Wraparound—Key information, evidence, and endorsements
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Brief Description	*Wraparound* is a team-based planning process intended to provide individualized, coordinated, family-driven care to meet the complex needs of children who are involved with several child- and family-serving systems (e.g. mental health, child welfare, juvenile justice, special education), who are at risk of placement in institutional settings, and who experience emotional, behavioral, or mental health difficulties. The wraparound process requires that families, providers, and key members of the family's social support network collaborate to build a creative plan that responds to the particular needs of the child and family. Team members then implement the plan and continue to meet regularly to monitor progress and make adjustments to the plan as necessary. The team continues its work until members reach a consensus that a formal wraparound process is no longer needed. The values associated with wraparound require that the planning process itself, as well as the services and supports provided, should be individualized, family driven, culturally competent and community based. Additionally, the wraparound process should increase the "natural support" available to a family by strengthening interpersonal relationships and utilizing other resources that are available in the family's network of social and community relationships. Finally, wraparound should be "strengths based," helping the child and family to recognize, utilize, and build talents, assets, and positive capacities. It should be noted that wraparound is more a specific method for treatment planning and care coordination than a single treatment like many that are often featured in lists of evidence-based practices. The theory of change for wraparound, however, provides rationale for why treatments included in the wraparound plan are likely to be more effective than they might be in the absence of wraparound (due to better treatment acceptability and family/child engagement, agreement about treatment goals, etc..), and why participation in the wraparound process itself may yield positive outcomes for youth/children and their families (due to increased optimism, self-efficacy, social support, coping skills, etc.).

Relevant Research	The research selected for inclusion in this Table include the nine controlled (experimental and quasi-experimental) outcomes research studies published in peer-reviewed journals relevant to the wraparound process. Studies are organized by the population studied. These include two studies of youth served through the child welfare system, two studies of youth served because of their involvement in (or risk of involvement in) juvenile justice, and five studies of youth served because of their intensive mental health needs. (References are provided at the end of this table.)	
	Citations	*Outcome(s)*
Randomized control study (18 months) of youth in **child welfare** custody in Florida: 54 in wraparound vs. 78 in standard practice foster care.	Clark, Lee, Prange, & McDonald, 1996; Clark et al., 1998.	Significantly fewer placement changes for youths in the wraparound program, fewer days on runaway, fewer days incarcerated (for subset of incarcerated youths), and older youths were significantly more likely to be in a permanency plan at follow-up. No group differences were found on rate of placement changes, days absent, or days suspended. No differences on internalizing problems, but boys in wraparound showed significantly greater improvement on externalizing problems than the comparison group. Taken together, the findings provided moderate evidence for better outcomes for the wraparound program; however, differences appear somewhat limited to boys and externalizing problems.
Matched comparison study (18 months) of youth in **child welfare** custody in Nevada: 33 in wraparound vs. 32 receiving MH services as usual	Bruns, Rast, Walker, Bosworth, & Peterson, 2006; Rast, Bruns, Brown, & Peterson (in submission)	After 18 months, 27 of the 33 youth (approximately 82%) who received wraparound moved to less restrictive environments, compared to only 12 of the 32 comparison group youth (approximately 38%), and family members were identified to provide care for 11 of the 33 youth in the wraparound group compared to only six in the comparison group. Mean CAFAS scores for youth in wraparound decreased significantly across all waves of data collection (6, 12, 18 months) in comparison to the traditional services group. More positive outcomes were also found for the wraparound cohort on school attendance, school disciplinary actions, and grade point averages. No significant differences were found in favor of the comparison group.

