INTEGRATED SUPPORTS FOR CHILDREN, YOUTH AND FAMILIES:

A Literature Review of the Wraparound Process

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In 2009, Alberta Education provided a conditional grant to Edmonton Public Schools for the development of a research project and resource materials to support school jurisdictions in establishing or strengthening the use of wraparound approaches.

To build capacity and knowledge related to wraparound approaches in provincial schools, a partnership was developed between Edmonton Public Schools, the University of Alberta and Alberta Education. These partners designed a project to be completed in three phases:

- The first phase included this review of existing research on wraparound approaches.
- The second phase involved research on the use of wraparound approaches in Alberta schools.
- The third phase was focused on the development of resource materials that will assist school jurisdictions and their partners to establish or strengthen wraparound approaches designed to support vulnerable children, youth and their families.

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HIGHLIGHTS OF INTEGRATED SUPPORTS FOR CHILDREN, YOUTH AND FAMILIES: A LITERATURE REVIEW OF THE WRAPAROUND PROCESS

The following is a brief summary of the Literature Review for the Wraparound Research Project. The full report includes: the definition of wraparound, including high fidelity wraparound; implementation of the wraparound process, including challenges and leadership roles; wraparound in education; evidence for outcomes and the challenge of establishing positive associations; a critical assessment of wraparound literature; and future directions of wraparound research.

Wraparound is a process through which the multifaceted needs of children and youth are addressed using a plan for services and supports that requires resources from more than a single school, system or sector. This intervention plan:

- should be focused on serving children and youth in their own communities
- should enhance community ties by connecting community supports and services to the children, youth and families who need them
- should be designed by a team consisting of family members, professionals and natural supports.

Wraparound is based on the belief that families should be equal partners in creating and implementing the plan, and that the plan should be focused on the strengths and assets of the child and family as opposed to focusing on traditional deficit-based practices. The fundamental principles of wraparound, as defined throughout wraparound literature, are:

1. **Family engagement characterized by voice and choice.** Family and youth/child perspectives are intentionally elicited, prioritized and actioned during all phases of the wraparound process.
2. **Team driven.** The wraparound team comprises individuals agreed upon by the family and those providing community support and services. All must be committed to the success of the family.
3. **Natural supports.** The team seeks out and encourages the full participation of team members drawn from family members' networks of interpersonal and community relationships.
4. **Collaborative.** Team members work cooperatively and share responsibility for developing, implementing, monitoring and evaluating a single wraparound plan.
5. **Community based.** The wraparound team implements strategies that take place in the most inclusive, responsive and accessible settings that promote home and community life.
6. **Culturally responsive.** The wraparound process respects and builds upon the values, preferences, beliefs, culture and identity of the child or youth, family and community.
7. **Individualized.** To achieve the goals laid out in the wraparound plan, the team develops and implements a customized set of strategies, supports and services.

8. **Strengths based.** The wraparound process builds on and enhances the capabilities, knowledge, skills and assets of the child or youth, family, community and team members.
9. **Unconditional Commitment.** A wraparound team does not give up on or blame children, youth or their families when there are setbacks. The team aims to meet the needs and achieve the goals until the team reaches agreement that a formal wraparound process is no longer necessary**.**
10. **Outcome based.** The team ties the goals and strategies of the wraparound plan to observable or measurable indicators of success, monitors progress and revises the plan accordingly. (Bruns, Walker, & The National Wraparound Initiative Advisory Group, 2008).

An aspect of wraparound that should be considered is the use of the term wraparound. There are other terms used that capture processes akin to wraparound, such as *network meeting, integrated care, individualized service support plan* and *collaborative services*. Many of these are used as interrelated and, at times, interchangeable terms. Yet, the literature presents a tension with the labeling of certain interventions as either wraparound or not wraparound. Proponents of high fidelity wraparound advocate the necessity of adhering to each of the 10 principles of wraparound (Kendziora, Bruns, Osher, Pacchiano, & Mejia, 2001). But in examples where the process of wraparound is not as tightly defined, such as in cases where wraparound refers to a case management style (McDougall, Worrall-Davies, Hewson, Richardson, & Cotgrove, 2008), it is difficult to determine whether the strong value-base of high fidelity wraparound is being adhered to or whether the only elements of high fidelity wraparound being adhered to are the case management components. This looseness of terminology creates ambiguity in the specificity of the wraparound procedures and the evaluation and measurement of the expected wraparound outcomes. Yet the opposite assumption cannot be made—just because a process is called wraparound one cannot assume that all components of wraparound are actually adhered to in practice. This conundrum may be inherent to any process, such as wraparound, that is required to be flexible, individualized and context-sensitive.

Wraparound, however defined, is based upon the premise that the needs of children and youth with multiple vulnerabilities can best be served when schools, agencies and services participate in both cross-sectoral and cross-agency collaboration. The needs of vulnerable children are often complex and multifaceted and can easily exceed the capacity of any one organization or group. Achieving meaningful change for children, youth and families at the service delivery-level may require integrated, coordinated support from both the organization and system levels. Necessary supports include: accountability structures; responsive bidirectional communication (top-down and bottom-up) between field staff and policy-makers; establishment of greater consistency of services through training, technical

assistance and research; and the political will to collaborate across traditionally separate sectors, such as education, health, social services and justice.

An examination of wraparound in education introduces the specific requirements and benefits of school-based wraparound (Eber & Nelson, 1997). The literature emphasizes that for wraparound to be successful and sustainable, schools must adopt a three-tiered behavioural management system that includes universal, targeted and intensive individual approaches, such as the Illinois Positive Behavior Interventions and Support system[1]. Embedding wraparound in an intervention system can result in greater buy-in from staff, increased sustainability of wraparound, a possible reduction of need for wraparound interventions and faster results (Eber, personal communication, November 24, 2009).

Even with effective processes and structures in place, effective wraparound can be difficult to implement and sustain without knowledgeable support and championing from leadership. An effective leader can help remove barriers to wraparound. For example, some of the implementation challenges noted in the literature for which leaders are essential are: (1) a lack of clarity and uniformity in the definition of wraparound, (2) meaningful inclusion of the family as fully participating team members, (3) the articulation of clearly defined team goals, (4) overcoming policies, organizational cultures and funding structures that work against a single comprehensive plan, (5) adapting a collaborative practice within team member organizations that builds on strengths rather than mitigates perceived deficits in the child, youth and family, (6) encouraging team innovation, creativity and flexibility in finding solutions to issues that arise, (7) difficulty in gathering, organizing and accessing data applicable to interventions, such as wraparound, (8) ensuring the sustainability of trained and competent team facilitators and collaborators, and (9) providing team members with the flexible time needed to participate effectively in the wraparound process. While leadership is no guarantee that these barriers will be overcome, the likelihood of this happening is much greater with an effective leader than without.

Wraparound has a wealth of support and numerous advocates, in spite of the limited measureable outcome evidence. While seemingly contradictory, it appears that many of the impediments to collecting outcome data are also what make wraparound effective. For example: wraparound addresses more than one specific type of concern in broad populations seeking myriad target outcomes; wraparound originated out of a “grassroots” development model without a single protocol as to “what kind of wraparound” is being practiced; and each wraparound planning process is intended to be multifaceted and individualized (Bruns, 2008a).

Though it would be useful to be able to determine the effectiveness of wraparound by gauging the impact on each individual child or family, a systematic assessment of this is impractical as each situation is unique and, often, success is measured relative to the

[1] See: http://www.pbisillinois.org/

current state. Because of this difficulty, wraparound success might best be judged by outcomes at the organizational and systems levels rather than at the individual level (Hernandez & Hodges, 2003). Changes in the culture of care, including documentation of authentic collaboration, sharing of resources and less duplication of services, are all used in the absence of or as a supplement to individual success data (often in the form of personal anecdotes). Evidence for wraparound effectiveness has also been determined through the use of evidence-based interventions included as part of the plan created by the wraparound team.

A critical examination of the body of wraparound literature reveals that it has been overly self-referential in the past and weak in outcomes evidence; however, more recent publications appear to be more deliberate and rigorous in areas of both outcomes data and critical practice. Broadening the scope of the peer-reviewed literature focused on wraparound would be beneficial to the corpus. Areas needing greater expansion in the literature are more peer-reviewed publications from outside the United States, non-expert led outcomes studies, and the differences in practice and theory between preventative and intervention type wraparound.

INTRODUCTION

The following literature review is an examination of peer-reviewed and non-peer-reviewed publications on the wraparound process in order to present the features, contexts and challenges of wraparound. Focus will be placed on the definition of wraparound, including high fidelity wraparound theory; implementation of the wraparound process, including challenges and leadership roles; wraparound in schools; evidence for outcomes and the challenge of establishing positive associations; and a critical assessment of wraparound literature and future directions of wraparound research.

Articles were initially found by searching the online databases ERIC, Nexis-Lexus, and PsychINFO for the term wraparound and related terms such as individualized support plans, social network support, integrated supports and collaborative services. After the 80+ refereed articles were gathered and reviewed, more publications were found via a snowball technique. Finally, a web search, using Google, was conducted to gather nonacademic articles, reports and wraparound-related websites. This review draws from over 140 publications from a broad range of sources including peer-reviewed articles, government reports, training guides and social agency reports, with dates ranging from 1987 to 2010.

The majority of the peer-reviewed literature is from the United States, presenting a national perspective that represents an American paradigm for care, although wraparound also is being adopted in other nations by groups wanting to find alternatives to traditional models of care. The literature from the United States typically focuses on approaches designed to address the needs of children and youth with behavioural and/or emotional difficulties ranging from moderate to severe (Clark & Hieneman, 1999). The few articles from other nations, most notably Canada and the United Kingdom, present wraparound as an approach to address a broad range of complex needs, which could include emotional and behavioural problems, immigrant and refugee challenges, severe physical disabilities, and issues resulting from perpetual poverty. Although the agencies utilizing wraparound theory and the populations participating in wraparound may differ, international literature ostensibly cites the same core components and practices advocated within the U.S.-based literature.

Currently, a wide body of literature defines the core concepts of wraparound, outlines the phases of implementation and examines the necessary requirements at both the practice and system levels. A caution is that although this body of literature is growing in breadth, practical application and academic study, there are still some gaps. There is also ambiguity

in the definitions and terminology of wraparound, weakness in the area of outcomes and evidence, and a dearth of international wraparound literature.

