Chapter Three

Wraparound Fidelity and Processes

Topical Discussion
The National Wraparound Initiative: Toward Consistent Implementation of High-Quality Wraparound

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The National Wraparound Initiative: Rationale and Description

The *wraparound process* for planning and administering care to children experiencing emotional and behavioral disorders (EBD) has been cited widely as a promising service delivery option for which more extensive implementation and empirical validation is warranted (Burns, Hoagwood, & Maultsby, 1998; U.S. Public Health Service, 2001). Like Multisystemic Therapy (MST; Schoenwald & Rowland, 2002) and Treatment Foster Care (TFC; Chamberlain, 2002), wraparound is guided by a set of elements and practice principles, but is administered in an individualized manner depending on the needs of the child and family (Burchard, Bruns, & Burchard, 2002; Burns & Goldman, 1999). However, unlike MST and TFC, there are no nationally recognized standards nor any definitive blueprint or "manual" to guide service delivery activities. As a result, many of wraparound's philosophical principles have not been consistently operationalized into specific provider behaviors. This situation has hindered service delivery and frustrated efforts to fully evaluate the impact of the intervention (Burchard, et al., 2002).

The Need to Specify Wraparound

Work by Walker and colleagues (2003), using observations and interviews of multiple stakeholders, has revealed the range of approaches and quality levels of different "wraparound" programs nationally. This multifaceted research endeavor, combined with cross-disciplinary literature reviews on topics such as team functioning, organizational relations, and supervision practices, has also resulted in a better understanding of the necessary system-, program-, and team-level conditions needed to support high-quality care management using the wraparound approach (see Table 1).

At the same time, Bruns, Burchard, and colleagues, in a series of studies, have found that programs nationally that purport to use the wraparound process demonstrate a wide range of service quality, with programs unable to consistently provide services with adherence to the recognized wraparound principles. These studies have found that (1) administrative and system characteristics of programs can explain much of the variation in sites' adherence to wraparound's philosophical principles (Bruns, Burchard, Suter, & Leverentz-Brady, 2003), and that (2) in turn, adherence to these principles predict future child and family service and functioning outcomes (Bruns, Suter, Force, Burchard, & Dakan, 2003), a finding that has also been supported by other exploratory research on the topic (Rast, Peterson, Earnest & Mears (2003); Hagan, Noble, & Schick, 2003).

The interpretation of these findings is that programs and sites employing the wraparound process will be more likely to achieve desired child and family outcomes if they maintain fidelity to wraparound's philosophical principles in the course of service delivery. Theory and research point to specific administrative and program prerequisites that support adherence to these crucial philosophical elements in team processes and service delivery. Finally, research across both the children's mental health (e.g., Henggeler, Schoenwald, Liao, Letourneau, & Edwards, 2002) and adult mental health (e.g., Mueser, et al., 2003) fields have consistently pointed to the importance of systematizing multiple processes to ensure high-fidelity implementation, including both supervision and service delivery.

Given the wide variation in practices found in previous wraparound research, the importance of organizational and system characteristics, and the individualized nature of the model, we observe several implications about what is needed to ensure higher-quality wraparound in the field:

- A full but flexible wraparound practice model that includes both minimum standards as well as a menu of practice options to choose from to meet these minimum standards;

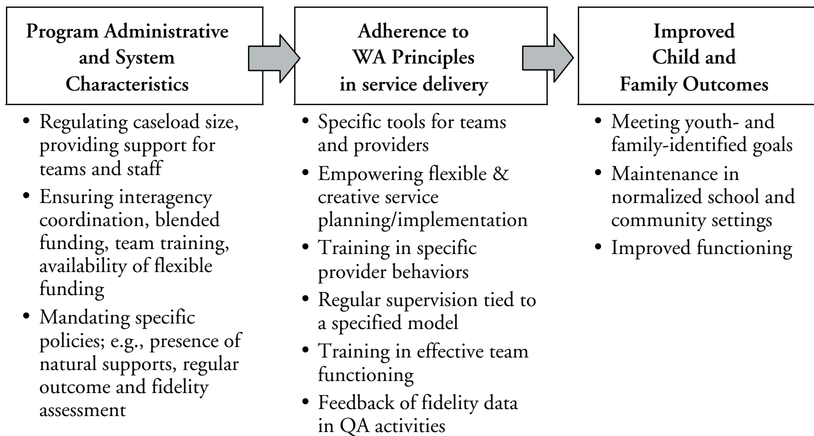
- Standards at the organizational and systems levels that relate to the empirically-derived set of necessary conditions for wraparound (Table 1);
- Manuals for practice and supervision linked to implementation fidelity measures; and
- Guides for parents, youth, team members, and community members

An overarching framework depicting research described above and the current project is presented in Figure 1.

Table 1
ISP/Wraparound Necessary Conditions

Team Level	*Organizational Level*	*Policy and Funding Context (System Level)*
Practice Model	**Practice Model**	**Practice Model**
i. Team adheres to a practice model that promotes team cohesiveness and high quality planning in a manner consistent with the value base of ISP.	i. Lead agency provides training, supervision and support for a clearly defined practice model.	i. Leaders in the policy and funding context actively support the ISP practice model.
Sub-conditions of practice model1-7	ii. Lead agency demonstrates its commitment to the values of ISP.	
	iii. Partner agencies support the core values underlying the team ISP process.	
Collaboration/Partnerships	**Collaboration/Partnerships**	**Collaboration/Partnerships**
i. Appropriate people, prepared to make decisions and commitments, attend meetings and participate collaboratively.	i. Lead agency supports team efforts to get necessary members to attend meetings and participate collaboratively.	i. Policy and funding context encourages interagency cooperation around the team and the plan.
	ii. Lead and partner agencies collaborate around the plan and the team.	ii. Leaders in the policy and funding context play a problem -solving role across service boundaries.
	iii. Partner agencies support their workers as team members and empower them to make decisions.	
Capacity Building/Staffing	**Capacity Building/Staffing**	**Capacity Building/Staffing**
i. Team members capably perform their roles on the team.	i. Lead and partner agencies provide working conditions that enable high quality work and reduce burnout.	i. Policy and funding context supports development of the special skills needed for key roles on ISP teams.
Acquiring services/supports	**Acquiring services/supports**	**Acquiring services/supports**
i. Team is aware of a wide array of services and supports and their effectiveness.	i. Lead agency has clear policies and makes timely decisions regarding funding for costs required to meet families' unique needs.	i. Policy and funding context grants autonomy and incentives to develop effective services and supports consistent with ISP practice model.
ii. Team identifies and develops family-specific natural supports.	ii. Lead agency encourages teams to develop plans based on child/family needs and strengths, rather than service fads or financial pressures.	ii. Policy and funding context supports fiscal policies that allow the flexibility needed by ISP teams.
iii. Team designs and tailor services based on families' expressed needs.	iii. Lead agency demonstrates its commitment to developing culturally competent community and natural services and supports.	iii. Policy and funding context actively supports family and youth involvement in decision making.
	iv. Lead agency supports teams in effectively including community and natural supports.	
	v. Lead agency demonstrates its commitment to developing an array of effective providers.	
Accountability	**Accountability**	**Accountability**
i. Team maintains documentation for continuous improvement and mutual accountability.	i. Lead agency monitors adherence to the practice model, implementation of plans, and cost and effectiveness.	i. Documentation requirements meet the needs of policy makers, funders, and other stakeholders.

Figure 1
A Conceptual Model for Work of the National Wraparound Initiative



The National Wraparound Initiative: Method

In true wraparound fashion, a team approach is being used to create the materials listed above.

National advisory group. On June 25, 2003, a diverse group of over 30 parents, parent advocates, wraparound trainers, practitioners, program administrators, researchers, and systems of care technical assistance providers convened in Portland, Oregon, as the Advisory Group of the new National Wraparound Initiative. At this initial meeting, the group debated the rationale for better specifying the wraparound model, discussed potential methods for conducting the work and, ultimately, identified the four types of necessary products listed in the previous section. Over the course of the project, members of the advisory committee will contribute tools, practice options and strategies to the coordinating committee; review products; and participate in a Delphi process (described below) for achieving consensus on standards and strategies.

Framework of necessary conditions. As described in the introduction, members of the coordinating committee of the National Wraparound Initiative have developed a conceptual framework that is derived from the child and family service delivery research base as well as organizational change and team effectiveness literature. This framework of necessary conditions for implementing high-quality wraparound was reviewed by the National Advisory Group and accepted as a means for organizing specific strategies for wraparound and minimum standards for its implementation.

A modified Delphi process for achieving consensus. As a means of moving ahead in the process of defining wraparound terms, practice standards, practice options, and specific mechanisms for achieving organizational and system support conditions, the National Wraparound Initiative is using a process modeled on the Delphi technique. The process has since been modified through use in a variety of applications, and we are using a specific technique that has been described as Decision Delphi (Woudenberg, 1991; van Dijk, 1990). This technique employs the following core procedural steps:

Step 1. Coordinators of the Delphi process consider the issue in an in-depth and open-ended manner.

Step 2. Coordinators synthesize the information and develop a questionnaire based on that synthesis for circulation to a chosen group of experts.

Step 3. The experts provide their responses to the questionnaire anonymously.

Step 4. Results from the questionnaire are aggregated by the coordinators, who circulate the results back to the experts in the form of a new questionnaire.

The strengths of the Delphi approach mesh well with the nature of the challenges that have limited past efforts in this area, including (a) the complexity of the wraparound process; (b) the wide variety of stakeholders and stakeholder types; and (c) the geographical distribution of expertise. Delphi is also seen as ideally suited to the exploration of issues involving a mixture of empirical evidence and moral and social values. In sum, the set of strengths associated with Delphi presents a good match for the challenges inherent in the process of defining practice parameters for wraparound.

Creation of an interactive web portal for the Initiative. As described above, the National Wraparound Initiative will require mechanisms for ensuring that partners nationwide can participate efficiently. A website for the initiative (www.rtc.pdx.edu/nwi) has been created at the Regional Research Institute at Portland State University, so that members of the Advisory Group can review, rate, and comment on specific terms, strategies, and indicators that are compiled and organized by the coordinating committee via the Delphi process. Advisory group members and other stakeholders are now able to use the website to access news, announcements, meeting minutes, and different versions of products from the Initiative.

Procedures and Initial Products

Though still preliminary, results to date of the Initiative have been significant, and will provide a foundation for future work in creating training and implementation materials that permit clearer understanding of what is required to implement the model, such as fidelity assessment and continual quality improvement activities, implementation in clinical trials, and replication across sites and communities. Results of the Initiative to date have included:

Revision of the principles of wraparound to reflect activities that focus specifically on the child, family, and team. It has been observed that the core philosophic principles of the wraparound process have spanned several levels of activity, and have been applied inconsistently. Thus, a first step was to examine the foundational principles described in Burns & Goldman (1999) and offer a revised framework to the broad Advisory Group for feedback and rating of acceptability. This has led to a revised set of principles with reasonably strong acceptance by the Advisory Group, as well as a second round of revisions and feedback via the *Delphi* process.

Description of a rationale for wraparound, based on theory, research, and family member and practitioner experiences, for each of the wraparound principles and/or steps in the wraparound process. This process has been undertaken by researchers at the Research and Training Center at Portland State as well as the University of Maryland, with assistance from participating trainers, program heads, and parent advocates. Publications of the rationale, as well as a proposed theory of change for wraparound, capable of driving evaluation and basic research studies on the process, are forthcoming.

Description of the core phases and activities of the wraparound process, based on a compilation and synthesis of exemplary practice models being used in the field. Given the wealth of program and training documents in the children's mental health field on implementing wraparound, this has been a massive undertaking that has required several preliminary rounds of feedback from a select set of wraparound innovators and program administrators before progressing to a *Delphi* process with the larger advisory group.

Tools and practice options for meeting each standard. With help from the core set of trainers and innovators, these also are currently being compiled from existing training manuals and protocols, and will also ultimately be presented to the Advisory Group for rating of their potential effectiveness in practice.

Minimum standards for the practice model, to be met in the course of completing each activity within the wraparound process. Also being compiled via assistance from the core group of innovators. To achieve consensus on these, standards will be presented to the Advisory Group by the coordinating committee for feedback and rating of the relative importance of codifying each proposed standard.

Terms and definitions relevant to wraparound are being compiled as necessary to ensure clarity in a parallel process for the delineation of such practice model documents as the principles, phases and activities, and tools and practice options. These would include both terms specific to wraparound, such as "wraparound team" or "family support partner" as well as concepts important to wraparound, such as "community-based" or "natural supports."

Minimum standards for organizational- and system-level supports. These are being generated from sources such as the framework of necessary conditions presented in Portland, as well as existing manuals and protocols, and will also be subject to a *Delphi* process by the national advisory group.

Strategies for meeting necessary supports standards, such as how to create appropriate financing and reimbursement mechanisms or how to facilitate the creation of needed interagency agreements, are also beginning to be compiled, based on conversations with providers and trainers nationally.

Conclusion

In any genuinely collaborative activity, the outputs of the process may well represent something of a surprise to those who participate. Ideally, what emerges from the collaboration is qualitatively different from the ideas or positions that individuals have at the outset. This is of course one of the major attractions of collaboration, yet it can also pose substantial risk to the participants, particularly when they have a moral, financial, and/or psychological stake in their original ideas or positions. The success of the National Wraparound Initiative depends on the willingness of a great many stakeholders to accept such risk in anticipation of unknown outcomes. That so many have been willing to do so is evidence not only of the importance of the Initiative's goals, but also of participants' willingness to take the same leap of faith that is required for success in wraparound itself.

