Over the last 25 years, the world-wide human services community has been faced with growing complexity of human services needs, especially for children, youth, and their families. This has been caused by many factors, not the least of which are poverty, societal stress, war, increasing focus on technology over human interaction, loss of family, and others. Recent studies have indicated that loss of connection to large numbers of “caring people” has been one of the most commonly cited factors that has led to increasingly negative outcomes for our children and youth. Caring people are those who look out for the child and youth on a daily basis, providing nurturing, guidance, and an example of strong adult behavior in the parenting areas.

One of the ways that our societies historically coped with the increasing complexity of the emotional needs of children, youth, and their families, was to “professionalize” the helping response. A huge human services industry of professional helpers has been created over the last 50 years. This movement proved beneficial in some ways, but in other ways created a dependence on professional advice and decision making, and a decrease of family voice and choice in decision making. It is important to stress that the historical roots of many human service agencies began with a greater focus on family voice and choice than now exists. For example, Hull House in Chicago, which is widely acknowledged as being the birthplace of social work in North America, began with a motto of “People Helping People” and a creed of family voice and decision making over family needs.

In addition, one of the factors that has influenced outcomes at the family level was the “silo effect”, caused by development of separate child welfare, juvenile justice, education, mental health, developmental disability, public health, addiction, housing, welfare, medical, vocational, legal, and other services models. 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. Families with complex needs would often have multiple and sometimes competing plans, and would be overwhelmed with professional demands.

In response to problems with the above separately developed silos, the notion of a “system of care” was conceptualized by Beth Stroul and Robert Friedman in 1986. The concept of the system of care has evolved over the last 20 years, which stresses the need for the silos to human services agencies are turning to their roots and indeed the roots of human kind, the use of small teams of helpers to assist our most vulnerable citizens. In the last 25 years, virtually every system has begun to use some version of team based planning. Some of these models are single system focused, some are collaborative, and some are integrated.
A key addition to the system of care movement has been the national development of family organizations for children and youth with serious emotional disturbance and their families. This development has been led by the Federation of Families for Children’s Mental Health, which now has chapters in almost every state. Associations for Retarded Citizens, Mental Health Associations, Alliance for the Mentally Ill Child and Adolescent Services, autism-focused family organizations, and many others have been established nation-wide. Family organizations participate in the system of care in many different ways, including policy development, program design and evaluation, and delivery of services and supports. For example, the system of care efforts in Tulsa, Oklahoma include use of family member graduates of the programs as mentors and supports to new families coming into services.

**Common Team Based Planning Models**

**Child Welfare: Family Group Decision Making.** This model uses a family team to come up with a plan to ensure a child’s safety in the community. It shifts the balance of power from service providers to family and community. It reduces the dependency of families on state provided services, and increases the level of understanding and cooperation between agency personnel, the birth family, extended family and community. The model is strengths-based, option and action focused, and stresses family cultural differences.

**Juvenile Justice: Restorative Justice Teams.** This model uses a family and a standing community team to evaluate the needs of the victim of crime and the needs of an offender, promotes restitution to the victim and community, and helps restore an offending youth to the positive graces of the community. The model ideally focuses on youth strengths, community connections and volunteers to help implement restitution plans, and on intensive individualization. The model balances community safety, the need for consequences for criminal behavior, and the need for youth and family skills to live crime-free in a community.

**Developmental Disabilities: Person Centered Planning.** This model, one of the oldest team based planning models, was innovated by John O’Brien and colleagues as a way of maximizing normalization of the lives of individuals with developmental disabilities such as mental retardation. These teams help an individual with developmental disabilities and their families set a vision of maximum independence and helps provide the support the individual needs to live in the community.

**Education: Positive Behavioral Support Teams.** This model, innovated by Rob Horner, George Sugai, and colleagues, involves the definition of child and youth positive behavioral goals and acceleration of positive behaviors over reduction of negative behaviors. This primarily school based model has been used in thousands of schools to form a small team of pupil, teacher, other school personnel, and parents to focus on behavior goals, and creation of an
individualized consistent plan to increase positive behaviors. It uses school and pupil strengths, and creates a highly individualized plan that often carries over into the home environment.

**Spirit and Healing Circles.** These models, widely used in North American by First Nation communities and Native American communities, focus a team of elders, family members, and youth on the goal of helping a family heal from trauma and other issues. There are many variations on these teams, which ideally are strengths-based, individualized, and have a strong focus on spirituality and the relationship of the family to the earth.

**Integrated Systems: Wraparound.** Wraparound is based on a normalization model, and has developed as a way of multiple systems coming together with the child, youth, and family and creating a highly individualized plan to address complex emotional issues. The process roots are from Belgium and Canada, and has been widely funded and used in the U.S., and has the largest research base of all team based planning models. Wraparound is an ongoing process that may last for many months or even years.

