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Wraparound Services

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WRAPAROUND SERVICES

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Description of the Models & Applicable Populations

Wraparound, also known by various other terms such as "individualized service planning"(ISP), has become recognized as an effective approach to providing community-based comprehensive services to youth whose needs fall outside of the boundaries of traditional mental health services and which span a variety of child-serving agencies. Wraparound has been described as a process, not a service, which maximizes the use of informal supports to create a comprehensive, integrated, and individualized treatment approach for youth. The goals of wraparound are to reduce the use of institutional care and to replace a fragmented approach to high risk youth with a more comprehensive program. The wraparound approach to providing services for children with behavioral health issues places the child and family at the center of identifying the child's strengths and then identifying and coordinating mental health and other (e.g. educational, recreational, and other social welfare) community-based resources. A case manager wraps these services and resources around the child and family to enable the child to continue living in the community.

Wraparound maximizes the use of informal supports to create a comprehensive, integrated, and individualized treatment approach for youth.

Although case management and flexible funds are central features of the approach and some have been charged with erroneously conflating wraparound with these features, wraparound involves more than just these mechanisms. In 1998, a group of stakeholders met at Duke University to achieve consensus on the definition, values, goals and essential elements of wraparound. The panel identified the following essential elements which are accepted as definitive components of the approach (Goldman, 1999:12-13):

- The approach and resources used are community-based, with the goal of enabling the child to remain living within the community;

- An individualized, strength-based approach is used to meet the needs of children and families across life domains (with the goals of promoting success, safety, and permanency in home, school, and community);
- The process is culturally competent;
- Families are included as full and active partners in every level of the wraparound process;
- A diverse team (including the family, child, natural supports, agencies and community services) work together to develop, implement, and evaluate the child's plan;
- Wraparound teams must have flexible approaches. One dimension of the flexibility requires adequate and flexible funding. Individualized service plans depend upon flexible funding to meet the needs of families and children and support them across various life domains. In addition, flexibility in the setting, location, time, and service response are also central components of wraparound;
- A balance of formal and informal supports are included to "wrap around" all aspects of the child's and family's life;
- Regardless of the difficulty or changeability of the needs of the child and family, the team makes an unconditional commitment to serve the child and family;
- The service plan is developed and implemented through an interagency community collaborative process; and
- Specific outcomes for each goal (achieving success, safety and permanency) for the child and family as well as the program are determined and measured.

Today these elements are accepted both by many notable wraparound programs such as Wraparound Milwaukee as they implement innovative strategies for children and families and by trainers who pass on the skills and knowledge to those starting up wraparound programs.

History of Wraparound

The development of the wraparound approach has been traced back to John Brown in Canada who developed the Brownsdale programs in which small group homes were established as an alternative to large institutional care of youth with emotional problems. The cornerstone of the Brownsdale programs was their use of unconditional care (independent of the youth's acting out) and individualized, flexible programming. In 1975, Brown's program (and its use of normalization concepts popularized by the European-based Larch movement) was adapted by the founders of what became known as the Kaleidoscope Program (in two Illinois communities). Later when the Kaleidoscope program became an independent entity, the group home model was replaced with intensive in-home family support services and led to Kaleidoscope becoming known as the oldest wraparound initiative in the U.S.

CASSP, a major federal program started in 1984, brought the wraparound approach into widespread use around the country.

During the 1980's, the wraparound approach became more broadly known and adopted in the United States, primarily through its affinity with and incorporation in "systems of care". In 1984, the wraparound process became a cornerstone of the largest federal conceptualization of children's mental health care through its Child and Adolescent Service System Program (CASSP) which was designed to establish multi-level community-based systems to serve children with emotional, behavioral, and mental health needs. Both CASSP and wraparound sought to address existing deficiencies in the mental health system including its fragmentation, overly professionalized service delivery, and use of restrictive and out-of-home treatments. Although the initial round of CASSP funding in 1985 supported programs in ten states, by 1989 all 50 states had received CASSP support. This federal initiative has directly established and indirectly influenced a host of child-serving community-based programs for children with serious emotional disturbances, all of which incorporate the wraparound process. One of the first of these programs, The Alaska Youth Initiative, is often cited as an example of wraparound. The success of AYI led

to many other community-based wraparound programs such as “Project Wraparound” in Vermont, led by John Burchard and Richard Clarke, which was among the first to document the benefits of wraparound. In 1995, many of the 31 sites funded as demonstration grants by CMHS incorporated wraparound as a foundation for their program.

At the same time that CASSP was funded, two Research and Training Centers on children’s mental health were established, one at the University of South Florida at Tampa focused on systems change and the other at Portland State University focused on family support and improving relationships between families and mental health providers. In addition, a Technical Assistance Center was funded, initially through CASSP, at the Georgetown University Child Development Center. All three of these entities would disseminate wraparound strategies and contribute to their wide-spread adoption. In 1986, the term “wraparound” was formally coined by Lenore Behar to describe the community-based method of providing individualized mental health services to youth with serious emotional disturbances. Shortly thereafter, North Carolina instituted a wraparound approach toward moving youth out of residential treatment as part of the settlement in the *Willie M.* lawsuit and the attention this received generated more widespread adoption of the approach. Other developments in the fields of children’s disability and mental health (such as the EPSDT program, the family movement, and the *Olmstead* decision) also contributed to the increased use of wraparound in a variety of settings.

Today, the wraparound approach has been widely disseminated, is a central feature of almost every federally funded system of care demonstration site, and one estimate is that over 200,000 youth receive some type of wraparound service (Faw, 1999). In addition, the approach has been widely adopted across the country. In a survey of State Mental Health liaisons, 42 out of 46 reported that some form of the wraparound approach is being used in their state (Burchard, 2002 as cited by Bruns in

www.rtc.pdx.edu/nwi/PresWAResearchPDX052004.pdf). Nonetheless, while wraparound has been identified as a "promising practice",[1] the evidence-base defining its contours and evaluating its effectiveness is relatively sparse (See sections on "Summary of Evidence" and "Cost Data"). Unlike other evidence-based practices such as MST and TFC, "there are no nationally recognized standards nor any definitive blueprint or 'manual' to guide service delivery activities…" (Bruns, Osher, Rast, and Walker, in press). Yet, there are strong indications that the approach does have merit and its adoption has been bolstered by the recommendation of the New Freedom Commission that services for children with serious emotional disturbances be based upon an individualized service plan. In efforts to disseminate information on wraparound which emanates from the research base, Portland State University hosts the National Wraparound Initiative (NWI), "a collaborative effort that seeks to promote the implementation of high quality Wraparound." (www.rtc.pdx.edu/nwi). NWI is explicitly developing standards, strategies, and tools for implementing these "high quality" wraparound programs.

