Practice Guidelines for Wraparound

Purpose:

To provide guidelines for best practice implementation of the wraparound process for outpatient providers who are serving clients not enrolled in MIDD Wraparound or Wraparound with Intensive Services (WISe).

Target Population:

Children and adolescents from birth up to age 21 who are receiving behavioral health services funded in whole or in part by the King County Behavioral Health and Recovery Division (BHRD), who are authorized for a "high intensity" case rate, and who are involved with at least one other child-serving system.

Expected System Outcomes:

It is expected that by implementing a high-quality wraparound delivery model children and youth will demonstrate improved functioning at home, school/work, and within the community and will be maintained within their home and community environments, decreasing the utilization of more restrictive placements such as inpatient hospitalization, residential placement, or juvenile justice involvement. Additionally, the implementation of the wraparound delivery model will allow providers to meet the goals that the family has set for itself while evolving to the point where the family is empowered to engage more informal community supports.

Requirements:

Providers shall improve quality and consistency in the implementation of the wraparound process for children, youth, and families by developing internal policies and procedures that lead to the integration of the Ten Principles of the Wraparound Process, as described below, into service provision. The policies and procedures will also ensure that the wraparound process consistently follows the phases and activities detailed in the guidelines. When the guidelines are not followed for a particular client, the rationale for not following the guidelines shall be documented in the chart.

Ten Principles of the Wraparound Process:

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2021 CLINICAL PRACTICE GUIDELINES

Providers shall ensure that all staff provides services in accordance with the Ten Principles of the Wraparound Process:

1. Family voice and choice: Ensure that the needs and priorities of the family determine how and when services are rendered, and that the intervention goals and desired outcomes are mutually defined with the family and youth. Family and youth/child 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-based: The wraparound team consists of individuals committed to the family and youth through informal, formal, and community support and service relationships. The family and youth will agree on all team members;

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 sources of natural support;

4. Collaboration: All 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 towards 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 utilizes the particular strengths, assets, resources, and needs of the youth and family to develop and implement 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;

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9. Persistence: Despite challenges, the team persists in working toward the goals included in the wraparound plan until the team reaches agreement that formal wraparound support is no longer required and eventually evolving into a team of community support; and

10. Outcome-based: The team ties the goals and strategies of the wraparound care plan to observable and measurable indicators of success, monitors progress in terms of these indicators, and revises the plan as necessary.

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Recommended Guidelines for the Wraparound Process:

The activities and phases described below are recommended as critical and necessary components for the implementation of high quality wraparound. The activities identify a facilitator as responsible for guiding, motivating, or undertaking the various activities. This is not meant to imply that a single person must facilitate all of the activities. The various activities may be split up among a number of different people. For example, on many teams, a parent partner or advocate takes responsibility for some activities associated with family and youth engagement, while a facilitator is responsible for other activities. On other teams, a facilitator takes on most of the facilitation activities with specific tasks or responsibilities taken on by a parent, youth, and/or other team members. In addition, facilitation of wraparound team work may transition between individuals over time, such as from a facilitator to a parent, family member, or other natural support person, during the course of a wraparound process.

Families, as defined by the wraparound process, may be a single biological or adoptive parent and child or youth, or may include grandparents and other extended family members as part of the central family group. If the court has assigned custody of the child or youth to some public agency (e.g., child protective services or juvenile justice), the caregiver in the permanency setting and/or another person designated by that agency (e.g. foster parent, social worker, probation officer) takes on some or all of the roles and responsibilities of a parent for that child and shares in selecting the team and prioritizing objectives and options. As youth become more mature and independent, they begin to make more of their own decisions, including inviting members to join the team and guiding aspects of the wraparound process.

The use of numbering for the phases and activities described below is not meant to imply that the activities must invariably be carried out in a specific order, or that one activity or phase must be finished before another can be started. Instead, the numbering and ordering is meant to convey an overall flow of activity and attention. For example, focus on transition activities is most apparent during the latter portions of the wraparound process; however, attention to transition issues begins with the earliest activities in a wraparound process.

Phase 1Engagement and team preparation:

During this phase, the critical components and elements of the wraparound process are initiated. The family and youth are oriented to the wraparound process. The foundation of wraparound is built around the essential characteristics of the family and youth. In some situations, this may happen prior to the formal beginning of wraparound services.

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1.1 Orient the family and youth to wraparound: The facilitator describes in detail the wraparound process and what level of participation is needed from each member of the group. The facilitator actively works to engage the family and youth in the wraparound process.

1.2 Address pressing needs and concerns: The family and facilitator identify the immediate needs in a way that provides for present and future stability. Any skills that need to be acquired to meet future needs may be identified at this time and used in the development of the wraparound care plan.