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Symposium
Building Evidence for Wraparound: Results from Four Emergent Evaluations

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Symposium Introduction

Carol MacKinnon-Lewis & Robert Friedman

Although wraparound is widely viewed as one of the most promising strategies for working with society's most challenged children and their families, significantly more empirical validation is needed to document the impact of this service process. Findings were presented in this symposium from four sites that had not previously appeared in the literature: Arizona, Sacramento, CA, Nevada, and California's Title IV-E Waiver Demonstration Project. Using data from a variety of sources and methods, these sites met the following criteria: a) adhered to the primary principles of wraparound; b) collected objective outcome data on the effectiveness of the intervention as evidenced by clinical significance and real world functioning; and c) assessed adherence to wraparound principles (fidelity), including well-described treatment procedures and monitoring of those procedures.

In recent years, increased attention has been paid to implementation issues and program integrity within wraparound (Walker & Bruns, 2004). Nonetheless, there continues to be an emphasis on expanding our understanding about the potential impact of wraparound. When such research employs both intensive data collection on implementation as well as child and family outcomes, it holds the promise of not only adding to the research base on effectiveness, but also contributing to the process of identifying the critical ingredients of the wraparound process that are most important to outcomes. The evaluations reviewed in this symposium provide examples of such emergent research.

A Post Hoc Comparison of Child and Family Outcomes to Fidelity of the Wraparound Process for Project MATCH

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Introduction

"Wraparound" has been referenced as a service delivery process since the late-1980s (VanDenBerg & Grealish, 1996) and has been cited widely as one of only a handful promising integrated treatment options for children with serious emotional disorders (SED; Burns, Hoagwood, & Maultsby, 1998). Summarized briefly, wraparound uses a family-centered process that identifies the unique strengths, needs, and culture of the child and family, and a team-based planning process that results in a unique set of community services focused on the family's self-described long-term vision. Wraparound is a service process that is guided by a set of principles but administered in an individualized manner for each family (Burns & Goldman, 1999).

Despite widespread application of service processes referred to as "wraparound," development of a standardized treatment approach has only recently been undertaken. The historical lack of standardization of wraparound, a result of the complexity of the model and its grassroots development, has rendered quality assurance as well as synthesis of a research base difficult (Burchard, Bruns, & Burchard, 2002). The developmental path of wraparound has been idiosyncratic compared with other integrated community-based treatment approaches. Certainly, its course deviates from the models for creating and testing evidence-based service approaches, such as the Community-based Intervention

Development (CID) model proposed by Weisz and colleagues (2003). Instead of progressing purposefully through scientific phases for developing services for children's mental health problems, wraparound began from a value base to wide-scale implementation without pilot testing of procedures, development of manuals, or creation of implementation measures to support replication of proven procedures (Bruns, 2003). The result has been a wide variety of processes being labeled "wraparound."

In response to the need to study the impact of wraparound, a reliable and valid implementation and fidelity measure has been developed and tested. The Wraparound Fidelity Index (WFI; Suter, Burchard, Bruns, Force & Mehrtens, 2002) now provides a means for evaluating success of implementation and interpreting results of evaluation studies. This paper describes a preliminary study of the importance of maintaining high levels of wraparound fidelity to ensure positive outcomes for children and families within a developing system of care.

Method

The subjects were 64 children and youth who met the criteria for SED and were receiving "wraparound" services through a system of care project in Tucson, Arizona. These 64 children and youth were selected for this post hoc analysis because they met two conditions: outcome data had been collected on them at intake and at six- and 12-month follow-up; and wraparound fidelity index (WFI) data had been collected between the six- and 12-month interval. The children and youth were then sorted into three groups based on the WFI scores. The highest 21 scores were placed in the high fidelity group and the lowest 21 scores were placed in the low fidelity group. The data for the other children was not used for this analysis.

The process evaluation for this study utilized the Wraparound Fidelity Index 2.1 (WFI-2.1; Bruns, Burchard, Suter, Leverentz-Brady, & Force, 2004). The WFI-2.1 is a multi-informant interview that measures adherence to the 11 principles of wraparound for an individual child and team. Brief interviews assess adherence to 11 core "elements" of wraparound using caregiver (CG), youth (Y), and resource facilitator (RF) versions of the instrument. For each element, trained interviewers administered questions related to four items and used a detailed manual (Suter, et al., 2002) to score each on a 0-2 scale, where 0 = *low fidelity* and 2 = *high fidelity*. The scores were then converted into a 100-point scale.

Child outcome data were collected in the following areas: frequency and severity of child behaviors on the Child Behavior Checklist (CBCL; Achenbach, 1991), magnitude of impairment in functioning due to child's emotional and behavioral disorder on the Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, 1997, Hodges & Wong 1996), school grades school disciplinary actions, and stability and restrictiveness and of the child's living arrangements using a modified Restrictiveness of Living Environment Scale (ROLES; Hawkins, Almeida, Fabry, & Reitz, 1992). The different types of residential settings have been grouped into six levels of restrictiveness. Outcome data were gathered on youth for the six months prior to wraparound initiation and at six- and 12-month intervals past entry.

The Family Resource Scale (FRS; Dunst, Trivette, & Deal, 1994) measures a caregiver's report on the adequacy of a variety of resources needed to meet the needs of the family as a whole, as well as the needs of individual family members. The FRS is a 30-item self-report measure asking parents to rate, on a five-point scale, the adequacy of resources including: access to food, shelter, financial resources, transportation, health care, time to be with family, child care, and time for self. The FRS has been found to be a reliable and valid measure, and useful for program evaluations where it might be important to understand barriers to the family's involvement in their child's program, as families with unmet basic needs may not have time or energy to participate actively in the child's program.

The data for all of the above measures were gathered by external evaluators contracted through the University of Arizona. These evaluators gathered the information directly from the primary caregivers and youth. The data was entered into a centralized database and an export of this data was used to do the post hoc analysis for this study.

Results & Discussion

The two groups of children and youth had similar behavioral and functional scores at intake, as well as similar levels of residential restrictiveness. Table 1 shows the average WFI scores for each of the two groups and the baseline levels for the five outcome measures. The children in the low fidelity group had slightly lower scores on the CAFAS and lower scores on the CBCL. The level of residential placement was the same for both groups but the children who received high fidelity wraparound had more residential moves on average in the six months prior to initiation of wraparound. On the Family Resource Scale the families who would later receive high-fidelity wraparound scored their resources as more adequate at the initiation of the process.

The process data show a significant difference in the fidelity of the wraparound process as measured by the WFI-2.1. The wraparound group had an average fidelity score of 85.3% which, compared to other studies is a very high rating. The low fidelity group had an average score of 53.6%, which is very low and the difference between the two groups is significant at the $p < .001$ level.

Figure 1 shows the different longitudinal trajectories for mental health symptoms (CAFAS) and behavior (CBCL) by fidelity group. As shown, average CAFAS scores for all 42 children showed a modest improvement from 129.8 to 120.8. The children for whom high fidelity scores were obtained showed a significant improvement (132 to 109) while the low fidelity group showed a slight deterioration (128 to 133). The difference in the amount of change between the two groups is significant at the $p < .005$ level.

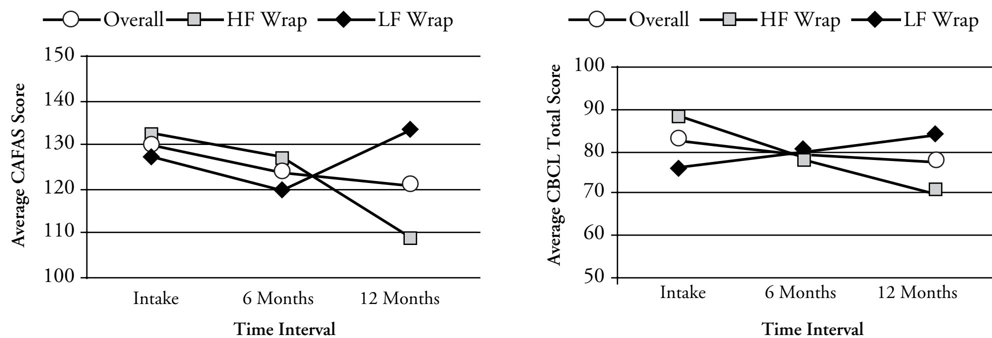
The graph on the right side of Figure 1 shows the Child Behavior Checklist (CBCL) scores. For the entire group the scores showed a slight improvement

Table 1
Group Comparisons

	High Fidelity Wrap	*Low Fidelity Wrap*
WFI Scores	85.3	53.6
CAFAS	132.0	128.0
CBCL Total	89.0	78.0
Level of Residential Placement	1.7	1.7
Number of Moves in Previous Six months	2.2	1.6
Family Resource Scale	3.5	3.1

Table one shows a comparison of the average wraparound fidelity index (WFI) scores for the two groups at 6 months and the average baseline scores for five of the outcome measures at intake. The second row shows the difference in the overall averages WFI scores for the two groups. The WFI eight-point scale has been converted to a 100-point scale for ease of comparison. Rows three through seven show the intake data for four of the primary child and on e primary family outcomes. These data reflect the six months prior to initiation of the wraparound process.

Figure 1
CAFAS and CBCL Scores



The graph on the left of figure two shows the average Child and Adolescent Functional Assessment Scale (CAFAS) Scores at intake and at six and twelve month intervals following intake. The open circles are the average scores for all 42 children, the black diamonds show the average for the 21 children receiving low fidelity wraparound and the grey squares show the data for the 21 children receiving high fidelity wraparound. The graph on the right shows the same data for the Child Behavior Checklist (CBCL) scores.

from 83.3 to 76.9 but again the low fidelity group had a slight deterioration (78 to 80) while the high fidelity group improved (89 to 79). The difference in the amount of change between the two groups is significant at the $p < .01$ level.

Figure 2 shows the changes in residential placement and stability for the two groups of children. The graph on the right shows the average change in the level of restrictiveness for each group. At intake, the average score for each group was 1.7. An examination of the individual placements found that five children in each group were in out-of-home placement at wraparound initiation. It can be challenging to maintain a child with mental health symptoms at the level scored on the CAFAS at intake. At the 12-month period the low fidelity wraparound group had an average level of placement of 2.6 compared to a 1.6 level for the group receiving high fidelity wraparound. The change in residential levels is significant at the p< .05 level. During the six month baseline the group who would later receive high fidelity wraparound averaged 2.1 residential moves. In the last six months this had decreased to an average of 1.4. The group that would later receive low fidelity wraparound averaged 1.6 moves during the six month baseline and 1.5 in the last six months.

Figure 3 shows the overall average for changes in FRS scores for all 42 caregivers (left graph) and for the two groups (right graph). In the overall report there appears to be little impact of providing wraparound on this family outcome measure. When the data are analyzed in terms of fidelity, however, the group that had high fidelity wraparound showed improved adequacy of self-reported resources and supports while the low fidelity group perceived less adequate resources. The difference in these scores is significant at the $p < .05$ level.

Conclusion

This post-hoc analysis looked at the association between the fidelity of wraparound as measured by the WFI and four child and one family outcome measures. On each measure the group of children and families that received high fidelity wraparound experienced significantly better outcomes than the group with low fidelity wraparound. Though it may be that better outcomes influenced WFI ratings for the high-fidelity group, these results align with other studies that are beginning to document the relationship between wraparound fidelity and outcomes (e.g., Bruns, Suter, Burchard, & Force, 2005). Nonetheless, there is a need to do this research in a more controlled manner. The implications of this study reinforce the theory, however, that it is important to maintain fidelity to the wraparound principles in practice. This line of research also underscores the importance for both researchers and program officials to measure the fidelity of the wraparound process.

Figure 2
Residential Outcomes

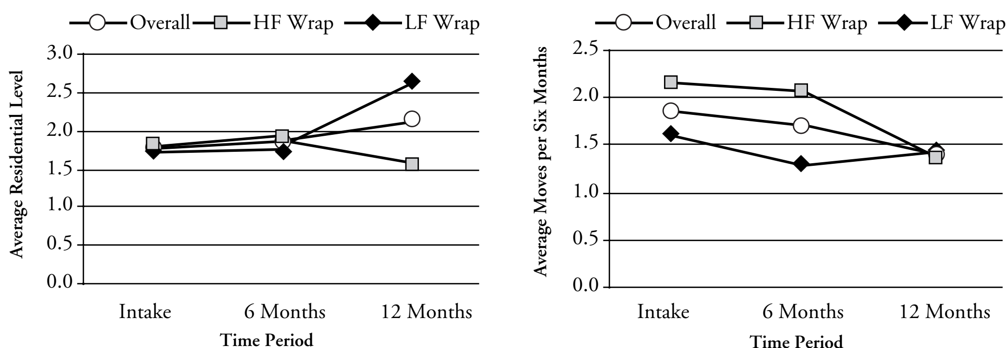


Figure Two shows a comparison of the impact of the fidelity of the wraparound process on the restrictiveness of residential placement (left graph) and on the stability of placement (right graph). The figure on the left shows the average level of residential placement on a six level version of the ROLES. The open circles show the average for all 42 of the children, the black diamonds the 21 with low fidelity wraparound and the grey squares the 21 with high fidelity wraparound. The graph on the right shows the average number of residential moves for each group using the same symbols.

