted in more flexible, individualized services in those states with carve-out managed care designs and decidedly less flexible service arrays in those states with integrated managed care designs.[32]

The availability of flexible funds at the micro or team level, to meet the unique needs of the families and children, is another important component that requires the support of the policy and funding context.[21,26,27,37] Although often associated with blended funding, flexible funds can and do exist in individual agencies within communities where blended funding has not been implemented. The important aspect of flexible funds is that they are not tied to or ear-marked for any specific service or support.[4,30] Rather they can be accessed to meet needs identified in the team plan for which there is no developed service or support available or when the available services are not acceptable to the family. Agencies working with ISP teams need the support of leaders from the policy and funding context who understand how important these flexible funds are and who help to educate other policy level stakeholders about their use.

iii. Policy and funding context actively supports family and youth involvement in decision making.

Inclusion of family voice at all levels is a key principle of the ISP philosophy; however, involvement of family and youth on teams seems to occur most consistently. Involvement of families and youth in agency level decisions or in discussion of policy and funding issues requires dedication, effort and may pose significant challenges.[12,18,22] Several examples are available in which involving families in the design of policies and programs or supporting their leadership of the process has led to more family centered and flexible services and supports.[1,2,13,35] It appears to be particularly important to ask for family member and youth input into the way that services are structured and delivered and deliberate with them about these decisions. The inclusion of families and youth on decision-making bodies within the larger funding and policy context supports efforts at the organizational and team levels [12] and also serves to publicly recognize the resources and time needed to make this collaboration effective.[22]

The challenges that agencies face when including family and youth on major decision-making bodies can be mediated by strong and public support from leaders at the policy level, particularly if agencies are recognized and rewarded for doing a good job

in this arena. The culture of the professional is far different from that of families, and strategies for closing this divide are still in their infancy.[22] Little research has been done on the impact of family and youth input, however, one of the key recommendations for achieving financial sustainability is the inclusion of key players, such as parents, on decision-making bodies.[23]

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Chapter 7: Necessary Conditions: Accountability

This chapter completes the discussion of the proposed necessary conditions for high quality implementation of collaborative team-based Individualized Service/Support Planning (ISP). The conditions covered in this chapter are those found in the last row of figure 1, and are related the need for accountability to ensure adherence to the ISP practice model, implementation of plans, and cost and effectiveness.

The chapter begins with a discussion of the need for teams to maintain documentation that supports mutual accountability and an effective planning process. The chapter goes on to discuss the conditions that need to be in place at the organizational level to monitor the quality of teamwork and supervision. Finally, the chapter discusses the conditions that must be in place in the policy and funding context (system level) in order to ensure that ISP programs provide stakeholders with comprehensive information about cost and effectiveness.

Accountability: Team level

i. Teams maintain documentation for continuous improvement and mutual accountability

Effective planning according to the model of "continuous improvement" requires that teams: determine goals and indicators of progress towards goals, decide on action steps and assign responsibility for tasks, and revisit progress on tasks and goals (Chapter 3, team level). If this sort of continuous improvement planning process is to occur, teams must maintain appropriate documentation of goals, action steps and indicators of progress. We have observed teams that hold meetings and attempt to plan without clear reference to any documented goals or previously-used strategies. In fact, as noted earlier, among the ISP teams we observed, fewer than one third maintained a team plan with team goals. In the absence of an overall plan, teams often appear to be directionless and without a sense of priorities. It is our feeling that a lack of goal structure and performance indicators contributes directly to the apparent lack of creativity and individualization in most ISP plans. When teams do not judge strategies against performance indicators, there is little rationale or motivation to alter strategies. Thus teams tend to stick with what they are already doing, which is usually providing traditional services. In contrast, teams with clear documentation are able to adjust strategies, and to gain support across the team for doing so.

Clear documentation also enables mutual accountability and a sense of team effectiveness. When team members know that they will be held accountable for carrying out action steps, their motivation to follow through on assigned tasks increases. What is more, clear documentation also provides teams with evidence of what they have accomplished, and builds a sense that the team can be effective. The experience

of being effective builds further effectiveness and helps keep team morale healthy. Conversely, it is clear that being ineffective and inefficient rapidly saps team morale.*

Accountability: Organizational level

i. Lead agency monitors adherence to the practice model, implementation of plans, and cost and effectiveness.

In addition to collecting information about how children are doing, it is important for the lead agency to collect evidence about whether ISP teams are adhering to the agreed upon practice model and to feed this information back into the supervision process. The lead agency should also collect information to help them monitor the extent to which supervisors are providing ongoing coaching that focuses in a structured way on building the skills required by the ISP practice mode.

Few sites have developed ways of measuring adherence to ISP that is specific to the practice model articulated in that agency. Some sites assess team-level adherence to a generic ISP philosophy by the use of questionnaires or surveys such as the Wraparound Fidelity Index,[2] a measure which focuses on the extent to which team members feel that team process is consistent with the value base of ISP. This approach appears to provide useful program level information. At the team level, feedback of this sort provides some indication of team functioning; however, without a clearly articulated and agreed upon practice model, it becomes challenging to translate this feedback into practice change and improvement. Other sites have used checklist observation forms such as the Wraparound Observation Form[3] to monitor adherence to general ISP values and practices, and this approach seems promising since it focuses on observable behaviors which are identified and can be remedied. Similarly, the Checklist for Indicators of Practice and Planning (ChIPP), presented in Chapter 8, focuses on observable indicators of team practice that promote both effective planning and the value base. The checklist approach may be particularly useful if data are to be incorporated into supervision such that facilitators or teams could be coached to improve their performance. Using a different accountability strategy, some sites reported occasional monitoring of plans to see whether or not they included community-based services, informal supports, or other indications of adherence to the ISP values.

If lead agencies are to ensure that team-level planning and implementation is proceeding effectively, it will need documentation that each team is following a clear set of goals and that the team is monitoring its progress toward those goals (including the use of flexible funds).[1] Although there is much information that could be collected about the plan for a child and family and how it is carried out, if these minimal elements are present, most stakeholders will be satisfied that the ISP program is being accountable. Team members frequently mention the stress created by organizational requirements to record data related to team meetings—for example to fill out additional case notes or treatment plans.[10,14] They are clear that requirements to document are best when they are kept to a minimum and when they simultaneously meet a need as

* Each of these points is presented in greater detail, with references to available research and theory, in the team level discussion in Chapter 3.

defined by the team. For example, the team's own planning documentation can simultaneously serve as case notes or a treatment plan. In one state, the team plan template has been formulated in such a way that it meets the requirements of the Medicaid plan, thereby considerably reducing the paperwork requirements for the care coordinators. Developing this innovation required substantial leadership and support at the system level as well as ongoing dialogue between managers in service programs and accountants in the state and regional offices.

Finally, the lead agency must gather information that can be used to assess whether or not the ISP program is providing good outcomes for children and families at reasonable cost.[7,12] Furthermore, these outcomes should include not only those related to child functioning, but also those related to family functioning, satisfaction, and quality of life. Program administrators and supervisors often emphasized the importance of having recent and accurate information on the outcomes of ISP and its costs.[8] They reported identifying or "targeting" influential individuals and intentionally providing them with regular updates about the effectiveness of ISP and its cost. Organizational leadership also reported using information about effectiveness to educate community and partner organizations and to proactively increase community trust so that suspicion doesn't develop about ISP.[10] Less frequently mentioned was the practice of disseminating evaluation findings directly to the group of families currently served by ISP. Although some sites employ a process of providing families with information collected from team members about their specific team's functioning, few have found an effective mechanism for informing families about the functioning of the ISP program as a whole. Although possible, the needs of the organization for cost and effectiveness data may be difficult to accomplish with the basic information system that places an acceptable level of burden on team members. Efforts to reconcile these two perspectives seems to be an ongoing challenge.

Accountability: Policy and funding context (system level)

i. Documentation requirements meet the needs of policy makers, funders, and other stakeholders.

A first priority for accountability at the system level is ensure that programs which claim to be providing ISP are in fact doing so. Policy and funding arrangements should require that ISP programs provide evidence that they are adhering to a practice model for ISP. Beyond this, policy makers and funders primarily need aggregated cost and outcome data so that they can determine whether team ISP is cost and outcome neutral (at a minimum) as compared to alternate arrangements.[5,7,8,13] In order to reflect the goals of ISP, which may differ substantially from the goals of other service delivery arrangements, evaluators may need to pursue different strategies and instruments for measuring outcomes.[6,11] For example, greater reliance on strengths-based instruments, measures of family satisfaction and empowerment, and assessment of caregiver strain are concepts important to team ISP. Ongoing dialogue is required between policy makers, family members, and team facilitators in order to select outcome measures which simultaneously reflect accountability at the policy and funding level *and* ISP

program goals. The needs of the policy and funding context are an important ingredient in the process of creating documentation which simultaneously serves team, organization, and policy and funding purposes. Creation of unified case plan templates and the development of understandings around how to reconcile Medicaid requirements with other service plans are areas where such collaborative planning can have a great impact on the ability of teams to function efficiently.

Another important concern at the policy and funding level is the family's need for services over time, the cost of those services, and the long-term outcomes that can reasonably be expected.[4,9] While some families may graduate from ISP and eventually have no further need of formal services, other graduate families will experience new crises, perhaps necessitating intensive services and supports once again. Still other families will continue to rely to some extent on formal supports due to the ongoing nature of their child's needs. Leadership at the policy and funding level must build realistic expectations about these possible trajectories for families into their long-term cost projections; and they should communicate this understanding to all the stakeholders in ISP, so that families, teams, and agencies are working in an environment that does not hold them to unrealistic expectations.

Most of the system level people we interviewed see the value of using evaluation data to modify programs and support the collection of data for this purpose. They noted, however, that it is sometimes difficult to allow time for modifications to be made before evaluating the program effectiveness. Although leaders at the policy and funding level understand the need for implementation time and are willing to delay major system changes until team based ISP has matured, external forces such as the legislature or a funding source may be less flexible. These leaders can be instrumental in assuring that a single system of accreditation is in place such that lead and partner agencies can focus on a single review or audit process.

