The Wraparound Approach in Systems of Care

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KEYWORDS

- Wraparound • Systems of care • Family-driven care
- Youth-guided care • Strengths-based planning

Child and adolescent psychiatrists and general psychiatrists who serve children and adolescents with complex mental health needs, generally find themselves interfacing with multiple child-serving systems, including mental health, child welfare, juvenile justice, developmental disabilities, addictions services, and primary health care. In these systems of care, psychiatrists will likely encounter the term "wraparound," which describes a key intervention ushered in with the system-of-care model of service delivery. To effectively integrate and coordinate psychiatric interventions with other services provided in the system of care, psychiatrists should become familiar with the wraparound approach. This article describes wraparound's historical context, philosophy, procedures, and the evidence supporting its effectiveness.

HISTORICAL CONTEXT

To understand the wraparound approach, it is helpful to review the context in which it was created and continues to flourish. Over the past 25 years there has been a major paradigm shift in the philosophy and organization of services for the estimated 4.5 to 6.3 million children and adolescents in the United States with serious emotional and behavioral disorders and their families.[1] In the 1960s through the 1980s, several reports documented a disorganized and fragmented system that was grossly failing these children.[2,3] Services in their communities were largely unavailable, resulting in frequent placement in out-of-state residential facilities. In response to these reports, the federal government established the Child and Adolescent Service System Program (CASSP) under the auspices of the National Institutes of Mental Health. CASSP articulated core values and guiding principles for a system of care for children and adolescents with severe emotional disturbance. These principles have served as

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a template for the evolution of child-serving systems across the nation targeting this population. The system-of-care framework developed by CASSP is defined as a comprehensive spectrum of mental health and other services and supports organized into a coordinated network to meet the diverse and changing needs of children and adolescents with severe emotional disorders and their families.[4] The major emphases of the CASSP principles are: (1) individualized care that recognizes strengths in the child, family and community and is tailored to the individual needs and preferences of the child and family; (2) family inclusion at every level of the clinical process and system development; (3) collaboration and coordination between different child-serving agencies and integration of services across agencies; (4) provision of culturally competent services; and (5) serving youth in their communities, or the least-restrictive setting that meets their clinical needs, using natural supports in the community whenever possible.

In 1992 the federal Center for Mental Health Services (CMHS), part of the Substance Abuse and Mental Health Services Administration (SAMHSA), made the largest investment to date in children's mental health services when they established the Comprehensive Community Services for Children and Youth and Their Families. Through this initiative, CMHS has funded over 100 6-year demonstration projects in diverse communities in all 50 states, as well as Native American tribes and United States territories, to implement systems-of-care programs, which must include a wraparound approach to service planning for children and adolescents with serious emotional disturbance and their families. The goals of these programs have been to implement CASSP values, provide a broad array of individualized, family-centered, and community-based services, and ensure the full involvement of families in the care of their children and development of local services. Specific performance measures defined by CMHS for the system-of-care grants, include: (1) increased interagency collaboration as measured by referrals from nonmental health agencies; (2) decreased use of in-patient or residential treatment by 20%; (3) improved child outcomes in areas such as school attendance and law-enforcement contacts; (4) decreased overall functional impairment of youth; (5) increased family satisfaction with services; (6) increased stability of living arrangements; and (7) decreased levels of family stress.[5]

Extensive data from the nationwide outcomes evaluation of this CMHS initiative indicates that system-of-care programs have reduced the number of hospital and out-of-home residential placements, improved school performance, improved youths' behavioral and emotional functioning, reduced violations of the law, and provided more services to children and families who need them.[6] These outcomes have supported continually increasing congressional appropriations for the program, from an initial appropriation of $5 million to the current appropriation of over $100 million.

Implementation of system-of-care values and principles has also been promoted in several states by class action law suits that were settled with consent decrees or, most recently in Massachusetts, with a judgment requiring availability of intensive home and community-based services, including the wraparound approach, to eligible children and their families, with support from federal Medicaid funding. However, the experience in many of these states is that without enactment of legislation mandating these services, the systems of care developed by these states reverted to a pre-suit level once federal court oversight ended.

