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“Becoming the Spoke in the Wheel”

Wraparound and the Theory of Change:

An Investigation into What Promotes Changes within Wraparound

A thesis presented in partial fulfilment of the requirements for the degree of

Doctor of Clinical Psychology

at Massey University, Wellington,

New Zealand.

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Abstract

The aim of the present study was to explore the changes that young people with high and complex needs and their families' experience through involvement with a Wraparound process. Also, to investigate if these changes aligned with those proposed by the Wraparound Theory of Change (WTOC; Walker, 2008). While there has been qualitative work done within the area of Wraparound, few studies have adopted Interpretative Phenomenological Analysis. Further, little Wraparound work has been done within the context of Aotearoa New Zealand. Finally, the WTOC is yet to be assessed and thus remains a theory. A fidelity measure was administered, and semi-structured interviews took place with five young people and six caregivers at the New Zealand Wraparound Program (NZWP) in the 'plan implementation and refinement' (third) phase of Wraparound. Analysis indicated NZWP families reported experiencing changes in the areas of family connectedness, psychological acceptance, self-efficacy, and supports. These findings were related to the pathways to change proposed by the WTOC which include (1) enhanced effectiveness of services and supports, individually and as a "package" leading to increased commitment to engage with services and (2) increased resources and capacity for coping, planning and problem-solving. Findings suggest the WTOC is accurate in its predictions for how changes come about for families involved in a Wraparound process. Such research supports future Wraparound refinement and evaluation. Additional international qualitative longitudinal research exploring change is required with young people and caregivers involved in Wraparound.

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List of Acronyms

ADHD: Attention Deficit Hyperactivity Disorder

CAMHS: Child and Adolescent Mental Health Services

CYFS: Child Youth and Family Services

CD: Conduct Disorder

DHB: District Health Board

DSM-IV: Diagnostic and Statistical Manual of Mental Disorders Fourth Edition

DSM-IV-TR: Diagnostic and Statistical Manual of Mental Disorders Fourth Edition Text Revision

DSM-5: Diagnostic and Statistical Manual of Mental Disorders Fifth Edition

HCNU: High and Complex Needs Unit

FGC: Family Group Conferencing

IPA: Interpretative Phenomenological Analysis

I-P-O: Input-Process-Output

NWI: National Wraparound Initiative

NZWP: New Zealand Wraparound Program

ODD: Oppositional Defiant Disorder

PDM: Participatory Decision-Making

PTSD: Posttraumatic Stress Disorder

WFI-4: The Wraparound Fidelity Index 4.0

WFI-EZ: The Wraparound Fidelity Index, Short Version

WHO: World Health Organisation

WTOC: Wraparound and the Theory of Change

I suppose we didn't really know what we were going to gain. But the truth is that the Wraparound process has been absolutely fantastic for us. For the simple reason that before that, we had all these different people involved in this process, and everyone was operating in their own corner. And having the Wraparound, and having the NZWP team in the middle of that, meant that they coordinated everything. 'Cause, before it was up to us to coordinate, and to be the spoke in the wheel. And they actually took over the spoke in the wheel function. So, that was really good…'cause the services actually don't work together particularly well. So they tend to be quite separate and operate all in their own little boxes. And Wraparound actually made sure that actually everyone was on the same page, that everything was happening in an integrated way that it wasn't all just splintered and siloed all over the place. Yeah, no seriously it's been a huge, huge help.

Chapter One: Thesis Overview

The current research explores changes experienced by young people with high and complex needs and their families involved with a model of care known as Wraparound. The Wraparound process explored in this study has been implemented by a District Health Board (anonymised for confidentiality purposes) in a large metropolitan city of New Zealand. The service adopting the Wraparound model bases their practice on guidelines provided by the National Wraparound Initiative, who define Wraparound as "an intensive, holistic method of engaging with children, youth, and their families so that they can live in their homes and communities and realise their hopes and dreams" (National Wraparound Initiative homepage, 2016a).

This thesis is made up of two manuscripts prepared for journal submission and four other chapters accompanying these. Chapter Two provides the context for this research by introducing concepts of young people with high and complex needs in New Zealand, the Wraparound process and the Wraparound Theory of Change, and the current research aims and questions. Chapter Three describes the relevant methodological and ethical considerations made for the research. Chapter Four presents the results of the study exploring Wraparound Fidelity of the NZWP (aiming to address Research Question 1), and themes arising from the Interpretative Phenomenological Analysis (aiming in part to address Research Questions 2 and 3).

Chapter Five presents the first manuscript which investigates family experiences associated with the Wraparound intermediate pathway to change proposed by Walker (2008a) describing an enhanced effectiveness of services and

supports, individually and as a package. Chapter Six, the second manuscript, explores family experiences associated with the Wraparound intermediate pathway to change proposed by Walker (2008a) describing increases in capacity and resources for coping and planning. Finally, Chapter Seven describes an overview of the findings, limitations of the study, clinical implications and a personal reflection from the researcher.

When reading a thesis containing manuscripts prepared for journal submission, it is inevitable that the reader will be faced with some repetition; such repetition is necessary as the manuscripts must be able to be read separately to the thesis. Repetition does occur in this thesis, particularly in chapters presenting introductory descriptions of Wraparound and the Theory of Change, the New Zealand Wraparound Program, in chapters describing the methodology for the research, and in results and discussion chapters. To assist smoother reading, all references are located at the conclusion of the thesis, including those cited within manuscripts.

There can be no keener revelation of a society's soul than the way in which it treats its children.

Nelson Mandela (1995)

Chapter Two: Introduction

This chapter aims to orient the reader to the area of youth with high and complex needs in Aotearoa New Zealand, the Wraparound model, the history and development of the Wraparound Theory of Change (Walker, 2008a). The New Zealand Wraparound Program and the aims and research questions for the current study are also presented.

Children and Youth with High and Complex Needs

Some children and young people have unmet needs so high and complex that general health, education and social services cannot accommodate them. High and complex needs might include behaviours putting the young person and others at risk such as suicidal behaviours, risk-taking activities, criminal activity, aggressive behaviour or substance abuse (High and Complex Needs Unit, 2005). Children and young people may also have needs that are so complex usual services are unable to meet them (Johnson, Davidson, Theberge, & Knitzer, 2008). They often require intensive interventions before improvements are possible, or have needs placing the caregivers under extreme stress resulting in compromised ability to provide adequate care. Caregiver stress may lead to children and young people no longer living with their families or caregivers, instead living in specialised placements (High and Complex Needs Unit, 2005). Young people with high and complex needs will often be involved with multiple services over an extended period and may experience little improvement (High and Complex Needs Unit, 2009). High and complex needs are importantly differentiated from needs which are related to mental health only.

According to the Aotearoa New Zealand Children, Young Persons, and Their Families Act of 1989, a child is defined as under the age of 14 years, while a young person is defined as being between the ages of 14 and 17 (Parliamentary Counsel Office, 2014). This thesis will adopt these definitions. The term family will refer to a family, whānau, hapū, iwi or family group (Child Youth and Family, 2014).

Youth Mental Health Statistics

Worldwide.

Mental health disorders are experienced by 10-20% of all children and young people globally, largely contributing to the global disease burden (Kieling et al., 2011; World Health Organisation, 2014). Broad mental health issues specific to children and young people according to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) include disorders of psychological development, and emotion and behaviour including attachment disorders, Attention Deficit/Hyperactivity Disorder (ADHD), Autism Spectrum Disorder (ASD), Conduct Disorder (CD), Depression, Encopresis, Enuresis, Generalised Anxiety Disorder (GAD), Oppositional Defiant Disorder (ODD), Posttraumatic Stress Disorder (PTSD), and Separation Anxiety Disorder (American Psychiatric Association, 2013).

A number of studies throughout the 1990s and 2000s investigated the prevalence of mental health disorders in children and young people up to the age of 17 in countries all over the world (Lawrence et al., 2015). Table 1 summarising the global prevalence rates of child and adolescent mental health disorders follows.

Table 1

Prevalence of Child and Adolescent Mental Health Disorders Globally

Country	Age (years)	Prevalence (%)
Australia	4-17	14.0
Ethiopia	1-15	17.7
Germany	12-15	20.7
India	1-16	12.8
Japan	12-15	15.0
New Zealand	3-15	24.0
Spain	8, 11, 15	21.7
Switzerland	1-15	22.5
United Kingdom	5-16	10.0
United States	1-15	21.0

It is difficult to accurately quantify the number of children and young people who would be considered as experiencing high or complex needs worldwide because of the limited data available and varied definitions across countries (World Health Organisation, 2014). Children and youth with high and complex needs demonstrate behaviours that are commonly linked to mental health diagnoses such as ADHD, ODD, PTSD, CD or ASD, among others (High and Complex Needs Unit, 2014a, 2014b). When considering mental health diagnoses, it is important to note that although these diagnoses are seen worldwide, contextual understanding of the diagnosis must be taken into account. Specific situations may impact the diagnosis of a child or youth such as exposure to conflict, economic and psychosocial difficulties, neglect, poor attachment, multiple school placements, migration, and the perceived rights of the young person in their society (World Health Organisation, 2003). Further, it is vital that

the cultural relevance and appropriateness of particular diagnoses be taken into account (American Psychiatric Association, 2000).

Aotearoa New Zealand.

The High and Complex Needs Unit (HCNU) is a department within the Ministry of Social Development in Aotearoa New Zealand which provides a coordinated interagency response for children and young people with high and complex needs (High and Complex Needs Unit, 2011). The HCNU receives referrals of children and young people with high and complex needs from a range of social services. Accepted referrals must demonstrate that the needs of these children have exceeded the capacity of at least two of three government agencies (Child, Youth and Family Services (CYFS), District Health Boards (DHBs) and the Ministry of Education). It is important to note, however, not all children or youth with high and complex needs will either be under the care of the HCNU. In 2011, 106 children and youth received three million dollars in funding to address their complex needs (High and Complex Needs Unit, 2011). Regarding age, 55.5% of individuals (59) requiring high and complex needs services were between 10 and 14 years of age (High and Complex Needs Unit, 2011). This was followed by 23.5% of children (25) between five and nine years of age, and 20% of young people (22) between 15 and 20 years of age. These data demonstrate that 80% of children and youth with high and complex needs needing services are under the age of 15 (High and Complex Needs Unit, 2011). However, as noted, the numbers of youth with high and complex needs is much greater than these figures which only include youth in the care of the HCNU.

Alongside needs which are high and complex, there is a high prevalence of mental health difficulties within the youth population of Aotearoa New Zealand.

Te Rau Hinengaro (The New Zealand Mental Health Survey) used structured interviews based on the Diagnostic and Statistical Manual of Mental Disorders (4th Edition; DSM-IV) to generate diagnoses for almost 13,000 people over the age of 16 in 2006 (American Psychiatric Association, 2000; Oakley Browne, Wells, & Scott, 2006). Overall, it was concluded that 28.6% of New Zealanders between the ages of 16 and 24 met criteria for at least one DSM-IV diagnosis. It was also concluded that anxiety disorders were the most commonly experienced type of disorder. Other common diagnoses included mood disorders and substance use disorders (Oakley Browne et al., 2006). Further, The Dunedin Multidisciplinary Health and Development Study found that 18% of 11-year-olds experienced criteria for a mental health diagnosis, rising to 35% by the age of 18 (Ministry of Health, McGee, Feehan, & Williams, 1996; Silva, 1990).

Ethnicity.

Historically, Māori have been underserved and continue to be underserved in mental health care (New Zealand Ministry of Health, 2012a). The number of individuals identifying as Māori seeking mental healthcare services for anxious and/or depressive symptoms has stayed relatively steady between 2006 (10.9%) and 2016 (10.5%; Ministry of Health, 2016). These data, however, likely under-represent the number of Māori requiring healthcare due to historical difficulties accessing appropriate care based on the enduring impacts of colonisation (New Zealand Ministry of Health, 2012b). Māori and Pacific peoples are both 1.52 times more likely to require mental healthcare than non-Māori and non-Pacific individuals (Ministry of Health, 2016). These data are not consistent with those found in The Youth 2012 secondary school survey, which found no differences in

numbers of European/Pākehā and Māori secondary students experiencing clinical depressive symptoms (Crengle et al., 2013).

Regarding high and complex needs, historically the ethnicity of children and youth with HCNU referrals were more likely for those who identified as New Zealand European (High and Complex Needs Unit, 2014a). More recently, half of the HCNU children and youth identify as being Māori, with a slightly smaller proportion identifying as New Zealand European, and smaller still identifying as Pacifica. The development of Kaupapa Māori and Whānau Ora based services which hope to aid in providing Māori increased access to services will hopefully assist with the increasingly higher proportion of Māori clients seeking support. Ensuring services are culturally competent, and service provision meets the health needs of Māori will also hopefully assist in providing improved care for Māori children and youth with high and complex needs (Rankin, 2010).

Gender.

The HCNU report that gender distribution for high and complex needs has always been significantly skewed toward males. Currently, eight males for every female are referred for high and complex needs (High and Complex Needs Unit, 2014b).

Service Provision

There is ongoing research supporting the practice development undertaken by CYFS specialists and social workers working with children described as having needs which are high and complex. Theoretical models used and programs developed to address each child's individual complex needs have been conceptualised as multi-disciplinary and multi-systemic (Calvert & Lightfoot,

2002). The HCNU report that the factors which support effective responses include tailored service plans, the joining of existing services, and effective case coordination (High and Complex Needs Unit, 2005). Other New Zealand researchers have proposed that a systemised, collaborative, whole family approach for young people with high-risk mental health (not high and complex) crises reduces the need for hospitalisation and medication (Bickerton, Ward, Southgate, & Hense, 2014). Children and young people requiring services for high and complex needs have established the following as important to them: (1) where they are living and whom they are living with; (2) being normal or regarded as normal; (3) program or services not intruding on their time at school or with their peers; (4) being active and doing "fun stuff"; (5) being part of the planning and (6) having hope for the future (High and Complex Needs Unit, 2009).

As reported by The Werry Centre (2015), support available for young people in New Zealand includes a range of alcohol and drug services; child and adolescent mental health services (CAMHS); cultural services for Kaupapa Māori, Pacific Island, Asian, refugee or migrant youth; eating disorder services; family support services; infant mental health services or teams; inpatient and residential services; other community services; peer support services; private services; psychosis early intervention services; school-based services; youth forensic services and youth health services.

Issues with Mental Health Service Provision

Worldwide.

Barriers to care for the mental health needs of children and youth exist in all countries at many levels. Barriers that have been identified as most significant

include stigma, transportation, limited financial resources, lack of ability to communicate effectively in the young person's native language, and lack of public knowledge about mental disorders (Chan, 2010; World Health Organisation, 2005). As seen in mental illness across the lifespan, there is a tendency for attention to be prioritised towards physical illnesses, without recognising the close association physical illness has with mental health difficulties or the burden that is associated with mental health problems (Gulliver, Griffiths, & Christensen, 2010; World Health Organisation, 2012).

Mental health difficulties are known to emerge during childhood and adolescence and occasionally endure into adulthood; and it has been demonstrated that the impact of inattention to early treatment may lead to later problems in adulthood (Chan, 2010; Kieling et al., 2011; World Health Organisation, 2012). Improving the treatment of mental illness in people of all ages can lead to improved physical well-being, increased stability and enhanced productivity. Conversely, failure to improve mental illness can result in unemployment, crime or violence (Shepherd et al., 2006).

Access to youth mental healthcare are likely to be even greater in countries where poverty is high, and where the proportion of children and adolescents in the population is higher. The limited resources for child and youth mental healthcare, especially in such countries, represents a major obstacle to decreasing the impact of mental health difficulties across the lifespan (Rocha, Graeff-Martins, Kieling, & Rohde, 2015).

The provision of specialised support for young people with mental health difficulties is generally inadequate. As a result, the World Health Organisation (WHO) advocate for the incorporation of a focus on adolescent mental health

within other programmes such as medical healthcare (World Health Organisation, 2012).

A key factor in improving service provision for young people with mental health difficulties is enhanced interagency collaboration (Chenven, 2010; Gulliver et al., 2010; World Health Organisation, 2005). There are several ways in which collaboration between agencies and collaboration with agencies and children and young people might be improved, such as developing interagency guidelines to support coordinated actions for children and youth in non-emergency settings; assisting in the active involvement of youth in program development and evaluation; developing interventions that target not only young people, but also their caregivers and wider social supports; contextualising programs individually for countries, ensuring relevant and culturally appropriate interventions; and exploring the role of communication technology in the delivery of mental health interventions (High and Complex Needs Unit, 2009; Kieling et al., 2011; The Werry Centre, 2009; World Health Organisation, 2012).

Aotearoa New Zealand.

Multiagency involvement is increasingly required for the complex mental health presentations of children and youth in Aotearoa New Zealand (Bernadette, 2013; High and Complex Needs Unit, 2009; Shailer, Gammon, & de Terte, 2013). Additionally, innovative interventions are more likely to be effective when the needs of these children and young people have not become so entrenched (High and Complex Needs Unit, 2011). Plans created by services are more likely to be successful when there is a shared team understanding; goals are specific, measurable, and achievable; a review is conducted of the goals achieved; vigorous

interventions are put into place, and the plan is straightforward (Bernadette, 2013; High and Complex Needs Unit, 2011, 2014a; The Werry Centre, 2009).

It is likely many of the global issues with service provision extend to Aotearoa New Zealand and to young people with not only mental health needs but also needs that are high and complex. For example, there is still an absence of a CAMHS tool in Aotearoa which seeks the specific views of youth. As such, the development of a CAMHS tool which allows specific youth feedback is relevant to service provision in Aotearoa New Zealand (McClintock, Tauroa, & Mellsop, 2016). Further, there is a requirement for services to better engage, involve and understand the needs of high-risk young people in New Zealand (Swanton, Collin, Bums, & Sorensen, 2007). Global issues with service provision also suggest that it is plausible that increases in interagency collaboration would improve outcomes for young people in Aotearoa New Zealand (Gulliver et al., 2010; Hall & McIver, 2010; Majumdar, 2006; World Health Organisation, 2005). Improving the well-being of children and young people with high and complex needs in Aotearoa New Zealand will have long-term impacts on their lives such as future education, employment ability, benefit dependency, reducing the likelihood of offending and improving their ability to positively parent their own children (Hall & McIver, 2010; Kekus et al., 2009; Ministry of Social Development, 2014).

The Wraparound Process: A Promising Practice for Youth with High and Complex Needs

Wraparound is a team-based, collaborative care planning practice proposing to provide individualised care for adolescents and their families with high and complex needs (Bruns, 2014; Walker & Bruns, 2006). Individuals

enrolled in Wraparound may be involved with child social services, foster care, juvenile justice, special education, or a combination of these (Erickson, 2012; Pullmann et al., 2006). Wraparound combines supports from the family's community, extended family, friends and services to create an individualised Wraparound team (Bruns et al., 2005). The team together with the family create a unique care plan, mission statement and family vision for potential youth and family outcomes. Strategies are guided by and created on the strengths of the family and young person to achieve the vision statement (Effland, Walton, & McIntyre, 2011; Walter & Petr, 2011). The Wraparound process leads to a family collection of resources, services and supports available to create sustainable change once Wraparound has ended (Stambaugh et al., 2007).

Informal and formal supports lead to the collection of various resources and talents for the family. including friends, extended family, the community and professionals (Bruns, Suter, Force, & Burchard, 2005; Walker & Schutte, 2004). Resources offered by each individual service might include funding for activities or interventions such as family therapy sessions, paired with support from informal supports such as sports coaching. These supports and various resources result in an individualised care plan for the family based on their priorities, needs and family vision. The plan of care also arises from the team with a mission statement, strengths, and strategies to address the youth and families' needs. The team continually monitors the plan and adapts it as needed (Bruns, Suter, & Leverentz-Brady, 2008; Effland, Walton, & McIntyre, 2011; Walker, 2008a; Walter & Petr, 2011). Most importantly, however, the plan and team process is driven and owned by the family and youth (Bruns, Suter, & Leverentz-Brady,

2008; Bruns, 2014). Table 2 describes various terminology associated with the Wraparound process.

Table 2

Wraparound Process Terminology

Phrase	Description
Formal supports	Services within the community e.g. CAMHS, probation officer, guidance counsellor
Informal/Natural supports	The family's interpersonal and community networks e.g. extended family members, pastor, sports coach
Individualised care plan	The team develops and implements a customised set of strategies, supports, and services to create family goals within an individualised Wraparound plan (VanDenBerg & Grealish, 1996)
Team mission statement	Wraparound team statement for what the team will be working toward together (Miles, Bruns, Osher, Walker, & National Wraparound Initiative Advisory Group, 2006)
Family vision	Created by the family for the team which describes how the family wish for things to be in their future (Miles et al., 2006)
Driven/Owned by the family	Family members' own perceptions of what they need and what strategies will help them to meet their needs and move toward their own vision of a better life (Walker & Matarese, 2011)
Wraparound team	A group of formal and informal supports with the family who works toward the team mission and family vision by implementing the individualised care plan (Miles et al., 2006)

The History of Wraparound

In the 1970s in North Carolina in the United States of America, lawyers, case workers and judges in the juvenile justice system were growing increasingly frustrated with the treatment and rehabilitative options for children and young people presenting in the courts (Dodge, Kupersmidt, & Fontaine, 2000; VanDenBerg, Bruns, & Burchard, 2008). This frustration was paired with the observation that children and young people presenting to the court system were becoming repeat offenders and eventually serious offenders. Often these children and young people were experiencing abuse or neglect at home and were also experiencing mental health concerns (Dodge et al., 2000; Kieling et al., 2011; VanDenBerg et al., 2008). Some concluded that the state of North Carolina was failing to provide educational and mental health services to support children and young people with mental and behavioural issues before ending up in court. All responsibility of the behaviours of these troubled young people lay with North Carolina corrections system. Taxpayers were unwilling to fund the services that young people needed, and the corrections department only continued to arrest them (Dodge et al., 2000; McDowall & Butterworth, 2014; VanDenBerg et al., 2008).

The expression ‘Wraparound’ was first used in the early 1980s by Doctor Lenore Behar, the state director in North Carolina of children’s mental health services. ‘Wraparound’ was used to describe the implementation of various flexible, all-inclusive community services. The concept of Wraparound came as a result of a class action lawsuit against multiple services, known as the ‘Willie M.’ case, but primarily due to the increasing need for non-residential placements resulting in poor outcomes for young people, and an increase in the number of

youths requiring these (Dodge et al., 2000; VanDenBerg et al., 2008). Newly implemented all-inclusive community services were used for young people with high mental health and behavioural needs as an alternative to psychiatric institutionalisation, juvenile justice and child welfare (Kamradt & Meyers, 1999; VanDenBerg et al., 2008; VanDenBerg & Grealish, 1996; Walker & Schutte, 2004).

It is important to observe that while Wraparound was being developed; similar programs were emerging in other contexts, such as person-centred planning and individualised plans within juvenile justice (Dodge et al., 2000; VanDenBerg et al., 2008). Interestingly, a collaborative family-provider planning process called ‘family group decision making’ was employed in child welfare systems in the United States. This family planning process has similarities with Māori tribal traditions in Aotearoa New Zealand (VanDenBerg et al., 2008).

During its creation in late 1985, Wraparound proponents from Alaskan social services, mental health, and education departments sought consultation from a Youth Initiative named Kaleidoscope (Kamradt & Meyers, 1999; VanDenBerg et al., 2008). The Kaleidoscope Program was developed in Bloomfield and Chicago in the United States, with an aim to reduce the number of ever increasing children being placed into residential care and return them to their communities. Adopting the Kaleidoscope Program format in Alaska resulted in the return of young people with complex needs who had been housed outside of the state. Eventually, this phenomenon was replicated in over thirty other states (Burns & Goldman, 1998; VanDenBerg et al., 2008). This Alaskan take on the Kaleidoscope Program was named the ‘Alaska Youth Initiative’ (Burns & Goldman, 1998). Principles that were inherent in these systems of care included

‘child-centred’; ‘family focused’, ‘community-based’ and ‘culturally competent.' These principles went on to form the blueprint for Wraparound (Cook & Kilmer, 2012; Poncin & Woolston, 2011). Major efforts based on Wraparound and system-of-care concepts received funding in the late 1980s, and studies of these programs proved to provide valuable information for further development of the process (VanDenBerg et al., 2008).

During the 1990s, Wraparound became associated with a series of values or principles; however, it was not until the late 1990s that these values and principles were made specific. From the year 2000, a large group of Wraparound workers came together and agreed to work to define Wraparound practice. The National Wraparound Initiative (NWI) based in Portland, went on to further define the Wraparound principles and to describe specific activities that are necessary components of a Wraparound process (Bruns et al., 2004; VanDenBerg et al., 2008; Walker, Bruns, Conlan, & Laforce, 2011; Walker, Bruns, & The National Wraparound Initiative Advisory, 2008).

Advocates for Wraparound at the time of its inception depicted it as a way of supporting children and young people to live positively and safely within their communities, and provide an alternative to residential treatment (VanDenBerg et al., 2008). Further, they saw it as a way of coordinating a group of committed and concerned people to take any steps necessary to achieve this. Wraparound advocates often used a collection of resources that would have otherwise been spent on treatment for children and young people outside of their homes (Burchard, Bruns, & Burchard, 2002; VanDenBerg et al., 2008; Walker, 2008a).

Wraparound Today

While Wraparound programs still vary internationally, an empirically supported model has been established by the NWI (Walker et al., 2011). Although Wraparound was primarily used as an alternative to residential care placement and bringing youth back into their communities, it is now being employed in a variety of contexts such as schools and family violence programs (Flemons et al., 2010). According to the NWI model, the planning process is based on 10 philosophical principles which provide the value base for Wraparound and four phases which offer a guideline for what activities need to be accomplished through the Wraparound process (Bruns et al., 2005; Bruns et al., 2004; Burchard et al., 2002).

The 10 philosophical principles encompassing the Wraparound process are: (1) family voice and choice, (2) team-based, (3) natural supports, (4) collaboration, (5) community-based, (6) culturally competent, (7) individualised, (8) strengths-based, (9) persistence and (10) outcome-based (Bruns et al., 2004). The four activity phases of Wraparound are (1) an introduction to the activities of Wraparound; (2) initial plan development; (3) plan implementation and refinement; and (4) transition (Bruns et al., 2004; VanDenBerg & Grealish, 1996). Table 3 details each of the Wraparound principles developed by the NWI.

Table 3

Ten Principles of the Wraparound Process

Principle	Description
1. Family voice and choice	Family and youth/child perspectives are intentionally elicited and prioritised during all phases of the Wraparound process. Planning is grounded in family members' perspectives, and the team strives to provide options and choices such that the plan reflects the family values and preferences.
2. Team-based	The Wraparound team consists of individuals agreed upon by the family, committed to them through informal, formal, and community support and service relationships.
3. Natural supports	The team actively seeks and encourages the full participation of team members drawn from family members' networks of interpersonal and community relationships. The Wraparound plan reflects activities and interventions that draw on sources of natural support.
4. Collaboration	Team members work cooperatively and share responsibility for developing, implementing, monitoring and evaluating a single Wraparound plan. The plan reflects a blending of team members' perspectives, mandates, and resources. The plan guides and coordinates each team member's work towards meeting the team's goals.
5. Community-based services	The Wraparound team implements service and support strategies that take place in the most inclusive, most responsive, most accessible, and least restrictive settings possible; and that safely promote child and family integration into home and community life.
6. Culturally competent	The Wraparound process demonstrates respect for and builds on the values, preferences, beliefs, culture, and identity of the child/youth and family, and their community.
7. Individualised	To achieve the goals laid out in the Wraparound plan the team develops and implements a customised set of strategies, supports, and services.
8. Strengths-based	The Wraparound process and the Wraparound plan identify, build on, and enhance the capabilities, knowledge, skills, and assets of the child and family, their community, and other team members.
9. Persistence	Despite challenges, the team persists in working toward the goals included in the Wraparound plan until the team reaches an agreement that a formal Wraparound process is no longer required.
10. Outcome-based service	The team ties the goals and strategies of the Wraparound plan to observable or measurable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly.

Note: Description of ten principles of Wraparound adapted with permission from Bruns et al. (2004). Ten principles of the Wraparound process. Portland, OR: National Wraparound Initiative, Research and Training Center on Family Support and Children's Mental Health, Portland State University.

Table 4, taken from Walker and colleagues (2008) describes each of the four Wraparound phases developed by the NWI.

Table 4

Four Phases of the Wraparound Process

Phase	Description
1. Engagement and team preparation	The groundwork for trust and a shared vision among family and team members is established, so people are prepared to come to meetings and collaborate. The tone is set for teamwork and team interactions that are consistent with Wraparound principles, through initial conversations about strengths, needs, and culture. This phase also provides an opportunity to begin to shift the family's orientation to one in which they understand they are an integral part of the process and their preferences are prioritised. The activities of this phase should be completed within 1-2 weeks if possible so that the team can begin meeting and establish ownership of the process as quickly as possible.
2. Initial plan development	Team trust and mutual respect are built while the team creates an initial plan or care using a high-quality planning process that reflects Wraparound principles. Youth and family should feel during this phase that they are heard, that the needs chosen are the ones they want to work on, and that the options chosen have a reasonable chance of helping them meet these needs. This phase should also be completed during 1-2 weeks, a rapid time frame intended to promote team cohesion and shared responsibility toward achieving the team's mission or overarching goal.
3. Implementation	The initial Wraparound plan is implemented, progress and successes are continually reviewed, and changes are made to the plan and then implemented, all while maintaining or building team cohesiveness and mutual respect. The activities of this phase are repeated until the team's mission is achieved and formal Wraparound is no longer needed.
4. Transition	Plans are made for a purposeful transition out of formal Wraparound to a mix of formal and natural supports in the community (and, if appropriate, to services and supports in the adult system). The focus on transition is continual during the initial engagement activities.

Note: Description of phases of Wraparound adapted with permission from Walker, J. S., Bruns, E. J., & The National Wraparound Initiative Advisory Group, (2008). Phases and activities of the wraparound process. In E. J. Bruns & J. S. Walker (Eds.), The resource guide to wraparound. Portland, OR: National Wraparound Initiative, Research and Training Center for Family Support and Children's Mental Health.

The young person together with the team create a unique care plan, mission statement and family vision for potential youth and family outcomes.

Strategies are guided by and created on the strengths of the family and young person to achieve the vision statement (Effland et al., 2011; Walter & Petr, 2011). Goals for the young person and their family may include wanting to remain in school, reduce substance use, or change other specific behaviours. The Wraparound team and its meetings are assembled by the Wraparound group facilitator from a Wraparound process on behalf of the family (Burchard et al., 2002; Walker & Schutte, 2005; Winters & Metz, 2009).

Creation of the Wraparound team involves identifying both informal and formal support that a can be 'wrapped around' the young person and family for as long as needed to reach their goals and to function effectively within their home and community (Burns & Goldman, 1998). Formal support might include a probation officer, family therapist or social worker. Informal supports may include a friend, neighbour, coach, pastor, community provider or extended family member (Cook & Kilmer, 2010; Walker & Sanders, 2011). The supports chosen are unique to each family based on their needs (Burchard et al., 2002; Kernan & Morilus-Black, 2010; Shailer et al., 2013; Walker & Schutte, 2005).

