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Executive Summary

Residential interventions and community-based systems of care for youth and families are service worlds that have co-existed and seldom intersected (Levison-Johnson & Kohomban, 2014). Historically siloed and mutually exclusive, these service sectors have developed over time, in parallel, and were oriented to providing niche services in the system marketplace with a similar objective: have youth succeed where they are. Occasionally, residential and system of care services overlapped (Allen, Pires & Brown, 2010) but often did so with difficulty, sometimes with acrimony, particularly when defining service ‘turf’ and responsibility for when one service starts or stops. This segmentation of services created fragmented approaches, impeded communication, and left youth and families with inadequate transitions from one service to another and adversely impacted the outcomes of the care provided (Stroul, 1996; United States Health and Human Services, 1999).

Current research and evidence illustrates the untoward outcomes associated with fractured services and the unintended consequences of non-integrated care (Magellan Health Services, 2008). But, in an era of accountability and demand for effective service, important efforts to transform service provision to youth and families are underway (Levison-Johnson & Kohomban, 2014). First on the transformation scene: High Fidelity Wraparound which is both a philosophy and a practice that embraces, “Nothing about us, without us” and orients its Child and Family Team-based approach toward identifying relevant youth and family goals, and providing supports and interventions in the home and community to promote success based on the family’s definition and terms (Bruns & Walker, 2015). Following and consistent with Wraparound’s inclusive and youth and family focused approach is the Building Bridges Initiative (BBI) (Harrington, Williams-Washington, Caldwell, Lieberman, & Blau, 2014) which strives to transform residential intervention through partnership and collaboration with youth, families, providers, and stakeholders to promote sustained positive post-residential outcomes for those served. Philosophically and functionally, Wraparound and BBI are two-sides of the same youth-guided/family-driven success in the home/community coin. They are a natural fit to align approaches and practices to help youth and families achieve success – wherever the service is provided.

This document offers a pragmatic translation and ‘de-construction’ of the Wraparound approach and applies the principles and process into residential best practices well-identified by BBI (Blau, Caldwell, & Lieberman, 2014). Central tenets, four phases of effort, and ten key principles of Wraparound are discussed and applied to BBI best practices. The different levels of operation are reviewed (the Child/Family Team, organizational, policy and administration) and within each level, specific strategies are identified to facilitate integrating Wraparound into residential intervention. In addition, content experts and their contact information, and sample agreements to promote service integration are also provided.
Introduction

The Building Bridges Initiative

The Building Bridges Initiative (BBI) is a national initiative to promote coordinated partnerships and collaborations between residential and community-based service providers, families, youth, advocates, and policymakers. BBI seeks to successfully implement improvements in policies and practices that will result in sustained positive outcomes for children and adolescents (hereafter often referred to as ‘youth’), and their families’ post-residential discharge. BBI has developed many different tools and resources as part of a commitment to support all stakeholders involved with residential interventions. These tools and resources, which include web-based training programs (with CEU’s) and webinars to promote system change, can be found on the BBI website (www.buildingbridges4youth.org). Stakeholders are encouraged to read BBI’s book, *Residential Interventions for Children, Adolescents, and Families: A Best Practice Guide* (Blau, Caldwell & Lieberman, 2014) to better understand how and why residential transformation is occurring across the country and some of the emerging and best practices that support sustained positive outcomes for youth and families’ post-residential intervention.

BBI & Wraparound: A Natural Fit

Building Bridges and Wraparound principles and practices complement each other well. They are synchronous and mutually aligned to supporting sustained positive outcomes for youth and families. Moreover, both approaches promote the full inclusion and engagement of youth, families, community services and supports to maximize success in the community. These approaches also provide residential and community stakeholders with additional tools to use in the continual process of service system improvement and transformation.

While there is considerable research that supports the use of Wraparound approaches with community programs and supports (Bruns & Suter, 2010), residential programs were not always viewed as part of systems of care nor invited to be part of Wraparound teams – even when the youth and families were served by a Wraparound team prior to residential intervention. However, there were exceptions to these practices (e.g., Wraparound Milwaukee/Wisconsin; Wraparound practices in Westchester County, New York), and now a growing number of systems of care communities recognize residential programs as part of their community of stakeholders.

This BBI informational document provides residential leaders with an introduction to some of the core concepts of Wraparound, and how residential providers can be integrated as effective team members in a community system of care. The tips and strategies provided in this document were developed by Wraparound experts, families, youth, and advocates, as well as residential and community providers with successful experiences implementing Wraparound with youth and their families. Successful programs included those in areas where High Fidelity Wraparound (HFW) was implemented (i.e. Wraparound Milwaukee), others were in areas where components of Wraparound were implemented (i.e. Los
Angeles County, CA), and some worked with their Child Welfare oversight agencies to implement Family Team Conferencing (FTC) (i.e. The Children’s Village, NY) – which is a practice for engaging families during team meetings.

Although FTC is not the same as the Wraparound Child and Family Team (CFT) practice strategy, both FTC and CFT include similar components. Information in this BBI document will also be relevant to child welfare stakeholders involved with Family Team Conferencing. It is always ideal to implement an evidence-based practice (e.g. HFW or Multi-Systemic Therapy [MST]) with fidelity to the model for youth and families. But, when systems are not organized or adequately resourced to fully implement multi-systemic models, providers or communities may attempt to ensure practices align as much as possible. For example, some residential programs are in communities where HFW is available and can be fully integrated into this service system (including HFW teams), but others are part of communities that do not use HFW. This BBI Informational document provides residential leaders with guidance on how Wraparound principles and strategies may be applied—whether any Wraparound approach is currently utilized in their local communities or not.
An Overview of Wraparound

Wraparound is an intensive, holistic method of engaging with individuals with complex needs (most typically youth and their families) so that they can live in their homes and communities and realize their hopes and dreams. Since the term was first coined in the 1980s, "Wraparound" has been defined in different ways. It has been described as a philosophy, an approach, and a service. In recent years, Wraparound has been most commonly conceived of as an intensive, individualized care planning and management process. But, Wraparound is not a treatment per se.