WHAT IS WRAPAROUND?

Wraparound is a definable planning process, first applied in the field of mental health for children and youth presenting with emotional and behavioural needs, that results in a unique set of community services and natural supports that are individualized for a child or youth and his or her family to achieve a positive set of outcomes (Burns & Goldman, 1998). Children and youth presenting emotional and behavioural needs are often found to have the highest dropout rates, the lowest grades and academic achievement, and the highest rate of restrictive and out-of-home placements (Eber, Nelson, & Miles, 1997). There is often confusion about whether wraparound refers to the *treatments and services* provided to the child and youth or to the *actual planning process* (Winters & Metz, 2009). Wraparound is the "*process* through which providers collaborate with families to develop an integrated and creative service plan tailored to the strengths and specific needs of the child and family" (Bruns, Suter, & Leverentz-Brady, 2006, p. 1586). Any type of social service, such as education, health, mental health or judicial, can use the wraparound process to address the needs of their complex cases. Programs or agencies may use wraparound by adhering to the fundamental components of wraparound as one of many strategies for facilitating change in children, youth and their families. A person with complex needs can be served in the best possible manner when all the partners in this treatment process are willing to collaboratively *wrap around* that person.

Within the literature, wraparound is presented as a positive alternative to traditional mental health services, especially since traditional agency-based services have not been that successful in supporting positive outcomes for children and youth with emotional and behavioural needs and have sometimes been ineffective and even detrimental to long-term success (Eber, Phillips, Upreti, Hyde, Lewandowski, & Rose, 2009). For example, Walker and Bruns (2006b) describe traditional children's service systems as "fragmented and uncoordinated, with a hodgepodge of providers, interventions, and payers. Community-based treatment options are often unavailable, and there is a continued over-reliance on residential treatment and other restrictive placements. Such out-of-home placements can cause irreversible damage to family and community ties (p. 49)."

Cailleaux and Dechief (2007) summarize some of the practical differences that distinguish wraparound from other case management approaches, as observed in the Maxxine Wright Place Project for High Risk Pregnant & Early Parenting Women in Surrey, British Columbia:

- wraparound adheres to a specific practice model of key principles that is based on participant voice, choice and ownership, the inclusion of informal supports, and the incorporation of strengths as the basis for planning
- wraparound is both a model of support and a movement that requires a fundamental shift in practice at multiple levels, e.g., front line, organizational and structural
- wraparound focuses significantly on supporting participants' integration into their communities
- practitioners of wraparound strive to move beyond collaboration and toward integration (2007, pp. 20–21)

Wraparound has been described as a progressive mental health intervention because it considers the family not as a cause or barrier to success, but rather as a valuable resource for instigating and sustaining change. Wraparound emphasizes the integration of traditionally separated sectors such as education, health, and children and youth social services.

Wraparound builds on the premise that the collaboration between families, community-based agencies and governmental bodies facilitate greater success in children and youth with multiple needs. The collaboration of system-level partners is based on the recognition that children and youth with complex needs present significant challenges that are extremely difficult for one sector alone to successfully address. Traditional silo-based approaches to case management have not had great success in finding positive outcomes for these youth (Eber, Breen, Rose, Unizycki, & London, 2008).

Wraparound has gained momentum over the last 20 years not only in the United States but in many other nations. It is currently employed by many systems, e.g., education, health, justice and service agencies. It is considered such a promising practice that in 2007 the Governor of Oregon initiated The Statewide Wraparound Project through a Governor's Order (No. 07-04). This order directed a steering committee to develop a strategic plan for statewide implementation of a Systems of Care approach, including wraparound, for the delivery of behavioural health services and supports for children, youth and families. The subsequent House Bill (HB 2144) that requires specified state agencies and commissions to participate in wraparound when providing services for children and youth was signed in 2009 (Oregon Live, 2010).

Not only has wraparound become a highly regarded approach for promoting change in children and youth who do not respond to traditional services (Eber, Hyde, Rose, Breen, McDonald, & Lewandowski, 2009), it is also being implemented as a preventive approach, in

addition to a crisis intervention (Eber, Sugai, Smith, & Scott, 2002), to address the complex needs of many diverse populations.

PRINCIPLES OF WRAPAROUND

The philosophy and practice of wraparound is fundamentally different from what are considered to be "traditional" paradigms of care. Emerging from the field of child and youth mental health and building on conceptual frameworks offered by VanDenBerg and Grealish (1996) and Burns and Goldman (1999), wraparound is characterized as a mechanism through which the multifaceted needs of children and youth are matched to integrated services and supports through a team-created individualized plan of care for a child or youth whose vulnerabilities or needs require services from more than one system or sector. Wraparound is based on the belief that the families of these children and youth are equal partners in creating and implementing the plan and that the plan focuses on the strengths and assets of child and family as opposed to the traditional deficit-based practice.

The intent of wraparound is that the family, in collaboration with a team consisting of both professional and nonprofessional support, should design the intervention plan for care. "Buy-in" from the youth and his or her family is established through collaborative decision-making and equal participation, leading to an iterative feedback loop that facilitates greater empowerment (Walker, 2008). Empowerment literature has shown that when parents and guardians feel empowered they are more satisfied with services, and report better child functioning (Resendez, Quist, & Matshazi, 2000). Ideally, practitioners of wraparound do not place blame on families or instinctively place youth in more restrictive or institutionalized environments (Malysiak, 1998). The subsequent wraparound intervention plan should focus on maintaining children and youth with complex needs within their own communities and on enhancing community ties by establishing natural supports and unique community services for the child or youth and his or her family.

After years of practicing wraparound in the absence of formal guidelines or practice paradigms, practitioners came to a consensus on the fundamental and essential principles of the wraparound process in 1998 (Bruns & Walker, 2010). These 10 core principles reflect a theoretical stance about how children and youth with complex needs and their families should be treated, and state that these families should have their needs met in a democratic and egalitarian way that mobilizes their own community resources (Forkby, 2009). Wraparound emerged as an entire paradigm shift rather than a simple transferable model of practice that could be applied to any case (Bruns & Walker, 2010). After the group of practitioners defined the fundamental principles of wraparound, a monograph (Burns & Goldman, 1999), which included the 10 principles of wraparound, was published and remains the primary guide for wraparound practice (Bruns & Walker, 2010). The

following 10 principles are considered to be fundamental to all current wraparound processes (Bruns, Suter, Force, & Burchard, 2005; Bruns, Walker, & The National Wraparound Initiative Advisory Group, 2008; Burns & Goldman, 1999):

1. **Family engagement characterized by voice and choice.** Family and child/youth perspectives are intentionally elicited and prioritized during all phases of the wraparound process. Planning is grounded in family members' perspectives, and the team strives to provide options and choices such that the plan reflects family values and preferences.
2. **Team driven.** The wraparound team consists of individuals agreed upon by the family and committed to the family through informal, formal and community support and service relationships.
3. **Natural supports.** The team actively seeks out and encourages the full participation of team members drawn from family members' networks of interpersonal and community relationships. The wraparound plan reflects activities and interventions that draw on natural support sources.
4. **Collaborative.** Team members work cooperatively and share responsibility for developing, implementing, monitoring and evaluating a single wraparound plan. The plan reflects a blending of team members' perspectives, mandates and resources. The plan guides and coordinates each team member's work toward meeting the team's goals.
5. **Community based.** The wraparound team implements service and support strategies that take place in the most inclusive, most responsive, most accessible and least restrictive settings possible, and that safely promote child and family integration into home and community life.
6. **Culturally competent.** The wraparound process demonstrates respect for and builds on the values, preferences, beliefs, culture and identity of the child/youth and family, and their community.
7. **Individualized.** To achieve the goals laid out in the wraparound plan, the team develops and implements a customized set of strategies, supports and services.
8. **Strengths based.** The wraparound process and the wraparound plan identify, build on and enhance the capabilities, knowledge, skills and assets of the child and family, their community and other team members.
9. **Unconditional.** A wraparound team does not give up on, blame or reject children, youth and their families. When faced with challenges or setbacks, the team continues working toward meeting the needs of the youth and family and toward achieving the

goals in the wraparound plan until the team reaches agreement that a formal wraparound process is no longer necessary.

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

These essential principles of wraparound embody an ecological perspective in which the child's or youth's ecological strengths (family, environment, context, etc.) are examined and addressed in a manner similar to that used in progressive community and international development, in which the process of democratic and equal participation is in itself both empowering and transformative (Burns & Goldman, 1999; Malysiak, 1998).

Many service providers also use these 10 principles as foundational principles for their own human service work (Cailleaux & Dechief, 2007; High Fidelity Wraparound, 2008)**.** Some proponents of wraparound claim that the care approach must adhere to all 10 principles, otherwise the approach cannot be called wraparound (Kendziora et al., 2001). The practical application of these 10 essential principles is discussed in detail in Kendziora et al.

The collaboration of agency and system-level partners, as emphasized in wraparound, is based on the recognition that children and youth with complex needs present significant challenges that are extremely difficult for one sector alone to successfully address. Such multisectoral collaboration, often necessitated by wraparound, is a major component of the *Systems of Care* paradigm.

The Systems of Care model, coming out of the United States, is described as an ambitious attempt to coordinate service components for children and young people with high needs. The model encompasses mechanisms, arrangements and structures to ensure that services between systems and sectors are provided in an integrated way (Schmeid, Brownhill, & Walsh, 2006). Systems of Care has been defined loosely as a range of services and supports, guided by a philosophy and supported by an infrastructure (Stroul & Blau, 2010). The system of care philosophy specifies that each community must determine its own "planning process to plan, implement, and evaluate its system of care based upon its particular needs, goals, priorities, populations, and environment and must change and adapt its system of care based on changes in its political, administrative, fiscal, or community context" (Stroul & Blau, p. 60).

Wraparound, perhaps the most direct practice-level representation of the systems of care philosophy (Bruns & Walker, 2010), is distinguished from other system of care processes by its philosophical underpinnings (Walker & Schutte, 2004). In a New South Wales

Department of Community Services document, wraparound is described as a “promising” systems of care intervention that provides more focused attention on the way in which service delivery is planned (Schmeid et al., 2006).