Figure 3
Family Resource Scale

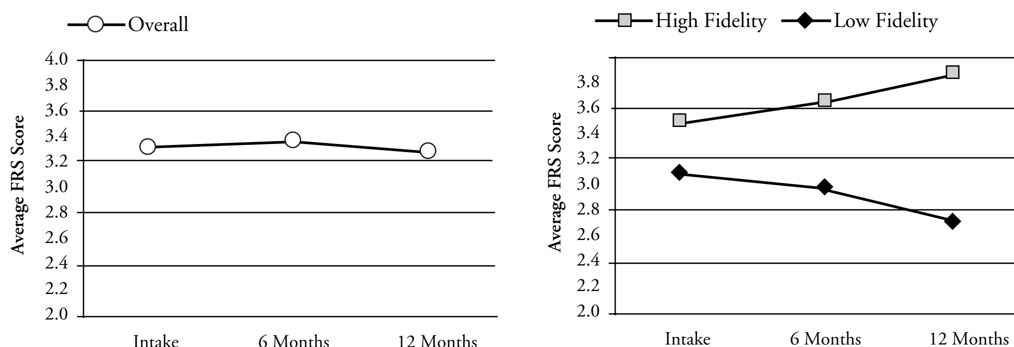


Figure Three shows the scores for the Family Resource Scale which measures a caregiver's report on the adequacy of a variety of resources needed to meet the needs of the family as a whole, as well as the needs of individual family members. Higher ratings demonstrate more adequate resources. The graph on the left shows the average rating for the caregivers for all 42 children. The graph on the right shows the average rating for each group. The gray squares are for the caregivers with the high fidelity wraparound and the black diamonds are for the caregivers with low fidelity wraparound.

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The Impact of Wraparound Services on Non-Typical Populations: Can We Bring These Youth Home?

Twylla Abrahamson & Kimberly Tyda

Acknowledgements: Research conducted in conjunction with Sacramento County Department of Health and Human Services, Mental Health Division. Appreciation is expressed to Daria Rostovtseva and Stanford Home for Children, Sacramento, California.

Introduction

The wraparound service model is a strength-based, family-focused team approach for creating individually defined services and supports for children and families. The process is designed to create a community partnership, in order to provide services in the least restrictive environment possible (Franz, 1994), with the overall goals of keeping children at home, in school, and out of trouble. Services are intended to move the family towards self-sufficiency and empowerment by using a multidisciplinary team that links the family to natural resources and community supports (Clarke, 2001; Kendziora, Bruns, Osher, Pacchiano, & Mejia, 2001). Wraparound values include family voice and choice, integration of services and systems, flexibility in funding and provision of services, and safety and permanence.

Background

Legislation (SB163, in conjunction with AB 2297 and AB 2706), authorized California counties the fiscal flexibility to provide wraparound services as an alternative to group care, under pilot project status. Sacramento County is participating in one of these five year pilot projects, coordinated by the University of California at Berkeley. Eligible families participating in the study are randomly assigned to experimental (wraparound) and control (outpatient or other intensive in-home services) groups.

Wraparound practice was intended for a mental health population of children who reside primarily with their parents or caregivers in the community. Sacramento County is somewhat unique in that many children being served by wraparound do not have an identified parent or caregiver involved in their lives. This is partially because many children are referred from Child Protective Services (CPS) and Probation agencies, and partially due to the fact that Sacramento County adopted two initiatives that impact the ability of providers to adhere to the model of wraparound. The first initiative, "Bring 'em Home," was

designed for children placed out of county in order to bring them back into the Sacramento community, either to live with family members or in foster care. The second initiative, "Wrap for All" was developed to transition as many in-county children from high level group homes back into a family, or other less restrictive environment. This evolution in Sacramento wraparound services, dictated by policy changes, has led to a shift from working with families in a community setting, to working with children, often without families, in non-community environments. Therefore, it is important to determine whether the uniqueness of the Sacramento population, and the evolution of its changing policies, has led to differential effects.

In an earlier study, trends related to successful outcomes of youth receiving services through Wraparound Sacramento were examined (Abrahamson, Tyda, Rostovtseva, Fraguela & Guadalupe, 2003). Youth were considered to be successful if they maintained or stepped-down into a community placement at time of discharge; the findings at that time were that 70% of discharged children met this criteria for success. The results were somewhat limited given the fairly small discharge population at the time; however, the findings were encouraging given that so many youth had been in a facility placement at time of admission. There were some notable differences between youth in a community placement at discharge (successful) and those in a facility setting (unsuccessful). Successful youth had experienced fewer family and environmental risk factors and had a history of greater placement stability, both prior to and during treatment. Referral source and placement status at admission were two other factors that seemed to be particularly important for determining whether the child was successful at maintaining or stepping down into a community placement. Specifically, children referred from Probation had higher success rates than those who were referred from CPS or Mental Health. In addition, children in placement at the time of admission were less likely to end up in the community after 12 months of service and at time of discharge. Success rates for those in the community at admission was 78%, compared to 62% for children who were in initially in a facility.

These data supported the conclusion that success in the program was somewhat dependent on the referral population, and where the children were living at admission. A fundamental question regarding the appropriateness of wraparound services for these children still remains. Are the services effective for these youth? Can children for whom wraparound services were not originally designed (those in placement; often with no identified caregiver) achieve success in the program? The purpose of the current study is to further investigate these questions with a larger discharge population, and to explore the differences between the CPS, Probation and Mental Health referral groups.

Method

The participants are 102 children and families who have discharged from wraparound Sacramento since its inception. At admission, all caregivers, or substitutes in the case of those in residential placements, signed informed consents to participate in the study. Outcome information was gathered at admission, every six months thereafter, and at discharge. Please note that data for this study was provided by two of the four providers of Wraparound in Sacramento County[1]. A segment of this research is also being coordinated by the Center for Social Sciences Research at the University of California, Berkeley.

Demographic/Evaluative information was gathered across various measurement domains and from multiple sources. This included assessments of behavioral and clinical functioning, as measured by The Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1983) and Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, 1995); demographic and risk factor information extracted from agency-designed tools; and wraparound model fidelity through the Wraparound Fidelity Index (WFI; Bruns, Suter, & Burchard, 2002).

[1] *River Oak Center for Children and Stanford Home for Children contributed data for this set of analyses.*

Results

Children discharged included 57 boys and 45 girls, with an average age of 13 years at admission. Most children were Caucasian (48%) or African-American (31%). Sixty-three percent of children were referred through CPS, 18% were Probation referred, and 19% were from the Children's Mental Health sector. Average length of stay in Wrapround Sacramento was 17 months.

Success rates looked strikingly different for the three referral groups. Probation and CPS youth were significantly more likely to be in a community setting at discharge than Mental Health youth χ^2 (2, n = 94) = 11.04, p = .004. There were also differences in placement changes for the groups. At time of admission, the majority of Probation youth were in a facility placements; by discharge, most had moved to community settings. Results for the CPS group were also positive, with 72% of youth ending up in the community; success rates for the Mental Health youth were the lowest of the three groups, with only 53% discharged to a community placement (see Figure 1). Mental health youth were also significantly less likely to have graduation as the reason for discharge χ^2 (2, n = 101) = 15.6, p = .000 (see Figure 2).

As shown in Figures 3 and 4, results of the CAFAS and the CBCL indicated poorer functioning and higher levels of behavioral impairments and less behavioral improvement for the Mental Health youth. While CPS and Probation showed significant decreases on both behavioral assessments, changes for Mental Health youth were not significant.

Figure 1
Changes in Placement

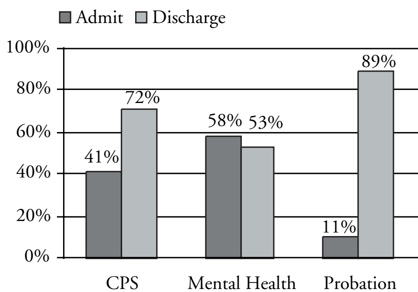


Figure 2
Reasons for Discharge

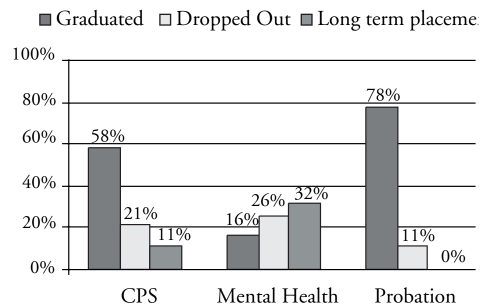


Figure 3
CAFAS Scores

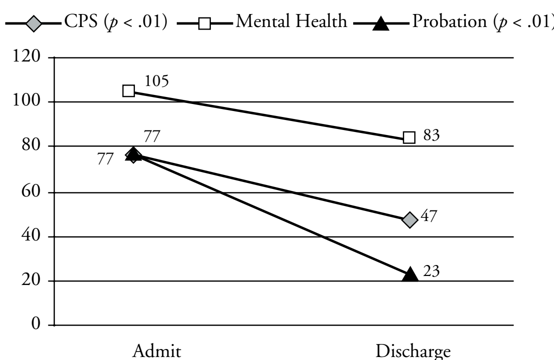
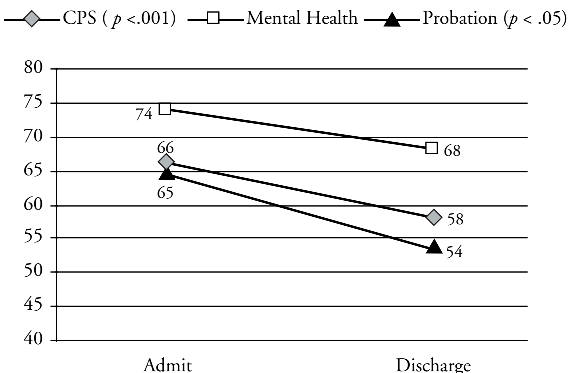


Figure 4
CBCL Scores



Results from the Wraparound Fidelity Index (Bruns, et al., 2002) revealed differences in model adherence for the services received by the three referral groups. The Mental Health group had lower fidelity scores across all three respondents (facilitator, caregiver, and youth). Although the differences between the referral groups was only significant for the youth fidelity scores, $F\,(2,52) = 3.80\; p \leq .05$, the pattern of results was in a similar direction for caregiver and facilitator fidelity scores. WFI scores were also related to client outcomes. Parent Total Fidelity scores were significantly lower for families who dropped out ($M = 4.91$, $SD = 1.51$) than for families who graduated ($M = 6.80$, $SD = .61$), $t(43) = 6.0$, $p \leq .01$ There were no differences in Facilitator Total Fidelity scores or Youth Total Fidelity Scores between families who dropped out and families who graduated.

Discussion

When interpreting these outcomes between referral groups, it is important to note that there were differences between the groups on a number of factors. The Probation group was older, had significantly more girls, and more identified strengths. Mental Health had a higher percentage of Caucasian youth, significantly fewer risk factors, lower scores in most family functioning domains, and youth were more likely to be diagnosed with Bipolar disorder. Future studies will focus on the impact of these factors on client outcomes.

Regarding the first question originally posed, "are these services effective for these youth?" the answer appears to be "yes, sometimes." They show differences in success rate, in part due to referral source. However, there is a need to further investigate the reasons for these differences in outcomes through predictors of success using demographics of the youth, rather than just assuming that the reasons are due to referral source alone. Question two, can "wraparound serve this unique population?' the answer also appears to be "yes, in many cases." Youth in all groups are making improvements, but they are not all deemed successful due to Sacramento County's restricted definition of "success." Perhaps it is more important to continue asking what characteristics of youth and families, in combination with their level of access to support, result in the best outcomes from the wraparound model.

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Wraparound Effectiveness: Comparing Traditional Services to Wraparound in Nevada

Christa Peterson & Jim Rast

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Introduction

Wraparound is a widely used service process that has not been adequately researched (Burns, 2002). It is estimated that the current number of youth with their families engaged in "wraparound" is approximately 200,000 (Faw, 1999). Reviews of site assessments for the Substance Abuse and Mental Health Services Administration (SAMHSA) Comprehensive Community Mental Health Services for Children and their Families (CCMHS) program shows that the vast majority of federally funded sites propose to utilize wraparound (SAMHSA, 1999). In addition, wraparound is included as a promising intervention in former Surgeon General Satcher's reports on both mental health and youth violence (US Public Health Service, 1999, 2001). However, despite a handful of promising initial studies (see Burchard, Bruns, & Burchard, 2002, for a review), implementation of wraparound in most federally funded systems of care projects—and the even more widespread use of the label "wraparound" to describe various service processes nationally—the model has not been evaluated using the types of rigorous methodology that are required to develop the evidence base to support and guide use of this process. Thus, we do not know how effective wraparound is when applied in large demonstration or service settings nor the extent to which the process represents an effective mechanism for reducing mental health problems and improving functioning of youth with SED and their families. This paper presents 18-month follow-up data on a controlled comparison of wraparound to traditional child welfare and mental health services for youth in the child welfare system in Nevada (Peterson, Rast, Gruner, Abi-Karam, and Earnest, 2004).

Method

The subjects were 65 youth in the child welfare system who met the criteria for experiencing a severe emotional disturbance (SED). These youth were all in the custody of the State of Nevada at study intake. Thirty-three of the youth were assigned to the wraparound group and 32 were assigned to a control group that received traditional child welfare and mental health services. It was decided to do the initial pilot work in four areas of the state (Reno, Carson City, and North and West Las Vegas). Eight youth were selected from three of these regions and nine from the North Las Vegas region. From each of these areas, eight additional youth were selected to serve as controls and received traditional services. Wraparound and control youth were matched by age, sex, race, current residential placement, and severity of mental health problems as measured by the Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, 1997, Hodges & Wong, 1996) and the Global Assessment of Functioning (CGAF; American Psychiatric Association, 1994)..