Implicit within its public health orientation, system-of-care methodology has a place in preventive efforts, especially for young at-risk children. Nevertheless, the primary target population continues to be children and adolescents with "serious emotional disturbance." The CMHS definition of serious emotional disturbance (SED) stipulates that the child or adolescent has a mental or emotional disturbance listed in the

Diagnostic and Statistical manual of Mental Disorders,[7] which must be associated with significant functional impairments interfering with major life domains, such as home, school, and community. Children with SED who are served in systems of care generally require the services of two or more child-serving agencies, such as mental health, education, juvenile justice, child welfare, or developmental disabilities. Therefore, coordination among different providers is critically important.

The goal of serving these youth more effectively in their communities and allowing them to maintain their relationships with families, schools, and neighbors is a central goal of systems of care. To that end, community-based treatment and supports are provided to the child or youth and family, often in the home, to enable the youth to stay at home. These include an array of individualized services, such as respite, mobile crisis services, crisis shelter care, intensive home-based services, skills-building, and mentoring, among others (**Box 1**).

The move away from out-of-home residential treatment toward community-based services has received support from a number of sources, including the limited effectiveness of hospital and residential treatment,[9] advocacy from family organizations such as the Federation of Families for Children's Mental Health (FFCMH),[10] and promising outcomes of home- and community-based interventions.[11,12] Additionally, it

Box 1
The range of community-based services that may be included in a system of care[8]

Case management (service coordination)
Community-based in-patient psychiatric care
Counseling (individual, group, and youth)
Crisis residential care
Crisis outreach teams
Day treatment
Education/special education services
Family support
Health services
Independent living supports
Intensive family-based counseling (in the home)
Legal services
Protection and advocacy
Psychiatric consultation
Recreation therapy
Residential treatment
Respite care
Self-help or support groups
Small therapeutic group care
Therapeutic foster care
Transportation
Tutoring
Vocational counseling

stands to reason that separating young people from their families to receive treatment makes it unlikely that problems in the home context will be addressed adequately, with the result that they may resurface after discharge.[13]

The system-of-care model places the child and family at the center of the clinical process and as full partners at all levels of system planning.[14,15] Through federal support and technical assistance to family advocacy organizations, such as the FFCMH and National Association for the Mentally Ill, the concept of "family-driven care" was developed and it is now a cornerstone of systems of care. Family-driven, as defined by the FFCMH,[16] means that families have a primary decision-making role in the care of their own children, as well as the policies and procedures governing care for all children in their community, state, tribe, territory, and nation. Family-driven care has had a significant influence on national policy for both child and adult mental health[9] and was embraced by the President's New Freedom Commission, which has as one of its six major goals that mental health care is consumer and family-driven.[17]

The concept of consumer- and family-driven care has been expanded to include youth-guided care, which allows youth to provide meaningful guidance to mental health professionals based on their own experience as recipients of services.[18] "Youth-guided," as defined by SAMHSA,[19] means that youth have the right to be empowered, educated, and given a decision-making role in the care of their own lives, as well as the policies and procedures governing the care of all youth in the community, state, and nation. Youth voice is being developed by a national organization Youth M.O.V.E. (Motivating Others through Voices of Experience). Youth M.O.V.E.[20] was organized with the support of CMHS to improve services that support positive growth and development by uniting the voices of youth and young adults who have lived experience in various systems, including mental health, juvenile justice, education, and child welfare. Guidelines for family-driven and youth-guided care guidelines call for families and youth to be given complete information and included in all decision-making about their care.

WHAT IS "WRAPAROUND"?

"Wraparound," coined in North Carolina,[21] is an approach that incorporates the guiding principles and values of CASSP and has evolved into a well-described and widely applied intervention. Wraparound is a definable planning process that results in a unique set of community services and natural supports that are individualized for a child and family to achieve a positive set of outcomes.[22] Services are "wrapped around" the child and family in their natural environments. The wraparound planning process is child- and family-centered, builds on child and family strengths, is community-based (using a balance of formal and informal supports), is culturally relevant, flexible, and coordinated across agencies; it is outcome driven, and provides unconditional care.[23] The term "wraparound" has intuitive appeal and has entered the lexicon of most child-serving clinicians and agencies. There is sometimes confusion about whether wraparound refers to the services themselves or the planning process, but over the years wraparound has been operationalized as a planning process with core elements. An emerging consensus on wraparound includes the following ten essential elements:[22,23,24,25]

Efforts are based in the community.

