Tier 3

Wraparound

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Tier 3 Intervention

According to the National Institute of Mental Health, 1 in 5 children experience a diagnosable mental disorder at some point during their school years (Merikangas et al., 2010). The children with the most severe and complex mental health needs often require services from legal, social, educational, and family providers; however, families are often unable or unaware of how to access and manage services across agencies (Copp, Bordnick, Traylor, & Thyer, 2007). Recent concerns have also been raised over whether emotional and behavioral functioning gains will continue after children are returned to their communities and schools from residential treatment programs. In response to these concerns, the National Institutes of Mental Health (NIMH) launched the Children and Adolescent Service System Program (CASSP) in 1984, with the goal of integrating social services into a comprehensive "system of care" (Bickman, Smith, Lambert, & Andrade, 2003).

What is Wraparound?

The wraparound process is a tool for building constructive relationships and addressing gaps in care (Copp et al., 2007), particularly for children with emotional and behavioral challenges (Kernan, 2014). "Wraparound is a process for planning and individualizing services at the individual level and is a way of implementing a System of care" (Kendziora, Bruns, Osher, Pacchiano, & Meja, 2001, p. 16). Wraparound must be individualized to meet the child and family's needs, and no wraparound team or plan will be identical (Kernan, 2014; Myaard, Crawford, Jackson, & Alessi, 2000). However, the team should include formal and informal supports across relevant domains of care (e.g., family, foster care, juvenile justice, education, mental health; Mendenhall, Kapp, Rand, Robbins, & Stipp, 2013). Wraparound provides support networks for youth with emotional/behavioral challenges, their families, teachers, and other caregivers (VanDenBerg, Bruns, & Buchard, 2003). Bickman et al. (2003) reports that wraparound can be defined as "a community-based program designed/developed on individual-needs driven-planning and services to support normalized and inclusive options for child and adolescent mental health patients and their families" (p. 136). This process, which is based on a family-centered, strength-based philosophy of care and interagency collaboration, is used to guide service planning for children with or at-risk of emotional or behavioral disabilities (EBD) and their families (Bickman et al., 2003; Skiba & Peterson, 2003). Use of wraparound has increased over the past two decades with as many as 400,000 youth participating in wraparound every year (Mendenhall et al., 2013).

Wraparound as a Part of a System of Care

A "System of Care" is generally considered to be a network of services that operates at the community level. This approach focuses on coordinating mental health, education, welfare, and other social services into a network to meet the individual needs of children with emotional and behavioral disorders and their families. These needs are intended to be met in the child's home and community in order to avoid institutionalization for youth with severe emotional and behavioral needs (Myaard et al., 2000; Office of Juvenile Justice and Delinquency Prevention, 2013; Pullman, Bruns, & Sather, 2013). Wraparound helps to create more sustainable and long-term placements for youth in these situations (Weiner, Leon, & Stiehl, 2011). Importantly, wraparound also aims to address these needs in the school context so that all students can attend school and have access to appropriate support (Eber & Teeter, 2011; Mendenhall et al., 2013).

Origin and extent of wraparound. Wraparound processes are an outcome of initial efforts by the National Institute of Mental Health and can also be applied to students whose needs are just emerging or not yet identified. No formal mental health diagnosis is necessary to participate in wraparound; however, most participants are those that have been diagnosed, but have not responded to traditional interventions (Office of Juvenile Justice and Delinquency Prevention, 2013; VanDenBerg et al., 2003). Coupled with funding from CASSP, in 1992 the Substance Abuse and Mental Health Services Administration (SAMHSA) began providing grants to state and local agencies for integrated system of care under the Comprehensive Community Mental Health Services for Children and their Families Program. Since 1993, the Substance Abuse and Mental Health Services Administration (SAMHSA) has offered approximately 164 grants totaling 1.5 billion dollars to implement systems of care via the wraparound process in all 50 states. The SAMHSA Wraparound Systems of Care model is one of the largest mental health initiatives in the United States and wraparound initiatives have been the focus of several graduate training programs in human services (Copp et al., 2007).

