



California
Children's
Trust

Wrapping Our Youth With the Supports They Need to Thrive

PART 1

**HOW THE HISTORY OF WRAPAROUND
SETS THE STAGE FOR SUCCESS NOW**

DECEMBER 2022



This issue brief is the first in a series to propose a blueprint on how the state can better support young people by delivering on its promise of wraparound for all system-involved youth.

The four-part series builds the case for wraparound, and proposes a tiered structure and implementation approach by exploring the following:

- **Part 1:** How the legislative, legal, and reform history of wraparound has led to the current opportunity to codify the administrative and financing structures to realize its promise.
- **Part 2:** Detailed look at how the groundwork for increased access to community based mental health services—and specifically wraparound—already exists through recent innovations and policy changes and can be structured and delivered with a three-tiered approach.
- **Part 3:** The case for wraparound: good news, potential challenges, and how to get youth absolutely everything they need.
- **Part 4:** How implementation best practices for new and evolving youth mental health reforms have the opportunity to meaningfully expand access to wraparound.

Introduction

California has a unique opportunity to meaningfully support some of our most vulnerable youth and families through the expansion of wraparound statewide. Now is the time to realize this opportunity due to the convergence of policy and funding reforms with a broad consensus about the urgency of better supporting young people’s mental health.

Much of the groundwork for increased access to community based mental health services—specifically wraparound—has already been built through recent innovations and policy changes, including Continuum of Care Reform, CalAIM, *Katie A.*, and deinstitutionalization. Enhanced Care Management (ECM), behavioral health payment reform, unprecedented growth in Mental Health Services Act (MHSA) dollars, and the recent DHCS Foster Care Strategies Note, create additional opportunities to promote access to wraparound and better support youth.

Most importantly, as spotlighted in recent conversations about the current mental health crisis, system-involved youth urgently need access to high quality community based mental health supports. As many as 80% of children in foster care have significant mental health needs,¹ and ALL have faced and overcome adversity and trauma. California has demonstrated a significant commitment to fundamentally reforming its mental health system to be trauma informed and ACEs aware, and we now have the moon launch moment to act at scale for some of California’s most vulnerable children.

The California Children’s Trust proposes a dramatic expansion of high fidelity wraparound services in defined models, at established costs, and developed via a shared and standardized implementation process across all counties. This paper describes high fidelity wraparound, details its relevance to current commitments and priorities, and proposes a three-tiered structure to expand it to all children in out of home placement.





What Is Wraparound and Why Is It Important?

Wraparound is an intensive, individualized, and team-based approach to working with children and families, and may be either a set of principles or a clearly identified practice with fidelity to a specific methodology. The term “wraparound” began to be more commonly used in the 1980s, arising out of a youth-serving ecosystem of other parallel developments and movements, including person centered planning, family group decision making, and individualized community safety planning among others. In the last forty years, wraparound has coalesced around certain core values and best practices, allowing us to identify the necessary components to meaningful and high-quality wraparound.

While the term “wraparound” can be used to describe a variety of methodologies, at its core it must be a collaborative, inter-agency approach to serve children and families that is:

- ✔ **Proximate**
Services delivered in home, school, and community.
- ✔ **Individualized**
The approach is individualized, strength-based, and team-based.
- ✔ **Unconditional**
There is an unconditional commitment to the youth’s success.

- ✔ **Embedded**
Delivery moves across life domains (such as family, living situation, education, psychological and emotional health, physical health, and more).

Additionally, an effective wraparound program should be:

- ✔ Clinically articulated but not necessarily clinically driven.
- ✔ Culturally concordant.
- ✔ Created with access to flexible funding.

Evidence now exists to support the success of wraparound. However, the research also shows that when fidelity to the wraparound model and principles is inconsistent, programs lose the effectiveness that is embedded in the constituent parts that make up a true wraparound service.

Wraparound services delivered with fidelity to the values and approaches listed above have been increasingly shown to be effective in supporting youth and families to thrive in their communities. For system-involved youth, wraparound has been shown to reduce placement changes; prevent unnecessary institutionalization; support least restrictive, most family-like settings; and reduce the need for foster care altogether.

Additional detail regarding the development of wraparound and the evidence base is included in the [Appendix: Expanding the Case for Wraparound](#).