The creation of the plan to achieve Wraparound goals is based on the vision of the family and their needs; the family's mission statement; and the strengths and strategies of the Wraparound team (Burchard et al., 2002; Walker & Schutte, 2005). Once a plan is made the team meets regularly to implement and monitor the plan to ensure its success (Bruns, 2014). The key point of difference in Wraparound is its creation of one plan for the family to follow. One clear plan replaces many plans from a range of services, with services all working together for the young person and their family rather than separately on multiple plans

(Burchard et al., 2002; Winters & Metz, 2009). The Wraparound process is demonstrated in Figure 1.

When carried out in its intended nature, Wraparound can lead to overcoming common barriers to care such as accessing effective service provision and support for children and youth with high and complex needs (Bruns et al., 2011; Erickson, 2012; Fries, Carney, Blackman-Urteaga, & Savas, 2012).

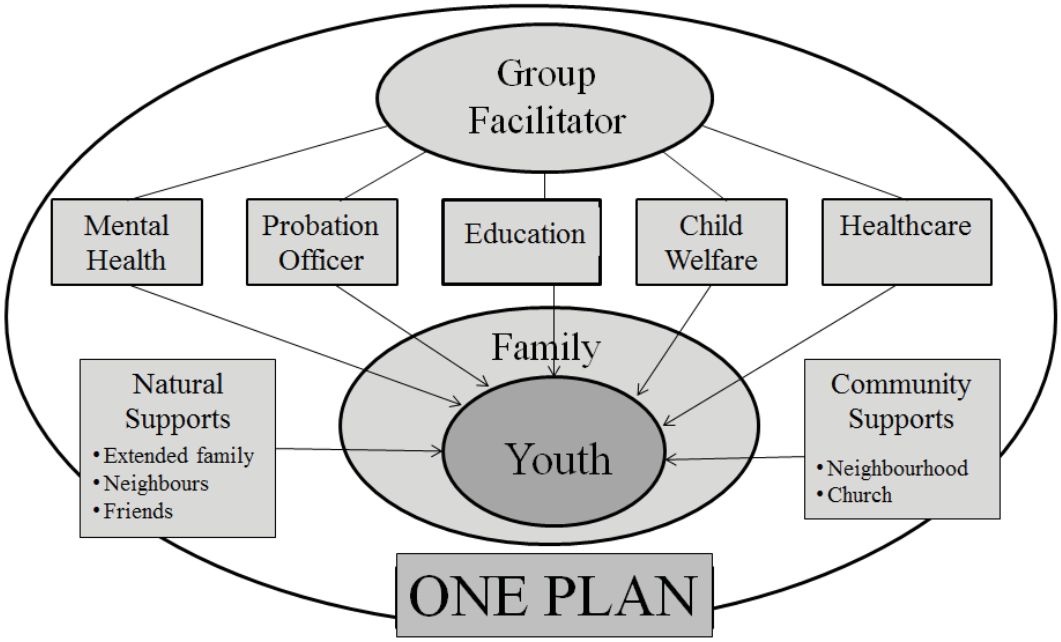

Figure 1: The Wraparound Process (Bruns, 2014)

Note: Figure reproduced with permission from Bruns, E. J. (2014). *Wraparound training*. *The Wraparound Process for Whanau with Complex Needs*. Wellington, New Zealand: National Wraparound Initiative, Research and Training Center for Family Support and Children's Mental Health.

Wraparound for Aotearoa New Zealand

Within Aotearoa New Zealand, all health and disability sectors aim to improve outcomes and a reduce health disparities for Māori. To achieve this objective all disciplines are bound by a similar code of ethics that promotes safe work between Māori and Non-Māori (New Zealand Psychologists Board, 2011).

Such practice is achieved by the principles set out in Te Tiriti o Waitangi (Bishop, 1999).

Te Tiriti o Waitangi (The Treaty of Waitangi) was signed in 1840 by the Māori and the British Crown. The Waitangi Tribunal was formed by the Treaty of Waitangi Act 1975. This was the first law to refer to the principles of The Treaty. Initially, Treaty principles were not defined, however over time through court cases, new legislation and Waitangi Tribunal findings, the meaning of The Treaty has been outlined for contemporary society. Goals of the original Treaty have been attributed to principles today that include Partnership, Protection, and Participation (Hayward, 2014).

It is essential that Wraparound be carried out in a culturally appropriate manner for the setting under which it is employed. This is achieved by following the 10 principles of Wraparound (Bruns et al., 2004). The close associations between Wraparound and Te Tiriti o Waitangi demonstrate Wraparound as a promising practice within an Aotearoa New Zealand context (Kirkwood, 2014).

Te Tiriti o Waitangi: Partnership

Partnership refers to ongoing relationships between the Crown and its agencies and Māori (Waa, Holibar, Spinola, & Alcohol and Public Health Research Unit / Whariki Runanga Wananga Hauora Mete Paekaka, 1998). Partnership places an obligation on the Crown to include Māori in the design of health legislation, policies, and strategies. It denotes that Māori need to share in decision making about the nature of their health services, leading to increased Māori control over their own health (Cole, 2001). Further, relationships are required to expand beyond central government, to local government, and attempt

to improve relations with local Iwi (Kingi, 2007). Partnership is seen in the Wraparound principle of family voice and choice. The family beliefs and values are paramount in the planning process, and the Wraparound team consistently aims to keep the families' perspective at the forefront of the Wraparound plan. Wraparound is carried out in collaborative negotiation throughout the process (Bruns et al., 2004; Kirkwood, 2014). Further, natural supports align with partnership within Wraparound. The family guides the Wraparound team to who their natural supports are within the community, and if these natural supports should take part in the Wraparound process with them. In this way, whānau, hapū and iwi partnerships (Māori terms for family groups) become strengthened (Kirkwood, 2014). Finally, partnership is found in the community-based Wraparound principle. The Wraparound team is dedicated to meet in and make plans for environments that are culturally appropriate, mana-enhancing and inclusive (Kirkwood, 2014).

Te Tiriti o Waitangi: Protection

Protection recognises that the Crown needs to actively promote health and develop preventative strategies. It reflects on the Crown's duty to actively protect Māori interests and to ensure that Māori can enjoy the same level of well-being as non-Māori (Kingi, 2007). This may require providing Māori with additional resources (Cole, 2001; Waa et al., 1998). Cultural competency is the Wraparound principle that most closely aligns with Te Tiriti o Waitangi principle of Protection. Cultural competence is encouraged for teams to create a culturally appropriate and comprehensive plan in collaboration with whānau. Culturally competent teams will support and enhance family beliefs, values, and identities. They will also encourage the ongoing strengthening of connections between the child or young

person to their whānau, Hapū, and Iwi community natural supports (Kirkwood, 2014).

Te Tiriti o Waitangi: Participation

Participation emphasises Māori involvement in all aspects of society within Aotearoa, including involvement in the planning, delivery, and monitoring of programmes that are relevant to Māori (Waa et al., 1998). Participation is about equality of opportunity and outcomes (Cole, 2001). Participation is linked to the principles of Partnership and Protection, but also the obligation to ensure that Māori participate in the delivery of health services. Māori participation in the health sector has generally been restricted to the role of consumer over the last century, and even then access has not always been assured (Kingi, 2007). Participation is also strongly linked to Wraparound principles of family voice and choice, collaboration, persistence and individualised. Family voice and choice emphasises the idea that the whānau are the experts on their lives and current situation. Their participation lets the team know what the whānau want from Wraparound, which the team then prioritises (Kirkwood, 2014). The plan is unique to the family, emphasising the principle of individualised. The individualised plan is made by the team members and whānau working together in collaboration. It is not a plan that is made for, or done to the whānau by the team; it is a genuine mana-enhancing partnership (Kirkwood, 2014). Once the plan has been established and is being implemented, it is up to the team to work together and persist in reaching Wraparound goals with the whānau (Kirkwood, 2014).

The New Zealand Wraparound Program

There are a number of different services throughout New Zealand which utilise the NWI empirically supported model of Wraparound. This study will focus on one such service operating through a District Health Board (DHB) in a large metropolitan city. DHBs operate throughout New Zealand as part of the public health system and contain mental health units. Various levels of service delivery within DHBs are related to the intensity of clients' presenting problems. Each regional DHB has a Child and Adolescent Mental Health Services (CAMHS) unit. Within some CAMHS teams, there is a specialised service for youths with high and complex needs. The purpose of this specialised service is to provide intensive clinical assessment and treatment services to children and youth who are in the care of CYFS with serious mental health, emotional and behavioural problems. The Wraparound program in this study operates as one of these specialised units. For the purpose of this research, this program will be referred to as the New Zealand Wraparound Program (NZWP). All identifying information about the service and the DHB under which it operates has been modified for confidentiality purposes.

The NZWP team is made up of members from multiple disciplines, including psychiatry, psychology, psychotherapy, nursing and social work. Service provision from the NZWP is available 24 hours per day, seven days per week. Referral criteria for children and youth entering the NZWP include: the child or young person are 6-17 years of age (up to 20 years if under the care of CYFS Chief Executive); the child or young person will most likely meet the criteria for a serious mental health diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (Revised 4th Edition; DSM-IV-TR; American

Psychiatric Association, 2000); the child or youth must also have ongoing and active involvement with CYFS and CAMHS.

NZWP facilitators work with families to create plans based on the 10 Wraparound principles specified by the NWI. The plan is based on the family's needs and specific, measurable outcomes, which are broken up into small achievable steps. The plan must include formal and informal resources with community-based and individualised supports that attempt to build on the natural supports and resources of the family (New Zealand Wraparound Program, 2006). The family or caregivers who have a significant role in supporting the child or youth are also regarded as clients of NZWP. Caregivers are current and future parents or caregivers where the adult impacts on the mental health, emotional, or behavioural needs of the child or youth.

Mental health diagnoses most prominently presenting in children and young people at NZWP include ADHD (18%); CD (11%), PTSD (10%), and ODD (9%). Other disorders seen in children and youth presenting to NZWP include substance-related disorder (6%), reactive attachment disorder (6%), anxiety disorder not otherwise specified (5%), psychotic disorder not otherwise specified (4%) and major depressive disorder (4%; District Health Board, 2011).

NZWP have employed a Wraparound model to meet their service delivery principles which include 'child, and young person focused practice', 'paramountcy of the child or young person,' 'family, whānau and caregiver participation' and 'cultural awareness' (Ministry of Social Development, 2014). With service delivery principles so closely aligned with Wraparound principles including 'family voice and choice' and 'culturally competent,' it is unsurprising Wraparound is their model of choice.

Evidence in Wraparound

A well-established research base for Wraparound has been slow to advance due to several details (Suter & Bruns, 2008). Wraparound is a care planning process rather than a specific treatment plan for any one particular concern (Farmer, Dorsey, & Mustillo, 2004). Also, Wraparound has developed over time involving a collection of people rather than one particular researcher (Bruns & Suter, 2010). Finally, Wraparound is difficult to study due to its highly individualised nature (Bertram, Suter, Bruns, & O'Rourke, 2011; Bruns et al., 2004). Despite these barriers, Wraparound research findings continue to demonstrate its usefulness (Bruns & Suter, 2010).

Reviews of the Wraparound evidence base describe it as a promising practice, showing positive results from randomised trials and experimental and observational studies (Browne, Puente-Duran, Shlonsky, Thabane, & Verticchio, 2014; Coldiron & Hensley, 2016; Kazi et al., 2011; Quick et al., 2014; West-Olatunji et al., 2011). Such studies include fidelity data as well as cost data, increasing an understanding of the outcomes of Wraparound (Bruns & Suter, 2010; Kilmer, Cook, & Munsell, 2011; Palamaro Munsell, Cook, Kilmer, Vishnevsky, & Strompolis, 2011). Study populations have included youth in child welfare, juvenile justice, and mental health services (Bruns & Suter, 2010; Stambaugh et al., 2007; Suter & Bruns, 2009).

For youth in child welfare, more of those in Wraparound have been able to return to their community placements, reducing the requirement for residential placement when compared with youth not in Wraparound; have experienced higher grade point averages and school attendance (Bruns, Rast, Peterson, Walker, & Bosworth, 2006); have had fewer days on runaway (Clark, Lee, Prange, &

McDonald, 1996); have shown improvement in functioning as assessed by the Child Behaviour Checklist (Achenbach, 1991; Hodges, 2004; Mears, Yaffe, & Harris, 2009; Weiner, Leon, & Stiehl, 2011); and have experienced higher rates of closed cases and discharge from child welfare with a permanency plan at follow-up when compared with conventional child welfare case management (Clark et al., 1996; Rauso, Ly, Lee, & Jarosz, 2009). In other Wraparound research with youth in child welfare, decreases in clinical symptoms and improvements in overall functioning have been observed when compared to traditional treatment with services not involved in a Wraparound process (Evans, Armstrong, & Kuppinger, 1996, 1998; Rauso et al., 2009; Snyder, Lawrence, & Dodge, 2012).

Wraparound studies with youth in juvenile justice have found improvements in school performance, self-efficacy, attendance and a lowered likelihood of expulsion; and decreased instances of running away from home or getting picked up by police compared to youth in conventional juvenile court services (Carney & Buttrell, 2003). Wraparound youth in juvenile justice are less likely to commit a crime (Artello, 2011; Carney & Buttrell, 2003; Pullmann et al., 2006). Further, there was found to be a significant improvement in male externalisation of behaviour and fewer days of incarceration (Clark et al., 1996). Finally, a more recent study suggested that youth involved in a high-fidelity Wraparound process involved with justice and welfare services committed fewer offenses, were less likely to be arrested, and were arrested fewer times in total if they were arrested compared to same-aged peers receiving treatment as usual. Further, these same youth were also more likely to experience positive changes in their living situation (Coldiron & Hensley, 2016).

With regard to mental health outcomes in Wraparound, research has documented reduced hospitalisations in young people, and there have been indications of significant improvements in mood and behavioural functioning, physical aggression, compliance, functioning at school and home, verbal abuse, grades, alcohol and drug use and peer interactions (Eber, Hyde, & Suter, 2011; Evans et al., 1996, 1998; James, 2011; Myaard, Crawford, Jackson, & Alessi, 2000; Painter, 2012; Pullmann et al., 2006). A recent study investigated if the addition of a Wraparound facilitator to regular child protection services improved youth and family functioning. Both groups improved significantly in the areas of psychological distress of the caregiver, and family resources. The addition of a facilitator, however, did not improve outcomes over regular services (Browne et al., 2014).

Wraparound fidelity is measured by the extent to which the 10 principles and four phases of Wraparound are followed during each phase of the Wraparound process (Pagkos, 2011). Recent research has reported a positive association between Wraparound fidelity and youth clinical outcomes (Bruns, Sather, Pullmann, & Stambaugh, 2011; Bruns et al., 2005; Kilmer et al., 2011; Pagkos, 2011; Shailer et al., 2013; Stambaugh et al., 2007). One study's findings suggest that managing caregiver and youth perspectives simultaneously during care and treatment planning is more strongly related to the quality of the team process than to youth age. This finding demonstrates the importance of effective planning, team process, and engagement by the Wraparound team, which can lead to meaningful youth participation without sacrificing caregiver satisfaction (Walker, Pullmann, Moser, & Burns, 2012).

Results have been varied in studies for populations with mental health concerns, family cohesiveness, job attendance and problem behaviours (Anderson, Houser, & Howland, 2010; Artello, 2011; Quick et al., 2014; Stambaugh et al., 2007). There have also been varied outcomes with youth in child welfare also involved with juvenile justice (Clark et al., 1996; Mears et al., 2009). For example, one recent study randomly assigned 93 youths with complex emotional and behavioural needs and involved with welfare services to Wraparound care coordination versus typical case management. The Wraparound group received more hours of care management on average and experienced better residential consequences to begin with. By 12 months, however, there were no group differences in functioning or emotional and behavioural symptoms (Bruns, Pullmann, Sather, Denby Brinson, & Ramey, 2015). Further, past evidence for Wraparound has pointed in a negative direction on occasion (Bickman et al., 2003; Carney & Buttrell, 2003; Della Toffalo, 2000). Bickman and colleagues (2003) found that participants receiving Wraparound services did not differ in a number of domains compared with those receiving treatment as usual. However, there was no assessment of fidelity in this study, putting forth the argument that it is likely the participants were not receiving 'true' Wraparound.

Even with scientific meticulousness, studies involving Wraparound can be difficult to generalise to other populations and localities (Poncin & Woolston, 2011). Previous investigations demonstrate a need for further research investigating Wraparound conducted outside of North America (Bertram et al., 2011; Flemons et al., 2010; Quick et al., 2014; Shailer et al., 2013; Suter & Bruns, 2008; Walter & Petr, 2011).

As described, although demonstrated as a promising practice, evidence regarding the efficacy of the Wraparound process remains mixed (Bertram, Suter, Bruns, & O'Rourke, 2011; Bruns & Suter, 2010; Stambaugh et al., 2007; Suter & Bruns, 2008, 2009). Wraparound may appear to many as relatively simple to implement. However, its implementation at both a family and systems level can prove to be challenging (Shailer et al., 2013). The lack of consistency in the use of the term Wraparound across a number of different countries, services and agencies can create a sense of confusion (Bertram et al., 2011; Bruns et al., 2011; Miles, Brown, & The National Wraparound Initiative Implementation Work Group, 2011). Both a strength and weakness is that each Wraparound program is implemented uniquely according to the local prescription and family need (Bruns et al., 2004; Miles et al., 2011).

Wraparound and the Theory of Change

Previous explanations as to why Wraparound should produce desired outcomes have been preliminary (Walker, 2008b). This may be due in part to various services around the world attempting to implement NWI Wraparound practices without adequate training, resulting in low fidelity practice (Bertram et al., 2011; Walker & Schutte, 2004). High Wraparound fidelity should result in a plan that elevates family relationships with the community and services (Burchard et al., 2002; Burns et al., 2000), thus the importance of high fidelity Wraparound practice.

The Wraparound Theory of Change (WTOC) is a recent model that proposes how desired outcomes from Wraparound might occur (Walker, 2008a). The WTOC attempts to build on relevant research evidence, not just from literature on effective team practice but also from a variety of other topics such as

ecological theory and self-efficacy research. The WTOC also attempts to describe how and why the Wraparound process is effective and appears to have evolved from historical models of team behaviours and processes over time.

Development of the Wraparound Theory of Change

A dominant model of effective teamwork known as 'input-process-output' (I-P-O) was established by McGrath in 1964 and contained ideas that would one day help shape the WTOC. This model has been adapted and changed continually, but core concepts remain related to McGrath's original model (Hackman & Morris, 1975; Yeatts & Hyten, 1997). A version of the I-P-O model is displayed in Figure 2.

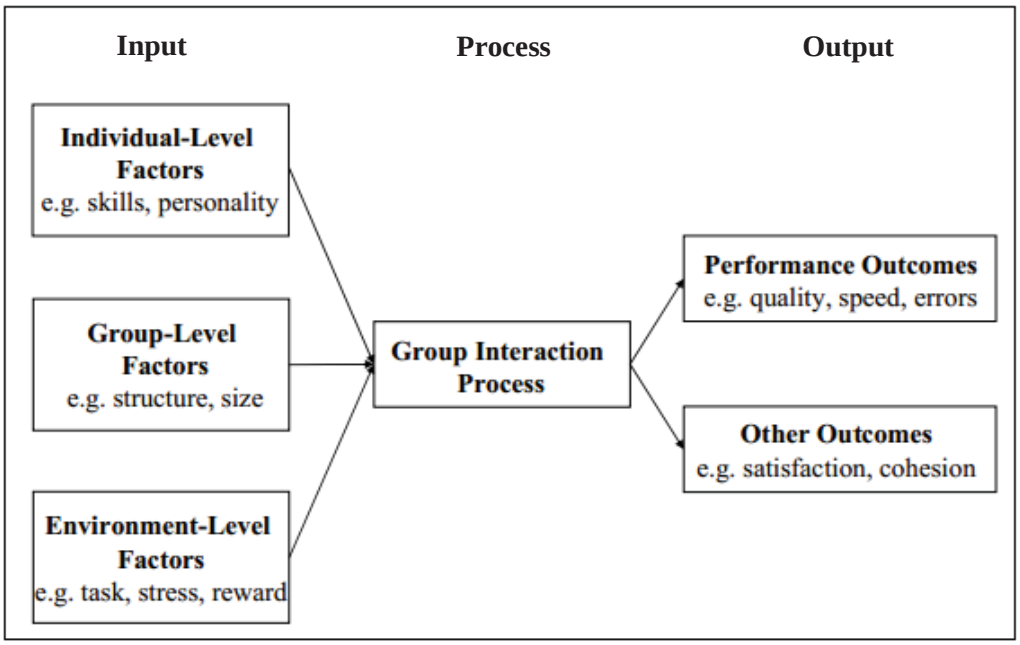

Figure 2: Input-Process-Output Model (McGrath, 1964)

Note: McGrath. *Social psychology: A Brief Introduction*, 1E. © 1964 South-Wester, a part of Cengage Learning, Inc.New York, NY: Holt, Rinehart and Winston. Reproduced by permission. www.cengage.com/permissions

‘Input’ factors are those that can be changed to alter the processes and outcomes that follow. ‘Input’ factors consist of the context in which the team is placed (environmental-level factor), the composition of the team (group-level factor), and the expertise of the team members (individual-level factor; Deneckere et al., 2012; McGrath, 1964). ‘Process’ factors include the coordination and interactions between team members (Deneckere et al., 2012). ‘Output’ factors (also known as outcomes; Littlepage, Schmidt, Whisler, & Frost, 1995) are the culmination of team processes (Sundstrom, de Meuse, & Futrell, 1990). Like ‘input’ factors, ‘output’ factors can occur at various levels such as the outcome for the client (performance-level), and the satisfaction of the team members from a job well done (other outcomes-level; Deneckere et al., 2012). Although this model was particularly successful and continues to inform team behaviour models, soon after its creation, it was deemed as somewhat simplistic and questioned by its advocates (Deneckere et al., 2012; Littlepage et al., 1995; Sundstrom et al., 1990).

A more recent teamwork model contributing to the WTOC was the theoretical ‘Model of Effectiveness for Wraparound Teamwork’ (Figure 3; Walker & Schutte, 2004). The authors argued that prior models had not adequately explained how inputs and processes influenced effective teams and their decision-making strategies (Walker & Schutte, 2004). The model attempted to explain this phenomenon by way of an elaboration of the I-P-O model (Hackman & Morris, 1975; McGrath, 1964), replacing various components with practices unique to Wraparound (Walker & Schutte, 2004).

Roots of this model lie within other programs named ‘Participatory Decision-Making’ (PDM) and ‘Family Group Conferencing’ (FGC; Walker, 2008a). Both PDM and FGC continue to be run successfully independently of

Wraparound but share many of Wraparounds' features (Kaner, Lind, Toldi, Frisk, & Berger, 1996). PDM suggests that if people do not participate in and take ownership of solutions to problems or agree to the decision, the implementation will be misunderstood and more likely to fail (Kaner et al., 1996). PDM has been evidenced to provide clients with long-lasting, effective clinical care in medical and educational settings (Epstein, Alper, & Quill, 2004; Kaner et al., 1996; King, Louis, Marks, & Peterson, 1996). FGC is heavily community focused and like Wraparound has consistencies with Māori tribal traditions. Such Māori traditions include social and kin-based functioning, problem resolution and Māori models of restorative justice (Love, 2009). Other models have been developed over time that also use philosophies that are seen in Wraparound (i.e. natural supports) and have also been evidenced to be effective (Malloy et al., 2010; Mueller, Bassett, & Brewer, 2012; Vishnevsky, Strompolis, Reeve, Kilmer, & Cook, 2012).

In the Model of Effectiveness for Wraparound Teamwork, 'inputs' include the task, the qualities of team members, the setting and the funding support. As this model is centred within Wraparound, the task will always be the same: creating an individualised plan for youths and families with high and complex needs, utilising community supports and services to achieve favourable outcomes (Burns & Goldman, 1998; Walker & Schutte, 2004).

A new addition not seen in previous I-P-O models includes the second stage of practices in-between 'inputs' and 'process'. 'Practices' are defined as intentional strategies used by the team to understand the principles of Wraparound and then create the Wraparound plan. As seen in Figure 3, these practices or strategies include: promoting the family perspective, building on the strengths of the family, promoting cultural competence, generating options, making decisions,

defining team goals, monitoring progress, and continuing to shape and revise the plan (Walker & Schutte, 2004).

‘Process’ within this model includes two underlying processes containing multiple tasks. These processes are where the team begins to define its identity and purpose. The first underlying process is named ‘collective activity’ where the plan is continually revised. This process includes activities such as goal setting, performance evaluation and the broadening of team perspectives. The second underlying process is named ‘collective identity’ where the team works toward cohesiveness. These two processes are continually impacting each other. They will change and grow dependent on the development of the other in a complex loop (Walker & Schutte, 2004).

In a concept similar to that of ‘outputs’, this model includes the ‘outcomes’ phase. Short- and long-term outcomes are described including high-quality decisions, family-driven goals, individualised plans, attainment of intermediate goals, enhanced feelings of competence and empowerment, achievement of the team mission and improved quality of life (Walker & Schutte, 2004).

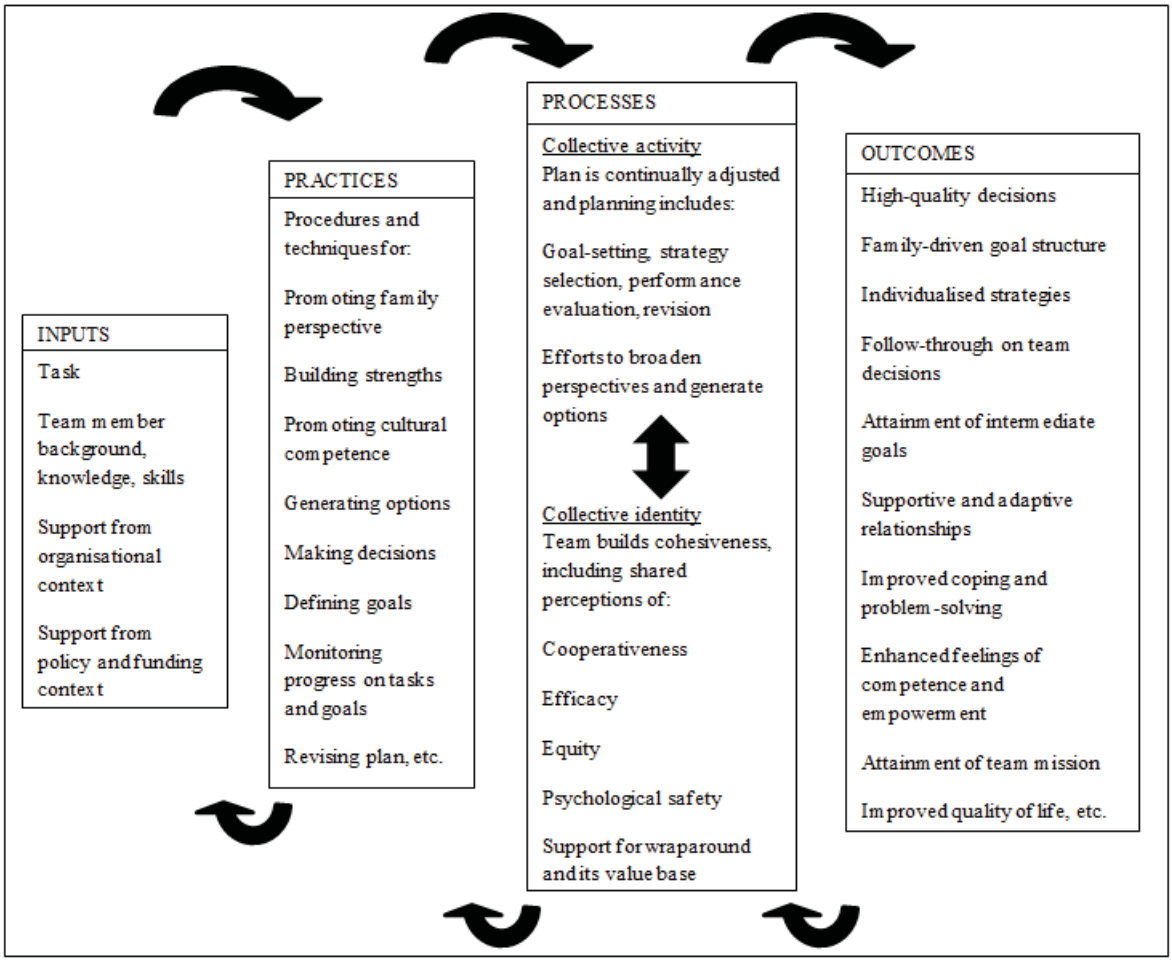

Figure 3: A Model of Effectiveness for Wraparound Teamwork (Walker & Schutte, 2004)

Note: Figure reproduced with permission from Walker, J. S., & Schutte, K. M. (2004). Practice and process in wraparound teamwork. *Journal of Emotional and Behavioral Disorders*, *12*(3), 182–192. doi:10.1177/10634266040120030501

Finally, an important addition to this model is the emphasis placed on several feedback loops operating between each stage. Walker and Schutte (2004) propose not only that there are ‘forward’ or linear impacts going from stage to stage, but there are also interrelationships between each phase that are too complicated to demonstrate in a simple model.

Walker and the Wraparound Theory of Change

Wraparound has consistently been described as family- and strengths-focused (Allen & Petr, 1998; Saleebey, 1996). These foci are said to result in effective goal attainment as families are more likely to invest in the team strategies if they feel as though they have contributed to their selection (Walker & Schutte, 2004). Further, such contributions are said to build family confidence and positivity for their future, which in turn increases the family's ability to solve problems in future (Walker & Schutte, 2004). Walker (2008a) decided that although theories on Wraparound being family- and strengths- focused paired with the 'Model of Effectiveness for Wraparound Teamwork' provided important groundwork, the connections between these theories and Wraparound had not been explored in enough detail. As a result, the implications for Wraparound were not entirely clear. A theoretical framework for Wraparound was also seen by Walker (2008a) as a necessity because successfully implementing an intervention requires not only training but also theoretical guidelines to provide structure for key intervention components, so they operate together consistently. Theory can also contribute to the team members' understanding of how and what elements of the team process lead to intermediate and long-term outcomes (Walker & Matarese, 2011).

A common theory of change is a series of hypotheses about causal connections, describing specific links between behaviours, intermediate outcomes (such as mediators) and long-term goals. The theory will describe the assumed mechanisms that lead to desired outcomes. In such cases, the theory will be developed through an extensive literature review, observation of the program, interviews with users and a review of training manuals and exercises (Walker &

Matarese, 2011). The WTOC followed a similar process of creation for a service model which already exists (Walker & Matarese, 2011).

For the development of the WTOC, Walker (2008a) conducted a literature review based on principles in the outcomes stage of the ‘Model of effectiveness for Wraparound teamwork’ (Figure 3; Walker & Schutte, 2004), and areas related to mechanisms of change (Walker & Matarese, 2011). Areas related to change included self-efficacy, social support, empowerment, optimism, resilience, teamwork and collaboration (Walker & Matarese, 2011). Through this work, Walker was able to ascertain what types of outcomes families sought through Wraparound, and how team behaviours might be linked to these outcomes through a causal chain (Walker & Matarese, 2011; Walker, 2008a). What resulted was the WTOC (Figure 4; Walker, 2008a).