In spite of widespread practice and identification as a "promising practice," wraparound still has a relatively sparse evidence base.

Current Models & Populations

While wraparound approaches do share common components, there are several theoretical bases which can influence any given program including: the ecological (e.g. Bronfenbrenner), systems (e.g. Munger) and family-centered (e.g. Allen and Petr) perspectives. Connections integrating these theories have not been explicitly generated. As a result, a variety of program models now exist which use the wraparound approach. The following models illustrate a few examples of the types of wraparound programs which exist: they vary in terms of population served, the lead agency implementing the program, programmatic emphasis, and type of fiscal structure used.

[1] Both by the Surgeon General's Report on Mental Health (USPHS, 1999) and the later report on Youth Violence (USPHS, 2001). In both these cases, however, wraparound was supported largely through less strenuous criteria (e.g. expert opinion) rather than rigorous scientific study (e.g. randomized trials).

➢ **Wraparound Milwaukee**

Wraparound Milwaukee, begun in 1989, is one of the oldest and best known wraparound programs which is supported by all of the major child-serving agencies in the system. The Milwaukee County Mental Health Division/ Children and Adolescent Services Branch oversees the program. As of 2001, Wraparound Milwaukee had served 869 youth and their families. Originally the program targeted youth in the mental health system, but then refocused to operate as a behavioral health carve-out within a managed care setting for youth with serious emotional disturbances who are under court order either in the child welfare or the juvenile justice system. By focusing on youth in the child welfare and the juvenile justice systems Wraparound Milwaukee has achieved national recognition for meeting the needs of youth with cross-sector issues. Given the population that Wraparound Milwaukee serves, its community team members include judges, district attorneys, probation officers, child welfare workers, public health nurses, mental health professionals, and school employees in addition to care coordinator supervisors and family members. Wraparound Milwaukee has been a site for CMHS' "Comprehensive Community Mental Health Services for Children and Their Families Programs."

Wraparound Milwaukee operates as a managed care behavioral carve-out and focuses on youth who are involved either in the child welfare or juvenile justice systems.

There are four components to Wraparound Milwaukee: the wraparound team, care coordination, a 24- hour mobile crisis team, and a provider network. In addition to the standard features found across wraparound programs, several distinct features include preauthorization of inpatient and crisis services, service monitoring and a reinvestment strategy (i.e. funds saved due to decreased use of more costly inpatient or residential services are returned to the wraparound program to reinvest in its increased capacity). The program has partnered, through a competitive RFP process, with over a dozen lead agencies in the community who provide care coordinators and supervisors.

Wraparound Milwaukee blends multiple funding streams. In addition to the mental health services grant from CMHS, it blends funds from:

- Medicaid (a monthly capitation rate);
- Insurance and SSI payments, if available to the participant; and
- The case rates from the county child welfare and justice offices.

Additional funds are available through the county welfare and/or juvenile justice office for youth within those systems who have serious emotional disturbances and require residential treatment, foster care, group home, and non-traditional mental health community services. The program assumes full risk for costs; any charges incurred in excess of the capitation rate are assumed by Wraparound Milwaukee.

Wraparound Milwaukee has been very influential and other cities and states (e.g. Madison, Wisconsin and the state of New Jersey) have adopted similar models which use integrated care, individualized services and pooled funding sources.

➢ **Alaska Youth Initiative (AYI)**

Although discontinued as of July 1st, 2003, the Alaska Youth Initiative (AYI) provided valuable leadership in wraparound. Because Alaska historically has had a relatively modestly developed social service infrastructure, the state had sent many of its youth to out-of-state placements in the lower 48 states. When Alaska received one of the first federal CASSP grants in the mid-1980's, AYI began with the goal of returning youth placed out of state to their home communities. Led by John VanDenBerg, AYI adopted the key concept of Kaleidoscope of "unconditional care" and sought to develop individualized programs to meet the needs of the youth.

Through initial funding from the National Institutes of Health, AYI used a team approach and individualized wraparound programs to implement the principle that "funds should follow the client." That is, whatever funds had

been used for youths' out-of-state placement followed them in returning to their home communities. Three components formed the individualized budget for each youth served: two core service costs (level C1 or the costs related to the local coordinator; and level C2 other vendor operating costs not associated with the youth) and a flexible service cost (based on the Individualized Service Plan). The core service costs were fixed and formula-based but the flexible service costs could vary. The flexible service costs were funded through existing categorical funding streams to the extent possible (e.g. school district's special education funding, Medicaid, private insurance or CHAMPUS) and flexible funds were used to cover the remaining costs.

Although AYI is no longer in operation, the program was known for implementing the principle that "funds should follow the client in order to prevent out-of-state and out-of-region placements."

As youth were returned to in-state care, the program's focus changed to prevent future out-of-state (and eventually, out-of-region) placement. AYI used cross system teams of welfare, education, juvenile justice, child mental health and developmental disability workers who collaborated with child/family teams. A state-level interagency steering committee was formed to decide how to place youth. This body also approved the youths' Individualized Budget requests. AYI targeted its program to a small portion of children with SED, namely those with significant impairments of at least one year in duration that required the intervention of multiple service systems and which involved specific diagnoses (i.e. pervasive developmental disability, mental retardation with other behavioral symptomatology, affective disorders, schizophrenia, and conduct disorder.)

AYI's contribution to the wraparound movement has been relatively far reaching. Vermont, Washington State, Idaho, and other states have used AYI's model as a basis for their programs. Key leaders from AYI, notably John VanDenBerg, continue to work in the area and are sought after speakers.

➢ **The Tapestry Program**

The Tapestry Program serves families of color in southeast San Diego and is funded through the California Endowment, Communities First Initiative. The program was developed to use wraparound services to address the over-representation of Latino and African-American children in the juvenile justice system. In its first year of operations, sixty percent of families involved in the program were Latino and the rest were African American. Since local Latino and African-American families did not make use of or trust existing mental health services and the community had already embraced the "natural helpers" or "promo toro" approach to health, parents were trained to act as wraparound facilitators. These Parent Partners are viewed as valued mentors who typically have had first-hand experience with having a child in the mental health, special education, and/or juvenile justice systems. Parent Partners receive intensive and on-going training to develop their natural skills and provide ongoing culturally appropriate education. The initial training and supervision plan was developed by a task force of community parents and providers. The program has overtly conceptualized culture in a very broad manner "to include the culture of poverty, the culture of raising youth with challenges, Latino and African American cultures and subcultures, and an examination of gender roles and single parenting." (Becker and Kennedy, 2003:27)

The Tapestry Program adapted the wraparound approach to more effectively serve Latino and African-American children in San Diego.