HIGH FIDELITY WRAPAROUND

The history of wraparound theory reveals that when too few implementation guidelines are available the quality and fidelity to the philosophical foundations are inconsistent (Bruns, 2008b; Bruns, Burchard, & Emold, 2001). Therefore, a greater emphasis on adherence to the *values* of wraparound rather than to the creation of prescriptive models has been emphasized in wraparound literature. This adherence to the philosophical underpinnings of wraparound has been called *high fidelity* wraparound.

Wraparound fidelity implies that:

- the 10 value-based principles of wraparound are being adhered to
- the basic activities of facilitating a wraparound process are actually occurring
- supports are available at the organizational and system levels (Bruns, 2008b)

In the late 1990's wraparound was in danger of being discredited, as a result of too many poor attempts at implementation (Furman, 2002) and not enough documentation on the positive outcomes associated with the process (Bruns, 2008b; Bruns, Suter, & Leverentz-Brady, 2008). Researchers proposed that adherence to the wraparound value base will promote the desired outcomes because adherence to the 10 principles requires teams to develop an understanding of a child and family's unique environment, and to build an individualized plan that promotes adaptive and supportive relationships among the family, community and service providers (Burchard, Bruns, & Burchard, 2002; Burns, Schoenwald, Burchard, Faw, & Santos, 2000; Walker, 2008). Both research and theory generated the expectation that high quality wraparound practice would improve outcomes for children and youth (Bruns).

In response to the concerns about fidelity and poor implementation practices, Burns and Goldman published a United States federally-funded monograph in 1999 that focused on the core elements and practice principles of wraparound as a need arose for greater clarification of the core phases, activities and steps/phases associated with the wraparound model. In 2003, a collaboration of wraparound practitioners (family members, researchers and experts) came together to publish another monograph (Walker, Koroloff, & Schutte, 2003) (the phases are listed in the Implementation section of this paper). Between the 1999 document, defining the core values of wraparound, and the 2003 document, defining the core activities and required system supports of wraparound, the literature became far more applicable and useful to practitioners in the field (Burns & Goldman, 1999; Walker et al.). In addition to providing a stronger consensus on the core phases and activities of the model, these robust

publications provided a critical starting point for facilitating better measurement of fidelity and the evaluation of wraparound outcomes (Walker & Bruns, 2006a).

Instruments for assessing fidelity to wraparound principles were initially developed after publication of the 1999 Burns and Goldman monograph. Again, following the 2003 monograph, more fidelity instruments emerged. Among the more widely used measures are the Wraparound Fidelity Index (WFI) (Bruns, Burchard, Suter, Leverentz-Brady, & Force, 2004), which collects interview data from parents, youth and wraparound facilitators, and the Wraparound Observation Form (WOF) (Epstein et al., 1998), which measures adherence to wraparound principles as observed during team meetings (Bruns, 2008a). The intent of the WFI is to assess adherence to the elements and practice principles from the vantage point of the individual family and team (Burchard et al., 2002). The WOF measures adherence to wraparound principles by practitioners during observation of wraparound team meetings with family members, community partners and the child (Epstein, 1998). Other scales that support measurement of outcomes have also been created, such as the Behavioral and Emotional Rating Scale: A Strength-based Approach to Assessment (Epstein).

Greater adherence to the 10 core principles, as measured by the WFI, has been associated with positive child and youth and family outcomes, including behavioural strengths ratings, child functioning, restrictiveness of living, placement changes, and parent satisfaction with the child's progress (Bruns, Suter, & Burchard, 2002; Bruns et al., 2005). In one United States study, WFI scores were significantly correlated with behavioural improvement as determined by a weekly log of negative behaviours over a six-month period (Bruns et al., 2005). The corollary to this—that lower adherence to protocol has been associated with poorer outcomes—has also been documented (Dane & Schneider, 1998).

The WFI and WOF are used to assess fidelity to the specific values of the wraparound theory, as opposed to other techniques that attempt to assess wraparound fidelity using alternative methods, although they have not been as useful. For example, Toffalo and Douglas' study, which examines outcomes associated with wraparound integrity, defined wraparound integrity as the percentage of service hours prescribed by a team versus hours actually received by the child (2000, p. 351). Toffalo and Douglas concluded that adherence to prescribed treatment hours may not be related to behavioural outcomes in a wraparound setting. The authors conceded that "the idea that more hours equal better outcome is philosophically incompatible with wraparound services. In contrast, the wraparound model posits that meeting individual service needs, which can vary greatly among children, is most salient to outcome" (Toffalo & Douglas, p. 359).

Fidelity to wraparound principles has an element of importance that goes beyond the measuring of outcomes and variables. High Fidelity wraparound ensures the propagation of the values and philosophies advocated in the 10 essential principles of wraparound (Bruns, 2008b). Some of the 10 essential principles of wraparound represent a *moral* implication regarding the value of the individual and his or her own right to quality of care, e.g., family voice and choice, cultural responsiveness, and unconditional commitment. It is this fundamental humanistic stance that proponents of wraparound do not want diluted.

WHO RECEIVES THE WRAPAROUND PROCESS?

The wraparound process was originally developed to address the needs of children and youth with emotional and behavioural needs within the mental health and child welfare systems (Scott & Eber, 2003). Practitioners of wraparound were especially focused on serving children and youth who were being referred to out-of-home placements due to their emotional and behavioural needs (Clark, Lee, Prange, & McDonald, 1996). Since traditional referrals to residential or out-of-home placements for children and youth with complex needs was not achieving positive change, a common goal of wraparound was to plan for community-based interventions as an alternative to institutionalized or residential care (Eber, Hyde et al., 2009). Reducing out-of-home treatment is considered to reduce the high cost of institutional care, address the lack of evidence for the effectiveness of institutionalization, and present a philosophical shift toward providing care in the most normalized setting (Walker & Bruns, 2006a).

Currently, wraparound is used for addressing numerous complex needs, not just limited to addressing emotional and behavioural needs. Wraparound, with its focus on the 10 principles, is an intervention process that can be applied to situations in which individuals have compound needs across all life domains, especially when such needs are addressed across many service agencies and/or government ministries. Other distinct populations with complex needs served by wraparound, as presented in publications, are recent immigrants (Human Resources and Skills Development Canada, 2008), transnational families (Furman, Negi, Schatz, & Jones, 2008), those with significant physical disabilities (Bradley et al., 2001; Freeman et al., 2006), teen mothers (Cailleaux & Dechief, 2007), youth in gangs (Totten, 2008), the unemployed (Skills Australia, 2009) and victims of torture (Kira, 2002).

IMPLEMENTATION OF WRAPAROUND

Initially wraparound researchers and practitioners were in a quandary about whether to provide clear steps and procedures for wraparound implementation, or leave greater flexibility for contextualization and individualization. Producing a series of implementation guidelines within handbooks and training manuals was thought to risk the creative and individualistic nature of wraparound being diminished (Bruns & Walker, 2010; Walker, 2008). Yet outcomes studies demonstrated that positive changes in clients were being associated with higher fidelity wraparound (Bruns et al., 2005; Bruns, Rast, Peterson, Walker, & Bostworth, 2006). Consequently guidelines and frameworks for implementation of higher fidelity wraparound were created.

There is little in the wraparound research literature on the prescriptive steps for implementation of wraparound, rather there is a greater focus on the phases of implementation and on case studies demonstrating contextualization and individualization. The following table of the phases of wraparound reflects the results of a research project intended to clarify the types of activities that must be included in a full wraparound process (Walker et al., 2004). The authors state that their publication "focuses on *what* needs to happen in wraparound; however, *how* the work is accomplished is equally important. Merely accomplishing the tasks is insufficient unless this work is done in a manner consistent with the 10 principles of wraparound" (Walker et al., p. 2).

Major Tasks/Goals and Activities
Phase 1: Engagement and team preparation
1.1 Orient the family and youth
1.1 a. Orient the family and youth to wraparound.
1.1 b. Address the legal and ethical issues.
1.2 Stabilize crises
1.2 a. Ask family and youth about immediate crisis concerns.
1.2 b. Elicit information from agency representatives and potential team members about immediate crises or potential crises.
1.2 c. If immediate response is necessary, formulate a response for immediate intervention and/or stabilization.
1.3 Facilitate conversations with family and youth/child
1.3 a. Explore strengths, needs, culture and vision with child/youth and family.
1.3 b. Facilitator prepares summary document.
1.4 Engage other team members
1.4 a. Solicit participation/orient team members.
1.5 Make necessary meeting arrangements
1.5 a. Arrange meeting logistics.
Phase 2: Initial Plan development

2.1 Develop an initial plan of care
2.1 a. Determine ground rules.
2.1 b. Describe and document strengths.
2.1 c. Create team mission.
2.1 d. Describe and prioritize needs/goals.
2.1 e. Determine goals and associated outcomes and indicators for each goal.
2.1 f. Select strategies.
2.1 g. Assign action steps.
2.2 Develop crisis/safety plan
2.2 a. Determine potential serious risks.
2.2 b. Create crisis/safety plan.
2.3 Complete necessary documentation and logistics
2.3 a. Complete documentation and logistics.
Phase 3: Implementation
3.1 Implement the wraparound plan
3.1 a. Implement action steps for each strategy.
3.1 b. Track progress on action steps.
3.1 c. Evaluate success of strategies.
3.1 d. Celebrate successes.
3.2 Revisit and update the plan
3.2 a. Consider new strategies as necessary.
3.3 Maintain/build team cohesiveness and trust
3.3 a. Maintain awareness of team members' satisfaction and buy-in.
3.3 b. Address issues of team cohesiveness and trust.
3.4 Complete necessary documentation logistics
3.4 a. Complete documentation and logistics.
Phase 4: Transition
4.1 Plan for cessation of formal wraparound
4.1 a. Create a transition plan.
4.1 b. Create a post-transition crisis management plan.
4.1 c. Modify wraparound process to reflect transition.
4.2 Create a "commencement"
4.2 a. Document the team's work.
4.2 b. Celebrate successes.
4.3 Follow-up with the family
4.3 a. Check in with family.

