

Department of Human Services
Summary of System of Care Values
& the Wraparound Process
December 16, 2009

The development of the wraparound process has been shaped by a unique combination of local, state, and federal innovations; contributions from individual consultants and researchers; and influential local, state, and national family organizations (VanDenBerg, Bruns, Burchard, 2003). The Wraparound planning process is informed by system of care values that were developed to coordinate and integrate care for children with complex mental health needs. The establishment in 1984 of the Child and Adolescent Service System Program (CASSP) outlined these core values for a system of care:

1. individualized care that is tailored to the individual needs and preferences of the child and family,
2. family inclusion at every level of the clinical process and system development,
3. collaboration between different child-serving agencies and integration of services across agencies,
4. provision of culturally competent services, and
5. serving youth in their communities, or the least restrictive setting that meets their clinical needs through providing a continuum of formal treatment and community-based supports (Winters, Pumariega, et al, 2006).

Wraparound is a definable planning process that results in a unique set of community services and natural supports that are individualized for a child and family to achieve a positive set of outcomes (Burchard, Bruns, Burchard, 2002). The 10 principles that provide the framework for the wraparound process are:

1. **Family voice and choice.** 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 agreed upon by the family and committed to them through informal, formal, and community support and service relationships.
3. **Natural supports.** Planning reflects activities and interventions that draw on the sources of natural support.

4. **Collaboration.** Team members work cooperatively and share responsibility for developing, implementing, monitoring, and evaluating the plan. It reflects a blending of team members' perspectives, mandates, and resources.
5. **Community-based.** Service and support strategies take place in the most inclusive, most responsive, most accessible, and least restrictive settings possible; they 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 and family, and their community.
7. **Individualized.** The team develops and implements a customized set of strategies, supports, and services.
8. **Strengths based.** The wraparound process and plan identify, build on, and enhance the capabilities, knowledge, skills, and assets of the child and family, their community, and other team members.
9. **Persistence.** Despite challenges, the team persists in working toward the goals included in the plan until the team reaches agreement that a formal wraparound process is no longer required.
10. **Outcome based.** The team ties the goals and strategies of the plan to observable or measurable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly (Miles, Bruns, Osher, Walker, & National Wraparound Initiative Advisory Group, 2006).

The wraparound process is a team-based activity that is organized and delivered by someone who is trained to facilitate the team. The team creates a plan that includes ways to assure that children and their families experience success in their communities, homes, and schools. The four phases of the wraparound process are:

1. **Engagement & team preparation phase.** The facilitator meets with the family to discuss the wraparound process, strengths and concerns, and identify potential child & family team members. Initial crisis planning is done if necessary.
2. **Initial plan development phase.** The team meets and formulates the plan by identifying strengths, needs, and action steps. The plan includes a safety/crisis plan.
3. **Plan implementation phase.** The team meets to review and update the plan as needed. Team minutes and progress reports document the planning process.
4. **Transition phase.** Planning includes review of goals and discharge criteria, family accomplishments, and how ongoing services and supports will be

accessed if necessary as documented in the discharge summary (Miles, Bruns, Osher, Walker, & National Wraparound Initiative Advisory Group, 2006).