Wraparound must be a team-driven process involving the family, child, natural supports, agencies, and community services working together to develop, implement, and evaluate the individualized plan.

Families must be full and active partners at every level of the wraparound process.

Services and supports must be individualized, built on strengths, and meet the needs of children and families across life domains to promote success, safety, and permanence in home, school, and community.

The process must be culturally competent, building on unique values, preferences, and strengths of children and families, and their communities.

Wraparound child and family teams must have flexible approaches and adequate flexible funding.

Wraparound plans must include a balance of formal services and informal community and family supports.

There must be an unconditional commitment to serve children and their families.

The plans should be developed and implemented based on an interagency, community-based, collaborative process.

Outcomes must be determined and measured for the individual child, for the program, and for the system.

How Wraparound Works

The wraparound process is a specific model of an individualized, family-driven and youth-guided team planning process. Through the team process, the child and family drive care planning by determining an overall vision of how the family will know when things are better; the composition of the team (unless custody lies with child welfare, in which case child welfare must have a place on the team); goals and desired outcomes of services regarding specific needs; evaluating the effectiveness of services; and having a meaningful role in all decisions, including those that impact funding of services. Empowering families and youth as drivers of the team process provides them an experience of "voice and choice," in which their goals, preferences, needs, and strengths guide all efforts. The personal expertise the family has about itself and its community is viewed as equally important to the expertise that professionals on the team have about their respective disciplines and agencies. Full inclusion of the youth and family as partners in the team process is expressed by the core concept "nothing about us without us."[26] It means that no decisions are made about care plans without parent or caregiver participation, but does not preclude communications between team members that do not include the family.

While the child and family are the driving forces of the team in that care plans generated by the team ultimately must be approved by the family, the generation of options to meet identified needs and the implementation of options selected in the child's care plan occurs through the team process. The team is facilitated by a care coordinator or care manager, and frequently there is also a paid family partner or family support specialist, who helps support family engagement and voice in the planning process. The family partner is a person who has experience raising a youth with SED and often is a person who comes from a similar cultural background as the family. The care coordinator and family partner have a primary responsibility to support a "no shame, no blame" atmosphere in the team meetings, in which mutual respect is actively modeled and recrimination and disrespect between team members is actively discouraged.

The team process facilitates interagency and interdisciplinary collaboration. An atmosphere of collaboration and shared goals helps promote a sense of hopefulness in families; this is in contrast to augmented hopelessness in families, often created by uncoordinated and even conflicting agency mandates and service plans. The complementary contributions of various team members function synergistically in identifying

system and community resources to promote better outcomes. The team is able to determine who can be most effective to work toward each of the goals and assigns appropriate responsibility and accountability. Use of a strengths-based orientation and discussion of needs rather than problems is less stigmatizing and promotes more active engagement of families and youth in service-planning activities. Individualization of the care plan is emphasized by the fact that if a plan is not successful in achieving its goals, the expectation is that the plan was flawed and needs revision, not that the family is "noncompliant" and should be ejected as having failed the process. Furthermore, rather than being driven by priorities and limited service menus of the categorical agencies (education, child welfare, juvenile justice, and other agencies), the child and family team has access to a broad array of home- and community-based supports, such as home-based therapy, respite and mentoring services, and the like.

Interventions designed to reinforce strengths of the child or youth and family may include nontraditional therapies, such as specific skills training or mentored work experiences that remediate or offset areas of challenge. For example, a youth at risk for substance abuse might receive funding for prosocial activities, such as a health club membership or computer training. These interventions generally are not included in traditional categorical mental health funding and may require flexible funds that are not assigned to specific service types. Thus, the wraparound planning process must have access to flexible, noncategorical funding. Such funds should be available for addressing individual needs other than formal treatment needs (eg, assistance with housing). Within limits, the child and family team has authority to approve expenditures of flexible funds. The care coordinator has responsibility to remind the team of explicit guidelines regarding acceptable uses of flexible funding (eg, flexible funds are spent after other mechanisms are explored, with a clear relationship to improving the mental health of the child, and with a plan for long-term sustainability).