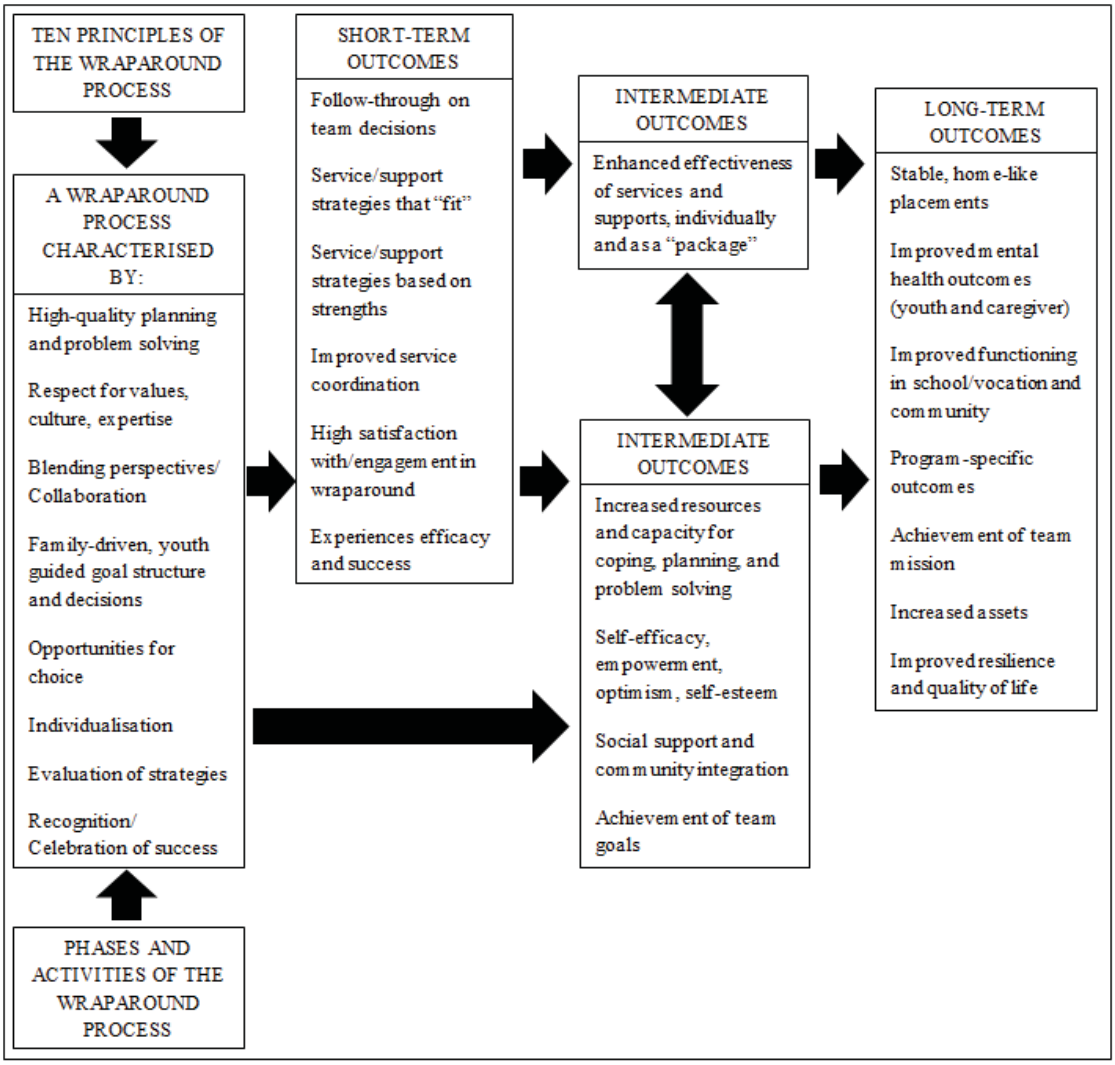

Figure 4: A Theory of Change for Wraparound (Walker, 2008a)

Note: Figure reproduced with permission from Walker, J. S. (2008a). How, and why, does wraparound work: A theory of change. In E. J. Bruns & J. S. Walker (Eds.), *The Resource Guide to Wraparound*. Portland, OR: National Wraparound Initiative, Research and Training Center for Family Support and Children's Mental Health, Portland State University.

For the WTOC to be realised, it is assumed that Wraparound has been delivered with high fidelity, adhering to the 10 principles and four phases of Wraparound (Walker & Matarese, 2011). Also, the WTOC was created in light of earlier models based on effective teamwork. In its creation, Walker (2008a) assumes the team collaborating to deliver Wraparound are carrying out processes which are consistent with effective teamwork including collaboration, problem-

solving, and respect for team members' culture, background and expertise (Walker, 2008a; Walker & Matarese, 2011). The combination of effective teamwork and fidelity to Wraparound principles is predicted to result in accomplishing short- and long-term goals or the team mission (seen in recent models as 'outputs'; McGrath, 1964; Walker & Matarese, 2011). The WTOC predicts families experience two interacting 'routes' on their path to achieving long-term goals. These are seen in Figure 4 as 'Intermediate Outcomes' (Walker, 2008a).

Intermediate Outcomes in the Wraparound Theory of Change

Enhanced Effectiveness of Services and Supports, Individually and as a 'Package'

It is hypothesised by one of the WTOC routes to change that a team whose decisions are owned by the values of the family will select and continually adapt formal services and natural supports so that together the services and supports complement each other and work more effectively than services and supports not coordinated and consistent with family/youth preferences (Walker & Matarese, 2011). Due to the enhanced responsiveness of these services, families are predicted to be motivated to remain engaged with services and supports included in their Wraparound process (Walker, 2008a). There are several reasons Walker (2008a) predicts increased family motivation to engage with services and supports included in their Wraparound. These include choice and motivation of the family; relevance and feasibility of services and supports; shared expectations of the family and Wraparound team; a strengths-based understanding of behaviours; and a whole-family focus (Walker, 2008a). Services are predicted to become more

effective because the Wraparound team is committed and unified, and they therefore work to ensure the family has access to the services and supports included in the plan. Also, because services and supports are selected and adapted based on values of the family, families have improved and ongoing commitment to, and engagement with, those services and supports (Walker, 2008a).

Choice and motivation.

People who feel that they are acting of their own will are more motivated, committed to, and invested in taking part in activities than those obliged to participate (Anderson et al., 2010; Mih & Mih, 2013). Further, they will also be more successful at the activity they have chosen to partake in (Doren, Lombardi, Clark, & Lindstrom, 2013). A collaborative Wraparound process maintaining family voice and choice, with the family determining their needs and selecting strategies and supports during Wraparound planning phases will likely lead to relatively high levels of youth and family commitment to the services and supports they have chosen for the Wraparound plan (Walker, 2008a).

Relevance and feasibility.

If treatment is deemed to be relevant and feasible by parents, it is more likely to be associated with better treatment outcomes for young people (Fields, 2008; Kazdin, Holland, & Crowley, 1997; Morrissey-Kane & Prinz, 1999; Murray, Rabiner, Schulte, & Newitt, 2008). The Wraparound team works conscientiously to couple families in a Wraparound process with services and supports that match needs they have defined themselves (Walker & Matarese, 2011). As a result, it is predicted families will be more likely to remain engaged with those services and supports, see the Wraparound plan as being relevant and

feasible, and benefit from that engagement (Walker, 2008a). Wraparound operates to a set of principles that include ‘community-based’ and ‘culturally competent’ and as such should be beneficial to parents and young people of all cultures and economic status’ (Bruns et al., 2004). As such, it is predicted the cultural competence of services provided in a Wraparound plan should also support family engagement and retention based on their perceptions of service and support relevance (Walker, 2008a).

Shared expectations.

Shared expectations for treatment between parents and clinicians has been demonstrated to be more likely to keep parents engaged with treatment for their children and enhance the effectiveness of treatment (Morrissey-Kane & Prinz, 1999; Poncin & Woolston, 2011; Walker, 2008a). Treatment is also enhanced when it is modified to suit family needs, as is seen in the Wraparound planning process (Morrissey-Kane & Prinz, 1999).

In Wraparound, success is determined by the level of impact that Wraparound strategies have had on indicators of success that the team has agreed upon (Walker, 2008a). For outcomes to be accurately assessed, it is key that the team has shared clear expectations for treatment at the outset; for example, what treatment is for and what is expected (Walker, 2008a). Also, services and supports being accessed by the Wraparound team for the family often become part of the Wraparound team. If not, the Wraparound team creates close communication with the service to discuss the purpose of their service and how to measure indicators of success from their involvement, which the entire Wraparound team are privy to (Walker, 2008a). The WTOC predicts these shared expectations between the

family and services and supports will result in improved engagement and retention in those services (Walker, 2008a).

Strengths-based understanding of behaviour.

Traditional mental health treatment tends to employ a deficit model, where a problem is identified and improving the problem is the focus of treatment (Evans et al., 1996; McDowall & Butterworth, 2014; Poncin & Woolston, 2011; Saleebey, 1996). A strengths-based approach, that reveals coping strategies and resilience, can be particularly useful for engaging with and helping families who are involved with a Wraparound process, as these families have complex needs and are often accustomed to working with multiple services from the perspective of failure (Mears et al., 2009; Poncin & Woolston, 2011).

An important part of Wraparound is a constant celebration of team and family successes, contributing to the ‘strengths-based’ principle (Bruns et al., 2004). The Wraparound team communicates a strengths-based understanding of challenging behaviours to the family and team members, which demonstrates the flexibility of behaviour and that it can be modified (Walker, 2008a; Walker & Matarese, 2011). This demonstration can lead to motivation in young people and their families to engage and remain in treatment with services and supports, and gain improved outcomes from treatment (Kirkwood, 2014; Morrissey-Kane & Prinz, 1999; Walker, 2008a).

Whole-family focus.

Wraparound concentrates on the needs of the family as a whole, which has been evidenced to improve treatment engagement, retention and outcomes (Bonfils, Fukui, Adams, Hedrick, & Salyers, 2014; Morrissey-Kane & Prinz,

1999; Stein et al., 2014; Walker, 2008a). According to the WTOC, providing support to the entire family will increase motivation to participate in the Wraparound process and engage with services and supports (Walker & Matarese, 2011; Walker & Schutte, 2004).

Building Capacity and Resources for Coping, Planning and Problem Solving

The other route to change of the WTOC emphasises that family participation in a high-quality Wraparound process produces benefits related to coping, planning and problem solving that directly contribute to positive long-term outcomes (Walker, 2008a; Walker & Matarese, 2011). The WTOC states that participation in a Wraparound process produces positive outcomes over and above the long-term positive outcomes expected to arise from participation in services and supports (which may also contribute to these long-term positive outcomes). According to the WTOC (Walker, 2008a), long-term outcomes expected to arise from involvement in a Wraparound process with supports and services include improved mental health, high quality of life and increased resilience, among other things. The capacities related to planning, problem-solving and coping that may contribute to the achievement of these long-term outcomes that are predicted to arise from participation in a Wraparound process include self-efficacy, empowerment and self-determination and social support.

Self-efficacy, self-determination and empowerment.

There has been much research to suggest that involvement in processes which are included in Wraparound such as active participation in planning, the experience of making choices, and setting and reaching goals help to develop increases in self-efficacy, self-determination and empowerment (Walker, 2008a).

Self-efficacy is “people’s beliefs in their capabilities to produce desired effects by their own actions” (Bandura, 1997, pg. 3). Theory surrounding self-efficacy posits that beliefs in one’s abilities play a crucial role in psychological adjustment, psychological and physical health, and professionally- and self-guided behavioural changes (Maddux, 2002). People who experience increased self-efficacy are better able to problem solve, have more confidence in their abilities in adverse situations and are more likely to maintain changes in their behaviour (Walker & Matarese, 2011). Knowledge surrounding self-efficacy supports the concept that involvement in a true, strengths-based Wraparound process will contribute to heightened self-efficacy in youth and their families (Bruns et al., 2004; Saleebey, 1996; Winters & Metz, 2009).

Empowerment has been described as a psychological state marked by a sense of perceived control and competence; and an internalisation of the goals of a team (Menon, 1999). Evidence from team building within organisations suggests that empowerment plays a crucial role in group development and maintenance (Conger & Kanungo, 1988). Effective Wraparound teams focus on a family empowerment model rather than following duplicated procedures. This is achieved by way of families being full and active partners in every level of the Wraparound process. It is assumed that the family best understand the strengths and needs of the young person. As such, Wraparound stresses empowerment of families, and sanctions that they have voice and choice at all times (Burns et al., 2000).

Self-determination is associated with motivation, curiosity, mastering new skills, and considerable effort and commitment (Gearing, DeVylder, Chen, Pogge, & Buccolo, 2014; Ryan & Deci, 2000; Vallerand, Fortier, & Guay, 1997). Studies

suggest motivation that is self-determined is associated with more self-esteem, excitement, interest and improved well-being. The result is greater creativity, performance and persistence (Ryan & Deci, 2000). When the family leads the Wraparound plan, they experience increased investment in creating solutions and changes in their lives. This occurs in Wraparound processes of being involved in planning, making choices, directing services and supports; and experiencing success in reaching meaningful goals. This results in feelings of enhanced self-efficacy, empowerment and self-determination (Artello, 2011; Burchard et al., 2002; Walker & Matarese, 2011; Walker & Schutte, 2004).

Overall, increases in self-efficacy, empowerment and self-determination enable people to better maintain behaviour change, manage stressful life events, and lead healthier lives (Walker, 2008a). It has also been noted that children and young people who are proficient in coping with problems have more optimism and are less likely to experience depression (Peterson & Steen, 2002). Further, young people who are optimistic tend to do better academically, have lower rates of substance abuse, and have better physical and mental health (Roberts, Brown, Johnson, & Reinke, 2002).

The WTOC predicts that due to participation in a Wraparound process, families will likely enjoy increased capacity for coping and resources such as overall confidence based on achieving meaningful goals, making choices and enjoying successes, and such resources and will directly contribute to the achievement of long-term goals.

Social support and community integration.

Broadly, social support has been deemed as information leading someone to feel "cared for and loved, esteemed, and a member of a network of mutual obligations" (Cobb, 1976, pg. 300). More recently, it has been suggested that there are several dimensions included in the construct of social support (Reid & Taylor, 2015). Dimensions of social support most commonly cited include emotional (demonstrations of empathy, love, encouragement), instrumental (tangible support such as assistance with problems, e.g. household chores), informational (the giving of advice or suggestions), and appraisal (information for self-evaluation; Reid & Taylor, 2015).

It has been suggested that people with friends, family members and spouses who provide psychological resources experience less hardship than those with few social supports (Cohen & Wills, 1985; Walker & Matarese, 2011). According to Walker (2008a), people with social support also experience coping and health improvements. Community integration is an assimilation into a social network and activities such as school, employment or volunteer work (Willer, Rosenthal, Kreutzer, Gordon, & Rempel, 1993). There is evidence to support mental healthcare consumers gaining social support benefits from participating in the planning of their reintegration into the community (Carling, 1990).

Including family and community supports on the Wraparound team (emphasising the principle of 'natural supports') highlights an attempt to generate and solidify community social support for families and young people (Kernan & Morilus-Black, 2010; Walker & Matarese, 2011). The WTOC predicts that bolstering social support contributes to coping, problem-solving and planning, and directly to the achievement of long-term outcomes (Walker, 2008a).

The Wraparound Theory of Change as a Complex Loop

Diagrams or cycles denote a notion of a linear or left-to-right process. The uniqueness of families within a Wraparound process paired with an ever-developing plan and multiple strategies contributes to a much more complex cycle. The Wraparound process may progress in many alternate directions than can be explained by a simple theory or diagram (Walker & Matarese, 2011; Walker, 2008a).

Each of the domains described above is related to one another and is not able to be completely teased apart. Each time one is strengthened there is the likelihood that another will become stronger also. For example, a strengths-based understanding of behaviour may boost family self-efficacy, resulting in improved coping and problem-solving. Improved coping and problem-solving may lead the youth and family to feel more motivated to voice their expectations and partake in deciding upon services and supports (increased engagement); leading to further heightened self-efficacy, which may result in the family becoming more integrated into their community, increasing their supports further, increasing self-efficacy, and so on. In this way, the Wraparound process involves a complex loop, which can be demonstrated by interactions between the various pathways to change, continuously reinforcing upon themselves and recirculating (as seen in Figure 4; Walker & Schutte, 2004; Walker, 2008a). Wraparound could thus be identified as a positive cycle that promotes and reinforces change through multiple pathways. However, this is too simple of an explanation as to how and why Wraparound can be expected to succeed (Walker, 2008a; Walker & Matarese, 2011). The actual process of change that a young person and their family might experience is much more complicated and unique than can be

portrayed in a brief discussion of theory or demonstrated in a single, simple diagram (Walker, 2008a). It is for this reason that such a theory will never be able to be assessed in its entirety but warrants further investigation.

Purpose of the Current Study

The WTOC places a high level of importance on outcomes that are not often measured, namely the intermediate routes to change (enhanced effectiveness of services and supports, individually and as a 'package'; and increased resources, self-efficacy, social support and achievement of team goals; Walker, 2008a). It also suggests not measuring these significant outcomes may underestimate the usefulness of Wraparound as these outcomes can change the lives of youths and their families (Walker, 2008a; Walker & Matarese, 2011). Additionally, "further research is needed to confirm and refine Wraparound's initial theory of change" (Bertram et al., 2011 pg. 721). Wraparound's intermediate routes to change need assessment because the WTOC has not been reviewed and as such remains a theory (Bertram et al., 2011). Also, previous work has generally been based in the United States of America and is largely positivist in nature (Bertram et al., 2011; Bruns & Suter, 2010; Rauso et al., 2009). The current research explored the following intermediate pathways as proposed by the WTOC within a New Zealand context:

1. Enhanced effectiveness of services and supports, individually and as a "package."
2. Increased resources and capacity for coping, planning and problem-solving:
    a. Self-efficacy, empowerment, optimism, self-esteem
    b. Social support

This study took place with current clients involved with a Wraparound process at the NZWP. This was one of the few services in New Zealand providing high fidelity Wraparound, grounded in the evidence-based Wraparound practices proposed by the NWI (Shailer et al., 2013).

The WTOC stipulates that change begins with the assumption Wraparound is carried out in a consistent manner and interactions clearly reflect the principles and phases of Wraparound. For this reason, the research was divided into two parts. Part A of the research explored Wraparound fidelity and included the administration of the Wraparound Fidelity Index-Short Version at the NZWP. Youth, caregivers, team members and group facilitators within a Wraparound process at the NZWP had the fidelity of their Wraparound process measured using this tool.

The primary focus of the research, Part B, explored the pathways to change within the NZWP process of Wraparound. Through interviews, youths and caregivers involved with Wraparound were asked to speak about their Wraparound experiences, and identify any outcomes they felt they had achieved through the Wraparound process. The outcomes discussed by youths and family were analysed using Interpretative Phenomenological Analysis and themes were then compared with the intermediate outcomes proposed by the WTOC to assess if they were aligned.

The current research aimed to advance an understanding of how and why Wraparound performs. Knowing more about how the pathways operate within Wraparound will contribute to future refinement of the Wraparound practice and

support more effective ways to measure outcomes (Bertram et al., 2011; Bruns & Walker, 2011; Walker & Matarese, 2011; Walker, 2008a).

Research Questions

1. Does the NZWP adhere to satisfactory fidelity ratings to ensure their service delivery is Wraparound as described by the NWI's model of Wraparound?
2. What outcomes are achieved from the Wraparound process as perceived by youth and caregivers?
3. To what extent do the described outcomes of Wraparound align with the intermediate outcomes as proposed by the Wraparound Theory of Change?

Chapter Three: Methodology

This chapter describes the methodology and data analyses undertaken for the research. The research was divided into two parts, Part A which involved exploring the Wraparound fidelity for youth in the NZWP and Part B which involved qualitative interviewing with youth and their caregivers.

Methodology Overview

Part A focused on evaluating the fidelity of Wraparound, specifically, answering Research Question 1: determining whether the NZWP adhere to satisfactory fidelity ratings to ensure their service delivery is authentic Wraparound (as described by the NWI's model of Wraparound). In the WTOC, Walker (2008a) stipulates that change begins with the assumption the team collaborating to deliver Wraparound are carrying out processes which clearly reflect the principles and phases of Wraparound (Bruns et al., 2004; Walker & Matarese, 2011; Walker, 2008a). If the WTOC is to be reviewed, it first needs to be ascertained that Wraparound delivery is being adhered to as specified by the guidelines set out by the NWI (Bruns et al., 2004). Part A was conducted to ensure changes and experiences reported by families in Part B were related to involvement with a genuine Wraparound process.

Part B of the research was weighted toward answering Research Questions 2 and 3 of this research: to gain an understanding of what outcomes were experienced by youth and their caregivers involved with Wraparound; and to investigate to what extent the experienced outcomes of Wraparound align with the intermediate outcomes as proposed by the WTOC.

Part B involved face-to-face semi-structured interviews with youth participants and their caregivers (see Appendix A for the Interview Schedule). Part B applied an Interpretative Phenomenological Analysis to the data which is discussed later in this chapter, along with a personal reflection from the researcher and ethical considerations for the study.

Study Inclusion Criteria

Participants for both Part A and Part B consisted of current clients in the third (plan implementation and refinement) phase of Wraparound at NZWP who consented to take part. The third and fourth (transition) phases were chosen for inclusion due to the fidelity measurement tool used in Part A requiring a minimum 90-day involvement in Wraparound and it was deemed by researchers that families were more likely to have had this length of involvement during these phases (Sather, Bruns, & Hensley, 2012). The Clinical Case Coordinator at NZWP assisted in identifying all families involved in their third or fourth phases of Wraparound with youths aged 11 and over. All eligible families who chose to take part in the study were coincidentally in the third phase of Wraparound, resulting in no participants in the fourth phase of Wraparound.

Clients must meet the following criteria to be referred to the NZWP:

1. Be between 6 and 17 years old (or 17 – 20 years if under the guardianship of the Director General of Child, Youth and Family);
2. Have a severe mental health problem;
3. Have ongoing Child, Youth and Family Services (CYFS) and Child and Adolescent Mental Health Service (CAMHS) involvement.

In addition, they must meet one or more of the following criteria:

- The young person has contact with multiple health and social services and requires active service coordination to develop and manage the number and complexity of services needed to improve outcome;
- requires a more intensive level of mental health clinical services than can reasonably be provided by CAMHS services;
- is not able to have their needs met by ‘Strengthening Families’ processes (a New Zealand Government initiative) or the usual network of health and social services;
- has an escalating pattern of multiple risk behaviours;
- has had multiple home/living placements within the past 6-12 months or the circumstances place the family or alternative caregivers under extreme stress;
- or, is under the custody of CYFS or status with the Department (New Zealand Wraparound Program, 2006).

Participants

Nine youths were in the NZWP who met criteria for being in Wraparound for 60 or more days at the time of the study being conducted. Participants under the age of 11 were ineligible due to requirements of the adherence measure used in this study. All nine eligible youths were approached by their Wraparound Facilitators at the NZWP, resulting in six youths, their caregivers, Wraparound Facilitators and team members taking part. All participants were given information sheets explaining what their participation in the research entailed. Participants over the age of 18 (i.e. caregivers, Wraparound Facilitators and team members) completed a consent form and an assent form if under the age of 18 (i.e. youths). Caregivers were also required to give their consent for youths under their

care to participate (See Appendices). Each youth, caregiver, Wraparound Facilitator and a Wraparound team member individually completed the fidelity measurement self-report tool (described below), resulting in 24 participants for Part A.

One youth participant who completed the fidelity measurement self-report tool in Part A chose not to be interviewed in Part B, and the interview took place with their caregiver only. Further, group facilitators and team members who were required to participate in Part A as prescribed by the NWI in administration of the WFI-EZ did not take part in Part B. The rationale for this was Part B aimed to investigate research questions which are grounded within gaining understanding of families' experienced outcomes in Wraparound that they have seen in their own lives, as such it would have been inappropriate for anyone other than the individuals themselves to comment. Thus, the number of participants in Part B was made up of five youths and six caregivers, totalling 11 participants. Families involved with the study were yet to complete their Wraparound process, with their length of involvement ranging from five to 18 months.

Demographic Information

Demographic information was collected for the youths who took part in this study, as collected by the fidelity measure described below. The study included two male, three female and one transgender (female to male) participants. Youths were between the ages of 12 and 17 with a mean age of 15.5. With regards to ethnicity, three youths identified as Māori; one as New Zealand European/Māori; one as British and one as South African.

Fidelity Measure: Wraparound Fidelity Index-Short Version

Wraparound fidelity was assessed using a self-report form called the Wraparound Fidelity Index – Short Version (WFI-EZ; Appendices B-E; Sather, Hensley, Bruns, & Wraparound Evaluation and Research Team, 2013). The WFI-EZ has recently been developed by the NWI and assesses key elements of the Wraparound process associated with the WTOC. The WFI-EZ is a brief version of the Wraparound Fidelity Index version 4 (WFI-4). The WFI-4 is a semi-structured interview consisting of either brief face to face or telephone interviews with four categories of participants in the Wraparound process: (1) parents or caregivers; (2) youth (11 and over); (3) Wraparound Facilitator and (4) a team member. Each WFI-4 interview consists of 40 items which are organised based on the four phases of Wraparound to evaluate the extent to which the 10 principles and four phases are being adhered to in the implementation of the Wraparound process (Bruns, Suter, Force, Sather, & Leverentz-Brady, 2009).

The WFI-EZ is a reliable and valid measure of adherence to key element Wraparound processes in the WTOC that is simpler to administer and less time consuming to the participants than that of the WFI-4. The WFI-EZ has 37 items, is organised in a way that allows the participant to skip items that are not applicable, and is completed by self-report.

The form consists of four sections. Section A, Basic Information, is made up of four ‘yes’ or ‘no’ questions about basic foundations of Wraparound (e.g. does the team meet regularly?). Section B, Experiences with Wraparound, includes 25 items about specific activities of the Wraparound Process (e.g. because of Wraparound, I feel like I get more support from friends and family). These items are responded to by way of a 5-point Likert scale. Likert scale scores

produce a Total Fidelity score. Key Element scores (outcome-based, effective teamwork, natural/community supports, and strength-and-family driven) are also calculated from five of the items. The Total Fidelity and Key Element scores are calculated as percentages of the total possible score. For example, if an individual marked “Strongly Agree” for each of the five items that make up the ‘Effective teamwork’ Key Element, that Key Element would receive a score of 100%. Section C, ‘Satisfaction with Services’, is made up of four items, also using a Likert scale. Only caregivers and youth respond to these items (such as ‘I am satisfied with the Wraparound process in which my family and I have participated’), which result in a total score calculated from the overall average of the four items. Section D, ‘Perception of Outcomes’, is made up of nine yes or no items related to specific outcomes such as ‘has the youth been suspended or expelled from school?’ (Sather et al., 2012). Demographic information for the youth is also collected, including gender, age, ethnicity, caregiver relationship to youth, and legal custody of youth (National Wraparound Initiative, 2016b).

Four versions of the fidelity measure for each family contribute to the WFI-EZ’s strong internal consistency (Cronbach’s Alpha = .937; Sather, Bruns, & Hensley, 2012) when compared with the WFI-4 (Cronbach’s Alpha = .51; Bruns et al., 2009). With regards to validity, the correlation of total scale scores from the 37 WFI-EZ items with total scores from WFI-4 interviews has been found to be significant at $p=.001$, $r(42) = .548$ (Bruns, Sather, & Pencer, 2012; Sather et al., 2012).

The WFI-EZ was modified for this study to cater to a New Zealand audience, comprised of an adaptation of New Zealand spellings and the inclusion of New Zealand ethnicities based on the 2013 census results.

Procedure

The WFI-EZ was completed by the youth, their caregiver, their Wraparound Facilitator and a team member of each Wraparound team in September and October of 2014. WFI-EZ's were given to each Wraparound Facilitator by the Clinical Case Coordinator at NZWP who distributed them to the youth, caregiver and a Wraparound team member in a regular Wraparound meeting. The WFI-EZ's were then completed individually in private and returned in individual sealed envelopes to the Clinical Case Coordinator who returned them unopened to the researcher. The measure took on average ten minutes to complete.

WFI-EZ data from all 24 participants were entered into an online reporting system named 'WrapTrack' which was developed by the creators of the WFI-EZ for analysis of the measure. 'WrapTrack' combined WFI-EZ data from the four self-report questionnaires of each Wraparound team for each youth (youth, caregiver, Wraparound Facilitator, team member) to produce Key Element Fidelity Scores (Effective Teamwork, Needs-Based, Natural and Community Supports, Strength and Family Driven, and Outcomes-Based) and a Total Fidelity score. It also compared the scores to other anonymised scores within WrapTrack.

The WFI-EZ was created for the measurement of fidelity within teams providing a Wraparound service, and to compare Wraparound fidelity scores across several services using WrapTrack anonymised data. The use of results obtained from the measure has been recommended for use in program improvement and research (Sather, Hensley, Bruns, & Wraparound Evaluation and Research Team, 2013). Services providing a Wraparound process are encouraged to investigate Key Element scores to identify fidelity strengths and

needs (Sather et al., 2012). These recommendations, paired with the relative infancy of the WFI-EZ and lack of standardised norms meant at the time of data collection, no singular percentage score recommended by WFI-EZ creators existed to determine whether or not teams had met ‘adequate’ fidelity. The WTOC specifies that for change to occur for families involved in a Wraparound process in the ways the theory posits, they must have been involved with ‘true’ Wraparound. The use of qualitative exploration was adopted to explore in more detail the experiences of families involved in a Wraparound process.

Part B Methodological Rationale

The key research objective was to gain an understanding of Wraparound outcomes as experienced by families and investigate the extent to which these outcomes aligned with the intermediate outcomes described in the WTOC. This was achieved through the collection and interpretation of personal narratives from individuals who have been involved in Wraparound. Narratives provided evidence of the ways in which young people and their caregivers understand their experienced outcomes of Wraparound. From these narratives, the researcher was able to interpret and represent the family’s experienced outcomes, and suggestions they may have for improving the process for other families involved with Wraparound. Thus, the research methodology needed to be able to accommodate diverse experiences and identify diversity within participants’ accounts of their experience. This suggested the overall methodology required development within an epistemological framework emphasising knowledge as understanding, that could take account of the specificity of experiences, and which honoured integrity.

Interpretative Phenomenological Analysis

Interpretive Phenomenological Analysis (IPA) was selected as the methodology for the present study. IPA is a suitable approach when aiming to investigate how individuals are experiencing particular situations they are facing, and how they perceive their personal and social world (Smith, Jarman, & Osborn, 1999). IPA is particularly useful when exploring a particular process, which is why it was selected for this research to explore the experiences of youth and families involved with Wraparound.