Along with the phases and activities required for any wraparound, there are guidelines that indicate system readiness for wraparound. The list of requirements builds on the essential 10 principles of wraparound by providing a firmer understanding of system resources

needed to implement effective wraparound. The following *Requirements for Practice* were presented in 1999 by Burns and Goldman:

1. The community collaborative structure, with broad representation, manages the overall wraparound process and establishes the vision and mission.
2. A lead organization is designated to function under the community collaborative structure and manages the implementation of the wraparound process.
3. A referral mechanism is established to determine the children and families to be included in the wraparound process.
4. Resource coordinators are hired as specialists to facilitate the wraparound process, conducting strengths/needs assessments, facilitating the team planning process, and managing the implementation of the services/support plan.
5. With the referred child and family, the resource coordinator conducts strengths and needs assessments.
6. The resource coordinator works with the child and family to form a child and family team.
7. The child, family, natural supports and facilitator function successfully as a team, with the child and family engaged in an interactive process to develop a collective vision, related goals and an individualized plan that is family-centered and team-based.
8. The child and family team develops a crisis plan.
9. Within the service/support plan, each goal must have outcomes stated in measurable terms, and the progress on each is monitored on a regular basis.
10. The community collaborative structure reviews the plans.

These *Requirements for Practice* emphasize the necessary structures and protocols that support high fidelity wraparound and the fundamental steps required to maintain the philosophical nature of wraparound (e.g., Requirements 6 and 7).

From 2008 onward, the National Wraparound Initiative in Portland, Oregon, has created an online resource presenting a vast amount of information about wraparound that is consistently updated. Wraparound-related subjects from the academic to the applied, such as the theory of change paradigm and the 10 most common mistakes teams make with families, are published online (www.rtc.pdx.edu/NWI-book). This rich resource presents a unified theory of wraparound and its practice, which had been defined through consensus among wraparound researchers, practitioners and families (Bruns & Walker, 2010). This online resource is provided to reduce certain implementation issues that have plagued wraparound since its inception. A few of the major areas presented in the wraparound

implementation literature (wraparound team and supervision of wraparound) are introduced in the following sections.

WRAPAROUND TEAM

The potential for positive change in individual clients through wraparound can be distilled down to the functioning of the wraparound team. Walker, Koroloff and Schutte define the wraparound team in its most basic form as "the caregiver and youth and at least two or three other consistently attending core members … who are charged with creating and implementing plans to meet the needs of the family and child with an emotional disorder. This core team may be supplemented as necessary by others who attend when their role in the plan is under consideration or when their input is invited" (2003, pp. 4–5). Team functioning is more than a network of collaborating partners; individual buy-in to wraparound process is also necessary (Pierce, 2008). A United Kingdom study of professionals working with children and young people with high needs stressed the value of good working relationships at the grassroots level (Worrall-Davis, Kiernan, Anderton, & Cottrell, 2004).

However, compared to its importance, little is published on the types of techniques, processes and procedures that translate the theoretical value of the wraparound team into the practical implementation of a highly functioning team (Walker et al., 2003); in fact creation of the team and its practices are rarely presented outside of detailed real life cases. An exception is the monograph by Walker, Koroloff and Schutte (2003) on effective strategies for team composition and on how to ensure greater commitment to the team. The authors emphasize some basic characteristics teams need to maximize the probability of effectiveness.

1. Team adheres to meeting structures, techniques and procedures that support high quality planning.
2. Team considers multiple alternatives before making decisions.
3. Team adheres to procedures, techniques and/or structures that work to counteract power imbalances between and among providers and families.
4. Team uses structures and techniques that lead all members to feel that their input is valued.
5. Team builds agreement around plans, despite differing priorities and diverging mandates.
6. Team builds an appreciation of strengths.
7. Team planning reflects cultural competence (Walker et al., 2003, p. 27).

Walker, Koroloff and Schutte add, “the intention is not to provide a full practice model. Instead, the sub-conditions summarize the *types* [authors’ emphasis] of information that should be included in a practice model” (2003, p. 27). Walker and colleagues also claim the efficacy of wraparound is dependent upon the team’s ability to promote cohesiveness and high quality planning in a manner consistent with the wraparound value base. Walker’s article (2008) examining the theory of change behind wraparound, discusses many aspects of running a team while also maintaining the fundamental principles of wraparound. This article merges the theory and practice of wraparound, especially at a team-level, and creates areas of focus for wraparound practitioners. Walker also claims that teams are most effective when they develop plans that incorporate intermediate and long-term goals, accompanying strategies, options and monitoring.

Familial buy-in is encouraged by the composition of the wraparound team. The makeup of the team is intended to avoid traditional, professionally driven and deficit-focused case management situations (Malysiak, 1998). In order for wraparound teams to be most effective in addressing the needs of the child and family, collaboration and coordination between families, agencies, schools, healthcare services and any other services is necessary. Prioritizing the family’s perspective is essential to effectiveness in wraparound, but it may be difficult to do. Building perceptions of cooperativeness and psychological safety is particularly difficult for teams whose members are diverse in terms of their knowledge, skills, values and backgrounds (Walker et al., 2003). Supporting families to feel comfortable in the team should be a primary concern, which is why the identification and involvement of natural supports on the team is so important. The team must resonate with the family; it should be *their* team. Following strict wraparound principles, the family should have the final say as to who is on the team, what needs should be focused upon, and how quickly or slowly these needs should be addressed (Debicki, 2009). In this way, the goal of the team is to put people back in charge of their lives so that they do not feel helpless and powerless (Debicki).

Wraparound teams endeavour to optimize efficiency by avoiding the duplication of services that so often happens when agencies deliver their services in an isolated, non-coordinated and vertically controlled manner. Traditional siloed approaches can lead to a feeling of hopelessness in families, created by uncoordinated and even conflicting agency mandates and service plans (Winters & Metz, 2009). Some agencies that function independently may resist adjusting to the collaborative model, yet agencies participating in the wraparound process should be amenable to reducing their power within the team. True collaboration between service agencies requires a level of system support that can

facilitate changes, such as the softening of service mandates, shared confidentiality agreements, consensual decision making and team ownership of decisions and outcomes.

According to the Vroon VanDenBerg (2010) wraparound website, a good wraparound plan is composed of not more than 25% formal services and supports and 75% natural supports. Natural supports are intended to be individuals from the community, e. g., neighbours, pastors, friends, family members, etc., who are able to provide support for the family during the implementation of the wraparound plan. The inclusion of these nonprofessional supports helps support sustainable change after the wraparound process is complete. Literature about wraparound teams generally infers that the inclusion of natural supports on teams is often lacking and is one of the most challenging components of wraparound (Dalder, 2006).

In the wraparound process, achievement of positive change for children, youth and their families is dependent upon the team, including child and youth, family, natural supports, and professionals, facilitating positive change (Walker, 2008). The preliminary positive changes initiate an iterative loop that supports better self-efficacy, adaptability and changeability for the youth and family (Walker). In practice, however, this theoretical iterative feedback is difficult to achieve; this will be discussed in the following section on implementation challenges.

IMPLEMENTATION CHALLENGES

When attempting high fidelity wraparound, challenges are to be found at all levels of implementation—from team level to the level of governmental policy-makers. These challenges are typically presented in non-peer-reviewed literature focusing on implementation issues rather than outcomes. The following are a few of the most commonly cited challenges encountered when wraparound is practiced:

- **The term wraparound is used too loosely.** Agencies claim they offer wraparound *programs* when almost none of the components of wraparound are adhered to. Wraparound is referred to as a specific service, even if the family is not part of decision making or it is taking place outside of the community in residential treatment centres (Burchard et al., 2002). Some agencies label their intervention as *wraparound* if they have used funding from two separate agencies, even though all families received the same array of services (Burchard et al.). In short, there is not always an awareness that wraparound is a comprehensive approach requiring a specific set of values, elements and principles, all of which have to be in place (Burchard et al.). In the John Howard Prince Edward Island wraparound evaluation, it

was evident that the practitioners adapted the principles of wraparound to the constraints imposed on their practice setting by their agency mandate and the level of stakeholder knowledge (Atlantic Evaluation Group Inc., 2006). Such adaptations, though necessary in most instances, dilute fidelity to the core components of wraparound.

- **True partnership between the professionals and the families of the children/youth is difficult.** There is an inherent power relationship between team facilitators and family members, especially when a family's participation in wraparound is mandated. Even in non-mandated instances, families are often not used to being in control of decisions in the realm of social services and there can be a hesitancy to bring forth ideas. Human service professionals may be skeptical of parents' expertise and parents' ability or desire to make decisions in the best interests of the child (Allen & Petr, 1998). When these differences occur, the professionals' viewpoints likely prevail during decision making and their higher social status can dominate discussion. Walker, Koroloff and Schutte (2003) offer practical solutions to this common failing of wraparound teams. Practitioners can often fail to define the true needs of the family, especially in a strengths-based manner, which makes equal partnership, let alone buy-in and empowerment, more difficult to achieve (Walker et al.).

- **Only one-quarter of wrapround teams surveyed in a recent study had clearly articulated team goals** (Walker et al., 2003). It is of central importance that wraparound teams become more aware of the importance of having both intermediate and long-term goal structures (Walker et al.).

- **Policies, organizational cultures and funding structures work against a single comprehensive plan that extends beyond formal services.** A successful cross-system unified plan is difficult to achieve, especially as it requires extensive support from leaders and policy-makers at both the jurisdictional and provincial/state levels (Walker, 2008). This is compounded by the existence of different criteria for eligibility and administrative processes required to access funding or services. At the practice level, practitioners often lack the skills, knowledge and services to implement these challenging collaborative plans (Walker).

- **Collaborating agencies do not follow strengths-based and recovery-oriented models of practice,** which often demonstrate different goals. Practitioners of wraparound often seek different outcomes than the outcomes sought from more traditional agencies and systems. The outlooks and attitudes of traditional partners can cause conflict

within the team setting, a lack of support for the clients and greater difficulty achieving effective collaboration (Walker, 2008).

- **Wraparound team plans often lack creativity and individualization,** which may be a result of limitations put on the team due to resources, policies and funding structures (Walker, 2008). Walker and colleagues (2003) found that only 12% of interventions were individualized and unique to each family. Teams with a diversity of perspectives have the potential to be more creative than more homogeneous groups because disagreement can stimulate a variety of solutions.