Leaders at the policy and funding level play an important role in educating others about the philosophy and goals of a variety of service options such as ISP and frequently use cost and outcome data for this purpose.[10,15] Several of our interviewees had championed the philosophy and goals of team-based ISP to others at their level and to policy makers in general and used research and evaluation results to build legitimacy and respect for this approach.

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Chapter 8: Assessing Implementation and Prioritizing Actions

This chapter addresses the question of how the framework of necessary conditions can be put to practical use to improve the quality of ISP implementation. This chapter introduces a series of assessments that were developed alongside the conceptual framework. The assessments—for team process, organizational support, and policy and funding (system) context—are designed to provide stakeholders with a structured way of examining the extent to which the necessary conditions for ISP are present in their local implementation. The assessments are not designed to provide a rating or ranking of the implementation, or to measure change over time. Rather, they are intended for use in discussions of the strengths of the implementation, as well as to help clarify and prioritize areas for further development. The assessments are included in the concluding sections of this chapter.

The assessments were designed with an eye towards issues of mutual accountability across the various levels of implementation of ISP. Traditionally, we think of people at the service delivery level as accountable for the quality of the services that they provide. When programs fail to deliver desired outcomes, the blame is often laid at the provider level. However, as our research has made abundantly clear, high quality work in ISP cannot succeed where the necessary organizational and system level supports are lacking. But how are people at these levels to be held accountable for providing an acceptable level of support? We believe that assessing the extent to which the necessary conditions are in place at the organizational and system levels provides a means for pushing accountability upward as well as downward. Used in the way that we envision, the assessment of organizational support and the assessment of policy and funding context are tools for this sort of *upward accountability*. In contrast, the team level checklist can be seen as a more traditional sort of tool, of the type that is used for supervision in a more familiar form of *downward accountability*.* The idea is that, rather than being two separate sorts of accountability, a balance of upward and downward accountability actually builds a culture of mutual accountability that encourages focused problem solving over defensive blaming.

Assessment at the team level

The team-level assessment is called the Checklist for Indicators of Practice and Planning (ChIPP). The ChIPP provides a list of indicators for the team level conditions necessary for the implementation of high quality ISP. The indicators are scored as "yes" when specific sorts of team behaviors or products are present during team meetings. If the

* We also envision that the team level assessment could be put to good use to encourage horizontal accountability, for example, when used as part of a process of peer coaching, or by teams as a form of self-assessment.

behaviors or products are not present, "no" is scored. Information on the reliability of an earlier version of the ChIPP can be found in Chapter 2.

Each indicator listed on the ChIPP is linked to one or more of the specific conditions laid out in Chapters 3-7 (these conditions are also listed in the first column of figure 1). Most of the indicators are linked to several conditions, reinforcing the idea that the elements of good practice in Individualized Service/Support Planning are densely interconnected. For example, the earlier chapters provided information about how a strong goal structure contributes not only to effective planning but also allows for higher levels of family voice, creativity, strengths orientation, and team collaborativeness.

The ChIPP is intended to be used either as a self-assessment or as an observational tool for supervision or peer coaching. It is not expected that all indicators would be present at every meeting. It is expected, however, that over a series of meetings a team would demonstrate a repertoire of skills consistent with a spectrum of the listed indicators. Similarly, across teams within a program, it would be expected that the full range of indicators would be seen. Consistent gaps would suggest that the practice model does not provide sufficient guidance to teams in particular areas.

As noted previously, the ChIPP, like the other assessments in this chapter, is not intended to provide an absolute rating or "grade" to teams or meetings. Instead, the ChIPP is based on the idea that when team members have a clear understanding of the conditions for successful ISP teamwork, they can make intentional, well-grounded decisions about when and why to apply the appropriate skills, techniques, and/or processes from the practice model. In making such decisions, team members are developing their metacognitive capacities as described in Chapter 4. Similarly, at the program level, the ChIPP provides a means for structuring discussions about the adequacy of the practice model. Where decisions are made to disregard some of the indicators in the ChIPP, or to substitute locally-derived indicators for indicators on the checklist, these decisions are made intentionally, again encouraging well-grounded thinking about what sorts of skills, techniques, and processes are important in the local context, and how they can be recognized in practice. Teams or programs wishing to use the ChIPP should contact the authors for further supporting documentation.

Assessment of organizational supports

The Assessment of Organizational Supports (AOS) for ISP uses a different assessment strategy than the ChIPP. The AOS assesses the necessary conditions at the organizational level from the perspective of team members looking "upward". Each section of the AOS focuses on one of the conditions listed at the organizational level in Chapters 3-7. These same conditions appear in Figure 1 in the central column. For each condition, the AOS lists a series of features that index the extent to which the condition is in place. Individuals completing the AOS provide two ratings for each feature. The respondent is asked to rate the extent to which the feature is in place, and the level of priority he or she assigns to improvement of this feature.

The AOS was designed to be completed by team members who participate on several teams, and who therefore have a sense of whether or not the features are consistently

in place. It is likely, however, that a given team member may not be able to fill out the entire assessment. It may well be the case that a respondent from a partner agency will not be aware of the level of supervision and support at the lead agency. Programs intending to use the AOS will therefore need to provide some instruction to respondents about which sections to fill out.

Similarly, it will be necessary for local decision makers to provide respondents with other instructions that are specific to the local context and local needs. Decision makers will need to clarify which agency or agencies respondents are to reference as they complete various sections of the assessment. For example, a facilitator in the lead agency may work with peers from many different partner agencies, and these partner agencies may offer different levels of support for their workers as team members. As the assessment is currently written, the facilitator would be asked to respond based on her general sense of the extent to which the required feature is in place across partner agencies. After data is gathered and fed back to programs, discussion on how to improve the implementation might focus on particular partner agencies with whom collaboration is problematic. Local decision makers could, however, ask facilitators to respond to the AOS by focusing on support available from one specific partner agency. Decision makers could also ask facilitators to fill out the portions of the assessment dealing with partner agencies several times, once for each key partner. In another example, team members from partner agencies might be asked to respond to the items on partner agency support with reference only to their own agency, or with reference to their general sense of whether or not the feature is in place across partner agencies that collaborate on ISP teams.

As is the case with the other assessments, the AOS is not intended to provide a rating or grade to agencies. Instead, the purpose of the AOS is to provide data that can help agencies clarify their understanding of the conditions that are necessary for local implementation, the extent to which these conditions are in place, and the priorities for action to improve implementation. Local decision makers may decide that, in their particular context, certain features are not good indices of a given condition, or even that certain conditions are not truly necessary. Discussions of such possibilities can help decision makers further develop their understanding of the goals and strategies for local implementation.

Assessment of the policy and funding context

Like the AOS, the Assessment of the Policy and Funding Context (APFC) for ISP uses an "upward" assessment strategy. Respondents to this system-level assessment might include managers, supervisors, and/or administrators in lead and partner agencies. Each section of this assessment focuses on one of the conditions listed at the system level (also called the policy and funding context) in Chapters 3-7. These same conditions appear in Figure 1 in the right hand column. For each condition, the APFC lists a series of features that index the extent to which the condition is in place. Individuals completing the assessment provide two ratings for each feature. The respondent is asked to rate the extent to which the feature is in place, and the level of priority she or he assigns to improvement of this feature.

The APFC recognizes that the policy and funding context will be different for each ISP program. Local decision makers will thus have to provide instructions to respondents about which levels and/or which parts of the policy and funding context they should think about when filling out the various sections of the assessment. In a manner similar to that described for the AOS, decision makers may also decide to tailor the APFC to reflect local goals and priorities for implementation.

Once again, this assessment is not intended to provide a rating or grade to individuals or groups in the policy and funding context. Data collected via the assessment provides input into decision making for improving local implementation.

Mutual accountability

Taken as a group, the assessments provide a framework for developing mutual accountability within and across the various levels of implementation of ISP. Teams are held accountable for demonstrating practice consistent with high quality ISP. At the same time, lead agencies are accountable for providing a coherent and comprehensive practice model, and for providing sufficient ongoing professional support for facilitators. Similarly, partner agencies are held accountable for supporting their staff in their roles on ISP teams. Finally, managers in the policy and funding context are held accountable for providing a hospitable environment for ISP teams and programs. Ultimately, all of these stakeholders are accountable to the public, and to the children and families who are served through ISP programs.

Individualized Service/Support Planning Teams: Checklist for Indicators of Practice and Planning (ChIPP)

Walker, Koroloff & Schutte[1] identify a series of necessary conditions for high quality implementation of Individualized Service/Support Planning (ISP). Necessary conditions are identified at the team, organization, and system levels (The system level is also called the policy and funding context.) At each level, the necessary conditions are grouped into five themes: practice model, collaboration/partnerships, capacity building/staffing, acquiring services/supports, and accountability.

The ChIPP provides a list of indicators of the extent to which teams demonstrate, during team meetings, that these conditions are present in their work. Information on the reliability of an earlier version of the ChIPP can be found in Walker, et al.[1] The ChIPP is intended to be used either as a self assessment, or as an observational tool for supervision or peer coaching. It is not expected that all indicators will be present at every meeting. It is expected, however, that over a series of meetings a team will demonstrate a repertoire of skills consistent with a spectrum of the listed indicators.

Many of the indicators have both an "a" and a "b" level. The "a" level indicators provide a higher level of confidence that the condition is in place. The "a" level indicator is a sign that teams are intentionally meeting the condition by using a defined technique or structured process. In contrast, the "b" level indicators are a sign that the condition is *possibly* being met in a more informal manner. In some cases, particularly where teams are functioning well, "b" level practice may be sufficient to fully meet a given condition. Using practice at the "b" level, however, should be a conscious choice made by team facilitators, and practice at the "a" level is usually considered more likely to contribute to team effectiveness.