The Wraparound process aims to achieve positive outcomes by providing a structured, creative and individualized team planning process that, compared to traditional treatment planning, results in plans that are more effective and more relevant to youth and their families. Additionally, Wraparound plans are more holistic than traditional residential 'treatment team' plans in that they are designed to also meet the needs of those important to the youth and families, including active kin, caregivers and siblings, and to generalize to all domains of a youth's life. Wraparound also aims to develop the problem-solving skills, coping skills, social/relational skills, and self-efficacy of the youth and family members.

Wraparound is commonly described as taking place across four phases of effort:

1. Engagement and team preparation;
2. Initial plan development;
3. Implementation; and
4. Transition.

During the Wraparound process, a team of people (The Child and Family Team [CFT]) who are relevant to the life of the youth (e.g., family members, members of the family's social support network, friends of the youth, service providers, and agency representatives) collaboratively develop an individualized plan of care. The Wraparound plan should reflect the family and the youth's goals and ideas about what types of service and support strategies are most likely to help them reach their goals. The Wraparound plan typically includes formal services, including best practices and evidence-informed and -based interventions as appropriate to build skills and meet youth and family needs. Additionally, community services and interpersonal support and assistance provided by friends, kin, and other people drawn from the family’s social networks are included in the plan. After the initial plan is developed, the team continues to meet to monitor progress by measuring the plan’s components against the indicators of success identified by the team. Plan components, interventions and strategies are revised when the team determines, with family and youth voice at the forefront of this determination, that they are not working, i.e., when the relevant indicators of success are not being achieved.

Wraparound requires a willing program and open system environment to be effective. As with BBI, these program and system supports include partnerships among policy-makers, providers, child-serving systems, family and youth advocates/partners, and other...
stakeholders who take collective action to build a comprehensive and community-based system of care that includes a full-service array of formal and informal supports. Residential interventions fit into this array of services as a type of intervention option used to meet specific needs of some youth and their families.

Bruns and colleagues (2004) described ten key principles of Wraparound (see Appendix A for a full explanation of each principle), all of which can be part of residential interventions for youth and families:
1. family voice and choice;
2. team-based;
3. natural supports;
4. collaboration;
5. community-based care;
6. culturally competent;
7. individualized;
8. strength-based;
9. unconditional; and
10. outcome-based.

Understanding the depth and breadth of each of these principles is important for high quality, Wraparound-informed practice. Explanations and examples of these principles can be found in Appendix A.
Assuring Permanency for Every Child

Research demonstrates that children thrive in stable, safe and loving homes (Annie E. Casey Foundation, 2009). Permanency provides something all people need in their lives: a sense of belonging. The benefits of permanency are:

- Family connections are associated with improved outcomes;
- Permanency makes past traumatic events easier to manage;
- Connection to family increases positive identity development; and
- Without family connections, treatment alone does not meet the needs of the youth.

When youth are removed from their home/community and enrolled in residential interventions, it is essential to ensure continual engagement of the identified family to whom the youth is returning. When there is not an identified viable family who can provide a safe, stable and loving home, there should be an urgent and comprehensive focus on the use of practice strategies such as Family Search and Engage, Family Finding, Ancestry.com and/or other permanency practices, to identify and engage permanency resources. Residential staff, advocates, and other stakeholders should prioritize permanency practices, with youths’ full participation and approval. These efforts should begin before the admission to the residential program and be the first goal of the residential intervention if a permanent home/family is not clear at the outset.

The Wraparound process supports successful permanency by building self-efficacy in youth and strengthening relationships within families. Wraparound involves youth in all decisions about their life. In addition, Wraparound CFT plans provide support to both the youth and family by identifying and prioritizing what the youth and family need to live together safely and creating natural supports to help maintain success.
Integrating Wraparound and Residential Interventions

This section provides tips and strategies for residential providers who would like to improve and sustain positive outcomes for youth and families using Wraparound approaches. Preparing and implementing Wraparound strategies is best conceptualized as occurring at three levels: Child and Family Team, organizational, and policy/administration.

Child/Family Team Strategies

Examples of strategies to use with the Child Family Team include:

- **Conduct all treatment planning through Child and Family Teams (CFTs) and with a goal of meeting the youth and family’s priority needs.** An essential component of Wraparound is the Child Family Team (CFT). Wraparound has a non-negotiable value, “Nothing about us without us,” which means no planning is done without the family and youth being present. The CFT consists of the youth, family members, and other persons who the family and youth chooses (e.g. natural supports, cultural brokers), supportive community members, and relevant professionals (i.e., those with a salient role in supporting youths to live and thrive in their homes and communities and meeting youth/family needs).

  The CFT works in partnership with the family and youth to learn about the family’s culture, create a vision of the family’s better future, identify their strengths and needs, and utilize that information to develop a plan for the youth that meets their unique needs. The CFT reviews the family’s initial set of identified needs, collectively prioritizes them, and then brainstorm both formal and informal services and solutions to meet those needs.

  When a youth enters residential with a CFT already in place and functioning, the role of a residential provider would be to either fully participate in all aspects of developing the plan (if not yet developed) and/or refining that plan, and then to assure its role is congruent with strategies to address one or more of the youth and family’s needs in conjunction with others on the CFT. Once a plan is developed, the CFT meets regularly to review goals and accomplishments and make adjustments when needed (Walker et al., 2004). Everyone works together and shares in the focus on achieving specific outcomes identified by the youth and family. As previously mentioned, Family Team Conferencing (FTC) has many of the same components of CFT and the principle of a coordinated and diverse team is consistent.

