

***TOOLS FOR PROMOTING EDUCATIONAL SUCCESS  
AND REDUCING DELINQUENCY***

**STEP 4.**

**Intensive  
Interventions**

- **Introduction**
- **Behavior Objective Sequence (BOS)** *(a promising practice)*
- **IDEA Partnership Seed Grant in New Hampshire** *(an emerging practice)*
- **Developmental Therapy Objections Rating Form (DTORF)** *(a promising practice)*
- **Life Space Crisis Intervention (LSCI)** *(a promising practice)*
- **Multisystemic Therapy (MST)** *(a best practice)*
- **Systems of Care (SOC)** *(a promising practice)*
- **The Wraparound Process** *(a best practice)*

# ***TOOLS FOR PROMOTING EDUCATIONAL SUCCESS AND REDUCING DELINQUENCY***

~ ~ ~ ~ ~

## **Step 4. Intensive Interventions**

### **Introduction\***

For many educators, the term ***intensive interventions*** may conjure up visions of actions that are complex, problem focused, time consuming, and often overly expensive. *Intensive* suggests that other, less involved interventions have failed, and that something is terribly wrong with the individual, the service system, or both. ***Intensive interventions*** do not necessarily need to be any of the above. However, a systematic approach to intervention that takes into account the unique characteristics of the individual is essential.

There are several key factors in developing and implementing intensive interventions in addition to simply selecting proven strategies. Some key factors include:

- partnering with the student and the family in the development of services;
- confirming, or developing as needed, local and state public policies supporting the strategies;
- ensuring that the process has adequate resources for the long term;
- developing formal linkages between providers of needed resources in the school and community;
- creating effective skill development for all parties to the intervention, including consumers and families; and
- engaging a formal evaluation process that informs both practice and policy.

Intensive interventions are based on a solid foundation of assessment. An accurate understanding of the present condition is developed in part by carefully constructing the critical events of the past. This must include a focus on the assets the student possesses. Assessment needs to focus not only on the individual but also on other factors, such as poverty, racism, family support, community assets, and availability of educational support and related services. As with evaluations for special education, multiple sources of information must be included. Given that mental and physical health are priority concerns for this population, both should be carefully assessed, diagnosed and treated when appropriate.

---

\* A *Reference List* for each of the nine Steps, including this Step, can be found in Appendix E.

One important aspect of the tools presented here is that each requires a degree of rigor from the professionals implementing these interventions. All of the tools, processes, and approaches require some directed training in order for staff to become proficient in their use. A clear understanding of the implications of the goals for the individual, the family and the systems providing services are needed. This does not mean that each professional understand and be competent in all aspects of an intervention. However, at a minimum the staff involved need to have a working knowledge of not only their role and responsibility, but the roles and responsibilities of each of the partners in the system of care.

It is essential to ensure that needs are appropriately matched with effective services. The first step with intensive interventions is ensuring, or actually creating, the system of services and supports that is needed. Educators play a critical role in this process if for no other reason than educators have more contact with youth than any other service sector. Of primary importance is the fact that the educational environment is ideally situated to focus upon the skill development aspects of intensive interventions.

It should be noted that intensive interventions do not necessarily need to follow failed attempts at universal and targeted interventions. The application of these interventions should be based upon individual need and the likelihood of effective intervention. In many cases, intensive resources have been withheld until concerns have spiraled out of control. Teams should have access to the full spectrum of services so the most appropriate service for the presenting concern can be applied.

Mental illness presents a particularly poignant example of the need to effectively match interventions to the concern. Youth involved in the juvenile justice system have a high probability of having a diagnosable mental illness. Some estimates are as high as 80% of the juvenile justice population. Similarly, mental health concerns are often evidenced in the school setting, but the youth may not receive treatment for their disorders. It is also well established that the longer a mental disorder goes untreated, the more difficult it is to be successfully treated. School personnel report that students frequently have with issues related to mental illness. Education professionals also report they feel inadequately trained and resourced to effectively manage the mental health problems they face.

Untreated mental illness has been identified as a leading contributing factor in social and behavioral difficulties for youth. The intensive tools listed here focus on addressing all aspects of the individual, especially mental health. The importance of skill development is not diminished at the intensive level of service. Rather, academic and social/behavioral skill acquisition remains the cornerstone of these interventions. The intensive level seeks to redouble efforts to understand the particular strengths and needs of the individual. In many cases this involves careful assessment of mental and physical health factors. Barriers to accessing effective health and mental health services are targeted. The students are supported in their efforts to access the needed services.

The system of services is held accountable for assuring that needed services are accessible and effective.

Educators who make themselves aware of the needs of troubled and troubling youth will find a host of information and supports that will assist them in creating effective and efficient interventions. Youth can and do benefit substantially from the many intensive interventions available in which educators play a critical role.

# ***TOOLS FOR PROMOTING EDUCATIONAL SUCCESS AND REDUCING DELINQUENCY***

~ ~ ~ ~ ~

## **Step 4. Intensive Interventions**

### **The Behavior Objective Sequence (BOS) (a promising practice)**

#### **BRIEF OVERVIEW**

*The Behavior Objective Sequence (BOS)* is a tool that provides a process for developing, implementing, and evaluating intervention plans. A special feature of the *BOS* is that the tool is both developmentally sequenced and strength-based. The *BOS* process incorporates skill assessment, program planning, monitoring, and cross provider planning into a single instrument. The *BOS*:

- yields information that can actually be used for individualized intervention planning;
- provides a positive view of the youth by specifying strengths; and
- defines pro-social behaviors not yet mastered that require instruction.

The *BOS* consists of 233 developmentally sequenced social competencies that are assessed through structured observation, by ratings in multiple settings, or both. The *BOS* provides goals and objectives that are easily communicated to all members of the planning team. This allows all team members to contribute to the development and implementation of interventions derived directly from assessment of current performance.

The *BOS* has three major components:

***Assessment Tool.*** A 233-item inventory arranged into six sub-scales. The *BOS* has been used with pre-school through adult learners.

***Program Planning Process.*** Consists of a set of forms from which the team can choose those most appropriate for the individual student. The forms provide for interagency planning.

***Data Collection Forms.*** Forms are included that allow customized intervention plans to be evaluated on an ongoing or interval basis.

#### **IMPLEMENTATION ESSENTIALS**

The *BOS* is founded on the following principles:

- There is a developmental process that supports social and behavioral skill development.
- Accurate assessment is needed in order to develop effective intervention programs.

- Assessment is the foundation for determining individually relevant intervention goals and objectives as well as for monitoring intervention outcomes.
- A strengths-based approach is consistent with effective practice.