Wraparound Addresses Current Mandates and Initiatives

Current wraparound as a discrete service for system-involved youth in California is the result of a series of legislation, litigation, and fiscal reforms.

LEGISLATIVE ORIGINS

1997 legislation birthed wraparound and is now the foundation for FFPSA step-down.

In California, wraparound for system-involved youth began in statute in 1997 when the State created a wraparound program under Senate Bill 163 (SB 163).² At the time, the bill allowed counties to use state funded Aid to Families with Dependent Children-Foster Children (AFDC-FC) for planning and service delivery as an alternative to placing youth in high-level group homes.³ Counties could use the higher AFDC-FC group home rate flexibly, creating supportive services to help maintain a child at home in a less restrictive setting, and then reinvest cost savings into more community based supportive services for other children.

SB 163 required counties to adhere to specific wraparound parameters such as services that were family-centered, individualized, culturally relevant, strength-based, team

and community based, and reliant on families' natural and community supports.⁴ The goal was always to maintain youth in the least restrictive environment, to track and evaluate outcomes, and to reinvest cost savings into child welfare programs. This program still exists, and CDSS recently updated its fiscal claiming instructions with CFL 20/21-94.⁵

This form of wraparound in California is being used to meet the requirements of the Family First Prevention Services Act (FFPSA), Section 672(k)(4)(F) of Title 42 of the United States Code in 2021, which requires six months of aftercare services to be provided to youth exiting Qualified Residential Treatment Programs (WIC 4086.6).^{6,7}

There are no state requirements for counties to integrate wraparound with any other Medicaid-funded wraparound service. The State has, however, clarified that "counties should ensure that Medi-Cal is the payor of "first resort" for wraparound services.⁸ Further, this form of wraparound is optional to the counties—meaning some counties do not provide it at all as a distinct service separate from meeting the aftercare requirement when a youth exits a Qualified Residential Treatment Program (QRTP).



CONTINUUM OF CARE REFORM

Strengthened the foundation for high fidelity wraparound, but fell short of mandating a clinical component to the wrap team.

In 2012, California launched Continuum of Care Reform (CCR), focusing on reforming its foster care rates and practices. As a result of CCR, California created a statutory requirement for Child and Family Teams (CFTs) tasked with providing supports to system-involved youth through an integrated, cross-system framework using a team-based approach.⁹ CDSS encourages counties to use the Integrated Core Practice Model (ICPM), which is based on the National Wraparound Institute's model for CFTs, and requires that CFTs be strength-based, include both professional and peer/family supports, emphasize community-based and culturally concordant supports, and be individualized and trauma informed.¹⁰ This means that every child in foster care should receive supports that are coordinated and delivered through a wraparound approach. What CCR did not do through the CFT coordinated wraparound model was to ensure that there was a clinical component to the wrap team.

KATIE A. AND INTENSIVE CARE COORDINATION

Further expanded access to the clinical components of wraparound, but only for a subset of eligible groups.

Access to wraparound services was further expanded through litigation in California which added a clinical component to the child and family team process if a youth was found to be eligible for these additional services. In 2002, a class action lawsuit, *Katie A.*, was filed with claims under Medicaid/EPSTDT, the Americans with Disabilities Act, and Section 504 of the Rehabilitation Act alleging that the State and Los Angeles County had failed to provide sufficient community based mental health services for children in or at risk of foster care. The lawsuit was filed on behalf of a group of children who were not able to access community-based supports, including some youth who were institutionalized as a result.

The penultimate settlement, reached in 2011, created a broad array of wraparound and community based supports for youth in California, including Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC).¹¹ *Katie A.* services, known by the umbrella term Pathways to Well-Being

Services, are wraparound services, and are specifically delivered through a team-based model following the wraparound principles based on the National Wraparound Institute and as set out in the State's ICPM.¹² All children who meet medical necessity for the service and are Medi-Cal beneficiaries are eligible for services created under *Katie A.*, including ICC, IHBS, and TFC. A child does not need to be in foster care to be eligible.¹³

CALAIM

Added the clinical component missing in CCR—for all system-involved youth—not just *Katie A.* eligible groups.