The necessary conditions for high quality implementation of ISP at the team level are listed below. The checklist links each of the indicators to one or more of these conditions as they appear in the outline below. Details on the conditions and rationale for the listed links is provided in Walker, et al.[1]

A. Practice model

i. Team adheres to a practice model that promotes team cohesiveness and high quality planning in a manner consistent with the value base of ISP.
   1. Team adheres to meeting structures, techniques, and procedures that support high quality planning,
   2. Team considers multiple alternatives before making decisions,
   3. Team adheres to procedures, techniques and/or structures that work to counteract power imbalances between and among providers and families,
   4. Team uses structures and techniques that lead all members to feel that their input is valued,
   5. Team builds agreement around plans despite differing priorities and diverging mandates,
   6. Team builds an appreciation of strengths, and
   7. Team planning reflects cultural competence.

B. Collaboration/Partnerships

i. Appropriate people, prepared to make decisions and commitments, attend meetings and participate collaboratively.

C. Capacity building/ Staffing

i. Team members capably perform their roles on the team.

D. Acquiring services/ Supports

i. Team is aware of a wide array of services and supports and their effectiveness.
ii. Team identifies and develops family-specific natural supports.
iii. Team designs and tailor services based on families' expressed needs.

E. Accountability

i. Team maintains documentation for continuous improvement and mutual accountability.

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Individualized Service/Support Planning Teams:
Checklist for Indicators of Process and Planning (ChIPP)

Definitions related to the practice indicators:

Mission: The purpose or long term goal for the team. (e.g. Michael will participate successfully in opportunities and activities that he chooses, and that will prepare him for a successful adulthood.)

Intermediate goals: The major strands of activity that the team undertakes in service of the mission. (e.g. Michael will get a job, and/or take training or classes to prepare him for employment.)

Measures of progress: Concrete indicators, selected by the team, used to measure progress towards each goal. (e.g. Michael is involved in work or educational activities 30 hours each week.)

Strategies: Method selected by the team to achieve an intermediate goal. (e.g. Michael will enroll in the community college program for web design.)

Action steps: Specific tasks to be carried out by team members to implement the strategies. (e.g. Michael and Marlon, his mentor, will complete the application prior to meeting with the community college admissions counselor on Thursday.)

Community experience: Opportunity to circulate in the community (e.g. go to a museum, attend a sporting event)

Community service: A class, course, or opportunity provided to the general community by a community organization (e.g. church youth group, soccer team, YMCA fitness)

Informal support: An unpaid individual undertakes specified activities with the family.

Note: Those interested in using the checklist should contact the authors for expanded definitions of the indicators.

	Indicator and description (Conditions indicated)	
1. Attendance	a. Key team members are present from start time to end of meeting. (A.i.1, B.i.)	Y N
	b. Key team members are present for sufficient portions of the meeting.	Y N
2. Agenda	a. Team generates a written agenda or outline for the meeting that provides an understanding of the overall purpose of the meeting as well as the purpose of the major sections of the meeting. (A.i.1)	Y N
	b. Team members share a strong implicit sense of the major sections of the meeting and the purpose of each section.	Y N
3. Meeting structure	a. Meeting follows an agenda or outline or clear implicit structure such that team members know the purpose of their activities at a given time. (A.i.1)	Y N
4. Team records	a. Team maintains a record of its work that is distributed to all members. (A.i.1)	Y N
5. Mission	a. Team discusses or has produced a mission. (A.i.1, B.i.)	Y N
6. Plan	a. Team creates/maintains a plan that guides its work. (A.i.1, A.i.3, A.i.5, A.i.7, B.i., E.i.)	Y N

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7. Crisis Plan	a. Team has confirmed or is creating a crisis plan. (A.i.1)	Y N
8. Intermediate goals	a. Team plan contains specific intermediate goals. (A.i.1, A.i.3, A.i.5, B.i, E.i.)	Y N
	b. Planning provides evidence of a strong implicit goal structure.	Y N
9. Measures of progress	a. Intermediate goals are associated with concrete measures that can be used to assess progress toward, or achievement of, a goal. (A.i.1, A.i.2, D.i., E.i.)	Y N
	b. Team has a shared definition of a "good enough" outcome for specific activities.	Y N
10. Linkage	a. Tasks and strategies are explicitly linked to intermediate goals that the team has determined *prior* to discussion of tasks/strategies. (A.i.1)	Y N
	b. Strong implicit linkage of tasks to goal structure.	Y N
11. Create options	a. Team considers several different strategies for meeting a need or furthering a goal OR considers and prioritizes several different goals. (A.i.2, A.i.3, A.i.7, D.ii., D.iii.)	Y N
	b. Team considers options for tasks or action steps OR considers options for minor changes to services or supports.	Y N
12. Enhance creativity	a. Team uses structured process or procedure to generate options or choices.	Y N
13. Assign responsibility	a. Team explicitly assigns responsibility for action steps. (A.i.1, B.i., E.i.)	Y N
	b. Strong implicit understanding of who is responsible for action steps.	Y N
14. Monitor activity	a. Team conducts a systematic review of members' progress on assigned action steps.(A.i.1, B.i., E.i.)	Y N
	b. Team members report on activities relevant to the plan.	Y N
15. Evaluate strategies	a. Team assesses goals and strategies using measures of progress, and revises plan if necessary. (A.i.1, D.i.)	Y N
	b. Teams discusses adequacy of goals/activities with reference to outcomes.	Y N
16. Caregiver voice	a. Team uses specific techniques or processes to provide extra opportunities for caregivers to speak and offer opinions, especially during decision making. (A.i.3, A.i.6, A.i.7, D.ii., D.iii.)	Y N
	b. Caregiver speaks, or is invited to speak and/or offer opinions, on many occasions during the meeting, especially during decision making.	Y N
17. Youth voice	a. Team uses specific techniques or processes to provide extra opportunities for youth to speak and offer opinions, especially during decision making. (A.i.3, A.i.6, A.i.7, D.ii., D.iii.)	Y N
	b. Youth speaks, or is invited to speak and/or offer opinions, on many occasions during the meeting, especially during decision making.	Y N
18. Caregiver story	a. Caregiver is invited to speak in an open-ended way about current and past experiences and/or about hopes for the future. (A.i.3, A.i.6, A.i.7, D.ii., D.iii.)	Y N
19. Youth story	a. Youth is invited to speak in an open-ended way about current and past experiences and/or about hopes for the future.	Y N

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	(A.i.3, A.i.6, A.i.7, D.ii., D.iii.)	
20. Caregiver Strengths	a. Team explicitly builds an understanding of how caregiver strengths contribute to the success of team mission or goals. (A.i.6, A.i.7)	Y N
	b. Team acknowledges or lists caregiver strengths.	Y N
21. Youth Strengths	a. Team explicitly builds an understanding of how youth strengths contribute to the success of team mission or goals. (A.i.6, A.i.7)	Y N
	b. Team acknowledges or lists youth strengths.	Y N
22. Inclusive process	a. Team provides multiple opportunities for community team members and natural support people to participate in significant areas of discussion and decision making. (A.i.3, A.i.4, A.i.7, D.ii., D.iii.)	Y N
	b. Team provides some role for community team members and natural support people.	Y N
23. Enhance equity	a. Team demonstrates awareness of how talking turns and quantity of speech is distributed across team members, and uses techniques or processes for enhancing equity in discussion and decision making. (A.i.4, A.i.5, B.i.)	Y N
	b. Talk is well distributed across team members and each team member makes an extended or important contribution.	Y N
24. Acknowledge input	a. Team explicitly recognizes each team member's input to a discussion or decision through verbal reflection or summary or written record. (A.i.4, A.i.5, B.i.)	Y N
	b. Team acknowledges each member's input at various points during the meeting.	Y N
25. Neutral facilitation	a. Facilitator focuses on process advocacy and rarely, if ever, evaluates input or decisions. (A.i.1, A.i.3, A.i.5, A.i.7)	Y N
	b. Facilitator reflection, summary, and process-oriented comments are much more prevalent than evaluative comments.	Y N
26. Collaboration	a. Team members demonstrate consistent willingness to compromise or explore further options when there is disagreement. (A.i.5, B.i.)	Y N
	b. Team members make decisions *after* having solicited information from several members or having discussed several options.	Y N
27. Decision process	a. Team adheres to an explicit process for making decisions. (A.i.1, B.i.)	Y N
	b. Strong implicit sense of process for decision making.	Y N
28. Successes	a. Team draws attention to and creates positive atmosphere around accomplishments or improvements. (A.i.6, B.i.)	Y N
	b. Team draws attention to improvements or accomplishments.	Y N
29. Responsive services	a. Formal services are significantly tailored as per team plan. (D.ii., D.iii.)	Y N
	b. Small changes to services are included in the plan.	Y N

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30. Community experience	a. Team is facilitating access to community experience. (A.i.7, D.ii., D.iii.)	Y N
	b. Team discusses or is exploring access to community experience.	Y N
31. Community-based Service	a. Team is facilitating access to community-based service. (A.i.7, D.ii., D.iii.)	Y N
	b. Team discusses or is exploring access to community-based service.	Y N
32. Tailor Community Support	a. Team is facilitating the tailoring of community supports or services to meet unique needs of child and/or family. (A.i.7, D.ii., D.iii.)	Y N
	b. Team discusses or is exploring the tailoring of community supports or services.	Y N
33. Enhance Natural Support	a. Team is facilitating natural support activities for the child/family. (A.i.7, D.ii., D.iii.)	Y N
	b. Team discusses or is exploring natural support activities for the child/family.	Y N
34. Support Family	a. Planning includes action steps or goals for other family members, not just identified child. (D.ii, D.iii.)	Y N

1 Walker, J.S., Koroloff, N. and Schutte, K. (2003) *Implementing high-quality collaborative individualized service/support planning: Necessary conditions*, Research and Training Center on Family Support and Children's Mental Health.

Assessment of Organizational Supports for Individualized Service/Support Planning

This tool assesses the organizational support for Individualized Service/Support Planning (ISP) from the perspective of team members. It should be completed by team facilitators and other individuals who are on several teams sponsored by this agency (e.g. family advocate, child welfare worker assigned to this agency, teacher in a facility-based classroom).