Wraparound is fundamentally not a clinical treatment but rather a team-based planning process, although it always needs to include clinical support, and the wraparound process itself is often psychotherapeutic in promoting increased self-esteem and adaptive functioning in the child and family. It has been noted that services are more likely to be effective if the wraparound process is informed by comprehensive clinical assessment addressing diagnostic and treatment issues, and if the specific interventions are evidence-based[27,28,29] and, above all, culturally relevant and able to promote sustained engagement of the family with the involved community-based supports.

A comprehensive description of the formal wraparound process has been recently summarized.[25] Four phases are described, including engagement and team preparation, with discovery of the strengths and needs of the child or youth and family; initial plan development by the team; plan implementation; and transition to address needs in additional domains (eg, school, behavior, housing, and so forth).

An important role in wraparound is that of the "parent partner," also called "family partner" or "family navigator." Parent partners provide critical peer support to parents and caregivers of youth receiving services. Parent partners are individuals whose own children have been through the service system and are able to share their own stories and knowledge of how to navigate the system. They provide culturally sensitive, nonjudgmental support to the family to help increase family involvement and serve as liaisons with professionals to decrease unintentional bias toward parents. Federal Medicaid has approved waivers in several State Medicaid plans to support payment of family partners as a medically necessary support.

A significant number of youth with SED served in systems of care are either in foster care or other out-of-home placements,[11] and consequently their most important

relationships with family members may have been interrupted or even severed. Wraparound programs are increasingly striving to expand a youth's network of supportive relationships by using family searching methods that have become frequent in child-welfare systems. Rather than assuming that children have no family, wraparound teams work to locate extended family members who have lost contact with the youth or were unaware that he or she was in foster care. They are invited to become involved in case planning with the youth, and explore the possibility of creating more meaningful relationships that can endure, especially as formal services decrease. Expansion of the youth and family's network of supportive relationships is believed to be one of the most positive aspects of wraparound (Galloway A, personal communication, 2008). Another important value of wraparound is to provide positive support structures for the child or youth to help them find a place where they fit in and can be part of a community.[30]

Another important aspect of wraparound is the use of "natural" or "informal" community-based supports. These can be as varied as the communities in which the youth and family live. They include extended family, friends, the faith-based community, boys and girls clubs, teachers, neighbors, and other resources. A goal of wraparound is to move toward replacing formal supports as the means of addressing the needs of the child and family with informal supports as much as possible. Informal supports interface with professional services, and all services and supports are combined into a single care plan with clearly defined goals. The team is progressively constituted by individuals providing informal support. Participation of a professional on a child and family team does not require attendance at a team meeting. Professionals can be team members and participate in the team process via meetings and other communications held with the youth and family and care coordinator outside of the regular team meetings.

WRAPAROUND CASE ILLUSTRATIONS

Case #1

Juan is a 13-year-old Hispanic boy who lives with his mother, younger half brother, and stepfather. Juan has a diagnosis of attention deficit hyperactivity disorder (ADHD), combined type, severe, and oppositional defiant disorder. He was referred by his school for the wraparound service-planning program because of significant discipline problems at school, including some instances of aggression toward other students and teachers. Juan's mother and stepfather speak little English. His mother had previous involvement with child welfare, when Juan was younger, because of domestic violence in the home, and Juan was briefly placed in foster care until his birth father left the home. Juan's parents are suspicious of professionals and fear reinvolvement of child welfare. Furthermore, they have not been willing to consider a trial of medication for his ADHD as recommended by his pediatrician, primarily because Juan's stepfather does not believe in medicine for behavior problems. Other efforts to engage the family in treatment were also unsuccessful. When he enrolled in wraparound, Juan had been suspended from school twice.

Juan's mother reluctantly agreed to consider enrollment in Coordinated Family Focused Care, a wraparound child and family team-planning process that involves work with a parent partner and a care coordinator to create a child and family team, in partnership with the family, to help Juan function better at school. Juan's mother established some trust with the parent partner assigned to work with her because the parent partner had a similar cultural background, spoke Spanish as her first language, and had her own history of caring for a child with serious mental health issues.