On January 1, 2022, California further clarified its access criteria for community based therapeutic supports, removing barriers and further promoting appropriate access for youth under Medicaid/EPSTDT. California became the first state in the country to move to a trauma-based children's behavioral healthcare system, recognizing the impacts of trauma and the importance of the EPSTDT services array to provide appropriate services and treatment. Further, California also moved to a system that recognizes the prevalence of trauma among children who are involved in various systems, creating automatic eligibility for a specialty mental health service that is medically necessary. As articulated in BHIN 21-073, California provided direction that:

*Covered specialty mental health services shall be provided to enrolled beneficiaries who meet either of the following criteria ... a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following: scoring in the high-risk range under a trauma screening tool approved by the department, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness.*¹⁴

Practically, this means that all children in the child welfare system—and not just those found eligible under the *Katie A.* agreement—should be eligible for some level of community based therapeutic supports, thereby adding a clinical component to all child and family teams for a more robust, high quality wraparound model. While this creates the statutory and fiscal structure for high quality wraparound for all system-involved youth, to realize this promise, child welfare and children's behavioral health will need to collaborate on outreach, access, and contracts to ensure that youth get the level of support they need when they need it and that the prevalence of services exist in the community.

Why Achieving the Promise of High Quality Wraparound is Necessary in California Now

High quality wraparound has increasingly been shown to be effective in supporting youth with complex care needs, especially in reducing institutionalizing, avoiding further systems involvement, and helping youth stay in the community with family.

California has embarked on a decades-long foster care reform effort with similar goals. Recent federal funding requirements have also put additional restrictions on therapeutic group care and institutionalization, making it even more important for youth to receive supports they need in the community.

As mentioned above, Continuum of Care Reform began in 2012 and put into place a number of statutory requirements that would restrict the placement of youth in congregate care settings. CCR phased out the old group home structure and created time limits and eligibility requirements for the newly created Short Term Residential Treatment Programs (STRTP). It also created some additional supports for community-based placements, including making it easier for relatives to be licensed and to receive funding and implementing the Pathways to Wellbeing intensive community mental health services, which came out of the *Katie A.* settlement agreement. Despite this increase in community supports within a wraparound model, most youth in foster care did not have a therapeutic component as part of their wraparound team. The barriers prohibiting this from happening should be addressed with the recent CalAIM changes.

Since CCR, California has passed additional reforms to decrease the placement of youth in institutionalized settings, including AB 153, which phases out the placement of youth in out of state facilities.

Families First Services and Prevention Act (FFSPA) is a federal law passed in 2018 that accomplished some of the same things as California's CCR but without creating a similar level of community and kinship supports. FFSPA puts even more restrictions on congregate care settings, including time limits and eligibility requirements in the newly created QRTPs. While FFSPA created limited opportunities to access federal funding for intervention services for youth not in foster care, it did almost nothing to help states provide additional supports for youth while they are in foster care.

As a result of these reforms, California is at a crossroads. Children have better outcomes when they are able to stay closer to their communities and with families. Best practices suggest that congregate care should only be used when absolutely necessary. Yet, if California does not build out an appropriate array of community based therapeutic services to wrap young people with supports so they can stay in family-based settings, then it runs the risk of endangering these same young people despite its good intentions. The results will be more young people in emergency settings, in offices, and/or pushed to the juvenile justice system and homelessness.

As legal and funding requirements push to decrease the number of youth in congregate care settings and increase alternative care settings that are in the community with family, it is vital for California to build a commensurate level of community based therapeutic services to make such changes possible. These supports should be based in high quality wraparound services and coordination that are already rooted in the existing Child and Family Teams with CalAIM-facilitated therapeutic supports. Without such commitment to widespread community supports, California's family-based foster care reforms cannot succeed.

PROPOSED WRAPAROUND LEVELS OF CARE

In partnership with many of California’s leading wraparound providers, we reviewed sample contracts and asked the providers how they might stratify and organize levels of care in the wraparound programs they administer. This proposed three-tier model is the result of those conversations, and is a foundational point in our proposal to expand high fidelity wraparound in California. Subsequent papers in this series will go deeper into the costs of each tier of service and supports, and will examine the various ways counties fund wraparound including 2011R, 1991R, MHSA, county general fund or other local tax or assessment revenue. All of these ideas require our collective thinking, revision, and action to deliver the best supports for our most vulnerable young people.