Implementing Wraparound

Wraparound teams. Wraparound teams include families, natural support providers (such as friends and relatives), and professionals from schools and other agencies such as mental health, child welfare, and juvenile justice. The ultimate goal of the wraparound process is to allow a child with severe emotional and/or behavioral needs to function in a natural environment by providing families with necessary resources and connections to community partners (Bickman et al., 2003; Kendziora et al., 2001). Ideally, these support services "wrap around" the child in this system of care and exist as an alternative to residential or institutional treatment (Duckworth et al., 2001; Myaard et al., 2000). These resources, along with input from the child's family, are key in creating not only a support network for the child, but also in generating, implementing, and evaluating a plan that will best result in positive child outcomes.

Wraparound facilitators. Most often the wraparound process starts with the creation of the individual wraparound team and is led by a trained facilitator. That person may be employed by any one of the types of community agencies involved with youth care, but most often are workers in the community mental health system who have received training for this role. The lead agency supporting these facilitators may also be the agency which accepts referrals for the wraparound process, and facilitators often have a caseload of youth for whom they facilitate the wraparound process.

Comprehensive planning. Wraparound teams develop comprehensive plans that blend role perspectives to identify and address the needs of the child, families, school personnel, and other service providers. They also inventory, coordinate, and if necessary, create supports, services, and interventions to address agreed upon needs of the youth and primary caregivers (i.e., families, teachers) across home, school, and community contexts. Combining natural supports (e.g., childcare, transportation, mentors, parent-to-parent support) with traditional interventions (e.g., positive behavior interventions, teaching social skills, reading instruction, therapy) can lead to more effective outcomes. Crisis intervention supports are often necessary and are also included in wraparound plans (SAMHSA, 2013). Wraparound is not a “service” but is a defined “process” for developing teams who create comprehensive plans with these children and their families (Skiba & Peterson, 2003).

School-based wraparound. Specifically, school-based wraparound supports may best be integrated by forming a team of school personnel that are familiar with the child and his or her needs. A school facilitator leads the group (i.e., school staff, family, community members) in reviewing progress of interventions and outcomes, ensures that all perspectives are involved, and organizes frequent meetings of team members (Eber & Teeter, 2011). This team may include academic supports and behavior plans that coincide with a school’s Positive Behavior Interventions and Supports (PBIS) or Response to Intervention (RTI) framework. Eber & Teeter (2011) describe the four phases of school-based wraparound implementation, which mirror the problem-solving process, as 1) team preparation (e.g., collect baseline data, gather team members), 2) initial plan development (e.g., hold planning meetings, use data to make intervention decisions), 3) plan implementation and refinement (e.g., hold ongoing meetings to review data and plan), and 4) plan completion and transition (e.g., monitor progress towards intended outcomes). This process blends wraparound with best practices in school-based prevention and intervention, including RTI, PBIS, data-based decision making, and intervention integrity. Due to costs, the time and resources needed, and the intensity of intervention, wraparound is most often reserved for the most high need and complex students and families.

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Core concepts of wraparound. According to Copp et al. (2007), “The wraparound system of care model is based on four primary concepts: that services should be family-centered and strengths-based, collaborative and community based, culturally appropriate, and families should be partners in systems of care” (p. 724). Other important components also include individualized services that are needs driven, access to flexible funding, unconditional service delivery (Kendziora et al., 2001), outcome measurement (VanDenberg & Grealish, 1996), and using data to monitor progress (Peters et al., 2013).

