

# UNDERSTANDING AND UTILIZING WRAPAROUND SERVICES





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## ABOUT

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This guide introduces the wraparound approach, highlighting its collaborative, team-based method. Originating as a response to limitations in traditional services, wraparound has evolved to address diverse needs across child welfare, mental health, education, and more.

Implementing wraparound requires careful planning, coordination, and partnership with stakeholders. Key elements include engaging individuals as decision-makers, fostering natural supports, and prioritizing individualized,

strengths-based approaches. Successful programs often involve formal agreements, dedicated care coordinators, and multidisciplinary teams.

Organizations can leverage existing resources and partnerships to support wraparound implementation. Case studies, such as the Montrose County Department of Health and Human Services and *Connections to Success*, illustrate the impact of wraparound in improving outcomes for vulnerable populations and fostering community development.



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## EXECUTIVE SUMMARY

This guide introduces the concept of wraparound services, which is a holistic approach to supporting individuals on their path to self-sufficiency by addressing their multifaceted needs through coordinated, community-based support.

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### KEY POINTS

#### 1. WRAPAROUND SERVICES OVERVIEW

- **Definition:** A team-based method providing personalized, comprehensive support.
- **History:** Started in the 1980s to improve traditional services.
- **Uses:** Applied in child welfare, juvenile justice, mental health, education, substance abuse, developmental disabilities, community support, elderly care, transition services, and trauma response.

#### 2. CORE VALUES AND PRINCIPLES

- **Collaborative Team:** Involves a team that designs and delivers services.
- **Care Coordinators:** Help create and follow personalized plans.
- **Comprehensive Care Plan:** Updated continuously to fit individual needs.
- **Outcome-Based:** Focuses on measurable success.

#### 3. IMPLEMENTATION GUIDELINES

- **Phases:** Engagement, plan development, implementation, and transition.
- **Training and Certification:** Necessary for effective implementation. Useful resources are available from the National Wraparound Initiative and others.
- **Partnerships:** Important for providing a full range of services.

#### 4. EXAMPLES OF WRAPAROUND SERVICES

- **Montrose County, Colorado:** Supports at-risk youth through coordinated services.
- **Connections to Success (CtS), Missouri:** Uses a comprehensive approach to reduce poverty, achieving significant results in employment and recidivism reduction.

### IMPLEMENTATION ACTIONS

#### 1. POLICY AND PROGRAM DEVELOPMENT

- Utilize existing programs that support wraparound services.
- Develop agreements and service teams.
- Ensure ongoing staff training and certification.

#### 2. PARTNERSHIP BUILDING

- Partner with experienced organizations.
- Expand networks to offer comprehensive support.
- Engage community stakeholders for better service coordination.

#### 3. CONTINUOUS IMPROVEMENT

- Use metrics to track progress and adjust plans.
- Participate in research to improve services.
- Share best practices with other organizations.

Wraparound services provide a flexible and comprehensive way to support individuals with complex needs, aiming to create stability and improve lives through coordinated efforts.

## INTRODUCTION

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Community economic development seeks to revitalize communities, improve the quality of life for residents, and provide economic mobility for individuals with low incomes. Activities associated with this process are diverse and include a variety of public, nonprofit, and private partners. The **Community Economic Development (CED) program** in the **Office of Community Services** located in the **U.S. Department of Health and Human Services** has provided funding opportunities for

community economic development for more than 50 years. As part of the commitment to support community development efforts, this practice guide introduces the topic of wraparound services and offers actionable suggestions on implementing this approach. Wraparound services provide valuable support for individuals with low incomes as they navigate the path to self-sufficiency.

## WHAT IS A “WRAPAROUND” APPROACH?

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Designing effective policies or programs to alleviate poverty is complex. Individuals experiencing poverty often face immediate concerns, such as feeding their families or securing housing, which can impede their ability to make the long-term investments necessary for upward mobility and economic stability. Poverty is like a complex puzzle with multiple pieces, each representing different challenges that people might encounter, such as limited access to education, health care, employment, or community or familial support. Wraparound is a collaborative team-based approach to service and support planning to help individuals achieve a stable and prosperous future. A wraparound team carefully identifies the specific needs of individuals and families on a case-by-case basis and helps them overcome barriers and achieve self-sufficiency. The wraparound approach is unique from other service delivery strategies in that it provides a comprehensive and holistic way of responding to individual, family, or community needs. Unlike other service delivery strategies, wraparound services engage individuals as decision-makers in a strength-based personalized approach. Strengths are identified in the family, school, and community, and are actively combined to address needs. Initially used for children



and youth with complex needs, wraparound services can be applied to various contexts where households have multifaceted needs that cannot be adequately addressed by a single service or intervention. The core principle of this approach is to provide coordinated, individualized, and community-based support to help people achieve their goals and improve their overall well-being.