As with the philosophy underlying Positive Behavioral Supports ([www.pbis.org](http://www.pbis.org)), use of this tool is predicated on the principle that youth need to be specifically taught the very skills that will enable them to be successful in school and in the community. Youth that come in contact with the juvenile justice system often have skill development that is uneven. This can be especially true regarding the prerequisite skills necessary to effectively engage in academic and social interventions. It is often these skill deficits that prevent youth from benefiting from a given intervention.

Staff implementing the BOS must have specific training in the use of the tools, forms and planning process. This training is available through the author.

There are a number of instruments that assess emotional and behavioral status. Examples of such instruments include:

- Epstein's Behavioral and Emotional Rating Scale (BERS) (1998), <http://www.nasponline.org/publications/cq287Test.html>;
- the Walker-McConnell Scales of Social Competence & School Adjustment (1995), <http://www.cfchildren.org.uk/ukcfc/eduf/assessf/pdfs/assessmentfaq.pdf>; and
- the Social Skills Rating Scale (SSRS) by Gresham and Elliot, <http://ags.pearsonassessments.com/group.asp?nGroupInfID=a3400>.

What sets the *BOS* apart from these tools is that the *BOS* process incorporates skill assessment, program planning, monitoring and cross-provider planning into a single instrument.

The author and the publisher have available manuals and research articles online at <http://www.researchpress.com/product/item/5015/> and <http://www.behavioralinstitute.org/>

## PROGRAM EVALUATION AND AVAILABLE EVIDENCE

Reliability and validity of the *BOS* have been recently reported.

- Wilder, L.K., Braaten, S., Wilhite, K., & Algozzine, B. (2005). *Concurrent Validity of the Strength-Based Behavioral Objective Sequence*. *Journal of Applied School Psychology*, 22 (1), 125-139. <http://www.haworthpress.com/store/ArticleAbstract.asp?sid=0W2RLB5EWJX78NMAW3QJ9LR86RHL2D2C&ID=64140>

## RESOURCES

- **Training and Technical Assistance.** In-service training, consultation, and workshops can be provided for a school, facility, or organization. Contact information for available dates:

## **Behavioral Institute for Children and Adolescents**

3585 Lexington Ave. N., Suite 163

St. Paul, Minnesota 55126

<http://www.behavioralinstitute.org/>

Phone: 651-484-5510

Fax: 651-483-3879

E-mail: [info@behavioralinstitute.org](mailto:info@behavioralinstitute.org)

- *Behavior Objective Sequence Assessment Manual*. Research Press (IL) (1998). <http://www.researchpress.com/product/item/5015/>. \$39.95 U.S. Available also on CD for \$150.00.

## **BACKGROUND READING**

### **Websites**

- Behavioral Institute for Children and Adolescents. <http://www.behavioralinstitute.org/>
- Council for Children with Behavioral Disorders. <http://www.ccbd.org/>
- NICHCY Connections... to Behavior Assessment, Plans, and Positive Supports. <http://www.nichcy.org/resources/behavassess.asp>

### **Reports and articles**

- Braaten, S. (1998). *Behavioral Objective Sequence*. Champaign, IL: Research Press.
- Fennerty, D., Lambert, C., & Majsterek, D. (n.d.). Behavior Rating Scales: An Analysis. Central Washington University. [http://eric.ed.gov/ERICWebPortal/Home.portal?\\_nfpb=true&\\_pageLabel=RecordDetails&ERICExtSearch\\_SearchValue\\_0=ED442042&ERICExtSearch\\_SearchType\\_0=eric\\_accno&objectid=0900000b80092ac4](http://eric.ed.gov/ERICWebPortal/Home.portal?_nfpb=true&_pageLabel=RecordDetails&ERICExtSearch_SearchValue_0=ED442042&ERICExtSearch_SearchType_0=eric_accno&objectid=0900000b80092ac4)

# ***TOOLS FOR PROMOTING EDUCATIONAL SUCCESS AND REDUCING DELINQUENCY***

~ ~ ~ ~ ~

## **Step 4. Intensive Interventions**

### **IDEA Partnership Seed Grant in New Hampshire (an emerging practice)**

#### **BRIEF OVERVIEW**

***IDEA Partnership Communities of Practice/Seed Grant.*** The IDEA Partnership ([www.ideapartnership.org](http://www.ideapartnership.org)) at the National Association of State Directors of Special Education (NASDSE) is a project funded through the Research-to-Practice Division of the U.S. Department of Education Office of Special Education Programs (OSEP), (<http://www.ed.gov/about/offices/list/osers/osep/index.html>) and is part of OSEP's National Technical Assistance and Dissemination Network. The IDEA Partnership reflects the collaborative work of more than 55 national organizations, as well as technical assistance providers, and state and local organizations and agencies. The Partnership has developed a new way of involving special educator stakeholders in Communities of Practice (CoP) to affect change at the state and local level to improve outcome for students with disabilities. The partnership has developed a CoP on school-based mental health and provided seed grants to a small number of states for their work.

Building on a seed grant from the IDEA Partnership, New Hampshire (NH) is working to improve the involvement of regional, community mental-health centers in school programs to ensure that youth and their families have access to effective mental health services and supports through structured collaborative processes including positive behavior interventions and supports (PBIS). Seed grant activities are aligned with other mental health and school initiatives that support integrated children's services.

The IDEA Partnership maintains two websites ([www.ideapartnership.org](http://www.ideapartnership.org) and [www.sharedwork.org](http://www.sharedwork.org)) that provide a wealth of information for community collaboration. The Partnership website also serves to connect individuals across the country who are working on similar initiatives.

#### **The goals for the seed grant work in New Hampshire are to:**

- develop an understanding of fiscal strategies necessary to establish and support collaborative work, not limited to direct mental health services to students;

- develop a model process and system that will assist schools in accurate identification of students and their families who would be eligible and who would benefit from available resources;
- increase knowledge of community resources and develop processes for service referral and access; and
- increase community mental health center involvement in planning and program development activities related to school-based mental health services.

## **IMPLEMENTATION ESSENTIALS**

### ***NH Hospital Discharge Protocol Manual***

In collaboration with NH's System of Care Grant (SAMHSA 1999), a partnership of family representatives, community mental health center and school personnel, and state agency representatives from children's mental health, child protection, juvenile justice and education developed the NH Hospital (NHH) Discharge Protocol Manual for use when children receive in-patient services at the Anna Philbrook School or the F-Unit of NH Hospital, NH's psychiatric hospital program for children and young adults.

The manual reflects a process that supports children and youth, their families, natural supports and community partners in the management of the admission and discharge processes. Central to the Manual's procedures are principles of family-driven, child/youth-centered, community-based care.

Goals for the Discharge Protocol Manual are:

- to improve the quality of the admission and transition process from hospital to community; and to ensure access to needed community services;
- to reduce the length of time that children with non-acute care needs spend in the hospital; and
- to improve the communication regarding diagnostic, clinical, educational, psychosocial, and behavioral assessments that are completed while a child is in the hospital.