In order to strengthen and build upon existing community ties, Tapestry staff have developed a collaborative relationship with The Mosaic Forum, a community collaborative or systems of care that is sponsored by Southeast County Mental Health. In addition, the wraparound program has consciously developed links with the faith-based communities in southeast San Diego in order to visibly demonstrate faith and mental health as two dimensions of healing (Becker and Kennedy, 2003:26).

➢ **South County Wraparound Project**

The South County Wraparound Project illustrates yet a different model for building a wraparound program. This program was developed in 2002 out of the Institute for Community Collaborative Studies (ICCS) at the California

State University (Monterey Bay) as part of a collaborative project between residents and service providers trying to meet the needs of Latino children who experience family mental illness and substance abuse problems. Community-based and state agencies which worked with ICCS to develop a plan for the wraparound program included:

- Gilroy Family Resource Center (a family program of the Department of Social Services) ,
- Resources for Families and Communities (a multicultural nonprofit organization which now is providing wraparound family case management),
- Rebekah's Children Services (a nonprofit organization serving children at high risk for mental health issues and whose previous model of wraparound was modified for use in the South County Wraparound Project),
- A District Assembly person (Simon Salinas), and
- other agencies serving children in southern Santa Clara County, such as the Santa Clara County Public Health Department, Mexican American Community Services Association, Economic Services Organization, and Santa Clara County Department of Alcohol and Drug Abuse.

Although still in its infancy, the South County program is notable for its focus on planning & consensus building prior to implementation.

In addition to these central participants, approximately 75 community programs are allied with the overarching South County Collaborative. Involving family members and the community in culturally sensitive ways has been a primary focus of this wraparound program. The South County Wraparound Program has received funding through a SAMHSA/CMHS Community Action Grant. The funds enabled the program to devote a significant amount of time to consensus building and planning. Unlike more mature programs which now are contributing to our knowledge about outcomes achieved with wraparound, this program, which is in its infancy, has devoted a significant amount of time to document its startup activities. In

particular, the program has focused on building consensus among the stakeholders (a process extensively documented in an evaluation by researchers from the University of Iowa (Richardson and Graf, 2003)).

➢ **LaGrange Area Department of Special Education Emotional & Behavioral Disorders Network**

The city of LaGrange Illinois operates a school-based wraparound program focusing on children, in grades K through 8, with emotional and behavioral disorders as they transition out of self-contained special education into less restrictive settings. While the state operates similar wraparound programs throughout the state, the LaGrange program was one of the first and has received greater scrutiny. The goal of these programs is to move children with emotional and behavioral disorders from Level 1 (children are in self-contained classrooms) to Level 2 (children are in their home school district and are served by individual wraparound teams). In addition children who are assessed at Level 3 (with the potential for having emotional or behavioral disorders in the future) also receive prevention services through wraparound interventions. Core program staff include Family Service Facilitators (who act as Care Coordinators and work with the family members) and Team Teachers who work with local teachers (to educate them about the wraparound approach and to model behavioral interventions). Together the Family Service Facilitator and the Team Teacher lead a strength-based assessment process, and meet with all team members (including the family and child) on a regular basis throughout the school year. During the summer, those children requiring ongoing services receive them from community agencies.

The LaGrange program, a form of school-based wraparound, aims to move children out of self-contained classrooms.

As of 1999 (Burns and Goldman), the LaGrange wraparound program had succeeded in reducing the number of self-contained classrooms for K-8 from eight to zero. Although the option still exists to institute self-contained classrooms, none were needed. In 1998, the program was reported (Burns and Goldman, 1999) to serve 50 children at Level 2 through a staff consisting of: 3 Family Service Facilitators, 3 Team Teachers, the in-school respite staff, a family resource developer, and a coordinator. The school system has provided

training sessions for school teams during the summer and other training has been funded through CMHS. In addition, teams from 125 schools completed a 2-day training with the National Center on Positive Behavior Interventions and Supports (PBIS) and 30 coaches/trainers completed a 4-day train-the-trainers program. Since wraparound has been widely disseminated throughout the state of Illinois, federal education funds now support regionally-based technical assistance. Child welfare standards (the only state department requiring certification) are used in training and a state-wide training curriculum (with core competencies) has been developed.

Initial funding from a private psychiatric foundation to place interns in schools has since expanded and LaGrange has received funding through a variety of sources including both the US Office of Special Education Programs (for a systems change grant) and CMHS (as a demonstration site). The school department also funds wraparound through two mechanisms. First, a line-item in the special education budget is used to purchase in-school respite services that can be tailored to students' individual needs. Second, a community-based local area network blends state-level funds to support children in the community.

The program has collected and reported on quality indicators for which it has collected data. The indicators assess areas of academic performance, teaming, social/emotional and behavioral well-being, family participation, community involvement, planning process, and evaluation and technical assistance (as reprinted in Burns and Goldman, 1999:60-64). In addition, data are routinely collected from other standard measures (such as the CAFAS, CBCL, the Restrictiveness of Living Environment Scale (ROLES), Educational Information Form (EDInfo), and the Teacher Report Form (TRF)).

➢ **The Kaleidoscope Program**

The Kaleidoscope Program, based in Chicago, is a licensed, community-based, not-for-profit child welfare agency in operation since 1973. Wraparound

The Kaleidoscope program is unique in its "no reject, no eject" policy; no matter how troubled a youth is, he or she will not be expelled from the program.

services are a cornerstone of the program's operations (including its systems of care and therapeutic foster care program) as it serves different populations of youth. The agency's "no reject, no eject" policy permeates all its programs and the agency is known for serving children and families who have been rejected from or disillusioned by other programs. Persistence in finding the right approach and the right services for youth are what distinguish this program. Nine principles guide the agency. Consistent with its wraparound philosophy, Kaleidoscope seeks to be:

- Community-driven;
- Family-focused;
- Creative;
- Unconditional;
- Strength-based;
- Individualized;
- Culturally competent;
- Cost-effective; and
- Outcome-driven.

In 2000, the Kaleidoscope Program was honored by the Anne E. Casey Foundation as one its National Honors Programs. The program has received funding and support from a variety of sources including:

- State agencies (the Illinois Department of Children and Family Services);
- Private foundations (Annie E. Casey Foundation; Dr. Scholl Foundation; Chicago Community Trust; Edna McConnell Clark Foundation; McCall Family Foundation; First Book Foundation; Paul Newman Foundation); and
- Businesses (LaSalle National Banks; Barnes and Noble).

Summary of Evidence

There is no recognized standardized approach to wraparound.