### BRIEF HISTORY OF WRAPAROUND SERVICES

The concept of wraparound services gained prominence in the 1980s and 1990s as a response to the limitations of traditional child welfare and mental health services. Dr. Lenore Behar, based in North Carolina, is credited with first using the term “wraparound” in the early 1980s. Since then, “wraparound” has taken on various definitions and evolved to represent

a philosophy, an approach, and a service.

**Wraparound is designed to fit the diverse contexts of communities and systems, as well as the unique requirements of individuals.**

The development of the wraparound process has been influenced by a unique blend of local, state, and federal innovations, as well as influential people and organizations at various levels.<sup>1</sup>

<sup>1</sup> VanDenBerg, J., Bruns, E., & Burchard, J. (2003). *History of the wraparound process. Focal Point: A National Bulletin on Family Support and Children's Mental Health: Quality and fidelity in Wraparound*, 17(2), 4–7.

## WRAPAROUND IMPLEMENTATIONS

The term “wraparound” signifies flexibility and comprehensiveness in delivering services, leading to diverse interpretations and applications,<sup>2</sup> including:

- **CHILD WELFARE AND FAMILY SERVICES:** Wraparound services are often employed to support families involved with child welfare agencies, especially those at risk of having children placed in foster care. These services aim to keep families together by addressing various behavioral issues, such as substance abuse, mental health challenges, and parenting skills. For a directory of state organizations working in this area, see [State Contacts & Related Organizations](#).
- **JUVENILE JUSTICE:** Wraparound services can be used as an alternative to juvenile detention or as a part of reentry programs for youth involved in the juvenile justice system. These services focus on addressing the underlying issues that lead to delinquent behavior, such as substance abuse or trauma. Learn more at [Wraparound Process](#).
- **MENTAL HEALTH:** Wraparound services are used to support individuals with mental health conditions who have complex needs. These services provide a range of interventions, including therapy, medication management, housing support, and peer support, to help individuals live successfully in their communities. Learn more at [What Are Wraparound Services in Behavioral Health?](#)
- **EDUCATION:** In K–12 schools, wraparound services are employed to support students with behavioral or emotional challenges. These services can include counseling, tutoring, mentoring, and family support to help students succeed academically and socially. Learn more at [Wraparound Services in Schools](#).
- **SUBSTANCE ABUSE TREATMENT:** Individuals struggling with substance abuse often have a wide range of needs, including housing, employment, and mental health support. Wraparound services can be used to provide comprehensive care to address these needs and promote recovery. [Research](#) has shown that wraparound services improve substance abuse treatment outcomes.
- **DEVELOPMENTAL DISABILITIES:** Individuals with developmental disabilities and their families may require wraparound services to access a variety of supports, such as adaptive equipment, respite care, vocational training, and housing assistance. Learn more at [Training Resources from A Day In Our Shoes and Don't IEP Alone](#).
- **COMMUNITY-BASED PROGRAMS:** Wraparound services can be implemented in various community-based programs aimed at supporting vulnerable populations, such as the unhoused, refugees, and immigrants. These services help individuals and families access housing, health care, legal assistance, and social services.
- **AGING AND LONG-TERM CARE:** In the context of elderly individuals or those with disabilities, wraparound services can help coordinate various aspects of care, including home health services, transportation, meal delivery, and social engagement. Learn more at [Wrap Around Services Help Older Adults Age in Place](#).
- **TRANSITION SERVICES:** Young adults transitioning out of foster care or special education programs may benefit from wraparound services to help them navigate the challenges of independent living, find employment, and access educational opportunities. Learn more at [Wraparound Services](#).
- **TRAUMA AND CRISIS RESPONSE:** Wraparound services can be utilized in the aftermath of traumatic events or disasters to provide immediate and ongoing support to affected individuals and communities.

<sup>2</sup> Burchard, John D., et al. (2009). “The Wraparound Approach.”

## WRAPAROUND VALUES

Several public agencies and research organizations, such as the [\*National Alliance on Mental Illness Multnomah\*](#), the [\*National Wraparound Initiative\*](#), and the [\*Substance Abuse and Mental Health Services Administration\*](#), have put forth individual definitions of what constitutes a comprehensive wraparound program. While definitions vary, the consensus is that wraparound is not something a client receives from a provider. It's something they do together, an active process rather than a static program or a service. The values listed below reflect a strong commitment to helping clients develop and empower themselves and achieve specific outcomes, without any conditions or wavering dedication from wraparound service providers.