This assessment is not intended to provide a rating or grade to agencies. Instead, the purpose of the assessment is to provide data that can help agencies clarify their understanding of the conditions that are necessary for local implementation, the extent to which these conditions are in place, and the priorities for action to improve implementation.

Lead agency is the organization which hires, trains and supervises team facilitators.

Partner agencies refer to all other organizations whose staff participate as team members.

For each feature, you are asked to rate two things:

1. The extent to which you believe this feature is in place to support your work. (Use the columns on the left to rate this.)
2. Your rating of whether working to put this feature in place should be a high, medium, or low priority for your agency. (Use the columns on the right to rate this.)

Practice model						
i. The lead agency provides training, supervision, and support for a clearly-defined practice model. This section focuses on the extent to which the lead agency supports a clearly defined practice model for ISP. The practice model specifies the techniques, processes and structures that teams should use to ensure that planning will be effective as well as family centered, individualized, culturally competent, and strengths and community based. For example, the practice model would include specific skills and techniques for: resolving conflicts, increasing the input of families and informal supports into decision making, reinforcing family strengths, deriving goals that address the family's unique needs, etc.						
This feature is currently…			**Feature**	**I rate the priority for improvement of this feature as…**		
In Place	Partially in Place	Not in Place		High	Med	Low
			1. Trainers, supervisors, and facilitators share a common understanding of the *specific techniques, processes and structures* that make up the ISP practice model.			
			2. Supervisors and trainers are experts in the specific techniques, processes and structures that make up the practice model.			
			3. On-going training, coaching, and/or supervision focus *in a structured way* on building the skills required by the practice model.			
			4. Supervisors incorporate first-hand information (e.g. direct observation, audio or video tapes) into supervisory sessions.			
			5. Facilitators receive sufficient training in the practice model, and have the opportunity to observe and/or co-facilitate teams before being asked to lead a team.			
			6. Other team members with special roles (parent advocate, resource developer) receive training and supervision that focuses in a structured way on the specific skills and techniques they need to carry out their roles in the practice model.			
			7. All team members receive orientation to the basic processes and structures in the practice model, and to their roles on the team.			

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Practice model (continued)						
ii. The lead agency demonstrates its commitment to the values of ISP. This section asks about the extent to which the lead agency is committed to the idea that services and supports should be individualized, family centered, and community based. It also asks about the extent to which the lead agency values the idea that interpersonal interactions—including those between and among staff—should be strengths-based, and should reflect respect for diverse cultures.						
This feature is currently…			**Feature**	**I rate the priority for improvement of this feature as…**		
In Place	Partially in Place	Not in Place		High	Med	Low
			8. Managers in the lead agency (e.g. program director, executive director, financial officer) have a solid knowledge of the values of ISP and the ISP practice model.			
			9. Managers of the lead agency "walk the walk"—they work to infuse the values of ISP throughout the agency (e.g. by ensuring staff do not engage in family blaming when families are not present, by engaging the agency in ongoing efforts to increase cultural competence).			
			10. Managers in the lead agency model the ISP values in their interactions with agency staff, and expect that other staff members will do the same (e.g. that supervision will be strengths based, that staff respect each others' cultures).			
			11. Managers in the lead agency make an effort to inform and educate their peers at other agencies about the values of ISP and the basics of the practice model.			

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Practice model (continued)						
iii. Partner agencies support the core values underlying the team-based ISP process. This section asks about the extent to which people from partner agencies act in ways that indicate they are committed to the values of ISP. It also asks about whether partner agencies believe that ISP is an effective way to meet the needs of children and families. Partner agencies are agencies—other than the lead agency--whose staff participate on ISP teams.						
This feature is currently…			**Feature**	**I rate the priority for improvement of this feature as…**		
In Place	Partially in Place	Not in Place		High	Med	Low
			12. ISP team members from partner agencies understand the basic elements of the ISP practice model and believe it is an effective way to support children and families.			
			13. Supervisors and managers in partner agencies understand the basic elements of the ISP practice model and believe it is an effective way to support children and families.			
			14. Partner agencies encourage and support staff members who participate on ISP teams in learning about the ISP practice model (e.g. agencies provide time and pay the costs of ISP training or orientation).			
			15. Supervisors and managers in partner agencies participate in workshops or training to learn about the ISP practice model.			

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Collaboration/partnerships						
i. Lead and partner agencies collaborate around the plan and the team. Because ISP teams work "between" agencies, they face special challenges. Most importantly, the team plan needs to be respected at each agency. If the team plan does not serve as the case plan for each participating agency, teams need assurance at least that various partner agencies will respect the goals and services/supports as decided by the team, and will not develop separate goals and plans that are inconsistent with or undermine the team plan or ISP values. Additionally, to prevent team members from getting overwhelmed, managers at the lead agency need to work with partner agencies to reduce and streamline unnecessary or redundant demands on team members.						
This feature is currently…				**I rate the priority for improvement of this feature as…**		
In Place	Partially in Place	Not in Place	**Feature**	High	Med	Low
			16. A family's ISP team plan serves as a basis for service/support planning at the lead and partner agencies (i.e. other plans which may be maintained at partner agencies are the same as--or at least consistent with--the goals and strategies expressed in the ISP plan).			
			17. Lead and partner agencies work to develop a common format for plans so that the team plan can serve as the case plan for each agency to the greatest extent possible.			
			18. Lead and partner agencies work to reduce inefficient or redundant requirements for paperwork and rules (e.g. developing common consent forms, reducing redundant documentation of needs, etc.)			
			19. Lead and partner agencies work together to develop mechanisms for sharing non-confidential information (e.g. information on all services received by a family, up-to-date information about types of assistance offered by various agencies).			

Collaboration/partnerships (continued)						
ii. Lead agencies support team efforts to get necessary members to attend meetings and participate collaboratively. Lead agencies need to do what they can to ensure that important team members from their own agency and from partner agencies are encouraged to attend team meetings. The lead agency also needs to help people from partner agencies understand that collaboration requires that they will be open-minded about how to satisfy mandates and about what goals the team should pursue.						
This feature is currently…			**Feature**	**I rate the priority for improvement of this feature as…**		
In Place	Partially in Place	Not in Place		High	Med	Low
			20. Supervisors and managers in the lead agency encourage all their own staff who need to be on ISP teams to attend meetings and be active on the team.			
			21. Supervisors and managers in the lead agency support all their own staff who are members of ISP teams by flexing their work time so that they can attend ISP meetings or complete other team tasks during off-hours.			
			22. The lead agency gives its staff authority to make decisions during team meetings about access to services and funding at the lead agency.			
			23. Managers in the lead agency support team efforts to get necessary people from partner agencies to join teams and attend regularly.			
			24. When team members from partner agencies who are needed don't attend meetings, managers from the lead agency will work with the partner agency to find a solution.			
			25. When a team member from a partner agency is not being reasonably open-minded or flexible with mandates, managers from the lead agency will work with the partner agency to find a solution.			

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Collaboration/partnerships (continued)						
iii. Partner agencies support their staff as team members and empower them to make decisions. This section asks about whether or not the partner agencies encourage their workers to attend team meetings and allow them to make meaningful decisions during the meetings. It also asks about whether partner agencies encourage their workers to be open-minded in finding ways to satisfy mandates, determining goals, and seeking solutions.						
This feature is currently…			**Feature**	**I rate the priority for improvement of this feature as…**		
In Place	Partially in Place	Not in Place		High	Med	Low
			26. Partner agencies demonstrate willingness to be flexible about their regular procedures to support the needs of the ISP process.			
			27. Partner agencies demonstrate willingness to be reasonably open-minded and flexible around how to satisfy mandates.			
			28. Team members from partner agencies get support from their agencies for attending meetings and being an active part of the team.			
			29. Partner agencies allow staff to flex their time so they can attend ISP meetings during off hours.			
			30. Partner agencies give their staff authority to make decisions during team meetings about access to services and funding at the partner agency.			
			31. Partner agencies recognize that being a member of an ISP team requires a time commitment beyond attendance at ISP meetings.			

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Capacity building/staffing

i. Lead and partner agencies provide working conditions that enable high quality work and reduce burnout. This section asks about the whether the agency that hires, trains and supervises team facilitators acts in ways that shows it values and rewards the special skills that team facilitators need. This section also asks whether or not the partner agencies and the agencies which hire and pay other team members with special roles (e.g. family advocate, resource developer, care coordinator) also demonstrate that they value the skills that these people bring to teamwork.

This feature is currently…			Feature	I rate the priority for improvement of this feature as…		
In Place	Partially in Place	Not in Place		High	Med	Low
			32. The lead agency has set a reasonable benchmark for facilitators' team workload (number of teams that a facilitator is involved with) and sticks to that benchmark.			
			33. Agencies set and stick to benchmarks for the team workload of other team members with special roles (family advocate, resource developer, care coordinator if not also the facilitator).			
			34. Higher pay and promotion opportunities are available to facilitators as they increase their capacity in the special skills needed to implement the ISP practice model.			
			35. People who act as professional parent partners or parent advocates receive compensation which reflects their value in the ISP process.			
			36. Partner agencies value and reward the skills gained by staff who participate on ISP teams.			

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Acquiring services/supports

i. The lead agency has clear policies and makes timely decisions regarding funding for costs required to meet families' unique needs. This section asks about whether teams are able to quickly get the funding they need to pay for costs required to meet families' unique needs (special equipment, non-traditional, or non-categorical services and supports, etc.) as called for by the ISP plan. Most frequently, but not always, these funds come from a pool of money specifically designated as "flexible funds"; however, your agency may provide access to funding for the special needs of a team plan through other channels.

This feature is currently…			**Feature**	**I rate the priority for improvement of this feature as…**		
In Place	Partially in Place	Not in Place		High	Med	Low
			37. Funds to pay for costs required to meet families' unique needs (special equipment, non-traditional, and/or non-categorical services or supports, etc.) are readily available to teams who require them for the ISP plan.			
			38. The procedure for requesting funds for unique costs is clear and followed by everyone in the agency.			
			39. Within specified limits, facilitators have the authority to immediately approve expenditures for unique costs.			
			40. Team members and lead agency managers share a common understanding regarding which sorts of unique costs are legitimate to fund under and ISP plan.			
			41. Managers in the lead agency are aware of potential community concerns about paying for unusual services or items, and they take steps to buffer facilitators from that reaction.			