If a youth does not have a current CFT when entering a residential intervention, the residential provider would:
• First - emphasize and embed family voice and choice throughout every component and practice of the residential program;  
• Engage all community members, extended family, outside supports and other social support in building a strong CFT for the youth;  
• Provide a qualified, trained Wraparound Facilitator who would lead a CFT that the residential program creates; and  
• Coordinate who is responsible for the follow through on strategies and action steps developed by the CFT.

The CFT is always led by a trained Wraparound Facilitator (Care Coordinator). Other members of the CFT include Youth and Family Partners, often referred to as peer-to-peer support partners, who are trained in Wraparound and are powerful advocates and supports for the youth and family. Although, the title of this role may vary from state to state, Youth and Family Partners have lived experience including the successful navigation of child-serving systems. They are often “graduates” of Wraparound themselves and having experienced the process of Wraparound serve several purposes:

• Provide emotional support to the youth and family;  
• Provide education about services and systems to the youth and family;  
• Advocate for and help explain youth and family perspectives, if youth and family request this type of advocacy;  
• Empower the youth and family to use their voice and self-advocate; and  
• Provide follow-up support for services and skill building.

The Youth and Family Partners often meet with the family a few times a week, especially in the beginning of a residential intervention. These roles are valuable in helping the youth, family, and residential staff – along with all members of the CFT – develop interventions for the youth and family that can transition back to the home environment.

Cultural considerations should be included in the work of the CFT. This includes practical matters such as language access for limited English proficient (LEP) family members or network members, or written materials in the relevant language at the relevant reading level. It also means consideration of world views, cultural beliefs and practices about family roles, the roles of helpers, decision-making, interpretation of behavioral/emotional/substance use problems, and the role of the child in decision-making. For some families, cultural concordance between the families and service providers is important.

• **Develop CFTs with strong youth and family involvement. Do not convene meetings that discuss youth and families without them being present.** Families play a non-negotiable role on the CFT. Over time, families are encouraged and empowered to lead...
the CFT. The team meets until sufficient progress toward meeting priority needs has been made and thus the formal team process is no longer needed. In order for families and youth to be Meaningfully involved, providers must prepare and engage them in the CFT by explaining what to expect and how the CFT works. Youth and Family Partners can play a critical role in preparing families and youth and helping them to speak and advocate for themselves and their children. These meetings should replace “provider only” meetings. With families and youth present, it is still critical to not talk about the youth as though they are not there. Speak to the young person whenever possible - not around them!

- **Ensure daily interaction between families and youth and daily interaction between residential staff and families for the CFT to be effective.** Youth and families have stated that engagement is important to create mutual trusting relationships. These include having on-going conversations about a range of activities (e.g., everyday activities; what is working well; what is not working; what the youth and family are doing that is making positive progress; and what else is needed to support progress). Focus should be on ensuring that families have the resources, and the coaching and support to carry out the action plans to meet their needs. The concept of “Do for, do with, cheer on” has proven an effective coaching tool to support youth and family self-efficacy and skill development.

**Tip from families:** At the initial intake meeting and throughout the process, talk to the youth and family about their strengths and emphasize what is going well. Cultivate positive relationships, since relationships are often more important to families and youth than the actual CFT meetings.

- **Develop individualized plans of care that consist of interventions that can easily be used in the family’s home and community.** With the CFT, any interventions developed must be realistic and “make sense” for the youth and family and be something that not only they can do, but that fits their culture, home environment, and addresses the strengths and challenges of their communities. Treatment is driven by the major needs, strengths, culture, vision and unique situations of the family. Plans of care should include as many activities and services as possible that promote integration into the community; these should begin at admission and continue throughout, with the goal being as many of these activities and services happening in the home community as soon as possible after admission (i.e. > 50%). For example, youth may be supported in staying connected to or joining a community-based sports team, or attending activities at a recreational center in their home community during their residential intervention. Residential staff, family members and natural supports can play an important role in

“Every youth must be treated in the context of their family system, and all services must be individualized. The expectation must be for residential and community providers to join the CFT to create and manage an individualized plan for each child and youth.”
- Frank Rider, American Institute for Research
supporting youth during community activities (e.g. attending sports games/music classes, coaching on how to address challenges faced, mentoring, and providing follow through for continuing the activities during and post-discharge from residential).

- **Have a primary and comprehensive focus on engaging the family and youth throughout the residential intervention.** With BBI recommended residential best practice - treatment shifts from youth completion of program requirements to family readiness and capacity to support their child at home. This requires strong engagement with the family from pre-admission and the CFT supports this engagement process. Family connections and information about the family of origin can be healing for youth. Families should have the name of a primary staff contact and a staff member who serves as a backup who they can contact with any questions or concerns. Additionally, they should be provided with the names and contact information of key staff members they and their child will interact with throughout the residential intervention.

  **Tip from families:** Encourage family interaction by providing gas money for families to bring their child home multiple times weekly during the residential intervention, and have staff drive the youth home if needed.

“Traditional” Residential Treatment Team Meetings vs. Wraparound-informed Child and Family Teams (CFT)

“Traditional” residential treatment team meetings focus on the youth’s treatment progress within the residential program and frequently recommend a defined length of stay to achieve ‘program’ goals. The Building Bridges Initiative promotes working closely with families, youth and communities, having shorter lengths of stay, and ensuring that length of time in the residential intervention is tied to completing the goals identified to meet the families’ needs. Such practices are consistent with the research on achieving sustained positive outcomes post residential intervention (Walters & Petr, 2008). Using Wraparound-informed CFT provides a viable and useful framework to shift the residential intervention focus from what happens within a residential program to continuous integration within the home and community. It puts an emphasis on building skills and readiness with the family to ensure a transition home as soon as possible.