Partners in the 1999-2005 System of Care Grant, CARE NH include:

- Department of Education (DOE);
- Division for Children Youth and Families (DCYF);
- Division for Juvenile Justice Services (DJJS);
- Bureau of Behavioral Health (BBH);
- Genesis Behavioral Health, Community Mental Health Center (CMHC) – Laconia;
- Granite State Federation of Families for Children's Mental Health (GSFFCMH);
- Mental Health Center of Greater Manchester (MHCGM);
- Moultonborough School District;
- National Alliance for the Mentally Ill – New Hampshire (NAMI NH);
- New Hampshire Hospital (NHH) - Anna Philbrook Center (APC) and F Unit; and
- South Eastern Regional Education Service Center (SERESC).

Training in the NHH Discharge Protocol has been rolled-out to state systems personnel at NH Hospital, DCYF, and DJJS. School district pilot training began in fall 2006.

### ***Integration of Schools and Mental Health Systems Grant***

NH has just received a grant from the U.S. Department of Education, Office for Safe and Drug-Free Schools. The overall goal of the project, *Mental Health and Schools Together-New Hampshire (MAST-NH)*, is to build the capacity of eight communities in five geographic regions of NH to provide children and their families with access to a full continuum of effective, culturally competent and linguistically appropriate mental health care. This goal will be achieved by creating a statewide training, technical assistance and dissemination network that strategically links school personnel involved in the positive behavioral interventions and supports-NH (PBIS-NH) systems-change initiative with qualified mental health, juvenile justice and community partners involved in NH's mental health care systems. Linkages will be promoted through professional development activities and collaborative interagency partnerships.

A key feature of MAST-NH will be training and technical assistance in the application of wraparound as a strengths-based, family-driven, child-centered planning process that engages family members (including the child and youth), their natural supports and service providers. Lessons learned from successful wraparound planning teams throughout the state, will inform the development of a data-driven model that can be tailored by each wraparound team to best address the planning process, and implemented with fidelity.

### **PROGRAM EVALUATION**

Program evaluation is an ongoing component of the process. Implementation of this aspect of the coordinated system of care and the Discharge Protocol is being implemented currently. Each of the funding sources will require evaluation. <http://nhcebis.seresc.net/>

### **AVAILABLE EVIDENCE**

Various aspects of this project have a growing evidence base. For example, the New Hampshire Center for Effective Behavioral Interventions and Supports (ND BEIS) has data on the impact of their PBIS initiative. All grant components have an evaluation component and as this project matures this data will be available.

### **RESOURCES**

#### **Contracts for more information:**

Virginia Irwin, Director  
Division of Instruction  
NH Department of Education  
[virwin@ed.state.nh.us](mailto:virwin@ed.state.nh.us)

Eric Mann, Co-Director  
NH Center for Effective PBIS  
[emann@seresc.net](mailto:emann@seresc.net)

## IDEA Partnership

- IDEA Partnership. <http://www.ideapartnership.org>
- IDEA Partnership's Shared Work website. <http://www.sharedwork.org/>

## New Hampshire (NH) Seed Grant.

- Grabill, D., et al. (9-28-2006). *Interagency Partnerships Can Improve Outcomes for Youth: Strategies and Challenges in Aligning Agencies Priorities and Initiatives*. Power Point presentation available at:  
<http://www.tapartnership.org/advisors/education/presentations/NH%20Presentation%20Ball.06.ppt>
- NH Hospital Discharge Protocol Manual. Available from: NH Health and Human Services, 115 Pleasant Street. Concord, NH 03301.
- NH MH-Schools Seed Grant website.  
<http://www.sharedwork.org/section.cfm?ms=4&ms2=0&as=54>
- NH Seed Grant For Mental Health And Schools.  
[Http://sharedwork.org/documents/nhmhschoolsseedgrantoverview.doc](http://sharedwork.org/documents/nhmhschoolsseedgrantoverview.doc)
- New Hampshire Center for Effective Behavioral Interventions and Supports (ND-CEBIS).  
<http://nhcebis.seresc.net/>
- Positive Behavioral Interventions and Supports-NH (PBIS-NH). <http://nhcebis.seresc.net/>

## BACKGROUND READING

### Websites

- Center for Evidence-Based Practice: Young Children with Challenging Behavior.  
<http://www.challengingbehavior.org>
- Center on the Social and Emotional Foundations for Early Learning.  
<http://www.csefel.uiuc.edu>
- Communities of Practice/Etienne Wenger's website. <http://www.ewenger.com/>
- **Positive Behavioral Interventions and Supports (PBIS)**.  
<http://www.pbis.org/main.htm>
- **School-Wide Information System (SWIS)** website. [www.swis.org](http://www.swis.org)
- **Systems of Care** information is available at:  
<http://mentalhealth.samhsa.gov/cmhs/ChildrensCampaign/grantcomm.asp>
- **Wraparound Services** information is available at:  
[http://www.reclaimingfutures.org/solution\\_ws.asp](http://www.reclaimingfutures.org/solution_ws.asp)

### Articles & reports

- Bazelon Center for Mental Health Law. (May 2006). *Way to Go: School Success for Children with Mental Health Care Needs*. Washington, DC. Available at:  
<http://www.bazelon.org/newsroom/2006/6-7-6-WayToGo.html>.
- Center on Positive Behavioral Interventions and Supports. (2004). *School-wide Positive Behavior Support: Implementers' Blueprint and Self-Assessment*. University of Oregon.  
<http://www.pbis.org/files/Blueprint%20draft%20v3%2009-13-04.doc>

# ***TOOLS FOR PROMOTING EDUCATIONAL SUCCESS AND REDUCING DELINQUENCY***

~ ~ ~ ~ ~

## **Step 4. Intensive Interventions**

### **Developmental Therapy Objectives Rating Scale (a promising practice)**

*Developmental teaching* is an approach for fostering social-emotional competence and responsible behavior in children and youth who display behavioral challenges. It matches a child's current social, emotional, behavioral, and cognitive abilities with specific goals, objectives, behavior management strategies, curriculum materials, activities and evaluation procedures.

#### **BRIEF OVERVIEW**

Until the early 20<sup>th</sup> century, little attention was given to the unique needs of children. However, with a general recognition that children's development occurs gradually over many years, educators and psychologists began to look for recurrent sequential patterns in child social, emotional, and cognitive development, and acquisition of related learned skills. Beginning in the late 1960's, Mary Margaret Wood and her colleagues at the Rutland Center in Athens, GA and the University of Georgia developed a hierarchically arranged sequence of skills that reflected this interaction of child development and learning. This sequence provided a basis for both assessment of child-skill level and an appropriate structuring of curriculum objectives to facilitate further growth.