- A **collaborative, community-driven interagency team** responsible for designing, executing, and overseeing the wraparound program within a specific jurisdiction. Typically, this team includes representatives from whatever entities the services receiver is in contact with, including social services agencies, mental and physical health agencies, the justice system, public education, and their family or community. In most instances, a designated lead agency is assigned to coordinate the wraparound effort.
- A **formal interagency agreement** documenting the proposed structure of the wraparound initiative and delineating its operational processes. At the very least, this agreement should specify the target population, enrollment procedures, service delivery and funding mechanisms, the roles of different agencies and individuals, and the resources committed by various stakeholders.
- Care coordinators tasked with assisting participants in **creating personalized treatment plans** and guiding individuals and their families through the care system. Often, these care coordinators are employed by the designated lead agency, which can be a public program or a private nonprofit organization.
- Service teams composed of family members, paid service providers, and community members (e.g., educators and mentors) familiar with the individual receiving treatment and their evolving needs. Led by the care coordinator, these **teams collaborate to ensure that the individual's needs are addressed comprehensively**, encompassing home, education, and the broader community.
- A **comprehensive care plan developed and regularly updated** by the individual and all members of the service team. This plan assesses the individual's specific strengths and weaknesses across different domains, establishes clear goals, and outlines the necessary steps for achieving these objectives. It also specifies the responsibilities of each team member, including the individual and possibly their family or community. Ideally, the plan is continually adjusted to reflect the individual's changing needs and progress.
- A **systematic approach emphasizing outcomes-based services**. Nearly all wraparound programs necessitate well-defined performance metrics, which are employed to monitor the progress of the wraparound initiative and steer its development over time.

## IMPLEMENTATION 101

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### ELEMENTS FOR IMPLEMENTATION

To standardize the wraparound process, the ***National Wraparound Initiative (NWI)*** developed resource guides aimed at enhancing comprehension and facilitating the effective implementation of wraparound service. The NWI also developed 10 fundamental principles of the wraparound process that serve as a guiding framework for policymakers and practitioners interested in adopting this approach:

1. **VOICE AND CHOICE:** Throughout all stages of the wraparound process, service recipients' perspectives are actively sought and given priority. Planning is rooted in the viewpoints of community members, and the team works to present choices and alternatives that align with family values and preferences.
2. **TEAM-BASED:** The wraparound team comprises individuals agreed upon by the family and who are dedicated to supporting the family through informal, formal, and community relationships.
3. **NATURAL SUPPORTS:** The team actively encourages and involves members from the family's existing networks of interpersonal and community relationships. The wraparound plan incorporates activities and interventions that draw upon these sources of natural support.
4. **COLLABORATION:** Team members collaborate and share responsibility for crafting, executing, monitoring, and evaluating a unified wraparound plan. The plan reflects a harmonization of team members' perspectives, mandates, and resources, guiding each member's efforts toward achieving the team's goals.
5. **COMMUNITY-BASED:** The wraparound team implements strategies and support measures within the most inclusive, responsive, accessible, and least restrictive settings possible. These actions aim to safely facilitate the integration of the child and family into their home and community life.
6. **CULTURALLY COMPETENT:** The wraparound process demonstrates respect for and builds upon the values, preferences, beliefs, culture, and identity of the individual, as well as their community.
7. **INDIVIDUALIZED:** To attain the objectives outlined in the wraparound plan, the team formulates and executes a tailored set of strategies, supports, and services.
8. **STRENGTHS-BASED:** The wraparound process and plan identify, build on, and enhance the capabilities, knowledge, skills, and assets of the child, family, community, and other team members.
9. **UNCONDITIONAL:** The wraparound team remains committed to service receivers without giving up, blaming, or rejecting them. When faced with challenges or setbacks, the team continues to work toward meeting their needs and achieving the goals in the wraparound plan until a formal wraparound process is deemed no longer necessary.
10. **OUTCOME-BASED:** The team links the goals and strategies of the wraparound plan to observable or measurable indicators of success. Progress is monitored in relation to these indicators, and the plan is adjusted accordingly.