The 33 youth in the wraparound group were assigned to one of four wraparound facilitators (one in each region) who were trained in the wraparound process. Each of these wraparound facilitators also received hands-on coaching as they learned and implemented the process. Children and youth in the control group received the standard child welfare and mental health services available in the system.

The process evaluation for this study utilized the Wraparound Fidelity Index 3.0 (WFI-3; Bruns, Burchard, Suter, Leverentz-Brady, & Force, 2004). The WFI-3 is a multi-informant interview that measures adherence to the eleven principles of wraparound for an individual child and team. Brief interviews assess adherence to 11 core elements of wraparound using caregiver (CG), youth (Y), and resource facilitator (RF) versions of the instrument. For each element, trained interviewers administered questions related to four items and used a detailed manual (Suter, Burchard, Bruns, Force & Mehrtens 2002) to score each on a 0-2 scale, where 0 = *low fidelity* and 2 = *high fidelity*. The scores were then converted into a 100 point scale.

Outcome data were collected in the following areas: frequency and severity of child behaviors on the Child Behavior Checklist (CBCL; Achenbach, 1991), magnitude of impairment in functioning due to child's emotional and behavioral disorder on the CAFAS, school attendance and performance; delinquency; juvenile justice involvement and restrictiveness and stability of the child's living arrangements using a modified Restrictiveness of Living Environment Scale (ROLES; Hawkins, Almeida, Fabry, & Reitz, 1992). The youth in Nevada lived in 19 different types of residential settings. For scoring the ROLES, these settings were grouped into six levels. The most frequent placement at each level is: (a) Level 1-with parents or extended family; (b) Level 2-foster care; (c) Level 3-therapuetic foster care; (d) Level 4 - group home; (e) Level 5-residential center or detention, and; (f) Level 6-psychiatric hospital. Outcome data were gathered on youth for the six months prior to study implementation and at six-month intervals for 18 months past entry.

Results

The process outcome data show a significant difference in the fidelity of the wraparound process as measured by the WFI for the two groups (e.g., wraparound and traditional services). The wraparound group had an average fidelity score of 75.5 at six months and 86.4 by 12 months. The traditional services group had scores of 61.3 and 62.4 at these same intervals. These results are shown graphically in Figure 1. Using a Students T-Test the difference in the fidelity ratings between groups was significant at $p<.005$ at each interval. An analysis of the caregiver and resource coordinator ratings for the wraparound condition found that the ratings by caregivers were only slightly higher than by the resource coordinators at six months (77.4% compared to 75.2% respectively) and at twelve months (87.2% compared to 85.8%).

The outcome results reveal significant improvements in the primary outcome measures for the youth receiving wraparound compared to the outcomes of the youth receiving traditional services. Figure 2 shows the changes in residential placement for the two groups of youth after eighteen months. Twenty seven of the 33 youth (81.8%) who received wraparound moved to less restrictive environments compared to only 12 of the 32 control-group youth (37.5%). In addition, seven of the 32 control-group youth (21.9%) moved to more restrictive placements compared to only two of those who received wraparound (6.1%). Using a students T-Test the change in residential level between the two groups was significant at $p < .005$. As part of the wraparound process a functional strengths, needs and culture discovery was completed. Through this process, family members were identified to provide care for 11 of the 33 youth in the wraparound group even though the youth had been in state custody for more than three years and their permanency plans had been for long term foster care prior to initiating the wraparound process.

In terms of mental health symptoms, both groups had decreases in CAFAS scores. The youth in wraparound had an average decrease of 39.5 points compared to a decrease of 2.4 points for the youth in the control group. The graph on the left side of Figure 3 shows the average scores for the two groups at six-month intervals. The graph on the right shows the average change in the CAFAS scores between intake and the last measurement. This difference in CAFAS scores between the two groups is significant at $p < .001$ level.

Figure 1
Wraparound Fidelity Score

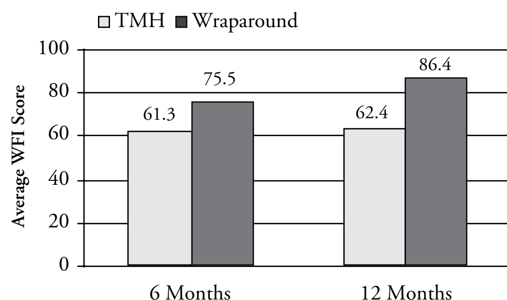
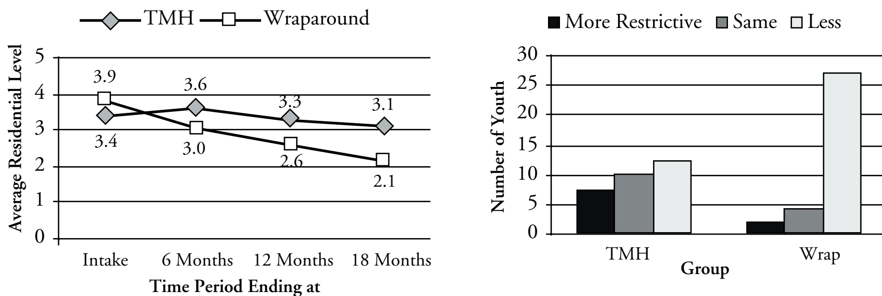


Figure One shows a comparison of the how well the two conditions match the principles of wraparound as measured by the wraparound fidelity index. The figure shows the overall average score for all elements for each condition at 6 and 12 months. The WFI eight point scale has been converted to a 100 pointscale for each in comparison. A Student T Test analysis finds that the difference in scores between the group at each interval is significant at the $p >.005$ level.

Figure 2
Changes in Residential Living Level After 18 Months



The graph on the left side of figure two shows changes in the restrictiveness of residential living placement for the two groups at six month intervals. The scores represent the average level of restrictiveness for each group. In Nevada there are 19 types of residential placement. The levels generally are: 1= with parents or relatives, 2= foster care, 3= specialized foster care, 4= group home, 5= residential treatment center, and 6= inpatient. A Student T Test analysis finds that the difference in the change over this time period is significant at the P>.001 level. The figure on the right shows the number of youth who moved to more, less or stayed at the same level of residential placement over the time period.

Figure 4 shows two of the primary school outcomes for the two groups. Twenty-nine of the youth in the control group and twenty eight of the youth in the wraparound group were enrolled in school. As shown, the youth receiving wraparound demonstrated a 7.7% increase in grade point average and a 38.5% decrease in disciplinary actions. The youth in the control group demonstrated a decrease in grade point average and an increase in disciplinary actions. The change in grade point average was significant at the $p < .01$ level and the change in disciplinary actions was significant at $p < .007$ using a Students T-Test.

Discussion

The results of the process evaluation are important for several reasons. First, wraparound fidelity, as measured by the WFI, can be produced for youth in the child welfare system even when they have been in out-of-home custody for extended periods of time. After six months of providing the service process, fidelity scores were significantly different for the wraparound group, compared to the control group. Perhaps more importantly, it was also found that, through continued coaching, the fidelity continued to improve over the next six months. This suggests that it may take more than six months to produce high fidelity wraparound, especially in sites that do not have provider organizations and systems with a history of administering high fidelity wraparound.

Second, the current study suggests that high fidelity wraparound can produce significantly better outcomes for youth in the child welfare system than traditional case work and mental health services. For youth in out-of-home placement (even those who have been in long-term placement), wraparound promoted placement in less restrictive settings and improved residential stability. The increased placements with parents and extended family suggest improved long-term permanency. The youth receiving wraparound had more improvement in mental health symptoms and school outcomes. In addition, though not presented formally in the results of this study, it should be highlighted that total costs over the first 12 months of services were found to average over $4000 more for the youths in the control condition, compared to youth in wraparound. Thus, contrary to some studies, in the system of care examined in this study, the positive impacts of the process were not achieved as a result of increased overall spending.

Finally, this study suggests a number of next steps in the process of determining the evidence to understand the implementation and impact of wraparound. Clearly, there is a need to do a follow-up study with random assignment of children to groups. Multiple-baseline single-subject design studies

Figure 3
Impact on Mental Health Symptoms

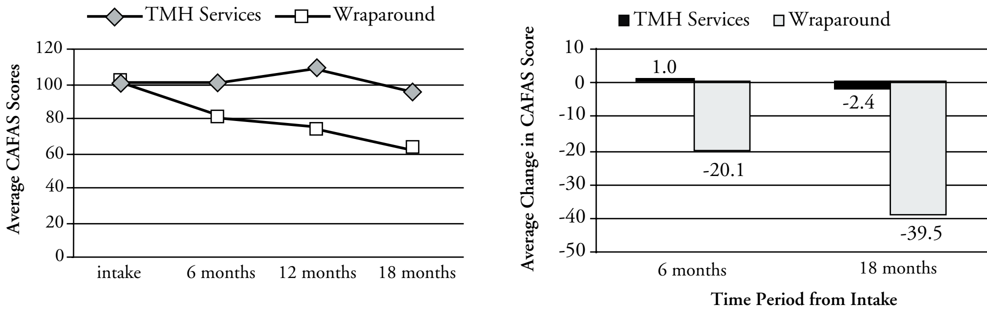


Figure three shows the comparison of Child and Adolescent Functional Assessment Scale (CAFAS) scores for each of the groups. The scores are based on eight scale calculation of the tool that measures the impact of mental health symptoms. The graph on the left shows the average scale for the two groups at each of the four time intervals. A Student T Test analysis finds that the difference in the change over this time period is significant at the $P > .001$ level. The figure on the right shows the changes in CAFAS scores at six and eighteen months for the two groups.

Figure 4
Impact on Academic Outcomes

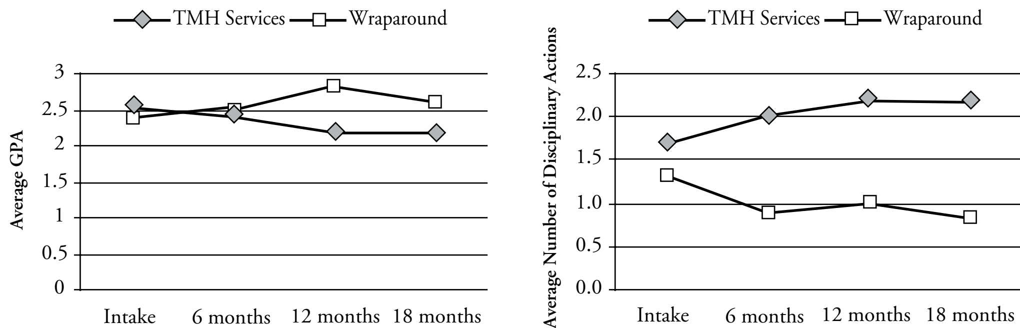


Figure four shows two of the academic measures for the study. The graph on the left shows the impact on the average grade point average for the youth in the study at six month intervals where A is a 4.0 and F is a 0.0. A Student T Test analysis finds that the difference in the change over this time period is significant at the $P > .1$ level. The graph on the right shows the average number of disciplinary actions (e.g., detentions, suspensions) for each group for each of the time intervals. A Student T Test analysis finds that the difference in the change over this time period is significant at the $P > .007$ level.

could also be employed at the program and system levels to assess the impact of changes in organizational and system support on wraparound team functioning over time. There is a need to use a more comprehensive set of measures to determine wraparound's impact on families and caregivers. Finally, there is a need to gather more complete cost and services and cost impact data, and to replicate this research with other subject populations.

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California's Title IV-E Child Welfare Waiver Demonstration Project Evaluation: An Analysis of Wraparound in Alameda County

Charlie Ferguson

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Introduction

This explanatory study is a sub-study of the evaluation of California's Title IV-E Child Welfare Waiver Demonstration Project. The Demonstration Project was sponsored by the US Department of Health and Human Services (USDHHS), and implemented in California by county public agencies under the auspices of the California Department of Social Services. The Title IV-E waiver approval allowed states to use federal money earmarked for specific foster care services to develop and implement innovative programming designed to improve the outcomes for federally eligible children in foster care. The Demonstration Project Evaluation was conducted by the Center for Social Services Research at the University of California at Berkeley .

Wraparound is targeted to children in the child welfare system who are currently living in the highest level of group care in California or are at risk of placement into that level of care. The present study is a preliminary analysis of wraparound in Alameda County. Alameda County's wraparound initiative is known as Project Destiny, a partnership between the Alameda County Department of Children and Family Services and three private not-for-profit social service providers.

Project Destiny was initiated in response to the increasing costs of providing services to children in high-level group care in California without the corresponding positive outcomes. Project Destiny can best be viewed as a managed care initiative, combining programmatic reforms with fiscal reforms made possible under the Waiver Demonstration Project. The goal of Project Destiny's capitated system is to increase fiscal flexibility through the loosening of fiscal regulations and the commingling of categorical funding streams in order to decrease service fragmentation and increase effectiveness. The second major component of the Project Destiny managed care model is the programmatic piece. Project Destiny uses a professional team structure comprised of county child welfare workers and professional staff from the not-for-profit agencies. The programmatic centerpiece of wraparound in Alameda County is each youth's child and family team (CFT), made up of the child and family (broadly defined), other significant individuals in the child's life, and service professionals.

The purpose of this study is to assess the effectiveness of wraparound at producing better outcomes for children in high-level group care, or at risk of such a placement setting. Specifically, the study tests three hypotheses: children receiving wraparound through Project Destiny will have (a) higher levels of child safety than children receiving traditional services, (b) higher levels of placement stability, and (c) higher levels of permanence than children receiving traditional services.