“Every family was involved in the service planning process, because we moved all meetings outside of the residential facility. Any staff facilitating the Wraparound process would go to the family’s home- the family’s home is where we had the meeting.” - Kelly Pipkins-Burt, Respectful Resolutions/BBI Project Lead
The table below summarizes examples of some philosophical and practice differences between traditional residential treatment teams and BBI best practices, specifically Wraparound-informed CFT.

<table>
<thead>
<tr>
<th>Traditional Residential Treatment Teams (TT)</th>
<th>Residential Informed by Wraparound Child and Family Teams (CFT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary focus of the TT is on the treatment and services that the youth receives within the residential program.</td>
<td>Primary focus of the CFT is on the needs of the youth and family to live together successfully in their home and community. Youth returning home is not dependent upon achieving certain goals or levels within residential, but rather the CFT is focused on supporting the youth and family in gaining the skills and supports necessary to live successfully together at home.</td>
</tr>
<tr>
<td>TT meetings occur even if family members cannot make the meeting.</td>
<td>With CFTs, no planning is done and no meetings occur without the family and youth, their advocates, and their identified natural supports, participating in person.</td>
</tr>
<tr>
<td>Residential staff have a primary role in defining treatment and support needs for the youth with traditional TT meetings.</td>
<td>With CFT, the primary focus is on youth and family voice and choice, with youth and family serving as key leaders of the Child Family Team; residential staff are partners, with other members of the CFT. Remember: &quot;Nothing about us without us.&quot;</td>
</tr>
<tr>
<td>There is no specific, systematic or comprehensive focus on continuing, developing and/or strengthening natural community supports. These supports are not part of the Treatment Team.</td>
<td>There is a strong focus on continuing, developing and strengthening natural community supports throughout the residential intervention, and they are included on the CFT. Youth and family invite friends or other important people with whom they feel connected to their CFT meetings. Natural supports can make up 50% of the total attendees of a CFT meeting.</td>
</tr>
<tr>
<td>Family/Parent and Youth peer-to-peer support partners are sometimes part of a residential program, and sometimes included in TT meetings, though are not central to traditional TT meetings. Family/Youth Partners generally never facilitate a TT meeting.</td>
<td>Family/Parent and Youth peer-to-peer support partners are an essential component of CFTs; one of their primary roles is to ensure that family and youth voice drives the CFT process. They meet with youth and families between CFT meetings to ensure the identified supports and interventions are in place and are working, and to gather youth and family perspectives that can be supported during the next CFT. Family and Youth Partners may be trained and serve as CFT facilitators.</td>
</tr>
<tr>
<td>Certain services and practices (e.g. group therapy sessions; standardized behavior management approaches, such as point and levels systems) are provided to every youth in residential. TT meetings focus on progress within standardized residential practices.</td>
<td>All services and solutions are individualized and culturally relevant, and tailored to the needs of each individual youth and family, based on feedback from the CFT. Standardized approaches (e.g., same group therapy sessions; standardized behavior management approaches, such as point and levels systems) are not utilized.</td>
</tr>
</tbody>
</table>
| Flexible funds to support the needs of individual youth and families are not a core part of traditional TT. | Flexible funds are an important component of CFTs, and used to provide non-traditional services to foster youth success at home and in the community throughout the
| Treatment Team meetings most often happen within the residential program, most often on days and times set up by the TT. | The CFT ensures that youth and family spend time together as often as possible in the home and community – a minimum of weekly and encouraging daily contact. When a CFT is involved, there are no standardized residential practices that limit or prevent a youth from spending time with family. If there are safety issues for the youth, then the CFT has already identified extended family for youth to spend time with weekly or more often. If the youth is experiencing extreme dys-regulation or is triggered while home, the first step is for staff to support the family in supporting the youth to address the situation - not just to return the youth to the residential program. |

**Organizational Strategies**

Leaders can use the following organizational strategies to support the use of wraparound in their agencies:

- **Learn more about Wraparound.** Residential providers can learn more about Wraparound through engaging in conversation with other community-based and residential providers already using Wraparound and Child and Family Teams. Residential providers may also learn about Wraparound through national and state experts who are leading Wraparound transformation efforts. The National Wraparound Initiative (NWI, www.nwi.pdx.edu) is a group of professionals that has provided resources regarding, and collected data on the process of Wraparound.

- **Train staff in Wraparound, including Wraparound facilitation.** After education on the Wraparound process, identify clear roles for residential staff. In a Wraparound approach, there are roles and activities that have specific skill sets. Determine who amongst the residential staff will have what roles and be responsible for the different skill sets to determine what training is needed. Ideally, all staff within the organization should receive training in the Wraparound process. This enables staff to have a clearer understanding of roles, responsibilities, and accountability.

- **Partner with those with Wraparound expertise to provide ongoing coaching, support, and technical assistance.** After staff are introduced to Wraparound through training, expert Wraparound coaches can teach the specific skills.
• **Anticipate geographical challenges.** Many states and their leaders are working to ensure that residential programs are geographically close to where youths and their families live. However, resource limitations persist and the unfortunate practice of placing youth far away from their families continues. It is recommended that residential and community stakeholders advocate with their state oversight agencies for residential options that align with the residential best practice of within a minimum of one to two hours from the family’s home. Residential organizations across the country have changed their business models and achieved improved outcomes for youth and families post-residential intervention based, in part, on their practice of ensuring youth spend time with their family and/or in their home community on a daily or multiple times weekly basis throughout the residential intervention. Some organizations limit their referrals to families within 30 minutes to one hour from their residential program (Dalton, 2014). Larger states with many rural areas may not yet have this opportunity. Residential leaders should set up technology (e.g., Skype; email; texting; phone calls; Face Time; etc.) to allow youth to connect multiple times daily with multiple family members and approved friends who reside a long distance away. Some residential programs have significantly increased their transportation budgets to support families (i.e. providing gas cards) and residential staff provide transportation home weekly – even with distances that exceed three hours. They report not increasing their overall budget- just switching monies between categories. Some programs have hired part-time staff to serve as drivers to meet family members half-way. Others have found private funding to pay for staff spending time in hotels close to the family’s homes so that they can work with the family when the youth is home. Some providers have worked with organizations in the home communities of the families to support transporting the youth to their home weekly. It is critical that residential leaders develop plans to reduce geographical barriers for most, if not all youth, and develop plans to ensure strong youth/family connections for those where geography poses a significant challenge.