IPA suggests the meanings attributed to events by individuals should be a central concern for researchers (Larkin, Watts, & Clifton, 2006; Smith, 2007, 2011; Smith et al., 1999). It may be useful to understand IPA as a 'position' to approach the task of qualitative data analysis from, rather than as a distinct 'method'. In this 'position', an IPA researcher must approach data in two phases: Firstly, attempting to understand their participants' world, and to describe 'what it is like'. This focuses on the unique characteristics of individual (idiographic) participants, attempting to understand and 'give voice' to the participants (Larkin et al., 2006; Savin-Baden & Major, 2012; Smith, 2011). The second phase of IPA aims to develop a more interpretative analysis, which places the initial report in relation to a wider social or cultural context. This second phase intends to lead the researcher to thinking about what it means for the participants to have made particular statements and expressed feelings or concerns in this specific situation (Brocki & Wearden, 2006; Finlay, 2011). This initially descriptive and then interpretative focus of IPA increases the likelihood that a deepening of understanding can occur (Savin-Baden & Major, 2012). IPA results in a set of

superordinate and subordinate themes that represent experiences and patterns of meanings.

It has been argued that it is impossible to ignore the influences of assumptions, expectations, language, culture or ideology (Rennie, 1999). Relatedly, IPA argues observation cannot be made without interpretation (Packer, 1992a). IPA cannot achieve an unaffected first-person account; the account is always constructed by the interpretations of both the participant and researcher (Larkin et al., 2006). A double hermeneutic or double interpretation occurs; the participant attempts to interpret their world, and the researcher attempts to interpret the participant attempting to interpret their world (Smith, 2003a).

IPA has theoretical underpinnings in phenomenology and symbolic interactionism (Smith, 2003b). Phenomenology focuses on interpreting an understanding of phenomena or experiences (Savin-Baden & Major, 2012). The phenomenologist aims to reveal any subject matter on its own terms, thus not according to the imposition of any preconceived set of assumptions and expectations (Starks & Trinidad, 2007). Phenomenology uses data from participants in a first-person perspective, precisely in the way that it is presented, such as interview transcripts. It does not attempt to test any predetermined hypotheses and is interested only in what has actually occurred (Smith, 2003b).

Symbolic interactionism is concerned with how individuals construct meaning in their social and personal world (Smith, 2003b). Symbolic interactionism posits that meaning and interpretations occur only through social interaction, and these meanings are essential to understanding human action (Smith, 2003). An observer of a social interaction does not have direct access to

the meaning of the acts taking place because people act in a situation that an observer does not share fully; further, they themselves do not comprehend all the important aspects of their own actions (Packer, 1992b).

IPA is interested in interpreting subjective meanings of particular processes, instead of abstracting objective, quantifiable data (Manly, Robertson, Anderson, & Nimmo-Smith, 1999; Smith et al., 1999). Instead, the intention is to create an articulate psychologically informed report, which tries to present a participant's view as accurately as possible (Larkin et al., 2006). However, IPA emphasises that the research is a dynamic process with an active role for the researcher, recognising that the reflections and interpretations of the researcher are a key and complicating part of the analysis, as well as recognising the creativity of the interpretative process (Eatough & Smith, 2006a; Smith et al., 1999). The researcher is aiming to get as close as possible to the participants' world but will never be able to do this completely (Smith et al., 1999).

IPA is respectful of participant involvement, combining questioning hermeneutics with an empathic hermeneutics (Smith et al., 1999). In this way, IPA attempts not only to understand the meaning of participant perspectives but to also take their side. In doing so, IPA reflects the first Wraparound principle of 'family voice and choice'. Using a research method that confines participant responses to standardised categories would undermine the integrity of research which aims to be collaborative and adhere to Wraparound principles and values. Positioning the participant as the 'driver' of the research because their data informs the research conclusions also aims to re-balance the research power dynamic which traditionally positions the researcher as the 'expert' (Savin-Baden

& Major, 2012).

IPA is ideally suited to small samples because of its idiographic focus (Winters & Metz, 2009), and entails data collection producing large volumes of data as in-depth interviews are transcribed verbatim (Eatough, Smith, & Shaw, 2008). It is therefore recommended that the number of participants be kept to a small, manageable size (Finlay, 2011). Smith and colleagues (1999) suggest that anywhere from one to 15 participants is an adequate number for IPA, and between three and five is sufficient for student research. This suggestion is made due to the painstaking detailed analysis required by IPA, which aims to investigate depth rather than breadth (Smith et al., 1999).

In summary, IPA is grounded in phenomenology and symbolic interactionism and aims to discover what a process is like from the participant's perspective by collecting their ideas about it. In this case, IPA attempted to discover participant perspectives of a Wraparound process. IPA was selected based on its close focus of the individual experiences of Wraparound involvement, and its alignment with Wraparound principles which place the youth and family as the experts of their experiences.

Semi-Structured Interviews

IPA recommends the use of semi-structured interviews as a form of data collection which can gather information to directly answer the research questions and are flexible enough to allow for follow-up on certain comments and reactions. Follow-up questions allow for the discussion of areas the researcher had not previously considered to be relevant (Gill, Stewart, Treasure, & Chadwick, 2008; Savin-Baden & Major, 2012). Interview limitations lie in the difficulty of

accurately recalling past events, or inhibitions to share personal information for fear of judgment (Eatough & Smith, 2006b; Rabionet, 2011). However, interviews can elicit rich data which goes beyond casual conversation, unwrapping attitudes and beliefs (Eatough & Smith, 2006a; Tomkins & Eatough, 2010).

To gain an understanding of outcomes experienced by families within Wraparound and be able to present these understandings in superordinate and subordinate themes, families were interviewed using a semi-structured approach which took around an hour and a half per family (see Appendix A for the Interview Schedule). Open-ended questions were employed to gain more understanding about participants' experiences of Wraparound. Interview questions were developed from a thorough review of existing Wraparound and theory-of-change literature and the researchers' personal knowledge of Wraparound meetings. With the consent of all participants, all interviews were voice recorded with the option of turning recorders off at any stage. Enquiry encompassed changes in familial, community and service relationships; problem-solving and coping strategies; self-perception; and interpretations of Wraparound strengths and weaknesses. Opportunities were also given to participants during interviews to expand on any answers given in the WFI-EZ forms.

Interviews occurred with caregivers and youths separately wherever possible, as recommended by Smith and colleagues (1999). However, at times sections or entire interviews took place with both the caregiver and youth together because the youth felt more comfortable with their caregiver present. Interviewing both caregivers and youth allowed the researcher to obtain multiple perspectives involved in the Wraparound process service delivery.

It is desirable with IPA for the participant to be more familiar with the setting than the researcher (Larkin et al., 2006). As such, interviews took place in participants' homes; ensuring participants were as comfortable as possible in their environment.

Interviews adhered to the following schedule: a thank you to participants and gifting of Koha; a brief statement of the limits of confidentiality; a summary of the investigation to follow up information sheets previously provided; an opportunity for the participants to ask questions about the study; the semi-structured interview; another opportunity for further questions or comments about the study; and a final thank-you.

Transcript Analysis

There is no singular definitive way to do IPA, as qualitative analysis is typically a personal process to the researcher (Smith et al., 1999). Smith and colleagues (1999) offer suggestions for the IPA process but recommend the researcher adapt their own particular procedure during analysis to suit their personal way of working. The guideline offered by Smith and colleagues (1999) includes the following steps of analysis: 1) interview transcription, 2) looking for emergent themes, named subordinate themes, 3) connecting the emergent themes into clusters, named superordinate themes. These steps are repeated for each transcript with the researcher remaining aware of themes that have presented in earlier transcripts but also being mindful of new information to arise.

Transcription is often regarded as the first stage of data analysis since transcription involves interpretative decisions about how to represent conversations between interviewers and participants (Braun & Clarke, 2006;

Savin-Baden & Major, 2012). For the present study, transcription was completed as soon as possible following interviews. Transcripts included verbatim interactions between the interviewer and participant including laughs, significant pauses and false starts. Verbal interruptions involving others and interviewees were not transcribed. Participants were offered the opportunity to review the completed transcripts. Those who chose to review their interviews were welcomed to respond with any changes or additional comments. No transcripts were returned.

As noted, the levels of theme development in IPA are referred to as subordinate and superordinate. Subordinate themes were noted on transcriptions using qualitative analysis assistant software program DeDoose. After looking for connections between subordinate themes, they were placed into clusters and clusters were repeatedly checked against the transcript in an iterative process. The researcher was continually checking her own sense making against what participants had said (see personal reflection below). A table of themes was then produced, identifying clusters of themes attempting to capture participant responses to each particular theme. These clusters were then each given names representing superordinate themes. After this process had been carried out for the first transcript, it was repeated for each, taking particular note of new themes. In line with the iterative process of IPA, new superordinate themes called for earlier transcripts to be reviewed again and as such were analysed in an ongoing process. Superordinate themes were finally refined and combined for all data sets (presented in Table 3, Chapter 4). Meanings inherent in participant experiences were produced from superordinate themes and are discussed in Chapters Five, Six, and Seven.

It is important to note that the flexibility of the IPA approach is not aligned with a lack of rigour. Rather, an extremely detailed analysis of participant accounts is the foundation of the IPA process. Its focus means that both a descriptive and interpretative analysis of the data increases the likelihood that a deepening of understanding occurs (Savin-Baden & Major, 2012). Relatedly, Guba (1981) offers suggestions to researchers using qualitative inquiry to address matters of ‘reliability’ and ‘validity’ as seen in rationalistic or other types of inquiry. Specifically, the matters of credibility, transferability, dependability and confirmability are raised (Guba, 1981).

Credibility is concerned with the testing of findings and interpretations with various sources, which could be seen to be related to internal validity (Guba, 1981). This research attempted to address credibility with member checks, prolonged time at a site, and peer debriefing. The primary researcher strived to build rapport with interviewees in order to obtain honest and open responses. During interviews, information was restated and summarised and the interviewer would seek accuracy from interviewees through further questioning. Following the interviews, participants were given their transcripts to view, comment on or change. Prior to interviewing, the primary researcher also spent a three-week period at the NZWP to engage with the principles and processes related to Wraparound and attend several Wraparound meetings. Finally, throughout theme identification, peer reviews were conducted to discuss findings and explore ideas from outside sources.

Transferability is linked with external validity and is concerned with the degree to which the findings are applicable in other contexts (Guba, 1981). IPA would argue that generalisations are implausible due to phenomena being

intrinsically linked to the environment or context in which they occur (Smith, 2003a). This study engaged in purposive sampling whereby the researcher relied on her own judgment when selecting the sample based on the characteristics of the population. In this particular context, the population was families involved in a Wraparound process in New Zealand supported by the NZWP adopting the NWI principles and phases. As such, it would be up to the discretion of the future researcher to determine if transferring these results to a different context is sensible.

Dependability is associated with reliability and asks if findings would be able to be consistently repeated if the study were to be replicated (Guba, 1981). IPA proposes that reality is socially constructed and is therefore constantly changing for both the researcher and the participants (Eatough & Smith, 2006b). As such, it is important for the researcher to track their own changing perceptions throughout the IPA process. The primary researcher in this study adopted a check/recheck procedure whereby after naming themes that were interpreted to arise from data, the researcher would look back at that same data several weeks later to recheck that data and evaluate the results.

Finally, confirmability is associated with the degree of neutrality that can be expected to come from the inquirer throughout analysis, related to objectivity (Guba, 1981). Confirmability requires that the data remains neutral irrespective of who is interpreting it. The researcher addressed the issue of confirmability by practicing reflexivity. The primary researcher admits to her own assumptions and biases based on personal experiences. These reflections are presented below.

Personal Reflection

To avoid qualitative research being considered biased or untrustworthy, it is central as a researcher to consistently evaluate one's self-awareness and involvement in the topic and data. I (the author) have been continually aware of how my life experience may impact on the analysis of the interviews. I have not experienced many of the life stressors that the caregivers and young people have faced. The interpretation of the interviews, therefore, comes from someone who empathised with the participants but had not experienced trauma or experience complex needs in the ways in which they had.

At the time of conducting interviews and the following IPA, having undergone nine years of psychology training both generally and in the clinical field, along with working in several related positions undoubtedly impacted my analysis. Relatedly, a clinical psychology training placement resulted in my attendance at several Wraparound meetings prior to commencing the study. These experiences demonstrate the impossibility of being completely without perspective or objectiveness and "should be seen as part of a process making research more accountable, transparent and easier to evaluate" (Coyle, 2007, p. 265).

The ability and willingness of participants to engage in research and recall both pleasant and challenging aspects of their Wraparound experience required my being able to inspire trust and safety in them (Guest, MacQueen, & Namey, 2011; Joffe, 2012). Although my psychological training and other personal life experiences impacted the analysis process as recognised by IPA, these

experiences simultaneously were likely advantageous in supporting participants to feel safe during the interview process.

Ethical Considerations

An application to the Health and Disability Ethics Committee of New Zealand was submitted on August the 18th 2014. After minor emendations, this application was approved on September 11th, 2014 (see Appendix E). For the study to take place at NZWP, ethical research approval was also required by the local District Health Board. This approval was granted in early October 2014 (see Appendix F).

One identified ethical issue included possible risk to the participants. Semi-structured interviews were to be carried out by a student researcher, and participants had potential to become distressed during the interview, with sensitive information such as the experience of suicidal ideation possibly being disclosed during interviews. This risk was mitigated by clinical psychologists at the NZWP and Massey University involved with the study making themselves available to be on call during interview times. Additionally, the research questions were approved by a Massey University clinical psychologist and deemed appropriate for the student researcher to use during the interview. Further, the student researcher had considerable experience in clinical interview settings.

Another ethical consideration included confidentiality of participants. This issue was addressed with data all being given a confidential number in place of names. All electronic data was password protected, and all paper data was stored in a locked cabinet at Massey University and will remain there for at least five years as per university policy before it is destroyed. WFI-EZ data was de-

identified and will be stored in the NWI database indefinitely. Participants were informed during the interviews of these processes, and the limits of confidentiality were discussed.

Finally, an issue of informed consent was raised due to youth participants being under the age of 18. All caregivers were entitled to make an informed decision and consent on behalf of youths. However, as this research included the critical perspectives of youths, while not legally binding, youth assent forms were also collected so that they were able to have a direct choice about their participation in this study.

Cultural Consultations

This research aimed to gain an understanding of the outcomes of Wraparound with all ethnicities currently involved in the NZWP, including Māori, Pacifica and other New Zealanders. All participants were active partners in the research. They were welcomed to end their participation in the research at any point and encouraged to voice any thoughts or feelings at any time about the process. Participants who wished to have a whānau member or other support person present during their interview were accommodated, resulting in interviews having both caregiver and youth present at various points. For this reason, there is variation throughout interviews related to who is present, which influences the resulting amount of input from both caregivers and youths, and the resulting findings.

While the current investigation did not raise any direct cultural issues, there is a high number of Māori youth and whānau involved in the NZWP Wraparound process. Cultural consultation was sought and carried out in-depth in

a face-to-face meeting with the researcher and the Māori Cultural Advisor at the NZWP (letter of cultural consultation attached in Appendix G). Where Māori ethnic identity was established as important by participants the researcher endeavoured to work towards meeting any desires and needs specified by individuals in accordance with the Treaty of Waitangi (discussed in Chapter Two) and best practice. Participants who identified as Māori were welcomed to voice how Wraparound may impact their whānau, hāpū or iwi, or Te Ao Māori generally.

Link to Chapter Four: Results

Chapter Two provided an overview of young people with high and complex needs in Aotearoa New Zealand, the Wraparound Process, the New Zealand Wraparound Program, and the Wraparound Theory of Change. Chapter Three discussed the methodology and theoretical underpinnings adopted to interview families involved in the Wraparound process at the New Zealand Wraparound Program. Chapter Four will provide the Total Fidelity score and Key Element scores obtained from the WFI-EZ WrapTrack reports for Part A of the study before interviews took place. The WFI-EZ results aim to answer Research Question 1 (Does the NZWP adhere to satisfactory fidelity ratings to ensure their service delivery is Wraparound as described by the NWI's model of Wraparound?). Chapter Four will also provide a table of themes resulting from the Interpretative Phenomenological Analysis (IPA) after interviews took place (also known as Part B). The IPA themes aim to answer Research Questions 2 (What outcomes are achieved from the Wraparound process as perceived by youth and caregivers?) and 3 (To what extent do the perceived outcomes of Wraparound align with the intermediate outcomes as proposed by the Wraparound Theory of Change?) The WFI-EZ and IPA results and a brief summary of these are presented in the following Chapter and Research Questions 1, 2 and 3 are more formally addressed in Chapter Seven.

Chapter Four: Results

Wraparound Fidelity Index – Short Version Results

Key Element Scores

Key Element Scores assessing fidelity to key Wraparound practices by the NZWP are displayed in Table 1. Also displayed are the overall Key Element Score means for the study and Key Element Score means of anonymised data in the WrapTrack system from the United States of America.

Table 1

Participant Key Element Scores with Means and USA National Means

	Key Element Scores				
Youth**	Effective teamwork	Natural/ Community supports	Needs-based	Outcomes-based	Strength-and-family-driven
1*	67.5	72.5	75.0	77.5	77.5
2	77.5	85.0	72.5	78.9	81.6
3	77.5	65.0	86.1	76.4	81.3
4*	78.6	80.0	90.0	88.3	85.0
5	76.3	68.4	68.4	78.9	68.4
6*	82.7	50.0	64.3	83.3	75.0
Mean	76.7	70.2	76.1	80.2	78.1
USA Mean	72.7	67.0	68.8	76.6	80.6

*Missing substantial data - 8 or more items answered “don’t know.”

**WFI-EZ scores are combined from forms completed by the Youth, Caregiver, Wraparound Facilitator and Wraparound Team Member to give one WFI-EZ fidelity score for each Youth

The Total Fidelity Score (the overall average of Key Element Fidelity Scores) was also calculated for each of the six youths in this study. Table 2 shows the Total Fidelity scores for youths in Part A. The USA means for Total Fidelity

Scores were unavailable at the time of data analysis and as such are not displayed here.

Table 2

Part A: Total Fidelity Scores for Participants Partaking in Wraparound at the New Zealand Wraparound Program

Youth**	Adherence to Wraparound as determined by WFI-EZ (%)
1*	74.0
2	79.1
3	77.1
4*	84.5
5	72.1
6*	70.7
Mean	76.3

*Missing substantial data - 8 or more items answered "don't know."

**WFI-EZ scores are combined from forms completed by the Youth, Caregiver, Wraparound Facilitator and Wraparound Team Member to give one WFI-EZ fidelity score for each Youth

Part A Results Summary

Overall, the lowest fidelity Key Element Scores present in the WFI-EZ data for this study were 'Natural/Community Supports', which previous studies have demonstrated as being typically the most challenging Wraparound process to adhere to with high fidelity (Kernan & Morilus-Black, 2010; Shailer et al., 2013). Key Element Scores indicated strongest adherence in this study to the key Wraparound process of Outcomes-based. These scores suggest the NZWP were able to tie goals and strategies of the Wraparound plan to visible indicators of success and monitor team progress throughout the Wraparound process with families in this study (Suter & Bruns, 2009).

As previously discussed, there are yet to be established adherence cut-off norms created for the WFI-EZ. However, as demonstrated by Table 1, Key

Element Scores compared favourably to USA national means, surpassing USA means in each key Wraparound process except Strength-and-family-driven, which still attained a favourable 78.1% adherence. These results indicate satisfactory adherence to key Wraparound processes by the NZWP in this study.

According to the WFI-EZ manual and WrapTrack, as 3 of the 6 youth answered more than 8 of their WFI-EZ items with “Don’t know”, this accordingly represents “missing substantial data”. As such, overall WFI-EZ scores are said to be compromised (Sather et al., 2013). Fortunately, due to the high completion rate of the WFI-EZ forms from each of their caregivers, Wraparound Facilitators, and Wraparound Team Members (with no other participants responding with 8 or more “Don’t know”), their combined WFI-EZ Key Element and Total Fidelity Scores continued to have internal consistency and were still useful data to include in the study (Sather et al., 2013).

This research takes a post-positivist approach which supports the notion that knowledge accessed using qualitative methods may be able to offer a deeper level of meaning and understanding (Baden & Wimpenny, 2014). As such, the researcher would argue “missing data” provides an opportunity to use qualitative processes to gather further data which provides rich information for further analysis and meaning-making (Eatough & Smith, 2006b). Further, the exclusion of participants in interviews for Part B for any reason would undermine research that aims to be inclusive and investigate individual experiences of a Wraparound process from the voice of those who have themselves experienced it. Thus, all youths and their caregivers were invited to be interviewed for Part B of the study.

Interpretative Phenomenological Analysis Results

Part B Results Summary

Following interviews with families, the primary researcher completed the Interpretative Phenomenological Analysis (IPA). As a result, four superordinate themes were identified, which all related to personal and service changes as a result of participation in a Wraparound process. These themes were changes in the family unit, psychological acceptance, changes in self-efficacy and changes in supports. Each superordinate theme and their corresponding subordinate themes, with the researchers' definitions for each and interview excerpts to demonstrate these are shown in Table 3. Discussion related to the themes and the ways in which they relate to the WTOC are presented in the following chapters.

Table 3

Findings: IPA Themes Identified in WTOC Interviews

Superordinate IPA Themes	Subordinate IPA Themes	Definition	Example Interview Excerpt
Changes in family unit	Connectedness	Wraparound teams connected families with family members included in the team as well as extended family members not previously involved in the care of the youths. These new connections deeply strengthened relationships between youths and caregivers, and gave youths and caregivers opportunities to communicate with other family members and extended family.	"I think my husband and I have got much better strategies for dealing with things. I think that they've worked very hard on strengthening relationships. Like my husband and my relationship, our relationship with all the girls."
Psychological acceptance	Understanding selves Understanding others	Psychological acceptance has been described as allowing, embracing, experiencing and making contact with private experiences, which previously elicited avoidance, aggression or escape (Cordova, 2001). Families in the study portrayed developing acceptance toward their difficult journeys prior to Wraparound, and acceptance for what their future would hold post-Wraparound. Acceptance came in the form of both a growth in understanding of themselves and of others.	"I wanted to kill myself... [but now] I kinda got more wiser, and I've accepted my family, and I'm trying to move on. My family did nothing for me, they pretty much forgot about me. It hurt me so much. All my Mum had to do to get me back was give up her [drug] habit, but she just didn't. I realised that and accepted it, and I'm just trying to get over it now. But [after speaking with the team] it's still way better, everything's changed. I feel way better, like a better person, more of a person, yeah."

Superordinate IPA Themes	Subordinate IPA Themes	Definition	Example Interview Excerpt
Changes in self-efficacy	Confidence	Caregivers and youths portrayed increases in their overall confidence, demonstrating feelings of confidence generally in their beliefs about themselves as people, and confidence in their abilities, specifically caregivers regarding their parenting skills, and youths and caregivers regarding confidence in their communication skills.	“He’s out and interacting with us, he's not shut up in his room all the time. He's more willing to talk to us, make eye contact. Before he would just come home and not say anything whereas now he can talk more about his feelings, he can say "I've had not such a good day, I'm gonna just go and have a bit of time to myself"”.
Changes in supports	Clarity Feeling unheard and overwhelmed Friends, neighbourhood Personalisation Wraparound team	Families spoke about changes in service and social supports in their lives in various ways. Caregivers and youths felt unheard and overwhelmed with the size of meetings and talked about historical distrust in services. They also portrayed low levels of current peer support in the community and changes to peer groups. Regardless of these experiences, caregivers and youths spoke at great length of the feelings of support they experienced from their Wraparound team, and the personalised, clear service they were offered which was a vast difference in their lives from previous services.	“[The Wraparound team] always say to me, "Sometimes you feel like you're not doing a good job" and they say to me, "You're doing a really good job" and that makes me feel good because they always tell me, "You're doing a good job", and they say, "We know how hard it is, but you're doing a fabulous thing". Oh yeah, maybe I am!”

Link to Chapter Five: Manuscript One

Chapter Five is the first manuscript of the thesis. The paper describes family experiences of change in a Wraparound process in New Zealand, aiming to investigate experiences for families involved with Wraparound at the NZWP related to the pathway to change in the WTOC that describes an enhanced effectiveness of services and supports (Walker, 2008a). The paper aims in part to answer Research Question 2 and 3 of the overall study (What outcomes are achieved from the Wraparound process as perceived by youth and caregivers? To what extent do the perceived outcomes of Wraparound align with the intermediate outcomes as proposed by the Wraparound Theory of Change?). Research Questions 2 and 3 are more formally addressed in Chapter Seven.

Chapter Five: Family Experiences of Wraparound and the Wraparound Theory of Change: An Exploration of Enhanced Effectiveness of Services and Supports, Individually and as a "Package"

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Abstract

This research explores one of the two routes to change proposed by the Wraparound Theory of Change (WTOC) which predicts families involved with a Wraparound process will experience the intermediate outcome of an enhanced effectiveness of services and supports individually and as a 'package' (Walker, 2008a). A Wraparound fidelity measure and semi-structured interviews were undertaken by five young people and six caregivers at the New Zealand Wraparound Program (NZWP) in the third phase of Wraparound. Transcripts were analysed using Interpretative Phenomenological Analysis (IPA), and themes related to the WTOC were extracted. The WTOC predicts youths and caregivers will be more motivated to engage with services and supports on their Wraparound team, because the services and supports will have become more effective through Wraparound based on Wraparound processes including choice and motivation, relevance and feasibility, shared expectations, a strengths-based understanding of behaviour and a whole-family focus (Walker, 2008a). A number of themes related to these areas were identified by the IPA and are discussed together with the implications for families. The present study suggests change for families involved in a Wraparound process may occur as predicted by the WTOC; due to enhanced effectiveness of services and supports, individually and as a package; improving family access, engagement, retention and commitment to services and supports.

Keywords: adolescent mental health, Wraparound, theory of change, qualitative

Wraparound

Wraparound is a team-based, collaborative care planning practice proposing to provide individualised care for adolescents and their families with high and complex needs (Bruns, 2014; Walker & Bruns, 2006). Individuals enrolled in Wraparound may be involved with child social services, foster care, juvenile justice, special education, or a combination of these (Erickson, 2012; Pullmann et al., 2006). Wraparound combines supports from the family's community, extended family, friends and services to create an individualised Wraparound team (Bruns et al., 2005). The team together with the family create a unique care plan, mission statement and family vision for potential youth and family outcomes. Strategies are guided by and created on the strengths of the family and young person to achieve the vision statement (Effland et al., 2011; Walter & Petr, 2011). The Wraparound process leads to a family collection of resources, services and supports available to create sustainable change once Wraparound has ended (Stambaugh et al., 2007).

The National Wraparound Initiative (NWI) is a collaborative project among research institutions in Portland, Maryland and Seattle in the United States of America. Each institution collaborates to define and uphold the Wraparound model, research Wraparound, make policy recommendations on Wraparound implementation, provide Wraparound training and workforce support, and develop tools to assess Wraparound fidelity (National Wraparound Initiative, 2016b). The NWI has created an empirically supported model for Wraparound, so Wraparound can be consistently implemented and measured. The model includes four activity phases and 10 philosophical principles which guide an effective Wraparound process (Walker, Bruns, Conlan, & Laforce, 2011). The four phases

of Wraparound are (1) engagement and preparation; (2) initial plan development; (3) plan implementation and refinement; and (4) transition. The 10 philosophical principles for Wraparound are (1) family voice and choice, (2) team-based, (3) natural supports, (4) collaboration, (5) community-based, (6) culturally competent, (7) individualised, (8) strengths-based, (9) persistence, and (10) outcome-based (Bruns et al., 2004). These principles and phases have been described extensively in previous research (Bruns et al., 2004; Shailer et al., 2013; Walker, Bruns, & The National Wraparound Initiative Advisory, 2008).

A Theory of Change for Wraparound

The Wraparound Theory of Change (WTOC) is a recent theory which proposes how desired outcomes from Wraparound occur (Walker, 2008a). The WTOC describes how and why the Wraparound model is effective and has evolved from historical models of team behaviours and processes over time (Walker & Matarese, 2011).

For the development of the WTOC, Walker (2008a) conducted a literature review based on principles and areas related to mechanisms of change in behaviour (Walker & Matarese, 2011). Fields related to change included self-efficacy, social support, empowerment, optimism, resilience, teamwork and collaboration (Walker & Matarese, 2011). Through this work, Walker (2008a) was able to predict the types of outcomes families may gain through Wraparound, and how team behaviours might be linked to these outcomes (Walker & Matarese, 2011; Walker & Schutte, 2005). What resulted was the WTOC (Walker, 2008a).

For the WTOC to be realised, it is assumed Wraparound has been delivered as a service in its truest form, adhering to the 10 Wraparound principles

and four phases as closely as possible (Walker & Matarese, 2011). In achieving the long-term goals from Wraparound, the WTOC predicts families experience two interacting ‘routes’ on their path to life changes, also known as ‘Intermediate Outcomes’ (Walker, 2008a).

Intermediate outcomes predicted by the WTOC include the improved effectiveness of services and supports, both individually and collaboratively; and increased family assets through participation in Wraparound for coping and planning such as self-efficacy and social support. Intermediate outcomes are proposed to arise from a combination of Wraparound principles, phases and processes which include being grounded in a strengths perspective, being driven by underlying needs, being determined by families, being invested in accountability and results; and having team members who are committed, optimistic, focused, strategic and effective (Walker & Matarese, 2011; Walker, 2008a).

The WTOC suggests not measuring these significant intermediate outcomes may underestimate the usefulness of Wraparound, as intermediate outcomes can lead to desired long-term outcomes for youths and their families (Walker, 2008a; Walker & Matarese, 2011). Further, Wraparound’s intermediate outcomes need to be explored because the WTOC has not been assessed, and therefore remains a theory (Bertram et al., 2011). This study aims to explore the WTOC, by examining the changes young people and their families experience through the Wraparound process; and if such changes are associated with the intermediate outcome describing an enhanced effectiveness of services and supports, individually and as a package.

Intermediate Pathway to Change in the Wraparound Theory of Change: Enhanced Effectiveness of Services and Supports, Individually and as a Package

One pathway to change in the WTOC states that a unified team whose decisions are driven by values of the family, will more effectively select, access and adapt formal services and natural supports (natural supports could include, for example, friends, extended family or school staff) than services as usual (Walker, 2008a). This is because selected services and supports will match the functional strengths of the family and their strategies will be designed to address identified needs to help the family move closer to their vision. This will then improve the family's access to services and supports, and their engagement, retention and commitment to those services and supports. Selected services and supports will be coherent and work holistically with the family, impacting their wider networks (Walker, 2008a; Walker & Matarese, 2011). Walker (2008a) predicts the following concepts to contribute to an enhanced effectiveness of services and supports and thus increased service engagement with families in Wraparound.

Choice and Motivation

Motivation is well studied in psychology, due to its groundings in cognitive and biological regulation; and relates to intention, direction, energy, and persistence (Atkinson, 1964; Ryan & Deci, 2000). Motivation to remain engaged is a persistent challenge in the delivery of mental health care for children and young people (Ingoldsby, 2011; Kazdin, 1996). Failure

to show for appointments at community mental health clinics is common (Stein et al., 2014), and unsurprisingly, young people who remain engaged in treatment along with their families experience better outcomes than those who do not (Stein et al., 2014; Walker, 2008a).