In the course of the initial strengths and culture discovery, Juan noted that he liked to draw and said he was interested in becoming an artist when he grows up. He did especially well in art last year, in the 7th grade, when he got an A and had a very positive relationship with his art teacher. Early in the team planning process, furthering Juan's interest in art was identified as a primary goal. Flexible funding through the program was made available to pay for drawing lessons at the local art museum. However, there was concern that without a mentor to support his effort in the art classes, there was a high likelihood that oppositional and defiant behavior could result in Juan being asked to leave the class. His art teacher from the previous year was invited to participate on the child and family team. She came to a team meeting and agreed to accompany Juan to his art lessons for a nominal stipend, again paid for with flexible funding assigned to the program.

Juan had a dramatic response to taking the art lessons. A drawing he did received an award and was displayed in the art museum, which was a source of much pride for Juan, his mother, and his stepfather. Nevertheless, his difficulties in school continued. In the context of success with the art class and the emerging trusting relationship that Juan's parents had with the parent partner and care coordinator, they were willing to have a consultation with the child psychiatrist providing support to the program, especially as the parent partner offered to attend with the parents and provide support with translation. After reconfirming the diagnosis of ADHD and listening to the concerns about medicines voiced by the parents, the child psychiatrist provided information about the evidence supporting the benefit of medication. With additional support from the child and family team, including the pastor of their church, Juan's parents agreed to a trial of Concerta. There was an immediate benefit in both Juan's grades and behavior. He was thrilled, as were his parents.

Case # 2

Celia is a 17-year-old young woman who entered a wraparound project when she was 15 years old. As a child, she was removed from her parents' care because of neglect and subsequently was placed in a series of foster homes, without finding a successful long-term placement. She started having behavioral problems in early adolescence. Because of her mood difficulties, self-harming behaviors, inability to function in school, substance abuse, runaway episodes, and periodic aggression, she entered residential treatment when she was 12 years old. She spent most of the next 3 years in different residential programs, with periodic unsuccessful attempts to return to the community. The wraparound team met her when she was in residential treatment. The initial focus of their efforts was to find a highly experienced foster family who was a good match for Celia, guided by Celia's perception of what would work for her. The family they found was able to provide structure but were clear that they were not going to overwhelm her with rigid rules, which was what Celia had hoped for. They were motivated to form a relationship with her and to be emotionally available, but they understood that because of Celia's early attachment difficulties, they should not pressure her to get too close too quickly.

To help this foster placement succeed, Celia and the foster family were provided with an array of formal and informal supports, including crisis respite services, individual therapy, home-based family therapy, and mentoring. Efforts were made immediately to contact Celia's siblings and locate members of her extended family to expand her network of support. Because Celia's foster parents understood her needs and felt supported by the wraparound team, when her family members re-entered Celia's life the foster family did not experience it as a threat and were able to be supportive. During Celia's stay with the foster family, the wraparound team helped her develop

her interest in art by advocating for her to take more art courses at her high school. She also developed her interest in music and began to perform at statewide conferences and meetings. Celia and her foster family connected so well that when they moved to an adjacent state, the child welfare agency, functioning as an integral part of the wraparound team, was willing to continue to support the placement. The team was able to stay together through a number of Celia's mental health setbacks, and Celia felt that she had a personal connection with every member of the team. Celia has now graduated from the wraparound program. She continues her interest in music and has ongoing contact with her siblings and some extended family members.

THE EVIDENCE BASE ON WRAPAROUND

One limitation of the research on wraparound relates to the fact that until recently it was not well-defined operationally and its applications varied across studies. Only recently has consensus been reached about the essential elements of the wraparound as an intervention.[22,25,31] Studies on wraparound have incorporated measures, such as the Wraparound Fidelity Index (WFI),[24] to ensure fidelity to the model as defined by the National Wraparound Initiative.[31] A recent study showed that higher fidelity, as measured by the WFI, was associated with better outcomes in multiple domains.[32]