The National Wraparound Initiative, established to create and monitor wraparound standards and strategies, routinely publishes information regarding the ten principles of the wraparound process (Kernan, 2014). Although other researchers have advocated for many or all of these components, the National Wraparound Initiative’s principles exist as a gold standard for all wraparound efforts. Bruns et al. (2004) summarizes the ten principles as follows:

- ***Family Voice and Choice.*** Family and child perspectives and needs permeate all stages of the wraparound process. Wraparound plans also are a reflection of family values because family members have the greatest influence on plan implementation. This principle also recognizes that wraparound plans and services that are provided are

more likely to produce successful outcomes if family preferences are considered and prioritized.

- ***Team Based.*** Wraparound is inherently a collaborative and team-based approach to mental health service acquisition. Above all, the team should include members that are committed to the child's well-being and all team members should be approved by the child's family. When a state agency has custody of the child participating in wraparound, that agency may have a more critical voice in team membership.
- ***Natural Supports.*** Wraparound efforts aim to include natural supports (i.e., family members, friends, church members, co-workers, community supports that are already connected to the family) since these parties are likely to continue to be involved in the child's life even after the formal wraparound process has concluded. These members may also provide support that professional agencies or formal supports may not be able to offer.
- ***Collaboration.*** Team members work together to develop, implement, monitor, and evaluate wraparound plans. The plan also needs to reflect each team member's perspective and resources. Each team member must be invested in the team's goals and the team's decisions. It is possible for wraparound to be both family-centered and team-focused by following and adhering to the ten principles of wraparound.

- ***Community-based.*** Services and plans are implemented in the least restrictive, most accessible environment for the child and his or her family. Support services should be located in the community that the family resides, if at all possible, to ensure that wraparound participants have full access to agreed-upon services.
- ***Culturally Competent.*** It is necessary for the wraparound process to respect the "values, beliefs, culture, and identify of the child/youth and family, and their community" (p. 9). In order for collaboration to be effective, individuals must feel comfortable expressing opinions and preferences in a safe environment. Diverse values and beliefs may also be useful in identifying natural supports and are considered strengths of the wraparound process.
- ***Individualized.*** Strategies and supports that are put into place must be tailored to the needs of the youth and the family. "Family voice and choice" should guide the individualization of wraparound plans and plan evaluation. Through this principle, teams may create new, customized strategies or services that directly cater to the participants.
- ***Strengths-based.*** The wraparound team acknowledges and utilizes the "skills, knowledge, insight, and strategies" (p. 10) that each team member may present. Wraparound aims to build on and enhance current skills and knowledge-base.
- ***Persistence.*** The team persists with interventions and meetings until the team collaboratively decides that wraparound is no longer required. Setbacks or negative outcomes are interpreted and used to revise or modify the wraparound plan. "Persistence" has recently replaced the notion of the wraparound process being "unconditional" since the latter was deemed to be unrealistic and ambiguous.
- ***Outcome based.*** Goals and interventions embedded within the wraparound plan are connected with measurable indicators of success and monitored over time. Revisions are made based on progress towards a given indicator and/or outcome.

The team-based, family-centered wraparound process is recommended for all students with chronic and intensive emotional or behavioral problems that warrant a comprehensive plan that crosses home, school, and community (Skiba & Peterson, 2003). These youth also have needs that are relevant to school, but that span across multiple contexts. Candidates for wraparound also may have difficulty communicating with service providers and have difficulty engaging in comprehensive planning (Eber & Teeter, 2011). A wraparound approach can ensure that the efforts of families, teachers, other caregivers, and service providers are linked and consistently implemented. A carefully monitored service plan that is evaluated regularly is necessary in order to ensure that each agency and/or stakeholder is implementing services effectively and with integrity. Analysis of unique needs in life domains such as safety, medical, social, psychological, basic needs, and living environment drive the planning process. Additionally, evidence-based behavioral and academic interventions are an important part of comprehensive wraparound plans for these students (Skiba & Peterson, 2003).