Walker (2008a) predicts that a collaborative Wraparound process maintaining family voice and choice with the family determining their needs, selecting services and strategies to include on the Wraparound plan will likely lead to relatively high levels of youth and family commitment to the services and supports they have chosen.

Relevance and Feasibility

If treatment is deemed to be relevant and feasible by parents, it is more likely to be associated with better treatment outcomes for young people (Fields, 2008; Kazdin, Holland, & Crowley, 1997; Morrissey-Kane & Prinz, 1999; Murray, Rabiner, Schulte, & Newitt, 2008). The Wraparound team works conscientiously to couple families in a Wraparound process with services and supports that match needs they have defined themselves (Walker & Matarese, 2011). As a result, it is predicted families will be more likely to remain engaged with those services and supports, see the Wraparound plan as being relevant and feasible, and benefit from that engagement (Walker, 2008a). Wraparound operates to a set of principles that include ‘community-based’ and ‘culturally competent’ and as such should be beneficial to parents and young people of all cultures and economic status’ (Bruns et al., 2004). As such, it is predicted the cultural competence of services provided in a Wraparound plan should also support family engagement and retention based on their perceptions of service and support relevance (Walker, 2008a).

Shared Expectations

Shared expectations for treatment between parents and clinicians has been demonstrated to be more likely to keep parents engaged with treatment for their children, and enhance the effectiveness of treatment (Morrissey-Kane & Prinz, 1999; Poncin & Woolston, 2011; Walker, 2008a). Treatment is also enhanced when it is modified to suit family needs, as is seen in the Wraparound planning process (Morrissey-Kane & Prinz, 1999).

In Wraparound, success is determined by the level of impact that Wraparound strategies have had on indicators of success that the team has agreed upon (Walker, 2008a). For outcomes to be accurately assessed, it is key that the team has shared clear expectations for treatment at the outset; for example, what treatment is for and what is expected (Walker, 2008a). Also, services and supports being accessed by the Wraparound team for the family often become part of the Wraparound team. If not, the Wraparound team creates close communication with the service to discuss the purpose of their service and how to measure indicators of success from their involvement, which the entire Wraparound team are privy to (Walker, 2008a). The WTOC predicts these shared expectations between the family and services and supports will result in improved engagement and retention by families in those services (Walker, 2008a).

Strengths-Based Understanding of Behaviour

Traditional mental health treatment tends to employ a deficit based model, where a problem is identified and improving the problem is the focus of treatment (Evans et al., 1996; McDowall & Butterworth, 2014; Poncin & Woolston, 2011; Saleebey, 1996). A strengths-based approach which reveals coping strategies and resilience, can be particularly useful for engaging with and helping families who

are involved with a Wraparound process, as these families have complex needs and are often accustomed to working with multiple services from the perspective of failure (Mears et al., 2009; Poncin & Woolston, 2011).

The Wraparound team communicates a strengths-based understanding of challenging behaviours to the family and team members, which demonstrates flexibility of behaviour and that it is not stable (Walker, 2008a; Walker & Matarese, 2011). This demonstration is predicted to lead to motivation in young people and their families to engage and remain in treatment with services and supports (Kirkwood, 2014; Morrissey-Kane & Prinz, 1999; Walker, 2008a).

Whole-Family Focus

Wraparound focuses on the holistic needs of the family as a whole, which has been evidenced to improve treatment engagement, retention and outcomes (Bonfils et al., 2014; Morrissey-Kane & Prinz, 1999; Stein et al., 2014), also impacting the family's wider ecosystems (Walker and Matarese, 2011). A collaborative Wraparound team will be more likely to be motivated in creating and developing an appropriate Wraparound plan based on the needs of the young person and their family as a unit (Snyder et al., 2012). As a result, families are predicted to be more motivated to participate in the Wraparound process and engage with services and supports (Walker & Matarese, 2011; Walker & Schutte, 2004).

New Zealand Wraparound Program

The New Zealand Wraparound Program (NZWP[1]) provides Wraparound to young people and their families with high and complex needs in a large metropolitan city in New Zealand. To be eligible to receive Wraparound support from the NZWP, clients must meet the following criteria: be between six and 17 years old; have a serious mental health problem; and/or have ongoing/active Child, Youth and Family Services (CYFS) and/or Child and Adolescent Mental Health Service (CAMHS) involvement. They must also meet one of the following:

- have an escalating pattern of multiple risk behaviours;
- have lived or be living in multiple home/living placements within the past 6-12 months;
- have involvement with multiple health and social services and require active service coordination to develop and manage the number and complexity of services;
- are unable to have their needs met by the usual network of health and social services;
- require a more intensive level of mental health clinical services than can be provided by CAMHS;
- experience circumstances placing the family or caregivers under extreme stress;
- or be under the custody of CYFS (New Zealand Wraparound Program, 2006).

[1] Name of service has been changed to protect identity of the clients

Aim

This study explored the changes in families involved with Wraparound at the NZWP as predicted by the WTOC, specifically, if families expressed increased levels of engagement with services and supports due to the Wraparound process enhancing the effectiveness of services and supports, individually and as a package. As described by Walker (2008a), increased levels of family engagement could be predicted to occur based on several Wraparound principles and processes, including choice and motivation, relevance and feasibility, shared expectations, a strengths-based understanding of behaviour, and a whole-family focus.

Method

Procedure

The principle researcher of this study convened with the Clinical Case Coordinator at NZWP who assisted in identifying all families involved in their third (plan implementation and refinement) or fourth (transition) phases of Wraparound. These phases were selected because families would have been involved with Wraparound for at least 90 days (as required by the fidelity measure described below). The NZWP Clinical Case Coordinator convened with each family's Wraparound Facilitator to assess their suitability for inclusion in the study. All eligible families who chose to partake in the study were coincidentally in the third phase of Wraparound resulting in no participants in the fourth phase of Wraparound.

In order to explore if the families involved in the study had been involved with a true Wraparound process as intended by the NWI, a fidelity measure

(described below) was completed by participants privately and returned in individual sealed envelopes to the NZWP Clinical Case Coordinator who returned them unopened to the researcher.

Measure

Wraparound fidelity was explored using a 37-item self-report questionnaire called the Wraparound Fidelity Index – Short Version (WFI-EZ), a succinct version of the Wraparound Fidelity Index, version 4 (WFI-4). The WFI-4 is a semi-structured interview conducted with four team members involved in the Wraparound process: (1) youth (aged 11 and over); (2) parents or caregivers; (3) Wraparound Facilitator and (4) another team member (Bruns et al., 2009). The WFI-EZ is a relatively new, valid and reliable measure of adherence to Wraparound principles which is less time consuming than the WFI-4. The WFI-EZ has strong internal consistency (Cronbach's Alpha = .937; Sather, Bruns, & Hensley, 2012). With regards to validity, the correlation of total scale scores from the 37 WFI-EZ items with total scores from WFI-4 interviews is significant at $p=.001$, $r(42) = .548$, (Bruns et al., 2012; Sather et al., 2012). The WFI-EZ covers four sections including basic information, experiences with Wraparound, perception of outcomes and satisfaction with services. There are yet to be peer-reviewed adherence norms created for the WFI-EZ, as such, there is currently no singular minimum fidelity score that deems families have been involved with a 'true' Wraparound process. However, Key Element Scores compared favourably to USA national means, surpassing USA means in four out of five key Wraparound processes. As such, the results indicated satisfactory adherence to key Wraparound processes by the NZWP for this study. The measure took on average ten minutes to complete. According to the WFI-EZ manual and

WrapTrack, as 3 of the 6 youth answered more than 8 of their WFI-EZ items with "Don't know", this accordingly represents "missing substantial data". As such, overall WFI-EZ scores are said to be compromised (Sather et al., 2013). Fortunately, due to the high completion rate of the WFI-EZ forms from each of their caregivers, Wraparound Facilitators, and Wraparound Team Members (with no other participants responding with 8 or more "Don't know"), their combined WFI-EZ Key Element and Total Fidelity Scores continued to have internal consistency and were still useful data to include in the study (Sather et al., 2013).

Participants

One young person chose not to go on to be interviewed following WFI-EZ completion and their interview was attended only by their caregiver, resulting in five youths and six caregivers being interviewed. Their data is included in the following participant information of interviewees.

Participants included two male, three female and one transgender youth and their caregivers. Youths were aged between 12 and 17 with a mean age of 15.5. With reference to ethnicity, three youths identified themselves as Māori; one as New Zealand European/Māori; one as British and one as South African. Mental health and behavioural concerns experienced by the youths included aggression, anorexia nervosa, attachment issues, attention deficit hyperactivity disorder, criminal offending, depression, encopresis, enuresis, gender identity issues, learning difficulties, partial seizures, self-harm, sexual abuse, social phobia, substance abuse and suicidality. Families involved with the study were yet to complete their Wraparound process, with length of involvement ranging from five to 18 months. All participant names have been changed to protect confidentiality.

Interviews

Semi-structured interviews were conducted and informed by the WTOC were conducted (Walker, 2008a). Enquiry encompassed changes in familial, community and service relationships, problem-solving and coping strategies, self-perception, and interpretations of Wraparound strengths and weaknesses (e.g. what changes have you noticed in your life since beginning Wraparound? What did you hope to gain from Wraparound?). Interviews occurred with caregivers and youths separately, where possible, however some youths chose to be interviewed with caregivers present. All interviews were audio recorded and then transcribed for analysis.

Analysis

Interpretive Phenomenological Analysis (IPA) was selected for analysis of interviews. IPA is a suitable approach when aiming to investigate how individuals are experiencing particular situations they are facing, and how they are perceiving their personal and social world (Smith et al., 1999). IPA is particularly useful when exploring a particular process, which is why it was selected for this research exploring the experiences of youth and families involved with Wraparound. It has been argued that it is impossible to ignore the influences of assumptions, expectations, language, culture or ideology (Rennie, 1999). Relatedly, IPA argues observation cannot be made without interpretation (Packer, 1992b). IPA cannot achieve an unaffected first-person account; the account is always constructed by the interpretations of both the participant and researcher (Larkin et al., 2006). However, IPA emphasises that the research is a dynamic process with an active role for the researcher, recognising that the reflections and interpretations of the researcher are a key and complicating part of the analysis, as well as recognising

the creativity of the interpretative process (Eatough & Smith, 2006a; Smith et al., 1999).

IPA is ideally suited to small samples because of its idiographic focus (Winters & Metz, 2009), and entails data collection producing large volumes of data as in-depth interviews are transcribed verbatim (Eatough et al., 2008). It is therefore recommended that the number of participants be kept to a small, manageable size (Finlay, 2011). Smith and colleagues (1999) suggest that anywhere from one to 15 participants is an adequate number for IPA, and between three and five is sufficient for student research. This suggestion is made due to the painstaking detailed analysis required by IPA, which aims to investigate depth rather than breadth (Smith et al., 1999).

It is important to note that the flexibility of the IPA approach is not aligned with lack of rigour. Rather, an extremely detailed analysis of participant accounts is the foundation of the IPA process. Its focus means that both a descriptive and interpretative analysis of the data increases the likelihood that a deepening of understanding occurs (Savin-Baden & Major, 2012). Relatedly, Guba (1981) offers suggestion to researchers using qualitative inquiry to address matters of ‘reliability’ and ‘validity’ as seen in rationalistic or other types of inquiry. Specifically, the matters of credibility, transferability, dependability and confirmability are raised (Guba, 1981).

Credibility is concerned with the testing of findings and interpretations with various sources, which could be seen to be related to internal validity (Guba, 1981). This research attempted to address credibility with member checks, prolonged time at a site, and peer debriefing. The primary researcher strived to

build rapport with interviewees in order to obtain honest and open responses. During interviews, information was restated and summarised and the interviewer would seek accuracy from interviewees through further questioning. Following interviews, participants were given with transcripts to view, comment on or change. Prior to interviewing, the primary researcher also spent a three-week period at the NZWP to engage with the principles and processes related to Wraparound, and attend several Wraparound meetings. Finally, throughout theme identification, peer reviews were conducted to discuss findings and explore ideas from outside sources.

Transferability is linked with external validity and is concerned with the degree to which the findings are applicable in other contexts (Guba, 1981). IPA would argue that generalisations are implausible due to phenomena being intrinsically linked to the environment or context in which they occur (Smith, 2003a). This study engaged in purposive sampling whereby the researcher relied on her own judgment when selecting the sample based on the characteristics of the population. In this particular context, the population was families involved in a Wraparound process in New Zealand supported by the NZWP adopting the NWI principles and phases. As such, it would be up to the discretion of the future researcher to determine if transferring these results to a different context is sensible.

Dependability is associated with reliability and asks if findings would be able to be consistently repeated if the study were to be replicated (Guba, 1981). IPA proposes that reality is socially constructed and is therefore constantly changing for both the researcher and the participants (Eatough & Smith, 2006b). As such, it is important for the researcher to track their own changing perceptions throughout

the IPA process. The primary researcher in this study adopted a check/recheck procedure whereby after naming themes that were interpreted to arise from data, the researcher would look back at that same data several weeks later to recheck that data and evaluate the results.

Finally, confirmability is associated with the degree of neutrality that can be expected to come from the inquirer throughout analysis, related to objectivity (Guba, 1981). Confirmability requires that the data remains neutral irrespective of who is interpreting it. The researcher addressed the issue of confirmability by practicing reflexivity.

Subordinate themes were noted on transcriptions using qualitative analysis assistant software program DeDoose. After looking for connections between subordinate themes, they were placed into clusters and clusters were repeatedly checked against the transcript in an iterative process. A table of themes was produced, identifying clusters of themes attempting to capture participant responses to each particular theme. These clusters were then named, signifying superordinate themes. After subordinate and superordinate themes had been produced, those related to the pathway in the WTOC describing enhanced effectiveness of services were extracted and are presented as follows.

Findings: Themes related to an Enhanced Effectiveness of Services and Supports, Individually and as a Package

Table 1 displays the concepts related to an ‘Enhanced Effectiveness of Services and Supports, Individually and as a Package’ and the superordinate and subordinate themes related to them as identified by the IPA. These themes are first

described in context and the ways in which they relate to the WTOC concepts are then discussed in further detail below.

Table 1

IPA Themes Associated with Concepts Related to WTOC Intermediate Pathway: Enhanced Effectiveness of Services and Supports

Concepts related to WTOC pathway*	Superordinate IPA themes	Subordinate IPA themes
Choice and motivation	Changes in supports	Feeling unheard and overwhelmed
Relevance and feasibility	Changes in supports	Wraparound Team
	Changes in supports	Personalisation
Shared expectations	Changes in supports	Clarity
Strengths-based understanding of behaviour	Changes in self-efficacy	Confidence
Whole-family focus	Changes in family unit	Connectedness

*(Walker, 2008a)

Themes Related to Walker's (2008a) Concepts of Choice and Motivation

Levels of choice and motivation during the Wraparound process appeared to be mixed for young people and their caregivers. Overall, it appeared the positive impact Wraparound was having in the lives of youths and caregivers in the study kept them committed and motivated to engage in the process; particularly due to the support provided to them by the Wraparound team. However, there were some processes families felt they had less choice in, particularly during the planning phase. Superordinate themes identified in the IPA related to concepts of choice and motivation were themes of feeling unheard and overwhelmed; structured by a subordinate theme related to changes in supports families experienced through Wraparound.

Changes in supports: feeling unheard and overwhelmed.

Overall, caregivers appeared pleased that the services they had dealt with for many years were finally working together. However, a common acknowledgement was that families had not had considerable choice in which services were included on their Wraparound team. Typically, services included on the team were those who had already been involved with the family prior, with little discussion of which services may or may not be appropriate to continue with. Despite this, when asked if they would have made any changes to their Wraparound team, families said they would not have changed the services or people involved. Jaden's caregiver discussed:

> It has been a long time coming to try and get everyone to work together so that has been really great for us…we didn't really talk about who should be in the Wraparound because they were services already involved in (Jaden's) care. But they all seemed to be the right ones to have involved…we wouldn't have chosen any differently, no.

Motivation to participate in Wraparound was compromised at times with some youths discussing feeling overwhelmed by the scrutiny of the team. This appeared to stem from the size of Wraparound meetings. Meeting size for each family seemed to be reflective of the needs displayed by the young person and the services involved. Therefore, for young people experiencing extremely high and complex needs, meetings had many team members, making them sizeable and lengthy. Some of the youth were experiencing concerns related to social anxiety,

making it particularly difficult for them to speak within the team setting. One youth (Georgia) summarised:

> I just didn't like talking about shit in front of so many people. It was just like, “it's none of your business” kind of thing, why does it need so many people? But maybe that's just me being narrow-minded, I don't know.

Jessica's caregiver also expressed unease regarding meeting size. Meetings for her family were becoming so large that services would clash and offer competing advice, contributing to her feeling confused, frustrated, and less inclined to take part in Wraparound meetings. She stated, “that kind of has made me feel a bit in a rock and a hard place a few times”. Similarly, Wiremu’s caregiver was anxious that if too many people were involved in meetings and giving confused opinions, Wiremu might become overwhelmed and revert to self-harm.

> If you have too many people saying, “I think you should do this”, I think it just becomes too overwhelming for him and at the end of the day we’re all here for him. If he can’t cope with it then, you know, he’ll start [self-harming] again.

Youths demonstrated decreased motivation through of reports of not wanting to take part in Wraparound meetings due to communication. First, some youths relayed frustration related to feeling unheard when speaking to services within the context of Wraparound, feeling as though they had been overlooked and unheard by the same services acting alone in the past. Sybil discussed how, fortunately, her Wraparound Facilitator was aware of her feelings based on

previous experiences and accommodated her needs accordingly, which kept her motivated to continue attending. This demonstrated an emphasis on the individualised principle of Wraparound.

> I feel like in most other meetings with services, they don't listen to me, so I can't really be bothered being there because it's just like, why should I waste my time, or energy being here when you're just gonna ignore me anyway? But at Wraparound [meetings], I guess it's a bit different because the Wraparound Facilitator understands how hard it is for me being in meetings and she'll let me walk out…she doesn't make me come to the whole meeting, so it's good.

Although these instances demonstrated difficulties related to choice and motivation for families, their reports related to other Wraparound processes suggest more generally of high levels of motivation and engagement. Family reports related to other areas of increased motivation for engagement are discussed as follows.

Themes Related to Walker's (2008a) Concepts of Relevance and Feasibility

Although families identified a lack of choice regarding who was on their Wraparound team, it was clear they felt the services and supports on their team were relevant to their needs. This was particularly evident from reports describing support given to them by their Wraparound team and Wraparound Facilitator, and the way the care provided by the Wraparound team was individual to their family. Further, Wraparound teams appeared so relevant and supportive to families, some caregiver's demonstrated distress at the thought of Wraparound ending.

Changes in support: Wraparound team.

Caregivers and youths alike reported feeling supported by their Wraparound Team and the unique new way in which they felt supported by the team and Wraparound Facilitator, who kept the family needs at the forefront. This was something families reported having not experienced from prior service providers. Wiremu's caregiver spoke about their experiences in a Wraparound process:

> Social services similar to them, they'd just sit down and go, "Oh that must be really hard for you", and you just wouldn't get anything else. And if somebody came over to the house they wouldn't do anything…they'd just sit there. Whereas over here, they actually talk to you like, "How can we work through this? What can we do to help it?"

Caregivers also reported appreciating the Wraparound team getting input from their youth about their wants and needs from services to make the process relevant for them, which was different from past experiences. Jaden's caregiver expressed this sentiment:

> They listen to him too, and they talk to him too, whereas [previously services] didn't really ask him questions or anything like that. I don't think they actually got down to his level enough to find out from him how he was doing. And that's where [the Wraparound team] has made the difference, they do talk to him and he's opened up really well…to get him to be really comfortable with someone is quite…it takes time.

Wiremu's caregiver spoke about his apprehension working with services within the context of Wraparound he had felt had not supported their family in the past. Through Wraparound he came to be pleasantly surprised with their work done during the process.

> I was a bit worried but it was completely different to what we expected. Like, we've had, [services] involved with us, in the past, and they did, nothing…they didn't do anything at all to help us. Whereas with [The Wraparound Facilitator] going you know, "he's got all these people, and you guys have to work for him." I was like, "Yes! Finally he's got people listening!"

Families in the study spoke about the vast change in support they experienced from the Wraparound team when compared with services and supports working alone in the past, and how relevant their support was. However, due to this extensive support, some caregivers were experiencing distress at the notion of Wraparound ending. Wraparound was due to close shortly for many of the families on the basis of their youth turning 18 (the age at which youths legally become adults and unless under the continued care of CYFS are therefore no longer eligible for Wraparound). The caregivers of some of these youth demonstrated concern their Wraparound was going to be finishing because their youth was turning 18, rather than because they felt ready. Jaden's caregiver said, "Can we handcuff them to our house!? That would kind of be the only thing; do they have to be on a time frame?!" Ava's caregiver also expressed:

> I have to tell you, I'm completely panicked at the idea of NZWP not being involved because they've been such an integral part of

> getting us to where we are. And I know how bad things were. So I mean my concern at this point is the fact that NZWP is age-related, or the Wraparound system is age related, rather than situation related. So it doesn't actually continue to a conclusion, it ends at a certain point based on age. So, I mean to me that would be a real concern. Well, it *is* a real concern.

Changes in supports: personalisation.

Caregivers expressed feeling valued with regard to the personalisation of their Wraparound process, keeping it relevant and unique to their family. Jaden's caregiver discussed the feasibility of having the service visit them at their home. She also expressed appreciation of Jaden being viewed as an individual which didn't often happen in the past. There had been ongoing issues with his treatment, and she felt discouraged by previous services – one of which had misdiagnosed him with Attention Deficit Hyperactivity Disorder. She spoke about the Wraparound process giving her the space to explore what else might be going on for Jaden.

> Having the kids and [the Wraparound team] coming to the house instead of me trying to get into an office with Jaden and then organise the other children and everything around appointment times, it's been huge, it's been so great... we're not having to arrange childcare, or vehicles or anything like that. It's more personal! Like, it's not being stuck in a little room…it's like having a friend over, more than professionals from a service. Because you take your child into a strange environment and then it's an environment that they have to get used to going into, so

> they're not actually seeing the child for who they are in the comfort of their own home…so it's kind of a false…you can't really diagnose a child in a strange environment.

Jessica's caregiver expressed similar sentiments with regards to the relief of finally being viewed as individuals. She indicated that in the past, individual services would treat concerns specific to their service. This had caused the family frustration due to the considerable relationship between all of Jessica's needs.

> Everything was very separated. And [Wraparound] was a really good way of bringing everyone together because so many of those things overlap and interconnect and one affects the other…that was also I think a good way for everybody to realise that this isn't this child with this one particular issue that they were dealing with.

Having a say in how frequently meetings took place also contributed to feelings of Wraparound feasibility for caregivers. For example, Ava's caregiver suggested changing the number of weekly meetings based on her family's needs, and felt confident she would be supported.

One family discussed at length feeling as though their culture was finally being valued and included as important to their care. Wiremu had been placed into over twelve foster family homes throughout his life, and it was not until he was involved with a Wraparound process that services took time to learn about what was important to him culturally. The services on Wiremu's Wraparound team then help him be placed with a family that suited these cultural needs. Thanks to Wraparound, Wiremu was integrated into a family who offered him relevant

cultural support, which provided him with comfort after years of feeling out of place.

> Caregiver: And it helps too, I think, um, you know even though it may sound ahh, racist, but um, you know, [the foster family] it's a…brown family.
>
> Wiremu: Yeah.
>
> Caregiver: Well, he's been in families before but they've been European…good people, but they just didn't quite…
>
> Wiremu: Just didn't get along well, yeah, I don't know why….

Themes Related to Walker's (2008a) Concept of Shared Expectations

Changes in supports: clarity.

Families demonstrated having shared expectations with their team for their Wraparound process. They expressed satisfaction with a clear, cohesive operation of services to serve their best interests. Georgia's caregiver expressed; "Wraparound just created a really strong structure around us, and very clear processes." Along with a clear sense of what was expected of the Wraparound team, caregivers expressed satisfaction with the follow-through on actions planned by the team. Jaden's caregiver reported:

> We look at how we can achieve that, who's going to do it, when they're going to do it, and the fact that before the next meeting, there's just like a little reminder: "You're down on the minutes as doing this, have you done that?" and it really makes it effective. Things really get done.

Ava's caregiver also summarised her satisfaction with the clear processes her Wraparound team had put into place, demonstrating their shared expectations:

> First of all we've got services that work together, and the Wraparound team has made sure that when people haven't been working effectively, or have been sort of wandering off, that, they've brought them back together and they've re-focused things in this process…They've been very defined clear goals, they've made sure everyone understood them. And, they followed up really. They've sort of kept on top of each stage. They've made sure that the process has been kept quite tight.

Themes Related to Walker's (2008a) Concept of a Strengths-Based Understanding of Behaviour

Youths and caregivers did not discuss themes explicitly related to the Wraparound team communicating a strengths-based understanding of youth behaviour, as described by the WTOC. However, there were several instances where caregivers spoke about Wraparound supporting their parenting decisions and building their confidence in doing so, due to a focus on their strengths. Other caregivers also spoke about witnessing changes in the behaviour of their youth during the Wraparound process. Witnessing changes in behaviour appeared to provide them with hope related to the maintenance of behaviour changes moving forward.

Changes in self-efficacy: confidence.

A strengths-based understanding was demonstrated by the Wraparound team to caregivers regarding their parenting. As caregivers of young people with

high and complex needs, some had viewed their parental actions in the past as leading to adverse actions of their youths, such as self-harm. Having a third party to comment on their parenting skills in a positive manner appeared to have been extremely meaningful for their self-worth.

Sybil's caregiver had experienced a difficult period transitioning from being her grandmother to unexpectedly becoming Sybil's primary caregiver. Having had little direct experience over the years with Sybil's difficulties, she found it hard to move from being a fun figure in Sybil's life to the person responsible for setting boundaries. As a result, Sybil's grandmother consistently felt as though she was parenting poorly and was embarrassed to confide in others about Sybil's difficulties. Slowly throughout Wraparound, Sybil's grandmother had her confidence built up from the strengths-based feedback provided to her by the team.

> [The Wraparound team] always say to me, "Sometimes you feel like you're not doing a good job" and they say to me, "You're doing a really good job" and that makes me feel good because they always tell me, "You're doing a good job", and they say, "We know how hard it is, but you're doing a fabulous thing". Oh yeah, maybe I am!

Wiremu's caregiver discussed difficulties he had at times with parental decision-making. His reports of the Wraparound team providing him with a non-judgmental platform to seek advice indicated a strengths-based approach. He felt comfortable to the point that if he had made decisions he was not proud of, he still felt able to tell the Wraparound team and seek support.

> I do feel that it is helpful, knowing that there is someone I can call and talk to about Wiremu if I need to. Yeah. Not someone that's gonna judge either, that's the best part I think. Yeah, yeah. It's great. That was the main thing that I have found, was the fact that, I could ring and there'd be a situation that, you know, I probably didn't take the right steps on, but they wouldn't judge. That was brilliant.

Changes in supports: Wraparound team.

The Wraparound process focusing on strengths gave caregivers opportunities to see improvements in their youths' behaviour. Caregivers spoke about the Wraparound team taking new approaches to communicating with their youth, and then seeing youth respond in new ways they had not yet seen. It was apparent from reports that behaviour changes were made by youths over time in Wraparound, which demonstrated to caregivers that youth behaviour was able to be changed. Jaden's caregiver spoke of Jaden's changes in behaviour regarding admitting to mistakes after he was able to build mutual trust with his Wraparound team, particularly his Wraparound Facilitator.

> I don't know what she does but he listens and he admits straight away which is really good, 'cause he's not really like that. You know, if he does something at school it will take them 20-30 minutes to get the truth out of him whereas [the Wraparound Facilitator] asks him a question and just, boof, there's your answer. That's quite a big achievement for Jaden considering nobody else can do it. Yeah. So, I think he's put a lot of trust into them.

Jessica's caregiver also discussed a change in behaviour she witnessed in Jessica throughout the Wraparound process. Before becoming involved with Wraparound, she felt at odds with how to move forward regarding the management of Jessica's behaviour. Through Wraparound she was able to change her perspective on Jessica's behaviour and how it might change in the long-term.

> Because of her condition before, she'd take her nastiness out on the younger ones. Very bad. Oh just nasty. Because she didn't know how else to, that's her way of lashing out. Take it out on everybody else. So I'm feeling very optimistic. Very optimistic. And I keep my fingers crossed and go, "another week, another month has gone and things have gone better". Before it was, "oh my God let's just get rid of her, I'm sick of it".

Themes Related to Walker's (2008a) Concept of a Whole-Family Focus

Changes in family unit: connectedness.

Caregivers and youths alike spoke about a whole-family involvement in Wraparound. Caregivers in particular reported a focus on the family as a whole being a new practice which previous services had not prioritised. Involvement of the whole family included focus on not only the caregiver and youth but also other caregivers, biological parents, siblings and grandparents. This inclusivity contributed to wider family members and those already in the Wraparound process feeling invested in participating in Wraparound. It also appeared to strengthen relationships of the family members as their needs as a unit were taken into account. Ava's caregiver discussed: "The rest of the family weren't actually that involved in the beginning. And over time they've actually, sort of, started to buy-in

a lot more." Sybil's caregiver discussed how Sybil's father had been historically uninvolved in her treatment, but over time the Wraparound process had resulted in him becoming more invested and motivated to become involved in the process. She indicated he had previously felt he played an unimportant role in Sybil's recovery and these feelings had slowly changed through Wraparound. He was also able to gain the confidence to interact with services and handle difficult situations in new ways. Sybil discussed the inclusion of her entire family in her care: "I wouldn't say things got perfect with my family, but it is like more cohesive now that [the Wraparound Facilitator] has given therapy to my parents and stuff so they're able to communicate more I guess."

Sybil's caregiver corroborated her sentiments:

> I think my husband and I have got much better strategies for dealing with things. I think that they've worked very hard on strengthening relationships. Like my husband and my relationship, our relationship with all the girls. Yeah, they really have tried to give us those kind of resources to manage things better.

Due to a whole-family focus, Wraparound teams connected families with extended family members or birth parents who were not previously involved in the care of the youths. Although this appeared to be a difficult adjustment at first, caregivers demonstrated the inclusion of extended family gave them opportunities to communicate with one another. Caregivers reported youths ocassionally receiving contradictory messages from other family members, so they used

Wraparound as an opportunity for everyone to get on the same page. Sybil's caregiver spoke about this:

> I spoke to her mother the other day and I said, "I think you need to become more involved because you tend to start making decisions with Sybil and then we bring it up and I'm like, "When was this made?" Sybil says, "Oh, mum and I talked about it". So I said to her mother, "At the moment I'm the sole caregiver so, you need to include me in everything" she said, "Oh, ok".

Sybil and Jessica's caregivers also reported that when caregivers felt uncomfortable speaking to biological parents about issues they wanted to address, the Wraparound Facilitator had systems in place to speak on behalf of them if they wished.