The evidence base concerning wraparound generally characterizes the approach as promising.[11,29] Positive results from three randomized, controlled trials and a number of quasi-experimental studies in different communities with diverse populations of at-risk children and families have been described. These studies have generally reported positive outcomes in terms of reduction of externalizing behavioral problems, increased level of function, reduction of out-of-home placement, improved family management skills and function, and increased consumer and family satisfaction.[33,34] However, a randomized, controlled study found no difference in clinical outcomes for wraparound versus usual treatment.[35] Another study comparing wraparound to Multisystemic Therapy (MST; see description below) found that youth who received only MST demonstrated more improvement in clinical symptoms than those who received only wraparound over the 18-month follow-up assessment.[29] It was noted by the investigators that because wraparound plans are individualized, the wraparound group may have had a mixture of effective and ineffective treatments, while the MST intervention is more standardized.

Interestingly, although wraparound is considered a promising but not yet strongly supported intervention, it has gained widespread acceptance as a planning approach, as evidenced by CMHS's requirement that it be used in system-of-care grant projects. Its popularity is likely because of its family-driven and strengths-based philosophical orientation. With such widespread use, however, it becomes difficult to obtain approval for randomized, controlled trials. This issue parallels the widespread adoption of the system-of-care model on the strength of its philosophy and values, which has required use of quasi-experimental designs.[36,37]

COMPARISON OF WRAPAROUND TO OTHER INTENSIVE COMMUNITY-BASED INTERVENTIONS

Several other intensive community-based interventions used in systems of care have been empirically evaluated, including MST, treatment foster care, and case management.[11,12,29] It is useful to examine how these models differ from wraparound (**Table 1**).

MST is an intensive home- and community-based family treatment model for children and adolescents at risk of out-of-home placement because of serious emotional and behavioral problems.[38] Originally developed for juvenile offenders, MST has been

Table 1
Overview of some intensive community-based interventions

Intervention	Essential Features	Who Provides Services	Where Services Provided
Multisystemic therapy	• Ecological case formulation, • 24/7 crisis availability, • high fidelity	Clinical MST team (mental health clinicians/ psychiatrist)	Primarily home-based or community-based
Wraparound planning process	• Family-driven team with facilitator; • strengths-based/ use of natural supports	• Any provider selected by team; • use of parent partners and natural supports	Community, home, or clinic
Intensive case management	• Intensive individualized services with assigned case manager	Varies	Usually home or community
Treatment foster care (Oregon MTFC model)	• Highly staffed; • use of intensive behavior modification; • family trained from outset	Foster family and behavioral consultants	Foster home and community consultation

applied to youth in the child welfare system, youth at risk for psychiatric hospitalization, and violent sex offenders. MST is an intensive intervention lasting 3 to 5 months in which all services are provided by the MST team. Interventions are based on systematic assessment of all aspects of the child and family using a social ecological perspective. MST has been carefully implemented to ensure adherence to the model. There have been nine randomized trials of MST demonstrating its efficacy.[39]

The evidence base for treatment foster care as a home-based alternative to residential treatment for youths with mental health needs or antisocial behavior derives primarily from research on the Oregon Social Learning Center model, called Multidimensional Treatment Foster Care (MTFC).[40] The Oregon model includes close supervision of foster parents by experienced therapists who train them in techniques of careful monitoring of behavior and consistent application of positive reinforcement and consequences. Two randomized, controlled trials demonstrated superiority of MTFC to treatment-as-usual for juvenile justice-involved youth, and a further study favored MTFC to treatment at a state psychiatric hospital.[11,41] MTFC has also been applied successfully to troubled youth in the child welfare system and to address the needs of preschoolers with aggressive and oppositional behavior.

Case management is a common strategy used in systems of care to coordinate care and ensure access to an array of services that will meet the child and family's needs. It includes various functions to meet these needs, including assessment, service planning and implementation, service coordination and monitoring, and advocacy.[42] Case-management approaches generally incorporate a specialist case manager or care coordinator who either functions as a broker of services or has a more intensive role, providing some direct support to the child and family, such as in the Children and

Youth intensive Case Management model.[43] There have been at least four randomized, controlled trials of case management which have generally shown positive findings in relation to comparison groups.[11] However, the findings are somewhat difficult to assess as a group because of the variations in intensity of case management models tested (**Table 2**).