The ***Developmental Therapy Objectives Rating Scale (DTORF)*** and related interventions was first described comprehensively in *Developmental Therapy: A Textbook for Teachers as Therapists for Emotionally Disturbed Young Children*, edited by Wood (Baltimore: University Park Press, 1975). The current printed resource is the 3<sup>rd</sup> edition, *Developmental Therapy-Developmental Teaching: Fostering Social-Emotional Competence in Troubled Children and Youth*, M.Wood, R. Davis, L. Swindle, and Quirk (Austin, TX: 1996).

As indicated by the title of the first edition, the initial focus was on younger children, especially those with special needs. Later work has broadened the developmental age span covered. The skills assessed are broader than those targeted in behavioral interventions, many better described as "skill clusters." The record keeping is based a daily rating rather than counts of specific behaviors.

The four basic tenets on which this intervention is based (as noted at [www.dtorf.com](http://www.dtorf.com)) are:

- Development is orderly and predictable while uniquely individual.

- A strength-based view of behavior fosters self-esteem and encourages behaviors that are healthy and typical of age peers.
- Constructive changes occur when acceptable behavior and relationships bring personally satisfying results.
- Learning results from events that have emotional and cultural meaning. It then spreads to all areas of a young person's life.

The *DTORF* is used by teachers, special education directors, and others. The *DTORF* online version ([www.dtorf.com](http://www.dtorf.com)) is a functional behavior assessment (FBA) system for evaluating the social, emotional, behavioral and cognitive competence of students. It helps in planning classroom instruction by instantly creating Behavior Intervention Plans (BIPs) and appropriate objectives for Individualized Education Programs (IEPs).

The goal of the curriculum based on the *DTORF* is to promote healthy emotional development. Activities and materials have been developed for this purpose. The books describing developmental therapy/teaching include methods for decoding behavior and positive behavior management.

## IMPLEMENTATION ESSENTIALS

The *DTORF* and its related curricular guides provide the basis for a comprehensive program for children beginning at very low levels of skill mastery.

While the use of the *DTORF* as a rating scale can be mastered fairly quickly, its application in structuring a curriculum and evaluating student progress requires intensive staff training and on-going supervision. Training is available from the Developmental Therapy-Teaching Program at the University of Georgia, [www.uga.edu/dttp](http://www.uga.edu/dttp).

Fully applied, this intervention requires a relatively high teacher-to-student ratio. Time must be provided for monitoring of progress and record keeping as well as lesson planning.

## PROGRAM EVALUATION AND AVAILABLE EVIDENCE

Developmental Teaching is nationally recognized as an effective program for troubled children by the U.S. Department of Education and the American Psychiatric Association. Schools and school districts can improve the services they provide to students without additional resources.

The *DTORF* has been recognized as an effective program.

- American Psychiatric Association. (1993). Significant achievement awards: Clinical and special education services for severely disturbed children – Developmental Therapy Program. Rutland Psychoeducational Services, Athens, GA. *Hospital and Community Psychiatry*, 44, 995-996.
- Davis, K.R. (1996). Developmental Therapy Model. In *Educational Programs that Work: The Catalogue of the National Diffusion Network* (22<sup>nd</sup> ed.), p. 12.11. Longmont, CO: Sopris West.

- Kaufman, A.S., Paget, K., and Wood, M.M. (1981). Effectiveness of Developmental Therapy for severely emotionally disturbed children. In F.H. Wood (Ed.). *Perspectives for a new decade*. 176-188. Reston, VA: The Council for Exceptional Children.
- Wood, M.M., Davis, K.R. and Swindle, F. L. (1998). *Documenting effectiveness*. Developmental Therapy Institute, Athens, GA.

## RESOURCES

- Contact for additional information and staff training.

Developmental Therapy Teaching Programs  
University of Georgia  
website: [www.uga.edu/dttp](http://www.uga.edu/dttp)

- Commercially available information can be found on the DTORF website. [www.dtorf.com](http://www.dtorf.com)
- The DTORF form is available from LetterPress Software. [www.lpsoftware.com](http://www.lpsoftware.com)
- *The Developmental Teaching Objectives ...and Rating Forms-Revised*. (4th Edition). <http://www.uga.edu/dttp/resources/software/evalkit.html>
- *Developmental Therapy-Developmental Teaching: Fostering Social-Emotional Competence in Troubled Children and Youth* (3<sup>rd</sup> edition, 1996) by Mary Margaret Wood with Karen R. Davis, Faye L. Swindle, and Constance Quirk is available from Pro-Ed Publishers. [www.proedinc.com](http://www.proedinc.com)

## BACKGROUND READING

- Wood, M. M., Brendtro, L., Fecser, F. A., & Nichols, P. (1999). *Psychoeducation: An Idea Whose Time has Come*. Reston, VA: The Council for Children with Behavior Disorders. [http://eric.ed.gov/ERICWebPortal/Home.portal?nfpb=true&pageLabel=RecordDetails&ERICExtSearch\\_SearchValue\\_0=ED435157&ERICExtSearch\\_SearchType\\_0=eric\\_accno&objectid=0900000b8008f43d](http://eric.ed.gov/ERICWebPortal/Home.portal?nfpb=true&pageLabel=RecordDetails&ERICExtSearch_SearchValue_0=ED435157&ERICExtSearch_SearchType_0=eric_accno&objectid=0900000b8008f43d)
- Wood, M. M., Davis, K. R., Swindle, F. L. & Quirk, C. (1996, 3<sup>rd</sup> Edition). *Developmental Therapy-Developmental Teaching: Fostering Social-Emotional Competence in Troubled Children and Youth*. Early Childhood Research Institute, University of Illinois- Urbana-Champaign. <http://clas.uiuc.edu/fulltext/cl02050/cl02050.html>
- Wood, M.M., Davis, K. R., & Swindle, F.L. (1998). *Developmental Therapy-Teaching Programs: Documenting Effectiveness*. Early Childhood Research Institute, University of Illinois- Urbana-Champaign. <http://clas.uiuc.edu/fulltext/cl02531/cl02531.html>

# ***TOOLS FOR PROMOTING EDUCATIONAL SUCCESS AND REDUCING DELINQUENCY***

~ ~ ~ ~ ~

## **Step 4. Intensive Interventions**

### **Life Space Crisis Intervention (LSCI) (a promising practice)**

#### **BRIEF OVERVIEW**

***Life Space Crisis Intervention (LSCI)*** was developed by Fritz Redl (1959) and others as a counseling intervention for use by teachers, child care workers, and other mental health professionals with children and youth in emotional/behavioral crisis. The goal of *LSCI* is to enable the interviewer to assess: the perspective of acting-out students on their behavior as it relates to themselves and others in the immediate setting ("life space"); the intensity of emotional arousal accompanying the behavior; and student capacity for identifying alternative behaviors that are more acceptable to others and willingness to behave in one of these alternative ways.

