Wraparound & Service Coordination

Principles

- Wraparound emerged as an attempt to address fragmented, overly professionalized, and overly restrictive treatment approaches. The wraparound process is based on a philosophy in which services are highly individualized to meet the needs of children and families (Burchard & Clarke, 1990; VanDenBerg & Grealish, 1996).
- In the wraparound process, a "facilitator" (a case manager, lead teacher, etc.) works with the family to discover their strengths, set goals, determine major needs, and develop strengths-based options.
- The process is used to help communities develop individualized plans of care. The actual individualized plan is developed by a Wraparound Team, the four to ten people who know the consumer best, including the consumer and their family. The team must be no more than half professionals.
- The plan is needs-driven rather than service-driven, although a plan may incorporate existing categorical services if appropriate to the needs of the consumer. The initial plan should be a combination of existing or modified services, newly created services, informal supports, and community resources, and should include a plan for a step-down of formal services.
- This plan is family centered rather than child centered. The parent(s) and child are integral parts of the team and must have ownership of the plan. No planning sessions occur without the presence of the child and family.
- The plan is based on the unique strengths, values, norms, and preferences of the child, family, and community. No interventions are allowed in the plan that do not have matching child, family, and community strengths.
- The plan is focused on typical needs in life domain areas that all persons (of like age, sex, culture) have. These life domains are: family, living situation, financial, educational/vocational, social/recreational, behavioral/emotional, psychological, health, legal, cultural, safety, and others.
- All services and supports must be culturally competent and tailored to the unique values and cultural needs of the child, family, and the culture that the family identifies with.
- The child and family team and agency staff who providing services and supports must make a commitment to unconditional care. When things do not go well, the child and family are not "kicked out", but rather, the individualized services and supports are changed.
- Services and supports are community-based. When residential treatment or hospitalization is accessed, these service modalities are to be used as resources and not as placements that operate outside of the plan produced by the child and family team.
- Planning, services, and supports cut across traditional agency boundaries through multi-agency involvement and funding. Governments at the provincial, state,

district, regional, and local levels work together to improve services. Outcome measures are identified and individual wraparound plans are frequently evaluated.

Goals

- Opportunity to shorten the logic chain between systems of care values and actual practice with families
- Opportunity to achieve appropriate, individualized fit between family needs and services/supports
- Full engagement of the family through strengths, needs, and culture discovery process
- Development of family members' self-efficacy
- Enhancements to cultural competence
- Well-implemented wraparound program provides for high-quality teamwork, and organizational characteristics conducive to high-quality service delivery

Service Coordination

Illback & Neill (1995), in describing the use of service coordination in Kentucky's system of care for children and youth, employ Solomon's widely accepted definition of case management: "a coordinated strategy on behalf of clients to obtain the services that they need, when they need them, and for as long as they need these services." In their model, service coordination is broader and qualitatively different than traditional case management models.

> "Although one of the central features of the wraparound approach is individual case management, wraparound interventions should not be confused with traditional **case management programs**. Conventional case management programs merely provide youth with an individual case manager …who guides them through the existing social services or juvenile justice system (Burchard et al., 2002). Such programs—when well run and staffed by committed individuals—can have a significant impact on the behavior of at-risk youth. For example, Baltimore's Choice Program and San Francisco's Detention Diversion Advocacy Program have both produced promising results by providing at-risk youth and juvenile offenders with intensive supervision and individualized treatment plans. Nevertheless, these case management programs do not operate in the same highly structured, integrated services environment that characterizes true wraparound initiatives."

http://www.dsgonline.com/mpg2.5/wraparound_prevention.htm

Service coordination began as the locus of treatment for people with psychiatric disorders shifted from the hospital to the community. These individuals needed a wide range of services both in the health and mental health fields, as well as housing, vocational training and legal services. The often difficult nature of navigating these services was recognized as a particular obstacle to successful integration into the community. Thus, an effort to develop more broadly based service plans, increase ease of access to services, and coordinate the multiple services required based was initiated. These tasks came to define the role of the service coordinator. Increasingly, these ideas

led to the perspective that it is the responsibility of all service providers to work together to ensure that services and supports are identified and provided based on the unique needs of the individual (person-centered planning). Services can then be delivered in an environment of interagency coordination, cooperation, and collaboration, which puts the needs of the individuals first. Service coordination serves to improve mental health treatment effectiveness and limit cost. It has received positive reviews from clinicians, practitioners, and families.