**Details: The Wraparound Process**

The basic hypothesis of this process is that 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 an improved life. This hypothesis has been central to life on the planet for thousands of years, and is certainly not a new concept. However, as the basis for formal efforts to decategorize services and improve outcomes, the field has been in development for approximately 25 years.

Some of the formative work came out of efforts by John Brown and his colleagues in Canada who operated the Brownsdale programs. These programs centered on the concepts of needs-based, individualized services that were unconditional. These concepts were utilized in designing the Kaleidoscope program in Chicago that began implementing private agency-based individualized services in 1975 under director Karl Dennis.

In 1982, Jane Knitzer in her book, Unclaimed Children, found 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 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) led by Ira Lourie, M.D., and envisioned as a comprehensive mental health system of care for children, adolescents and their families. 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 established to support best
practice development, research and evaluation of wraparound and systems of care.

In 1985, officials of the State of Alaska social services, mental health, and education departments sought consultation from Kaleidoscope, and formed the Alaska Youth Initiative, managed by John VanDenBerg. This effort was successful in returning to Alaska almost all youth with complex needs who were placed in out-of-state institutions. The Alaska efforts were quickly followed by replication attempts in Washington, Vermont, and in more than 30 other states.

System of care and wraparound practice development from the same philosophical base as the Kaleidoscope programs includes the work of Naomi Tannen in New York and Vermont. She has been instrumental in promoting a flexible, needs-based approach. In Canada, Ontario has been the leader in establishing the wraparound process.

Developments parallel to the wraparound process have been occurring simultaneously in other fields. The work of John O’Brien and colleagues in the field of developmental disabilities has led to enormous system improvements through development of needs-based, individualized services in communities. The work of John McKnight and his colleagues on restructuring communities to support individuals with complex needs has been vital to the field. International progress in the field of police reform has led to community policing projects where the role of the officer is similarly tailored to the needs of the local community. State of the art practice in social work and mental health are evolving along parallel lines.
The Wraparound Process: Guiding Principles from the U.S. National Wraparound Initiative

Overview of the Wraparound Process, Principles and Steps: The wraparound process is a way to improve the lives of children with complex needs and their families. It is not a program or a type of service. The process is used by communities to support children with complex needs and their families by developing individualized plans of care. The key characteristics of the process are that the plan is developed by a family centered team, is individualized based on the strengths and culture of the child and their family, and is needs rather than services driven. The wraparound process was innovated from the grass roots of America and Canada. Consequently, the process and outcomes of the process varied widely state to state, province to province. In 2002, a group of wraparound innovators began discussions about development of US national standards for wraparound, which have been completed. Go to National Wraparound Initiative in Google for a comprehensive overview of these standards. Canada wraparound innovators are currently developing similar standards for Canada.

The U.S. National Wraparound Initiative, led by Eric Bruns, Ph.D., Janet Walker, Ph.D., Trina Osher, Jim Rast, Ph.D., and others, has standardized ten guiding principles:

1. Family Voice and Choice
2. Team Based
3. Natural Supports
4. Collaboration
5. Community Based
6. Culturally Competent
7. Individualized
8. Strengths Based
9. Persistence
10. Outcome Based

The family are integral parts of the team and must have ownership of the plan. No planning sessions occur without the presence of the family. This principle is referred to as Family Voice and Choice. The actual individualized plan is developed by a wraparound team, who consist of the family and the three to seven people who care and know the child and family best. The team is selected by the family and typically has no more than half professionals. The team represents the principle of Team Based. The individualized plan is child-centered and family-focused with maximum family involvement, with variation depending on the needs of the child and family. The process focuses on strengthening the natural family, extended family and social supports for the child by involving them in the planning and implementation process. These social supports represent the principle of Natural Supports.
Many families who are served through the wraparound process have needs which have traditionally been met by more than one services system or schools. These services systems and schools agree to the principle of Collaboration, working together and moving to Integration where all parties work in a team with the family and design and implement one plan. Services and supports are based on the principle of being Community-based. When residential treatment or hospitalization is accessed, these service modalities are to be used as stabilization resources and not as placements that operate outside of the plan produced by the child and family team. All services and supports must be based on the principle of being Culturally Competent. That is to say, services and supports must be tailored to the unique culture of the child and family. Family culture refers to family race and ethnicity as well as family habits, preferences, beliefs, language, rituals, and dress, based on “one family at a time”.

The principle of true Individualization is at the heart of the wraparound process. Each child, youth, and family has an individualized plan. The plan may include services (such as therapy or day treatment) that other plans have included but when they do include these more typical services, the team always evaluates and understands why the service is a precise match for the unique needs of the child, youth, and/or family. The plan is structured around the principle of Strengths Based, where the plan is based on the unique strengths, needs, values, norms, preferences, and culture, and vision of the child, family, and community. No interventions are allowed in the plan unless they have matching child, family, and community strengths. By building on these strengths, the plan supports who the child is and how the child will positively progress in life. The plan is focused on typical needs in life domain areas that all persons (of like age, sex, culture) have. These life domains are: independence, family, living situation, financial, educational, social, recreational, behavioral, emotional, health, legal, cultural, safety, and others.