History of the Wraparound Process

The term "wraparound" was first used by Dr. Lenore Behar in the early 1980s to refer to comprehensive, flexible community services tailored to meet the needs of individual families. North Carolina was the first known state to implement wraparound services as an alternate to institutionalization. Several other programs (e.g., Brownsdale Programs in Canada, Kaleidoscope Program in Chicago) also began operating around this time that aimed to normalize individuals with severe emotional needs and maintain their placement in homes rather than institutions (Bruns et al., 2004; VanDenBerg et al., 2003). Additionally, similar efforts emerged in other fields, including Person-Centered Planning, Personal Futures Planning, and Family Group Decision Making, all which were generated to meet the needs of individuals (e.g., developmentally disabled, juvenile law offenders) and keep them functioning in the community. Since then, interpretations and definitions of wraparound have tended to vary with local, state, and federal legislation influencing the composition of the wraparound process.

In 1985, Alaska became another pioneering state when it formed the Alaska Youth Initiative, which was effective in returning nearly all institutionalized youth back to their communities. Washington, Vermont, and roughly 30 other states followed in Alaska's footsteps. Many of these states received funding from the CASSP and SAMSHA in the late eighties and early nineties (Bruns et al., 2004; VanDenBerg et al., 2003). National conferences were developed that brought together innovators in the field, as well as those just beginning to discover and implement the wraparound process. In 1998, after speculation that there was a lack of consensus regarding wraparound standards, researchers and practitioners at Duke University disseminated 10 core elements of the wraparound approach, which are the same 10 elements summarized previously by Bruns et al. (2004). Some elements serve to guide direct work with families (i.e., team level), while others inform practices of agencies (i.e., program level) or community activities (i.e., system level; Bruns et al., 2004). Wraparound also began to have a much more salient family focus as the result of overall mental health efforts emphasizing family advocacy.

What Do We Know About Wraparound?

All 50 states have been the recipients of the NIMH grant funding to be used to coordinate integrated service delivery models across these health and human service domains (i.e., public health, law enforcement, schools, and social services). Moreover, roughly 88 percent of states and U.S. territories use some form of wraparound model to deliver appropriate services to children and adolescents with or at-risk of developing severe emotional and behavioral needs (Bickman et al., 2003). Despite the wide use of these services, more research is needed before wraparound can be advertised as a promising approach based on empirical evidence alone.

One of the central arguments used to promote wraparound is that service in the community is inherently less costly (Weiner et al., 2011) and more humane than service in a residential

treatment center or emergency treatment. Preliminary evidence suggests that community-based alternatives to residential treatment do result in less costly programs (Kendziora et al., 2001; Skiba & Peterson, 2003). Still, it is difficult to assess wraparound effectiveness with large participant samples since the independent variable (i.e., wraparound) is individualized and will differ depending on the individual. Moreover, adherence to a central wraparound model proves difficult on a larger scale and fidelity to the wraparound standards is often difficult to measure (Mendenhall et al., 2013).

The National Wraparound Initiative has worked to develop the "Wraparound Evaluation and Research Team" which monitors the fidelity and adherence to wraparound principle through a specific tool, which is the 40-item Wraparound Fidelity Index Version 4 (WFI 4.0; Bruns et al., 2004). The measure has been deemed reliable and assesses a unidimensional construct (Pullman et al., 2013). Caregivers, youth, and the wraparound facilitator respond to items assessing the wraparound principles and process, resulting in significant differences in wraparound fidelity being reported between these parties. In one recent study, wraparound facilitators reported higher fidelity scores than both youth and caregivers (Kernan, 2014). Youth were also less likely to be engaged throughout the process than adults or facilitators, a finding that was often targeted in further wraparound meetings in the aforementioned study.