APPLICATIONS OF WRAPAROUND

Wraparound was developed in the late 1980s and expanded in the 1990s, and subsequently has been used as a viable alternative to residential treatment. The Kaleidoscope Project in Chicago, Wraparound Milwaukie, and the states of Alaska and Vermont initiated some of the earliest and most successful wraparound programs in the country. Current SAMHSA system-of-care grants require high-fidelity wraparound. These grant communities now include tribal communities, a new wave of early childhood grants for children ages 0 to 8 (who hadn't been included in previous system-of-care programs), and state transformation grants. There is now a substantial literature on wraparound and the National Wraparound Initiative,[31] providing information and technical support. One of the most successful wraparound programs is Wraparound Milwaukie,[34] which has been used as a model for other states in developing similar initiatives. Wraparound Milwaukie was implemented with a SAMHSA grant in Milwaukee County, Wisconsin in 1995 to serve high-risk youth in the Child Welfare and Juvenile Justice Systems who were at immediate risk of placement in residential, hospital, or correctional settings. The program uses a wide array of community-based interventions as alternatives to out-of-home placement. Wraparound Milwaukie was able to sustain its program after the grant period by developing a unique managed care entity in which four public agencies pool funding to create maximum flexibility and sufficient funding to meet the comprehensive needs of an average of 560 culturally diverse youth and families per year.[34]

A number of states, including Vermont, Oklahoma, Oregon, Mississippi, Massachusetts, and Arizona, among others, have implemented wraparound on a statewide basis or are in the process of doing so. As noted above, litigation has played a role in implementation of wraparound, such as occurred in Arizona in the J.K. consent decree in 2001 and in the recent Rosie D. settlement in Massachusetts.[44] There are unique challenges in statewide applications of wraparound, including development of state-level administrative mechanisms for blended funding, large-scale training of the workforce in wraparound methodology, and decision-making about allocation of resources to wraparound versus other community-based models.

Another issue that arises in applications of wraparound to larger populations is selection of an appropriate target population. In Oregon's statewide Wraparound

Table 2
Levels of evidence supporting intensive community-based interventions

Community-Based Intervention	Level of Evidence
Multisystemic therapy	5
Wraparound process	3
Intensive case management	4
Multidimensional treatment foster care	4

Definitions of levels of evidence:[59] 1, not evaluated; 2, evaluated but unclear (no or possibly negative effects); 3, promising (some evidence); 4, well established; 5, better or best.

Initiative,[45] a decision was made to include children who are at risk for serious mental health issues, as well as those already identifiable as having SED, to provide the benefits of wraparound as an early intervention strategy. In this application, modifications to wraparound, such as shorter-term applications and smaller teams may be appropriate. There has been little systematic examination of what might be considered "partial applications" of wraparound. However, there could be a role for applying the principles and some components of wraparound to different populations and in different contexts. This might include, for example, team-based processes in schools[46] or child welfare family decision-making meetings.[47] Interventions partially adhering to the wraparound model include incorporation of system-of-care values and principles into traditional psychotherapy and pharmacotherapy.[27]

POTENTIAL LIMITATIONS OF WRAPAROUND

It has been suggested that wraparound, a planning process which has a good record of engaging family and community support, would benefit from being combined with the strengths of specific evidence-based approaches.[48] It is thus likely that difficulties accessing specific clinical interventions needed by the youth and family will limit the effectiveness of wraparound.[29] The national shortage of mental health therapists, and especially child and adolescent psychiatrists, creates a problem in accessing these services, especially in rural areas and for those living in poverty.[49] Child and adolescent psychiatrists, who are needed to address complex diagnostic, psychopharmacologic, and other treatment needs of youth with SED, have limited opportunities to participate directly in wraparound teams, even in urban areas (Hedrick L, personal communication, 2008). There may also be gaps in access to evidence-based practices that should be included in the wraparound plan.