Discussion

Wraparound is an individualised process for unique families who are engaged in an evolving plan and multiple strategies. Outcomes from such a process may travel in multiple directions and are difficult to explain by a simple theory or diagram (Walker & Matarese, 2011). In one route to change, Walker (2008a) predicts the effectiveness of services should be enhanced, and families should experience increased motivation to engage with services due to a Wraparound process and principles including choice and motivation, relevance and feasibility, shared expectations, a strengths-based understanding and a whole-family focus (Walker, 2008a). These concepts all relate to one another and are not able to be completely teased apart. Each time one concept is strengthened there is likelihood that another will become stronger also, such as a relevant and feasible

Wraparound process being enhanced by shared expectations and/or a strengths-based understanding of behaviour. In this way, the Wraparound process involves a complex loop, continually strengthening each individual concept, resulting in an overall strengthening of the WTOC intermediate pathway. This continual recirculating and reinforcing of concepts and pathways demonstrates that phenomena taking place within a family during the process of Wraparound are unlikely to be able to be completely described by a diagram such as the WTOC, or assessed in entirety (Walker, 2008a). This study attempted to explore the WTOC with a focus on the intermediate pathway emphasising enhanced effectiveness of services and supports, and interviewed youths and caregivers involved in a Wraparound process to do so.

Choice and Motivation

In Wraparound, families should be included in all aspects of decision making, thus leading to more investment, ownership and commitment to the process (Walker, 2008a). This is based on research which indicates that people who feel they are acting of their own will are more committed, invested and successful when taking part in activities than those who have been obliged to participate (Doren et al., 2013; Mih & Mih, 2013; Walker, 2008a).Walker (2008a) describes in the WTOC that family involvement in the decision making phases and monitoring of ongoing strategies in their Wraparound process should result in increased commitment to the plan, and increased likelihood of following through on decisions.

Families reported having no choice about who was included in their Wraparound teams. This finding is consistent with previous research which suggests many Wraparound teams face ongoing challenges when creating a

collaborative and individualised team of supports and services (Bruns et al., 2004). Families in the study also reported occasional difficulty feeling motivated to attend meetings. This was in relation to strained communication with the team due to the at times overwhelming size of meetings; and dealing with leftover frustrations of historical dealings with the same services. These reports indicate the Wraparound principle of family voice and choice may not have been adhered to in the Wraparound team preparation and initial plan development phases. Wraparound would typically prioritise the family and youth perspective regarding the inclusion of particular services and supports on the team. Low motivation by youths to participate in group meetings has arisen in previous Wraparound research (Walker et al., 2012). Retaining engagement with families in Wraparound is vital because low motivation for young people and their families to engage with Wraparound may result in either non-attendance at Wraparound meetings and related activities, or lowered quality of participation at meetings they attend (Ingoldsby, 2011). It may therefore be necessary for the NZWP to place a limit on how many people from each service are in attendance at Wraparound meetings and for this number to be decided upon this number while in the Wraparound planning stages. This limit should be decided upon by the youth and caregiver, as decisions for the team should be led by the family in keeping with Wraparound philosophical principles.

The absence of choice reported by families regarding the selection of services and supports for the Wraparound team did not appear to be paired with overall low motivation for engagement with the Wraparound process. Motivation to remain engaged with services and supports included in their Wraparound team even when not involved in their selection may have not been impacted for several reasons. First, families still felt they had a voice in other areas of the process,

helping them to remain engaged and commited to the overall process. For example, the choice given to Sybil to attend only the parts of meetings she felt comfortable with. As such, having a say in other decisions, strategies or activities during the Wraparound process may have made up for a lack of choice in the team planning phase. Second, families reported they would not have chosen alternative services and supports to be included in their Wraparound teams given the opportunity. This may have indicated families were satisfied with the teams in their chosen form as they were relevant, resulting in motivation not being impacted. Finally, other areas predicted by the WTOC to increase levels of motivation and engagement may have been strong enough to keep these at a satisfactory level. For example, families felt they were not given choices about which services or supports to include on their Wraparound team, but still appeared to find these services and supports to be relevant to their needs, and for these services and the rest of the team to share their expectations, while receiving a strengths-based understanding of behaviour and whole-family focus. It may be that these other processes were strong enough for families to maintain ongoing comittment and engagement with the process, as predicted by the WTOC (Walker, 2008a).

Relevance and Feasibility

Historically, individual services for the families in this study were uncoordinated and not meeting their needs, as demonstrated by Jaden's caregiver: "[Services in the past] just haven't listened, basically". However, within the context of Wraparound families reported a personalised service met their needs regarding culture, and meeting location, times and frequency.

Although families reported not being involved in the decision-making process regarding which services would be included on their Wraparound team, it was apparent that strategies and services in the Wraparound plan of families in this study were prioritised to be highly relevant and feasible for them. As such, it is likely these families will continue to develop a stronger commitment to the Wraparound process and commitment to engage with services and supports included on their plan (Bickman, Lambert, Andrade, & Penaloza, 2000). Unfortunately for some families, the highly relevant and feasible nature of their Wraparound experience resulted in a level of distress at the idea of Wraparound closure. As such, it is important that a strategy is devised for Wraparound programs not to be as constrained by time or funding. Until the pertinent issue of Wraparound funding is addressed for families in New Zealand, it is important for Wraparound services such as the NZWP to continue to adhere to Wraparound principles such as persistence (despite challenges, the team persists in working toward the goals in the Wraparound plan until the team reaches an agreement that a formal Wraparound process is no longer required; Bruns et al., 2004). In doing so it is hoped families may continue to develop autonomy and feelings of success and take these through with them to their lives post-Wraparound.

Shared Expectations

Shared expectations for treatment between caregivers and clinicians are more likely to keep caregivers engaged in treatment for their youths and enhance the effectiveness of treatment (Bonfils et al., 2014; Stein et al., 2014; Walker, 2008a). Shared expectations for treatment between the family and the rest of the Wraparound team have also been suggested to enhance the effectiveness of services and supports within the team because the team works together more

effectively to tailor an individual plan for the family, the family are more engaged, and retention rates are increased (Walker, 2008a).

Families reported having a shared set of expectations with their Wraparound team. Due to feeling informed about what would happen in their Wraparound process, they experienced feelings of satisfaction with a clear, cohesive plan and goals, and follow-through on actions from the team. This appears to have been able to occur from ongoing communication among team members and the family which maintains and reinforces a shared perspective as predicted by the WTOC (Walker, 2008a; Walker & Matarese, 2011).

It is predicted that shared expectations between Wraparound team members and the family will have contributed to enhanced engagement and retention of families to the Wraparound process due to families being privy to expected treatment outcomes from Wraparound (Walker, 2008a).

Strengths-Based Understanding of Behaviour

The WTOC posits that the Wraparound process demonstrates a strengths-based understanding of behaviour to the team, including the youth and family, so they are able to understand challenging behaviour is changeable. Although there were many instances in interviews where caregivers and youths alike gave reports of a focus on strengths as described by the Wraparound principle of strengths-based (where the Wraparound process enhances the capabilities, knowledge, skills, and assets of the child and family, and other team members; Bruns et al., 2004), these reports were not specific to the demonstration by the team of behaviour being changeable. However, the Wraparound process itself led to the

change in behaviours of several of the youth, which demonstrated to caregivers that their behaviour was not permanent, as predicted by the WTOC.

It may be the case that although families did not speak about learning about the malleability of behaviour, due to a demonstrated focus on strengths in their Wraparound process (related to their parenting strategies) paired with witnessing behaviour changes in the youth, they were still able to learn about the changeability of behaviour. There were no interview reports to suggest that the youths in this study came to learn about the malleability of their own behaviour however. The family may develop these understandings further with time.

The WTOC posits that a development in understanding of behaviour being changeable helps for families to become further motivated to engage with services as they learn challenging behaviours are able to be adjusted, which motivates them to continue working toward altering troubling behaviours (Walker, 2008a; Walker & Matarese, 2011). It is predicted that although families did not explicitly report a development of understanding of the changeability of behaviour, their reports in other areas suggested they were able to learn challenging behaviours are able to be adjusted, and as such, the focus on strengths by the Wraparound team has led to commitment to engage with services and supports on the team regardless.

Whole-Family Focus

A whole-family focus is predicted by the WTOC to enhance the effectiveness of services and supports as the supports are a better fit for family systems as a whole, which promotes family engagement and retention (Walker & Matarese, 2011; Walker & Schutte, 2004). Analysis of interview data identified a

whole-family focus in Wraparound for families, including other siblings, caregivers, and even birth parents who were not previously involved with the care of the youth. This inclusivity contributed to increased investment for youths, caregivers and wider family members to participate in Wraparound. It also appeared to strengthen these familial relationships.

Due to the Wraparound teams at the NZWP focusing on the goals and needs that were important for families as a whole, strategies implemented were able to fit the family context, and families demonstrated experiences of improved engagement and commitment to the Wraparound team services and supports further. This supports predictions made by the WTOC (Walker, 2008a).

There were no families involved in this study in their fourth (transition) phase of Wraparound. Interviewing families during this phase may help to better explain the long-term changes that families experience and further determine processes related to increases in engagement and motivation. Further, based on choices made by families, it was not always possible to interview the youth and caregiver separately. This may have resulted in less candour from both the caregiver and youth. Also, one interview also consisted only of the caregiver and not the youth as the youth chose not to be interviewed. There were also multiple extraneous variables in the immediate environment to negotiate such as the entry and exit of others and the resulting volume of interviewees.

The small data set limits the extent to which generalisations are able to be made, but does not limit the exploratory scope of the study due to the adoption of IPA. Further, exploration of Wraparound outcomes for families at multiple Wraparound programs internationally is recommended. Finally, the data were

collected at one point in time. The Wraparound process involves continual personal development and as such a longitudinal study looking at the changes that families experience over time would be recommended.

Complex Interactions

This paper discusses themes present in interviews with caregivers and youths involved in a Wraparound process, with particular focus on themes related to the pathway of change predicted by the WTOC (Walker, 2008a) that discusses enhanced effectiveness of services and increased motivation for engagement with those services. Predictions made by the WTOC include a discussion of the complex interaction between the pathways to change for families involved in a Wraparound process, and how these interactions are not completely able to be separated or teased apart. Such interactions were present in the analysis of the interviews from this study and the resulting themes. Interactions included overlap between key concepts predicted to contribute not only to the pathway to change highlighting the enhanced effectiveness of services and supports but also the pathway to change in the WTOC that highlights increases in resources and capacity for coping such as increased self-efficacy and social support. Examples of theme overlap between pathways included the strengths-based understanding of behaviour of caregivers' parenting strategies (enhanced effectiveness of supports) which was also related to increases in self-efficacy (increased capacity and resources for coping and planning). Also, a whole-family focus (enhanced effectiveness of supports) appeared to increase natural social supports as extended family members came to be included in the Wraparound process that the family had not recently had contact with (increased capacity and resources for coping and planning). Further, there were overlaps between key concepts within this pathway

alone such as the similar concepts of caregivers expressing satisfaction with a clear Wraparound process, and having openly shared expectations with the Wraparound team.

These theme overlaps reiterate Walkers (2008a) explanation of the Wraparound process being highly individualised for each family involved with it, utilising unique services, supports, strategies and goals, and family changes being highly complex. As such, no theory attempting to describe the pathways to these highly complex changes can ever be assessed in its entirety (Walker, 2008a).

Conclusion

Based on interview analysis, it appears families in this study experienced feelings of being overwhelmed and unheard at times. However, based on their reported perceptions, it appears they were also able to experience an enhanced effectiveness of services and supports which led them to report experiences related to high levels of family commitment and motivation to engage with services and supports included on the Wraparound plan. Increased motivation and commitment for engagement was highlighted by family reports related to relevance and feasibility, shared expectations, a focus on strengths, and a whole-family focus. Based on these findings, it would be predicted by the WTOC that families in this study experienced a Wraparound process guided by Wraparound principles and phases, and characterised by planning solving and planning, respect for culture and expertise, collaboration, opportunities for choice, individualisation, strategy evaluation, the celebration of success and a process driven by the family. It is also predicted by the WTOC that as a result, families have been able to benefit from the achievement of short-term outcomes such as team follow-through, helpful team strategies based on strengths, better service coordination,

experiences of success and satisfaction with the process. Experiencing an enhanced effectiveness of services and supports on their journey through Wraparound is then predicted to lead to continued accomplishment of long-term outcomes such as stable home settings, improved mental health, improvements in school and work, improved quality of life and increased resilience (Walker, 2008a). Future research is necessary to assess the other intermediate outcome proposed by the WTOC.

Link to Chapter Six: Manuscript Two

Chapter Six entails the second manuscript of the thesis. The paper describes family experiences of change in a Wraparound process in New Zealand and similarly to Chapter Five is focused on the WTOC. This paper will investigate the other WTOC pathway to change that describes building capacity and resources for coping and planning (Walker, 2008a). The paper also aims in part to answer Research Question 2 and 3 of the overall study (What outcomes are achieved from the Wraparound process as perceived by youth and caregivers? To what extent do the perceived outcomes of Wraparound align with the intermediate outcomes as proposed by the Wraparound Theory of Change?). Research Questions 2 and 3 are more formally addressed in Chapter Seven.

Chapter Six: Family Experiences of Wraparound and the Wraparound Theory of Change: An Exploration of Building Capacity and Resources for Coping and Planning

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Abstract

Wraparound is “an intensive, holistic method of engaging with children, youth, and their families so that they can live in their homes and communities and realise their hopes and dreams” (National Wraparound Initiative homepage, 2016b). This research explores the proposed route to change highlighting building capacity and resources for coping and planning as experienced by young people and their families involved with Wraparound, as predicted by the Wraparound Theory of Change (WTOC; Walker, 2008a). A Wraparound fidelity measure and semi-structured interviews took place with five young people and six caregivers at the New Zealand Wraparound Program (NZWP) in the third (plan implementation and refinement) phase of Wraparound; transcripts were then analysed using Interpretative Phenomenological Analysis (IPA). Themes related to the WTOC were extracted, with a particular focus on the pathway to change named ‘Building capacity and resources for coping and planning’. The WTOC proposes that families experience change through Wraparound by way of gaining more resources or strategies for coping with various situations in life and learning to plan for the future (Walker, 2008a). These resources are predicted to arise from participation in Wraparound and directly contribute to the achievement of positive long-term outcomes from a Wraparound process. The WTOC proposes that increased resources for families include self-efficacy, empowerment and self-determination; and social support. Themes related to these concepts were identified through IPA and the implications are discussed. The present study suggests young people and their families in Wraparound may achieve long-term outcomes in Wraparound in part from increasing and resources for coping and

planning, thus supporting Walker's proposed pathway to change in the WTOC.

Keywords: adolescent mental health, theory of change, Wraparound

Wraparound

Wraparound is an approach to care planning, building on the collective actions of a committed group of family, friends, community and professional supports. Services and supports lead to the collection of various resources and talents for the family. The services and supports work as a team to produce a care plan which, importantly, is driven and owned by the family and the youth. The team continually monitors the individualised plan and adapts it as needed (Bruns et al., 2008).

While Wraparound programs vary internationally, an evidence-based model has been established by the National Wraparound Initiative (NWI: Walker, Bruns, Conlan, & Laforce, 2011). According to their model, the planning process is based on 10 philosophical principles and four phases that offer a guideline for which activities need to be completed through the Wraparound process (Burchard et al., 2002). The 10 philosophical principles encompassing the Wraparound process are: (1) family voice and choice, (2) team-based, (3) natural supports, (4) collaboration, (5) community-based, (6) culturally competent, (7) individualised, (8) strengths-based, (9) persistence and (10) outcome-based (Bruns et al., 2004). The four activity phases of Wraparound are (1) an introduction to the activities of Wraparound; (2) initial plan development; (3) plan implementation and refinement; and (4) transition (Bruns et al., 2004; VanDenBerg & Grealish, 1996).

Wraparound and the Theory of Change

Wraparound has been described as family- and strengths- focused. However it has been suggested such descriptions have not been explored in enough detail and as a result, the implications of Wraparound are unclear (Allen & Petr, 1998; Saleebey, 1996; Walker & Matarese, 2011). The Wraparound Theory of Change (WTOC) has been developed to explain why the Wraparound model is effective and how outcomes might occur (Walker, 2008a). It proposes that the combination of effective teamwork and adherence to Wraparound principles, activities and phases result in the achievement of short- and long-term outcomes In achieving the long-term outcomes from Wraparound, the WTOC predicts that families experience two interacting ‘routes’ on their path to these life changes. One route to change in the WTOC states that a unified Wraparound team will select professional services and natural supports so that collectively and individually the services and supports complement each other and work better than services and supports provided outside of a Wraparound process. This enhanced effectiveness of these services is predicted to be associated with better engagement, retention and commitment from families in that process (Walker, 2008a). The other route to change highlights that family participation in a high-quality Wraparound process produces benefits separate to the specific services and supports the family receives, and family assets are able to be built based on the experience of participation in the Wraparound process alone (Walker & Matarese, 2011).

The WTOC was devised from research into effective teamwork and mechanisms of change (Walker & Matarese, 2011; Walker & Schutte, 2004).

Mechanisms of change reviewed included self-efficacy, social support, empowerment, optimism, resilience, teamwork and collaboration (Walker & Matarese, 2011). The WTOC gives emphasis to Wraparound outcomes that are not often measured, specifically the interacting intermediate pathways to change. The WTOC suggests not investigating these meaningful pathways may devalue Wraparound as these outcomes can be significant for families (Walker, 2008a; Walker & Matarese, 2011). For the WTOC to be realised, it is assumed that Wraparound has been delivered in adherence to the NWI principles and phases as closely as possible (Walker, 2008a; Walker & Matarese, 2011).

This study explored the changes young people and their families experience through Wraparound and then assessed if these changes were associated with the second intermediate pathway in the WTOC. The other intermediate outcome predicted by the WTOC (an enhanced effectiveness of services and supports, individually and as a 'package') has been explored in additional research conducted by the authors.

Building Capacity for Coping and Planning through increased Self-Efficacy and Social Support

One of the two routes to change in the WTOC emphasises that family participation in a high-quality, high fidelity Wraparound process produces benefits independent of the specific services and supports on the Wraparount team (Walker, 2008a; Walker & Matarese, 2011). The WTOC suggests these benefits include more resources for coping, planning and problem solving such as self-efficacy and social supports. These resources are predicted to lead directly to positive long-term outcomes such as increased resilience, higher quality of life and improved mental health (Walker, 2008a; Walker & Matarese, 2011). It has

been noted that young people who are proficient in coping with problems have more optimism and are less likely to experience depression (Peterson & Steen, 2002). Further, young people who are optimistic tend to do better academically, have lower rates of substance abuse and have better physical and mental health (Roberts et al., 2002).

Self-efficacy, self-determination and empowerment.

There has been much research to suggest that involvement in processes which are included in Wraparound such as active participation in planning, the experience of making choices, and setting and reaching goals help to develop increases in self-efficacy, self-determination and empowerment, concepts all closely related to one another (Walker, 2008a).

Self-efficacy is "people's beliefs in their capabilities to produce desired effects by their own actions" (Bandura, 1997, pg. 3). People who experience increased self-efficacy are better able to problem solve, have more confidence in their abilities in adverse situations and are more likely to maintain changes in their behaviour (Walker & Matarese, 2011). Knowledge surrounding self-efficacy supports the concept that involvement in a true, strengths-based Wraparound process will contribute to heightened self-efficacy in youth and their families (Walker, 2008a).

Empowerment has been described as a psychological state marked by a sense of perceived control and competence, and an internalisation of the goals of a team (Menon, 1999). Evidence from team building within organisations suggests that empowerment plays a crucial role in group development and maintenance (Conger & Kanungo, 1988). Effective Wraparound teams focus on an

individualised family empowerment model rather than following procedures focused only on continuous duplication of a service (Patricia Miles et al., 2011). This is achieved by families being full and active partners in every level of the Wraparound process. It is assumed that the family best understands the strengths and needs of the young person. Therefore, Wraparound stresses empowerment of families, sanctioning they have voice and choice at all times (Burns et al., 2000). Increased empowerment is also predicted by Walker (2008a) as a resource for families in Wraparound to cope, plan and problem solve.

Self-determination is associated with motivation, curiosity, mastering new skills, and considerable effort and commitment (Gearing et al., 2014; Ryan & Deci, 2000). Studies comparing people whose motivation is self-determined with those who are externally driven for achievement suggest motivation that is self-determined is associated with more self-esteem, excitement, interest and improved well-being. The result is greater creativity, performance and persistence (Ryan & Deci, 2000). When the family leads the Wraparound plan, they experience increased investment in creating solutions and changes in their lives. This occurs in Wraparound processes by including the family in planning, making choices, directing services and supports; and experiencing success in reaching important goals, which then results in feelings of enhanced self-efficacy, empowerment and self-determination (Artello, 2011; Walker & Matarese, 2011; Walker & Schutte, 2004).

Social support.

Broadly, social support has been deemed as information leading someone to feel “cared for and loved, esteemed, and a member of a network of mutual obligations” (Cobb, 1976, pg. 300). More recently, it has been suggested that

there are several dimensions included in the construct of social support (Reid & Taylor, 2015). Dimensions of social support most commonly cited include emotional (demonstrations of empathy, love, encouragement), instrumental (tangible support such as assistance with problems, e.g. household chores), informational (the giving of advice or suggestions), and appraisal (information for self-evaluation; Reid & Taylor, 2015).

It has been suggested people with friends, family members and spouses who provide psychological resources experience less stress and adversity than those with few social supports (Walker, 2008a; Walker & Matarese, 2011). They also experience benefits with regards to morale, health, and coping (Walker & Matarese, 2011). Community integration is an assimilation into a social network and activities such as school, employment or volunteer work (Willer et al., 1993). The experience of less stress and adversity, and the benefits of morale, health, coping and community integration are predicted by the WTOC as resources to support families within Wraparound to plan, cope and problem solve (Walker, 2008a).

A common component of community-based mental health care like Wraparound is a focus on strengthening youth and family connections to supportive people within the community (Cook & Kilmer, 2010; Walker, 2008a). Including family and community supports on the Wraparound team demonstrates efforts to create community social support for families and young people (Kernan & Morilus-Black, 2010; Walker & Matarese, 2011). The WTOC includes the prediction that increasing social support contributes to resources related to coping, planning and problem solving (Walker, 2008a).

New Zealand Wraparound Program

The New Zealand Wraparound Program (NZWP[1]) provides Wraparound to young people and their families with high and complex needs in a large metropolitan city in New Zealand. To be eligible to receive Wraparound support from the NZWP, clients must meet the following criteria: be between 6 and 17 years old; have a serious mental health problem; and/or have ongoing Child, Youth and Family Services (CYFS) and/or Child and Adolescent Mental Health Service (CAMHS) involvement. They must also meet one of the following: have an escalating pattern of multiple risk behaviours; have had multiple home/living placements within the past 6-12 months, have worked with multiple health and social services and require active service coordination to develop and manage the number and complexity of services; unable to have their needs met by the usual network of health and social services; require a more intensive level of mental health clinical services than can be provided by CAMHS; experience circumstances placing the family or caregivers under extreme stress; or be under the custody of CYFS (New Zealand Wraparound Program, 2006).

Aim

This study aimed to explore the changes that families involved in a Wraparound process at the NZWP experienced, and then to explore if changes they reported were related to increased resources and capacity for coping planning and problem solving as described by the WTOC (Walker, 2008a). Increased

[1] [1] Name of service has been changed to protect identity of the clients

resources would be suggested by themes related to self-efficacy, social support and community integration (Walker, 2008a).

Method

Procedure

The principle researcher contacted the Clinical Case Coordinator at NZWP who assisted in identifying all families involved in their third (plan implementation and refinement) or fourth (transition) phases of Wraparound. These phases were selected as they would be most likely to have families involved with Wraparound for at least 90 days (as required by the fidelity measure described below), and for families to have started experiencing changes from the Wraparound process. The NZWP Clinical Case Coordinator convened with each family's Wraparound Facilitator. All families who chose to take part in the study were coincidentally in the third phase of Wraparound resulting in no participants in the fourth phase of Wraparound.

In order to explore if the families involved in the study had been involved with a true Wraparound process as intended by the NWI, a fidelity measure (described below) was completed by participants. The Wraparound Fidelity Index (Short Version; WFI-EZ) was completed by the youth, their caregiver, their Wraparound Facilitator and a team member of each Wraparound team. Four versions of the fidelity measure for each family contribute to the WFI-EZ's strong internal consistency (Sather et al., 2012). WFI-EZ's were given to the Wraparound Facilitator by the Clinical Case Coordinator at NZWP who distributed them to the youth, caregiver and a Wraparound team member in a regular Wraparound meeting. The WFI-EZ's were then completed individually in

confidence and returned in individual sealed envelopes to the Clinical Case Coordinator who returned them unopened to the researcher. The measure took on average ten minutes to complete.

Measure

Wraparound fidelity was assessed using a 37-item self-report questionnaire called the Wraparound Fidelity Index – Short Version (WFI-EZ), a succinct version of the Wraparound Fidelity Index, version 4 (WFI-4). The WFI-4 is a semi-structured interview conducted with four team members involved in the Wraparound process: (1) youth (aged 11 and over); (2) parents or caregivers; (3) Wraparound Facilitator and (4) another team member (Bruns et al., 2009). The WFI-EZ is a relatively new and valid and reliable measure of adherence to Wraparound principles that is less time consuming than the WFI-4. The WFI-EZ has strong internal consistency (Cronbach's Alpha = .937; Sather, Bruns, & Hensley, 2012). With regards to validity, the correlation of total scale scores from the 37 WFI-EZ items with total scores from WFI-4 interviews is significant at $p=.001$, $r(42) = .548$, (Bruns et al., 2012; Sather et al., 2012). The WFI-EZ covers four sections including basic information, experiences with Wraparound, perception of outcomes and satisfaction with services. There are yet to be peer-reviewed adherence norms created for the WFI-EZ, as such, there is currently no singular minimum fidelity score that deems families have been involved with a 'true' Wraparound process. However, Key Element Scores compared favourably to USA national means, surpassing USA means in four out of five key Wraparound processes. As such, the results indicated satisfactory adherence to key Wraparound processes by the NZWP. According to the WFI-EZ manual and WrapTrack, as 3 of the 6 youth answered more than 8 of their WFI-EZ items with

“Don’t know”, this accordingly represents “missing substantial data”. Overall WFI-EZ scores are said to be compromised (Sather et al., 2013). Fortunately, due to the high completion rate of the WFI-EZ forms from each of their caregivers, Wraparound Facilitators, and Wraparound Team Members (with no other participants responding with 8 or more “Don’t know”), their WFI-EZ Key Element and Total Fidelity Scores continued to have sufficient internal consistency (Sather et al., 2013).

Participants

One young person chose not to be interviewed and their interview was attended only by their caregiver. Their data is included in the following participant information of interviewees, resulting in WFI-EZ data from six youths and caregivers. Participants included two male, three female and one transgender youth and their caregivers. Youths were aged between 12 and 17 with a mean age of 15.5. With reference to ethnicity, three youths identified themselves as Māori; one as New Zealand European/Māori; one as British and one as South African. Mental health and behavioural concerns experienced by the youths included aggression, anorexia nervosa, attachment issues, attention deficit hyperactivity disorder, criminal offending, depression, encopresis, enuresis, gender identity issues, learning difficulties, partial seizures, self-harm, sexual abuse, social phobia, substance abuse and suicidality. Families involved with the study were yet to complete their Wraparound process, with length of involvement ranging from five to 18 months.

Interviews

Semi-structured interviews were conducted, comprised of questions related to changes in familial, community and service relationships, problem-

solving and coping strategies, self-perception, and Wraparound strengths and weaknesses (e.g. what was the best part of Wraparound for you or your family? What did you need more of from Wraparound?) Interviews occurred with caregivers and youths separately, where possible, however some youths chose to be interviewed with caregivers present. As mentioned above, one young person chose not to be interviewed and their interview was attended only by their caregiver. All interviews were audio recorded and then transcribed for analysis. All participant names have been changed to protect confidentiality.

Analysis

Interpretive Phenomenological Analysis (IPA) is useful when aiming to investigate how individuals experience particular situations they face, and how they perceive their personal and social world (Smith et al., 1999). IPA was selected for this research to explore the experiences of youth and families involved with Wraparound as it is particularly useful when exploring a particular process. IPA argues observation cannot be made without interpretation (Packer, 1992b). IPA cannot achieve an unaffected first-person account; the account is always constructed by the interpretations of both the participant and researcher (Larkin et al., 2006). However, IPA emphasises that research is dynamic with an active role for the researcher, recognising that the reflections and interpretations of the researcher are a key and complicating part of the analysis, as well as recognising the creativity of the interpretative process (Eatough & Smith, 2006a; Smith et al., 1999).

Smith and colleagues (1999) suggest that anywhere from one to 15 participants is an adequate number for IPA, and between three and five is sufficient for student research. This suggestion is made due to the painstaking

detailed analysis required by IPA, which aims to investigate depth rather than breadth (Smith et al., 1999).

It is important to note that the flexibility of the IPA approach is not aligned with lack of rigour. Rather, an extremely detailed analysis of participant accounts is the foundation of the IPA process. Its focus means that both a descriptive and interpretative analysis of the data increases the likelihood that a deepening of understanding occurs (Savin-Baden & Major, 2012). Relatedly, Guba (1981) offers suggestion to researchers using qualitative inquiry to address matters of ‘reliability’ and ‘validity’ as seen in rationalistic or other types of inquiry. Specifically, the matters of credibility, transferability, dependability and confirmability are raised (Guba, 1981).

Credibility is concerned with the testing of findings and interpretations with various sources, which could be seen to be related to internal validity (Guba, 1981). This research attempted to address credibility with member checks, prolonged time at a site, and peer debriefing. The primary researcher strived to build rapport with interviewees in order to obtain honest and open responses. During interviews, information was restated and summarised and the interviewer would seek accuracy from interviewees through further questioning. Following interviews, participants were given with transcripts to view, comment on or change. Prior to interviewing, the primary researcher also spent a three-week period at the NZWP to engage with the principles and processes related to Wraparound, and attend several Wraparound meetings. Finally, throughout theme identification, peer reviews were conducted to discuss findings and explore ideas from outside sources.

Transferability is linked with external validity and is concerned with the degree to which the findings are applicable in other contexts (Guba, 1981). IPA would argue that generalisations are implausible due to phenomena being intrinsically linked to the environment or context in which they occur (Smith, 2003a). This study engaged in purposive sampling whereby the researcher relied on her own judgment when selecting the sample based on the characteristics of the population. In this particular context, the population was families involved in a Wraparound process in New Zealand supported by the NZWP adopting the NWI principles and phases. As such, it would be up to the discretion of the future researcher to determine if transferring these results to a different context is sensible.

Dependability is associated with reliability and asks if findings would be able to be consistently repeated if the study were to be replicated (Guba, 1981). IPA proposes that reality is socially constructed and is therefore constantly changing for both the researcher and the participants (Eatough & Smith, 2006b). As such, it is important for the researcher to track their own changing perceptions throughout the IPA process. The primary researcher in this study adopted a check/recheck procedure whereby after naming themes that were interpreted to arise from data, the researcher would look back at that same data several weeks later to recheck that data and evaluate the results.