In another study of wraparound in Kansas, researchers interviewed parents, support staff, and youth participating in wraparound. The investigators reported that those participating in wraparound shared an understanding of the philosophy and purpose of the process (i.e., aiding families and children in increasing mental health functioning at home, in school, and in the community). Most wraparound teams also appeared to be following a similar set of steps prescribed by state agencies. Other study participants voiced feeling supported by a team of experts, as well as familiar peers and relatives. Differences in implementation included the frequency of meetings, who was present at the meetings, and the qualifications and/or role of the wraparound facilitator (Mendenhall et al., 2013). Ultimately, studies such as these serve to obtain perspectives from all parties involved in wraparound so as to better meet individualized goals and needs, as well as aiming to increase fidelity to wraparound standards.

Myaard et al. (2000) asserted that wraparound services result in sustainable decreases in critical behaviors (i.e., verbal abuse, drug/alcohol use, physical aggression) and improvements in other behaviors (i.e., compliance, peer interactions) over time in four teenage youths. This process was particularly effective when behavior management interventions were employed, such as shaping and differential reinforcement, as part of the wraparound process. This study used a multiple baseline design to assess changes in key behaviors over time. These investigators claim that small case designs are ideal to assess wraparound given the individuality of each participant and his/her interventions. However, no control group was used in this study, making it difficult to attribute any gains to the wraparound intervention alone (Bickman et al., 2003).

Duckworth et al. (2001) evaluated the effectiveness of a wraparound intervention with male students with emotional and behavioral disorders in a self-contained classroom over the course of 18 months. The majority of these students were from low-income families and qualified for free and reduced lunch. The wraparound team consisted of a multitude of community players, including university special education professors, university education majors serving as mentors, a special education teacher, guidance counselor, principal, clinical child psychologist, director of a local alternative school, and parents of the participating children. In particular, the services provided through the wraparound process consisted of data-based decision making and observations of classroom functioning, a "therapeutic suspension" that reduced full day suspensions, family counseling and school consultation with a clinical psychologist, a social skills curriculum, and monthly parent meetings. The researchers presented promising findings, such as reduced suspensions, decreased absences, fewer office

referrals, and increased conferencing with parents. The investigators attributed these positive effects to their data-based system, building trust with teachers, and the use of evidence-based interventions as part of this procedure.

A recent study also reported successful and sustainable gains in emotional and behavioral functioning following the use of wraparound. Caregivers of youth with severe emotional and behavioral needs indicated significant improvement in emotional and behavioral strengths, mental health symptoms, and caregiver stress both 6-months and 24-months after the intervention. In contrast, youth did not report significant improvements until 12 or 18 months after the wraparound process (Painter, 2012). Youth also endorsed lower levels of symptoms at intake (i.e., prior to participating in wraparound). Thus, although wraparound continues to show promise, promoting youth engagement in the process is critical to reduce mental health symptoms and capitalize on strengths.

In addition, one of the most successful wraparound initiatives in the U.S. is Wraparound Milwaukee. The initiative is managed by the Milwaukee County Behavioral Health Division and participants pay a flat fee (often covered by Medicaid) to participate in the programming. Youth and families involved with the process are then introduced to a multitude of treatment options and services. Families are also integrated into the case management and problem-solving process that is integral to wraparound. Evaluations of Wraparound Milwaukee have shown that participants have improved behavior, social skills, and lower rates of recidivism than participants in traditional residential care. Evidence has also suggested a lower cost for Wraparound Milwaukee than residential treatment (Office of Juvenile Justice and Delinquency Prevention, 2013).

Wraparound may also be particularly helpful for those students with mental health needs, who are also involved in the juvenile justice system. The Connections program in Clark County, Washington provides services and engages families in the comprehensive wraparound process when the youth have both mental health and legal problems. Students in the connections program were less likely to re-offend than a control group. When youth in the Connections program did re-offend, they perpetrated less severe crimes and were detained for significantly fewer days than those in the control condition (Office of Juvenile Justice and Delinquency Prevention, 2013). A similar program in California, the Repeat Offender Prevention Program, also offers wraparound support to youth struggling with chronic truancy, gang involvement, and substance abuse. An evaluation of the program reports that it served to improve behavior and academic performance, and youth from the program were twice as likely to complete probation as youth not involved with the program (Office of Juvenile Justice and Delinquency Prevention, 2013).