Method

The data collection design for the present study is a posttest-only control group design (Campbell and Stanley, 1963). The salient characteristic of the design is the random assignment of study subjects to two groups: a treatment group receiving wraparound and a comparison group receiving traditional child welfare services. Children included in the study were federally-eligible child welfare dependents in a high level group care placement, or at risk of such placement at the time of enrollment, and eligible for enrollment between June 1, 1999 and June 30, 2002. Children were randomly assigned at a ratio of 5:3, treatment and comparison groups.

Data for the study were acquired in a number of ways and included demographic information, a baseline behavioral measure, services information, a measure of program fidelity, and administrative-level child welfare data. The Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, 1997) was used as the baseline measure of behavior. The primary purpose for the CAFAS in the Demonstration Project Evaluation was to assess the behavioral functioning of children in the two target populations for differences to ensure that the groups could be analyzed together. The Wraparound Fidelity Index (WFI; Bruns, Burchard, Suter, Force, & Leverentz-Brady, 2004) was used to provide the assessment of model fidelity of the intervention.

Quantitative data on the variables of child safety, stability, and permanence were the primary means with which comparisons were made between the treatment group receiving wraparound and the comparison group receiving traditional child welfare services. These data were drawn from a longitudinal relational database containing data from California's child welfare management information system. Outcome analyses include: substantiated maltreatment while in the study, number of placement moves (three or fewer placements/more—logistic regression), stepping down from high level group care/ stepping up into high level group care (event history analysis), and exiting from care due to permanency (reunification, adoption, guardianship/no—logistic regression).

Results

The sample for this study included 194 children: 121 (62%) in the treatment group and 73 (38%) in the comparison group. The majority of children in the sample were at risk of high-level group care placement (n=157, 81%).

The WFI analyses indicated that a statistically significant ($p = 0.02$) proportion of the Project Destiny group (92%), as compared to the group receiving traditional child welfare services (37%), reported that decisions regarding services and supports were made by a child and family team. The analysis of the WFI Overall Score showed a statistically significant ($p = .002$) difference between the average percentage for the Project Destiny group (78%) and the comparison group (67%). Fourteen children had at least one substantiated maltreatment report while in the study: eight children (7%) in Project Destiny and six children (9%) in the comparison group. The difference between the groups was not statistically significant.

Approximately 84% of children in both groups had three or fewer placement moves during their time in the study. Logistic regression analysis that controlled for length of time in the study showed that children in Project Destiny had slightly greater odds ($OR = 1.108$) of having three or fewer placement moves, but the finding was not significant ($p = 0.8054$).

For the target population of children in high-level group care at the time of enrollment, Project Destiny children were more likely to step down to less restrictive care over the first 200 days post-enrollment. Overall, however, the risk of stepping down for children in Project Destiny was roughly 13% less than the comparison, though the finding was not statistically significant ($p = 0.8549$). For the target population of children at risk of high level group care placement, Project Destiny children were less likely to step up over time. The risk ratio of 0.871, produced by the Cox regression analysis, indicated that the risk of stepping up decreased by roughly 13% for children in Project Destiny, though the finding was not statistically significant ($p = 0.6607$).

At the time of enrollment into the study, approximately 39% of the children receiving Project Destiny services were living in a family-based placement compared to approximately 37% of children receiving traditional child welfare services. At the end of the study period, the corresponding proportions were 53% and 30% ($p = 0.0022$). The finding held in a logistic regression analysis, controlling for time, where children in Project Destiny had greater odds (OR=2.643) of being in a family-based placement at the end of the study ($p = 0.0023$).

Fifteen children exited the child welfare system due to reunification, adoption, or guardianship: 11 (9%) in Project Destiny, and 4 (6%) in the comparison group. Children in Project Destiny had slightly greater odds ($OR = 1.708$), controlling for time in the study, of having three or fewer placement moves, but the finding was not significant ($p = 0.3916$).

Discussion

Overall, children receiving wraparound through Project Destiny, as compared to children receiving traditional child welfare services, did not have higher levels of child safety, placement stability, or permanence. However, the three main hypotheses are broad and comprised of several indicators. The results suggest that wraparound is having some positive impact on child welfare outcomes, most notably the finding that children receiving Project Destiny had greater odds of living in a family-based (i.e., less restrictive) environment at the end of the study.

A number of factors may account for the less than robust findings. First, the status of Project Destiny as a mature program is questionable; it may be that the program was evaluated prior to reaching the necessary maturity to be effective. Second, the sample had a high level of heterogeneity in a number of areas, a situation that may make influencing the selected outcomes more difficult. Finally, what appears to be the most likely reason for the less than resounding findings is the distal nature of the outcomes selected (child safety, placement stability, and permanence) for assessment in relation to the intervention's focus (changing/managing child behavior). It does not seem surprising that positive changes would be undetectable in such a relatively short amount of time in variables somewhat removed from the direct intent of the intervention.

The findings suggest a number of programmatic recommendations. First, a reduction in the heterogeneity of the target population would help concentrate the intervention. Second, a focus on the development of informal supports would increase model fidelity. And third, improved capacity to work with family situations where a primary caregiver is not immediately identifiable my lead to improved outcomes. Finally, as a question of policy, the findings appear to support the continuation of wraparound in Alameda County.

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Symposium Discussion

Eric J. Bruns

Wraparound is one of children's mental health's "mystery boxes." Just about every state in the nation has several programs for youth with mental health challenges that call themselves "wraparound." The vast majority of Center for Mental Health Services-funded systems-of-care sites propose to use the wraparound process as a way to implement individualized care planning and management. Yet, there have been only four published experimental or quasi-experimental studies of wraparound. One of these studies did not even refer to itself as wraparound, two had massive attrition problems to the ultimate samples studied, and none of the studies used implementation measures to help determine what treatment process was actually administered. Wraparound's research base is poorly developed for several reasons. For one, it has been innovated in multiple directions by many individuals and communities rather than through a systematic process by one individual or research team. Perhaps most importantly, wraparound is always described as a process—not a treatment—and its individualized, multi-modal nature makes it a very complex process at that. Also, depending on who you talk to, wraparound is a process that is proposed to achieve many different outcomes across many different levels, including the child and family level as well as program, jurisdictional, and system levels. Yet, 20 years since

"wraparound" programs began to gain attention, we are only now beginning to flesh out this complex theory of change about the critical ingredients of wraparound, its intended population, and proposed outcomes. Doing so is critical to our ability to conduct research studies and interpret their results.

Given this history, any well-conducted study of the implementation or impact of wraparound is extremely relevant and important to the children's mental health field. The studies presented in the current symposium significantly advance the research base, especially because they all present data on wraparound implementation, consider their target population and study samples, and explain their selection of outcome measures. At the same time, they also provide a useful synopsis of the major issues we must contend with as we research individualized service and support planning processes. Four main examples come to mind. These examples extend across the "logic chain" of wraparound, from population served to the specifics of the wraparound model to outcomes.

At the front end of the logic chain is the question of population served. As we see from the Abrahamson & Tyda evaluation of Wraparound Sacramento, outcomes can vary greatly across types of youth and family who receive wraparound. Meanwhile, in Ferguson's study of California's Title IV-E Child Welfare Waiver Demonstration Project, the wraparound process was found to have been provided to children and families with a broad range of needs, but the program's proposed outcomes were highly specific to a child welfare population, possibly diluting the likelihood of finding impact. In general, this is a critical issue facing providers who wish to employ the wraparound process, as well as researchers—currently, there is little understanding of which families and youth will benefit most from the process. As for any other treatment approach, theory and research must advance in this area if we are to make the most of our investments in the wraparound process.

Progressing along the wraparound logic chain, the second issue illuminated by these studies is that of the model's critical ingredients, and their relationship to child and family outcomes. Here we see that all studies incorporated a measure of wraparound implementation—a positive indicator that the research base on wraparound is advancing. What's more, we see from the Ferguson evaluation that the implementation measure used, the Wraparound Fidelity Index, can reliably distinguish a wraparound condition from a comparison condition. This is highly encouraging in that it tells the field that wraparound is a distinct and measurable intervention option, and that we have a measure that can evaluate the extent of its implementation. Finally, we also see (from the Sacramento, Nevada, and Arizona studies) that greater wraparound adherence as measured by the WFI seems to be associated with better outcomes for families. Needless to say, this is also a highly important finding that reinforces the need to maintain fidelity to the core principles of wraparound. However, in light of our other findings that different types of youths may not benefit equally from the process, it seems we must now begin to move toward a better understanding of those factors that are most reliably associated with different types of outcomes. Again, this points to the need to determine the theory of change for wraparound and test it through more rigorous designs.

This leads us to the next "box" in the wraparound logic chain—that of proposed outcomes. Specifically, we see that some of these studies find significantly positive results across the range of outcomes tested (e.g., in Nevada; in Arizona, for families who receive "high-fidelity" wraparound, and in Sacramento, for certain referral groups), while other programs did not fully achieve intended impact. Most saliently, perhaps, we see that outcomes measured across the studies vary greatly, and that it is possible the outcomes chosen for the California Title IV-E Waiver program were too distal from the actual effects of wraparound (and the population served too heterogeneous) to find impact. As described above, a well-defined theory of change for wraparound, combined with research that tests impact across a set of carefully considered outcomes (including intermediate outcomes such as parents' perceived support, family member self-efficacy, involvement of natural supports in the family's life, etc.), will aid our selection of outcome measures so that they are most appropriate. In this way, we can learn from other evaluations of complex, multi-level efforts (e.g., systems of care) that highlight the need to make sure the "logic chain" is not too long between efforts undertaken and proposed outcomes for actual children and families.

Finally, consideration of all the above issues begs the question: What will be the most useful research designs to use in order to advance the wraparound research base? At this juncture, wraparound seems to be in the paradoxical position of still being at a formative stage of evaluation, while simultaneously the field is demanding summative evidence for effectiveness. We should probably be conducting parallel scopes of work; a theory of change for wraparound needs to be proposed, aligned with associated implementation procedures and manuals, and tested via formative quantitative and qualitative procedures. At the same time, extant wraparound models (assuming they are specified well enough to have fidelity measured and ultimately be replicated) can be tested via quasi-experimental or experimental protocols (as done preliminarily in several of these evaluations) or, perhaps even more appropriately, through a series of single-subject studies across several contexts. Needless to say, comparison group designs will always require careful consideration of the comparison being employed. Should the counterfactual be non-community treatment settings such as residential-based care? Or perhaps an alternative community-based approach, such as traditional case management? Such decisions will need to be based on practical questions as well as on what the field needs to know.

Overall, the conclusions of these four studies are unanimous in proposing that wraparound demonstrated benefits for the children and families studied; however, the outcomes that were found varied as a function of the target population and the degree of adherence to the wraparound principles. For those who are most interested in validating specific practice options in children's mental health, these studies continue to build a base of positive evidence for the impact of wraparound. However, the implications about the complexity of the relationship between wraparound and outcomes may be just as important, and will hopefully encourage researchers to fully engage themselves in looking carefully and creatively into the "mystery box" of the wraparound process.

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The Impact of Multisystemic Therapy on Children Within a System of Care

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Introduction

The search for effective interventions for children with serious emotional disorders is a critical issue. Serious emotional disorders are estimated to affect between 9-19% of youth (Friedman, Kutash, & Duchnowski, 1996). This population has low graduation rates, high rates of involvement with the justice system and high unemployment rates upon reaching adulthood (Koyanagi & Gaines, 1993). A number of approaches have been promoted to effectively remediate the negative effects of serious emotional disorders. Stroul and Friedman (1986) proposed a systems-of-care approach that includes an array of service options, coordination of funding across child-serving systems, and adherence to a set of principles including cultural competence, family involvement, and interagency collaboration. Closely related to the systems-of-care model is the wraparound services model, which outlines methods for individualizing services for each child and family (e.g., Lourie, Katz-Leavy, & Stroul, 1996; VanDenBerg & Graelish, 1996). Although the research on systems of care and the wraparound approach has not yielded tremendous empirical support (Della-Toffalo, 2000), these approaches tend to be widely adopted. For example over 88% of states report the use of the wraparound approach for children with mental health problems (Rogers, 2003). Both the systems-of-care and wraparound approaches are central features of the Department of Health and Human Services Comprehensive Community Mental Health Services Program for Children and Their Families—fiscally the largest effort by the federal government in children's mental health.

Other efforts to address the mental health needs of children have focused on the development of specific clinical interventions. One of these, Multisystemic Therapy, focuses on changing behaviors within the natural environments of the youth (e.g., family, school, peer group, community; Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998). Numerous studies using rigorous research designs have demonstrated the effectiveness of Multisystemic Therapy (MST) with juvenile offenders (e.g., Henggeler et al., 1997), youth with substance abuse histories (Schoenwald, et al.,1996), and youth with psychiatric disorders (Schoenwald et al., 2000).

The youth involved in the Multisystemic Therapy studies have generally not been involved in a system of care or served through a wraparound approach (Henggeler et al., 1986). Given the prevalence of these models in the United States, it is important to determine whether Multisystemic Therapy can produce positive outcomes for youth with serious emotional disorders who are served in a systems-of-care/wraparound context.