## PHASES OF THE WRAPAROUND PROCESS

Walker and Bruns in 2006<sup>3</sup> organized a multidisciplinary advisory group to refine wraparound activities and identify a general process for this approach. The specific activities involved in this approach were divided into four phases:

- 1. ENGAGEMENT AND TEAM PREPARATION:** This phase includes orienting the individual to the wraparound program; addressing legal and ethical issues; stabilizing any immediate crises; facilitating conversations with the individual, their family, and community; and engaging other team members.
- 2. INITIAL PLAN DEVELOPMENT:** This phase involves developing an initial plan of care and a crisis or safety plan, completing the necessary documentation, and addressing logistics. It is generally completed during one or two meetings that take place over the course of one to two weeks. Program staff focus on building trust and mutual respect between the wraparound team and the service receiver.
- 3. IMPLEMENTATION:** This phase focuses on implementing the action steps laid out in the initial plan of care. Activities also include monitoring, evaluating, and revising the plan, including celebrating successes and addressing issues of concern. This phase concludes when the team achieves their initial goals and the individual no longer requires formal wraparound services.
- 4. TRANSITION:** In this phase, the team develops a plan to facilitate a purposeful transition out of formal wraparound to a mix of formal and natural supports in the community.



For more information, the [\*\*\*National Wraparound Initiative\*\*\*](#) and the [\*\*\*National Wraparound Implementation Center\*\*\*](#) offer comprehensive practice resources, professional development, a fidelity index, and new research to help case managers and social workers learn more about the framework. For information about wraparound service delivery in rural communities, the Rural Health Information Hub has resources in their [\*\*\*Rural Services Integration Toolkit\*\*\*](#) for implementing wraparound services in rural communities.

Many federal grant programs require recipients to engage in support services that could include a wraparound approach. For example, the [\*\*\*CED program\*\*\*](#), the [\*\*\*Diapers Distribution Demonstration and Research Pilot \(DDDRP\)\*\*\*](#), and the [\*\*\*Affordable Housing and Supportive Services Demonstration \(AHSSD\) grant\*\*\*](#) all have social supports as a feature of their programs. For the DDRP and AHSSD grants, wraparound services are an integral feature of the design (the “Supportive Services” of the AHSSD). The idea is to get the client in the door servicing one specific need, diapers and housing, respectively, and then connect the client to other supports such as food banks or health care through a wraparound system, collaborating with the local service providers, the community, and the client.

<sup>3</sup> Walker, Janet S., and Eric J. Bruns. (2006). “Building on Practice-Based Evidence: Using Expert Perspectives to Define the Wraparound Process.” *Psychiatric Services* 57(11):1579–85.

## GETTING STARTED WITH WRAPAROUND

Wraparound is a process that requires time, commitment, and teamwork. For some community development organizations, partnering with an experienced social service organization may be necessary to learn from an experienced partner and support high-quality implementation of the wraparound approach. Organizations just getting started with wraparound should begin by identifying the policies and programs that support the effort. Most states and many counties have existing programs that provide technical assistance, funding opportunities, and other resources that are useful for the implementation of a wraparound approach. **Some states** will also have certification requirements and training opportunities for individuals working in wraparound. For example, the ***National Center for Innovation & Excellence*** provides training that is approved by some states for certification as a wraparound provider or facilitator. Understanding the opportunities and requirements of your specific state is a necessary first step.



Successful implementations of a wraparound approach will have identified coordinators to manage the process. Organizations interested in adopting this approach should consider identifying a specific staff member who will serve in the role of a social services or personal navigator to help support the implementation. These navigators are common in some public organizations, including the ***U.S. Department of Labor*** and numerous state social service agencies. For organizations new to wraparound, this navigator can serve as a connector between individuals needing services and the appropriate resources in the community to help meet those needs while a full wraparound program is developed. As organizations become more experienced and have fully adopted a wraparound approach, this navigator can play a major role in guiding activities and keeping the implementation on track.

The individuals being served in a wraparound process typically have complex needs requiring a range of services. Even the most experienced organizations will likely need external partners to effectively provide a wide range of appropriate services and resources to support unique and individualized needs. As organizations gain experience with the wraparound approach, partnerships can expand and be streamlined through formal agreements, resource and information sharing, co-location, and other forms of robust partnerships that support the needs of individuals and families.