The principle stages of a *LSCI* interview are to:

- drain off the student's intense emotions by acknowledging feelings;
- discover the student's point of view by using affirming and listening skills;
- identify the student's vital interest and select an appropriate LSCI intervention strategy;
- use interviewing skills to help the student recognize and change self-defeating behavior patterns;
- teach the new skills needed for behavior change; and
- prepare the student to reenter the on-going activity and setting.

*LSCI* is a therapeutic strategy for using a crisis situation as an opportunity to help students learn alternatives to aggressive, disrespectful, and other out-of-control behavior. Teachers, administrators, and others who deal with youth in conflict situations can use *LSCI*. It applies a blend of psycho-dynamic, cognitive, behavioral, and pro-social methods as a teaching intervention for youth displaying challenging behavior.

Stages one and two are worthy of special comment. Teachers and other authority figures are responsible for assessing problem situations and responding quickly. Some often assume they can comprehend the "why" of such situations as quickly as the "what" and the "when." Teachers trained in LSCI understand the importance of listening to student explanations of the "why" from student perspectives before intervention, whenever circumstances permit. Listening first may avoid unnecessary escalation of the crisis and lead to a more desirable outcome.

## IMPLEMENTATION ESSENTIALS

*LSCI* can be used as the central component of an intervention program or together with other interventions. Implementation requires staff training and resources.

- Staff need to be trained in using the procedure and have supervised practice in the choice of incidents for application of the intervention. A certified training program is available.
- Resources for on-going program support are needed.
- Flexible staffing with backup is needed if *LSCI* is applied at the time of a behavior crisis, which is recommended.
- Supervision by trained mental health personnel is desirable to ensure appropriate use and provide teacher support.

## PROGRAM EVALUATION

Two multiple baseline-across-subjects designs were employed to evaluate the effects of LSCI on two female and two male participants separately. Data were collected in the classroom over a three-month period. The dependent measure was discrete events of challenging behavior that was operationalized individually for each student. There was a radical decrease in challenging behavior for each participant after implementation of the LSCI. [Abstracted from: Grskovic, J. A. and Goetze, H. 2005. An Evaluation of the Effects of Life Space Crisis Intervention on the Challenging Behavior of Individual Students. *Reclaiming Children and Youth*, 13:4, 231-235.]

Naslund, S. R. 1987. Life space interviewing: A psychoeducational interviewing model for teaching pupils insight and measuring program effectiveness. *The Pointer*, 32:2, 12-15.

## AVAILABLE EVIDENCE

LSCI was evaluated by research using a quasi-experimental design with two matched school populations. Staff in one school received the LSCI model of crisis training, while staff in a second school received support in developing their own strategies for managing crisis. There were significant reductions in the number of student crises, and there were fewer suspensions. [Abstracted from: Dawson, C. A. 2003. A Study on the Effectiveness of Life Space Crisis Intervention for Students Identified with Emotional Disturbances. *Reclaiming Children and Youth*, 11:4, 223-250.]

Another study explored the effects of the Life Space Interview on academic and social behavior of eight residentially placed adolescent behaviorally disordered students. Baseline data was collected for each subject's target behavior as well as academic performance in reading and mathematics. The results of this study supported the value of the LSCI with these behaviorally disordered adolescents. (Abstracted from: DeMagistris, R. J. and Imber, S. C. 1980. The Effects of Life Space Interviewing on Academic and Social Performance of Behaviorally Disordered Children. *Behavioral Disorders*, 6:1, 12-25, <http://www.lsci.org/lscistudy.pdf>)

Long, N. J. (1990). Comments on Ralph Gardner's article: "Life Space Interviewing: It can be effective but don't...". *Behavioral Disorders*, 15, 119-125.

Wood, M., & Long, N. J. (1991). *Life Space Intervention. Talking with Students in Crisis*. Austin: Pro-Ed Publishers.

## RESOURCES

- Contact for information about training leading to certification in *LSCI*:

**Frank A. Fecser, Ph.D.**

Life Space Crisis Intervention Institute  
Positive Education Program  
3100 Euclid Avenue  
Cleveland, Ohio 44115  
Phone: 216-361-7760 ext. 123  
E-mail: [Fecser@pepcleve.org](mailto:Fecser@pepcleve.org)

- An overview of *LSCI* by its creators, Frank A. Fecser and Nicholas J. Long is available on the Center for Effective Collaboration and Practice (CECP) website.  
<http://cecp.air.org/interact/authoronline/april98/1.htm>
- A synopsis of *Life Space Crisis Intervention* is available on the UMFS website.  
<http://www.umfs.org/pdf/LSCI.pdf>
- Life Space Crisis Intervention Institute. [www.lsci.org](http://www.lsci.org)
- *Life Space Crisis Intervention*, from *Psychoeducational Strategies*. Pro-Ed Publishers. [http://www.psychoed.net/PSYCHOEDNET/Page\\_18.html](http://www.psychoed.net/PSYCHOEDNET/Page_18.html)
- Long, N.J., Wood, M. M., & Fecser, F. A. (2001, 2<sup>nd</sup> ed.), *Life Space Crisis Intervention: Talking with Students in Conflict* (2001, 2<sup>nd</sup> edition). Pro-Ed Publishers. [www.proedinc.com](http://www.proedinc.com)
- Redl, F. (1959). Strategy and techniques of the life space interview. *American Journal of Orthopsychiatry*, 29, 721-736.

## BACKGROUND READING

- **Psychoed.net**. (A website designed for educators and others, provides information about psychoeducational strategies and approaches for helping children and youth with learning, emotional & behavior problems.) <http://www.psychoed.net/>

# ***TOOLS FOR PROMOTING EDUCATIONAL SUCCESS AND REDUCING DELINQUENCY***

~ ~ ~ ~ ~

## **Step 4. Intensive Interventions**

### **Multisystemic Therapy (MST) (a best practice)**

#### **BRIEF OVERVIEW**

*Multisystemic Therapy (MST)* is primarily a home-based approach to treatment by developing and strengthening the natural support systems of the family. The focus is on removing barriers that keep youth and families from accessing needed services. This approach seeks to empower the family by developing skills that serve to support the effective implementation of therapeutic interventions.

*MST* has been specifically applied in populations of youth who are serious or chronic offenders. It has been proven effective with males and females, multiple ethnic groups, and urban, suburban and rural populations. *MST* is based on the belief that serious antisocial behavior results from the interplay of the individual, family, peer group, school, and community. This approach addresses the fact that individually applied therapies for this group of youth were minimally effective as well as expensive.

Antisocial behavior stems from multiple sources; therefore interventions need to address many aspects of a youth's life. In particular, the *MST* process seeks to develop skills for youth to more effectively engage in school and vocational endeavors. Schools play an important part in the *MST* process.