Methods

The Nebraska Family Central project presents a unique opportunity to study the impact of Multisystemic Therapy as implemented through a systems-of-care/wraparound approach. Nebraska Family Central is a Comprehensive Community Mental Health Services for Children and Families Grant project funded from 1997 through 2003. This project adopted the systems-of-care and wraparound approaches and also developed Multisystemic Therapy as a clinical intervention in its array of services. In the Nebraska Family Central project, children with serious emotional disorders and their families are served through a child and family team using a wraparound approach. If a child meets the criteria for Multisystemic Therapy, he or she and the family are referred for this service. Generally, youth referred for MST exhibit a combination of the following behaviors: (a) physical aggression in the home, at school or in the community: (b) verbal aggression, verbal threats of harm to others; (c) school truancy; (d) school failure; (e) other criminal or delinquent behavior; (f) association with delinquent peers; and (g) substance

abuse in the context of these inclusion criteria. The Multisystemic Therapist becomes a member of the child and family team and MST becomes one of the interventions/strategies employed to address the needs of the child and family.

Participants in the study were youth enrolled in the project that received Multisystemic Therapy (*N* = 54). The Nebraska Family Central utilized the Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, 1994) and the Weekly Adjustment Indicator Checklist (WAI; Burchard, 1990) to assess the needs of the child and to measure progress in services. The CAFAS was administered semiannually by individuals who received training from qualified trainers in the use of the CAFAS, and the WAI was administered weekly through caregiver interviews. Measures from both scales collected before and after admission into Multisystemic Therapy were used in the analyses.

Results

A *t*-test of mean scores on the CAFAS scale before and after entering Multisystemic Therapy (MST) indicated that behavior significantly improved overall, $t(54) = 3.494$, $p = .001$. This difference was driven by significant improvement in behavior on several of the CAFAS subscales: home role performance, behavior toward others, moods/emotions, and self-harmful behavior (all means and *t*-tests presented in Table 1).

Non-significant decreases in behavior were observed on a few of the CAFAS subscales. Substance use decreased slightly, but because substance use was low to begin with, this decrease was not significant, pre-MST mean = 3.27, post-MST mean = 2.82, $t(54) = .448$, $p = .656$. Thinking issues were also low before entering MST (pre-MST mean = 6.73), and only decreased slightly (post-MST mean = 6.00). Again, this difference was not significant, $t(54) = .649$, $p = .519$. School role performance and community role performance also did not change as a result of MST (see Table 1 for means and *t*-tests).

For the Weekly Adjustment Indicator Checklist (WAI), *t*-tests on both negative and positive behaviors indicated improvement after entering MST (means presented in Table 1). Negative behaviors decreased significantly, $t(42) = 5.055$, $p < .001$), while positive behaviors increased significantly, $t(42) = -3.240$, $p = .002$.

Table 1
Mean Scores Pre-MST and Post-MST, and T-statistics for Selected Measures

	Pre-MST Mean	*Post-MST Mean*	*T-Statistic*	*df*	*P-value*
CAFAS					
TOTAL CAFAS	126.48	105.45	3.494	54	0.001*
School Role	23.18	22.09	0.815	54	0.419
Home Role	26.61	23.36	2.381	54	0.021*
Community Role	14.61	11.00	1.949	54	0.057
Behavior Toward Others	21.88	18.09	2.841	54	0.006*
Moods/Emotions	20.24	16.82	2.596	54	0.012*
Self-Harmful Behavior	10.15	5.82	3.419	54	0.001*
Substance Use	3.27	2.82	0.448	54	0.656
Thinking	6.73	6.00	0.649	54	0.519
WAI					
Negative Behaviors	9.12	5.91	5.055	42	<0.001*
Positive Behaviors	15.53	17.58	-3.240	42	0.002*

*Indicates 2-tailed significance at the .05 level.

Discussion

The results indicate that children within the system of care achieved significant increases in positive behaviors, decreases in negative behaviors, and improved functioning after participating in Multisystemic Therapy. These youth showed significant improvement on four of the eight CAFAS subscales: home, behavior toward others, moods, and self-harmful behavior.

The literature tends to depict wraparound/systems of care and Multisystemic Therapy as alternative approaches in the treatment of children with serious emotional disorders. The results of this study provide preliminary evidence that Multisystemic Therapy used in the context of a systems-of-care and a wraparound approach can be effective in addressing the needs of the target population. Therefore, a service delivery model that incorporates elements of all three approaches is a viable and promising paradigm.

This phase of the study used a simple pre-post design using two outcome measures. As the study progresses, we will employ a more rigorous quasi-experimental design using a matched control group. Later phases of the study will also use additional outcome measures.

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Treatment Fidelity and Parent Participation in a Multi-Site Wraparound Initiative

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Introduction

The Coordinated Family Focused Care (CFFC) initiative was developed to better coordinate the care of children and adolescents who are at risk of hospitalization or residential placement because of serious emotional disturbance (SED). The program builds on family strengths and available support systems to help children remain in or return to the community. The CFFC is a wraparound initiative sponsored by the Massachusetts Secretary of Health and Human Services and five human services agencies: the Department of Mental Health (DMH), the Department of Social Services (DSS), the Department of Youth Services (DYS), the Division of Medical Assistance (DMA) and the Department of Education (DOE). The Massachusetts Behavioral Health Partnership, which manages Medicaid mental health benefits in the Commonwealth, manages the CFFC program. There are five CFFC sites.

CFFC has been designed to be consistent with the National Institute of Mental Health's Children and Adolescent Support Services Programs (CASSP) principles, which require services to be child-centered, family-focused, community-based, multi-system, culturally competent, and provided in the least restrictive environment. Wherever possible, services are being provided by staff who are of the same ethnicity as the families. Services are also provided in the family's native language whenever possible. Enrolled children have a two-staff team assigned to them, which consists of the Care Manager (a Master's level clinician) and a Family Partner (an individual who has been a primary caregiver for a child with SED).

Through a grant from the Center for Health Care Strategies, the University of Massachusetts Medical School is studying program outcomes at the five CFFC sites. Outcomes measured include child's mental health status; child's functioning at home, school and community; services received and costs; parent-child interactions and stress; child strengths; satisfaction with services; parent participation in services; and fidelity of treatment to CASSP principles.

Measurement of treatment fidelity is a central aspect of this inquiry. This summary describes initial findings regarding fidelity to the wraparound model and child functioning, and the methodology developed to assess this relationship. Although wraparound has become one of the most popular strategies for systems treating children with serious emotional or behavioral disorders, there is no single set of standards that can be used to implement high quality wraparound practices (Burchard, Bruns & Burchard, 2002). The term "wraparound" is used to describe many very different types of services processes. Even if a community intends to provide wraparound in accordance with its theoretical principles and elements, it is harder to accomplish this task than one may think. Therefore, in order to replicate the wraparound program, it is vital to establish fidelity to the treatment model.

Procedures and Methods

In order to be eligible for enrollment in CFFC, the child must be 3-18 years old; at risk for residential or more restrictive placement; have attained a score of 100 or higher on the Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, 2000) and/or the Preschool and Early Childhood Functional Assessment Scale (PECFAS; Hodges, 1999); reside in one of the CFFC designated communities and; have a serious emotional disturbance. A parent or caregiver must also agree to participate in the child's services and service team.

As part of their child's clinical care, caregivers complete a number of questionnaires about the child's symptoms, functioning, and strengths. They are asked to share this information with the evaluation team and to participate in phone interviews three and nine months after their child's intake into CFFC

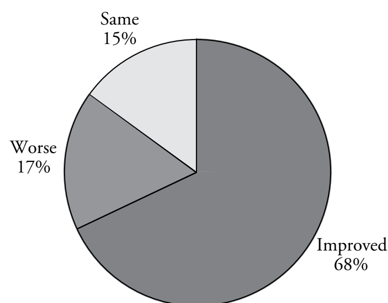
services. The interviewers are not affiliated with the child's care. Consent for participation in the study is obtained by the child's care manager upon intake into services. The risks and benefits are explained, and a consent form approved by the UMass IRB is signed. Participants are paid $10 for each phone interview. Clinical services are not denied if families refuse to consent to information sharing and the phone interviews, but families are required to complete the questionnaires as part of their clinical services.

The evaluation team administers the WFI (Wraparound Fidelity Index; Bruns, Burchard, Suter, Force, & Leverentz-Brady, in press) to assess how closely the five CFFC sites are implementing the program. The WFI includes caregiver ratings of the theoretical elements of the wraparound Process. These elements are Voice and Choice, Youth and Family Team, Community-Based Services, Cultural Competence, Individualized and Strength-Based Services, Natural Supports, Continuation of Care, Collaboration, Flexible Resources and Outcome-Based Services. To address how involved parents and caregivers feel they are with their child's services, the Family Participation Measure (FPM; Friesen & Pullmann, 2002) is administered via phone interviews. Since previous research has indicated that family empowerment is related to reductions in externalizing problems for children in such services (Taub, Tighe & Burchard, 2001), the Competency subscale of the Family Empowerment Scale (FES; Koren, DeChillo, Friesen, 1992) is administered.

Results

Intake and three-month interview data were obtained for the first 41 enrolled children. One-third (*n* = 14) were female. Seven percent were five years old or younger; 51% were between the ages of 6 - 11; 25% between the ages of 12 - 15 years, and 17% were 16 years or older. The mean CAFAS score at intake indicated severe impairment (*M* = 141) for this sample; at three month follow up the mean score reflected reduced levels of impairment at 116. Two-thirds of the group showed improvement in their CAFAS scores from intake to three month follow up; 15% remained the same; and 17% showed increased impairment (see Figure 1).

Figure 1
Changes in CAFAS Score (*N* = 41)



Results from the WFI indicated high fidelity scores in a number of areas. Each element has four items scored as a 0,1 or 2, for a maximum total score of 8. Results ranged from a mean score of 4.35 (*SD* = 1.9) on Natural Supports to a mean of 7.42 on Continuation of Services (*SD* = 1.1) and 7.43 on Voice and Choice (*SD* = 0.9). Cultural Competence was also an area of great strength, with a mean score of 7.05 (*SD* = 1.9). Results from all the WFI elements can be seen in Figure 2.

As shown in Table 1, correlation coefficients revealed that Community Supports was the only WFI element that was significantly related to reductions in CAFAS scores from Intake to three month follow-up (*N* = 39; $p > .05$). A number of WFI elements were positively correlated with the FPM: Youth and Family Team, Individual Supports, Flexible Resources and Funding, Collaboration, and Outcome Based Services and Supports. Finally, both Natural Supports and Individual Supports were positively related to scores on the Competency scale of the FES.

Discussion

This data reflects outcomes for our first 41 enrollees to the CFFC program. We are continuing our efforts as the program reaches full enrollment of 250. We will also conduct follow-up interviews with caregivers at nine months into services. Given that these results are preliminary, we have gained some

Figure 2
Wraparound Fidelity Index Elements

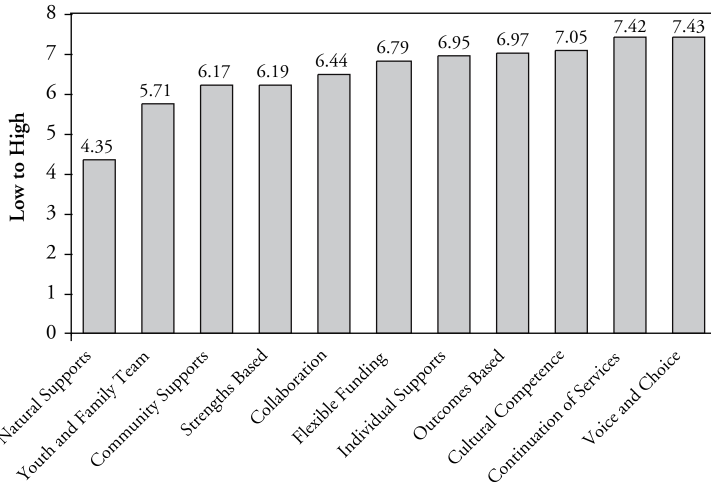


Table 1
Correlations

	WFI Elements	*Youth & Family Team*	*Community Supports*	*Individual Supports*	*Natural Supports*	*Collaboration*	*Flex funds*	*Outcome based*
CAFAS 3 month Follow up	Pearson Correlation		-.322(*)					
	Sig. (2-tailed)		.046					
	N		39					
CAFAS change score (Intake to 3 months)	Pearson Correlation		.339(*)					
	Sig. (2-tailed)		.035					
	N		39					
Family Participation Measure	Pearson Correlation	.343(*)		.394(*)		.356(*)	.525(**)	.393(*)
	Sig. (2-tailed)	.032		.016		.036	.004	.029
	N	39		37		35	28	31
Family Empowerment Scale (Parent subscale)	Pearson Correlation			.335(*)	.496(**)			
	Sig. (2-tailed)			.040	.003			
	N			38	34			

*Correlation is significant at the 0.05 level (2-tailed).
**Correlation is significant at the 0.01 level (2-tailed).

useful information from this study. While our providers appear to be doing quite well in maintaining treatment fidelity in almost all areas, there is still room for improvement in the areas of Natural Supports and the Youth and Family Team. It is perhaps not surprising that developing a natural support system for challenged families who are involved with multiple professionals and providers might take time to establish. This study has also found that both Individual Supports and Natural Supports are positively related to caregivers' feelings of competency on the Parent Empowerment Scale. Providers report that families are often isolated and do not have many natural supports, or they do not have friends or family whom they trust to be part of a treatment team where personal and family issues are discussed. At the same time, establishment of such supports plays a role in parental feelings of competency, so it is an important focus for treatment. It is hoped that the feedback from these initial findings will help the providers focus more attention on this aspect of treatment.

Another useful finding from this study is that the primary element of wraparound treatment fidelity, Community-Based Services and Supports, was found to be positively related to children's functioning scores. It will be useful to assess which specific services are utilized, and whether these services also have an impact on children's clinical symptoms. Overall, these results are preliminary, and we look forward to seeing whether findings are reflected within our larger sample, and over time longitudinally. In the future, we will examine how results change over time in fidelity measures; differences between the five sites; differences by ethnicity, and; how treatment fidelity relates to child clinical symptoms, parental stress, and service utilization.