- **The lack of natural and informal supports on the team is problematic.** Families often think the natural supports are being asked to "help" the family, rather than support the team (Meyers & Miles, 2003). A recent United States survey of 10 wraparound processes in nine states used the Wraparound Fidelity Index (WFI) to measure the presence of natural supports within 667 families participating in wraparound. The survey showed that natural supports were minimally represented: 60% of families had no natural supports, 32% of families had one person available as a natural support, and only 8% of families had two or more natural supports involved with their team (Meyers & Miles). Natural supports are important to the wraparound process, especially to help advocate for parents, since participation in wraparound can be intimidating for families (McGinty, McCammon, & Koeppen, 2001).

- **The difficulty of gathering, organizing and accessing data is a challenge for wraparound teams.** Wraparound rests heavily upon measurable outcomes and use of data. This is especially important in certain systems, such as education. School leaders need to view and champion data use as integral to school reform processes (Lachat & Smith, 2005), but the gathering and application of data often requires support and training.

- **The sustainability of trained and competent team facilitators is a continual problem for wraparound programs** (Northwest Wraparound Group, 2010). High quality wraparound is a complex undertaking. Professionals serving on wraparound teams require significant training and other supports (Walker et al., 2003), including a grounding in the evidence-based services and supports that might be used within the wraparound process (Bruns, Walrath, & Sheehan, 2007).

- **Wraparound is a demanding process that requires consistent internal evaluation in order for it to be successful.** These assessments should focus on collected data, self-assessment of the wraparound implementation style and philosophy, and achievement of measurable outcomes and planned goals (Cailleaux & Dechief, 2007).

- **The most important resource required for wraparound is personnel time.** Practitioners of wraparound often practice out of overly taxed agencies and services. This problem is further compounded by limited access to referring agencies. The challenges that wraparound approaches face are not insurmountable; however many of the concerns and challenges cannot be addressed at the level of the team. Many need to be addressed at a supervisory level for an effective decision-making body to be available to instigate change and reduce barriers to implementation.

SUPERVISION OF WRAPAROUND

Barriers to wraparound can exist at all levels of intervention, which is not surprising considering that successful wraparound requires numerous shifts in multiple venues of attitudes, programming and funding (McGinty et al., 2001). Challenges are inevitable, but consistent self-reflection of practice helps to ensure that the principles are understood and actually being practiced. It is freely recognized that wraparound requires intensive and ongoing training, supervision and administration support (Bruns, 2008b).

For successful wraparound, one of the most important factors is the support and cooperation of the organizational structures within which the wraparound team and collaborative partners operate (Bruns, Walker et al., 2008; Koroloff, Schutte, & Walker, 2003). Evidence demonstrates that the presence or absence of necessary support conditions will likely influence the quality of service planning and the implementation of such services (Bruns, Suter et al., 2006). In general, wraparound needs to be supported by all levels of supervision. This vertical supervisory structure obviously differs between agencies, contexts and regions. These contextual differences make defining specific supervisory structures unlikely, however working definitions of various levels of supervision are necessary.

Walker, Koroloff and Schutte present a three-tiered wraparound structure: (1) team level, (2) organizational level, and (3) systems level (2003). The organizational level can be defined as the agency, school or body taking the lead of the wraparound and the responsibility for hiring, training, and supervising team facilitators. The collaborating partner agencies are also part of this level of implementation and supervision. The dynamics of the collaboration between organizations are entirely context-dependent. The organizational level is responsible for all operational decisions and supervision of the team and the resultant collaboration. The systems level or *policy and funding context* is the larger service policy and economic context that surrounds the teams and the team members' agencies. The systems level represents multiple organizations that may focus on

a specific set of services (e.g., mental health), a geographic area (e.g., county), a population (e.g., children), and multiple governmental entities at the county, regional or provincial level that set policy, monitor or enforce policy, or interpret state or national policies to local service providers (Walker et al.).

Support for wraparound is required from all layers of supervision and for all aspects of wraparound, but advocacy and communication, flexibility, funding and accountability are some of the areas most commonly cited as needing support.

Advocacy and Communication

In order for systems-level decision makers to be conversant in the needs of wraparound, they must be aware of or even trained in the precepts and values of wraparound. These systems-level individuals are able to become the necessary champions wraparound requires when trying to address old problems with new methods. These champions are necessary to oversee and advocate for wraparound at the systems level when inevitable issues—such as policy, funding and cross-sectoral mandates—arise.

The wraparound process is supported through openness and direct avenues of communication between all participants, including all participating organizations and policy-makers. Being part of a larger system of care requires that agency-level compliance, relevant legislation, administrative rules and funding requirements are created and enforced; thus, creating the need for a top-down or forward-mapping approach (Walker, Koroloff, & Bruns, *in press*). However, a system designed to facilitate individualized wraparound plans cannot be successful unless it also has the capacity to be backward mapped from the agency level up to the policy level (Walker & Koroloff, 2007; Walker et al., *in press*). In *backward mapping* the focus needs to move upward through the levels of implementation, to identify the policies, resources and supports that are needed from higher levels if the desired outcomes at the team level are to be achieved (Walker et al.). In other words, communication routes need to be simultaneously bottom-up and top-down to ensure quality assurance and accountability of the programs that practice wraparound (Bruns, Suter et al., 2008).

Organizational leadership needs to be aware of operational issues and be able to address the barriers to cooperation and collaboration in order to create a better understanding of wraparound, its role in a system of care and its goals for the client(s). For example, when wraparound is practiced, internal struggles and difficulties may arise due to wraparound practitioners having seemingly lower caseloads and higher funding (Atlantic Evaluation

Group Inc., 2006). Any shift in service delivery that requires a change in the status quo may create staff reticence; moreover the philosophical tenets of wraparound may arouse additional resistance due to shifts of power outside of agencies toward family and community, the use of non-measurable outcomes, and mandatory collaboration (Cailleaux & Dechief, 2007). The context and sources of challenges such as these should be communicated to supervisory structures at the organizational level, and possibly even to systems-level structures. Both of these supervisory structures must be amenable to backward mapping of communication and also forward mapping by communicating support and solutions from the supervisory level to the organizational level in order to address such structural tensions.

Flexibility

Wraparound relies upon flexibility within the wraparound process and the collaborative agencies. The organizational structure hosting the wraparound process can support and enhance the process by increasing the flexibility of its own programming. An example of the required flexibility is helping families choose providers that meet their needs, as determined in the plan, such as personal care services and respite care, as opposed to having the services chosen for them (Walker et al., 2003). Traditional contracts or service arrangements may have to be softened to facilitate more individualized services by allowing the team to drive the demand for the services, which allows for greater individualization and empowerment of the team (Koroloff et al., 2003). Individual choice supports the iterative loop that further bolsters the participatory nature and empowerment of the team (Walker, 2008). The blend of formal and informal services in the community, one of the hallmarks of wraparound, can be difficult to support due to administrative, funding and structural barriers. These barriers can become more flexible and permeable in order to facilitate greater community collaboration. These challenges can only be addressed when the decision makers at both organizational and systems levels are present, and are championing wraparound within the realms of their purview.

Funding

At the organizational level, teams require flexible funding for nontraditional community-based services for both child and family. Flexible funding has been highly recommended as a necessary component of wraparound (Resendez, 2002). Flexible funding also requires support from all levels of implementation (Burns & Goldman, 1999) in order to bypass the limiting of budgeting systems for application and reporting. System support can be found within a wide range of funding practices, such as incentives for keeping children and youth

within their own communities and/or homes and using the resulting savings from reduced residential treatments to increase the service capacity of the community (Burns & Goldman). Wraparound requires a fundamental shift in philosophy for policy-makers and service providers alike; it requires spending time, energy and money on families who may have moved beyond immediate crises, and on the prevention of further crises (Cailleaux & Dechief, 2007).

ACCOUNTABILITY

One of the most important roles for leadership at the organizational (or higher) level is in the realm of accountability. Accountabilities could be focused on the actual wraparound process, on staffing and related issues and on gauging outcomes. A primary concern for supervisors is how meaningful change is documented, and what types of evidence are considered relevant and the most *demonstrative* of positive change, especially for funders and policy-makers at the systems level (Hernandez & Hodges, 2003; Walker, 2004).

Just as team leaders are expected to be accountable to both the families and their agencies, supervisors need to be accountable to both to staff in the field and to the funding structures and their mandates. At the organizational level, the lead agency is responsible for monitoring operations, such as adherence to the practice model, implementation of plans, cost and effectiveness (Walker, 2004). Organizational-level supervisors must also ensure that documentation requirements meet the needs of systems-level policy-makers, funders and other stakeholders (Walker). If there is a disconnect between the organization and systems-level requirements, a communication structure that facilitates forward and backward mapping is necessary.

Each level of accountability requires some form of coordination and responsibility; these systematic components must be initially built into the wraparound process and structure to ensure sustainability and systemic accountability. An example of how wraparound builds accountability structures into the whole system is taken from the Illinois PBIS website[2], which clearly defines the structure of a supervisory team. Though this supervisory team reflects the requirements of a school system incorporating wraparound into a school-wide behavioural plan, this collaborative leadership structure would be similar to other systems

[2] *Positive Behavior Interventions and Supports (PBIS) is a proactive systems approach to establishing the behavioural supports and social culture and needed for all students in a school to achieve social, emotional and academic success. Wraparound is an integrated component of the Illinois PBIS tertiary intervention strategy. See http://www.pbisillinois.org/.*

engaged in systems of care practice, such as wraparound. According to PBIS Illinois, supervisory teams should include: (1) a director of special education (or other district-level decision maker), (2) a district external coach for school-wide behavioural support system, (3) a district wraparound coach, (4) a principal from each school-based wraparound team (referred to as the tertiary team), and (5) wraparound facilitators from each school-based wraparound team (may represent more than one school team each) (Illinois PBIS Network, 2010). Lucille Eber, the Statewide Network Director for Illinois PBIS, considers this commitment of participation and resources from supervisors a prerequisite to successful wraparound. She does not support practicing wraparound without this level of leadership commitment (personal communication, November 24, 2009,).