#### **IMPLEMENTATION ESSENTIALS**

With regarding to schools, *MST* requires the development of a system of supports that encourage positive relationships with peers and school staff. Schools are required to develop consistent discipline practices, and to teach and reinforce the expected behaviors to students. Comprehensive assessment of academic and behavior skills supports the development of appropriate academic and behavioral intervention plans. Without accurate assessment and evaluation data, school personnel run the risk of frustrating the learner. Appropriately challenging expectations encourage positive engagement of the youth.

School personnel can use *MST* to link with families in proactive ways. The process also provides support for connecting community resources with school efforts. It is proven that schools can be effective partners in developing protective factors in this population. Many of the protective factors that youth need to function effectively are developed in a school context. *MST*

compliments school efforts in both academic and behavior intervention planning. *MST* also takes into account the mental health needs of youth and makes these resources available to the school team.

## PROGRAM EVALUATION

*MST* has been recognized as:

- an “exemplary” program in OJJDP’s *Model Programs Guide* (May 2003), U.S. Department of Justice. <http://www.dsgonline.com/mpg2.5/search.htm>
- [http://www.dsgonline.com/mpg2.5/TitleV\\_MPG\\_Table\\_Ind\\_Rec.asp?id=363](http://www.dsgonline.com/mpg2.5/TitleV_MPG_Table_Ind_Rec.asp?id=363)
- a “model” program by *SAMHSA Model Programs: Effective Substance Abuse and Mental Health Programs for Every Community* (2002), Center for Substance Abuse Prevention. [http://www.modelprograms.samhsa.gov/template\\_cf.cfm?page=model&pkProgramID=21](http://www.modelprograms.samhsa.gov/template_cf.cfm?page=model&pkProgramID=21)
- a “model” program in *Blueprints For Violence Prevention*, (2000). Center for the Study and Prevention of Violence (CSVP). Boulder, CO: Institute of Behavioral Science. <http://www.colorado.edu/cspv/blueprints/model/programs/MST.html>

## AVAILABLE EVIDENCE

*MST* has a history of formal studies spanning more than 20 years. Numerous evaluations of *MST* consistently support the achievement of positive outcomes while maintaining cost effectiveness. There is strong evidence to support the effectiveness of *MST* in reducing criminal activity and institutionalization while developing pro-social and academic skills. The Office of Juvenile Justice and Delinquency Prevention (OJJDP) includes extensive research citations that support the effectiveness of *MST*.

This program was part of a cost-benefit analysis completed by the Washington State Institute for Public Policy on several violence prevention and reduction programs, including six Blueprints programs, *Watching the Bottom Line: Cost-Effective Interventions for Reducing Crime in Washington*.

## RESOURCES

- **Contact for more information:**

**Marshall E. Swenson**  
**Manager of Program Development, MST Services**  
**701 J. Dodds Blvd., Suite 200**  
**Mt. Pleasant, SC 29464**  
**Phone: 843-856-8226**  
**E-mail: [marshall.swenson@mstservices.com](mailto:marshall.swenson@mstservices.com)**

- ***MST Services***, an affiliate of the Medical University of South Carolina and the Family Services Research Center, supports those interested in implementing *MST*. The *MST* website contains background material, research and information regarding licensing. <http://www.mstservices.com/>

- **MST Fact Sheets**
  - Multisystemic Therapy: An Overview. (1998).  
[http://www.mstservices.com/text/mst\\_overview.pdf](http://www.mstservices.com/text/mst_overview.pdf)
  - The Principles Underlying Multisystemic Therapy.  
[http://www.mstservices.com/text/mst\\_principles.pdf](http://www.mstservices.com/text/mst_principles.pdf)
  - Multisystemic Therapy: How is it Done?  
[http://www.mstservices.com/text/mst\\_how\\_done.pdf](http://www.mstservices.com/text/mst_how_done.pdf)
  - The Effective Use of Multisystemic Therapy.  
[http://www.mstservices.com/text/mst\\_effective\\_use.pdf](http://www.mstservices.com/text/mst_effective_use.pdf)
  - Multisystemic Therapy: Clinical Outcomes and Cost Savings.  
[http://www.mstservices.com/text/mst\\_clinical\\_outcomes.pdf](http://www.mstservices.com/text/mst_clinical_outcomes.pdf)
  - Multisystemic Therapy: A Comparison with Other Treatment Approaches.  
[http://www.mstservices.com/text/mst\\_comparison.pdf](http://www.mstservices.com/text/mst_comparison.pdf)

## **BACKGROUND READING**

- Aos, S., Barnoski, R., & Lieb, R. (January 1998). *Watching the Bottom Line: Cost-Effective Interventions for Reducing Crime in Washington*. Olympia, WA: Washington State Institute for Public Policy. <http://www.wsipp.wa.gov/pub.asp?docid=98-01-1201>
- Blueprints Model Program FACT SHEET. (2006). *Multisystemic Therapy*. Center for the Study and Prevention of Violence.  
<http://www.colorado.edu/cspv/publications/factsheets/blueprints/pdf/FS-BPM06.pdf>

# ***TOOLS FOR PROMOTING EDUCATIONAL SUCCESS AND REDUCING DELINQUENCY***

~ ~ ~ ~ ~

## **Step 4. Intensive Interventions**

### **Systems of Care (a promising practice)**

#### **BRIEF OVERVIEW**

*Systems of Care (SOC)* is a philosophy and approach that is based on a set of values and principles to develop and implement efficient and effective services and supports for children and youth with complex mental health needs and their families. This approach places the youth and family at the center of the decision-making process as well as being major partners in the planning and policy development for the system itself. A SOC approach supports the creation of formal networks and linkages among the various public child-serving agencies and private community service providers.

*SOC* is a framework for interagency service delivery that recognizes the importance of family, school and community, and seeks to promote the full potential of all children and youth by addressing their physical, emotional, intellectual, cultural and social needs. *SOC* evolved over the last 20 years from the consensus of many individuals working with children and families in the field as well as well-documented studies that carefully examined both successful and unsuccessful service delivery models. The process focused particular attention upon children and youth with complex and multiple mental health needs and the many public agencies and service providers working with these families.

#### **Key Components of Systems of Care**

The *SOC* approach requires the adoption of a set of beliefs or values. These values then drive the development and implementation of the services and supports that will be made available to the child/youth and family in the community. For many community service providers this approach will require a new way of thinking and of doing business. Often policy changes are needed at both the state and local levels in order to create a system that reflects the values required by the *SOC* approach.

There are three core values and ten core principles. The following are a summary of these values and principles.

- **Child-centered and family-focused.** The recognition that: (a) the context of the family is central to the care of all children; (b) families are important contributors to, and equal partners in, any effort to serve children; and (c) all system and service processes should be planned to maximize family involvement.