Finally, confirmability is associated with the degree of neutrality that can be expected to come from the inquirer throughout analysis, related to objectivity (Guba, 1981). Confirmability requires that the data remains neutral irrespective of who is interpreting it. The researcher addressed the issue of confirmability by practicing reflexivity.

Subordinate themes were noted on transcriptions using qualitative analysis assistant software program DeDoose. After looking for connections between subordinate themes, they were placed into clusters and clusters were repeatedly checked against the transcript in an iterative process, resulting in a set of subordinate and superordinate themes. Related subordinate themes were grouped together and recurrently checked against the transcript in an iterative process. A table of themes was produced, identifying clusters of themes attempting to capture participant responses to each particular theme. These clusters were then named, signifying superordinate themes. After subordinate and superordinate themes had been produced, those related to the pathway in the WTOC describing increased resources for coping, planning and problem solving were extracted, and are presented as follows.

Findings: Themes related to Building Capacity and Resources for Coping and Planning

The IPA identified themes related to building capacity and resources for coping and planning as described by the WTOC. These themes and the ways in which they relate to the WTOC concepts are discussed in further detail below and are presented in Table 1.

Table 1

IPA Themes Associated with Concepts Related to the WTOC Intermediate Pathway: Building Capacity and Resources for Coping, Planning, and Problem Solving

Concepts related to WTOC pathway*	Superordinate IPA themes	Subordinate IPA themes
Self-efficacy, empowerment, and self-determination	Changes in self-efficacy	Confidence
Social support and community integration	Changes in supports	Friends, neighbourhood
Other	Psychological acceptance	Understanding selves Understanding others

*(Walker, 2008a)

Themes Related to Walker's (2008a) Self-Efficacy, Self-Determination and Empowerment

Changes in self-efficacy: confidence

Youths and caregivers communicated via many reports that their confidence had increased from participation in the Wraparound process. When asked about the changes he had seen in himself in the Wraparound process, Wiremu responded with the following: "I've become more confident in myself…I can actually talk to people. It makes me feel pretty good. A big change from before." Jaden's caregiver spoke about how Jaden was more able to speak up about things he wanted for himself which she saw as new for him:

> He's out and interacting with us, he's not shut up in his room all the time. He's more willing to talk to us, make eye contact. Before he would just come home and not say anything whereas now he

> can talk more about his feelings, he can say "I've had not such a good day, I'm gonna just go and have a bit of time to myself".

Jaden then went on to demonstrate this confidence in the interview setting. Jaden was typically called J by professionals, friends and family. The interviewer called him J at one point in the interview and he then asked the interviewer to call him Jaden instead. He said: “It’s only recently that I’ve decided I'd much prefer Jaden to J, I think it sounds much more professional.” His caregiver added, “He never would have spoken up and asked for what he wants like that before Wraparound.”

The Wraparound team members modelled the philosophical principle of family voice and choice to families during the Wraparound process. Team members demonstrated to families that they were able to safely communicate their views and goals in the Wraparound meeting setting, giving families the confidence to do the same. This confidence was then able to extend to other areas in their lives, as reported by Georgia. Georgia looked up to the other team members for their confident communication, particularly her Wraparound Facilitator: “Basically she’s really really really confident about stuff. She is a very confident lady. So I feel confident when I’m with her. I feel happier, more mature and more confident.”

When asked about changes they had seen in themselves since beginning the Wraparound process, youths also indicated newfound confidence with clear, simple statements such as the following: “I used to think I was daft. But I'm not. But I'm not. I'm onto it I think? I'm onto it” (Sybil). “I feel good with myself”

(Wiremu). “I’ve become much more confident” (Ava). “I've become more outgoing and more outspoken than I normally would be” (Jessica).

Caregivers also gave evidence of gaining confidence through their participation in the Wraparound process. Sybil’s caregiver spoke about the Wraparound process using family voice and choice leading to changes in the way the Wraparound process was operating, increasing her confidence in herself and in the services and supports in the Wraparound process.

> I've noticed how much we've progressed. So, before I thought it was all about them telling us, Sybil and myself, what we should be doing. But the more we met, the more I realised that without our, without Sybil and my input, it wasn't working because it was all sorta Mickey Mouse and one person wanted this and that. So once I started to get involved and say "No, I think she needs to do this and this, and, what’s the opinion of everybody?", I felt it started to get really good then it made me feel a bit more confident with myself. Yeah.

Contrary to some caregivers who were distressed at the notion of Wraparound ending, due to the confidence she was able to gain through Wraparound participation, Jaden’s caregiver felt able to move on with her life, plan for the future and cope with whatever may arise.

> Whilst it’s been great having the input and the organisation of Wraparound there, I felt that we need to now start trying to live like an ordinary family. And not just have so many agencies

> involved…I think we have got enough skills to deal with things. As I say they've made me feel more confident about things.

Confidence in parenting.

Caregivers described historical feelings of low confidence regarding their parenting abilities. A gain in parental confidence was expressed by Georgia, Jessica, Jaden, Ava and Sybil's caregivers through participation in the Wraparound process. For example, Georgia's caregiver reported new confidence based on the changes she had applied to her parenting with the help from Wraparound, and the change this was having in her relationship with Georgia. "With the support we've had, I'm starting to feel more confident, rather than just, 'Oh god, everything's a mess' and also, Georgia has worked a lot on herself, the relationship is completely different".

Jaden and his family had the traumatic experience of losing Jaden's brother after he committed suicide. Following this event, his caregiver discussed how her parental confidence was able to grow through participation in a Wraparound process which included the celebration of success and a focus on strengths and feedback:

> I felt that I wasn't making headway lots of the time, that it knocked that confidence quite a bit. And then, when you lose a child that really knocks that even quite more in that, "Well, what could we have done? How did it come to get to be this bad?" and, I think what they've done is really bolstered that. They've sort of said, "No, you know, that's as much as you could do, that was OK, that's a good thing to have done."…Any suggestions of doing anything different have really come across as good and positive

> suggestions, not, kind of like, “We should have been doing this” type suggestions.

Sybil’s caregiver also spoke about the confidence she was able to build in her parenting abilities based on the feedback her Wraparound team provided her with through a celebration of success and a focus on her strengths.

> [The Wraparound team] always say to me, "Sometimes you feel like you're not doing a good job" and they say to me, "You're doing a really good job" and that makes me feel good because they always tell me, "You're doing a good job", and they say, "We know how hard it is, but you're doing a thing". Oh yeah, maybe I am!

Confidence in communication.

Increased caregiver and youth confidence was evident with regard to learning new ways to communicate. Confidence was developed for Sybil’s caregiver who experienced long-term difficulty speaking up in group situations. She had noticed similar changes also occurring for Sybil at Wraparound meetings through a focus on family voice and choice.

> [The Wraparound team] don't care whether you're emotional. I thought they're gonna say, “This woman's always crying!” But they don’t care! They just wanna hear how you're feeling and what your opinions are. So I speak up a lot more now. I’ve become much more confident. Sybil's starting to get more involved too. It is difficult for her because it’s all about her. But she's starting to speak up and say what she wants. Before it was just mumbling and looking down, now it’s looking up. And starting to say, "Well, I

> want to do this and I think I should do that" So it's definitely working. Oh yeah.

Jaden's caregiver also spoke about the changes she experienced in her communication through participation in Wraparound team meetings. A Wraparound process with emphasis on family voice and choice was able to bring about these changes:

> These people come in and you have to talk with them and it's very difficult to share things, share your emotions and how you feel, because they're here to support me as well. But eventually, as you get to know them, it's more relaxing and you start to get to know them so you open up a little more and you tell a bit more than, you know, I would have six months ago.

Jessica's caregiver discussed her journey of developing confidence within herself and her new role in Jessica's life. She had always identified herself as Jessica's Grandmother and found the transition to becoming Jessica's primary caregiver difficult. Over time through participation in the Wraparound process, her confidence grew and she became empowered to communicate boundaries to Jessica and fulfil her role as primary caregiver.

> What I realised through Wraparounds is that, I am her Nana, but I am her full-time carer, so I have to now take on a parental role. Nana's can do anything they want. But now, I have to make the rules, talk differently to her, act differently, do things differently. That was the hardest thing I had to do. But I'm more confident as

> a parent now and I do talk to her a lot more, and I don't feel bad about saying it. Now I can say what I feel.

Ava's caregiver mentioned that up until recently when she ran out of alternative strategies with Ava and her siblings, she would resort to yelling. Through the confirmation of family strengths acknowledged and identified by the Wraparound team, she no longer feels she needs to yell at Ava to be heard. She reported this change being due having more confidence in herself and Ava: "I keep it a lot more straightforward now, I don't lecture her as much." Georgia's caregiver also discussed developing confidence in opening up to Georgia: "I feel less anxious talking to her now and talking about things has started to work much better."

Sybil identified being able to speak with her mother more confidently: "I never used to be able to talk to her about anything 'cos I thought that she would always just rage but she doesn't now…she's like my best friend." Sybil's mother recognised she had to make changes to the way she responds to Sybil for this connection to have developed. A Wraparound process with a focus on strengths appeared to have contributed to this change: "When she rants I know that something's not right here and I'm gonna have to bite my tongue. There's no point in bat-and-balling." Another youth (Jaden) also mentioned being able to approach his caregiver about various topics of conversation without feeling anxious: "I can talk to her more confidently now."

Themes Related to Walker's (2008a) Social Support and Community Integration

Changes in support: friends, neighbourhood.

Families in this study generally did not appear to benefit from large increases in social support. Specifically, caregivers and youths reported low social support from peers. For caregivers, this appeared to have been due to connections being developed or strengthened within the context of the care of their youth and having less time available to them to build relationships outside of this care. Jaden's caregiver spoke about a history without close peer support.

> I found it to be quite isolating when you have two children with quite visible problems. You find that people say, "Come and visit us when you haven't got the boys". Well, there's no time when we haven't got them…I've been very much over the last four years tied to the house a lot because I've had a mentally ill child in the house who's not wanted to get up and go out. And then in the evening, you're still looking after them when everybody else is free, and then nobody wants to babysit them.

Caregivers however did report slight elevations in community support from groups such as the school, police and neighbours; increasing their levels of community integration. Although she was not able to maintain many friendships due to the demanding nature of caring for Jessica, it appeared Jessica's caregiver was able to reach out to her neighbour based on confidence which was increased through the Wraparound process. Where previously she was too shy or embarrassed to seek support, following Wraparound she gained confidence in

speaking up, planning and coping. Through doing this, she was able to discover the support she could then gain from other members of her community.

> The neighbour ended up saying, "If you ever need anything just give us a yell" and I'm thinking, "Oh, I should've done this before!" There are more people around than you think who wanna help, but you're just too embarrassed or ashamed to tell them, so you just keep it to yourself and suffer like hell.

It was evident that youths were not experiencing social support from their peers. These missing peer relations appeared to arise through a transitional period of moving from old peer groups to new potential peer groups following Wraparound participation. In some cases, youths had not had any friends prior to Wraparound; either due to always being in meetings with services, or due to peer isolation because of their high or complex needs. An example of this experience was demonstrated by Ava, who spent years in the hospital due to her battles with Anorexia Nervosa:

> I would say I definitely do not have a single friend. I tend to isolate myself a lot. And I haven't been to school for like, years. I never get in contact with anybody my age so, it's all just like all of that kind of like meshed together. I did meet the girl in hospital but, we don't talk unless we're in there.

Georgia spoke about the difficult change in her life trying to move away from an untrustworthy peer group with whom she regularly used marijuana. Before becoming close to that group of friends, she was well-liked and close with many people at school but moved away from them all. Through Wraparound, she

decided to move on from the drug users also. “Oh f**k friends, I have none…I used to always have friends. [I’d] always be around them 24/7. And going from friends to no friends is a massive difference. And it’s not all good.” However, through a strengthened bond with her caregiver, Georgia was reassured during the interview that her friendship group would be restored in due time, with her caregiver saying, “Your friends, they’ll come. We’re gonna move house and get out more, they’ll come”. Both Jessica and Jaden’s caregivers spoke about their youths not having or being able to keep friendships. They spoke about the surroundings for their youths not being conducive for meaningful or even safe friendships. Jaden’s caregiver reported the following:

> He's never really made a friend and kept a friend. He might be best buddies with somebody for a couple of days, but it never lasts…the big thing now is just sheer loneliness. He’s just is so desperate for a friend and cannot make and keep a friendship. Unfortunately, he's in a school with a lot of other children with other problems that aren't going to be the best role models or the most reliable of people.

Connecting with peers was a goal that had been set for many youths by their caregivers at the beginning of Wraparound. Both Ava and Jaden’s caregivers spoke about wanting to connect their youths with peers. Their desire for this goal had come about from their youths spending much time in the hospital, and also at schools specific to their complex needs. The caregivers had felt that these environments had not supported the fostering of healthy peer relationships. However, it was evident that the goal for new peers in these families had not yet been achieved. Jessica’s caregiver discussed her key Wraparound goal of wanting

Jessica to try and change the way that she interacted with others and to connect with people her own age:

> My main goal was to get her back into a mainstream school to be with her peers. She doesn't wanna hang ‘round with an old woman like me, you know? She needs to get back in and have communication and talk to boys and girls and not take everything so personally.

Other Themes Related to Increased Resources and Capacity for Planning, Coping and Problem Solving

Psychological Acceptance

Psychological acceptance has been described as allowing, embracing, experiencing and making contact with private experiences, which previously elicited avoidance, aggression or escape (Cordova, 2001). According to Acceptance and Commitment Therapy (ACT), acceptance is essential for change strategies to develop, and can also be itself a catalyst for change (Trompetter, Bohlmeijer, Fox, & Schreurs, 2015). Families in the study portrayed acceptance toward their difficult journeys prior to Wraparound, and an acceptance for what their future would hold post-Wraparound. Acceptance came in the form of both a growth in understanding of themselves and others, and appeared to stem from involvement in a high-quality Wraparound process with a focus on strengths, individualisation, respect for values, culture and expertise, the recognition and celebration of success, and family voice and choice.

Understanding others.

A deepened understanding of the psychological experience and needs of their youths was suggested by caregivers. Caregivers learned more about what was going on for their youth through participation in the Wraparound process which appeared to emphasise individualisation, the evaluation of strategies, strengths, family voice and choice and respect for expertise. These experiences appeared to foster an acceptance from caregivers with regards to why their youths behave in certain ways. Jaden's caregiver demonstrated a deeper understanding and acceptance toward Jaden's experiences and how best to support him. Over time, with the support of perspectives from various team members, participation in Wraparound helped her to understand that his struggles related to the suicide of his brother, his gender identity, and his chronic depression and anxiety would not be as straightforward to resolve as she had initially thought. This acceptance appeared to bring a sense of calm and awareness of what lay ahead.

> When I first took Jaden along, I thought yes, that there would be therapy, he'd talk it all out, and he'd come out and there'd be no more problems. And then it gradually dawned on me, "It's not gonna work like that". Now I see how integral it is that the way he thinks causes him difficulties in his life - it's so much part of who he is.

Understanding selves.

A deepened understanding of their own psychological experience through participation in the Wraparound process was suggested by youths and caregivers. Wiremu discussed his personal journey of self-discovery and acceptance through the Wraparound process, which had helped him to move forward in life. His

childhood was made up of 12 different foster families following his birth mother's troubles with substance use, additionally his family also had strong gang affiliatons. Wiremu attributes his journey to acceptance to the regular support and respect of the members on his Wraparound team.

> I wanted to kill myself...[but now] I kinda got more wiser and I've accepted my family and I'm trying to move on. My family did nothing for me, they pretty much forgot about me. It hurt me so much. All my Mum had to do to get me back was give up her [drug] habit, but she just didn't. I realised that and accepted it, and I'm just trying to get over it now. But [after speaking with the team] it's still way better, everything's changed. I feel way better, like a better person, more of a person, yeah.

Wiremu also discussed how his new sense of acceptance and allowed him to take control of the decisions in his life. He discussed historical feelings of guilt related to having to testify against his family members in court. They had since ceased all contact with him. Through Wraparound, he grew to feel empowered by his actions and the ones he continues to make for his future. "It's weird, all of a sudden I just found out what I wanna do. And I just did it. Like without anyone's permission, I just did it."

Ava's caregiver described a shift in understanding of herself and her husband toward the care of their daughter. She portrayed coming to a place of acceptance through her experience in Wraparound regarding what was within her control for her daughters' recovery from Anorexia Nervosa and what was beyond

her control. This acceptance toward letting certain issues go appeared to be empowering and helpful in planning for the future.

> I think that we have become much better at knowing how to respond to her, and knowing when to respond to her… [Wraparound] also helped us, in a big way, to define our role - that we're there to support her, not to actually make anything happen. That's been a really good shift for us, for everybody.

Themes Related to Positive Long-Term Outcomes

The WTOC suggests the experience of being involved in a Wraparound process may lead to increased resources and capacity for coping, planning, and problem solving, such as increases in self-efficacy, empowerment, and self-determination and social support and community integration. The theory also suggests that these increased resources may directly contribute to the achievement of positive long-term Wraparound outcomes such as improved mental health, healthy changes in behaviour, increased resilience, and increased quality of life (Walker, 2008a). The interviews identified the achievement of several positive long-term outcomes as a result of Wraparound. Families discussed outcomes related to improvements in mental health, healthy behaviour changes, improvements in academic and vocational areas, reduced substance use, and reduced criminal behaviour to mention a few.

Youths such as Georgia, Jessica and Wiremu discussed goals to gain employment, perform better academically, improve their fitness, and plans to find a new home with friends after leaving school. It appeared these achievements were related to increases in self-efficacy, self-determination, and empowerment.

Long-term outcomes related to changes in self-efficacy, empowerment, and self-determination

Georgia demonstrated increases in self-determination after being involved with the Wraparound process when deciding she wanted employment, not letting obstacles get in her way of achieving this. “[The social worker] was like, ‘I'll take you out to hand out C.V.’s and stuff to the shops’ and I was like, ‘Oh yeah sweet as’ and she didn't text back ‘til the holidays so I just went and did it myself.” Georgia also demonstrated gains in self-determination following involvement with the Wraparound process to perform better academically after several difficult discussions with the school Principal. In order to achieve this, she needed to move away from a group of friends who regularly used marijuana. Georgia’s caregiver demonstrated pride in her actions, telling her, “Nobody else took you away from them, you did it yourself”. Georgia agreed, “I’m proud of myself… even when I was there blazing, I’d be thinking, ‘No, I don’t want to do weed all my life’”. She also expressed a new desire to get a drivers’ license, giving herself a two-month time limit to achieve this goal. Finally, Georgia spoke about gaining confidence through health and fitness by attending the gym, which coincidentally also improved her relationship with her Mother as it was a new activity for them to enjoy together.

> I'm closer with Mum and I feel good with myself ‘cos I'm going to the gym and stuff, so I’ve actually got something to do with my days so it's not like, "Oh I haven't got anything to do" it’s like, "Na I've got gym". And that's really cool.

Several youths discussed wanting to work towards a career in social work. Sybil's caregiver discussed increased determination from Sybil to work towards helping other young people who had been through similar experiences.

> Sybil had always wanted to be a chef and now because of all this, she's considering getting her social work degree…she wants to help people like they're helping her. I said, "You know you have to actually go to school, and you have to actually go to University or Tech." She said, "Yeah, you can go to whatever school," and I said, "You have to spend about three years studying." She said, "Oh yeah I know," Okay! Good for her.

Due to participation in the Wraparound process and increases in self-efficacy, youths also demonstrated developing self-determination not only to work through their mental health concerns but to maintain these changes once they had done so. Ava had experienced severe Anorexia Nervosa and been hospitalised for nearly three years. Once Wraparound was introduced, the team adopted high-quality planning and problem solving and secured funding to get Ava a cat, under the condition Ava remained well enough to stay out of hospital to be able to care for it. This strategy worked extremely well and not only managed to keep Ava out of hospital for eight months (at time of interviewing), but also gave her a great form of support. "He's saved my life so many times…he's my baby. He'll know if I'm having a panic or something and he'll just come and sit with me. I had to work really hard to get him, but I'm happy."

Jaden's caregiver also spoke about the changes in his mental health she had witnessed as a result of Wraparound participation. She also indicated he was able to maintain these changes.

> He seems to have had about six months of not self-harming, whereas before it was quite serious self-harming. His lows aren't as low, and he comes back to a stable level much quicker than he would have done. Um, and with less input from myself, with more doing it for himself, so yeah. There's still a lot of issues, but they're nothing like they were last year, nothing like they were last year.

Finally, increased confidence due to their changes in behaviour was reported by several youths who had experienced difficulty with criminal activity in the past. Through Wraparound and the development of self-efficacy and self-determination they were able to cease this behaviour, contributing to them feeling more confident within themselves.

> Wiremu: I used to have a file opened up from the Police but, oh yeah! The officer came to talk to me last term, and he told me that he closed my file.
>
> Interviewer: How do you feel about that?
>
> Wiremu: All better.

Discussion

Wraparound is a team-based, collaborative care planning practice proposing to provide individualised care for adolescents and their families with high and complex needs (Bruns, 2014; Walker & Bruns, 2006). Outcomes from such a process may travel in multiple directions and are difficult to explain by a simple theory or diagram (Walker & Matarese, 2011). As predicted by Walker (2008a), through participation in the Wraparound process, family assets are predicted to increase such as self-efficacy, empowerment, and self-determination; and social support and community integration. In this instance, the outcomes involved for families were indicated to be increased assets for coping and planning for the future in the forms of increased self-efficacy and psychological acceptance. Aligning with predictions by the WTOC (Walker, 2008a), these outcomes are closely related and are difficult to tease apart entirely. As such, this study is limited by the extent to which it is able to assess the WTOC as the outcomes being investigated are deeply intertwined.

Self-Efficacy, Self-Determination and Empowerment

Changes in self-efficacy: confidence

According to Schunk (1991), confidence and self-efficacy are closely related concepts under the global construct of self-concept. People who experience an increase in self-efficacy have more confidence in their abilities in the face of adversity (Margalit & Ben-Ari, 2014). Motivation is also associated with self-efficacy, excitement, interest and improved well-being (Ryan & Deci, 2000). Knowledge surrounding self-efficacy supports the prediction that a true, strengths-based Wraparound process will contribute to increased self-efficacy in youth and

their families (Bruns et al., 2004; Winters & Metz, 2009). In particular, the WTOC predicts that participation in Wraparound alone can contribute to increased assets for families to cope, plan and problem solve, which directly contribute to long-term positive outcomes. Self-efficacy, empowerment and self-determination are included in the predicted increased assets, which were present in the IPA themes for families in the current study.

Caregivers and youths in this study portrayed increases in their overall confidence, and in particular increased confidence in parenting and communication skills. It has been suggested that continuous feedback regarding goal attainment raises self-esteem (Bandura & Cervone, 1983).Through the NZWP Wraparound process caregiver and youth confidence was boosted by the Wraparound team giving continual encouragement with a focus on strengths (e.g. Jessica's caregiver), feedback (e.g. Jaden's caregiver), an emphasis on family voice and choice (e.g. Sybil's caregiver), recognising and celebrating family success (e.g. Sybil's caregiver), and using high-quality planning and problem solving (e.g. Ava). This continual positive feedback created 'buy-in' and mastery for the families as services became more effective for them, increasing their motivation, and overall self-efficacy. This is congruent with research suggesting persistent feedback can lead to eventual mastery and self-efficacy (Anderson et al., 2010). As suggested by Walker (2008a), families with increased confidence may be able to cope better than families with lower confidence or self-efficacy when faced with obstacles in future. Families with higher levels of confidence also believe they can solve problems, are better able to manage stress, and are more likely to maintain changes in behaviour (Walker & Matarese, 2011). The results of this study suggest families in this study were able to experience an increase in

assets related to self-efficacy, empowerment and self-determination which will support them with future planning, coping and problem solving. Further, it is suggested by the WTOC (Walker, 2008a) that increases in these assets will lead directly to family achievement of team goals and long-term outcomes such as changes in mental health, improved resilience and improvements in vocational and academic activity.

Social Support and Community Integration

Changes in support: friends, neighbourhood.

Individuals with friends and family members who can provide them with support experience less stress and adversity than those with limited social supports (Walker, 2008a; Walker & Matarese, 2011). Consistent with previous research (Shailer et al., 2013), the families involved with Wraparound at the NZWP in this study did not report generous family increases in social supports. Caregivers and youths alike reported low levels of social support from peers. Although not strongly, some community support was indicated. Community support such as that provided to Jessica's caregiver by her neighbour demonstrates a Wraparound process promoting family integration into home and community life (community-based principle).

Low increases in community support and lack of other social supports did not correspond with predictions made by the WTOC that participation in a Wraparound process leads to increases in social support which facilitate family planning, coping and problem solving. The lack of increased social support for families suggests there was less emphasis on the Wraparound principles of persistence (as increased peer support for youths was a goal set by some

caregivers), and natural supports in their Wraparound process, where the plan reflects activities and interventions that draw on sources of natural support that then continue on as supports after Wraparound concludes. It is important to note, although peer and community support did not increase significantly, it was suggested in interviews that social support was somewhat strengthened from family members. This was demonstrated by alterations in family communication between caregivers and youths due to their increased confidence, and by strengthened bonds from doing new activities together, such as Georgia and her mother attending the gym together.

Aside from the potential lowered adherence to principles emphasising family connection to social and community supports by the NZWP, increased social support from peers and the community predicted to occur by the WTOC through participation in Wraparound may not have been reported for several reasons. These include potential stigma or social developmental delays.

The unfortunate stigma surrounding the mental health difficulties of these young people with high and complex needs experience remains an issue within modern society. It is possible youths may need to have completed Wraparound in its entirety and have moved into the next phases of their lives before they are able to experience reduced stigma, due to possible stigma from peers related to being involved with Wraparound. This may then lead to increases in peer support. Families involved with the study were yet to complete their Wraparound program, with length of involvement ranging from five to 18 months. As such, peer connections for some young people involved with this study may have been yet to occur.

Further, there is a relationship between young people who experience mental health and behavioural issues and delays in development when compared with same-aged peers without such difficulties (North, Wild, Zwaigenbaum, & Colman, 2013). Mental health difficulties present for the youths in this study may have resulted in a deficit in development of their social skills that their Wraparound process was yet to attend to. This possibility, coupled with the reality that many young people in the study were attending schools catering for other young people with high and complex needs may have intensified any social difficulties connecting with peers. The young people in this study who *did* indicate having peer support were maintaining relationships with other young people with similar needs, which both youths and caregivers indicated as being unhelpful for their recovery.

It is important to note, although youths did not report strong increases in social support from peers, in some families a reduction in social support from peers could be viewed as a positive first step toward recovery. For example, Georgia stated she used to have many friends who smoked marijuana. Through Wraparound, she was able to gain the confidence to step away from not only from her marijuana use but also from that group of peers. She may be experiencing less peer support than before she began participating in Wraparound; but it is due to the confidence that participation in this process gave her that she was able to understand the negative impact this group was having on her life and then be able to step away from them. This could be viewed as a first step in gaining future positive social support.

Social support experienced by caregivers was typically associated with the care of their youth in some capacity - such as a close relationship with their

Wraparound Facilitator, school, and police - and there was little social support outside of this context. Although there were some connections made to the community (for example Jessica's caregiver connecting with their neighbour), it was apparent that the majority of caregivers also did not experience an increase in social support from peers. It is necessary to explore the possibilities behind caregivers having less difficulty connecting to community supports when compared with youth.

Caregivers may have taken on more responsibility to reach out to community services for support than youths. They may have deemed it to be part of their role in the recovery of their youth to follow through on actions such as contacting community supports. The role may also have been assigned to them within Wraparound meetings – perhaps caregivers may have found this an easier task to follow up on than youths. It is possible that caregivers experienced less stigma associated with their needs compared to youths and thus found it less daunting to seek community support. This suggestion requires further exploration.

It would appear useful generally for Wraparound teams to place more emphasis on connecting families to peer and community supports. This might be achieved by having the team and family research together some appropriate neighbourhood hobby or support groups they could attend. Attendance at such groups may likely have a flow-on effect, connecting them to others, their self-efficacy through agency, connecting them even further, again increasing their self-efficacy, and so on. According to Kernan and Black (2010), extending caregiver and youth social connections through Wraparound will then support them through times of crisis and lessen the impacts of negative life events, also supporting increases in planning, coping and problem-solving (Walker, 2008a).

Other Themes Related to Increased Resources and Capacity for Planning, Coping and Problem Solving

Psychological acceptance.

Psychological acceptance has been said to be related to self-efficacy, increased increased problem solving, and has been shown to increase the psychological resilience of youths with chronic mental health issues (Kalapurakkel, Carpino, Lebel, & Simons, 2014; Snead, 2013). Psychological acceptance is also associated with better school functioning, and fewer depressive and anxiety symptoms (Sikorskii et al., 2015; Snead, 2011). Through participation in the Wraparound process, families in the present study described developing acceptance toward their journeys prior to Wraparound, and acceptance for what their future could hold post-Wraparound. Caregivers appeared to learn more about what was occurring psychologically for their youths as a result of participation in the Wraparound process, while youths also demonstrated a deepened understanding and acceptance of other family members' actions. Youths and caregivers also demonstrated a deepened understanding of themselves and their abilities. Youth's demonstrated psychological acceptance related to growth in self-efficacy; such as Wiremu who was able to accept his prior family difficulties and become confident in his decision-making thereafter.

Acceptance is essential for change strategies to develop, and can also be itself a catalyst for change (Trompetter et al., 2015). Increased acceptance and understanding of selves and others is predicted to have developed from a Wraparound process with emphasis on several principles and processes including strengths-based, individualisation, respect for values, culture and expertise, the recognition and celebration of success, and family voice and choice. As suggested

by the WTOC, participation in Wraparound should increase family resources and capacity for planning, coping and problem-solving, directly contributing to long-term positive outcomes. The results of this research predict that the development of psychological acceptance as a result of Wraparound participation will assist families in planning, coping (e.g. Wiremu) and problem-solving (Jessica's caregiver), and lead directly to the achievement of long-term outcomes such as resilience and improved mental health outcomes.

Long-term outcomes related to changes in self-efficacy, empowerment, and self-determination

The WTOC (Walker, 2008a) suggests that increased capacity and resources for coping, planning and problem solving directly contributes to long-term positive outcomes. Youths and caregivers in the study spoke about such outcomes achieved related to increases in their confidence. Common youth reports included motivation to gain employment, better academic performance, improved fitness, and reductions in criminal activity.

Research suggests that team outcomes associated with youth home and school improvement will be achieved with a well-structured team (Eber, Osuch, & Redditt, 1996; Hyde, Burchard, & Woodworth, 1996). Alongside a well-structured team and close adherence to the NWI model for Wraparound, the WTOC predicts families are able to benefit from increased assets for coping and planning through the family experience of proactive planning throughout their Wraparound experience, receiving confirmation of their family strengths, and an ongoing celebration of their successes (Walker, 2008a). As such, it is predicted that families in this study were able to be involved with a Wraparound process emphasising these qualities. It also appears participation in Wraparound leading to

increases in self-efficacy and psychological acceptance which supports planning, coping and problem-solving contributed to the long-term positive outcomes occurring for families listed above.