Other empirical reports of wraparound effectiveness have produced less conclusive results. Bickman et al. (2003) conducted a large scale evaluation of wraparound outcomes as part of a wraparound demonstration project for child and adolescent military dependents. Wraparound included traditional mental health services, as well as psychiatric in-home services, respite care, therapeutic respite and group homes, art, music, and drama therapy, recreation services, Alcoholics and Narcotics Anonymous, and mentoring. As compared

to the control group, the wraparound group received more non-traditional services, such as case management and in-home care. Participation in the wraparound group also resulted in fewer days of residential treatment and more continuous services, although the wraparound services were deemed more expensive and less cost-effective than the treatment as usual (TAU) control group. Furthermore, the two groups did not differ significantly on post-implementation assessment of mental health outcomes (e.g., symptoms, life satisfaction, positive functioning). Similarly, the quality of the services delivered to the two groups did not significantly differ (e.g., therapeutic alliance between client and provider was rated similarly by the two groups). The investigators attributed the higher expenses for the wraparound group to the non-traditional services employed and the intensity of these services. Given the higher costs for wraparound and the indistinguishable mental health outcomes between groups, the investigators hypothesized that ineffective services may have been delivered or inappropriate services may have been utilized (i.e., case managers did not appropriately match the child with corresponding services).

In a more recent study, Copp et al. (2007) aimed to evaluate participant mental health functioning at intake and after six months participation in the wraparound process in Georgia. The investigators did not find any meaningful differences on outcome measures of mental health functioning after six months and had a high participant attrition rate. The researchers emphasized that assessing the fidelity of implementation (e.g., through the use of a fidelity checklist) of the model may have produced more promising findings. Additionally, the researchers used roughly a dozen different assessments with participants, which may have been a potential contribution to individuals dropping out of the program or refusing to be re-assessed.

Another recent article by Bruns et al. (2010) attempted to capture the current state of the literature on wraparound. The authors reported results from the first meta-analysis, conducted by Suter and Bruns (2009), which established an overall effect size of .39 for seven controlled studies comparing wraparound to TAU. While this is a medium effect size, the results must be interpreted with caution because of the various methodologies used in each study. Because some of the studies were conducted prior to the adaptation of set wraparound procedures, it is unclear if these results are representative of a "true" wraparound process (Bruns et al., 2010). In summary, the authors of the Bruns et al. (2010) article make it clear that despite the mixed methodology and limited research, results favor wraparound versus other conventional services for emotional and behavioral problems.

Future research should include more longitudinal studies (i.e., longer than six months) and investigate implementation fidelity and/or integrity to determine the effectiveness of wraparound. An article by Bertram, Suter, Bruns, & O'Rourke (2011) addressed the gaps in wraparound literature, suggesting that future research should look at various populations in order to learn more about how wraparound creates change for specific populations and identify other potential populations for which it might be effective. They also suggest studies which control various components of the process (e.g., fund availability, caseloads, staff selection, coaching, and the program installation/fidelity.

Overall, research regarding wraparound suggests its utility with a wide variety of students, including those who have been in resident treatment and juvenile justice facilities, but has not yet been established as an evidence-based process (Bruns et al., 2010). Through the use of wraparound, students are made to feel connected to a variety of individuals (i.e., the facilitator, caregivers, and community members).

Wraparound has lead to decreases in critical behaviors (i.e., verbal abuse, drug/alcohol use, physical aggression, suspensions, absences, office referrals) and improvements in other behaviors (i.e., emotional and behavioral functioning, compliance, peer interactions, conferencing with parents).