- **Individualized.** Provision of care that is expressly child centered, addresses child-specific needs and recognizes and incorporates child-specific strengths.
- **Culturally and linguistically competent.** Sensitivity and responsiveness to, and acknowledgment of, the inherent value of differences related to race, religion, language, national origin, gender, socioeconomic background, and community-specific characteristics.
- **Interagency.** The involvement and partnership of core agencies in multiple child-serving sectors, including child welfare, health, juvenile justice, education, and mental health.
- **Collaborative/coordinated.** Professionals working together in a complementary manner to avoid duplication of services, eliminate gaps in care, and facilitate child and family movement through the service system.
- **Accessible.** The minimizing of barriers to services in terms of physical location, convenience of scheduling, and financial constraints.
- **Community based.** The provision of services within close geographical proximity to the targeted community.
- **Least restrictive.** The provision of services in settings that maximize freedom of choice and movement, and that present opportunities to interact in the child's and family's regular environments (e.g., school and family).
- **Advocacy.** A system of care should advocate for the child and provide mechanisms to protect the rights of children and their families
- **Nondiscrimination.** A system of care should have a policy of nondiscrimination in the delivery of services and ensure that children and youth with needs have access to quality services and supports.

## IMPLEMENTATION ESSENTIALS

Building and implementing a SOC requires complex set of policies, processes, services, and supports depending on the community and the scope of the services included in that community's service array. In a SOC there typically are multiple partners from various organizations, agencies, and disciplines. System-building efforts can pose particular challenges as service providers often have their own language, set of customs, requirements for service provision, and timelines. This is further complicated where: communities have not yet started system-building efforts; families have difficulty accessing services, if available; or families are not fluent in the varying nomenclature of participating disciplines. Building a community-based system of care that operationalizes the values and principles takes many years. Four framework components have been identified that should guide the work: (1) program context; (2) guiding principles; (3) strategies; and (4) outcomes.

There exists an extensive network of resources including evaluation studies, implementation process reports, consultants, technical assistance and research centers to guide a community's

efforts in developing a SOC. Studies have shown that successful SOC initiatives have one consistent component – an individual or small group of highly motivated, competent proponents. Evaluations also indicate that the support of policy makers at the state and local level is critical.

The following are additional key components:

- effective outreach to consumers and families to assure input and participation;
- strict adherence to the guiding principles of SOC;
- engaging a community process that is open to multiple partners; and
- on-going evaluation of process and outcomes.

## PROGRAM EVALUATION

Evaluation studies of the SOC process can be found on the website of the Technical Assistance Partnership for Child and Family Mental Health. <http://www.tapartnership.org/>.

The Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services has an extensive website with background materials and research reports at: <http://systemsofcare.samhsa.gov/>.

## RESOURCES and BACKGROUND READING

- Contact for more information about Systems of Care approaches:

**Gary Blau**

Chief, Child, Adolescent and Family  
Branch, CMHS  
Phone: 240-276-1921  
E-mail: [gary.blau@samhsa.hhs.gov](mailto:gary.blau@samhsa.hhs.gov)

**Diane Sondheimer**

Deputy Chief, Child, Adolescent and Family  
Branch, CMHS  
Phone: 240-276-1922  
E-mail: [diane.sondheimer@samhsa.gov](mailto:diane.sondheimer@samhsa.gov)

- **Systems of Care website, SAMHSA.** <http://systemsofcare.samhsa.gov/>
- **Systems of Care Fact Sheet.**  
<http://systemsofcare.samhsa.gov/newinformation/docs/SOCfactsheet.doc>
- **National Technical Assistant Center for Children’s Mental Health** at the Center for Child and Human Development, Georgetown University, houses an extensive library of research publications on SOC. <http://gucchd.georgetown.edu/index.html>
- **Research & Training Center for Children’s Mental Health**, University of South Florida, offers empirical information on SOC. The Center also has an annual conference on SOC. <http://rtckids.fmhi.usf.edu/>
- The University of South Florida offers an online graduate certificate focused on SOC. [http://cfs.fmhi.usf.edu/cfsnews/cfsnews\\_pubs/GraduateCertificateflyer.pdf](http://cfs.fmhi.usf.edu/cfsnews/cfsnews_pubs/GraduateCertificateflyer.pdf)
- Hodges, S., Ferreira, K., Israel, N., & Mazza, J. (2006). *Strategies for System of Care Development: Making Change in Complex Systems. A framework for analysis of Case Studies of System Implementation: Holistic Approaches to Studying Community-Based Systems of Care.* Tamps, FL: University of Southern Florida (USF).  
[http://rtckids.fmhi.usf.edu/rtcpubs/Study2\\_StrategiesSOCDev.pdf](http://rtckids.fmhi.usf.edu/rtcpubs/Study2_StrategiesSOCDev.pdf)

# ***TOOLS FOR PROMOTING EDUCATIONAL SUCCESS AND REDUCING DELINQUENCY***

~ ~ ~ ~ ~

## **Step 4. Intensive Interventions**

### **THE Wraparound Process (a best practice)**

#### **BRIEF OVERVIEW**

*The Wraparound Process* is an intensive, individualized care management process for youths with serious or complex needs. Wraparound was initially developed in the 1980s as a means for maintaining youth with the most serious emotional and behavioral problems in their home and community. In recent years, however, it has been applied within child welfare, juvenile justice, and in schools as a way to improve school outcomes for students with serious emotional disturbance, as well as maintain them in regular school settings. Wraparound is increasingly being applied in school settings in conjunction with Positive Behavioral Supports (PBS), as a means of supporting students with the most serious and complex behavioral needs.

During the *wraparound process*, a team of individuals who are relevant to the well-being of the child or youth (e.g., family members, other natural supports, service providers, and agency representatives) collaboratively develop an individualized plan of care, implement this plan, and evaluate success over time. The wraparound plan typically includes formal services and interventions, together with community services and interpersonal support and assistance provided by friends, kin, and other people drawn from the family's social networks. The team convenes frequently to measure the plan's components against relevant indicators of success. Plan components and strategies are revised when outcomes are not being achieved.

The process of engaging the family, convening the team, developing the plan, implementing the plan, and transitioning the youth out of formal wraparound is typically facilitated by a trained care manager or "wraparound facilitator," sometimes with the assistance of a family support worker. The wraparound process, and the plan itself, is designed to be culturally competent, strengths based, and organized around family members' own perceptions of needs, goals, and likelihood of success of specific strategies.

Wraparound has been implemented nationally for over 20 years and presented as a promising practice in many publications. However, specification and consistent implementation of the model has occurred only in the past few years. As recently specified, wraparound is conceived of as a four-phase process:

- engagement and team preparation;
- initial plan development;

- plan implementation; and
- transition.

The full description of the activities that typically take place in each of these phases can be found in “Phases and Activities of the Wraparound Process,” a document available on the website of the National Wraparound Initiative at (NWI) [www.rtc.pdx.edu/nwi](http://www.rtc.pdx.edu/nwi).