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Acquiring services/supports (continued)

ii. The lead agency encourages teams to develop plans based on child/family needs and strengths, rather than service fads or financial pressures. This section asks whether the lead agency helps teams get services and supports that are called for in the ISP plan. It also asks whether the lead agency works to develop new services and supports when teams request them.

This feature is currently…				**I rate the priority for improvement of this feature as…**		
In Place	Partially in Place	Not in Place	**Feature**	High	Med	Low
			42. The lead agency expects that teams will develop ISP plans that are directly related to the family's needs and preferences.			
			43. The lead agency buffers teams from <u>pressures within the lead agency</u> (e.g. service providers whose caseloads are not full, lack of providers for desired service) that might otherwise shape the services called for in the plan.			
			44. The lead agency buffers teams from pressures <u>within the services system</u> (e.g. over- or under-supply of certain services, relative costs of desired services) that might otherwise shape the services called for in the plan.			
			45. Team members are encouraged and given support to locate and/or individualize services and supports when called for by an ISP plan.			
			46. The lead agency works strategically to respond to emerging needs for services and supports that tend to be identified by ISP teams (e.g. mentoring, respite, behavior support, community-based recreation).			

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Acquiring services/supports (continued)

iii. The lead agency demonstrates its commitment to developing culturally competent services and supports. This section asks whether the lead agency acts in ways that show it is committed to developing cultural competence, and to helping teams provide culturally competent services and supports.

This feature is currently…			Feature	I rate the priority for improvement of this feature as…		
In Place	Partially in Place	Not in Place		High	Med	Low
			47. The lead agency has initiated an inclusive process for identifying the service and support needs of diverse families receiving ISP services.			
			48. The lead agency has a specific plan, developed through an inclusive process, for increasing cultural competence in the work of its ISP teams.			
			49. When hiring people who will perform special roles on teams (facilitators, family advocates, care coordinators), the lead agency places an emphasis on finding people who are connected to the community (e.g. have history living or working in the community, have many community ties, represent the diversity and/or speak the languages of the community).			

Acquiring services/supports (continued)						
iv. The lead agency supports teams in effectively including community and natural supports. This section asks about whether or not the lead agency supports teams in attracting and maintaining community and natural supports.						
This feature is currently…				**I rate the priority for improvement of this feature as…**		
In Place	Partially in Place	Not in Place	**Feature**	High	Med	Low
			50. The lead agency encourages team members with special roles (resource developers, care coordinators, family advocates) to increase their knowledge of diverse resources within the community, and to apply this knowledge in the ISP process.			
			51. The lead agency has dedicated resources to developing new community supports or adapting existing ones.			
			52. Supervisors are knowledgeable about specific strategies for increasing the participation of community and natural supports in the ISP process.			

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Acquiring services/supports (continued)

v. The lead agency demonstrates its commitment to developing an array of effective providers. This section asks whether the lead agency acts in ways that show it is committed to ensuring that the services and supports available for ISP teams are of the highest available quality. Effective providers are those who adhere to evidence-based approaches, who conform to best practices, and/or who demonstrate effectiveness through other means. Effective providers can provide formal (psychotherapy, substance abuse treatment), non-traditional (tundra walking), or community services (mentoring, recreation, behavior support).

This feature is currently…			Feature	I rate the priority for improvement of this feature as…		
In Place	Partially in Place	Not in Place		High	Med	Low
			53. The lead agency has knowledge about effectiveness considerations across a range of services and supports.			
			54. The lead agency obtains accurate information about the effectiveness of available services and supports, and makes this information available to its staff and to teams.			
			55. If the team or family feels that a provider is not working effectively with the family, the lead agency supports the team in finding another provider.			
			56. The lead agency actively encourages local providers to increase their effectiveness (e.g. by adopting best practices or evidence-based approaches).			

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Accountability						
i. The lead agency monitors adherence to the practice model, implementation of plans, and cost and effectiveness. This section asks whether the lead agency collects information to make sure that teams are using the ISP practice model, and to document how children and families are doing.						
This feature is currently…			**Feature**	**I rate the priority for improvement of this feature as…**		
In Place	Partially in Place	Not in Place		High	Med	Low
			57. The lead agency performs quality management studies or program evaluation to see if teams are successfully implementing the ISP values and practice model.			
			58. The lead agency ensures that supervision for facilitators incorporates data on the extent to which the facilitators' teams are adhering to the ISP values and practice model.			
			59. The lead agency has a mechanism for monitoring whether supervision focuses in a structured way on building skills required by the ISP practice model.			
			60. The degree to which ISP plans are implemented is considered an important outcome by the lead agency.			
			61. The lead agency keeps accurate records of the costs associated with teams' plans and the ISP program.			
			62. The lead agency monitors data on the outcomes associated with ISP teams and uses this data in programmatic decisions.			
			63. In addition to outcomes related to child functioning, the lead agency values outcomes associated with the family (e.g. family satisfaction, caregiver burden).			

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Assessment of the Policy and Funding Context for Individualized Service/Support Planning

(Sometimes referred to as the "system context")

The purpose of this checklist is to provide a structured way to assess the policy and funding context that surrounds Individualized Service/Support Planning teams (ISP teams) and the lead agency that houses these teams. This assessment is to be completed by individuals responsible for managing the ISP program in your agency. This might include individuals who supervise team facilitators, as well as program managers and administrators of the agency or agencies that are primarily responsible for implementing ISP.

This assessment is not intended to provide a rating or grade to people or agencies in the policy and funding context. Instead, the purpose of the assessment is to provide data that can help stakeholders clarify their understanding of the conditions that are necessary for local implementation, the extent to which these conditions are in place, and the priorities for action to improve implementation.

The ability to produce good ISP services is affected by the decisions and actions of higher-level individuals from outside the lead organization. The *policy and funding context* is the term we use to refer to this larger political and economic context that surrounds the lead agency and the teams. It includes those individual leaders and groups that:

1. Make decisions about funding for ISP teams, ISP training, or administrative costs;
2. Audit, certify, accredit or review the ISP program or related parts of the lead organization (e.g. business office);
3. Make laws, rules or set procedures that affect the functioning of the teams or the lead organization (e.g. how long services and supports will continue, how flexible dollars can be spent); or
4. Prepare contract language that affects the way that ISP teams function or are supported.

The policy and funding context will be different for each organization that hosts ISP teams. It may include all or some of the following: inter-organizational committees at state, regional or community levels; leaders at state or county departments of mental health, child welfare, education and juvenile justice; and accounting or billing offices or others with the power to control funds or team activities.

Please use the space below to write down the major groups or individuals you think comprise your policy and funding context.

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NOTE:
IF YOU FEEL that an item is not applicable to your situation, or that you do not have enough information or knowledge to respond to an item, feel free to leave it blank.

Practice model						
i. Leaders in the policy and funding context actively support the ISP practice model. This section focuses on the extent to which leaders in the policy and funding context make rules and allocations of resources that support the essential elements of ISP. By "practice model," we mean a team process that is driven by the needs of the family, uniquely tailored to meet these needs, and grounded in community and natural supports and services.						
To what extent is this feature present?			**Feature**	**I rate the priority for improvement of this feature as…**		
A lot	Some	Very little		High	Med	Low
			1. There are some influential leaders in the policy and funding environment who actively advocate for the needs of ISP teams. (In some sites these leaders are called "ISP champions.")			
			2. Leaders from the policy and funding context understand the basic components of the ISP practice model.			
			3. When policies or agreements that support ISP are in place but are not actually being implemented, leaders in the policy and funding context will work actively for implementation.			
			4. When leaders in the policy and funding context make decisions, they are able to foresee how their choices will have direct and indirect impacts on ISP teams' ability to function.			
			5. When leaders in the policy and funding context make decisions, they choose options which are supportive of the needs of ISP teams.			
			6. Leaders in the policy and funding context make an effort to educate their peers about the components and values of ISP.			

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Collaboration/partnerships

i. The policy and funding context encourages interagency cooperation around the team and the plan. To encourage partner agencies to cooperate with the team-based ISP process, there must be active support and/or pressure for them to work together. This requires various incentives, as well as flexibility in both the funding mechanisms and the way policies are written.

To what extent is this feature present?			**Feature**	**I rate the priority for improvement of this feature as…**		
A lot	Some	Very little		High	Med	Low
			7. The policy and funding context encourages agencies to collaborate to deliver ISP more effectively. (For example, by encouraging mechanisms for sharing information about services and assistance offered at different agencies, by encouraging co-training or co-funding of staff positions, or by encouraging mechanisms to share client information in ways that do not violate confidentiality).			
			8. Policies and funding guidelines are written in ways that support team members' attendance at team meetings. (For example, allowing team members flexible hours to attend meetings, reimbursing attendance as a legitimate service cost, or allowing several team members from the same agency to attend a meeting).			
			9. Policies and funding guidelines are written in ways that support team members' carrying out tasks assigned by the team. (For example, reimbursing time spent on tasks, or writing up team documentation).			
			10. Leaders from the policy and funding context work to ensure that ISP teams aren't required to do redundant work to satisfy the requirements of various partner agencies. (For example, by consolidating requirements for documenting plans, or by supporting streamlining of consent process).			

Collaboration/partnerships (Continued)

ii. Leaders in the policy and funding context play a problem-solving role across service boundaries. In order to identify and solve mutual problems, there needs to be a recognized way—at the state, county, or regional level—to address policy issues that span agencies and that affect the ability of teams to work effectively. This function can be performed by an individual or key individuals acting mostly informally, or it can be performed by an individual or group that is formally charged with this responsibility. Regardless, the individual or group must have sufficient decision-making authority to be effective in resolving problems.