• **Change transition and discharge criteria from program success to family readiness.** Traditional residential intervention typically provides standardized services and group behavioral approaches (i.e. must achieve a certain level on level system for discharge consideration). BBI best practices and Wraparound/ CFT focus on an individualized, family stabilization-focused residential discharge plan, based on family readiness. In other words, “What do you need to have your child at home?” There is a shift from a primary focus on remediating or improving specific child behaviors to assessing what the youth and family needs to live together safely.

• **Develop a strategic timeline in which to roll out the programmatic changes that will be needed to move from a traditional Treatment Team approach to a CFT approach.** It is best to not implement too many changes at once. Plan what can be done right away and what changes will be implemented later. Identify what supports will need to be in place in order to create buy-in from the staff and create long-term
adoption and wide-spread implementation of the Wraparound approach with all residential staff, and community partners.

- **Prioritize a focus / population when getting started with Wraparound.** Select a specific group of youth and families, such as youth involved in the child welfare system, youth under the age of 13, youth who are new to residential, youth who have used residential interventions for a long time, or youth involved with the juvenile justice system. By selecting a specific group with common challenges/needs, residential providers can direct resources appropriately and reflect on outcomes and lessons learned prior to bringing Wraparound to scale within the organization.

- **Conduct in-depth strength and cultural assessments as part of intake paperwork.** This can be included as part of a current assessment, but the information collected shifts from “problem” or deficit-based information to a history of what has worked in the family and what the youth does well. Individualized treatment should embed the strengths and cultural information of the youth and family being treated. CFTs require that an assessment include detailed examples of the strengths and culture (not just bullet points), so staff can have structured, daily discussions with the youth and families about their goals, dreams, and what is working and not working for them.

  **Tip from families:**
  Encourage family engagement, ask about the family’s culture, including what is important to them. Ensure that residential staff represents the ethnicities and cultures of the families served. Support language access for family members with LEP.

  It is important to note that cultural assessments are meant to guide conversation. When used well, it can produce a rich conversation giving insights into the individual and family culture. Examples of some recommended cultural assessments are the American Psychiatric Association’s [APA] Cultural Formulation Interview (CFI), located in the DSM-5 manual (APA, 2013) and the Strengths, Needs, and Cultural Discovery within the process of HFW (www.nwi.pdx.edu).

- **Create clinical staff schedules that are 100% flexible rather than traditional 9-5 schedules.** Best practice residential interventions commit to flexible scheduling and having multiple scheduling options for staff to accommodate the family. This includes evening and/or weekend work. Having CFT meetings in the family’s home or community is essential for a successful CFT. Staff must also work with the family in their homes when it is convenient for family members; this is often evenings and weekends.

  “The clinicians understand upon hire that schedules are based around the family’s schedule. If the family is working and the only time they can meet is on the weekend or in the evening, then that’s the time we’re going to meet. Once we start engaging that way, the family doesn’t see us as “the system” and they start to feel empowered- they start really engaging in their plan.”
  - Joe Ford, Senior Vice-President, Hathaway-Sycamores, CA
• **Hire culturally diverse staff and Youth and Family Partners to engage families and ensure the representation of the youth and family voice during CFT meetings.**

Family Partners\(^1\) empower the family and prepare them for participation on the CFT. For some families and youth, cultural concordance is important to achieve engagement and serve as cultural broker to the CFT. Some organizations choose to train Family Partners in Wraparound facilitation so they can lead the CFTs. If Family Partners cannot be immediately hired by the residential program, consider partnering with a family-run organization to provide this support. Family-run organizations have a long history of providing parent and youth peer support providers to work with families raising children, youth and young adults with complex emotional, behavioral, and mental health care needs. The parent and youth peer support providers employed by family-run organizations all have lived experience. Some distinct benefits of partnering with a family-run organization for parent and youth peer support providers are: a) the ability of the family-run organization to train, coach and supervise the peer support providers with seasoned family and youth leaders who also have lived experience; and b) the peer support providers can continue to support the family post residential discharge. Residential and community providers can also hire Peer Youth Advocates\(^2\) to ensure that practices are youth-guided and to promote youth voice in services. These Advocates can prepare youth to participate during CFT meetings and attend the meetings to help the youth to self-advocate. It is important to ensure that Peer Youth Advocates themselves have support from the organization, and the organization provides on-going skill-based coaching, including any agency-specific training that will support the knowledge and experience Peer Youth Advocates bring.

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1 Family Partners, also referred to as Parent Peer Support Partners, are parents of youth with emotional or behavioral health challenges. As parents, they have firsthand experience navigating child-serving systems.

2 Peer Youth Advocates are youth or young adults with lived experience who have received services. Peer Youth Advocates are trained in advocacy and then work with youth who are receiving residential or community services to ensure that their voices are heard.

“An advantage of providing services in the family’s home is that access to informal support is easier. The supports the family identifies become part of the treatment process with the family….and then this can happen more informally once the child leaves residential, and not so much from a formal meeting perspective.” - Luke Spiegelhoff, Family, Adolescents and Children Therapy Services, Inc.