Evaluation efforts have been challenged both by the complexity in the design and administration of wraparound services (i.e. its use of cross-sector, interagency collaboration) and by lack of standardization within a single program given the emphasis on individualized services. Researchers have noted that while there is a great deal of agreement about the definition of and the values underlying wraparound (Walker, Koroloff, and Schutte, 2003) there is not one shared model of practice. Research using the Wraparound Fidelity Index (See "Fidelity Materials" Section) to assess actual practice against a particular standard has verified that actual implementation varies across key wraparound components (Bruns et al, 2004). Programs have not operationalized the values and components in the same ways and, therefore, wraparound has not developed as a single manualized approach. In addition, wraparound has addressed a variety of behavioral problems. Therefore, assessing the evidence on wraparound has been challenged by the variety of approaches.

The majority of research on wraparound programs has not used rigorous experimental designs. While much of the published literature reports on outcomes of a particular program (citing one time-point), there are fewer comparative designs including 9 pre-post studies, three quasi-experimental studies and two randomized trials (presentation by Eric Bruns, Technical Assistance Partnership Seminar, August 5, 2004). Yet these studies have consistently reported positive outcomes, including improved functioning of the child in the family, social, school and community settings and increased ability to live in less restrictive settings (cf. summary in Burns and Goldman, 1999). In addition, some studies have demonstrated reduced costs of programs using the wraparound approach. More specifically, evaluations of and reports by individual wraparound programs report a range of benefits which includes:

- Wraparound tends to reduce the use of residential placement and has been successful in placing youth in less restrictive

environments. For example, Wraparound Milwaukee reports that the number of children in residential care has been reduced by approximately one-third. While 360 children were in residential care per day before 1995, since the program has been in operation, there are 240 per day; likewise the number of days that children were in psychiatric hospitals has been reduced from 23,000 to approximately 13,000 (Goldman and Faw, 1999: 32).

- Specific wraparound programs report improvement in the functioning of youth served. For example, the Tapestry program reports significant improvement in the youths' scores on the Connors Scale over those assessed when the youth entered the program. As part of a 5-year evaluation of the Illinois school-based wraparound programs (including LaGrange), evaluators found that while the number of students identified for and receiving emotional and behavioral supports increased, 67% of students moved to less restrictive settings (Eber, Rolf, and Schreiber, 1996). Teachers also reported a decreased need for extra assistance with school work. In addition, the average number of days spent in a psychiatric facility dropped from 8 to less than 1 day per year. School referrals to local area networks (systems of care) also were tracked and associated with interagency coordination of services. Likewise clinical outcomes, as assessed by CAFAS, improved for delinquent youth in Wraparound Milwaukee (Kamradt, 2000) at 6 months and one year after enrollment.

- Likewise programs report improvement in the parents' or caregivers' functioning, such as reduction in stress. These results tend to be less consistent, however, and with some programs (e.g. Becker and Kennedy, 2003: 28) these results do not reach the level of statistical significance.

- In addition to cost reduction (See "Cost Data" section) and individual-level improvements in functioning, evaluations of various wraparound programs such as the Alaska Youth Initiative (Burchard et al, 1993), Kentucky IMPACT (Illback and Neill, 1995) and the Ventura Planning Model (Jordan and Ichinose, 1992) have demonstrated positive community-level outcomes as well. Wraparound services have been shown to improve relationships among participating systems (mental health, juvenile justice, and child welfare) (Goldman and Faw, 1999:32).

- Finally, wraparound programs which target youth involved in the juvenile justice system tend to report findings similar to those of Wraparound Milwaukee where legal offenses of youth involved in the program are reduced from what they were prior to involvement in the program (Seybold, Gilbertson, and Edens, 2002). Furthermore, recidivism remained low even at 1 year follow-up upon discharge from Wraparound Milwaukee (Kamradt, 2000).

Despite these consistencies in the literature, other studies have demonstrated more controversial results. Most notably, the quasi-experimental evaluation of the Wraparound Demonstration Evaluation (Bickman et al 2003), mandated by the Department of Defense, concluded that there were no differences in clinical outcomes between the wraparound and the usual care group. Furthermore, wraparound was significantly more costly to implement ($12,192 vs. $7,469 per child) but this increase was attributable to the longer stay in treatment (and additional costs borne by other systems with the usual care group were not considered). Advocates of wraparound have been critical of this study and fault it for not implementing an adequate model of wraparound. Furthermore, one feature of wraparound which differentiates it from other treatment approaches, such as MST, is that it is long-range (Burns et al 2000). An

adequate comparison of wraparound can not be made to an approach which is less intensive in nature. Nonetheless, the authors of the study concur with others that additional research is needed to more clearly understand how wraparound affects clinical outcomes, particularly in a) specifying differential effects based on symptom severity, level of functioning, and use of different treatment components, b) the stability of these outcomes over time, and c) the role of system-level reform in producing clinical outcomes.

Cost Data

While much of the literature has documented the relatively cost-efficient nature of wraparound programs, some evidence has suggested that the costs of wraparound services may be greater when the wraparound program provides care for a longer period of time than the comparison treatment. The study by Bickman and colleagues (2003) found that the per capita cost of the wraparound program was $12,192 compared to $7,469 for the usual care group. Yet several significant methodological issues cloud these findings. Most prominently, without addressing the outstanding questions of whether or not the model implemented in the program retained a high degree of fidelity to the wraparound model, it is difficult to accept the conclusions as a definitive judgment about wraparound.

Much of the literature indicates that wraparound programs provide community-based services which are less costly than residential.

In fact, the bulk of the literature indicates that wraparound programs provide services in the community which are less costly than services available in residential treatment. For example, the Alaska Youth Initiative has reported a reduction from $72,000 per child per year to $40,000 during the first year that children were returned to the state from out-of-state residential placement (Buchard and Clark, 1990). Similarly, costs for Wraparound Milwaukee (including administrative costs) were $3,400 per child per month which was less than the $4,700 per month paid by child welfare and juvenile justice for

residential treatment or the $15,000 for psychiatric hospitalization (Goldman and Faw, 1999: 32).

One of the more rigorous cost-related studies (using a quasi-experimental design which matched children in wraparound with similar children in a comparison group receiving traditional services) has been conducted by Brown and Loughlin (2004) in Ontario, Canada. Due to the complexity of calculating costs based on frequency of service, the cost analyses were limited solely to the most costly portion of treatment: out of home placement. Researchers found that mean out-of home costs for children in wraparound were significantly less than those for children in the comparison group ($9,175.30 vs. $27,748). Although the amount of time each group spent in out-of-home care was approximately the same, the children in wraparound were placed in less costly settings (either in treatment foster care or group homes) compared to the comparison group (residential treatment or juvenile detention facilities).

The funding required to implement wraparound varies significantly by program, depending on variations in population served, level of flexible funding provided, etc.

