Foundations of Wraparound

Values, Practice Patterns and Essential Ingredients

By Patricia Miles and John Franz

What is wraparound and how can you tell if you, or your organization, or your community are actually using the wraparound approach? Since its introduction as a human services practice strategy about 12 years ago, wraparound has grown and evolved. Now communities across the United States and Canada proclaim that they are doing wraparound. Yet what is being called wraparound in one place can look strikingly different from what is happening in another location. The goal of this article is to provide an introduction to the concepts used in the wraparound approach and to offer some guidelines for measuring the degree to which the current state of practice in a community reflects wraparound principles.

Four basic ideas

When a person or family in our community has complex needs that cut across the lines that usually divide our service agencies, we have a choice: should we provide support to help them address and resolve these needs or should we intervene to compel changes in their behavior or situation? This is a difficult decision. Wraparound challenges us to reinvent the metaphor of help – and as such it confronts many of the unspoken assumptions implicit in the design and operation of traditional publicly funded human services systems.[1]

In making a choice to respond using a metaphor of support rather than intervention, wraparound presents four basic assumptions on which its practice and structural components are based:

First Idea:	Destructive behaviors are usually driven by unmet needs.
Second Idea:	The biggest unmet need for many people with destructive behavior is loneliness.
Third Idea:	Getting a service doesn't necessarily mean your needs are being met.
Fourth Idea	It is harder to institutionalize new ideas than people.

All of us experience needs across the various domains of our lives: finding a place to live, maintaining positive relationships in our family, learning, obtaining physical and emotional healing, finding fulfilling work to do, and so forth. None of us are able to meet

[1] For a thorough, thoughtful and extraordinarily challenging critique of our country's systems for professional helping, please read *Careless Society: Community and its Counterfeits* by John McKnight. 1995. Basic Books: New York, NY.

all of our needs, but most of us, either by ourselves, or more often through our interdependence with friends and family members are able to meet enough of our needs to get along. For some of us, however, our life situation or our physical, developmental or emotional state, or a combination of situation and state makes it more difficult to meet our needs. The more we are cut off from others, the more likely it is that we will be frustrated in our attempts to meet our own needs. The more this frustration grows, the more destructive our behaviors can become.

One option when people are cut-off and frustrated and destructive is to wall them off even more from their families and our communities. Another is to re-involve them in a social context that generates enough support and relationships to help them find ways to address their key unmet needs in a more positive way. Selecting that second response is the choice we make in using the wraparound approach.

The technology of wraparound

Creating a supportive social context, a circle of care, around any one person or family requires no special arrangements. This is a natural human response that can be found in every culture. We gather together and pitch in to help. But where there are many disconnected people engaging in behaviors that are harmful to themselves or others, the wave of need can overwhelm our natural and informal responses.[2] Then we have to get organized in order to do wraparound on a larger scale. In sense there are two types of wraparound. Little w wraparound is a natural strength-based response to help others in need. Big W wraparound consists of the specific tools and techniques a community gathers together to provide structured and reliable support to large numbers of people when the natural options for assistance are not sufficient.[3]

In order to make wraparound happen for a large group of people, communities need to add or enhance six aspects of their service technologies:

- A planning process that provides a common vocabulary to help participants from widely varying backgrounds unite in coherent and creative circles of support and provides these teams with reliable steps for moving quickly from discussion to action.

- A commitment to creative, strength-based, needs-driven action plans that is supported and reinforced by a management information system that reflects the core values of wraparound and insures accountability for both process and outcomes

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[2] John McKnight would argue that the waves of disengaged and destructive people we are experiencing may in part be the result of the loss of our natural patterns of caring.

[3] Possibly the greatest danger in starting a project using Big W wraparound is that it will further erode the natural options for healing and support. That is why it is critical to incorporate natural supports at the heart of every action plan.

- A cross-system funding and service access infrastructure that enables support teams to develop and implement unified, comprehensive plans that incorporate and align the actions and resources of all of the service systems with which an individual or family is involved.

- Consistent and sustained training, support and guidance for team facilitators, family members and service system staff who may be asked to be members of teams to insure that the planning and implementation process is undertaken in a culturally competent way and that action plans incorporate community-based, normalized living opportunities for marginalized and labeled individuals and families.

- An operational orientation and quality assurance system that insures that the individuals and families who are at the focus of wraparound circles of support are able to have access, voice and ownership in the preparation and implementation of each action plan.

- An explicit commitment expressed in policy and contracts that wraparound teams will remain in place to support individuals and families despite whatever setbacks and problems may occur, until the team is not needed or the person or family is able to transition to a more natural or informal supportive context.

These technologies can be implemented in many different ways, depending on the nature of the needs of the individuals and families being supported, the current human service infrastructure and the culture and traditions of the community.

Misconceptions of wraparound

Wraparound is not a funding source. It's not therapy. It's not a program. It's not a new way to get stuff. Wraparound is sometimes compared to or even confused with two of the better known types of intensive family interventions: Functional Family Therapy and Multi-Systemic Therapy. But it isn't MST or FFT or a competitor to them. Wraparound isn't case management. Wraparound isn't a residential treatment center without walls. Wraparound isn't a specialized treatment option for a small group of children or adults.