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**Tip from families:** Provide family therapy, services and support in the family home throughout the residential intervention. The CFT should be planning for and implementing services and supports the family and youth will need at home and in the community from the first CFT meeting.
• **Ensure that family interactions are a regular part of the residential intervention.** Residential best practices put a strong emphasis on youth and families spending time together at home as often as possible, with multiple times weekly being the recommended best practice. Families should also be able to see their children in residential whenever they wish. Policies that support this, such as no specified visiting hours, help to encourage strong family relationships. Strategies for addressing common barriers to strong family involvement should also be integrated. Financial resources to assist families with the cost of transportation and child care for younger siblings are just a few examples. Youth should have ways to connect with their families and important natural supports, including approved friends, multiple times daily (phone, text, Skype, etc). Residential interventions should never decrease family contact as a form of punishment, or frame family contact as a reward for good behavior. Family contact is a right, not a privilege. The CFT regularly promotes this best practice.

• **Provide services and supports within the family’s home and in the community frequently (i.e. weekly; multiple times weekly).** Another residential best practice is for residential staff to provide coaching and support to the families in the home to build self-efficacy, foster family relationships, and develop skills. Likewise, the CFT should work to identify and implement a crisis or safety plan and viable back-up plans to respond to potential crisis challenges when the youth returns home ensuring that the family and youth, as well as their support systems, know the different plans and practice the plans in the home and in the community.

  “Every plan of care has a crisis safety plan, which is signed off on by the family. All practitioners have copies of the plan and when a crisis hits, we refer youth, families, and practitioners back to the plan. When more intervention is needed, we have a crisis access line…and we can dispatch mobile crisis.”

  - Chad Jones, Viewpoint Health

  “Work with the family to revisit the safety plan- did it work? If it didn’t, how do we change it? Build relationships with family so they tell you what’s going on and so you can intervene before a crisis.”

  - Michael Rauso, Department of Children and Family Services, LA County

**Tip from families:** Provide detailed information to families regarding the different crisis response services available to them once their child returns home. Ensure that families are well-versed on how to access these services prior to residential discharge. Residential staff should check with families regularly post-discharge to be sure their chosen crisis plan remains strongly in place.
**Policy and Administration Strategies**

Oversight agency and residential and community executive leaders can consider using the following policy and administrative oversight strategies:

- **Ensure that strong leadership is in place to commit to best practice principles and foster significant organizational change.** Leaders must work diligently to develop an organizational commitment to fully partner with youth and their families in order to transition the youth back into their home and community in as short a time as possible (i.e. ideally less than three to four months).

  Residential best practice and the Wraparound CFT aims for shorter lengths of stay (i.e. less than three to four months), with all skills focused on supporting the youth and family to be successful at home and in the community utilizing their strengths and culture. Residential leaders need to have a clear vision for the work they wish to embark upon, and to communicate the vision to referral sources, potential partners, funders, families, youth and staff. Leaders must also model ways to think differently about families, the challenges they face, and continually communicate a message of hope and resiliency for youth and families.

  Change will also require the creation of, or addition to, current documentation to focus on strengths and cultural information. Leadership has to prepare to make these changes in a way that is manageable for staff but still meets all oversight agency regulations.

- **Anticipate frustration, concern and even resistance to proposed organizational changes.** Staff may have challenges with implementing new practice expectations. Moving from traditional treatment team approaches to using the CFT, where decision making is shared and the focus moves to family readiness and not solely youth skill development, may make some staff uncomfortable. Some residential staff fear losing what is familiar and do not have a basic understanding of how to engage and partner with families, especially families with complex challenges and/or families of different cultural identities from themselves. Some staff believe that long-term residential interventions are warranted, or that family involvement is not positive for youth with histories of family conflict. For some, the shift in power dynamics reveals cultural biases that were not previously apparent. Comprehensive training and mentoring/coaching plans for staff will be important to gaining buy-in from staff. Staff turnover can sometimes be expected when making this type of values based change and is for the best in some cases.

  “[Ask stakeholders] are you really ready to do Wraparound? This is what you’re saying yes to. You have to know all the ins and outs and all the details so you know what you’re really saying yes to.”
  - Kelly Pipkins-Burt, Respectful Resolutions, BBI Project Lead

  “Trying to facilitate change has been a big challenge...change is slow. It is important to have supportive leadership behind this and to anticipate growing pains and mistakes.”
  - Lindsey Meekins, Jefferson School
• **Make policy, fiscal, and resource changes to support transformation.** Residential providers who are taking steps towards transformation should consider resource changes, such as hiring Youth and Family Partners, training them in Wraparound, and transform current job descriptions to reflect any new duties. Provide orientations to ensure staff have an accurate picture of the new expectations. Work groups can be created for the oversight and implementation of Wraparound. Policy changes may entail support for flexibility in the service array (e.g. providing services in the family’s home; doing away with provider-led traditional treatment team meetings in favor of CFT meetings). Fiscal changes may include the availability of flexible funds that support non-traditional activities, such as music lessons, football uniforms, or flexible funding (financial and material) to offset the cost of transporting the youth home multiple times per week. Other fiscal changes include paying for staff to work in the home and communities of the youth and families. Targeted funding is a way to tell a specific story in order to raise necessary funds or materials to help youth and families achieve their goals and achieve successful and sustained reunification. A more advanced fiscal change may entail changing the language of contracts to allow for flexibility and coordination between community-based and residential-based services. For example, community-based planning with the family is not discontinued because a youth enters a residential program.