It is important to note that the level of funding required to support wraparound programming varies quite widely across programs, depending at least in part on the assets of the community from which the program may draw in creatively designing individualized service plans, and the degree of the youth's need, reflected in part by the type of population served (e.g. involved with a single vs. multiple child-serving agencies). While the previously cited wraparound programs are relatively well-funded at the state level, other successful wraparound programs operate on a more constrained budget. For example, in addition to its staff and operating costs, the Tapestry program reports that it spends an average of $400 annually per family providing services through flexible funds (Becker and Kennedy, 2003: 28). Its economical use of community-based services is maximized because of its intimate familiarity with the neighborhoods and people it serves.

Finally, flexible funding is a central feature of wraparound programs. Some research has been conducted (Dollard et al 1994 reported in Handron et al 1998) which suggests that the top four categories for which flexible funds were used by one program were: providing economic support; respite care; social recreational needs; and transportation.

Training Needs & Requirements

A key concern of the wraparound approach is that training be replicable and therefore considerable effort should be devoted to establishing a viable training component for wraparound services. Yet in 1998, a survey of state mental health directors in all of the U.S. states and territories indicated that few states had formal training curricula (Faw, Grealish and Lourie, 1999:85). Of those with curricula, four states (California, Illinois, North Carolina and Florida) had the most comprehensive training materials, and additional details are provided in Chapters IV and V of Burns and Goldman 1999.

Available information, however, is sufficient to indicate that training is necessary in order to implement services which consistently conform to the wraparound principles. Although the services are individualized to meet the unique needs of a child and his/her family, programs are encouraged to provide a common skill and knowledge base by:

- Using training curricula and protocols to implement a general wraparound approach. A comprehensive curriculum would address a range of issues, including "values, operational elements, and wraparound requirements, as we well as cross-system issues (including jurisdictional issues, services, and financing), mentoring and coaching strategies, and evaluation strategies." (Burns and Goldman, 1999: xvii);
- Incorporating different training modalities such as workshops or seminars, videos, dissemination of manuals, supervision, coaching,

mentoring, internships, certification programs, or degree programs (which emphasize wraparound). The selection of modality will depend in part on the needs of the wraparound participants, the particular topic, and the resources available to the program;

- Providing intensive-levels of training over an extended and ongoing period of time. More intensive forms of training might include observing, coaching, and certifying facilitators; engaging and supporting supervisors; and collecting data and monitoring outcomes. These issues are discussed in greater detail in the "Implementation Issues & Requirements" section.

Therefore, those who are beginning to implement wraparound programming will need to establish the following components to support the ongoing viability of the program:

- Core training for providers;
- Core training for supervisors;
- Ongoing re-training and in-service training; and
- Monitoring outcomes and conducting quality assessment to refine and target ongoing training and program implementation.

In addition, some programs will want to consider implementing accreditation standards. This may be especially salient for programs which will receive state funding, particularly if managed care funds are involved. Although accreditation is not an easy task, it can provide clear-cut criteria to which staff can be held. Programs interested in accreditation will need to partner with an accrediting body, such as the Council on Accreditation (COA). The wraparound program and its representatives along with the accreditation group will decide how to translate the programmatic elements and values into measurable standards.

Unlike other evidence-based approaches, no single training program has emerged as the gold standard against which others are judged. Yet several groups are making on-going efforts to develop materials which can be used nationwide. For example, VanDenBerg and Grealish were the first to publish a training manual which is supplemented with training videos (available through the authors). In addition, many of the long-established programs (including some of those included in the "Current Models & Populations" section) also consult with and provide ongoing training to other programs throughout the United States and internationally. Those who are interested in establishing a training component for their wraparound programming may consult the "Other Resources" section for a partial listing of consultants and trainers, and the "Training & Other Ancillary Materials" section for selected training materials.

The National Wraparound Initiative (NWI) aims to create a standardized wraparound approach and increase the fidelity of programs to that model.

Finally, the National Wraparound Initiative (NWI) (www.rtc.pdx.edu/nwi) has taken on the task of providing leadership in issues of establishing fidelity to the wraparound model and incorporating those elements into training and other support materials. NWI currently is producing materials (e.g. descriptions of the phases of wraparound; tools for providers; system and organizational standards) which may be used in training for and implementing wraparound services. In developing both training and QA procedures, as well as fidelity and implementation measures, the NWI is explicitly linking these materials to particular phases, activities and standards in wraparound. The goal is to standardize wraparound approaches and increase fidelity of the programs. Since these materials currently are in development, interested readers are urged to consult NWI directly.

Fidelity Materials

An ongoing criticism of the wraparound approach is that it is not manualized or standardized in the way in which it is implemented. Furthermore, because the approach is based on values, the concrete steps which are used to

operationalize these values can differ. Research has demonstrated that wraparound programs vary tremendously in terms of program quality and adherence to wraparound principles (cf. Rast, VanDenBerg and Peterson, 2004; Hagan, Noble, and Schick 2003; Bruns, et al, 2003; Bruns, et al 2004). Common shortcomings, for example, include (as reported in Rast and Bruns, 2003):

- Omitting key members of a child's life from the wraparound team, especially school professionals, family friends, and other advocates;
- Not maximizing the use of community activities which the youth enjoys and in which they excel;
- Not using family and/or community strengths to identify resources and plan services; and
- Limited use of flexible funding.

Given the salience of these and other issues related to fidelity, a major portion of the both the 14th and 16th Annual Conferences put on by the Research and Training Center for Children's Mental Health (at the University of South Florida /The Louis de la Parte Florida Mental Health Institute) was devoted to discussing maintaining fidelity in implementing wraparound services. Interested readers are urged to consult Chapter 7 of the 14th Annual Proceedings (2002) and Chapter 6 of the 16th Annual Proceedings (2004).

In addition, several approaches and tools have been developed to assist those interested in establishing wraparound programming, most notably the Wraparound Fidelity Index and the Wraparound Observation Form, which can be used to compare actual performance in the ongoing operations of wraparound programs against the principles of wraparound programs.

➢ **Wraparound Observation Form & Manual**

The Wraparound Observation Form (W.O.F.) emerged out of earlier work on quality assurance measures and assesses the fidelity of the team meeting process to the core wraparound principles. Independent observers (not

The Wraparound Observation Form (WOF) assesses fidelity to the principles underlying the formation and implementation of the child & family team.

connected with the child or family being observed) use the W.O.F. to document which elements of the wraparound process are being used at the child and family team level. The observer sits at an unobtrusive distance and documents the planning and use of services at child team meetings. Now in its second version, the form contains 48 items and was developed through a committee of family members, care coordinators, and administrators who identified core components of wraparound. In addition to documenting the composition of the wraparound team and the life domain areas to be assessed by the individualized service plan, the W.O.F. assesses the following characteristics of how wraparound is implemented:

- Community-based resources (5 items);
- Individualized services for the youth and family (9 items);
- Family-driven services (10 items);
- Interagency collaboration (7 items);
- Unconditional care (3 items);
- Measurable outcomes (3 items);
- Management of team meeting (5 items); and
- Care coordinator (6 items).

