When I made the decision to go back to school and get a master’s degree in social work, I had already been working in the field for several years. At the time, I was a Parent Aide in Lowell, a small city outside of Boston, and had begun to realize how hard it was to facilitate positive change effectively. I hoped that by continuing my education, I would learn more about how to best support the change process. After graduate school, I moved to California and got a job with Seneca Center. Now called the Seneca Family of Agencies, the social services nonprofit’s mission is to sustain children and families through the most difficult times of their lives. For the majority of the 12 years I have been at Seneca, I have worked in or overseen wraparound programs. I feel lucky to have found what I believe is an effective way to approach helping people make positive change.

Wraparound is a goal-oriented, problem solving and skill building practice that uses “team” meetings as its central strategy. Teams are usually made up of a clinician, a mentor/behavioral coach, and a family partner (a peer parent), as well as the youth, family members, natural supports, and referring party. Teams work together to identify client (youth) and family needs and develop plans to meet those needs, so the client and his or her family increase success across all life domains and reduce formal county agency involvement.

All wraparound programs are comprised of these elements and are guided by the Wraparound Principles. I call programs that stick solely to this composition ‘Traditional Wraparound.’ Seneca and some other agencies, however, provide a different version that I call “Treatment-Oriented Wraparound.” This version of wraparound adds mental health services. It is the combination of traditional wraparound and mental health services together that I have found to work so well. In other words, emphasis on connecting relationships plus skilled intervention often equals success (no surprise there)!

We receive wraparound referrals from Children and Family Services, the Department of Juvenile Probation, and until recently, Community Mental Health. The referrals we receive cover a broad range of issues stemming largely from poverty and include issues from criminality on the part of the youth to extremely challenging family dynamics. For youth to meet criteria, they have to either be at risk of out-of-home placement or returning to a family after being placed in a group home. While the youth are technically our clients, we work from a systems perspective and bring the family as fully into the process as possible. It is the responsibility of the entire team, which is led by the master’s level clinician, to assist the family in crafting a plan that identifies the steps needed to obtain the agreed upon goals. Although participation in the program is voluntary, because the referrals are made by the department of juvenile probation or children and family services, we assume that families often feel pressured to participate. So, as you can imagine, we find family members to be at different places on the change-readiness continuum with a wide range of motivations.

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To illustrate the question of how best to facilitate change within a treatment-oriented wraparound model, I thought it might be helpful to use a couple of different case examples. I changed names and details to protect the clients and typify the work being done in the wraparound field.

**CASE EXAMPLE 1:** John was referred for wraparound services by the Department of Juvenile Probation. John was a 14-year-old Caucasian male, was constantly breaking probation, and was at risk for out-of-home placement. He was initially placed on probation because of gang involvement, fighting at school, truancy, and stealing. He lived with his aunt because he and his mother were arguing so much. His father was not in the picture. His mother also had a history of gang involvement and domestic violence. Seneca’s wraparound team was asked to work with the family to help John meet his probation requirements and get back on track. He was attending school only occasionally and continually came home after curfew. His gang involvement and experience witnessing domestic violence appeared to be driving a lot of his behavior.

The team was faced with a difficult situation, as John refused services when the team initially met with him and his aunt. His aunt and mother both agreed to participate, however, and signed him up. The question the team had to answer was how to engage John and his family in services and in the change process. The team ended up working with this young man and his family for almost a year, and it was only in the last three months that John began to fully engage in services. This is not an unusual case scenario. Social workers everywhere can probably identify with it.

In the end, the intervention that seemed to make a difference with John was the relationship his mentor was able to develop with him. His mentor’s ability to listen without judgment to John talk about why he felt so loyal to his gang buddies played a big part in him being able to develop the relationship. This is such a basic intervention, but such an important one. His mentor was able to employ some motivational interviewing techniques and modeled for him that men can talk about feelings without being considered weak. In addition, John was suffering from depression and PTSD resulting from early trauma that occurred while he was still living with his mother and father. He also struggled with attachment issues and reported feeling as if he didn’t belong anywhere or to anyone, but that changed when he entered the gang.

John’s relationship with his mentor helped him feel safe enough to begin to explore his feelings of loneliness, fear, and rejection with the clinician involved, which in turn set the stage for him to be able to develop insight into his behavior. Validation, insight, and understanding slowly began to shift his behavior and opened him up to the possibility of change.
CASE EXAMPLE 2: Brandi, a 12-year-old Latina female, was referred from the Children and Family Services Agency. She was referred because her mother, a recovering drug addict, was struggling to find her footing as a parent now that her daughter, Brandi, had returned from group care. The county worker explained that the daughter was very angry at her mother for everything that had happened while the mother was using drugs. Brandi was having a hard time accepting limits her mother set and often stayed out for days at a time. Mom often resorted to yelling when she was feeling scared and powerless to protect her daughter and described feeling incredibly anxious all the time.

Seneca staff met with the mother and daughter, and they shared some of their history and ways that trust had been broken. When asked what they needed for things to get better and what that would look like, Brandi said she was sick of her mother yelling at her all the time. Brandi’s mom was tired of trying to get Brandi to do what she was supposed to do. Helping Brandi and her mom learn how to communicate was the first step, but neither Brandi nor her mom seemed to know how to break out of the cycle. It was ultimately the family partner, who was also a recovering drug addict, who was able to connect with the mom and help her think about what was underlying her feelings and behavior toward her daughter. Brandi’s mom felt supported through this relationship and was able to listen more to what her daughter was saying without shutting down. The family partner helped Brandi’s mom also feel more comfortable with the idea of family therapy. Subsequently, the family therapist was able to work with Brandi and her mom on communication and on helping the mom set more consistent limits, despite the guilt she felt over the past. Brandi and her mom were able to rebuild trust slowly and things between them began to improve.

It seems clear that the program’s capacity to build relationships and address the underlying mental health issues simultaneously ultimately resulted in good outcomes. It is my experience that assigning a skilled clinician to each family allows the wraparound service to go that extra mile and offer interventions that help foster greater functionality, which in turn helps the family take advantage of the wraparound service being offered. It is also clear that relationship and connectedness are essential ingredients in the success of both of these cases. Hence, the combination of relationship and a strong support network propped up by an ability to patiently teach and model new skills, often through a therapeutic process, helps facilitate positive, sustainable change.

I believe that wraparound works because it is not limited to a prescribed methodology, but rather builds on these tenets and creates an individual map to success for each youth and family.

Katherine Schwartz, LCSW, has more than 16 years of experience in the mental health field. Twelve years have been spent at the Seneca Family of Agencies providing intensive, community-based mental health and social services to severely emotionally disturbed youth and their families. While at Seneca, Ms. Schwartz has been the administrator in charge of the successful start-up and implementation of three wraparound programs in three different counties. She has also overseen Seneca’s Intensive Treatment Foster Care, Therapeutic Behavioral Services, and Mobile Crisis programs. Through her extensive experience in the wraparound field, she has developed a deep appreciation for this particular kind of work and its efficacy.