Wraparound is a different way of organizing and operating our helping businesses. As such it is hard work for everyone because it doesn't fit into the accustomed slots and categories that our systems use. But by combining the six technologies listed above service systems can blend support and intervention in a new way that creates opportunities and options where none existed before.

The six elements are not new, nor are they associated only with wraparound. Practitioners in many human service disciplines have proposed strength-based human

service approaches.[4] Similarly, there are models for developing collaborative systems of care, for blended or braided funding of services, for family-centered practice, and client-driven quality assurance. What makes wraparound unique is putting all of the elements together in order to establish alignment and coherence at the practice, program, inter-agency and community levels of human service operation. Wraparound is a whole systems model for organizational and operational change.

The wraparound equation

Relationships are at the heart of healing. Wraparound facilitates healing relationships by creating an infrastructure for forming and sustaining circles of support for people and families with complex needs. Underlying this model is a simple equation: strengths + team + needs + plan + unconditional care = help.

Here's an example: Julie and Peter Jones are having trouble holding their family together. Peter is a 15 year old who has been labeled as having a bi-polar mental health disorder. He has been in and out of school and has gotten in trouble with the law. His mother, Julie, provides a foster home for an adult with developmental disabilities and also works as an advocate at an agency for people with disabilities. Peter is at risk of being placed in a residential treatment center because of his destructive behaviors.

Acting on her own, Peter's probation officer/case manager has developed the following comprehensive and well-thought-out treatment plan for the summer months: Peter is to attend a day treatment program in the morning and find a part time job in the afternoon. He is to be monitored for medication by a psychiatrist and see a therapist twice a month, at least. A paraprofessional will spend time with Peter twice a week. He and his mother are authorized to take one trip out of state during the summer to visit Peter's uncle. Julie is required to stop allowing Peter to smoke, to drop him off at day treatment every morning and to find her a separate therapist to help her work on her own issues. Julie is not to intervene if Peter's behavior gets out of control, but should call the assigned paraprofessional or the local crisis intervention unit.

Although this is a good plan and is well resourced, it isn't working for this particular family. Peter and Julie are still having blowups and the paraprofessional and the crisis team haven't been able to respond many of the times that they have been called. Peter has had two short-term hospitalizations as a result and could be looking at a reappearance in juvenile court.

Strengths. It was decided to use a wraparound team to support the family. Following the first step of the equation, the team facilitator helped Julie and Peter to identify some of their strengths. For example, the facilitator learned that Peter was a good hockey player. This was the source of several functional strengths: including the fact that Peter can function as a team member in a fast-paced, competitive sport and that Peter can follow

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[4] See, for example, Saleebey, Dennis (1996) "The Strengths Perspective in Social Work Practice: Extensions and Cautions" *Social Work*: Vol. 41, No. 3, p. 296ff..

the direction of a coach when he feels successful. In addition, it was learned that Peter had some other interpersonal skills: including an ability to use humor with adults to strike up a conversation and keep it going, a deep sensitivity for the needs of the older man for whom his mother provides foster care, and a playful attitude that leads younger kids in the neighborhood to look up to him.

Some of Julie's strengths were her strong sense of independence, her thorough understanding of bi-polar disorder based on years of research and attending conferences, her commitment to hold onto her son, her quick wit, her ability to mobilize resources when the chips are down, and her ability to tolerate experimentation on the part of the system as it struggled to find answers for her son's disorder.

Team. A small team was assembled including a friend of Peter's, a friend of Julie's, the probation officer, a staff person from the day treatment center who had a good relationship with Peter, the nurse from Peter's psychiatrist's clinic and the facilitator.

The team expanded the strengths inventory to include resources that all of the members brought to the circle and then adopted a mission statement: to help Julie and Peter get along well, live safely together and contribute to their community.

Needs. Continuing the equation, the team listened as Peter and Julie thought through their key needs. Peter needed to feel sure that his mother would be there for him, to be in control of age appropriate parts of his life, to have good friends who don't get him in trouble, to learn positive ways to ask for time with his mom, to be able to play hockey, to develop good job skills and to start finding ways to be more independent from his mother.

Some of Julie's needs were to be reassured that the professionals weren't going to take her son away from her, to feel like she is not alone in dealing with her son when he is moody or mouthy, to feel reassured that she is a good mother and to feel like she has reliable back-up when she sets limits for her son.

Plan. The team came up with several actions. Some of them are as follows: Peter was having trouble finding an afternoon job. The team decided to contract with the staff person from day treatment to provide supported employment coaching to help Peter work at a used sports equipment store where he fixed up equipment, including skates and sticks for sale. Peter was not doing well with taking his medication on time, and this was the source of many of his conflicts with his mother. The child and family team decided to organize a peer team with Peter of other kids having trouble taking medications and recruit a coach to work out a game plan with them. To help Julie have backup when setting limits, the paraprofessional agreed to wait outside and talk her through options by cell phone rather than run in and take over immediately.