To what extent is this feature present?			Feature	I rate the priority for improvement of this feature as…		
A lot	Some	Very little		High	Med	Low
			11. There is a person or group with sufficient decision-making authority who acts to resolve problems that are encountered by ISP teams or programs and that arise from insufficient inter-agency collaboration. (For example: problems about who will pay for what, problems about access and different eligibility criteria, problems stemming from conflicting rules).			
			12. Individuals involved in ISP teams and/or programs feel comfortable bringing their complaints and concerns to this problem-solving individual or group.			
			13. When this individual or group has made a decision, follow-through is monitored to ensure that the decision is implemented.			

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Capacity building/staffing						
i. The policy and funding context supports development of the special skills needed for key roles on ISP teams. The skills needed by people in key roles on ISP teams (facilitator, parent advocate, resource developer, care coordinator) are in many ways different from the skills needed for service delivery in traditional models. Policies and contracts must reflect an understanding of the value of these roles and their importance to the effective functioning of ISP teams.						
To what extent is this feature present?			**Feature**	**I rate the priority for improvement of this feature as…**		
A lot	Some	Very little		High	Med	Low
			14. The policy and funding context reflects an understanding of the need for hiring people to fill the special roles on ISP teams. (For example, facilitator, parent advocate, community resource developer).			
			15. The policy and funding context encourages agencies that hire people for these special roles to provide compensation that reflects their value to ISP teams.			
			16. Leaders in the policy and funding context support reasonable team workloads for people who perform these special roles.			

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Acquiring services/supports						
i. The policy and funding context grants autonomy and incentives to develop effective services and supports consistent with the ISP practice model. This section asks whether the policy and funding context provides incentives or erects barriers affecting the agencies' ability to respond to the needs that emerge from the individualized planning process. It also asks about the extent to which agencies are supported in developing new or modified services and supports. It also asks whether ISP teams and programs are supported in their efforts to ensure that the services and supports acquired by ISP teams are of the highest possible quality (i.e. the providers conform to evidence-based approaches, adhere to best practices and/or support the value base of ISP).						
To what extent is this feature present?			**Feature**	**I rate the priority for improvement of this feature as…**		
A lot	Some	Very little		High	Med	Low
			17. Incentives in the policy and funding context clearly encourage community-based placements over other placements (residential care, detention, hospital) whenever possible.			
			18. When ISP teams or programs are able to save money by avoiding out-of-community placements, the resources saved are returned to the community to support further development of needed services and supports.			
			19. The policy and funding context provides incentives that encourage the development of services and supports consistent with the ISP practice model.			
			20. Policies and contracts allow flexibility in (sub)contracting so that ISP teams and programs can seek out the most effective providers.			
			21. Policies and contracts do not provide incentives to over-purchase certain kinds of "standard" services (e.g. psychotherapy, psychiatry) and/or under-purchase other kinds of services and supports (e.g. respite, behavioral support, mentoring, sweat ceremonies).			
			22. Contracts for funding contain language that require elements of ISP (e.g. family involvement, natural supports).			
			23. Policies and contracts recognize the costs associated with training providers in the ISP values and practice model.			

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Acquiring services/supports (Continued)

ii. The policy and funding context supports fiscal policies that allow the flexibility needed by ISP teams. ISP teams thrive in a funding context that supports flexible fiscal policies such as blended funding and flexible funds. ISP teams need to have access to funds to pay for the costs required to meet families' unique needs as called for in the plan (e.g. for special events or equipment, or for non-traditional or non-categorical services or supports). The policy and funding context must recognize these as legitimate costs and must support teams in accessing funds to pay the costs in a timely manner.

To what extent is this feature present?			**Feature**	**I rate the priority for improvement of this feature as…**		
A lot	Some	Very little		High	Med	Low
			24. Leaders in the policy and funding context identify and encourage the use of funding streams that can be blended.			
			25. Children who are not Medicaid eligible have access to ISP, flexible funds and most other services.			
			26. The policy and funding context supports paying for costs to meet unique needs by encouraging blended funding or other mechanisms.			
			27. Leaders in the policy and funding context understand that costs to meet unique needs are legitimate expenditures.			
			28. Leaders in the policy and funding context help to educate other stakeholders (politicians, the public) about why ISP funds are expended for items, services, and/or supports that are non-traditional, unique, or "different."			

Acquiring services/supports (Continued)						
iii. The policy and funding context actively supports family and youth involvement in decision making. Inclusion of family voice at all levels is a key principle of the ISP philosophy and monitoring this inclusion within the policy and funding context is important. Inclusion of family members on policy and funding decision-making bodies encourages greater attention to family and youth input at the organizational and team levels.						
To what extent is this feature present?			**Feature**	**I rate the priority for improvement of this feature as…**		
A lot	Some	Very little		High	Med	Low
			29. Policy and funding arrangements recognize the costs of partnering with families and youth in the ISP process (e.g. reimbursing travel or child care costs).			
			30. Family members are included on major policy-making bodies or groups involved in making fiscal decisions that impact ISP teams.			
			31. Policy and funding arrangements recognize the costs associated with including family members and youth on policy-making bodies (e.g. stipends, reimbursement for travel and child care).			
			32. Agencies are recognized and rewarded for doing an outstanding job of including family members and youth on policy-making bodies and on teams.			
			33. Policies and funding arrangements recognize that family members and youth will need training and orientation in order to participate most effectively in policy and funding decision making.			
			34. The policy and funding context supports the inclusion of a variety of representative youth and family members across different opportunities to participate in decision making (e.g. not always the same people, not just a single “token” person, people with a diversity of backgrounds and opinions).			

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Accountability

i. Documentation requirements meet the needs of policy makers, funders, and other stakeholders. Leaders in the policy and funding context will need information on aggregated cost and outcome data so that they can determine whether team-based ISP is cost and outcome neutral (at a minimum) as compared to alternate arrangements. In order to reflect the ISP practice model, which may differ substantially from the goals of other service delivery arrangements, different strategies and instruments may be needed for measuring outcomes. For example, greater reliance on strengths-based instruments, measures of family satisfaction and assessment of caregiver strain are concepts important to team-based ISP. Teams, agencies, and providers should also have access to data that will help them deliver ISP more effectively.

To what extent is this feature present?			Feature	I rate the priority for improvement of this feature as…		
A lot	Some	Very little		High	Med	Low
			35. Policies and funding arrangements require that ISP programs provide evidence that they are adhering to a practice model for ISP.			
			36. The documentation for ISP programs required by the policy and funding context provides sufficient data to evaluate the costs and the effectiveness of ISP.			
			37. Measures of family satisfaction, reduction in caregiver strain, and other family-oriented outcomes are accepted as legitimate indicators of the effectiveness of ISP.			
			38. Leaders in the policy and funding context use data to diagnose challenges and barriers to the effective functioning of ISP teams and programs.			
			39. Leaders in the policy and funding context use data to educate peers and build support and build recognition for successes of ISP (e.g. among members of the state legislature or the public).			
			40. Documentation required by the funding and policy context is realistic and not burdensome for teams or lead organization.			
			41. Policy and funding arrangements recognize the costs associated with collection of data on costs and outcomes.			
			42. Documentation required by the policy and funding context is coordinated with documentation maintained for organizational and team needs.			
			43. Policies and funding arrangements support sharing cost and outcome data with lead and partner agencies, and with providers.			
			44. Leaders in the policy and funding context communicate realistic expectations about the costs of ISP programs, what sorts of outcomes can be expected from ISP programs, and how long it will take to achieve results.			

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Figure 2: A Model of ISP Team Effectiveness

ISP Inputs

Team member background, knowledge, and skills

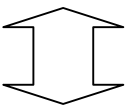
Organization and system support

ISP Practices

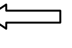
Specific techniques and procedures for making decisions, defining goals, ensuring family centeredness, building on strengths, etc.

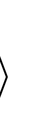
ISP Team Processes

Planning. The planning process prioritizes family/youth perspective and includes attention to
- Defining team mission* and goals* with associated strategies and performance criteria.*
- Exchanging information,* broadening perspectives,* and generating multiple options before making decisions.*
- Continually evaluating* and revising* goals and strategies.



Building cohesiveness. Team members build shared perceptions that
- Team members hold goals* and values* in common, including the values associated with ISP (cooperativeness).
- The team can be effective* and ISP is an effective intervention (efficacy).
- The team follows fair procedures during discussion and decision making* (equity).
- Team members are respected, even when they disagree or make mistakes* (psychological safety).





ISP Outcomes

Team achieves appropriately ambitious goals in a manner consistent with the ISP value base.

Increased coordination between services/supports and needs

Supportive and adaptive relationships

Increased family empowerment and quality of life

*These attributes of process have been linked to team effectiveness in studies across a variety of contexts.

Role Description

JOB TITLE: Clinician

DEPARTMENT: Connections Wraparound

JOB CATEGORY and JOB TYPE:

- ☒ **Arranger**
  - ☐ **Resource**
  - ☒ **Coordination and Oversight**
- ☐ **Intervener**
  - ☐ **Direct Peer Care**
  - ☐ **Direct Child Care**
  - ☐ **Direct Therapeutic Care**
  - ☐ **Direct Instruction**

REPORTING RELATIONSHIP:

■ **Lead** ☐ **Supervisor** ☐ **Manager** ☐ **Assistant Director** ☐ **Director**

PURPOSE OF THE POSITION:

The role of the Arranger Clinician is to provide clinical coordination and oversight, consultation, evaluation and direct mental health/case management services (as required) to youth, young adults and their families and to assure timely and accurate documentation of the services provided through a multi-disciplinary and inter/intra-agency team. This role will be achieved in a manner that is behavioral oriented with a strength-based, family-focused and needs-driven philosophy.