Randomized control study (18 months) of "at risk" and **juvenile justice** involved (adjudicated) youth in Ohio: 73 in wraparound vs. 68 in conventional services	Carney & Buttell, 2003	Study supported the hypothesis that youth who received wraparound services were less likely to engage in subsequent at-risk and delinquent behavior. The youth who received wraparound services did not miss school unexcused, get expelled or suspended from school, run away from home, or get picked up by the police as frequently as the youth who received the juvenile court conventional services. There were, however, no significant differences, in formal criminal offenses.
Matched comparison study (>2 years) of youth involved in **juvenile justice** and receiving MH services: 110 youth in wraparound vs. 98 in conventional MH services	Pullmann, Kerbs, Koroloff, Veach-White, Gaylor, & Sieler, 2006	Youths in the comparison group were three times more likely to commit a felony offense than youths in the wraparound group. Among youth in the wraparound program, 72% served detention "at some point in the 790 day post identification window" (p. 388), while all youth in the comparison group served detention. And of youth in the Connections program who did serve detention, they did so significantly less often than their peers. Connections youth also took three times longer to recidivate than those in the comparison group. According to the authors, a previous study by Pullman and colleagues showed "significant improvement on standardized measures of behavioral and emotional problems, increases in behavioral and emotional strengths, and improved functioning at home at school, and in the community" (p. 388) among Connections youth.
Randomized control study (12 months) of youths referred to out-of-home placements for serious **mental health** problems in New York State: 27 to family centered intensive case management (wraparound) vs. 15 to treatment foster care.	Evans, Armstrong, & Kuppinger, 1996; Evans, Armstrong, Kuppinger, Huz, & McNulty,1998	Significant group differences were found in favor of the case management/ wraparound program for behavioral and mood functioning. No differences were found, however, with respect to behavior problems (internalizing and externalizing), family cohesiveness, or self-esteem. No differences found in favor of the TFC group. Overall, small sample size plus loss of data on many of the outcome measures resulted in the study having very low power to detect differences between groups.

Quasi-experimental (6 months) study in Department of Defense demonstration site of youths with serious **mental health** issues: 71 in wraparound group vs. 40 in comparison group (study refusers/ineligible youths).	Bickman, Smith, Lambert, & Andrade, 2003	Findings included higher utilization of "wraparound services" (e.g., case management, in-home supports, and nontraditional services) for the demonstration group, higher costs for the demonstration group (primarily due to this group remaining in treatment longer), and no consistent differences between the groups on outcome measures (e.g., behavior, functioning, caregiver strain, perceived social support, family environment). Limitations of this study include the short time span (6 months) and whether the demonstration project truly followed the wraparound process. Authors stated the "wrap" condition had access to informal services and flexible funding, but authors did not assess "wrapness" and stated that, "there is no evidence that the content or the quality of the services were different for the Wraparound children." (p.151)
Quasi-experimental (24 months) study of youths with serious **mental health** issues in urban Baltimore: 45 returned or diverted from residential care to wraparound vs. 24 comparison.	Hyde, Burchard, & Woodworth, 1996	Primary outcome was a single rating that combined several indicators: restrictiveness of youth living situation, school attendance, job/job training attendance, and serious problem behaviors. Youths received ratings of "good" if they were living in regular community placements, attending school and/or working for the majority of the week, and had fewer than three days of serious behavior problems during the course of previous month. At 2-year follow-up, 47% of the wraparound groups received a rating of good, compared to 8% of youths in traditional MH services. Limitations of the study include study attrition and group non-equivalence at baseline.

Quasi-experimental (multiple-baseline case study) of four youths referred to wraparound because of serious **mental health** issues in rural Michigan.	Myaard, Crawford, Jackson, & Alessi (2000).	The multiple baseline case study design was used to evaluate the impact of wraparound by assessing whether outcome change occurred with (and only with) the introduction of wraparound at different points in time. The authors tracked occurrence of five behaviors (compliance, peer interactions, physical aggression, alcohol and drug use, and extreme verbal abuse) for each of the youths. Participants began receiving wraparound after 12, 15, 19, and 22 weeks. For all four participants, on all five behaviors, dramatic improvements occurred immediately following the introduction of wraparound.
Comparison study (12 months) of youth in a **mental health** system of care in Nebraska: 271 in wraparound vs. 157 in Multisystemic therapy (MST) vs. 28 who received both wraparound and MST	Reay, Garbin, & Scalora, 2003	Outcomes assessed were limited to child functioning as assessed by the CAFAS. All three groups showed significant improvements over the 12-month period, but no between-group differences were found.