SYSTEMS-LEVEL POLICY

Interestingly, Handron, Dosser, McCammon, & Powell (1998) claim that the concepts of wraparound and systems of care have done well within conservative political party systems in the United States due to the fact that such services appeal to family-oriented and community-based values. However, the increasing demand for comprehensive, individualized, family-driven care support plans, such as wraparound, is not matched by the capacity for implementation because these approaches do not necessarily flourish within traditional agencies and systems. This dilemma has highlighted the need for information about how the systems level must evolve if it is to provide a hospitable implementation environment for individualized interventions such as wraparound (Walker & Koroloff, 2007). Issues such as how flexible funding is accessed and spent, or how staff 'turfdom' concerns are managed, are administrative; but how intersectoral collaboration is facilitated, or even mandated, and determining who is accountable for the quality of a program, are issues related to legislation and policy at the systems level.

Systems-level barriers can derail wraparound implementation before it begins, so governmental ministries responsible for vulnerable populations requiring wraparound may have to alter policy or administrative practice. Governmental ministries responsible for facilitating a shift in the culture of care paradigm would need to examine issues such as incentives for wraparound and changes to the curtailing structural impediments such as confidentiality and funding. Consequently, the bodies governing sectors relevant to the collaborative practices of wraparound, such as justice, health, mental health, education and social services, would need to be aware of the wraparound practice and some of its requirements. Issues such as shared funding, softening of sector mandates, and shared confidentiality agreements are a few of the barriers that may be addressed at this level of

leadership. Finally, systems-level leadership should be able to provide the structural framework and sectoral linkages for wraparound, but should not be involved in discrete procedural programming and service delivery.

The power and authority of the provinces/states and communities to address their needs locally and independently has led to an appreciation for the critical role of provincial/state governments in ensuring the accountability and uniformity of services across locations and systems (Handron et al., 1998). Accountability and uniformity are supported through training, technical assistance, policy and research. Yet, as discussed in the previous section, communication and accountability structures should be both forward and backward mapped. Wraparound literature emphasizes that achieving meaningful change at the level of agency delivery requires extensive support from the organizational level, as well as from the systems level (Clark et al., 1996; Koroloff et al., 2003). Communication channels must be open and bidirectional.

WRAPAROUND IN SCHOOLS

One of the best examples of a wraparound practice embedded within organizational and systems-level structures can be found in the Illinois school system. Traditionally the most common focus for wraparound has been in child and youth mental health and welfare services. However, wraparound has become more common in the realm of education; schools, in fact, have actually begun to assume a primary role in initiating wraparound (Nordness, 2005). Yet wraparound is more than just the planting of professional supports in school; rather the culture of the whole school must be addressed to achieve sustainable change for vulnerable children and youth, and for collaboration to be productive (Cooper, 2008).

In the United States and other nations, schools are usually the initial, and often *de facto*, mental health system for children and youth (Burns et al., 1995). Mainstream school-based wraparound, as opposed to mental health and special education community of care services, has been shown to have positive impact on children and youth and their families (Eber & Nelson, 1997). Research also suggests that youth who receive wraparound in school are more likely to maintain community-based educational placements, demonstrate improved classroom performance and experience fewer residential placements (Epstein, Nordness, Gallagher, Nelson, Lewis & Schrept, 2005, p. 86). These citations suggest that providing educators with training that facilitates the incorporation of wraparound philosophies, such as a focus on strengths and multi-agency collaboration, can lead to greater success for children, youth and their families (Epstein et al., 2005).

Schools are considered to be a natural and effective entry point for wraparound interventions for young people (Eber et al., 2008; Epstein et al., 2005). Schools not only have students for a large portion of the day; they also have well-trained staff on site, broad access to services and mandated service delivery mechanisms (Epstein et al.). However, implementing wraparound in mainstream schools faces unique challenges because it requires a leap from the traditional stance of teachers working in isolation to a collaborative model (Epstein et al.). Also, many authors consider that wraparound in schools is contingent upon school-wide behavioural management systems (Eber, Hyde et al., 2009; Eber et al., 2002; Scott & Eber, 2003).

Lucille Eber, one of the foremost authors on wraparound in education, recognizes that schools can be an effective site for intervening in complex student situations, but for wraparound to be successful and sustainable in the school environment, schools must adopt more preventive universal approaches for establishing behavioural standards, such

as the School-Wide Positive Behavioral Intervention System (SW-PBIS) (Eber et al., 2008; Epstein et al., 2005). These approaches "often require significant changes in how schools respond to students with complex needs, including application of research-based behavioural practices, and integration of community/family supports with school-based services" (Eber, Hyde et al., 2008, p. 668).

PBIS is a preventative system that addresses the behaviour of the entire student body in a three-tiered system of behavioural support.

- The primary tier of this system is preventative in intention and uses universal interventions to stem behavioural or learning problems before they start. The primary tier serves between 80 and 90 percent of the student body (Scott & Eber, 2003).
- The second level of intervention focuses on the 5 to 15 percent of students who do not respond to the primary intervention and who demonstrate risk factors associated with school failure (Scott & Eber, 2003). If school-wide behaviour programming is being practiced, then wraparound or tertiary level of interventions will only be necessary for 1 to 7 percent of the student body.
- Those students who do not respond to primary or secondary interventions and who demonstrate a persistent pattern of behavioural and/or learning problems that will affect their school outcomes and result in a lifetime of poor outcomes will require the intensive tertiary intervention (Epstein et al., 2005).

PBIS also addresses the challenges schools might face in balancing precious resources between the high needs of 1 to 7 percent of the student body and the basic needs for the remaining 80 to 99 percent by utilizing the *Response to Intervention* model. The Response to Intervention model facilitates access to appropriate levels of both academic and social behaviour intervention support by increasing the level of intervention to the level of need demonstrated by the student (Fairbanks, Sugai, Guardino, & Lathrop, 2007).

Within the wraparound-in-school literature, primary-level (school-wide) interventions are considered a fundamental prerequisite for both secondary and tertiary interventions. Primary-level interventions may include: (a) identifying and defining classroom expectations; (b) implementing a continuum of strategies to positively recognize and reinforce appropriate behaviours; and (c) using evidence-based instructional practices (Fairbanks, Simonsen, & Sugai, 2008).

The Illinois Positive Behavior Intervention Network trains staff at school demonstration sites in the delivery not only of PBIS interventions but also of data rules about when to scale up interventions. The development of such on-site expertise facilitates appropriate levels of intervention and wraparound fidelity, and it is critical to successful student outcomes (Eber, Phillips et al., 2009). Secondary-level interventions increase in scale and typically consist of group work and the use of Functional Behavioural Assessment (FBA). In Illinois demonstration-site schools the following are second-tier interventions: (1) check in/check out[3]; (2) social academic instruction groups; (3) group interventions with an individual feature; (4) brief functional behaviour assessment or behaviour intervention planning (BIP); and (5) complex or multiple FBA/BIP. For students who do not respond to these interventions, Wraparound, a tier-three intervention, is initiated (Eber, Phillips et al.; Scott & Eber, 2003). If secondary interventions are not successful with a student then it is essential to ensure accurate alignment of interventions with assessment information and data, so a Functional Behavioural Assessment (FBA) is highly recommended. FBA is based on the philosophy that "what can be predicted can be prevented" (Scott & Eber). This data-heavy assessment process is used to create a more targeted behavioural intervention. The steps of a functional behavioural assessment are: (1) define the problem behaviour; (2) identify relationships between the behaviour and surrounding environment; (3) hypothesize the function of the behaviour; and (4) verify the hypothesis (Scott, Anderson, Mancil, & Alter, 2009). Scott and Eber suggest that FBA and wraparound are necessary and related pieces of positive behaviour support systems.

In literature on school-wide PBIS and wraparound in schools, data-based decision making is emphasized as a core component to a wraparound practice. The Illinois PBIS Initiative uses an integrated data collection and management system, called SIMEO, which aggregates individual student outcomes across settings. Illinois PBIS created SIMEO as a statewide online data collection and management program, which was developed to support implementation of wraparound as a tertiary tier intervention in school-wide PBIS (Ebe, Phillips et al., 2009). Both scaling up and scaling down of all interventions are decided based upon certain data-based thresholds to which all wraparound participants have provided their personal feedback.

[3] *Students participating in check in/check out interventions attend daily meetings with an adult before and after school to monitor their progress in meeting identified behavior goals. Depending upon the need, students may check in with teachers after each class to receive immediate feedback about their behavior during that class period. Progress is monitored through daily behavior performance reports and communicated back to the students, their teacher, and their parents (Lindsey & White, 2009).*

Embedding wraparound in a whole intervention system can result in increased staff buy-in, ease in training and support of personnel, and more time-efficient wraparound plans, because the wraparound team can use parts of the universal intervention system as part of the wraparound plan. PBIS results in a proactive-rich environment in the schools in which it is implemented. However, without a school-wide behavioural system in place, the third tier, or wraparound, is very difficult to maintain, as it will feel too much like a burden to sustain (Eber, personal communication, November 24, 2009).

Developing the practices needed for school personnel to effectively support students with complex behaviours is a major undertaking (Eber, Hyde et al., 2009). Schools need to demonstrate their capacity for this work. In fact, the Illinois PBIS Network will not train school-based personnel in wraparound without the implementation of nine district-level components ensuring adequate human resources, physical supports, extra funds and training plans. (See www.PBISillinois.org for these documents.) PBIS Illinois also defines the necessary structure for the supervisory team that is accountable for all wraparound/tertiary intervention in the school. This team is responsible for guiding, reviewing and monitoring implementation and progress of tertiary-level interventions. The tertiary-level implementation process teams should include: (1) a building administrator; (2) a district tertiary coach; (3) two or more personnel who work directly with families/students with tertiary-level needs (i.e., social worker, counsellor, school psychologist, special education teacher, etc.); (4) an internal PBIS coach; (5) one or more members of the Universal PBIS Team (may be the internal coach); (6) one or more members of the secondary PBIS team (may be represented by personnel described in item #3 above); and (7) one or more individuals recommended to represent “family voice” (i.e., a member of a local parent organization or a parent of a child with tertiary-level needs).