MINIMUM QUALIFICATIONS:

- Masters in Social Work or a related field; Licensed or registered LPHA; completed required BBSE hours
- Experience not required, but preferred
- Must have skills necessary to engage and work with others from diverse backgrounds
- Maintain a non-judgmental attitude toward families
- Maintain required licenses and certifications to perform role

ESSENTIAL FUNCTIONS:

1. **Universal Engagement Skills: The competent Hathaway-Sycamores employee who primarily functions as an arranger/organizer of services and supports will consistently demonstrate the capacity to:**

   - Meet, greet and make youth/young adult and family feel welcome
   - Explain and clarify their role and the role of services
   - Assess immediate risk for safety and coordinate resources for stabilizing that risk
   - Arrange for the collection of relevant information regarding the family's story, current situation, and family strengths and needs
   - Coordinate team membership for planning team
   - Clarify and communicate initial conditions that brought referrals to the agency for help
   - Complete regulatory documents and outcome measures in a timely manner
   - Reach agreement with youth/young adult and family about privacy needs

   Specific Engagement Skills: The skilled Clinician should consistently demonstrate the capacity to:

   - Organize, individualize and apply the use of appropriate assessment tools for each presenting situation

2. **Universal Planning Skills: The competent Hathaway-Sycamores employee who primarily functions as an organizer/arranger of services and supports will consistently demonstrate the ability to:**

   - Organize team members for a planning meeting
   - Engage team members in developing an overall plan of care that includes a team mission statement, addresses initial conditions that brought the youth/young adult /family for help, builds on strengths, addresses needs, documents safety contingencies, details actions and specifies an evaluation process
   - Guide the team members towards open, strengths based, family friendly problem solving
   - Coordinate and maintain necessary paperwork
   - Locate, engage and coordinate services and resources across Hathaway-Sycamores, system, community and family resources

   Specific Planning Skills: The skilled Clinician should consistently demonstrate the capacity to:

   - Guide team to implement the interventions of the plan and update as necessary

- Monitor cases to ensure continued eligibility

3. **Universal Implementation Skills: The competent Hathaway-Sycamores employee who primarily functions as an arranger/organizer of services and supports will consistently demonstrate the capacity to:**

   - Facilitate communication among all team members in planning meetings regarding the follow through, timeliness and outcomes of planned interventions
   - Coordinate and allocate resources needed to implement the interventions outlined in the plan of care
   - Coordinate additional services (i.e. health, medication, psychological testing) and provide linkages / referral to these services as identified in IPC
   - Involve team members in decisions to make changes as needed
   - Maintain a healing and helpful relationship with youth, young adult and family

   Specific Implementation Skills: The skilled Clinician should consistently demonstrate the capacity to:

   - Guide team to implement the interventions of the plan and update as necessary
   - Monitor cases to ensure continued eligibility

4. **Universal Transition Skills: The competent Hathaway-Sycamores employee who primarily functions as an arranger/organizer of services and supports will consistently demonstrate the capacity to:**

   - Empower team members to assess the appropriateness of a shift into the transition phase
   - Analyze progress toward the meeting of service goals
   - Review existing crisis response strategies
   - Empower family members to revisit and revise safety plan as needed
   - Prepare and distribute a written transition plan that communicates schedules for ending formal services and follow-up or community resources available
   - Prepare all necessary reports for referring and participating agencies related to the close of service

   Specific Transition Skills: The skilled Clinician should consistently demonstrate the capacity to:

   - Assist specialists to end with families in a healthy manner

TEAM:

- Exercise tact and sensitivity in performance of job duties

- Proactively work to ensure that all information is appropriately communicated to others both orally and through maintenance of agency logs and records
- Treat all staff with respect, including arriving punctually for all shifts and scheduled meetings; exhibit flexibility in scheduling; follow through on all assignments; communicate both honestly and positively; does not gossip or denigrate
- Develop relationships of trust and respect with all staff members with whom he/she interacts
- Work cooperatively with all staff, including those not involved in program delivery
- Provide and accept communication and feedback to strengthen overall programs and activities
- Seek assistance and advice when appropriate
- Complete all required reports and documentation in a timely manner; ensure integrity of documentation
- Actively seek to solve problems

COMMITMENT TO MISSION, VALUES, AND PHILOSOPHY:

- Understand and demonstrate commitment to agency mission, values, and philosophy in performing skills specific to role
- Maintain all ethical and legal requirements of the Agency
- Assume responsibility for meeting and maintaining all licensing, JCAHO or agency requirements for personal health, training or other certifications
- Know, comply, and maintain all licensing standards, audit requirements and JCAHO standards
- Know and consistently implement agency safety and health procedures
- Know and follow agency policies and procedures in carrying out all job duties
- Represent the Agency professionally and appropriately with all constituencies and in the community
- Perform all other duties as assigned

I have read the above role description, have had the opportunity to ask questions and understand the nature of my role and its importance in meeting the agency's goals and objectives. I understand that the specific functions of this role may change from time to time to meet the evolving needs of the agency.

____________________________________ _________________________

Employee Name Print/Signature Date

Core Skills for Pre-Service

Foundational Skills	Definitional Skills	Critical Skills
$ Meet, greet & make youth/young adult & family feel welcome $ Build mutual respect, confidence & trust $ Reach agreement $ Redirect problem statements that assign blame $ Listen to the family & child's perspective, concerns & interests $ Share information with families & colleagues $ Generate & communicate enthusiasm about next steps	$ Explain & clarify role & role of services $ Assess immediate safety risk $ Solicit & review family/youth strengths, needs & history $ Clarify & communicate initial conditions that brought referrals to the agency for help $ Organize team members for a planning meeting $ Communicate & translate information with staff, parents & youth/young adult in a way everyone can hear $ Involve team members in decisions to make needed changes $ Maintain a healing & helpful relationship with youth, young adult & family $ Utilize parent/family expertise in problem solving around specific needs & patterns $ Review existing crisis response strategies $ Empower families to revisit & revise safety plan as needed $ Inspire confidence in families about their strengths & ability to move ahead	$ Guide team members towards open, strength based family friendly problem solving $ Develop thorough understanding of youth/young adult U& family history including past interventions $ Encourage youth/young adult & family empowerment & ownership concentrating on natural support & independence

Job Title: School Sector Coordinator (Four Positions Total) **Job Code:**
Job Classification: **Department/Division:**

Job Summary: Under the supervision of the Wraparound/SOC Supervisor and the Clinical Director of Child and Adolescent Services will identify community members to participate regularly in a Resource Review Panel in their sector of the county. Will be a liaison between schools, social service agencies, the Family Council and the Resource Review Panel. Will chair the Resource Review Panel in their sector and ensure accurate record keeping of all Panel meetings. The School Sector Coordinator may have limited travel throughout the county (especially between each school district in their sector), with periodic out of county.

Because this is a grant-funded position, the duties and or requirements of the position, may be modified as required by the funding source.

Work Hours: 37.5 hours per week (1.0 FTE); Occasional night and/or weekend work.

Essential Functions:
-Identify community partners to participate regularly in Resource Review Panel.
-Convene and Chair Resource Review Panels in their sectors.
-Coordinate and ensure accountability of Child and Family Teams in each school sector.
-Be a Liaison between Schools, social service agencies, the Family Council, and the Administration Team.
-Provide consultation to Child/Family teams in their sector and on occasion participate as a member of a Child and Family Team as needed.
-Oversee the structure and activities of their sector, and carry out other administrative duties of the project.
-Actively participates in quality improvement processes as applicable to the position.
-Understands and supports the mission, vision and values of the Mental Health Board.

Organizational Relationships:
Supervised By: Wraparound Supervisor and the Clinical Director of Child and Adolescent Services

Supervises: NA

Internal: All departmental personnel that are employed by the MCMHB

External: Clients, general public, regulatory and licensing agencies, county, state and federal representatives, and all organizations that interact with MCMHB.

Professional Background and Experience: At minimum the following is required:
Education: Bachelors degree in a related field

Experience: Parent and/or caretaker of a child or adolescent with a serious emotional disturbance and/or
co-occurring substance use disorder and living experiences in navigating the mental health system; 3 - 5 years living experiences in navigating the mental health system preferred; Related employment experience preferred.

Prior experience preferred: Two to four years recent experience working with parent support and advocacy groups. Experience in Wraparound training and advocacy for youth.

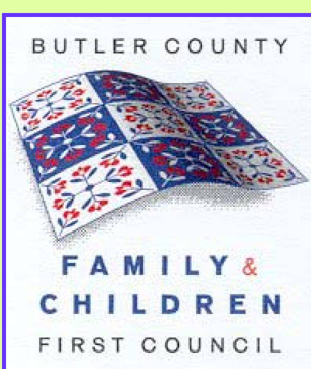
Skills & Capabilities:

-Ability to communication clearly, both orally and in writing and knowledge and experience of Wraparound philosophy, school advocacy for serious emotionally disturbed youth.
-Knowledge specifically of the school districts in their sector, federal disabilities laws, parent training, and advocacy.
-Strong commitment to child and family centered services and excellent communication skills.
-Possess valid driver's license.
-Provides certificate of automobile insurance per policy.

Physical Abilities:

-Ability to read, write and communicate in English.
-Bilingual Spanish preferred.
-Ability to lift and/or move at least 10 pounds using proper body mechanics.
-Visual acuity to read a computer screen and other documents.
-Ability to utilize the telephone and respond to callers.

Other duties as assigned



Butler County Community Wraparound 2006 Year End Report

A year in Review:

On July 1, 2006, the Butler County Family & Children First Council officially changed the mechanism of providing service coordination from Cluster to Community Wraparound. Significant efforts were applied to go from ground zero to fully operational. Utilizing the *Vroon Vandenburg* curriculum, FCFC staff, as well as community facilitators, were trained to provide facilitation for family teams utilizing the ten core values of

- **Family Voice and Choice**
- **Team Based**
- **Natural Supports**
- **Collaboration**
- **Community Based**
- **Culturally Competent**
- **Individualized**
- **Strength Based**
- **Persistence**
- **Outcome Based**

Community Wraparound provides an opportunity for family teams to become mobilized and empowered while implementing individualized plans to help children with behavioral-health needs. Facilitators are responsible for guiding families through the eight core steps of the Wraparound process:

1. **Engagement**
2. **Immediate Crisis Stabilization**
3. **Strengths, Needs, and Culture Discovery**
4. **Child and Family Team Formation**
5. **Developing the Wraparound Plan**
6. **Crisis Plan**
7. **Tracking and Adapting the Plan**
8. **Transition out of Wraparound**

Throughout the process, individualized outcomes and target goals are also measured and monitored to assess the Wraparound plans and interventions utilized by families.