Typically, service coordination begins at high levels and is stepped down over time, presumably as services are accessed and crises diminish. For the most at-risk populations, however, this may not always be the case. Illback & Neill (1995) indicate that within the Kentucky program (for youth with more severe disorders), crisis response rates remained high throughout participation in the program." Instead of less crises, service coordinators perceived that the qualitative nature of the crises experienced by families changed over time and became more manageable. Recognizing that youth and families can become dependant through this approach, rather than self-sufficient, they warn that some of the most troubling crises can occur when services begin to be reduced. Thus, they stress the importance of clear exiting goals and criteria that do not require the individual or family to be "problem-free." Mueser et al. (1998) suggest that some of the difficulties of stepping down services could be avoided by "ensuring a close continuity of care over the transfer period" and ensuring that there are more permeable boundaries between services.

Bedell, Cohen & Sullivan (2000) identified the following categories of Case Management in their research:

- Full Service – this method limits the amount of services that are brokered out to other agencies and instead attempts to provide all of the services needed by a specially trained team.

- Broker Case Management – This was among the first approaches, where the case manager connects the individual to service providers within the community and coordinates care between providers.

- Hybrid – A combination approach where some services are provided and some are brokered.

Of the three approaches, Bedell, Cohen & Sullivan (2000) found that "only full service programs received ratings of 'effective', meaning they were always or almost always associated with positive outcomes" in areas such as Satisfaction, reduction of symptoms, reduced cost of treatment, increased level of functioning, reduced hospitalization and increased retention and compliance with treatment. They found the broker model to be associated with the poorest outcomes.

Mueser, Bond, Drake & Resnick (1998) also broke down models of community care into three types:

- Standard Case Management –broker and clinical case management models

- Rehabilitation-Oriented Community Care - strengths and rehabilitation models. The strengths model was developed to counter the perception that most treatment tend to emphasize the limitations or impairments of the service recipient. Its purpose is to focus on assets of the individual and set goals that are achievable and to help foster integration of the individual into the larger community. Similarly, the rehabilitation model focuses on the attainment of the individual's desires and goals, as opposed to those of the service provider, but it also emphasizes "remediating instrumental and affiliative skills that may promote community tenure and the attainment of personal goals."

- Intensive Comprehensive Care - such as Assertive Community Treatment (ACT) and Intensive Case Management (ICM). These programs were developed for patients with the greatest need. Their characteristics include low patient to staff ratios, services provided in the patients home or other natural environments rather than in medical offices, 24 hour coverage, time unlimited services and services that are provided by a specific team and not brokered out.

Muesur et.al. (1998) suggest that broker and clinical case models are "effective for many persons with mental illness" but are insufficient for those who are severely ill, and may benefit more from ACT or ICM models. They also discussed the innovations of the strengths and rehabilitation models, while noting that there is not enough research to speak to their effectiveness. Finally, they advise that "it is becoming increasing clear that there is no single model that is equally appropriate across all services" and that it may be best to "determine which model is best for whom or to explore whether hybrid models can be developed to meet multiple needs currently addressed by different models."

Bedell, Cohen & Sullivan (2000) also addressed the use of paraprofessionals in case management, quoting Powell and Cameron as stating, "The clinical effectiveness of paraprofessionals has been well established, particularly with low income persons who receive services in public mental health settings." Bedell and his colleagues (2000) attribute this effectiveness to the indigenous status of paraprofessionals and the idea that this shared common background between the service recipient and the paraprofessional "may facilitate treatment by fostering better understanding and rapport."

