INTRODUCTION TO WRAPAROUND

The wraparound process is a way to improve the lives of consumers who have complex needs. It is not a program or a type of service. The process is used to help communities develop individualized plans of care. The actual individualized plan is developed by a Wraparound Team, the four to ten people who know the consumer best, including the consumer and their family. The team must be no more than half professionals.

The plan is needs-driven rather than service-driven, although a plan may incorporate existing categorical services if appropriate to the needs of the consumer. The initial plan should be a combination of existing or modified services, newly created services, informal supports, and community resources, and should include a plan for a step-down of formal services.

This plan is family centered rather than child centered. The parent(s) and child are integral parts of the team and must have ownership of the plan. No planning sessions occur without the presence of the child and family.

The plan is based on the unique strengths, values, norms, and preferences of the child, family, and community. No interventions are allowed in the plan that do not have matching child, family, and community strengths.

The plan is focused on typical needs in life domain areas that all persons (of like age, sex, culture) have. These life domains are: family, living situation, financial, educational/vocational, social/recreational, behavioral/emotional, psychological, health, legal, cultural, safety, and others.

All services and supports must be culturally competent and tailored to the unique values and cultural needs of the child, family, and the culture that the family identifies with.

The child and family team and agency staff who provide services and supports must make a commitment to unconditional care. When things do not go well, the child and family are not "kicked out", but rather, the individualized services and supports are changed.

Services and supports are community-based. When residential treatment or hospitalization is accessed, these service modalities are to be used as resources and not as placements that operate outside of the plan produced by the child and family team.

Planning, services, and supports cut across traditional agency boundaries through multi-agency involvement and funding. Governments at the provincial, state, district, regional, and local levels work together to improve services. Outcome measures are identified and individual wraparound plans are frequently evaluated.

IF IT DOESN'T HAVE THESE ELEMENTS, IT ISN'T WRAPAROUND!

The wraparound process includes a set of framing elements which serve as the philosophical base for the process. The elements were presented at the first conference on the wraparound process, held in Pittsburgh in 1991.

1. Wraparound efforts must be based in the community.
2. Services and supports must be individualized to meet the needs of the children and families.
3. The process must be culturally competent and build on the unique values, preferences, strengths of children and families.
4. Parents must be included in every level of development of the process.
5. Agencies must have access to flexible, non-categorized funding.
6. The process must be implemented on an inter-agency basis and be owned by the larger community.
7. Wraparound plans must include a balance of formal services and informal community and family resource.
8. Services must be unconditional. If the needs of the child and family change, the child and family are not to be rejected from services. Instead, the services must be changed.
9. Outcomes must be measured. If they are not, the wraparound process is merely an interesting fad. Fortunately, the wraparound process is increasingly the object of scientific investigation. The results of

initial studies are promising.

TEN OPTIONS TO IMPLEMENT THE WRAPAROUND PROCESS

1. A community team with broad representation: Agencies, schools, the business community, cultural leaders, neighborhood leaders, clergy, advocates, law enforcement, and others. Larger communities may have multiple community teams, or one overall team with neighborhood subcommittees. *A good wraparound plan is always a blend of formal and informal resources. The agencies and schools broker the formal resources, the other team members broker the informal resources.*
2. A broker agency or agencies to work under the community team and broker implementation of the wraparound process. Broker agencies can be public or private, as long as they represent the larger community.
3. Establishment of a referral mechanism into the wraparound process. Many communities start with children and families with more complex needs, but the process can start with an early intervention focus.
4. Establishment of wraparound process facilitators (case managers, service coordinators, etc.) who often work for the broker agency and who are specialists in managing the wraparound process.
5. With the referred child and family, the facilitator does a thorough strengths discovery to identify the strengths, values, preferences, cultural identity, and norms of the child and family. *The wraparound process cannot be done without this step.*
6. The facilitator works with the child and family to identify four to ten persons (in addition to the child and family) who will form a child and family team. This team must not be more than 50% professionals.
7. The child and family team looks at strengths, values, preferences of the child, family and the community, systematically looks at life domain needs. The team produces a plan that is based on the discovered strengths, values, and preferences.
8. A crisis plan is produced by the child and family team. The crisis plan is intended to help prevent crises, but also to deal with them if they occur.
9. Outcome indicators are designed and outcome information is collected as the plan is frequently evaluated. *Without outcomes, the wraparound process is just one more fad.*
10. The plan is reviewed by a sub-committee of the community team. The community team reviews outcomes and begins to modify the system of care to better meet needs of children and families.

CHILD AND FAMILY TEAMS

FUNCTIONS: Developing wraparound plans; planning for crisis; supporting the implementation of the plan; accessing informal and formal supports/resources; monitoring services; inspiring unconditional care; long term support of family long after formal services are gone.
MEMBERS: Parents, kids (if they can handle it), and the 4-8 people who know the family best. If you don't know the strengths and needs of the family, you can't be on the child and family team.
WHO DETERMINES WHO IS ON THE TEAM: The facilitator works with the family to see who knows them best.
MEETING PLACES: Where ever it is comfortable for the family
MEETING TIME: Set the meeting times at the convenience of the team members who have the most difficult schedules.
MEETING FREQUENCY: At first, the team meets every week. Within four weeks or so, the meetings drop to once a month. Later, the team meets quarterly or as needed.
Ideally, the membership of the team should be at least one-half non-professionals who have access to informal resources and supports which the professionals may not be familiar with. Experience has shown that a team composed primarily of professionals can serve to discourage family access, voice, and ownership, and the resulting plan may be primarily composed of existing formal services which may not reflect the individual needs of the child and family. The professionals on the team must be those who are or have been involved with the family, since strangers are not likely to know the strengths, culture, and values of the family.
Facilitators are trained to see the team as a dynamic process in which some members may be added or subtracted as the needs of child and family change over time. If the team has been correctly configured, it is likely that the culture of the family will be represented by several members of that culture. Therefore, the eventual plan is likely to be culturally competent.