Tier	Summary of Services	Staff / Roles Available	Direct Service Hours (Average per Month)
Wrap Tier 1	<ul style="list-style-type: none"> • Case Management • Linkages • Behavioral Coaching 	BA/Mental Health Rehabilitation Specialist (MHRS) Counselor BA Coach/Peer Support	12 to 23
Wrap Tier 2	Tier 1+ <ul style="list-style-type: none"> • CFT Facilitation • Behavioral Coaching • Parent Support/Advocacy • Family Finding and Engagement • Flex Funds • 24/7 Support 	MA Facilitator/Clinician, Parent Partner BA/MHRS Counselor, Permanency Specialist	24 to 36
Wrap Tier 3	Tier 2+ <ul style="list-style-type: none"> • Intensive In-Home Stabilization • Therapy 	MA Facilitator/Clinician, Parent Partner BA/MHRS Counselor, Permanency Specialist	45 to 75



Evidence That Wraparound Works

Wraparound services, when delivered with high fidelity to the values and approaches previously stated, have been increasingly shown to be effective in supporting youth and families to thrive in their communities. For system-involved youth, wraparound has been shown to reduce placement changes; prevent unnecessary institutionalization; support least restrictive, most family-like settings; and reduce the need for foster care.

Specifically, based on a 2021 meta-analysis that is an update from a 1991 analysis, research indicates:¹⁵

- ✔ Wraparound has positive effects on a range of behavioral health outcomes, especially for supporting youth with complex care needs in the home and community.
- ✔ Wraparound also has lower service costs for youth compared to treatment as usual (TAU).
- ✔ And, there is evidence that wraparound may result in more positive effects among young people, partly due to the fact that the systematic process of identifying individualized needs and tailoring support to meet those needs may result in particularly robust benefits to youth and families who are not well served by “treatment as usual,” including those from diverse backgrounds.

Additionally, nearly every state uses wraparound care coordination, partly due to its reimbursement via Medicaid and fewer exclusion criteria than most EBTs. Wraparound can thus be used as a care management strategy for youths with complex needs across multiple sectors, not just behavioral health, but also child welfare, education, and juvenile justice.

See further evidence of the success of wrap in [APPENDIX: The Evidence Base](#)

A Path Forward to Deliver on the Promise

Wraparound is a powerful intervention that helps youth stay in their community with family, thereby preventing unnecessary institutionalization, juvenile justice involvement, and other traumatic outcomes.

In the last decade, California has built an unprecedented framework that has the ability to ensure all system-involved youth have access to wraparound teams complete with community based therapeutic supports. This has been the result of progressive legislation and child welfare reform, the approval of the 1915 b waiver removing barriers to medically necessary services, the legacy of the *Katie A.* legal settlement, and more.

And yet, California has not yet realized this promise consistently in implementation. There is no clear blueprint on how to finance the practical expansion of wraparound and community based therapeutic services so that all youth get what they need when they need it and in the amount they need. We have also failed thus far to standardize wraparound best practices across California’s fifty-eight counties. As a result, it ranges across the state from being legally required to being scarcely accessible at all.

Subsequent papers in this series will outline what implementation of such an approach could look like and how to leverage past reforms as well as changes on the horizon—including behavioral healthcare payment reform and the new Enhanced Care Management benefit. The State has an unprecedented opportunity to deliver the services that system-involved youth need to remain with their families and supported in their communities. California can get there. California’s children need us to.

Appendix: Expanding the Case for Wraparound

THE MODEL

The wraparound approach is intensively individualized and centered on the voice and preferences of the youth and family. As one researcher notes, “the more complex the needs of the child and/or family, the more intensive the individualization and degree of integration of the supports and services around the family.”^{16, 17} This argument is furthered by claiming that if wraparound is implemented and executed properly, wraparound services provide dedicated care coordinators that work together with the family and youth to identify needs, strengths, and potentially effective strategies and align these resources into one single, coordinated, and individualized plan of care.^{18, 19}