Wraparound Process Implementation-Facilitator Duties

Phase One: Engagement and Preparation

- Meets with family & stakeholders
- Gathers perspectives on strengths & needs
- Assess for safety & rest
- Provides or arranges stabilization response if safety is compromised
- Explains the wraparound process
- Identifies, invites & orients Child & Family Team members
- Completes strengths summaries & inventories

- Arranges initial Wraparound planning meeting

Phase Two: Plan Development
- Holds an initial Plan of care Meeting
- Introduces process & team members
- Presents strengths & distributes strength summary
- Solicits additional strength information from gathered group
- Leads team in creating a mission
- Introduces needs statements & solicits additional perspectives on needs from team
- Creates a way for team to prioritize needs
- Leads the team in generating brainstormed methods to meet needs
- Solicits or assigns volunteers
- Documents & distributes the plan to team members

Phase Three: Plan Implementation & Refinement
- Sponsors & holds regular team meetings
- Solicits team feedback on accomplishments & documents
- Leads team members in assessing the plan
  - For Follow Through
  - For Impact
- Creates an opportunity for modification
  - Adjust services or interventions currently provided
  - Stop services or interventions currently provided
  - Maintain services or interventions currently provided
- Solicits volunteers to make changes in current plan array
- Documents & distributes team meetings

Phase Four: Transition
- Holds meetings
  - Solicits all team members sense of progress
  - Charts sense of met need
  - Has team discuss what life would like after Wraparound
- Reviews underlying context/conditions that brought family to the system in the first place to determine if situation has changed
- Identifies who else can be involved
- Facilitates approach of "post-system" Wraparound resource people
- Creates or assigns rehearsals or drills with a "what if" approach

<u>Implementation Questions</u>

1. **Wraparound practice**– Do we understand wraparound and do it in keeping with the wraparound principles?
2. **Collaboration/Partnerships**- Do we work together flexibly and cooperatively?
3. **Capacity building/Staffing**- Do we have the right jobs and working conditions?

4. **Acquiring services and supports-** Do we provide the services and supports teams need?
5. **Accountability-** Do we have tools to make sure we're doing a good job?

<u>Barriers to Positive Wraparound Outcomes</u>

- Co-morbidity and complexity of child and family needs
- Lack of full engagement of families
- Lack of adaptation and individualization of treatments, including adaptation to the culture of the family
- Interagency coordination is not sufficient:
    - Attention to organizational and system context is necessary
    - Applying technologies that allow for high-quality implementation of effective practices is highly recommended

Kazdin (1993) notes that children from vulnerable populations are less likely to stay in treatment past the first session. Further, 40-60% families may drop out of services before their formal completion.

Factors related to drop-out include:

- Stressors associated with treatment
- Treatment irrelevance
- Poor relationship with therapist
- Triple threat: poverty, single parent status and stress
- Concrete obstacles: time, transportation, child care, competing priorities
- Previous negative experiences with mental health or institutions

Participation rates can be increased by intensive engagement interventions that are tailored to the entire family (McKay,1999).

<u>Resources and Websites</u>

- National Wraparound Initiative: www.rtc.pdx.edu/nwi
- Wraparound Fidelity Index: www.uvm.edu/~wrapvt
- Walker, Koroloff, Schutte monograph on necessary supports for ISP/wraparound www.rtc.pdx.edu
- Vroon VanDenBerg, LLC: www.vroonvdb.com
- Focal Point issue on Quality and Fidelity in Wraparound: http://www.rtc.pdx.edu/pgFocalPoint.shtml
- CMHS monographs on wraparound (2001, vol 1; 1998, vol 4): http://mentalhealth.samhsa.gov/cmhs/ChildrensCampaign/practices.asp
- Paperboat, www.paperboat.com, is an excellent resource for wraparound information. It is dedicated to providing information about the way community-based support and assistance is designed and delivered.

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