• **Actively participate in service system reform that incorporates residential into a full array of well-supported services.** States and communities are beginning to embrace new policy and funding models that organize services for youth with the most complex needs and their families, regardless of system (juvenile justice, child welfare, behavioral health, etc.), around Care Management Entities (CMEs). Such methods of organization ensure that funding for youth with complex needs and their families are pooled together. Funds are used to purchase services identified by CFT’s via a case rate provided to the CME to achieve the best outcomes possible for each youth, and keep them in home and community. CME functions include:
  • High-quality Wraparound implementation;
  • Development and management of provider networks;
  • Screening, assessment, and clinical oversight;
  • Utilization management and quality improvement;
  • Outcomes management;
  • Information management, including real-time data;
  • Training for CME staff, providers, families, and referring entities;
  • Access to family and youth peer supports and advocacy;
  • Care monitoring and review; and
  • Access to crisis supports.

Within such models, residential providers are part of the service array managed by the CME and are held accountable to adhering to Wraparound principles, providing care continuity for families, and contributing positively to outcomes. Fiscal rules allow
residential providers to get paid even when enrolled youth spend substantial time at home, as part of a comprehensive plan of care developed by the CFT.\(^3\)

- **Partner with outside community programs to establish cross-system Wraparound Facilitators.** Residential referral sources, outpatient community programs, and residential agencies can all benefit from sharing Wraparound Facilitators (Care Coordinators) and sharing Wraparound training opportunities as well. This greatly enhances integration efforts when several different agencies agree on shared, highly trained facilitators that understand the mandates of the agencies and can guide CFTs seamlessly through the process. This results in cost reduction, as no one agency carries the financial burden of funding a full salary or trainer costs.

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\(^3\) For more on CMEs, see http://www.nwi.pdx.edu/pdf/CME-Primer-Fact-Sheet.pdf
Maintaining Continuity from Residential to Community-based Care

Residential programs that deliver best practice service must be flexible as both residential and community providers need to work together to support youth and families. Wraparound includes planning for discharge from the start of the residential intervention and keeping all involved community providers as part of the CFT throughout the residential intervention. Residential and community providers should consider the following strategies to facilitate the transition:

- **Ensure the same CFT continues to meet and stays involved with the youth and family, regardless of where the youth is located.** Funding structures that allow the same team to continue meeting for 3-12 months after a youth is discharged from residential should be explored. This may be possible even within existing funding streams. In situations where continuity of the full team is not possible, new team members should integrate with the current CFT far in advance of any transitions, to ease the process as much as possible for the youth and family.

- **Provide continuous services with the same providers, whenever possible.** Accomplishing this requires flexibility in oversight agency funding practices and policies, as well as flexibility and strong partnerships between residential and community organizations. Allowing residential staff to work in the home and community while also allowing community staff to continue to work with the youth and family throughout residential interventions allows consistency of staff and support for the family. When full continuity of services is not possible throughout the residential intervention, linking families to sustainable services in the community well in advance of the transition from residential proves helpful. In this scenario, residential and community providers should collaborate and focus on how goals can be aligned.

- **Carefully plan transitions.** From the first day in residential, the goals should be for the youth to spend time at home daily and to sleep at home whenever possible. Residential programs used to have practices that did not permit youth outside of the program during the first days of a residential intervention. Rather than impose specific and definable restrictions or steps, the residential intervention should be a seamless back and forth between residential, home, and community from the beginning of the intervention. As the family develops more skills and puts in place more supports to ensure the youth can spend extended time at home safely and successfully, then the transition home will result in far more time at home than in residential. The CFT can

“We follow the child no matter where they go....this was developed to counteract the child being separated from family and community when placed....so the same team that worked with the youth in residential was the same team who worked with them in the community, and there was no need for the family to retell their story or reengage with new staff. It allowed for a continuous story and for the family to continue their path.”

- Michael Rauso, Department of Children and Family Services, LA County
lead the move to spending more and more time at home according to the family and youth’s strengths and needs. Depending upon the child’s proximity to their home, a youth may go home after school each day for dinner and homework, but return to residential for the rest of the evening and sleep time. There are many examples of how different programs and CFTs have implemented successful transitions over time.

- **Ensure that the family is always acknowledged as the child’s primary caregiver.** All decisions should be made in partnership with the family to ensure that when a child enters residential program the family does not abdicate their parental role. In planning for transition reinforcing the parental role to the child is critical.

- **Ensure natural supports play a key role in supporting transitions.** The CFT should think about ways in which natural supports, including culture-specific organizational supports, can assist the family- particularly since providers will eventually step away. Natural supports can help to implement components of the individualized plan of care, such as providing transportation to services and community activities, helping youth with school work, intervening in crisis, and providing mentoring. Engaging natural supports at a very early stage of the residential intervention is especially helpful, as they will be committed to supporting the family. Linking the family to a family organization or a support group can be a source of support and connection for the family while the child is in a residential program as well as when the child returns home.

- **When community services are limited or difficult to access, continue to offer services from the residential after discharge.** It can be challenging for families to access particular services in their communities due to long wait lists or a lack of options. To address this challenge, organizations can allow youth and families to continue accessing services, such as clinical or psychiatric services from the residential post-discharge. In rural areas, tele-psychiatry and other long distance services have also helped to address this issue. It is important that the CFT explore creative ways to meet the needs of a youth and family within their own homes and communities. When formal services are not available or are limited by time or resources, how else can the CFT meet the need utilizing what the youth has available every day?