Contrary to traditional methods of care, wraparound approaches implement a comprehensive planning process that radically includes youth and families’ priorities in decision making and makes them equal members of the planning team. In this planning process, formal services are balanced with natural supports such as interpersonal support and assistance that can be provided by friends, peers, and other social connections. Collaboration, cultural competence, and outcomes are achieved and actualized through a team-based process that includes cooperation and shared responsibility for a single plan of care.²⁰ In a wraparound approach, there is no “giving up,” blame, or rejection, even in the face of significant challenges or barriers. Strategies are tailored to meet the individual and unique needs of the youth and family to provide them with the most inclusive and least restrictive setting possible.²¹

HISTORY

The term “wraparound,” coined in the 1980s, refers to a set of individualized, team-based service planning and care coordination processes that are intended to improve outcomes for youth and families struggling with complex behavioral health and social challenges.²² This holistic form of planning, coordination, and monitoring integrates the efforts of a well-defined interdisciplinary team to create an effective treatment plan that supports parents, caregivers, and the youth involved. While there is no one standardized definition of the wraparound service, general consensus and public service providers such as the California Department of Social Services (2020) have generally defined wraparound services as a **strengths-based** planning process occurring in a team setting with individually tailored services that **wrap around** youth and families to promote resilience and allow youth to thrive through a whole-child, whole-family, community-based approach.

Wraparound services seek to effectively empower youth and their families to overcome complex challenges in order to live safely within their home environments and communities by building on the strengths of the youth’s entire network to achieve concrete, measurable outcomes. The California Department of Social Services defines key principles of wraparound as: *Community-based services, delivered in home, school, and community, that are individualized, strength-based, and delivered through a team approach with an unconditional commitment to the youth’s success and focus across life domains (family, living situation, education, psycho-emotional health, physical health, etc.).*

It is also commonly agreed that wraparound in California should include clinically articulated services that are not necessarily clinically driven, culturally concordant, and have access to flexible funding. Bruns and Walker²³ and the University of California Davis²⁴ similarly agree with the California Department of Social Services by defining the key ten principles of wraparound as family voice and choice, team-based, natural/informal/formal support, collaboration and integration, community-based, culturally respectful, individualized, strengths-based, persistent, and outcome-based approach. This list aligns closely with other proposed definitions.

Wraparound seeks to strengthen communities as well as the individual youth by creating what some have called a “therapeutic community.” Because wraparound is strength-based and works in deep collaboration with families and community, it acknowledges that a young person’s youths’ behaviors are frequently adaptive responses to their environment. As such, wraparound’s individualized services work to help strengthen the environment to meet the youth’s and family’s needs for connection, care, and stability. Wraparound in many ways is about making the environment (including family relationships) more trauma-responsive and creating an ecosystem of support across life domains.

ORIGINS AND EARLY ADOPTION

Wraparound emerged as a philosophy and grassroots movement in the 1970s, especially in the Brownsdale programs in Canada and Karl Dennis’ Kaleidoscope program in Chicago. Dr. Lenre Behar is credited with coining the term “wraparound” through work connected to the *Willie M.* lawsuit, which was settled out of court in 1980 and created an array of community based supports in North Carolina as an alternative to institutionalization for certain categories of youth with unmet needs. Dr. Behar used wraparound to describe the application of comprehensive, community-based services to individual families caring

for youth suffering from complex behavioral health and community-driven challenges.²⁵ Since the *Willie M.* lawsuit wraparound services have been gradually introduced into state children behavioral healthcare programs throughout the United States.²⁶

Oftentimes, the creation of an array of community based therapeutic supports and wraparound models have come about as the result of litigation. Medicaid for children under the age of 21 includes the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. EPSDT provides for beneficiaries to receive:

Such other necessary health care, diagnostic services, treatment, and other measures ... to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan. 42 U.S.C. 1396d(r)(5).

Litigation bringing claims under this Medicaid/EPSDT entitlement combined with the legal requirement to provide such services in the least restrictive environment has helped to create community based mental health services throughout the country. This has included *Rosie D.* (Massachusetts), *TR* (Washington), *Jeff D.* (Idaho), *JK* (Arizona), *Katie A.* (California), *Kevin S.* (New Mexico), and many others.



THE EVIDENCE BASE

Evidence now exists to support the success of wraparound. However, the research also shows that when fidelity to the wraparound model and principles is lost, programs lose the effectiveness that is embedded in the constituent parts that make up a true wraparound service.

The wraparound approach has spread rapidly throughout the country and is considered effective—especially at decreasing placement moves and periods of institutionalizations—while also resonating with children and families and aligning with contemporary systems of care approaches.