The child and family team and agency staff who provide services and supports must make a commitment to the principle of Persistence in delivery of services and supports. When things do not go well, the child and family are not “kicked out”, but rather, the individualized services and supports are changed. Planning, services, and supports cut across traditional agency boundaries through multi-agency involvement and funding. Governments at regional and local levels work together with providers to improve services, and commit to the final principle of being Outcome Based. Both system of care issues and issues of individual plans are considered. Outcome measures are identified and individual wraparound plans are frequently evaluated. The collaborative funders of services agree to focus funding on efforts like wraparound which have solid evidence for effectiveness.

**Systemic Changes Needed to Support Team Based Planning**

The national movement toward collaboration within services to children, youth, and families is based on the fact that many children and youth, and their family
members, have complex needs which do not fit neatly into our pre-conceived service models and silos. Over the last few decades, increasing realization about structural changes to the system of care has led to major innovations in how states design their overall systems. Sheila Pires, a leading system of care expert, in her monograph, Building Systems of Care: A Primer (2002), says:

The structures that are created send a message about values, either undermining or reinforcing the values and principles that have been adopted. For example, individualized, flexible service provision is a key principle of systems of care. However, if the financing structure attaches dollars only to programs, the principle of individualizing care will be undermined – not that it is impossible to incorporate individualized service provision within this structure, but it is more difficult. The structure in this instance sends a message about how much the system truly values an individualized, wraparound approach.

States have been pushed to develop systems of care in part due to a series of lawsuits, beginning with Willie M. vs. The State of North Carolina in the 1980’s. These lawsuits have reinforced the right of children with complex needs to be served in the least restrictive and most therapeutic environment. Family members have brought these class action lawsuits in more than 20 states. An example of a recent lawsuit is the Jason K. settlement in Arizona. This lawsuit settlement establish “Child and Family Teams” in a wraparound model as the primary decision making body for design and delivery of behavioral health services for children and youth, and their families. Arizona state level behavioral health has been establishing structure that puts these family centered teams in the middle of the system, and is using the teams to establish medical necessity for Medicaid reimbursement purposes.
**Collaboration vs. Integration**

In a collaborative model of care, child serving agencies learn about each other's systems, "staff" families together, and attempt to establish cross-system values and standards. The movement to collaboration has been in reaction to the lack of cross-system training and education about each categorical system’s mission and structures. However, there are limits to a collaborative model, even though collaboration is an important developmental step for many communities and states. In a collaborative model, each system communicates, but at the end of the day, each system makes their own decision about the intervention for the family. This results in multiple service plans for the one family, which may potentially be in disagreement and result in one family having been ordered to go to literally dozens of appointments over a month. When these well-intentioned plans fail, the family is often blamed.

To move beyond collaboration, the concept of integration and system transformation has been established. In a transformed, integrated system, the multiple systems establish structures for decision making with the family in the middle of the process, using voice and choice as foundational principles. In an integrated model of services implementation, the child, youth, and family would have one plan. The family would be in the driver's seat in plan development and approval. It is important to note that the wraparound process is a process for integration of services.

**Research Outcomes**

Recent research on High Fidelity Wraparound has demonstrated that the process can produce significantly better outcomes for children and families with significant needs than traditional approaches, including: Increased permanency and stability for children; decreased restrictiveness of residential environments; improved behavior and mental health symptoms, improved school and early care outcomes, decreased family and child safety issues and risk factors; increased family and child protective factors; increased family engagement and satisfaction with services; and increased family resources to support their own children.

Over the last several years, important controlled research on wraparound has been carried out. In a recent study in Nevada, child welfare referrals to wraparound were assigned to a “standard treatment group”, getting typical services such as therapy, case management, and day treatment. Another group was assigned to an “Intensive case management” group, with a case manager with low case loads and access to flexible funding. The third group in the study was a High Fidelity Wraparound Group, based on the phases and activities of the National Wraparound Initiative. These children and their families received highly individualized services and supports, an integrated plan, and a team where the parents were in charge to the maximum extent...
possible, given the safety issues for the children. In this study, the first two groups made no statistically different progress over a year, and yet the wraparound group made statistically different progress, which resulted in this group dropping out of clinical range for being assessed as severely emotionally disturbed. Recent studies have produced very similar outcomes to the Nevada study, and new research has been coming out over the last two years. Wraparound is well on its path to being considered evidence-based practice.

**Summary**

Team-based planning for children, youth, and their families is growing rapidly in North America. Each major child-serving system is currently involved with development of methods of team-based planning. A strong national network of family organizations is helping drive and support this movement. Of the team-based planning methods, the wraparound process is the most developed and researched, and is showing that children and youth can be appropriately served within their communities, in their family homes, and in a manner that respects the dignity and importance of the family.