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## CONCEPT IN ACTION: MONTROSE COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES

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The ***Montrose County Department of Health and Human Services (MCDHHS)***, located in rural Colorado, has developed a wraparound program to support at-risk youth and their families through the Colorado Collaborative Management Program (CMP). Rural human service providers face significant challenges, including higher poverty rates and the unique difficulties of serving a smaller client base spread over large geographic areas. The CMP coordinating group brings together representatives from the county's government, schools, and community to improve the coordination of services for individuals who are ***entering or at risk of entering the child welfare system*** by helping clients access programs, including:

- WIC (Women, Infants, and Children)
- Childcare assistance
- SNAP (Supplemental Nutrition Assistance Program)
- TANF (Temporary Assistance for Needy Families)
- Empowering Dads
- Family support and independence programs
- Medicaid Nurse-Family Partnership Program
- Immunizations
- Early childhood mental health consultations
- Health screenings
- Emergency preparedness
- Health improvement and prevention programs

Additionally, the Montrose County Area Agency on Aging handles a similar range of programs that bridge health and human services, offering transportation and assistance services to seniors in need. The small community size and co-location of services enable a high level of coordination between programs.

To enhance the coordination of juvenile services for high-risk youth and their families, MCDHHS started participating in Colorado's CMP in 2010. The CMP supports local initiatives to integrate treatment services provided by various agencies and encourages collaboration and resource sharing. In 2012, half of Colorado's counties were part of the CMP, administered by the Colorado Department of Human Services. The focus of Montrose County's CMP became collaboration among organizations dealing with juvenile justice issues.

Rather than managing the collaboration themselves, MCDHHS allowed two community organizations, Hilltop Community Resources and the Midwestern Center for Mental Health, to lead the coordinating committee. These partner organizations emphasized strong community investment, including client involvement, to reduce duplication and fragmentation of services and ensure that services effectively support at-risk children and families. Funding from the CMP allowed Montrose County to hire a central coordinator who further formalized service coordination.

Formal collaboration through the CMP also led Montrose County to apply for Colorado's Title IV-E waiver program, aiming to prevent children and families from entering child welfare and protective systems and intervening effectively when needed. Importantly, the steering committee for Colorado's Title IV-E waiver program includes participation from counties of varying population sizes.

Bringing together multiple programs under one roof allows for informal collaboration and coordination, ultimately benefiting clients. When health and human services offices co-locate, even if programs have different eligibility criteria, it helps ensure that families with low income receive the services they require. The CMP partnership encourages families with at-risk youth to participate in staffing meetings and actively contribute to the development of a plan that addresses their specific needs. Community stakeholders define the integration of services as the ability to unify multiple goals and perspectives into a single coordinated plan.

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## CONCEPT IN ACTION: CONNECTIONS TO SUCCESS

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***Connections to Success (CtS)*** is a nonprofit state organization with three locations in the State of Missouri. CtS serves individuals and families experiencing poverty by providing a comprehensive network of services, supports, and a lifelong mentoring model. Recognizing that poverty is a complex issue, CtS utilizes a wraparound approach for tackling the causes and consequences of poverty while also addressing the unique circumstances faced by the individuals being served. A holistic approach is used to help participants achieve success, and services are “wrapped around building healthy lifelong relationships.”<sup>4</sup>



The primary goal of this organization’s work is to “empower those who participate to reach their full potential.” CtS utilizes an evidence-based, data-driven model to support successful outcomes for participants and engages in a continuous improvement process to ensure that their methods of service provision stay effective and innovative. Alongside ongoing data collection, research, and evaluation occurring within CtS, the organization is also a member of the ***Global Homeboy Network***. Being a member of this group provides CtS with an international network of organizations to learn from and support their emphasis on continuous improvement and successful outcomes.

CtS provides numerous services and programs within the organization and has enjoyed success in improving outcomes for the participants they serve. For example, participants in the CtS re-entry program have a 74% initial employment rate, 70% job retention at 9 months, and an 8% recidivism rate (compared to a 44% national average) for those in the mentoring program. Alongside these successful internal programs, CtS has also developed an ***extensive network of external partners*** to support the efforts of addressing the complex problems associated with poverty. CtS actively seeks to meet people where they are and create a lifelong relationship with participants. These partnerships provide an extensive array of resources, supports, expertise, and funding to help achieve that goal.

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<sup>4</sup> Connections to Success (n.d.). Connections to Success Case Study. <https://aspe.hhs.gov/sites/default/files/private/aspe-files/262741/ctscasestudy.pdf>



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## CONCLUSION

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In conclusion, the wraparound approach offers a promising framework for addressing the multifaceted needs of individuals and families facing complex challenges. Through partnerships, careful coordination, and a commitment to client-centered care, organizations can effectively implement wraparound programs to provide comprehensive support tailored to each person's unique

circumstances. The success stories of organizations such as the Montrose County Department of Health and Human Services and Connections to Success highlight the potential of wraparound approaches. By integrating services, engaging communities, and leveraging external resources, these organizations have made significant strides in improving outcomes for vulnerable populations.



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