Recently, an article in the *Journal of the American Academy of Child and Adolescent Psychiatry* found that wraparound consistently has positive outcomes, especially for youth with complex care needs and youth of color.²⁷ The meta-analysis identified a total of seventeen peer-reviewed studies that met the criteria for wraparound approaches. With the use of random effects modeling in version 3 of the comprehensive meta-analysis standards, and effect sizes calculated using Hedges Homogeneity in Q statistics, indicators were found identifying positive effects for youths in both their homes and communities.

Other studies have similarly found strong positive outcomes for youth and families who participate in wraparound services. In Evans, Armstrong, and Kuppinger's study,²⁸ forty-two children from New York State who were referred to out-of-home placements were assigned to foster care or family-centered intensive case management. It was found that family-centered case management employed most of the values and elements of an official wraparound process and worked to help youth stabilize. Findings in this study focused on a significant reduction in behavioral symptoms, lower rates of juvenile justice system involvement, and lower externalization of "social problems and thought processes."²⁹

Another study further identified one hundred and thirty-one youths in the foster care system that were randomly assigned to a wraparound program or traditional foster care. One major finding of the study produced results suggesting there were fewer placement changes in those who received wraparound services. Further results provided that those with wraparound care had fewer missed days of school, and lower rates of delinquency.³⁰ Both studies strongly suggested wraparound services can reduce unnecessary institutionalization and reduce system involvement.

A more recent study by Cosgrove, Lee, and Unick³¹ evaluated the impact of a statewide implementation of wraparound on mental health service use over time among a diverse sample of youth with significant behavioral health needs. Using a longitudinal design that included twenty-two quarters of panel data, covering the period of January 2009 to June 2014, Cosgrove et al. was able to find that enrollment in wraparound was associated with a two-thirds decrease in use of residential treatment and an increase in use of outpatient therapies, with results sustaining through two years post-intake.³²

As noted earlier, some programs referred to as wraparound may not have fidelity to the model or core principles as outlined above and in the National Institute of Wraparound standards. There have been multiple studies suggesting fidelity matters, including studies that seem to show youth and families have better outcomes when facilitators were more adherent to the wraparound model.³³ Based on stakeholder interviews with County Child Welfare and Behavioral Health staff and providers in California, this was referred to as the difference between "wraparound" and "crap wrap." Looking at the research base, this makes sense. Separating out constituent components of wrap, youth and families have better outcomes when care is individualized, integrated in the community, is team based and collaboratively planned, and when youth and families are centered and are equal collaborators in the treatment plan. In other words, when fidelity to the wraparound model and principles is lost, programs lose the effectiveness that is embedded in the constituent parts that make up a true wraparound service.