Implementing Wraparound

Currently, variations on the delivery of wraparound are being tried including "school-based wraparound" where schools are more prominently involved in wraparound, and "community wraparound" where community volunteers provide wraparound for children and families with less complex needs. Other variations target specific age groups (e.g., preschoolers), diagnoses (e.g., autism), or service delivery issues (e.g., transition; Duckworth et al., 2001). It is unclear why research has produced mixed outcomes regarding the wraparound process, although variability in implementation may be a factor (Mendenhall et al., 2013; Pullman et al., 2013). More longitudinal research that controls for confounding variables is necessary, as well as a consideration of necessary and effective components of the wraparound process. A variety of steps may be required to effectively implement wraparound (Adapted from VanDenBerg & Grealish, 1996):

- Develop an overall community committee composed of the key stakeholders in services and supports for children and families.
- Develop subcommittees to define identification, referral, and confidentiality issues and processes for wraparound, and to deal with local service delivery issues.
- Once a child/family is identified and information releases are signed, the team coordinator/facilitator performs an informal strengths assessment, identifies potential individualized services and supports based on strengths of that child and family, and organizes information to present to relevant parties (Peters et al., 2013).
- When meeting with families, potential areas of discussion may include how to handle stress, losing a job, financial issues, transportation, trust building, behavior management, and accessing community resources. Assessing family needs and tailoring discussions to those needs is critical in building rapport with families and generating intervention efforts (Duckworth et al., 2001).
- An individualized team of four to ten members is created which includes the child, and those close to the family. A combination of community and natural supports (i.e., family, school) should be included on the team (Bickman et al., 2003; Myaard, 2000).
- An individualized service plan (wraparound plan) is then developed at a team meeting.
- The plan is then implemented, with the team continuing to meet frequently and discuss the success of the plan, revising and updating as needed. Outcomes should be measured at the "system, program, and individual client and family levels" (Bickman et al., 2003, p. 137).
- Utilize measures of wraparound fidelity (e.g., WFI 4) to obtain perspectives on the acceptability of wraparound and adherence to wraparound principles and philosophy (Pullman et al., 2013).

Conclusion

According to VanDenBerg et al. (2003), the basic tenant of wraparound is simple: "If the needs of the youth and family are met, it is likely that the youth and family will have a good (or at least an improved) life" (p. 4). Therefore, wraparound appears to be a promising process for coordinating and organizing the delivery of services to children and youth with serious emotional and behavioral disorders. Preliminary findings suggest mixed results for the cost-effectiveness and long term effectiveness of wraparound in addressing mental health symptoms, although its widespread use and many positive evaluations albeit without consistent fidelity and measures implies that communities see value in implementing wraparound. Wraparound approaches appear to enable students with severe disorders to maintain behavioral gains in less structured settings than residential treatment.

Resources on Wraparound

National Wraparound Initiative

The National Wraparound Initiative is a collaborative effort to better specify the wraparound practice model, compile specific strategies and tools, and disseminate information about how to implement wraparound in a way that can achieve positive outcomes for youth and families. The NWI now supports youth, families, and communities through work that emphasizes four primary functions: supporting community-level planning and implementation, promoting professional development of wraparound staff, ensuring accountability, sustaining a vibrant and interactive national community of practice.
http://nwi.pdx.edu/

Office of Juvenile Justice and Delinquency Prevention Model Programs-Wraparound/Case Management

This page provides a brief history of the wraparound process, as well as critical elements for implementation. This website also profiles several successful wraparound initiatives (e.g., Milwaukee, Clark County) in the United States and lists links to those model programs.
http://www.ojjdp.gov/mpg/progTypesCaseManagementInt.aspx

The Art and Science of Wraparound with Lucille Eber

This video and its accompanying resources provide a comprehensive definition of wraparound, defines the relationship between Wraparound and PBIS, and gives tips for establishing a team. This resource also includes parents and professionals sharing their challenges and successes and guidelines for the initial team meeting. The above link includes information related to purchasing the video.
http://www.forumoneducation.org/catalogstore/wraparound_video.shtml

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