- **Develop community agreements.** Residential interventions should occur in partnership with family and community members. When there are multiple community providers that the residential program works with, create an agreement on how people are working together through the phases of Wraparound and how roles are defined and honored. Please see simple examples of community agreements in Appendix B.
**Summary**

Ideally, residential providers should be well integrated into community-based systems of care that include wraparound care coordination and teamwork for youth with the most complex needs and their families. Such systems of care have policies and include fiscal and other incentives for providers to work together to ensure families are supported to care for their youth at home, and clearly defined criteria is in place for when residential intervention is indicated. Regardless of whether residential providers operate in such a system, Wraparound offers strategies for implementing BBI residential best practices that are consistent with achieving sustained positive outcomes post-residential discharge. Major components include elevating the role of family and youth, utilizing CFT, infusing support in the home, having strong partnerships with community resources, and shared decision-making with all team members with the family and youth in the driver’s seat. Wraparound requires a clearly expressed vision and buy-in and skills from staff on all levels of an organization. Wraparound provides one way to support an organization in implementing practices that correlate to sustained positive outcomes for youth and families post-residential discharge.
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References


Appendix A: Ten Key Wraparound Principles (Bruns et al., 2004) – with examples of adaptation to residential programs

1- **Family voice and choice** - family and youth goals and perspectives are privileged and prioritized at all stages of the process. All planning is done with the family and youth, and they have a primary decision-making role. Families are engaged and infused into all components of the residential program.

2- **Team based** - Wraparound includes a team that the family agrees upon, which includes formal, informal, and community supports and service relationships. This CFT\(^4\) meets to develop and implement and individualized plan for the youth and family. The team helps strengthen the supports for the family, including extended family, friends, community organizations, and other social support through involving them in the planning and implementation process.

3- **Natural supports** - the team also includes individuals involved in the family's social support network (e.g. relatives, neighbors, mentors, coaches, pastors, etc.). Wraparound Child and Family Teams ideally have at least 50% natural support representation on the team.

4- **Collaboration** - the team works collaboratively to implement the "Wraparound plan" that is developed by the team. The team functions from one plan that addresses all needs for the youth and family.

5- **Community-based** - services are designed to take place in “the most inclusive, most responsive, most accessible, and least restrictive setting possible.” Community-based services are designed to support and promote the youth’s safe and successful integration into the family and community. These services are used as stabilization resources and do not operate outside of the family plan.

6- **Culturally competent** - services are responsive and respectful of a family's cultural background and values. Services are tailored to the unique race, ethnicity, family habits, preferences, beliefs, language, rituals, and dress. Detailed examples of each family’s culture are infused into residential interventions.

7- **Individualized** - strategies and services are customized to meet the specific needs of the youth and family. Needs are prioritized by the family and are a blend of natural supports and formal services.

\(^4\) The CFT is called a “Wraparound Team” in some systems. This team meets regularly to develop and implement the course of care, and discusses the family’s strengths, culture, hopes, dreams, and what is needed to foster success. The family is the center of the team and identifies natural supports to join the team to play important roles in the plan of care.
8- **Strength-based** - the process and plan identifies and builds upon the strengths, skills, and assets that youth and families bring to the table. By building upon these strengths, the plan supports who the youth is and how the youth and family will positively progress through life.

9- **Unconditional** - the team continues to work toward the goals identified in the plan, even in the face of setbacks and challenges, until the team agrees that the formal Wraparound process is no longer needed by the family. Families don’t fail, plans fail. Plans are reviewed and updated until the family achieves success.

10- **Outcome-based** - the team identifies a way to measure the goals of the Wraparound plan through observable/measurable indicators of success. The team monitors progress and revises the plan based on this information. Outcomes of success should be measured by the residential provider 1-3 years post-discharge.
Appendix B: Sample of Community Agreements

SAMPLE AGREEMENT ABOUT THE ESTABLISHMENT OF COMMON PRINCIPLES

Date:

We, the undersigned, agree that our community of _______ is committed to moving toward a more integrated system of care that recognizes the potential complexity of child, youth, and family needs. We are implementing this effort in the best interest of children, youth, and families and to strengthen our community, our agencies and schools. We also implement this effort to demonstrate our individual dedication to improvement of our services systems. In signing this agreement, we commit to a team based planning model titled Wraparound, and commit to the following principles:

1. We partner with youth and family members at every level, including system design, implementation, and evaluation. We commit to use of the maximum possible level of youth and family voice and choice at the individual family service level, while maintaining the safety of the child and community.

2. We commit to a practice model that is based on: individualization; use of family and community strengths and culture; a child focus in the context of family; persistence in sticking with the family even in tough times; and appreciating and building on natural supports in the lives of children and families.

3. We commit to continuous quality improvement which consists of collecting information about our implementation, and striving to gradually improve the fidelity of our team based planning practice model, and the integrity of our system of care.

4. If a family with needs across systems already has a team from any one or more systems, we commit to coordinating all single system planning methods such as Family Support Team, Family Group Decision Making, Restorative Justice Teams, Positive Individualized Behavioral Support Teams, Child and Family Teams (name all known planning methods) using good integration and system of care principles.
SAMPLE AGREEMENT ABOUT THE PRACTICE MODEL

Date:____________

We, the _______ [name the System of Care [SOC]] commit to the implementation of the SOC Principles. These standards describe the tasks through each SOC Principle.

Key tasks for:
1. Family Voice and Choice-
2. Team Based-
3. Natural Supports-
4. Outcome Based/Cost Responsible-
5. Individualization-
6. Strength Based-
7. Culturally Responsive-
8. Unconditional Care-
9. Integration-
10. Community Based-
SAMPLE AGREEMENT ABOUT STAFF ROLES

Date: ____________

We, the undersigned _____________ (name the SOC and agencies) commit to the following staff roles:

1. We will have Facilitators/Care Coordinators to manage the integration planning process. These Facilitators will be employed by ______ (name the agency) but are working for the entire system of care as integration specialists, with the children, youth, and families who are true integration resources.

2. Each of the Facilitators/Care Coordinators must have a designated supervisor who is skilled in skill based supervision and coaching to the agreed upon principles. This supervisor must work closely with supervisors of other system partners and with the family-run organization (name the family organization).

3. Each of the Facilitators/Care Coordinators must be competent in the single system decision making planning systems, and work closely with the facilitators of each of these systems to ensure that no duplication of effort negatively impacts family outcomes or costs of services.