Often schools are already testing and planning for the specific learning, physical and behavioural needs of their students. The resultant individualized educational plans may resemble wraparound plans because they are both intended to be individualized and often are collaborative with outside agencies. Individualized educational plans typically have three basic parts: an assessment of the child's knowledge as compared to that of his or her peers; a set of personalized goals for the year and specific activities for moving toward those goals; and a way (or ways) of monitoring that progress (Vogel, 2006). However wraparound is different from these academically-oriented individualized educational plans in that each member of the wraparound team, including parents and natural supports, has a specific and necessary role in carrying out the conditions for interventions that address and support all quality of life domains, not just educational (Eber, Hyde et al., 2009).

Moreover, a significant effort is placed on building positive relationships and community-based support networks for the child and family (Burchard et al., 2009; Eber, Hyde et al., 2009).

By aligning both academic and behavioural support through a multi-tiered problem-solving team, schools are better able to determine which students need greater supports, to reduce duplication of efforts and services and to streamline resources (Ebe, Hyde et al., 2009).

Wraparound is also different from what is commonly referred to as *full-service* or *community schools*, which are schools that operate longer hours and offer a range of extra services and on-site supports (Blank, Jacobson, & Pearson, 2009; Santiago, Ferrara, & Blank, 2008). Full-service schools may support and bolster community agency availability and supports, a fundamental part of wraparound, but the specific process of wraparound is unique and quite different than the philosophy of full-service schools.

EVIDENCE OF OUTCOMES

Examining the evidence for the impact of wraparound is a complicated endeavour. Evaluation and outcomes studies for wraparound are difficult due to the fundamental nature of the practice. The three primary reasons wraparound is so difficult to evaluate are: (1) wraparound addresses more than one specific type of concern (e.g., physical disabilities, addiction, aggression, school attendance problems) in broad populations (e.g., populations including immigrants, those with behavioural problems, those living in poverty) seeking a myriad of target outcomes (e.g., improved grade point average, better speaking skills, cultural adjustment); (2) wraparound originated out of a "grassroots" development model without a single protocol or a common understanding of which wraparound is being practiced; and (3) each wraparound planning process is intended to be multifaceted and individualized (Bruns, 2008a). It appears that the elements that make wraparound a promising practice can also be the impediments to guaranteeing quantifiable outcome data. Beyond the challenges of capturing outcome data, it also is more challenging to capture client and family change originating from their participation in wraparound's shared process focused on empowerment, community engagement and true collaboration.

Despite all of the challenges, some have attempted to present a unified and rigorous assessment of wraparound outcome studies. Suter and Burns conducted a meta-analysis of current publications examining wraparound outcomes for children and youth with emotional and behavioural disorders (2009). The authors examined studies that were conducted between 1986 and 2008 and limited their analysis to those in which the effects of participating in wraparound were compared to control groups. The authors included only seven studies in the meta-analysis (Bickman, Smith, Lambert, & Andrade, 2003; Carney & Buttell, 2003; Clark et al., 1998; Evans et al., 1998b; Hyde et al., 1996; Pullman et al., 2006; and Rast et al., 2008). Fewer than 20 percent of the outcome studies included in an earlier review (Suter & Bruns, 2008) were included in the meta-analysis, primarily due to a lack of control groups. Interpretation of the results from these seven studies is complicated by the lack of fidelity controls, comparable data, contextual variability across target populations, differences in goals, and a variety of methodological concerns. The difficulties with the data available for the meta-analysis underscore the challenges inherent in evaluating the effectiveness of wraparound programs.

The data from these seven studies on wraparound reveal "modest evidence" for both the efficacy (positive findings for specific disorders from carefully controlled research trials) and effectiveness (positive findings demonstrated in real world settings with diverse

samples) (Suter & Burns, 2009, p. 346). Three experimental studies (Carney & Buttell, 2003; Clark et al., 1998; Evans et al., 1998b) yielded "a small positive effect" (Suter & Burns, p. 346). Yet due to high attrition, lack of a single treatment manual and heterogeneity of target populations, these studies do not provide unequivocal support for efficacy. There was a demonstration of "some evidence for the effectiveness of wraparound with studies taking place in real-world settings" (Suter & Burns, p. 347), yet the outcomes studies provide insufficient details about the implementation of the wraparound process (e.g., duration, frequency, fidelity) and participants (e.g., race, ethnicity, gender, age) to demonstrate clear evidence that wraparound would be effective with specific populations and settings. Other publications that assess the impact of wraparound, though not specifically with control groups, determine that wraparound serves youth with mild to moderate challenges well, but evidence for children and youth with severe emotional and behavioural disorders appears not to be as positive (Cox, Baker, & Wong, 2010; Myaard, Crawford, Jackson, & Alessi, 2000).

Evidence-based practices for youth and families are a subset of child & adolescent interventions with empirical support for their efficacy and/or effectiveness, and recent definitions include not only scientific rigor, but also clinical judgment and consumer preference (Aarons, 2005). There are practical and fiscal implications of a practice or intervention being labeled as an evidence-based practice, such as public and private health insurance providers limiting coverage for practices that achieve the evidence-based practice label. The Institute of Medicine defines *evidence-based practice* as a combination of the following three factors: (1) best research evidence[(2) best clinical experience; and (3) consistent with patient values (2001). For an intervention to be considered evidence-based, the outcome studies providing that evidence must have positive findings from at least two independent studies, with good experimental design and positive outcomes for both efficacy and effectiveness. The cited wraparound studies do not meet these criteria (Suter & Burns, 2009). Under guidelines such as these, wraparound is not eligible to be labeled as an evidence-based practice.

Determining individual positive outcomes in a practice such as wraparound is very challenging. Yet seeking more detailed methods of data collection can overwhelm a wraparound practice and its participants with documentation and research exhaustion, and may simply be impractical. It might be prudent to consider what types of evidence are most appropriate for determining the positive impact of wraparound. Hernandez and Hodges assert that any *system of care* that seeks to improve organizational relationships should be judged by outcomes focused on the organizational level rather than on the

individual level (2003). Wraparound is considered to be both an individual-level intervention (a defined, team-based planning process) and a systems-level intervention (requiring communities to collectively oversee implementation, agencies to collaborate, and the service array to be comprehensive) (Bruns, 2008a). Consequently, outcome data could focus on both levels of impact. Differentiating between interagency collaboration and simple interprofessionalism (the process of multiple disciplines working together) (Butt, Markle-Reid, & Brown, 2008) is a level of evaluation that could reveal the successful operation of wraparound teams. A systems-level evaluation rests upon the assumption that changes in the culture of care, including documentation of sincere collaboration, sharing of resources and less duplication of services will provide a solid basis for high quality and effective wraparound and, therefore, will lead to better individual outcomes.

Eric Bruns, co-director of the National Wraparound Initiative in the United States, asserts that evidence for wraparound should be examined within certain frameworks rather than by simply trying to assess individualistic positive outcomes. Instead of seeking "evidence *for* wraparound," outcomes studies should be reframed as "examinations of the evidence base *and* wraparound" (Bruns, 2008a, p. 3) by recognizing that wraparound is a planning process that uses myriad evidence-based practices within the plan. One example of this new framework is assessing the adherence to the principles of wraparound that are supported by evidence as well as by common sense and social justice, such as voice and choice, team-based collaborative planning, community-based care and individualized care. This framework for examining evidence is parallel to the argument supporting high fidelity wraparound.

Qualitative evidence for the success of wraparound is very important and is available from the stories and informal reports of numerous service agencies (Burchard, Burchard, Sewell, & VanDenBerg, 1993; Burns & Goldman, 1999; Cailleaux & Dechief, 2007; Kendziora et al., 2001). Parental and practitioner satisfaction surveys are another mechanism for assessing the impact of wraparound. A survey of 615 providers working within systems funded by the Children's Mental Health Services in the United States demonstrated that 77 percent of all providers believed wraparound resulted in positive outcomes for youth and families (Bruns, 2008a). This percentile revealed a higher satisfaction rate than several other prominent treatment types with evidence for effectiveness, including multi-system therapy (68 percent), treatment foster care (67 percent) and functional family therapy (49 percent) (Bruns).

Some authors claim that evaluation of wraparound would benefit from a cost-benefit analysis, comparing the costs associated with wraparound to those associated with

residential, institutional or judicial treatments (Burns et al., 1995; Malloy, Cheney, & Cormier, 1998). Though the evidence base for wraparound is called “weak” by Farmer, Dorsey and Mustillo (2004), due to the challenges of capturing evidence of change, there appears to be a consensus in wraparound literature that wraparound results are largely positive.

It is apparent that more rigorous design, data collection and evaluation are needed. Bruns, Walrath and Sheehan (2007) state that the primary impediment to the use of rigorous research designs has been the model’s history of poor specification and inconsistent implementation; however, this has been addressed in recent years through description of specific wraparound principles (Burns & Goldman, 1999; Walker et al., 2003), a description of provider and team activities (Walker & Schutte, 2004) and necessary system and program supports (Walker et al.).

Determining wraparound outcomes might require capturing and examining evidence with more novel methodologies because the current methodologies are limited in capturing the significant client change practitioners proclaim. More significant quantifiable outcome data could support wraparound. However, the body of wraparound literature could also benefit from a rethinking of what type of evidence best reflects the process-oriented nature of wraparound at both individual and systems levels.

CRITICAL BODY OF LITERATURE

The body of literature on wraparound is growing, with a conscious attempt to increase the rigour and to address practice-oriented concerns. Included are peer-reviewed and research-based articles as well as non-peer-reviewed reports published by service providers. Initially the body of literature was slow to develop due to the individualized and grassroots nature of wraparound (Bruns, 2008b). Moreover, an innovation like wraparound has no ‘‘owners’’ so no single definition has legitimacy over other definitions (Bruns). According to Cox, Baker, and Wong (2010) the current focus on revealing stronger associations between fidelity to wraparound principles and positive outcomes is causing more rigorous studies to become available in a wider variety of sources.

In general, the body of literature on wraparound is relatively self-referential, with many articles written by the same authors and the majority of authors citing the same references. However, it appears that the literature is on the brink of introducing more critical and practical publications, including critiques of wraparound theory, implementation and outcomes (Cox et al., 2010; Eber, Phillips et al., 2009; Forkby, 2009). These self-reflective critical pieces can only improve the field and encourage more accountability and reliability, for which experts in the field are already advocating.