Training Team:

Sharon Custer, MSW, LISW
Family & Children First Council

Suzanne Prescott
Educational Service Center

Dorothy McIntosh Shuemake
Parent Representative

Deb Miller, M.Ed., LPC
St. Joseph's Orphanage

Debi Robertson, M.Ed.
Board of Mental Retardation
& Developmental Disabilities

Heather Wells
Educational Service Center

Sandy Wolf
Children Services Board

Our gratitude is also extended to the following members who were integral in the implementation of Wraparound, but who are no longer able to serve on the team: Shannon Gantzer, formally a member of Help Me Grow; Jaylene Schaefer, formally a member of Help Me Grow; and Robin Solazzo, Educational Service Center

Trainings and Presentations:

- **16 *Wraparound 101: This Isn't Cluster Anymore* trainings were conducted for 349 participants**
- **5 presentations on Wraparound were conducted for 68 participants**
- **4 *Wraparound Facilitator Trainings* were conducted for 43 participants**

The following trained facilitators served families through Community Wraparound in FY 2006

Judy Campbell, Fairfield City Schools
Christina Curcio, Community Member
Marva Duvall, St. Aloysius
Kathy Flatt, LifeSpan
Jenny Fleming, Help Me Grow
Melissa Gray, Community Member
Kelly Girts, MRDD
Jamie Green, Community Member
Tracy Mackey, Community Member
Lisa Nazworth, Community Member
Rosina Philpot, Butler County Success
Sandra Prunier, Butler County Success
Debi Robertson, MRDD
Jaylene Schaefer, Community Member
Linda Woodward, Fairfield City Schools

Families Served:

As of June 30, 2006:	
Number of referrals received	112
Number of families who enrolled in the Wraparound process	76
Number of families who declined Wraparound services	28
Number of families on the waiting list for Wraparound services	8
Number of cases closed after receiving services	16
Number of cases active with Wraparound	60
Number of families who received consultation services	20
Number of families who utilized a Parent Advocate	11

Presenting Risk Checklist

The Presenting Risk Checklist is completed by the referral source to assess current concerns and allows FCFC to properly match services and facilitators to each individual family's needs. The checklist ranges in score from 0 to 56.

Average score for referrals	n=100	15.6
n= 45	Average score for females	16.5
n= 55	Average score for males	14.9

Top Presenting Risks

Impulsive Behaviors (77)

Limited Ability to Control Anger (74)

Emotional or Educational Disability (66)

Referral Sources for all Referrals Received

Name	No.	%**
Board of MRDD	3	2.5
Butler County Success	1	< 1%
CARE Case Mgt	29	26%
Children Services Boards	3	2.5%
Comprehensive Counseling	3	2.5%
Fairfield City Schools	10	9%
Help Me Grow	3	2.5%
HOPE/Rescue	1	< 1%
Juvenile Justice Center	17	15%
Lakota Local Schools	2	2%

Name	No.	%
LifeSpan	1	< 1%
Middletown City Schools	2	2%
Parent (Self Referral)	26	23%
Pressley Ridge	3	2.5%
SELF	1	< 1%
St. Aloysius/KEYS	3	2.5%
Talawanda City Schools	1	< 1%
Talbert House Northstar	1	< 1%
WINGS	2	2%

** Sum does not add to 100% due to rounding of figures

Demographics of Families Served:

Age

	N	%
4 and under	2	2 %
5-8	15	13 %
9-11	19	17 %
12-14	31	28 %
15-17	45	40%
18 +	N/A	N/A

School District

	N	%
Edgewood City	3	2.5%
Fairfield City	22	20 %
Hamilton City	40	36 %
Lakota Local	12	11%
Madison Local	6	5%
Middletown City	19	17 %
Monroe Local	1	1 %
New Miami Local	3	2.5%
Ross Local	3	2.5%
Talawanda City	3	2.5%

Gender

	N	%
Male	63	56 %
Female	49	44 %

Race

	N	%
Caucasian	82	74 %
African-American	14	12 %
Hispanic	1	1 %
Biracial	6	5%
Asian	1	1 %
Other	N/A	N/A
Unknown	8	7 %

TANF Eligibility

	N	%
Yes	74	66 %
No	33	29.5 %
Undetermined	5	4.5 %

Outcomes Status:

PROBLEM SEVERITY:
Problem Severity scale is the sum of the first 20 items on the Ohio Scales Youth, Parent and Agency Worker forms. The scale ranges from 0-100, with higher scores indicating more problems or increased severity of problems.

Youth Rating

	N	Mean
Initial Report	24	25.83
Ongoing	18	27.17
Termination	N/A	N/A

Parent Rating

	N	Mean
Initial Report	37	39.25
Ongoing	29	33.14
Termination	2	19

Agency Rating

	N	Mean
Initial Report	33	31.94
Ongoing	29	30.83
Termination	2	15

FUNCTIONING:
The Functioning scale is the sum of the last 20 items on the Ohio Scales Parent, Youth, and Agency Worker forms. The scales ranges from 0-100, with higher scores indicative of better functioning.

Youth Rating

	N	Mean
Initial Report	20	52.10
Ongoing	19	55.32
Termination	N/A	N/A

Parent Rating

	N	Mean
Initial Report	37	31.95
Ongoing	29	39.31
Termination	2	47.50

Agency Rating

	N	Mean
Initial Report	33	32.12
Ongoing	28	38.39
Termination	2	51

Outcomes Status:

HOPEFULNESS:
The Hopefulness scale is the sum of the first four items on the second page of the Ohio Scales Youth and Parent forms. Youth rate their own well-being/optimism; parents, rate the degree to which they are hopeful about their ability to parent. The scale ranges from 4-24, with higher scores indicating <u>less</u> hopefulness.

Youth Rating

	N	Mean
Initial Report	17	10.90
Ongoing	19	11.47
Termination	N/A	N/A

Parent Rating

	N	Mean
Initial Report	34	14.95
Ongoing	29	13.66
Termination	2	11.5

SATISFACTION:
The Satisfaction scale is the sum of the second four items on the second page of the Ohio Scales Youth and Parent forms and measures overall satisfaction with behavioral health services. The scale ranges from 4-24, with higher scores indicating <u>less</u> satisfaction.

Youth Rating

	N	Mean
Initial Report	18	10.33
Ongoing	19	9.53
Termination	N/A	N/A

Parent Rating

	N	Mean
Initial Report	35	8.77
Ongoing	39	7.22
Termination	2	4.0

Community Resource Team:

The Community Resource Team (CRT) was established to act as the cross systems decision-making body for multi-system children recommended for funding from the Pooled Funds and FAST$. The CRT is comprised of system representatives from all of the public, child-serving systems as well as a parent representative. Individual family teams requesting funding as part of the Wraparound plan presented to the CRT for plan approval and recommendations. The CRT also is charged with monitoring the planning process to ensure fidelity to the Wraparound model. Although many of the plans did not require any funding, those presented to the CRT were for the following services/needs:

FAST $

Category	Amount
Bed	$ 167.97
In-home services/supports	$ 15,192.00
Respite	$ 640.00
Safety Devices/Alarms	$ 312.20
Service Coordination/Facilitation	$ 5,154.37
Social/Recreational	$ 8,311.54
Utility Assistance	$ 304.59
Administrative Fee	$ 7,333.00
Grand Total:	$ 34,415.67

Pooled Funds

Category	Amount
Car Repair	$ 1,023.41
Childcare	$ 372.25
Homemaking Services	$ 1,204.60
Housing Assistance	$ 3,800.00
In home therapeutic supports	$ 24,101.91
Outpatient Therapy	$ 9,207.00
Utility Assistance	$ 2,626.95
Grand Total:	$ 42,336.12

Wraparound Process:

At the end of each Wraparound Team meeting, participants are asked to fill out a satisfaction survey. The questions were designed to assess quality assurance relative to the principles and values of Wraparound implementation. (n =555). 4 = Strongly Agree; 3 = Agree; 2 = Disagree; 1 = Strongly Disagree (Blank or N/A scores were not computed).

1. The right people were included on this child and family team. (3.59)
2. The team was able to find a good time for all members to meet. (3.56)
3. The team was able to find a good place for all members to meet. (3.63)
4. The meeting was conducted in a strength-based (no shame, no blame) manner. (3.66)
5. The customs and beliefs of the family were considered as plans were developed. (3.65)
6. The team developed goals for the child based on the strengths and preferences of the child and family and their long range vision. (3.62)
7. The safety of the child, family, and community was discussed and the plan developed addresses any needed safety concerns. (3.56)
8. The plan includes action steps needed to meet the goals to lead to the long range vision. (3.61)
9. I feel that this is a good plan to support this child. (3.58)
10. I feel that my input and contribution to this team was respected and valued. (3.65)
11. The facilitator did a good job ensuring that everyone's input was obtained. (3.71)
12. The facilitator did a good job keeping the meeting going and respecting people's time. (3.69)

Looking Ahead:

Community Wraparound in Butler County has already taken on many changes and reforms in order to better meet the needs of the families and systems partnering with the Family & Children First Council. Goals for the upcoming year include:

- Standards and procedures for allocation of funds administered by the Community Resource Team
- Accountability standards from service providers funded through pooled or FAST funds
- Shifting team focus to include more informal and natural supports to meet family's needs instead of replying upon formal programs
- Establishing community partnerships with businesses and organizations that could donate goods, services, and/or time to provide families with needed enrichment activities, services, or mentors.
- Better utilization of Ohio Scales to assess individual as well as aggregate data among designated cohorts
- Collaborative effort to compare data subsets among system partners to assess Wraparound outcomes relative to individual system attributes
- Establishing Parent and/or Youth Policy Council to provide families the opportunity to have a voice in Wraparound policy and implementation.