1.3 Explore strengths, needs, culture and vision with child and family: The facilitator leads the family through a process of identifying strengths of individual members and the family as a whole. The facilitator gathers information from the family in regards to the identified culture, values, and the vision the family has for itself. Goals and tasks of the wraparound care plan will be based on strengths and aligned to the family vision. Outcomes will be based on progress toward this vision.

1.4 Solicit participation of team members, build team cohesion: The family and facilitator work together to identify potential team members and decide how to illicit their participation. The facilitator and family work to ensure representatives from all systems involved with the family participate on the team. This might require exploring options regarding who is the most appropriate member of each system to attend. Peer counselors may be utilized in this process.

1.5 Arrange meeting logistics: Meetings should be arranged at a time and location convenient to the family. This may mean meetings outside of regular business hours at locations in the community, which are easily accessible and convenient to the family.

Phase 2 Initial plan development:

During this phase, the team works to develop the initial wraparound care plan. This care plan should utilize existing strengths and identify skills that need to be developed over the course of care. The plan should be developed with the ultimate goal of transitioning to informal and community supports.

2.1 Identify goals and tasks of the wraparound care plan: The team identifies goals and tasks needed to help the family move toward its vision and sets appropriate timeframes for completion of each task. The wraparound care plan uses existing strengths and builds skills needed to accomplish goals. The wraparound care plan addresses the family's transition into the community and informal supports.

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2.2 Develop a crisis prevention plan: The team works together to create a crisis prevention plan that utilizes community and natural supports as well as formal services to resolve a crisis as quickly as possible at the least restrictive level of intervention. The plan should also incorporate strategies to prevent future crises. Any skills needed to resolve or prevent future crises should be identified and incorporated into the overall wraparound care plan.

Phase 3 Implementation:

During this phase, the initial wraparound care plan is implemented, progress and successes are continually reviewed, and changes to the wraparound care plan are made as needed. The activities of this phase are repeated until sufficient progress toward the goals identified in the wraparound care plan is made and the family is empowered to transition to less formal supports.

3.1 Implementation of the wraparound care plan: For each goal in the wraparound care plan, team members assume responsibility for tasks. Tasks should be shared amongst team members.

3.2 Track progress and evaluate successes: At each meeting, the team evaluates and monitors progress toward existing goals and modifies or adds any new goals identified by the team.

3.3 Increase and strengthen informal and community supports: New members may be added to the team to reflect identified post-transition goals, services, and supports. The team discusses and plans for responses to potential future situations, including crises, and negotiates the nature of each team member's post-wraparound participation with the team/family.

3.4 Maintain team cohesiveness and trust: The facilitator helps the team to maintain cohesiveness and satisfaction by continually educating team members – including new team members – about wraparound principles and activities. The team shares the responsibility of open communication, active problem-solving, and ensuring adherence to the values and principles of wraparound.

Phase 4 Transition:

As the implementation of the wraparound care plan evolves and progress toward goals is achieved, the team moves toward a purposeful transition where the family is empowered to engage more informal community supports.

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4.1 Empower informal and/ or community supports to take on increasing leadership of the team: The facilitator and team work to identify an informal or community support person or persons to facilitate the team process. First consideration should always be given to the family, caregiver, or youth. This process may begin during the implementation phase through shared responsibility for leadership of the team.

4.2 Implement transition to informal supports: The team is continually supporting a natural progression from a team of formal support and service professionals to a team made up largely of community and natural supports. The family and youth are empowered to utilize their natural support systems to assist in skill building and resource gathering. The team reviews strengths and needs and identifies services and supports that can meet the needs that will best serve the youth and family beyond the formal wraparound team.

4.3 Ongoing process: As determined by the family, the team of natural and community supports continues to meet and support the family on an ongoing basis. To ensure that the family is continuing to experience success in meeting its goals, the team develops a procedure that empowers the family to identify and access appropriate services when needed. This may include inviting formal services to join the ongoing team to address a specific need or goal.

These guidelines meet the State Department of Social and Health Services (DSHS)-contracted mandate for practice parameters in accordance with the Balanced Budget Act.

For further detail regarding the phases and activities of the wraparound process, please refer to the following references and all subsequent practice guidelines accessed at the National Wraparound Initiative website: http://nwi.pdx.edu.

Walker, J.S., Bruns, E.J., VanDenBerg, J.D., Rast, J., Osher, T.W., Miles, P., Adams, J., & National Wraparound Initiative Advisory Group (2004). *Phases and activities of the wraparound process.* Portland, OR: National Wraparound Initiative, Research and Training Center on Family Support and Children's Mental Health, Portland State University; and

Bruns, E.J., Walker, J.S., Adams, J., Miles, P., Osher, T.W., Rast, J., VanDenBerg, J.D. & National Wraparound Initiative Advisory Group (2004). *Ten principles of the wraparound process.* Portland, OR: National Wraparound Initiative, Research and Training Center on Family Support and Children's Mental Health, Portland State University.

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