Researcher-Led Practice

Different behavioural modification techniques are often dependent upon each other, and each can build upon the strengths of the others. Functional Behavioural Assessment (FBA), as discussed in the section Wraparound in Schools, is based on the philosophy that “what can be predicted can be prevented” (Scott & Eber, 2003). FBA and wraparound are considered critical features of prevention as well as intervention for creating safer schools for all students (Scott & Eber). Similar to the challenges of measuring and demonstrating positive outcomes for wraparound, FBA has had challenges demonstrating evidence of its success. FBA is well supported within the literature, but more field demonstrations of FBA are needed, especially as the majority of studies on FBA are based on demonstrations sited in atypical settings and conducted by researchers or by teachers with extensive support from researchers (Scott et al., 2009).

Wraparound faces similar critiques about researcher-led success. With fidelity being the predictive marker for positive wraparound outcomes, successful high fidelity wraparound is often associated with expert supervision and/or mentoring, as FBA has been (Eber, Phillips et al., 2009). Wraparound and FBA are both promising practices within the positive

behavioural interventions and support system, yet schools struggle with their ability to employ FBA techniques and to build greater capacity for implementing this level of support without the use of outside experts (Hawken & O'Neill, 2006). Reliance on external experts is especially difficult when services are mandated at district and systems levels without adequate internal training and/or supports (Bruns et al., 2007). Future wraparound studies should reflect the tension between demonstrations of research-led high fidelity wraparound and the "softer" implementation of wraparound in the field.

National Origin of Literature

Overwhelmingly, peer-reviewed wraparound literature originates from the United States, though the wraparound philosophy is being applied in communities of other nations with different political philosophies and frameworks. A number of Canadian case studies and informal discussions about the implementation of the wraparound theories are becoming accessible through various service providers and project reports (Atlantic Evaluation Group Inc., 2006; Cailleaux & Dechief, 2007; Northwest Wraparound Group, 2010; Totten, 2008). Australia and its system of care are also demonstrating increased interest in wraparound (Ainsworth, 1999; Centre for Parenting and Research, 2006; Skills Australia, 2009; Wyles, 2007). However, there is a critical need to expand the body of peer-reviewed publications from outside of the United States, especially to reveal the impact of different social and political structures on and from the wraparound process. Universities and other research bodies should address this call for more international peer-reviewed literature.

Nations tend to apply wraparound to different populations and areas of need. In the United States, the majority of the literature focuses on children and youth with emotional and behavioural needs. The overt focus of U.S.-based wraparound literature on mental health is not as evident in literature from Canada. In Canada, wraparound is certainly regarded as a promising practice for children and youth with mental health concerns; however, wraparound is also a recommended practice for more diverse populations. The Government of Canada website advocates the use of wraparound for adult immigrants settling into educational programs in Canada (Human Resources and Skills Development Canada, 2008). The John Howard Society of Prince Edward Island uses wraparound to aid in the transition from institutional to community living (Atlantic Evaluation Group Inc., 2006).

In the United Kingdom the wraparound model has been used with parents and their children and with youth with disabilities in Northern Ireland (Farrell, Elliott, & Ison, 2004). In Australia, wraparound is being examined as a care approach for out-of-work individuals

(Skills Australia, 2009) and as a promising model for service coordination and integration at a broader systems level (Centre for Parenting and Research, 2006).

It is important to stress that different nations have different applications for wraparound, as well as very different systems of care and implementation structures. Other nations use many different terms to refer to comparable practices that include value-based underpinnings similar to those that are fundamental to wraparound (Forkby, 2009; McDougall et al., 2008; Hancock, Cooper, & Bahn, 2009; Cross-Governmental Strategy, 2009). Consequently, for example, when the terminology for wraparound-type processes is expanded to include the terms family network perspective and social network intervention, the instances of international application of wraparound-type philosophy are more numerous.[4]

Gaps in the Literature

Though wraparound literature is developing, there are some distinct holes in the overall body of wraparound literature. One area that has received little attention is the criteria that a child or youth must meet in order to enter a wraparound process. The thresholds, both practical and systemic, for instigating wraparound seem to differ greatly among programs and nations. Similarly, little information is available about exit criteria for determining when a wraparound process is complete or concluded. The omission of entrance and exit thresholds in the literature can be linked to the difficulty in associating elements of the wraparound process to outcomes. These thresholds are revealing to the differences of various systems of care. For example, U.S.-based literature emphasizes that wraparound is often initiated when the threat of residential treatment is imminent.

Another gap in the literature is the difference between preventative and crisis intervention wraparound processes. When the wraparound process is used to address crises, such as in cases of children and youth being referred to out-of-home placements due to violence or suicide, a certain protocol is suggested; this process is addressed in much of the literature. However, when the wraparound process is used to address more systemic challenges in children's lives, such as physical disabilities or recent refugee status, the wraparound process should conceivably have a change of focus from that of crisis intervention protocols. Wraparound is described as both a preventative process for children and youth presenting behavioural and emotional issues and as an intervention for extreme cases of

4 See: http://www.bruker-med-virkning.no for a paper on wraparound in Norway in Norwegian.

behaviour, but the differences between these two types of wraparound practices are rarely discussed outside of demonstrative case studies. The distinction between these two purposive practices need to be further elaborated in peer-reviewed literature.

As previously discussed, the wraparound literature could benefit from focusing more upon the structural and organizational changes resulting from new collaborative structures and functioning, rather than on individual outcomes. Future studies should also include data from multiple wraparound sites, so that relations among site characteristics, fidelity and outcomes can be explored. It appears that if more data is available, there is a greater likelihood that components of the wraparound approach can be associated with positive outcomes (Bruns et al., 2005).

Finally, the obvious focus of wraparound literature on establishing evidence-based outcomes is paralleled by literature focusing on implementation strategies and processes. Neither of these topics addresses the social critiques of an intervention like wraparound. There is a need to critically examine the impact of wraparound or individualized support plans on the children, their families and their communities. Forkby (2009), writing from Sweden, stresses that social network interventions are understood as an attempt to mobilize resources from the community and to build egalitarian relationships in a democratic problem-solving process. The very nature of this approach challenges traditional expert-led interventions. However, Forkby critiques the expansive gap between the practical method and the actual intent of the ideology of the intervention; therefore, the author claims it remains difficult to determine whether wraparound fosters empowerment, and what it actually brings to practical social work (Forkby). Forkby argues that practitioners must be aware of the power dynamics within all discourse, especially within team meetings. By presenting more critical examinations of wraparound—such as Forkby's critique of the power relationships between families, teams and agencies in team planning—practice can be improved and enhanced by exposing the gaps between theory and practice.

CONCLUSIONS

Wraparound is a field with enormous possibility and application. The philosophy of valuing every individual and ensuring equal access to social, economic and educational opportunities results in a treatment process featuring individualized, ecological and strength-based care. The available wraparound literature presents a process for addressing the needs of individuals with high vulnerabilities and complex needs through shared planning and shared accountabilities. Anecdotally, as demonstrated in newsletters and informal publications[5], wraparound is found to be positive and effective, although anecdotes also emphasize numerous implementation challenges and practice inconsistencies. The body of wraparound literature demonstrates a theoretically developed practice paradigm that is maturing into a field that seeks and supports a more critical and rigorous stance in that literature.

Evidence supports that fidelity to the core principles of wraparound makes the difference between achieving positive outcomes or not (Bruns et al., 2005). Practically, wraparound has been found to be a resource-heavy process with limited measurable outcomes, due to the challenge of gathering rigorous data. Furthermore, wraparound cannot be presented as a panacea for severe emotional and behavioural disorders (Bickman, Smith, Lambert, & Andrade, 2003; Cox et al.). Unfortunately, positive outcomes might remain elusive for children and youth exhibiting the highest levels of functional impairment (Cox, 2010). Yet both practitioners and families consider wraparound to be an effective intervention (Burns, 2008a).

An aspect of wraparound that should be considered is the use of the term wraparound. Other terms—such as *network meeting, integrated care, individualized service support plan*, and *collaborative services*—capture processes akin to wraparound. Many of these terms are used as interrelated and, at times, interchangeable. Yet, the literature presents a tension with the labeling of certain interventions as either wraparound or not wraparound. Proponents of high fidelity wraparound advocate the necessity of adhering to each of the 10 principles of wraparound. But in examples where the process of wraparound is not as tightly defined, such as in cases where wraparound refers to a case management style (McDougall et al., 2008), it is difficult to determine whether the strong value-base of high

5 Focal Point. Fall 2003 (See: http://www.rtc.pdx.edu/pgFPF03TOC.php); iConnections: Immigrant Services Calgary. Dec 2007 (See: http://www.immigrantservicescalgary.ca/index.php/family_support_programs_at_mosaic_centre/menu-id-74.html); and Salem Care. Spring 2005 (See http://www.wrapcanada.org/html/pdf/WrapAround%20-%20A%20Way%20to%20Care.pdf)

fidelity wraparound is being adhered to or whether only the case management components of high fidelity wraparound are being adhered to. This terminology looseness creates ambiguity in the specificity of the wraparound procedures and in the evaluation and measurement of the expected wraparound outcomes. Yet the opposite assumption cannot be made—just because a process is called wraparound one cannot assume that all components of wraparound are actually adhered to, in practice. This conundrum may be inherent to any process that is required to be flexible, individualized and context-sensitive.

The expanding body of literature is helping to inform policy-makers of the essential elements and necessary requirements that make wraparound a successful practice for addressing the difficult needs of certain children and youth, such as those with emotional and behavioural disorders, former refugees, the physically disabled and other vulnerable populations. Nations, states, provinces, municipalities and human service agencies are applying this extensive body of knowledge and creating successful programming that captures the spirit and goals of wraparound: a family-oriented, democratic practice that demonstrates a faith that each person with complex needs can be served in the best possible manner when they have their own “voice and choice” and partners are willing to collaboratively *wrap around* them. When comparing wraparound to the siloed, deficit-based, expert-led and non-participatory interventions common in traditional case management, it is evident that wraparound represents far more than another case management style. It is a value-based process that seeks improved positive outcomes, but its inclusive, process-oriented nature is, in itself, one of the positive outcomes of this type of intervention (Walker, 2008).

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