All items are coded yes, no, or not applicable. Research has documented good inter-rater reliability with an average percent agreement of 97% (Nordness and Epstein 2003).

The W.O.F. is being used increasingly by wraparound programs. The Tapestry Program, for example, uses the W.O.F. and provides ongoing training for Parent Partners in its use. An initial 12 hours of training in the assessment tool is supplemented with 8 hours of role plays and 4 hours on rater agreement. After the initial training, other trained raters assess the ratings made by the new raters at 30 days and then again at 6 months. W.O.F. materials (including the form itself and the manual can be obtained directly from one of its developers, Philip D. Nordness, Ph.D. at Western Illinois University, Horriban Hall 25, 1 University Circle, Macomb, IL 61455-1390 or at PD-Nordness@wiu.edu .

➢ **Wraparound Fidelity Index**

While the W.O.F. assesses fidelity to the principles for creating and implementing the child and family team, it does not address other steps in the wraparound process such as tracking and adapting the individualized wraparound plan for the child and family. Therefore, those contemplating how to measure performance of a wraparound program might want to also consider using the Wraparound Fidelity Index. The Wraparound Fidelity Index is a widely used tool which is used to collect information through interviews with 3 types of respondents per child: the youth themselves (11 years and older); caregivers; and resource coordinators or case managers. Eleven elements of wraparound are assessed:

The Wraparound Fidelity Index, in contrast to the WOF, assesses all aspects of a wraparound program based on a set of 11 elements.

- Voice and choice;
- Youth and family team;
- Community team;
- Cultural competence;
- Individualized services;
- Strength-based services;
- Natural Supports;
- Continuation of care;
- Collaboration;
- Flexible resources and funding; and
- Outcome-based services

The WFI contains measures for each element and each item is rated on a scale from 0 (low fidelity) to 2 (high fidelity). While data are collected at the family level, they also are aggregated to describe how well a particular provider or an entire program measures up to the standards associated with wraparound.

Although its developers are currently field testing the third version of the WFI, it has been found to have good test-retest reliability and internal consistency

across as well as within individual respondents (as reported in www.uvm.edu/~wrapvt/approach.htm and in Bruns et al 2004). Those interested in more detail on the underlying structure of the WFI, as assessed through confirmatory factor analysis, might wish to consult Suter, Bruns, and Burchard, 2004.

The Wraparound Fidelity Index is available from the research team at Wraparound Vermont (www.uvm.edu/~wrapvt/index.html). In addition, the program will also supply its collaborators with a *WFI User's Manual* (with information on training, setting up interviews, administering interviews, and data management) as well as data entry forms in Excel or SPSS to facilitate data management.

➢ **Theory-Based Approach**

Finally, while not as widely used, a theory-based approach to assessing fidelity in implementing wrap-around services (Malysiak, 1998) has been developed. This theory base can be used to construct a wraparound program and to then assess the implementation of the program. This theoretical approach identifies three dimensions essential to the wrap-around philosophy: the degree of family participation; the team composition and structure of the wraparound program; and the extent to which strengths across systems (home, school, community) and life domains are included. Malysiak and colleagues have produced two forms which programs may use to assess how well specific programs and the wraparound teams measure up against these dimensions (The School, Family, and Community Team Meeting Observation Form and the Fidelity Form). For additional detail on these forms, see the paper by Malysiak-Betram et al, 2000 presented at the 12th Annual Conference by Research and Training Center for Children's Mental Health (at the University of South Florida /The Louis de la Parte Florida Mental Health Institute).

Implementation Issues & Requirements

Wraparound programs face unique challenges in implementing individualized care in a collaborative, interagency and family-centered approach. The complexity of these challenges is due, in part, to the context in which wraparound programs operate. Successful implementation requires that multiple levels of the service delivery system embrace wraparound. Therefore, there are challenges at the system (policy/funding) level as well as at the organizational (program) and team (child/family) levels. While some of the most relevant issues are detailed below, interested readers are urged to read the monograph by Walker, Koroloff and Schutte (2003) in which they detail conditions necessary to successfully implement wraparound (or what they call, "Individualized service plans").

➢ Implementation Issues for the State

Implementing wraparound requires the state to reconsider its typical contracting procedures and to promote interagency collaboration.

Some issues are particularly salient for state agencies. For example, wraparound programs require the elimination of fixed contracts. While this change empowers care coordinators and the child/family teams make decisions about what to include in a child's (and family's) service plan, it signals a very different way of doing business for the state and for providers accustomed to traditional service delivery methods.

In addition, interagency collaboration is one of the cornerstones for implementing wraparound services. Therefore if mental health agencies do not have existing relationships with child welfare, juvenile justice, and education, then new relationships will be necessary. While interagency work can raise turf issues, sensitive and knowledgeable administrators can facilitate the process by being aware of the issues and policies most salient in these other sectors. For example, public schools are key entities to involve in wraparound service planning and their experience with IDEA and ADA enforcement must be considered.

➢ **Implementation Issues for Programs**

Agencies or programs which adopt the wraparound approach will face challenges in both service delivery and program management/organization.

Issues at the program level include: fostering collaboration, avoiding "slot-based solutions," being creative in identifying and using resources, building consensus, obtaining sustainable funding, adhering to data collection and reporting requirements, and addressing workforce turnover.

First, true collaboration may be a unique and challenging undertaking for all the partners involved in implementing wraparound. It often is difficult to achieve consensus and create a shared understanding of what a particular child's strengths and needs are. Such collaboration may be constrained by competing philosophies, programmatic loyalties, and fiscal constraints the formal partners experience. In addition, engaging families as equal partners with providers may be hampered by the families' distrust as well as by the providers' traditional training.

Second, providers tend to think in terms of component programs rather than individualized services and transitioning into wraparound services requires them to change their operating philosophy. Rather than starting from an array of existing services and using what have been called "slot-based solutions" (Franz, Brown and Miles, 2003), providers first must look to the strengths and needs of the youth whom they serve.

Third, wraparound programs often find themselves either in competition for scarce resources or with no resources available. In either case, programs are challenged to be creative and often develop new partnerships or identify new avenues for providing alternative treatment and/or informal supports. Research (reported in Walker, 2004) has pointed to two types of creativity-enhancing practices that may help team members realize their goal of creating an individualized plan. First, practices that broaden perspectives may enhance problem-solving and decision-making. Then practices that generate multiple options may increase the quality of the options selected. Both of these strategies can enable participants to gain greater insight into the issues at hand, and produce a better match between the goals and the resources identified.