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Team Members' Perceptions of Wraparound Teamwork: An Intensive Analysis of Videotaped Meetings

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Introduction

Wraparound has become one of the most popular strategies for implementing the systems of care philosophy for children with serious emotional or behavioral disorders (Faw, 1999). However, achieving high quality implementation of wraparound has proven to be difficult. In part, this difficulty stems from the fact that while there is agreement about the values that should guide the wraparound process, there is no generally agreed-upon model or manual for translating those values into practice (Burchard, Bruns, & Burchard, 2002; VanDenBerg, Bruns, & Burchard, 2003).

Part of this difficulty stems from the nature of value-based practice in wraparound. The wraparound process is supposed to be strengths based, family centered, culturally competent, and individualized (Burns, Schoenwald, Burchard, Faw, & Santos, 2000), yet there is little specific guidance available that tells treatment planning team members what they should do to ensure that teamwork will in fact promote these values. What is more, the team is required to promote the value base while at the same time engaging in a collaborative planning process that will mobilize services and supports to meet the family's needs.

The study described here uses the intensive study of videotaped team meetings to explore the extent to which team members perceive that wraparound teamwork is building team effectiveness by promoting (a) high quality planning, (b) collaborativeness or team "cohesiveness," and (c) adherence to wraparound values.

Method

For the study, 11 wraparound team meetings were videotaped. Each of the teams was in the midpoint of its work (i.e., team members had worked together and with the family for more than six months) and was using the meeting to update plans. The 11 teams were drawn from seven different wraparound programs in six different states. Five of the teams were drawn from communities recognized by the Comprehensive Community Mental Health Services for Children and Their Families Program of the Center for Mental Health Services for best practices related to wraparound (e.g., Kendziora, Bruns, Osher, Pacchiano, & Mejia, 2001). At the conclusion of the meeting, team members filled out a brief questionnaire that asked them to rate the quality of the meeting along two dimensions: team cohesiveness and team planning productivity. Team members were also asked to briefly list the best and worst aspects of the meeting.

Within two days of the meeting, portions of the videotape were reviewed separately by the key participants from the team (i.e., family member caregivers, youth [where appropriate], facilitators, and practitioners). Each key team member reviewed nine 5-minute segments from the meeting: three consecutive segments from the beginning of the meeting, four consecutive segments from the middle of the meeting, and two consecutive segments from the end of the meeting. After each 5-minute segment, the videotape was paused for debriefing.

Participants then responded to a series of open- and closed-ended questions that probed for the their impressions regarding both the quality of the planning process and the team's cohesiveness during that segment. Participants first rated, on a numerical scale, the interpersonal climate during the segment

and the productivity of the team during the segment. They were then asked to explain the factors that they considered in making their ratings. A non-participant, experienced parent-facilitator also reviewed each tape and participated in the same cued recall procedure. All comments during the cued recall were taped and transcribed. A total of 62 team members from the 11 teams participated in the cued recall procedure, with a total of 558 segments rated.

Coding

A coding system was developed to code transcripts from the cued recall. The coding system was based on a model of effectiveness in wraparound teamwork (Walker & Schutte, 2004) that sees wraparound team effectiveness as arising from the ability of the team to (1) maintain a high quality planning process and (2) build cohesiveness while (3) using practices that promote the value base. The coding system was designed to classify the rationale offered by participants for their ratings of the quality of the planning process, the level of team cohesiveness, and the extent to which team interactions reflected the value base during each segment of the meeting.

The coding system was revised many times to increase the extent to which participants' views were captured by the coded categories, and to increase inter-rater reliability; however the final coding system retained the basic structure with a focus on high quality planning, cohesiveness, and value-based practice (see Table 1). Because of the tendency of participants to make the same points and use similar statements throughout debriefing on a particular segment, the whole response for a segment was used as the unit of analysis. Coders thus were to determine which of the coded categories were present in each unit. After the coding system was finalized, coders trained for 40 hours and achieved an overall inter-rater agreement in excess of 85%. Inter-rater agreement on individual items ranged from .74 to .97. Ongoing reliability checks were preformed to maintain this level of agreement and guard against drift in coding.

Two additional categories were added during the development of the coding scheme. One category coded participants' comments related to meeting facilitation and the effectiveness or ineffectiveness of various team members' efforts to guide meeting process. The other category coded participants' comments related to the parameters of the meeting and included a series of subcategories focusing primarily on meeting logistics: where it was held, who was there, whether there was food or childcare available, etc. For each category, a given unit of analysis could be coded as having a positive example (i.e., the team or a member was described by the participant as having demonstrated this element) and/or a negative example (the team or a member failed to demonstrate the element or impeded others' efforts to do so). Each coded text unit was also associated with an "actor" who was demonstrated or failed to demonstrate the element. Thus, for example, a complete coding could indicate that the speaker had pointed to whole-team success in sharing information or that a professional team member had failed to act in a family-centered manner.

The transcripts of the meetings were also coded—segment by segment—for data related to the number of speaking turns by each team member, length of speaking turn, and salient aspects of the content (this portion of the coding system was developed from approaches used in the study of conflict resolution (Kimsey, Fuller, Bell, & McKinney, 1994; Pearson & Thoennes, 1989).

Table 1
Coding Categories for Debriefing Transcripts and Rank of Frequency of Use[1]

Coding Category Sub-category	Rank of Use		
	Total	*Positive*	*Negative*
Process advocacy/facilitation			
Teamwork is guided, facilitated appropriately	4	5	4
Planning/Productivity			
Team[2] is businesslike			
Team starts meeting on time			
Team stays on task	2	3	1
Team develops plan/goals			
Team members share information	1	1	3
Team members provide information that is reliable/accurate			8.5
Team employs expands perspectives or generates options			
Team holds members accountable			
Team evaluates and/or revises/adjusts strategies as needed			
Strategies are appropriate			
Cohesiveness/Collaboration			
Team is cohesive		7	
Team acts in a collaborative manner	6	6	6.5
Team shares values			
Team members care about child/family			
Team members support wraparound			
Team members act in ways that are family centered	3	2	2
Team communicates strengths-based view of family/youth	5	4	
Team strives to provide community-based services/supports			
Team promotes cultural competence			
Team provides psychological safety	7	8	8.5
Team ensures a safe environment for emotional support/venting			
Team ensures a safe environment for openness and honesty	10		
Team discusses difficult issues tactfully			
Team promotes equity and a sense of fairness	8	9	10
Team allows all members to fully express views			6.5
Team builds a sense of efficacy and hopefulness		10	
Meeting parameters			
Needed people attended meeting			
Meeting held at appropriate location			
Meeting held at appropriate time			
Food was available			
Breaks were taken when necessary			
Child care was provided/child in meeting	9		5

[1]Rank provided for ten most frequently-used categories only
[2]In this table, *team* may refer to the team as a whole or any subset of members that is the focus of the participant's comment.

Results and Discussion

The final coding system for the comments during the debriefing sessions retained the focus on planning/productivity, collaboration/cohesiveness, and value-based practice (see Table 1). Overall, more of the units of analysis included positive descriptions of team/team member contributions to teamwork than negative descriptions, and this was also true of most of the individual coding categories as well. For example, for the most frequently coded category, *team members share information*, there were 380 instances in which participants cited positive examples of sharing information versus 77 examples of failing to do so. This pattern held generally true for the remainder of the ten most frequently used coding categories. The overall positive view of meetings was also reflected by participants' responses to the post-meeting surveys. The mean rating of team members' scores for *team cohesiveness* was 8.10 out of a possible 10, and for *team planning productivity* was 8.18 out of 10.

There was one exception to this generalization. The exception was with regard to the category ranked ninth in overall use. This category captured comments related to having a child (other than the identified child/youth) in the meeting. For this category, negative comments predominated, and referenced disruptions by children (usually siblings) in the meetings, interruptions by children or childcare providers for children who were not in the meeting, or the need to alter the content of communications due to the presence of children in the meeting. Further analyses will examine the extent to which different types of participants (caregiver, youth, facilitator, professional) appear to be focusing on the same categories when describing the positive and negative aspects of meetings, and the extent to which team members focus on the same elements during their evaluation of a given meeting segment.

Despite the overall positive view of meetings, there was considerable segment-to-segment variation in members' ratings of planning and cohesiveness. For many segments, there was also considerable variation between members' ratings within segments. In one team, the mother and the school psychologist rated the productivity of a number of segments at the opposite ends of the scale from each other. Preliminary analyses indicate that team members were more likely to rate segments in which talk was dominated by one speaker as both less productive and less cohesive. During these same segments, however, the speaker him or herself tended to rate productivity and cohesiveness higher than other team members. Ratings of satisfaction and team productivity tended to decline from the beginning of meetings to the end. Future analyses will be necessary to confirm the preliminary findings and to examine the extent to which particular types of coded teamwork elements are associated with most positively and most negatively rated meeting segments.

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Negotiating Practice: The Use of Communication to Construct Family Centered Care in a Community Mental Health System of Care

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Introduction

This research employs communication theory to investigate the experiences of participants in wraparound team meetings in the Tampa Hillsborough Integrated Network for Kids (THINK) program in Hillsborough County, Florida. The THINK project, along with the other CMHS-funded programs, is based on a systems-of-care philosophy and wraparound service provision principles. We were specifically interested in how the team process as related to effective group communication influenced the inclusion of systems-of-care and wraparound principles in service planning.

Method

The team meetings allow for observation of the team process in a naturalistic setting. One or two observers attend each child and family team meeting, using both a quantitative checklist (Epstein, et al. 1998; Epstein, et al. 2002), and a qualitative, ethnographic methodology. This paper focuses on the qualitative results of the research. Because the study is ongoing, this summary reports on the findings from the first 100 observations.

Results

A grounded theory analysis of the data yielded five communication factors that seem to influence the team's adherence to systems-of-care or wraparound principles; these are:

Systems orientation. The attitude held by a team and its members such that the whole is experienced as being greater than the sum of its parts; that is, the whole is made up of parts that are interconnected and interrelated (Watzlawick, Bavelas, & Jackson, 1967).

Framing and sensemaking. Framing makes explicit the foundation of beliefs, values and expectations for team members. For example, if systems-of-care principles are core values for planning activities, overt framing would include reminding the team members of their obligation to incorporate them.

Meeting Structure. The structure of the meeting may also influence communication between members by, for example, allowing more or less time for individual comments, a commitment to starting and ending on time, etc.

Empowerment. An empowered team is one that has the capability, responsibility, and authority to carry out the mission (Parker, 1994) of the wraparound team. Empowered team members understand that they are both allowed to and capable of carrying out the group's mission. For example, in the child and family team meetings, family empowerment includes skill building to help families meet their needs and those of their child.

Role clarity. Individuals possess many different social identities, each with their own rules for behavior and interaction. Social scientists call these our social "roles," and suggest that these multiple identities shift according to the context in which we find ourselves (Goffman, 1967, 1974),

We found that a *systems orientation* was not always evident in the team meetings. Some meetings were fragmented, with members talking in dyads and participating only at certain points during the meeting. Some meetings included one or two members who said nothing and behaved more like an observer than

an active participant. Many of the non-professional team members (e.g., clergy, extended family, friends, and neighbors), did not participate as full team partners. They spoke less often than others, and were addressed less often, or were ignored by the other meeting participants. These non-traditional partners tended to participate only when directly invited to do so and when they did talk, their comments were much more limited than others.

A few notable exceptions were observed, which manifested a successful systems orientation: members seamlessly played off of one another's comments, questions, strengths, and skills. The meetings were characterized by smooth turn taking and transitions, lengthy exchanges between all or most participants, and content that indicated increased levels of interpersonal knowledge among all members.

Overt *framing* attempts were not always made in the meetings. Often, team leaders did not state the system-of-care principles at the onset of the meeting. When the principles were stated, they were not always explained fully. They were usually offered in an attempt to deflect problem communication by saying, for example, "we want to focus on strengths," after a lengthy discussion of youth deficits. Yet there would be no further explanation of strengths v. deficits. In comparison, meetings that began by listing strengths for the team typically focused on strengths throughout the entire meeting; that is, the opening discussion framed the entire meeting.

Some meetings were more *structured* than others. The more structured meetings seemed to better reflect the systems-of-care and wraparound principles, but this structure also may inhibit some team members from voicing their ideas. Less structured meetings also may inhibit voices if other team members dominate the meeting; such meetings seem less likely to be oriented toward a system approach. It seems that it is not simply having a structure, but the nature of the structure, that is important for directing a team toward a systems orientation. Structures that both overtly and covertly frame the meeting around the systems-of-care and wraparound principles appeared to be the most effective for ensuring adherence to those principles. The most successful approach included implicitly stating guidelines and rules and modeling them both verbally and nonverbally.

In terms of empowerment, in most meetings, the team acted as an advocate to the family and youth by ensuring that their voices were heard, and by working for needed services or resources for them; such activities reinforce family empowerment. The teams usually involved the family in the meetings and appeared to respect them by exhibiting good listening behaviors. However, instances were observed in which the team did not respond to the family's comments, sometimes ignoring them entirely, looking away, or avoiding eye contact. These behaviors did not seem intentional, but they convey a disempowering message.