Evidence based practice related websites on which wraparound has been highlighted (e.g. NCTSN, SAMHSA, Colorado Blueprints etc)	National Association of State Mental Health Program Directors: NASMHPD Research Institute: Center for Mental Healthcare Quality and Accountability—Posted on SAMHSA's System of Care website http://www.systemsofcare.samhsa.gov/headermenus/docsHM/MatrixFINAL1.pdf State of Oregon: Mental Health and Addiction Approved Evidence-Based Practices http://www.oregon.gov/DHS/mentalhealth/ebp/practices.shtml NCTSN National Child Traumatic Stress Network: Empirically Supported Treatments and Promising Practices (Listed under "Family Advocate Program") http://www.nctsnet.org/nctsn_assets/pdfs/promising_practices/NCTSN_E-STable_21705.pdf The National Center on Education, Disability, and Juvenile Justice has recognized wraparound as a "best practice" for promoting educational success and reducing delinquency. The write-up on wraparound is largely based on the work of the National Wraparound Initiative and the resources on the NWI website. http://www.edjj.org/focus/prevention/JJ-SE_downloads.htm Wraparound is featured as a promising practice for placement stabilization on the website of the California Evidence-Based Clearinghouse for Child Welfare. http://www.cachildwelfareclearinghouse.org/

Program Basics	
Target Population	Wraparound is designed for children/youth with severe emotional, behavioral, or mental health difficulties and their families. Most often these are young people who are in, or at risk for, out of home/institutional/restrictive placements; and who are involved in multiple child- and family-serving systems (e.g. child welfare, mental health, juvenile justice, special education, etc.) Wraparound is wildely implemented in each of these various settings; however, because the youth have multi-system involvement, wraparound participants have many similarities across settings.
What is the recommended intensity	This can vary. Usually there is an intensive engagement and initial planning process that may require 2 1-1.5 hour sessions with the family and 2 1-1.5 hour team sessions during the first three weeks to a month. The team continues to meet thereafter, usually with increased intensity in the early phases (often once per month or even more) and decreasing thereafter. The care coordinator/facilitator and/or parent partner have other contacts with the youth and family as necessary, and services and supports called for in the plan are provided by other team members or by people not included on the team.
What is the recommended duration	See above: regular team meetings average 1.5 hours. Well established programs provide services for an average of 14 months or so.
Homework component	Team members, including youth and family, carry out their roles in implementing the wraparound plan as determined by the team.

Essential Components	Please refer to these documents: Walker JS, Bruns EJ, Rast J, VanDenBerg J, D., Osher TW, Koroloff N, Miles P, Adams J, National Wraparound Initiative Advisory Group. *Phases and activities of the wraparound process*. Portland, OR: National Wraparound Initiative, Research and Training Center on Family Support and Children's Mental Health, Portland State University; 2004. http://www.rtc.pdx.edu/nwi/PhaseActivWAProcess.pdf Bruns EJ, Walker JS, Adams J, Miles P, Osher TW, Rast J, VanDenBerg JD, National Wraparound Initiative Advisory Group. Ten principles of the wraparound process. Portland, OR: National Wraparound Initiative, Research and Training Center on Family Support and Children's Mental Health, Portland State University; 2004. http://www.rtc.pdx.edu/PDF/TenPrincWAProcess.pdf Bruns EJ, Burchard JD, Suter JC, Leverentz-Brady K, Force MM. Assessing fidelity to a community-based treatment for youth: The Wraparound Fidelity Index. *Journal of Emotional and Behavioral Disorders*. 2004;12:79-89.
Education and Training Resources	See the listing of consultants provided at: http://www.rtc.pdx.edu/nwi/NWIConsultants.htm This is not an exhaustive list. Also, Many states (e.g., Indiana, Michigan, Arizona) provide training and technical assistance to wraparound programs
Identified Resources	Most of the cost is in personnel. Programs typically hire care coordinators with caseloads of 10-15 families. Additionally, most programs hire parent advocates/parent partners to work with teams. Because wraparound is necessarily a collaborative effort, implementation usually (but not always) requires some sort of interagency oversight or governance body with representation from participating child- and family-serving agencies and organizations.
Minimum Provider Qualifications	Most programs require at least BA-level people as care coordinators and supervisors. Requirements for family partners are flexible. However, the most important qualification is expertise in wraparound itself.