Fourth, wraparound may be seen as a special program which is favored by the agency and/or the funder. Often when this occurs, the program's initiators have not spent time achieving consensus and community buy-in, processes which permit the open discussion of the wraparound philosophy and its collaborative use of resources.

Fifth, programs which use the wraparound approach often find that outsiders (the public as well as policy-makers and providers) are not familiar with, and may even be at odds with, the wraparound philosophy. Since the approach requires that programs sustain public funding and partner with constantly changing teams of professionals, wraparound case managers need to anticipate resistance on the part of those new to wraparound.

Incorporating school systems into wraparound programs presents unique challenges, often due to workforce issues. Those who work in the area of mental health disorders have the highest attrition rate among all special education teachers. Likewise turnover among school psychologists and social workers is high (Koyanagi and Gaines, 1993). Therefore, wraparound programs will likely confront an ongoing need to educate new personnel about the philosophy and operations of wraparound programs. A related challenge is that the high case loads of these counseling professionals can impede their active and creative participation in wraparound service provision.

Sixth, funding a wraparound program may, under certain conditions, be difficult to sustain. When wraparound is funded entirely through Medicaid fee-for-service, programs will have difficulty accessing flexible funds.

Seventh, particular funding sources may impose data and other administrative requirements. For example, if wraparound services are funded through the Medicaid program, programs will be expected to collect QA/QI data and monitor performance. While the information will provide valuable feedback to

program operations, it will require the program to implement new procedures and possibly hire additional staff.

Eighth, historically there has been relatively high turnover of facilitators and care coordinators in wraparound programs. Not only does a program's ability to retain their workforce affect the quality of care which individual children and families receive, but it can directly influence the fidelity of the wraparound program implemented. Therefore, in the initial planning, a wraparound program should pay attention to developing realistic job descriptions, providing adequate supervision and support for facilitators, and supplying ongoing training for the facilitators.

Finally, as programs mature, implementation and sustainability will continue to be a challenge. Programs can learn from others' past experiences that the value base and mission statement should be revisited frequently; family members should be included in all aspects and all levels of operation; outcome data should be shared among stakeholders; MIS and QA technologies can enhance program operations; and continued training is necessary to ensure the ongoing presence of skills in the wraparound teams (Meyers and Miles, 2003)

➢ **Implementation Issues for Families**

Families who participate in wraparound services may need to be educated to become stronger advocates for their children. Many parents and other caregivers of children with serious emotional disturbances are placed in the position of having to become instant experts in multiple service systems when their children seek services or are placed in treatment. Yet parents can be taught to build upon their existing strengths and to incorporate new strategies, through sensitive and empowering ways, that will increase their ability to successfully navigate the multiple systems operating in wraparound programs. Some programs use other parents as mentors, while case managers in other programs take on this role.

Families may also have difficulty enlisting the help of natural supports. In some cases, the families may have few pre-existing supports (both for the family as a whole and for the child). Other times, potential participants may be resistant to participating.

➢ **Requirements for the State**

Accountability/Monitoring: Although traditional programs often blame providers when programs are not successful, the wraparound approach depends upon the successful collaboration of the service, organizational, and systems levels (Walker, Koroloff, and Schutte, 2003). Therefore tools to assess both upward accountability (the degree of organizational support and the type of policy/funding contexts) and downward accountability (a more traditional notion of team level conditions necessary to implement wraparound). Examples of both these assessments are provided in Walker, Koroloff, and Schutte (2003) – The Assessment of Organizational Supports (AOS) and the Checklist for Indicators of Practice and Planning (ChIPP). While states and programs may or may not adopt these specific tools, consideration should be given to explicitly incorporating some mechanism to encourage a culture of mutual accountability among all partners.

An alternative and statistically sophisticated method, using Lorenz curves to conduct QA on programs, has been proposed by Lewis et al (2003). Since wraparound encourages individualized treatment but QA demands some form of standardization against which to assess performance, these investigators propose a method similar to that used in measuring inequality within a country's income or resources (where Lorenz curves are used in conjunction with the Gini Coefficient). The Lorenz curves and Gini coefficients would identify those providers who are best operating in the spirit of wraparound by matching treatment and resources with the individualized needs of youth.

Ongoing training: As with any complex intervention, the efficacy of wraparound requires ongoing training for those implementing the approach. Studies (e.g. Bruns. 2004) have shown that modest trainings produce only limited increase in fidelity to wraparound and suggest that greater fidelity can be achieved by ongoing intensive training, which includes observation and coaching of facilitators, engaging and supporting supervisors, and collecting data and monitoring outcomes. In addition, research (Rast and Peterson, 2004) has found that outcomes for families are increased when case managers/facilitators receive greater supports and therefore maintain higher fidelity to the wraparound approach. Therefore, in funding wraparound programs, states should consider not only the initial training needed to initiate a program, but the need for and value of ongoing training for program staff and partners. Furthermore, anecdotal evidence (e.g. Becker and Kennedy, 2003: 28) suggests that training needs change as program staff mature in their positions. Some research also has suggested that when fidelity is compromised, it often occurs due to shortcuts taken in the wraparound process (See Franz, 2003: e.g. skipping process steps or lacking team members). Periodic retraining on these issues can be used with the goal of increasing fidelity.

Certification: The formal certification of facilitators (through training) can help to increase fidelity. When facilitators are individually and explicitly evaluated against distinct criteria, they maintain greater fidelity to the wraparound process in their practice. (See "Training Needs & Requirements" section for more information on accreditation)

Other ongoing support: In addition to training, the state will need to consider how it will provide on-going support at the team, organization (lead and partner agencies), and systems (policy and funding context) levels in five areas (Walker, Koroloff, and Schutte, 2003):

- Wraparound practice: using an approach and implementation consistent with wraparound principles;
- Collaboration/Partnerships at the team, program and system levels;
- Capacity building/staffing with adequate and well-tailored positions and working conditions in agencies and at the system level ;
- Acquiring services and supports from within the community that meet the individualized service plan of children and families within the wraparound program; and
- Accountability, as documented by measuring processes and outcomes across the team, agency and system levels.

➢ **Requirements for the Program**

In implementing wraparound, programs will confront two broader-level system issues: legitimacy and sustainability.

Legitimacy and sustainability are two of the key concerns related to program success.

First, in order to be viewed as a legitimate program, wraparound programs need key stakeholders, located within the system, who will act as champions. These individuals will help eliminate misunderstandings other providers may have about wraparound – especially if others perceive wraparound staff as being privileged (e.g. due to small caseloads, availability of flexible funding).