Endnotes

- 1 National Conference of State Legislatures, [Mental Health and Foster Care](#). November 11, 2019.
- 2 [SB 163](#). Approved by Governor, October 8, 1997.
- 3 California Department of Social Services. [CDSS Programs: Foster Care: California Wraparound](#). 2022.
- 4 This is outlined in ACIN I-52-15. 2022.
- 5 State of California, Health and Human Services Agency. Updated Comprehensive Claiming Instructions for the Wraparound Program, [County Fiscal Letter No. 20/21-94](#). April 30, 2021 .
- 6 See ACL 21-116: “[A]ftercare services must utilize California’s Wraparound model pursuant to statute and must be aligned with the ten Wraparound Principles, comply with the California Wraparound Standards currently specified in ACIN I-52-15 ...”
- 7 Walker, J. National Wraparound Initiative. [New Systematic Review Shows Wraparound to be Effective, Particularly for Youth of Color](#). April 12, 2021.
- 8 CFL 20/21-94 at page 10.
- 9 For more on CFTs, see WIC 16501, WIC 16501.1, ACL 16-84, and ACL 18-23.
- 10 See ACL 18-23 at 2, 10-11; ACL 16-84 at 5; and, BHIN 21-073 at 4.
- 11 [Medi-Cal Manual ICC, IHBS, and TFC Services for Medi-Cal Beneficiaries, Third Edition](#), at page 7. January 2018.
- 12 See [ACIN I-21-18 California Integrated Core Practice Model for Children, Youth, and Families](#) at page 5.
- 13 State of California, Health and Human Services Agency Department of Health Care Services, [MHSUDS Information Notice NO.: 16-004](#). February 5, 2016.
- 14 State of California, Health and Human Services Agency Department of Health Care Services, [BHIN 20-043](#). December 10, 2021.
- 15 Olson, J. R., Benjamin, P. H., Azman, A. A., Kellogg, M. A., Pullmann, M. D., Suter, J. C., & Bruns, E. J. [Systematic review and meta-analysis: effectiveness of wraparound care coordination for children and adolescents](#). *Journal of the American Academy of Child & Adolescent Psychiatry*, 60(11), 1353–1366. 2021.
- 16 VanDenBerg, J. [History of the wraparound process](#). In E. J. Bruns & J. S. Walker (Eds.), *The resource guide to wraparound*. Portland, OR: National Wraparound Initiative, Research and Training Center for Family Support and Children’s Mental Health. 2008.
- 17 VanDenBerg, J. [Reflecting on wraparound: Inspirations, innovations, and future directions](#). In E. J. Bruns & J. S. Walker (Eds.), *The resource guide to wraparound*. Portland, OR: National Wraparound Initiative, Research and Training Center for Family Support and Children’s Mental Health. 2008.
- 18 Bruns, E. J., Walker, J. S., Zabel, M., Matarese, M., Estep, K., Harburger, D., Mosby, M., & Pires, S. A. [Intervening in the lives of youth with complex behavioral health challenges and their families: the role of the wraparound process](#). *American Journal of Community Psychology*, 46 (3-4), 314–331. 2010.
- 19 Cosgrove, J. A., Lee, B. R., & Unick, G. J. [A longitudinal evaluation of wraparound’s impact on youth mental health service use](#). *Journal of Emotional and Behavioral Disorders*, 28(3), 156–166. 2019.
- 20 Bruns et al. 2010.
- 21 Ibid.
- 22 Bruns, E. J., Pullmann, M. D., Sather, A., Brinson, R. D., & Ramey, M. [Effectiveness of wraparound versus case management for children and adolescents: results of a randomized study](#). *Administration and policy in mental health*. 42(3): 309–322. 2015.
- 23 Bruns et al. 2010.
- 24 UC Davis. [California Wraparound Standards](#). 2020.
- 25 VanDenBerg, J. [History of the wraparound process](#), at page 2. 2008.
- 26 See for example [The evidence base and wraparound](#), estimating that over 90% of states responding to the survey have some form of wraparound initiative.
- 27 Olson et al. 2021.
- 28 Evans, M.E., Armstrong, M. I., & Kuppinger, A. D. [Family-centered intensive case management: A step toward understanding individualized care](#). *Journal of Child and Family Studies*, 5, 55-65. 1996.
- 29 Ibid.
- 30 Evans, M.E., Armstrong, M. I., & Kuppinger, A. D., Huz S., & McNulty, T. L. Preliminary outcomes of an experimental study comparing treatment foster care and family-centered intensive case management. In: Epstein MHEK, editor. [Outcomes for children and youth with emotional and behavioral disorders and their families: Programs and evaluation best practices](#). 1998.
- 31 Cosgrove et al. 2019.
- 32 The success of this demonstration should be interpreted with attention to the quality of wraparound service delivery as Bruns et al. (2015) concludes that wraparound is only effective when implemented well. In this particular study, wraparound services were shown to be delivered with adequate fidelity statewide; however, certain fidelity subscales such as identifying and accessing natural supports, availability, and accessibility of community-based activities for the youth, individualized services, and a focus on outcomes showed lower scores (Cosgrove et al.). Although findings were significant in favor of the demonstration’s goals, concurrent with adequate overall fidelity, the effects may have been stronger if certain principles of wraparound practice had been better implemented (Cosgrove et al.).
- 33 See for example [Research Base for Wraparound](#), at page 7.



The California Children's Trust (CCT) is a statewide initiative to reimagine our state's approach to children's social, emotional, and developmental health. We work to transform the administration, delivery, and financing of child-serving systems to ensure that they are equity driven and accountable for improved outcomes. CCT regularly presents its Framework for Solutions and policy recommendations in statewide and national forums.

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CCT FRAMEWORK FOR SOLUTIONS