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References

Bickman, L., Smith, C., Lambert, E. W., & Andrade, A. R. (2003). Evaluation of a congressionally mandated wraparound demonstration. *Journal of Child & Family Studies, 12*, 135-156.

Bruns, E.J., Rast, J., Walker, J.S., Peterson, C.R., & Bosworth, J. (2006). Spreadsheets, service providers, and the statehouse: Using data and the wraparound process to reform systems for children and families. *American Journal of Community Psychology, 38*, 201-212.

Carney, M. M., & Buttell, F. (2003). Reducing juvenile recidivism: Evaluating the wraparound services model. *Research on Social Work Practice*, *13*, 551-568.

Clark, H.B., Lee, B., Prange, M.E. & McDonald, B.A. (1996).Children lost within the foster care system: Can wraparound service strategies improve placement outcomes? *Journal of Child and Family Studies, 5*, 39-54.

Clark, H. B., Prange, M. E., Lee, B., Stewart, E. S., McDonald, B. B., & Boyd, L. A. (1998). An individualized wraparound process for children in foster care with emotional/behavioral disturbances: Follow-up findings and implications from a controlled study. In M. H. Epstein, K. Kutash & A. Duchnowski (Eds.), *Outcomes for children and youth with emotional and behavioral disorders and their families: Programs and evaluation best practices* (pp. 513-542). Austin, TX: Pro-ED, Inc.

Evans, M.E., Armstrong, M.I., Kuppinger, A.D. (1996). Family-Centered Intensive Case Management: A Step Toward Understanding Individualized Care. *Journal of Child and Family Studies, 5,* 55-65.

Evans, M. E., Armstrong, M. I., Kuppinger, A. D., Huz, S., & McNulty, T. L. (1998). Preliminary outcomes of an experimental study comparing treatment foster care and family-centered intensive case management. In Epstein, M.H. (Ed); Kutash, K (Ed); et al. (1998). *Outcomes for children and youth with emotional and behavioral disorders and their families: Programs and evaluation best practices. (pp. 543-580). Xviii, 738 pp.*

Hyde, K. L., Burchard, J. D., & Woodworth, K. (1996). Wrapping services in an urban setting. *Journal of Child & Family Studies, 5*(1), 67-82.

Myaard, M. J., Crawford, C., Jackson, M., & Alessi, G. (2000). Applying behavior analysis within the wraparound process: A multiple baseline study. *Journal of Emotional & Behavioral Disorders, 8*, 216-229.

Pullmann, M. D., Kerbs, J., Koroloff , N., Veach-White, E., Gaylor, R., & Sieler, D. (2006). Juvenile offenders with mental health needs: Reducing recidivism using wraparound. Crime and Delinquency, 52, 375-397.

Reay, W. E., Garbin, C. P., & Scalora, M. (2003). The Nebraska evaluation model: Practice and policy decisions informed by case and program specific data. In C. Newman, C. J. Liberton, K. Kutash & R.M. Friedman (Eds.), *The 15th annual research conference proceedings, a system of care for children's mental health: Expanding the research base* (pp. 49-52). Tampa, FL.