## IMPLEMENTATION ESSENTIALS

Wraparound is intended to ensure that youth with complex needs (and multiple agency involvement) benefit from a coordinated care planning process that produces a single plan of care that cuts across all agencies and providers. Wraparound plans and wraparound teams require access to flexible resources and a well-developed array of services and supports in the community. As a result, wraparound implementation requires that the child-serving system is supportive of wraparound. Some of the key types of community and system supports include:

- **Community partnership.** Key stakeholder groups, including agencies, providers, and representatives of youths and families have joined together in a collaborative effort to plan and implement wraparound.
- **Collaborative action.** Stakeholders involved in the wraparound effort take concrete steps to translate the wraparound philosophy into concrete policies, practices and achievements.
- **Fiscal Policies.** The community has developed fiscal strategies to support the wraparound effort and to better meet the needs of children and youth participating in the wraparound effort.
- **Access to needed supports and services.** The community has developed mechanisms for ensuring access to the services and supports that wraparound teams need to fully implement their plans.
- **Human Resource Development and Support.** The system supports wraparound staff and partner agency staff to work in a manner that allows full implementation of the wraparound model.
- **Accountability.** The community has implemented mechanisms to monitor wraparound fidelity, service quality, and outcomes, and to oversee the quality and development of the overall wraparound effort.

In addition to system supports, the wraparound process requires skilled facilitators and family support partners who have the right working conditions to do their jobs. As a result, the lead agency responsible for implementing the wraparound process for families must support implementation in several key ways, including maintaining adequately low caseload sizes; ensuring that primary staff receive comprehensive training and skill development; supporting wraparound team efforts to get necessary members to attend meetings and participate collaboratively; and making timely decisions regarding funding for strategies developed by teams to meet families’ unique needs.

The wraparound process is not proprietary. The NWI website includes a description of the practice model, as well as many implementation resources compiled from trainers, technical assistance providers, and program sites nationally. The NWI website also includes a list of consultants and trainers that communities and organizations may wish to access. More comprehensive examples of how wraparound has been implemented in schools can be found at

the Illinois Positive Behavioral Supports network website, <http://www.pbisillinois.org>, and in Eber (2003). Information about implementation and fidelity measures for wraparound can be found at the Wraparound Evaluation and Research Team's website, <http://depts.washington.edu/wrapeval>.

## PROGRAM EVALUATION

The wraparound process has been implemented widely across the United States and internationally because of the documentation of its successful use in several communities, its alignment with the value base for systems of care, and its resonance with families and family advocates. However, the formal wraparound research base has been slow to develop for several reasons: (1) its status as a care management *process* rather than a specific treatment for a specific disorder; (2) its grassroots development rather than development by a single research team; and (3) its individualized nature, in that the identified needs and specific strategies for each family participating in wraparound should be unique.

At the same time, the research base on wraparound continues to expand and evolve.

- To date, positive results have been found from three published experimental studies, six published quasi-experimental studies, and numerous pre- and post-longitudinal studies.
- The wraparound process has been cited as a promising practice in the Surgeon General's reports on youth violence and mental health.
- Since the wraparound practice model has been more fully specified, four random assignment control studies have been begun in four different locations, all with a consistent practice model and training and coaching model. Fidelity measures aligned with the wraparound model described above are also now available and in use in all the above studies.

## AVAILABLE EVIDENCE

As noted above, the evidence base on wraparound is broad and until recently has not been generated on a consistent and specified model. A review of outcomes studies as of 2002 is provided in Burchard, Bruns, & Burchard (2002), and is currently being updated. Other reviews and information are available at the NWI website, [www.rtc.prdx.edu/nwi](http://www.rtc.prdx.edu/nwi).

## RESOURCES

- **Training and Technical Assistance.** Many communities and programs have been trained and coached by experts on the wraparound process to successfully implement the wraparound process. Typical curricula include initial four-day training sessions for staff (e.g., facilitators and parent partners) followed by shadowing of experienced staff, and in-vivo coaching. Supervisors also receive a series of human resource development activities so they can collect data about staff performance and support staff over the long term via intensive group and individual supervision, as well as ongoing coaching.

- **Resources for understanding Wraparound.** <http://www.neglected-delinquent.org/nd/resources/articles/articlessummary20060119a.asp>
  - *The Parent's Guide to Wraparound*
  - *Wraparound Planning*
  - *National Wraparound Initiative*
  - *The San Diego Wraparound Training Academy*
  - *The Gun Court Initiative*
  - *Wraparound Milwaukee*
  - *History of Wraparound and Systems of Care*
- National Wraparound Initiative. [www.rtc.prdx.edu/nwi](http://www.rtc.prdx.edu/nwi)
- Video and manual on wraparound: Eber, L. (2003). *The Art and Science of Wraparound*. Bloomington, IN: Forum on Education at Indiana University. [http://www.forumoneducation.org/wraparound\\_video.html](http://www.forumoneducation.org/wraparound_video.html)
- Wraparound Planning mini-website. Center for Effective Collaboration and Practice, American Institutes for Research. <http://cecp.air.org/wraparound/default.htm>

## BACKGROUND READING

- Eber, L. (2001, April). *School-Based Wraparound and Its Connection to Positive Behavior Interventions and Supports: A Component of Safe/Effective Schools for All Students*. National Evaluation and Technical Assistance Center. <http://www.neglected-delinquent.org/nd/resources/articles/articlessummary20060119a.asp>
- Kamradt, B. (2000). Wraparound Milwaukee: Aiding youth with mental health needs. *Juvenile Justice* 7,14-23. [http://www.ncjrs.gov/html/ojjdp/jjjnl\\_2000\\_4/wrap.html](http://www.ncjrs.gov/html/ojjdp/jjjnl_2000_4/wrap.html)
- Kendziora, K., Bruns, E., Osher, D., et al (Eds). (2001). *Wraparound: Stories from the field. Systems of care: Promising practices in children's mental health, 2001 series: Volume I*. Washington, DC, Center for Effective Collaboration and Practice, American Institutes for Research. [http://cecp.air.org/AIR\\_Monograph.pdf](http://cecp.air.org/AIR_Monograph.pdf)
- Pires, S. (2002). *Building Systems of Care—A Primer*. Washington, DC: National Technical Assistance Center for Children's Mental Health, Center, Georgetown University. Available at: [http://gucchd.georgetown.edu/programs/ta\\_center/object\\_view.html?objectID=2500](http://gucchd.georgetown.edu/programs/ta_center/object_view.html?objectID=2500)
- Walker, J.S., Koroloff, N., & Schutte, K. (2003). *Implementing high-quality collaborative Individualized Service/Support Planning: Necessary conditions*, Portland OR: Research and Training Center on Family Support and Children's Mental Health. <http://www.rtc.pdx.edu/PDF/pbImpHighQualISP.pdf>