For example, families were invited to help design the child's Family Support Plan, and were specifically asked for feedback. However, sometimes the request for feedback seemed superficial, and leading questions would be asked, such as, "Are you okay with the plan? It's good, right?" Not surprisingly, the parent would agree. A similar problem emerged when the request for an answer did not allow for "pause time" in order to give the caregiver an opportunity to truly agree or to voice reservations.

A need for role clarification was evident in observations. Without adequate framing of the child and family team meetings, team members seemed unclear about their roles on the team. Because a team member may have numerous social roles outside of the team meeting setting (e.g., social worker, neighbor, parent, aunt, etc.), without clear definition it may be difficult to focus on and perform their role as *team member* in the context of the planning team.

Conclusion

Merely assigning people to a team and inviting them to a meeting does not create a child and family team, nor ensure a systems-of-care orientation. An effective team is motivated by a shared culture and a shared passion. Results from this study of communication patterns during meetings suggest that effective teams need senior management commitment, a shared vision, a clear mandate of authority, clear performance targets, success indicators, defined roles and responsibilities, trust, a balance between attention to task and process, realistic expectations, and goals (Parker, 1994). In order to successfully incorporate systems-of-care and wraparound principles within planning activities, a multi-step process is recommended:

- ***Develop a shared vision.*** "Shared visions… create a sense of commonality that permeates the organization and gives coherence to diverse activities… A shared vision is a vision that many people are truly committed to, because it reflects their own personal vision" (Senge, 1990, p. 206). An effectively crafted shared vision will frame the teams into a system attitude in which all team members are equally empowered and have equal voice (Parker, 1994; Senge, 1990).
- ***Create clear team goals***. It is important that team members work in the same direction and with the same goals in mind. An aligned team empowers the individual members, who will in turn empower the whole team. If the team does not share the same goals, and especially when individuals are empowered, desired outcomes will be more difficult, if not impossible (Parker, 1994; Senge, 1990).
- ***Create a plan for achieving goals.*** Teams need to decide on a common approach, including who will handle what responsibilities, how decisions will be made, how work will be planned, and how conflict will be handled (Parker, 1994; Senge, 1990).
- ***Gain the commitment of team members and stakeholders.*** To become a team, each member must be willing to succeed or fail together. Successful child and family teams commit to mutual accountability for the success or failure of their goals (Parker, 1994; Senge, 1990).
- ***Emphasize collaborative efforts and team rewards***. It is important for team members to recognize each other for their contributions to the team's process and their child and family goal achievements (Parker, 1994; Senge, 1990).
- ***Provide training to team leaders and team members on team and system approaches.*** Typically, team leaders and members are chosen for their technical skills or knowledge, and not for their management or interpersonal skills. Team training will help frame the meetings with systems of care and wraparound principles (Arnold, 1996; Parker, 1994; Senge, 1990).
- ***Create policies and procedures within the professional systems that are a part of the community mental health care system that support an interorganizational team approach.*** Organizations must create evaluation and reward systems that reward interorganizational teamwork (Parker, 1994; Recardo & Jolly, 1997).

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Training Curriculum: Strategic Communication for Effective Wraparound Facilitation

Christine S. Davis

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Introduction

This presentation describes a training curriculum for wraparound team meeting facilitation sponsored by the Tampa Hillsborough Integrated Network for Kids "THINK" program in Hillsborough County, Florida.

This training combines findings from two systems of care and wraparound fidelity measures–The Team Meeting Observation Project adapted from the Wraparound Observation Form (Epstein, Jayanthi, McKelvey, Frankenberry, Hardy, Dennis, & Dennis, 1998; Epstein et al., 2002) and the System of Care Practice Review (Hernandez, Gomez, Lipien, Greenbaum, Armstrong, & Gonzalez, 2001)—with communication theory on team meeting facilitation, to instruct how to facilitate a child and family wraparound team meeting that adheres to system of care and wraparound principles.

Research using the fidelity instruments has identified challenges wraparound teams have in fully implementing system and care and wraparound principles: helping the family form well-formed goals that are objective, measurable, and achievable; connecting child, family, and team strengths to needs and goals; following through on all child and family needs and identifying deep level needs that can empower the child and family; giving full voice to the family and informal supports; and forming a system or team from the individuals from varied backgrounds that come together to meet the needs of the child and family.

This training, presented to representatives of over a dozen community organizations in Hillsborough County, draws upon findings from these two projects to discuss how systems of care and wraparound principles can be operationalized into a team meeting; how to define well-formed family support plan outcomes; how to ascertain child and family needs that are both deep and long lasting; and how to create a Family Support Plan that adheres to the wraparound principles of being family centered, individualized, and strengths based. It also draws from research in communication and team facilitation to discuss communication basics such as nonverbal communication, listening skills, and rapport; and communication factors such as creating a system oriented team, framing the meeting, communication networks, team member empowerment, clarity of team roles, and power, credibility, and authority of the team leader. This paper discusses two of these topics: building a well-formed Family Support Plan and assessing family needs.

Family Support Plans

A goal or desired outcome that is well-formed is specific, measurable, and tangible, and is behaviorally precise (see Figure 1 for an example worksheet). The desired outcome is worded in such a way that anyone, even someone not present at the team meeting, could read it and tell exactly what was expected. A measurement can be *yes/no*, (as in, *was it done or not? Yes/no*), but it is better if it is measured incrementally with time frames (*will improve grades from a "C" to a "B" by the end of the grading period*). It is important to turn an attitude-change desired outcome into a behaviorally specific desired outcome. For example, rather than stating that you want the youth to "have more respect for his parents," define what "respect" would look like (e.g., cleaning his room, helping around the house, doing his/her homework without being asked). In translating a desired outcome into one that is specific, measurable, and tangible, you may create multiple desired outcomes. It is much easier to accomplish many small specific tasks than one large vague task.

Figure 1
Well-Formed Outcome Plan

<table>
<tr><td>What specifically do I want? How will I know that I am getting it? Where/with whom do I want it? What will I be doing? Saying? Thinking?</td><td colspan="3">(State in positive; within your control; sensory based description--what will I see/hear/feel</td></tr>
<tr><td>Present Situation: What am I currently doing/ saying/thinking about this situation?</td><td colspan="3">(Where am I now? How does my outcome differ from my present situation?)</td></tr>
<tr><td>When do I want it?</td><td colspan="3"></td></tr>
<tr><td>Cultural Competence Question: How does this support my life/work mission?</td><td colspan="3">(How does this support what my family/culture believes to be important--our values, beliefs, and lifestyle?)</td></tr>
<tr><td>How will getting it affect my life? What price(s) will I have to pay for getting it?</td><td colspan="3"></td></tr>
<tr><td>What benefits will I receive as a result of achieving this desired outcome?</td><td colspan="3"></td></tr>
<tr><td>How do my strengths support this specific desired outcome?</td><td colspan="3"></td></tr>
<tr><td>How do my team's strengths support this specific desired outcome?</td><td colspan="3"></td></tr>
<tr><td>What stops me from getting it now? What might get in the way of achieving it?</td><td colspan="3"></td></tr>
<tr><td>What resources do I now have this will help will achieve this desired outcome?</td><td colspan="3"></td></tr>
<tr><td>What resources do I need to achieve this desired outcome?</td><td colspan="3"></td></tr>
<tr><td>What actions will I need to take to overcome these obstacles? How will it be possible to achieve this desired outcome?</td><td colspan="3"></td></tr>
<tr><td rowspan="8">What specifically will I do to achieve this desired outcome? What steps will I take? When will I take them?
TAKE ACTION!</td><td>Step</td><td>Person Assigned</td><td>Date Due</td></tr>
<tr><td>1.</td><td></td><td>1.</td></tr>
<tr><td>2.</td><td></td><td>2.</td></tr>
<tr><td>3.</td><td></td><td>3.</td></tr>
<tr><td>4.</td><td></td><td>4.</td></tr>
<tr><td>5.</td><td></td><td>5.</td></tr>
<tr><td>6.</td><td></td><td>6.</td></tr>
<tr><td>7.</td><td></td><td>7.</td></tr>
</table>

Desired outcomes should be stated in the positive, in terms of what the family wants rather than what they don't want. For example, "Youth will sign up for after-school music lessons" is more positive than "youth will stop loafing around the house after school." In order to create a desired outcome, it is helpful to ask the family the following questions: What specifically do you want? How will you know that you're getting it? Where/with whom do you want it? What will you be doing/saying/thinking when you have it?

Desired outcomes also should be attainable and realistic. Is the desired outcome within the youth's or parent's control? Is it realistic to ask them to move into a larger apartment without determining if another desired outcome (making more money) should be accomplished first? If the youth is flunking all of his/her classes, is it attainable for him/her to get straight "As" by the end of the grading period?

It is also helpful to analyze each of the desired outcomes, first in terms of the present situation. What does the family have now, and how does what they want differ from what they currently have? One important question to ask is, "why don't they already have this?" Analyzing what has been getting in their way of achieving this desired outcome thus far will enable the family to identify and overcome the obstacles they will face in overcoming it in the future.

It's important also to ask how the desired outcome supports their life work and mission. This is really a question about cultural competence. Each family has a culture, with its own beliefs, attitudes, plans, and dreams. Will this desired outcome support their culture? Will it support what they want for their family? Will it support what they think is important for their family?

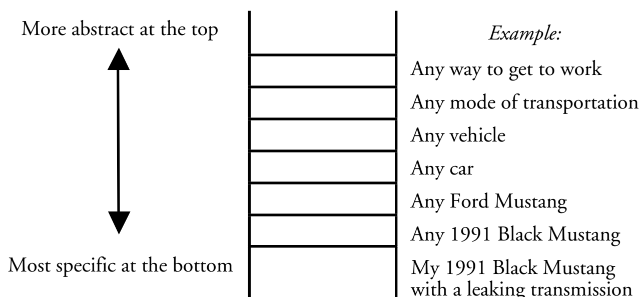
The next question to ask is, how will getting this desired outcome affect their life? What price will they have to pay to achieve it? Everything has a price. Achieving this desired outcome will require the family to accommodate to change. They may have to expend extra effort, take extra time or money (that they may not have), change their view of themselves or their world, do something risky or scary, or simply change the equilibrium in their lives. Discussing that before they face the challenges will give them an opportunity to be ready for them.

It is also important to discuss the benefits to be realized from achieving the desired outcome. When the "going gets tough," it will be helpful to remind the family (and the team members) why they are going through this. It is these benefits that will help the family maintain motivation to work through challenges. Remember that these are the benefits from the point of view of the family, which may not necessarily be the same as those seen by the rest of the team.

The final questions lead into the action steps to reach the desired outcome. First, ask, "What resources does the family need in order to achieve this desired outcome?" These may take the form of money, support, tutoring, respite, etc. Turn this list into actions by asking, "What actions will the team need to take to overcome these obstacles? How will it be possible to achieve this desired outcome?" then listing these as action steps with the question, "what specifically will we do to achieve this desired outcome? What steps will we take? When will we take them?" (Knight, 1995; Laborde, 1994; O'Conner & Seymore, 1990). Figure 1 can serve as a model for developing a worksheet to run through these steps with a family.

It's important that families set a mixture of long-range and short-range desired outcomes in their Family Support Plan (think of goals based on different levels of Maslow's hierarchy of needs). Short-range outcomes address urgent needs such as paying rent or catching up on an overdue electric bill before the power is shut off. If only urgent needs are addressed, families are not taking steps to escape chronic chaos. Long-range outcomes that result in preventing emergencies at a future point in time will empower families.

Figure 2
Ladder of Abstraction



The Ladder of Abstraction: Redefining Context

Our language has many different levels of abstraction. A term may be highly abstract, such as "freedom" or "respect," or highly concrete, such as "red Corvette" or "President Bush." More abstract terms vary in their definition; they require knowledge of context and experience to come even close to commonly understood meanings (Pula, 1993) One can think of these levels of abstraction as being on a ladder of nouns (things), with the most concrete types of things on the bottom rungs of the ladder, and the most abstract types of things on the top rungs (Reynolds & Gutman, 1988; Durgee, O'Conner, & Veryzer, 1996). Often, when exploring goals, clients will describe what they want to accomplish in very abstract terms: they want their child to show them respect, they want to have less stress, or they want things to go better. It is difficult to achieve a desired outcome when it is very abstract. In this case, it is desirable move the discourse down the ladder (see Figure 2), to something more concrete, where specific desired outcomes can be defined and attained. For example, if a client's concerns are that her child is disrespectful to her, it will be difficult to change that behavior until we know how, specifically, the child behaves, under what circumstances, and how, specifically, she wants the child to behave under those same circumstances.

Conversely, sometimes a client will speak in terms of problems, and often these problems are very specific; so specific, in fact, that it is difficult to see alternative solutions or situations. In this case, it is desirable to support the client's move up the ladder of abstraction, where a more abstract level will open up additional possibilities. In the following example, a client's problem is that their 1991 Black Mustang has a leaking transmission. To achieve a desired outcome around that problem, the client has one option—to fix the transmission. If the client cannot fix the transmission, he/she is without choices. Yet if the client moves up the ladder, it becomes apparent that any car will do—perhaps she just needs assistance obtaining another car with lower insurance and maintenance costs. If that is still not a viable option, the answer may be farther up the ladder. Now he/she has more options—other modes of transportation (bus, taxi, bicycle), or other ways to get to work (get a ride, walk). Moving up the ladder of abstraction has opened up a new host of possibilities for your client.

Through this process of laddering, you help clients translate an abstract desire into a specific means to reach that desire; when they are "un-stuck" there are new possibilities for addressing their underlying needs (Hewson, 1996; Laborde, 1994). Working in concert with well-formed outcomes, these strategies empower families to achieve success in their lives.

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