It has been noted that wraparound requires significant training and other supports.[50] A lack of systematic use of wraparound manuals by wraparound care coordinators, found in a recent study,[51] could limit the effectiveness of wraparound. Even beyond training in wraparound methodology, care coordinators need to have knowledge of evidence-based clinical interventions, and there is some evidence that wraparound providers are less familiar with some evidence-based practices than nonwraparound providers.[51] Administrative issues also impinge on the effectiveness of wraparound. Limitations to interagency collaboration may extend from local, state, or federal administrative barriers to key aspects of wraparound, including blending of funds, information sharing, and development of interagency service plans. Competing agency mandates may also create barriers to effective collaboration and service integration. Lack of organizational and system supports, such as manageable caseloads, availability of flexible funds, and standards for team composition, may interfere with fidelity.[52]

Another access issue concerns the limited availability of foster parents who have the experience, skills, and motivation to parent youth with complex mental health needs and histories of disrupted relationships. As shown in Case #2 above, young people who have had many failed relationships may require a unique set of attributes on the part of the foster parents, including tolerance for behavioral and emotional instability. Needless to say, it is difficult to locate uniquely well-matched foster parents for each youth. Availability of respite and other supports to these foster homes is also needed to allow youth to remain in the community and may require significant financial investment. Expanding their network of supportive relationships can allow youth to sustain treatment gains over time, but this process can be resource intensive as well.

FUTURE DIRECTIONS FOR RESEARCH AND IMPLEMENTATION

Given the significant national investment that has been made in wraparound, further research on high-fidelity wraparound is clearly needed. Future research should focus on identifying the most important ingredients for positive outcomes, and emphasis should be placed on the specificity of clinical interventions, particularly incorporation of evidence-based practices.[29,48]

Wraparound methodology will need to be refined for new and diverse populations, such as tribal communities, young children, and children who are showing early signs of developing more serious emotional or behavioral difficulties. Another challenge in application of wraparound is the frequent difficulty of engaging youth and families who may be quite isolated and mistrustful of "the system" to participate in services in the system-of-care. Callejas and colleagues[53] have described access to services as the "front porch" of a continuum of culturally competent mental health services; the front porch is built through outreach activities in the community, reciprocal linkages with community services, and creation of a welcoming reception area in an agency. A related issue is the need to create mechanisms to provide services to parents of SED youth who may need mental health and addictions services. Given the substantial literature on effects of parental depression and other mental disorders on children, this should be a central focus of systems of care.[54,55]

As noted above, future expansion of wraparound by states will need to address barriers to blended funding and integrated service planning and delivery, cross-training of an interdisciplinary workforce, and defining which specific subgroups should receive high-fidelity wraparound versus partial applications. Finally, as the national agenda moves toward comprehensive care that integrates mental and physical health care,[17,56] wraparound interventions within systems of care will have to do a better job of interfacing with primary care providers. The Academy of Pediatrics "medical home" model is very compatible with wraparound's coordinated, comprehensive, family-driven approach and closely overlaps with system-of-care values and principles.[57]

SUMMARY

The wraparound approach has become a national standard for service planning for children and youth with complex mental health needs and their families. Its philosophy and methods are consistent with national trends toward family-driven care and more positive, less-pathologizing approaches to mental health services. Aspects of wraparound that account for its appeal and positive outcomes likely operate at multiple levels. At the system level, wraparound requires administrative modifications that allow different agencies to work closely together, develop single, coordinated service plans, and create mechanisms for combining funds and creating opportunities for flexible funding in the interest of the youth and families served. At the level of the child and family, the values of wraparound truly put the child or youth and parents at the center of the process and allow them to chart their own course. By virtue of its strengths-based approach, the youth's self-esteem and sense of self-agency are reinforced by professionals, family members, and the network of people that wraparound builds around the child. This network of supports can remain with the child even after the team process is no longer part of a wraparound program. Just as it has been demonstrated that child-therapist relationship variables are predictive of youth mental health-treatment outcomes,[58] it makes sense that the relationship-building aspect of wraparound is helpful in promoting positive outcomes for children and families. Provision of an atmosphere of acceptance and encouragement in which the youth

and parents feel a growing sense of personal agency and enhancement of their self-esteem and competence is a critical ingredient of any successful psychotherapy.

In terms of its evidence base, wraparound is still at the level of a promising intervention. The resources required for high-fidelity implementation of wraparound are considerable. To better understand its value, research examining specific components of wraparound, both formal and informal, is needed to determine which are most strongly associated with positive outcomes.

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