Secondly, as individual wraparound programs mature, sustainability issues will take on added salience. In order to ensure longevity and vigorous use of the program, all levels of staffing will need to promote the ongoing participation of a range of supports (informal, nontraditional and natural supports) which may fluctuate but remain involved over time. Programs may be especially challenged by the specific tasks necessary to ensure sustainability. Programs will need to understand how to communicate the philosophy of wraparound in a way that is consistent with the mission of traditional providers; to build incentives into their program which reward participants in meaningful ways;

and to partner with parents and other community members across as wide a range of tasks as possible.

More specifically, in designing a program which incorporates a wraparound process, program administrators should consider how they will implement the 10 practice requirements identified by researchers (Goldman, 1999:14-16). Programs should give thought to how:

- A community collaborative structure will manage the wraparound process;
- A lead organization will take responsibility for administering and managing the implementation of wraparound;
- A referral mechanism will be established to determine the children and family to be included;
- Resource coordinators will facilitate the process by conducting strengths/needs assessments; facilitate the team planning; and manage the implementation of the individualized plan;
- A strengths and needs assessment will be conducted which will serve as a foundation for the wraparound process;
- A child and family team will be formed;
- The team will work with the child and family to engage in an interactive process and arrive at consensus in developing the individualized plan;
- A crisis/safety plan will be developed by the child and the rest of the team in a proactive manner, anticipating that some crises will occur;
- Measurable outcomes for each goal in the individualized plan will be monitored on a regular basis; and
- The community collaborative structure will review each plan to gain community support and identify/create needed services.

Training & Other Ancillary Materials Available

Selected training materials which are available from some of the more established programs are listed below. (The "Other Resources" section contains contact information for these and other wraparound programs referenced in this brief.) In addition, interested readers are urged to consult the National Wraparound Initiative (NWI) (www.rtc.pdx.edu/nwi) which currently is producing training and implementation materials (e.g. descriptions of the phases of wraparound; tools for providers; system and organizational standards). In developing both training and QA procedures, as well as fidelity and implementation measures, the NWI is explicitly linking these materials to particular phases, activities and standards in wraparound.

➢ Training Materials

The Wraparound Process Training Manual (By John VanDenBerg and E.M Grealish)

Materials from the LaGrange Wraparound Program:

- Training Outline (www.ebdnetwork-il.org/pbis/downloadables/pdf/toutline.pdf)
- Information sheet for training activities(www.ebdnetwork-il.org/pbis/downloadables/pdf/Training%20and%20Evaluation%20Information%20form.pdf

Wraparound Milwaukee Materials:

- Wraparound Milwaukee (available both in Goldman and Faw, 1999 (within the Promising Practices Series) and directly from Wraparound Milwaukee, see the "Other Resources" section for contact information)
- Wraparound Milwaukee Plan of Care
- Crisis Plan

LaGrange Materials:

- Implementation Survey (www.ebdnetwork-il.org/pbis/downloadables/pdf/impcheck.pdf)
- Implementation checklist (www.ebdnetwork-il.org/pbis/downloadables/rtf/tcheck.rtf)
- School profile form (www.ebdnetwork-il.org/pbis/downloadables/rtf/tcheck.rtf)
- Referral for wrap program (www.ebdnetwork-il.org/pbis/downloadables/pdf/ilsrefer.pdf)
- Educational information form (www.ebdnetwork-il.org/pbis/downloadables/pdf/edinfo.pdf)
- Parent/Primary Caregiver Satisfaction Instrument (www.ebdnetwork-il.org/pbis/downloadables/pdf/psatisf.pdf)
- Youth Satisfaction Instrument (www.ebdnetwork-il.org/pbis/downloadables/pdf/ysatisf.pdf)
- Collaborative Team Planning Form (www.ebdnetwork-il.org/pbis/downloadables/pdf/ctpf.pdf)
- Youth and Family Checklist (www.ebdnetwork-il.org/pbis/downloadables/pdf/yfcheck.pdf)
- Effective Behavior Support (EBS) Self-Assessment Survey (for schools staff) (www.ebdnetwork-il.org/pbis/downloadables/pdf/ebssurv.pdf)

➢ Other Tools

Other tools have been developed to supply wraparound staff (supervisors, coaches and others) with information to assist in implementing the wraparound program and to guide the certification of facilitators in wraparound programs. The consulting firm of Vroon VanDenBerg has provided leadership in this area and offers assistance through training and consultation. Interested readers are urged to consult its principals, either Jim Rast, Ph.D. (jim@vroonvdb.com) or John VanDenBerg, Ph.D. (john@vroonvdb.com) for additional information.

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Other Resources

- **Training Resources (a partial listing)**

Kaleidoscope Program:

1279 N. Milwaukee, Suite 250

Chicago, IL 60622

Telephone: 773- 278-7200

Kaleidoscope Program Contact: Karl Dennis, Ph.D.

Illinois State Board of Education: (which oversees the LaGrange program described in the "Current Models & Populations" section)

Emotional and Behavioral Disabilities/

Positive Behavior Interventions and Supports Network - (Illinois state only)

West 40 ISC#2

928 Barnsdale Road, #254

LaGrange Park, IL 60526

Telephone: 708-482-4860

FAX: 708-482-4875

National Wraparound Initiative (NWI):

The Research and Training Center at Portland State University

Website: www.rtc.pdx.edu/nwi

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Tapestry Program (Parent-to-Parent Services):

Harmonium Inc. Main Office
10717 Camino Ruiz, Suite 104
San Diego, CA 92126
Telephone: 858-566-5740
Fax: 858-566-6430
E-mail:info@harmonium-inc.com
Tapestry Program Contact: Julie Becker, Ph.D.

Vroon VanDenBerg (VVDB) LLP:

98 Inverness Drive East
Suite 310
Englewood, CO 80112
Telephone: 303-790-4099
FAX: 303-790-1926
Website: www.vroonvdb.com
Vroon VanDenBerg Contacts: Jim Rast, Ph.D. and John VanDenBerg, Ph.D

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➤ **Internet Sites**

www.rtc.pdx.edu/nwi

The Research and Training Center at Portland State University --- hosts the website for the National Wraparound Initiative (NWI) which is supported by the Maryland Department of Juvenile Services; Maryland Mental Hygiene Administration; CMS; and the Technical Assistance Partnership, American Institutes for Research.

www.air.org/cecp/promisingpractices/Default.htm

Center for Effective Collaboration and Practice –- listing of wraparound materials available from Comprehensive Community Mental Health Services for Children and Their Families Program

www.paperboat.com/index.html

A web-based site for sharing information targeting tradition programs transitioning toward a comprehensive or wraparound approach.