Unconditional care. Practicing unconditional care means constantly improving on action plans. When an idea doesn't work, the support team figures out what's been learned and modifies the plan accordingly. Core relationships are maintained through transitions in

action strategies. For Peter and Julie, several more iterations in the plan were needed, but finally a new pattern established itself. Membership on the child and family team also shifted several times then settled in. Probably the most interesting addition was Bob, Julie's adult foster client, who didn't have a lot to say, but kept things real for everyone.

Help. Help doesn't mean cure. As action planning with Julie and Peter moved through stages of stabilization, implementation and transition, their lives got better - but Peter still had a neurobiological disorder and Julie didn't loose her ornery independence. Through the summer and fall Peter did learn how to be a teenager and started holding onto friends who didn't get him into trouble. A balanced medication regimen evolved. Peter and Julie worked out rules and roles for living together more effectively. Peter almost made the high school hockey team and was able to stick with a less competitive club team, continuing to work part time to pay for his equipment and ice time fees.

So, is wraparound happening out there?

How can you tell whether, and to what degree your community has implemented the wraparound approach? The following table can be used to take the pulse of your wraparound effort by focusing on the nature of the end product - the action plans and collateral information produced by wraparound teams. With permission from the individuals or families involved, pull the records of ten wraparound teams that have been up and running in your community for at least 6 months. Use the table to take a rough measure of the degree to which these files reflect each of 7 wraparound indicators.

Four descriptive statements follow each indicator. Add the appropriate number of points for each statement that is reflected in the action plan and record for the individual or family. If all four descriptions are applicable, add 10 points for that indicator. A file in which all of the indicators were at the top level would score 70 points. . This table can be used as the basis for system planning, quality improvement discussions or as a teaching tool.

Wrap Indicator	1 point	2 points	3 points	4 points
Are functional strengths identified for the individual or family that is the focus of concern and for the other participants on the wraparound team?	A section in the file lists strengths of the individual or family that is the focus of involvement.	Strengths are listed for the primary client, other family members and friends and also for the other people in the circle of support.	The strengths inventory is updated regularly.	The strengths are concrete and functional.[5]

[5] Functional strengths are skills which can be applied in an organized way to target specific needs, and that make sense in the context in which the team is operating. For example, noting that Peter is a good ice skater is a descriptive strength. Telling a story about how well Peter held things together the winter he was on a junior hockey team puts that strength in context. Building an action strategy around this skill makes it a functional strength.

Is there an action plan that aligns all of the assistance the individual or family is receiving, including formal, informal and natural sources of support?	The file contains a section that describes specific actions to be taken to implement the action plan.	The action plan states specifically who is going to do what, when and with what resources.	The plan describes both formal (paid) support and informal (voluntary) and natural (provided by family members or friends) assistance that will be provided.	The plan incorporates directly or by reference all of the support and services the individual or family will be receiving through all service systems.
Does each component of the action plan build on specific strengths of the individual, family or the other members of the circle of support, and does each component address a critical need that has been identified by the individual or family?	There is an explicit connection between actions and strengths in the plan.	The strengths of other team members are included as foundations for action.	Strength-based actions are linked to a set of prioritized needs.	The file indicates that needs were described and prioritized by the individual or family who are the focus of concern.
Does the action plan include a goal or mission statement and outcome criteria to measure the effectiveness and impact of the plan?	The plan includes a specific statement that describes the goal or mission of the team in functional terms.	The mission statement is used to align the strategies included in the plan.	Outcome indicators are used to measure progress towards the plan's goals.	The team has regularly taken data on the outcome measures and used this information to improve the action plan.
Have potential risks been identified and is there a safety plan that addresses them?	There is a crisis response plan in the record.	The safety plan includes both preventative and responsive components.	The plan has backup alternatives if the first options aren't available or don't work.	The team has used prior critical events as learning opportunities for updating and improving the plan
If initial efforts were not effective, has the primary circle of support remained intact as new strategies and options were developed and implemented?	The team has retained at least 50% of its membership over during the last six months.	At least half of the current members of the team are people who are not paid helpers.	The majority of the team members have specific tasks to carry out in the current action plan.	Members of the team who are paid help givers are implementing strategies that require significant modifications of their standard roles or are stepping completely outside those roles
Has the individual or family that is the focus of concern had access, voice and	The individual or family is regularly asked to indicate their satisfaction with the process	The individual or family members were present for and were active participants in	The individual or family's observations and opinions are explicitly used to	There is a specific inquiry into and report of the degree to which the individual or

ownership in the preparation and implementation of the action plan?	and outcomes of team's efforts.	each team meeting.	identify or prioritize needs and brainstorm possible actions.	family member buys into or feels ownership of the current action plan.

Searching for the real wraparound

Making wraparound happen on a regular basis is hard. Sometimes we can become frustrated with our lack of progress. Many places have experienced surges of progress only to find themselves sliding back. To hold onto the gains we have made, and to use them as a basis for improvement, wraparound must be more than a philosophy or a buzzword. It must be real. Real enough that we can tell when we are using it and when we aren't. Real enough that other people know what to expect from us. Real enough that we can teach it to the next generation of helpers. Real enough that they can see it for what it is and find ways to make it better.

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