Limitations

There were no families involved in this research in their fourth (transition) phase of Wraparound. Interviewing families during this phase may help to better explain long-term changes for families, such as further increases in social support and community integration. Related to this, the data were cross-sectional. The Wraparound process involves continual personal development and as such, a longitudinal study looking at the changes that families experience over time would be recommended. Beyond this, exploration of Wraparound outcomes for families at multiple Wraparound programs internationally is also recommended. It may be viewed as a limitation that during one of the interviews it was not possible to interview the youth and caregiver separately, as this was the choice of the participants. This may have resulted in less candour from both the caregiver and youth. There were also multiple extraneous variables in the immediate environment to negotiate such as the entry and exit of others and the resulting volume of interviewees. One interview also only consisted of the caregiver and not the youth as they chose not to be interviewed. These aspects may have influenced the balance of information shared between youths and caregivers. In future research it may be advantageous to engage in focused interviewing with specific participants in the Wraparound process. This may result in more open sharing of experiences from those being interviewed and a blance of information. For the purpose of this study, it was seen as appropriate to interview caregivers and youths in the configuration of their choice. This was due to the research

ethical considerations, which would have deemed it as unethical to refuse participants support in interviews from family members of their choice. For this reason, there is variation throughout interviews related to who is present, which influenced the resulting amount of input from both caregivers and youths, and the resulting findings. Further, exploration of Wraparound outcomes for families at multiple Wraparound programs internationally is recommended.

Complex Interactions

The WTOC includes discussion regarding the multifaceted interactions between the pathways to change for families involved in a Wraparound process, and how the pathways are interwoven. Such interactions were present in the analysis of interviews from this study and the resulting themes. Interactions included overlap between key concepts predicted to contribute not only to the other described pathway to change (highlighting an enhanced effectiveness of services and supports), but also the pathway to change in the WTOC described in this paper that describes increases in resources and capacity for coping such as increased self-efficacy and social support. Further to this, themes to arise from the study suggested that interactions were also present between the key concepts within each of the pathways.

Caregivers gave evidence of increased confidence through participation in the Wraparound process. Sybil's caregiver spoke about the Wraparound process using family voice and choice leading to changes in the way the Wraparound process was operating, increasing her confidence in herself (increased resources for coping, planning and problem solving) and in the services and supports in the Wraparound process (enhanced effectiveness of services and supports contributing to engagement). Further, Jessica's caregiver experienced increases in

her confidence through participation in the Wraparound process. This increased confidence led her to feel more able to seek support from her neighbour when she needed help with Jessica, thus increasing her community social support, and demonstrating the ability to problem solve and cope with difficult events (increased assets in the form of self-efficacy and social supports for coping, planning and problem-solving). Jessica's caregiver also demonstrated psychological acceptance when coming to terms with being her caregiver as well as her grandmother, which appeared to be related to development of self-efficacy (increased assets in the form of psychological acceptance and self-efficacy for coping, planning and problem-solving).

Caregivers and youths in this study portrayed shifts in confidence and psychological acceptance, which are closely related concepts, suggesting the more one increases, the more it is likely the other will increase also. These examples of growth in self-efficacy and psychological acceptance demonstrate the unique and highly complex experience families are involved in with Wraparound. Each family has individual goals, supports, qualities and needs, and each team will be made up of different team members with varied expertise, backgrounds and cultures. The changes and outcomes the family may experience could travel in many alternate directions and as such, assessing Wraparound and related theories such as the WTOC in its entirety is implausible.

Conclusion

This paper discusses themes present in interviews with caregivers and youths involved in a Wraparound process, with particular focus on themes related to the pathway of change predicted by the WTOC (Walker, 2008a) discussing increased resources and capacity for coping, planning and problem-solving. The

WTOC (Walker, 2008a) predicts that when families experience a Wraparound process guided by Wraparound principles and phases, characterised by planning solving and planning, respect for culture and expertise, collaboration, opportunities for choice, individualisation, strategy evaluation, the celebration of success and a process driven by the family, they will experience increases in their self-efficacy, self-determination and empowerment, and social supports which support planning, coping and problem-solving and lead directly to long-term positive outcomes. Analysis of interviews from this study suggested that both caregivers and youths in this study reported increases in self-efficacy and psychological acceptance. Caregivers reported subtle increases in community supports. Families may still experience an increase in social supports as their levels of self-efficacy increase post-Wraparound and they become more confident in forming social connections. Themes present in interviews also demonstrated increases in self-efficacy and psychological acceptance related to positive long-term outcomes such as changes in fitness behaviour and mental health, improvements in academic functioning and reductions in criminal activity.

Based on the WTOC (2008a), it is predicted through participation in the Wraparound process at the NZWP that families were able to gain direct experience of how planning and coping within a team can be used to achieve goals, family values helped create the Wraparound plans, and family members were actively engaged in creating and following through on that plan; they were able to become problem-solvers in their own lives and experience positive changes. Such experiences then led families with the NZWP to report increases in their self-efficacy and psychological acceptance, and then report the achievement of long-term positive outcomes. Experiencing increased resources for coping,

planning and problem solving will likely lead families to continue to accomplish long-term outcomes such as stable home settings, improved mental health, improvements in school and work, improved quality of life and increased resilience (Walker, 2008a). The findings of this study support predictions made by the WTOC (Walker, 2008a) that participation in a high-quality, high-fidelity Wraparound process leads to increased resources for coping, planning and problem solving.

Link to Chapter Seven: Overview of Findings and Discussion

Chapter Six described family experiences of change in a Wraparound process in New Zealand, with a focus on the WTOC pathway to change that describes building capacity and resources for coping and planning (Walker, 2008a). Chapter Seven synthesises the results found throughout Chapters Four, Five and Six to formally address the Research Questions. Study limitations, clinical implications and personal reflections on the research process from the researcher are also described. Chapter Seven is followed by the references and appendices for the research.

Chapter Seven: Overview of Findings and Discussion

After completing the Interpretative Phenomenological Analysis (IPA), four superordinate themes were identified: These themes were changes in the family unit, psychological acceptance, changes in self-efficacy and changes in supports. As suggested by Braun and Clarke (2006), each theme has superordinate themes to help give structure to subordinate themes and to demonstrate the level and depth of findings within each theme. These themes are displayed in Table 1 and the original Research Questions are addressed below.

Answering the Research Questions

Research Question One: Does the NZWP adhere to satisfactory fidelity ratings to ensure their service delivery is Wraparound as described by the NWI's model of Wraparound?

There are yet to be peer-reviewed adherence norms created for the WFI-EZ, however WFI-EZ is shown to be a reliable and valid measure, comparable to the WFI-4, upon which it is based. An average of the WFI-EZ WrapTrack norms was calculated in October of 2014 and Key Element Scores compared favourably to USA national means, surpassing USA means in each key Wraparound process except Strength-and-family-driven, which still attained a favourable 78.1% adherence. Overall, the lowest fidelity Key Element Scores present in the WFI-EZ data were 'Natural/Community Supports', which previous studies have demonstrated as being typically the most challenging Wraparound process to adhere to with high fidelity (Kernan & Morilus-Black, 2010; Shailer et al., 2013). Key Element Scores indicated strongest adherence in this study to the key

Wraparound process of Outcomes-based. Key Element Scores suggest the NZWP were able to successfully tie goals and strategies of the Wraparound plan to observable indicators of success and monitor team progress throughout the Wraparound process with families in this study (Suter & Bruns, 2009).

Overall, the WFI-EZ results indicated satisfactory fidelity ratings to key NWI Wraparound processes by the NZWP in this study to ensure their service delivery is 'true' Wraparound as described by NWI's model.

Research Question Two: What outcomes are achieved from the Wraparound process as perceived by families?

After the researcher completed the Interpretative Phenomenological Analysis (IPA), four superordinate themes were identified, which all related to change in a Wraparound process. These themes were changes in the family unit, psychological acceptance, changes in self-efficacy and changes in supports. As mentioned, each superordinate theme has subordinate themes to help give them structure and to demonstrate the level and depth of findings within each theme (Braun & Clarke, 2006). Along with descriptions of each in previous chapters, the superordinate themes and their corresponding subordinate themes found in this study are displayed in Table 1.

Table 1

Findings: IPA Themes Identified from Interviews

Superordinate IPA Themes	Subordinate IPA Themes
Changes in family unit	Connectedness
Psychological acceptance	Understanding selves
	Understanding others
Changes in self-efficacy	Confidence
Changes in supports	Clarity
	Feeling unheard and overwhelmed
	Friends, neighbourhood
	Personalisation
	Wraparound team

Families spoke about many positive changes they were able to experience as a result of involvement in a Wraparound process. Caregivers and youths developed stronger relationships with each other and their wider family members, they were able to learn more about each other and themselves which afforded them a level of acceptance and understanding about their past and future, they developed confidence in many areas of their lives, and they gained new supports from services on their Wraparound team and some in the community. These positive changes were also helpful in families making other changes in their lives related to home-living, academia, mental and physical health, and reduction in criminal activity.

Related to supports, young people felt unheard at times by the Wraparound team in meetings. They also found it difficult to connect with their peers even though this was desired by their caregivers. Young people and caregivers felt

overwhelmed at times by the number of people in attendance at Wraparound meetings. These factors did not appear to impact their engagement with Wraparound or commitment to continue with the process due to the many other positives they spoke about. Families were impressed with the individualised nature of their Wraparound process, the clarity of team plans and follow-through of these plans, which led to them feeling more motivated and committed to remain involved.

In Chapter Six, Jaden's caregiver demonstrated increased self-efficacy in feeling able to move forward with, plan and cope with their lives post-Wraparound. However, based on their experiences in Wraparound as described in Chapter Five, some families felt such relevant and positive support from the Wraparound Team they did not yet feel ready or capable to continue on without Wraparound. These results might suggest positive increases in support from a Wraparound process but slower increases in self-efficacy for those families. As discussed, it will be useful for Wraparound services such as the NZWP to continue to adhere to Wraparound principles such as persistence, strengths-based, family voice and choice, community-based and natural supports so that families may continue to develop autonomy and feelings of success and take these through with them to their lives post-Wraparound. Further, it may be beneficial for Wraparound teams to discuss issues of age-determined closure in the planning phases of Wraparound for caregivers that are not yet aware that Wraparound ends for youths at the age of 18 (unless under the continued care of CYFS, ending age 20), as specified by the Aotearoa New Zealand Government agency Child, Youth and Family (discussed under 'The New Zealand Wraparound Program' in Chapter Two). Qualitative research conducted in New Zealand has indicated that young

people with high and complex needs and their caregivers who experienced a transition of care value pre-transition information, being listened to, family involvement, culturally appropriate care, and follow-up care after the transition (Embrett, Randall, Longo, Nguyen, & Mulvale, 2015; Geary, Lambie, & Seymour, 2011; Munford & Sanders, 2015). Impacts of fragmented transition of care can result in young people moving back and forth between a state of dependence and independence, and in some cases a perceived lack of caring from their caregivers (Rogers, 2011). Such findings suggest that the topic of youth and their families transitioning out of Wraparound needs special consideration (Haber, Cook, & Kilmer, 2012). According to the NWI, a high-quality, high fidelity Wraparound will focus on transition during the initial engagement activities (Walker et al, 2008a).

Research Question Three: To what extent do the described outcomes of Wraparound for families align with the intermediate outcomes as proposed by the Wraparound Theory of Change?

Diagrams or theories tend to denote a linear or left-to-right process. The uniqueness of families within Wraparound paired with an ever-developing plan and multiple strategies contributes to a complex series of progressions. Such progressions may travel in more directions than can be explained by a theory or diagram (Walker, 2008a). In this instance, the intermediate outcomes of the Wraparound Theory of Change relate to one another and are not able to be completely teased apart. Each time one outcome is strengthened, the other may become stronger also. In this way, the Wraparound process involves a complex loop, continually strengthening each individual concept, resulting in the continual strengthening of each intermediate pathway. This recirculating and reinforcing of

pathways demonstrates that the phenomena that take place within a family during the process of Wraparound are unlikely to be able to be assessed in entirety. Therefore, this study was limited by the extent to which it was able to assess the WTOC as it is unlikely any diagram or related research would be able to explicitly assess or specify how families involved with Wraparound experience evolving changes in their lives.

Nevertheless, all of the themes identified by the IPA were associated with experiences of change. All themes were also associated with the changes Walker (2008a) predicts to be intermediate outcomes in the WTOC. The IPA themes associated with the pathways to change Walker (2008a) describes in the WTOC are displayed in Table 2.

Table 2

IPA Themes Associated With Intermediate Pathways of the WTOC

Intermediate pathways of the WTOC as proposed by Walker (2008a)	Superordinate IPA themes to related to intermediate pathways of the WTOC
Enhanced effectiveness of services and supports, individually and as a "package" as evidenced by:	
Choice and motivation	Changes in self-efficacy
Relevance and feasibility	Changes in supports
Shared expectations	Changes in supports
Strengths-based understanding of behaviour	Changes in self-efficacy
Whole-family focus	Changes in family unit
Increased resources and capacity for coping, planning, and problem solving as evidenced by:	
Self-efficacy, empowerment, and self-determination	Changes in self-efficacy
Social support and community integration	Changes in supports
Other	Psychological acceptance

As demonstrated by Table 2 and Chapters Five and Six, all themes identified by the IPA related to the WTOC intermediate pathways. As described by Walker (2008a), the high-quality Wraparound team adheres to Wraparound phases and principles and the team is characterised by blended perspectives, respect for background and expertise, collaboration and creative problem solving.

These characteristics not only lead to the achievement of team goals but also desired outcomes are predicted to occur via two routes or pathways to change.

Enhanced effectiveness of services and supports individually and as a package.

One route to change in the WTOC states a unified team whose decisions are driven by the family's values, will select, access and adapt formal services and natural supports so that, as a 'package', the services and supports complement each other and work better than services and supports that are provided outside of a Wraparound process (Walker, 2008a). The collaboration of the services actually enhances each of the supports and strategies, leading to increased family commitment to and engagement with those services and supports. Increased motivation to engage with services is predicted to come about due to a Wraparound process that emphasises choice and motivation, is relevant and feasible for the family, has shared expectations, and adopts a strengths-based understanding of behaviour and whole family perspective. Wraparound outcomes represented by themes in the IPA related to this WTOC pathway were suggested by families. Analysis identified themes of feeling supported by their NZWP Wraparound team with a personalised, clear process with a focus on their strengths; and a connectedness to the wider family. These findings map onto the concepts described by Walker (2008a) as displayed by Table 2.

Based on interview findings, the WTOC predicts the NZWP was able to support families by way of individualised programs, clarity and follow-through indicate that services and support strategies have matched the functional strengths of the family and have been specifically designed to address their identified needs and support the attainment of their goals and vision; which led to improved

access, engagement, retention and commitment to services by families (Walker, 2008a). The WTOC also predicts findings suggest service practitioners were able to change their approach based on information gathered through the team to address needs and build on strengths. This suggestion was corroborated by WFI-EZ results. Changes in approach by services in Wraparound appear to have led to improved access, engagement, retention and commitment from families and higher cohesion between family needs and how their needs were addressed, confirming predictions made by the WTOC. Enhanced effectiveness of services and supports leading to improved access, engagement, retention and commitment from families will improve their outcomes. Motivation to remain engaged is a persistent challenge in the delivery of mental health care for youths (Ingoldsby, 2011; Kazdin, 1996). Young people who remain engaged in treatment along with their families experience better outcomes than those who do not and are more likely to reduce the costs associated with global mental health difficulties (Stein et al., 2014; Walker, 2008a). To continue to evaluate this particular route to change, Walker (2008a) recommends continued assessment of caregiver and youth perceptions of service relevance, coordination and helpfulness.

Increased capacity and resources for coping, planning and problem-solving.

The other route to change in the WTOC emphasises that family participation in a high-quality, high fidelity Wraparound process produces benefits that are largely independent from the specific services and supports that the family receives which can directly contribute to long-term positive outcomes (Walker, 2008a; Walker & Matarese, 2011). The WTOC suggests that participation in Wraparound leads to increased resources for families for coping,

planning and problem solving such as improved self-efficacy, empowerment and self-determination, and social support (Walker, 2008a). In the present study, themes related to these concepts were suggested by families. The IPA identified themes of confidence, psychological acceptance, support, and achievement of long-term positive outcomes. As with the other pathway to change, these findings map onto Walker's concepts as displayed by Table 2. Findings paired with the WTOC suggest that family participation in the NZWP with a committed, optimistic, focused, strategic and prepared team was able to build family assets through the experiencing proactive planning and coping and the reinforcement of family strengths leading to them derive new meaning from their situations and experiences (Walker, 2008a; Walker & Matarese, 2011). Although families reported a lack of peer support, this is typical in Wraparound generally and may still occur as their Wraparound process evolves. Further, although the inclusion of natural and family supports is an important Wraparound principle; it typically is less adhered to than other principles (Shailer et al., 2013; Walter & Petr, 2011). The NZWP and other Wraparound service providers who find lower adherence to the provision of natural supports for families may want to consider placing more emphasis on this, and continue ongoing monitoring of the achievement of this with families. Ongoing fidelity assessment may also be beneficial as high Wraparound fidelity is predicted to be associated with more positive outcomes (Bruns et al., 2005).

As discussed, psychological acceptance is related to self-efficacy, increased problem solving, and has been shown to increase the psychological resilience of youths with chronic mental health issues (Kalapurakkel et al., 2014; Snead, 2013). Psychological acceptance is also associated with better school

functioning, and fewer depressive and anxiety symptoms (Sikorskii et al., 2015; Snead, 2011).

In this instance, psychological acceptance appeared to emerge from a Wraparound process emphasising several principles and processes including strengths-based, individualisation, respect for values, culture and expertise, the recognition and celebration of success, and family voice and choice. Another possible reason that psychological acceptance was able to occur for families was the combining of Wraparound principles which emphasise both that it is driven by underlying needs whilst also based in strengths. Whilst some of these principles could be seen to be in conflict, they may have combined in the context of Wraparound to demonstrate to youths and caregivers that they are able to view their own and others' needs in a non-judgmental, future focussed and positive way. A focus on strengths may provide a much-needed safe space for caregivers and youths to reflect upon and accept themselves and each other. Due to the complex interactions at play, it is difficult, however, to surmise which Wraparound processes specifically contributed to such a phenomenon.

Although related to the concept of self-efficacy, it was viewed as important by the primary researcher to include psychological acceptance as a standalone resource for coping, planning and problem-solving. Acceptance appeared supportive in the increase of self-efficacy in some instances (for example, Wiremu), but was in and of itself a supportive resource for families in this study. Further, it appears increases in psychological acceptance may have also been supportive in achieving the long-term positive outcomes families discussed such as improvements in mental health. As such, it is predicted that increases in psychological acceptance is likely to directly lead to other long-term positive

outcomes in the WTOC such as improved resilience and quality of life. Further, the researcher predicts psychological acceptance alone to endure as a long-term outcome for families as a result of participation in the Wraparound process. Psychological acceptance could be considered to be included in WTOC pathway to change emphasising increased resources and capacity for coping, planning, and problem solving, as well included amongst the 'increased assets' displayed in long-term outcomes (Figure 1). Ongoing assessment of changes in psychological acceptance is recommended in future research assessing the WTOC. Further, Walker (2008a) recommends continued assessment of caregiver and youth empowerment, self-efficacy and optimism to monitor this pathway to change.

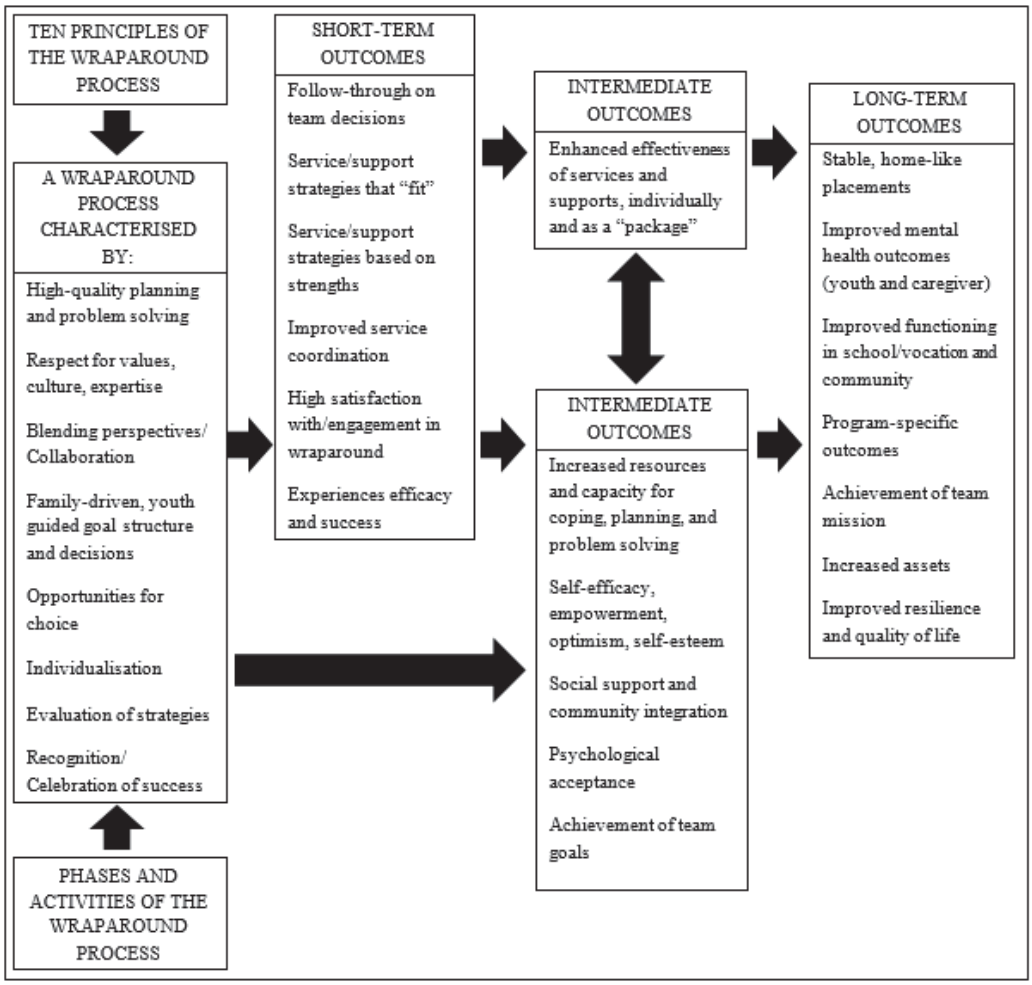

Figure 1: WTOC including intermediate outcome 'Psychological Acceptance'

When exploring the increased assets predicted to arise for families involved with a Wraparound process as predicted by the WTOC, it is important to query how this might inform future practice. The results from the current study align somewhat closely with the predicted outcomes from the WTOC, as such it may be pertinent for families to be informed about what types of assets they may hope to gain from the Wraparound process. Such information given to families would offer services that are transparent with all those who choose to become involved (enhancing shared expectations). It was not evident that families interviewed in this study were aware they may experience increases in their resources or assets for planning, coping and problem solving. Ideally, offering a complete picture of the outcomes families may hope to gain from Wraparound, with the inclusion of increased assets, may lead to families becoming more invested, engaged, and committed to the process. The sharing of this information should be approached with caution, however. The increased assets predicted to come about for families such as increased self-efficacy are much more internalised and individual when compared with other outcomes (for example, increased physical health). As such, some youths or caregivers may not experience an increase in assets in the ways they had imagined as it will likely be an incredibly varied response between individuals. Resultingly, the way in which this information is relayed must be cautious in offering the possibility that these assets may be gained for some and not others, and in varying amounts and capacities.

In answering Research Question Three, findings suggest that the WTOC (Walker, 2008a) is accurate in its predictions that change comes about for families in Wraparound by way of an enhanced effectiveness of services and supports,

individually and collectively, leading to family motivation to commit to and engage with services, as well as by way of increased resources and capacity for coping, planning and problem solving through Wraparound participation.

It is important to note that although the intermediate outcomes experienced by families in this study aligned very closely with those predicted by the WTOC, they did not align perfectly. For example, some families experienced increases in distress when considering Wraparound closure, some families did not experience increases in social support, and increases in psychological acceptance were experienced by others which was not predicted. It is important to explore why this imperfect match may have occurred, and how to increase the potential of these outcomes becoming more aligned with the WTOC in future.

As mentioned previously, families were not privy to the knowledge that they may benefit from additional outcomes such as increased assets and resources for coping from being involved in a Wraparound process. Further, they had not set the specific goals of increasing these resources (for example, their self-efficacy). If families do not make these goals explicit for their Wraparound plans, it is not expected that these things should occur. Families could perhaps be made privy to these potential intermediate outcomes regardless of what their Wraparound goals are. As a result, families could then be directly given tools or instruction as to how to improve these intermediate assets by the Wraparound team alongside their typical goals. It then may be more likely for families that these intermediate assets may increase and thereby increase the likelihood of other typical Wraparound goals occurring also (based on the way they are closely related to one another). Further, it would be useful for the development of these assets to be tracked during the Wraparound process (using perhaps an appropriate measurement tool

or questioning), so that the predictions of the WTOC may be even more closely achieved. A measurement tool may also support families further in assessing comfort closer to Wraparound closure, as it is likely that increases in assets for coping would support this transition.

As described in introductory paragraphs, typically theories of change are created in an ad-hoc fashion, and consult literature and proponents of change in an attempt to create them. It may be the case that the way these theories are created do not always predict accurately because they are created based on literature that predominantly uses rationalistic inquiry. Perhaps the use of naturalistic inquiry, which seeks to make meaning from the voices of people experiencing change themselves, may be better positioned to predict changes that individuals may come to experience based on the experiences they themselves discuss.

Study Limitations

It was a limitation of this study that there were no families involved who were in their fourth (transition) phase of Wraparound. Interviewing families during this phase may help to better explain the long-term changes that families experience and further determine their achievement of team goals – a suggestion for further research.

It may be viewed as a limitation that during one of the interviews it was not possible to interview the youth and caregiver separately, as this was the choice of the participants. This may have resulted in less candour from both the caregiver and youth. There were also multiple extraneous variables in the immediate environment to negotiate such as the entry and exit of others and the resulting volume of interviewees. One interview also only consisted of the caregiver and

not the youth as they chose not to be interviewed. These aspects may have influenced the balance of information shared between youths and caregivers. In future research it may be advantageous to engage in focused interviewing with specific participants in the Wraparound process. This may result in more open sharing of experiences from those being interviewed and a blance of information. For the purpose of this study, it was seen as appropriate to interview caregivers and youths in the configuration of their choice. This was due to the research ethical considerations, which would have deemed it as unethical to refuse participants support in interviews from family members of their choice. For this reason, there is variation throughout interviews related to who is present, which influenced the resulting amount of input from both caregivers and youths, and the resulting findings.

Exploration of Wraparound outcomes for families at multiple Wraparound programs internationally beyond the NZWP is recommended. Due to the qualitative nature of this work and the assessment of fidelity, there is also a possibility of the Hawthorne effect being present which states that people change or improve an aspect of what they are saying or doing due to an awareness of being observed (Jung & Lee, 2015).

The results of this study are limited regarding the scope to which they are able to be generalised. IPA would argue that generalisations are implausible due to phenomena being intrinsically linked to the environment or context in which they occur (Smith, 2003a). This study engaged in purposive sampling whereby the researcher relied on her own judgment when selecting the sample based on the characteristics of the population. In this particular context, the population was families involved in a Wraparound process in New Zealand supported by the

NZWP adopting the NWI principles and phases. As such, it would be up to the discretion of the future researcher to determine if transferring or generalising these results to a different context is reasonable.

Recommendations

The following recommendations will typically already be present in a Wraparound program with high adherence to the principles. However, as reported by Miles and colleagues (2011), Wraparound fidelity should not be considered synonymous with Wraparound quality; a Wraparound team that scores highly on getting the basic Wraparound processes completed may still need improvements in the quality of its work. With this in mind, adherence may have been achieved at an adequate level by the NZWP as recorded by the WFI-EZ but not always resulted in Wraparound principles being achieved. For this reason, although they may be typical recommendations in high-fidelity Wraparound models, the following recommendations are made in light of the findings from the present research with the NZWP.

- Wraparound processes would be enhanced by an increased emphasis on strengthening social support for youths related to peer connections

Based on caregiver and youth reports, it was evident that youths were not receiving support from their peers. This is consistent with previous research and as such, it is the recommendation of this and previous research that there be particular focus placed on the strengthening of peer supports for youths when engaged with a Wraparound process (Kernan & Morilus-Black, 2010). It is expected that this focus will also help to strengthen both intermediate outcomes in

the WTOC, as resources for coping, planning, and problem-solving will be increased, and the effectiveness of supports will be enhanced.

- Wraparound effectiveness will be enhanced by family inclusion in the selection of services

Concerning effectiveness of supports, it is recommended that families have a more defined role in helping select which services be included in their Wraparound team, emphasising the Wraparound principle of family voice and choice. Also consistent with previous research (Walker et al., 2012), young people did not appear motivated to take part in Wraparound meetings, feeling unheard by the Wraparound team. Presenting opportunities for young people to make choices and voice opinions (family voice and choice) on what elements of Wraparound they feel comfortable taking part in may result in heightened motivation and involvement in Wraparound over time. By raising youth motivation and involvement, it is probable that Wraparound services and supports will become more effective for young people (Stein et al., 2014).

- Wraparound service delivery will be enhanced when young people and families are fully engaged with their participation in Wraparound meetings - a review of all participants in meetings is recommended

Another indicator of low motivation to take part in Wraparound meetings from both youths and their caregivers was the feeling of being overwhelmed by the number of people attending meetings. It may therefore be necessary to place a limit on how many people are in attendance at Wraparound meetings and decide upon this number whilst in the Wraparound planning stages. These changes in

decision-making processes would emphasise the Wraparound principles of family voice and choice and individualised. Inclusion of the caregivers and youths in such decisions will also ideally increase motivation for Wraparound attendance.

- Transitioning from Wraparound requires significant planning commencing early in the young person and their families' participation in the Wraparound process

It may also be beneficial for Wraparound teams to discuss issues of age-determined closure in the planning phases of Wraparound for caregivers that are not yet aware that Wraparound ends for youths at the age of 18, as specified by the Aotearoa New Zealand Government agency Child, Youth and Family Services (unless under extended care until the age of 20). Ideally this would be done early in the initial plan development phase (if not before) so that a gradual tapering off process is able to occur throughout, reducing any family distress associated with Wraparound closure.

Finally, the data were collected at one point in time. The Wraparound process involves continual personal development and as such a longitudinal study looking at the changes that families experience over time would be recommended.

Conclusion

Families in the study experienced an enhanced effectiveness of services and supports leading to high levels of family commitment and motivation to engage with services and supports included on the Wraparound plan. Increased motivation and commitment for engagement was highlighted by family reports related to relevance and feasibility, shared expectations, a focus on strengths, and

a whole-family focus. Families were also able to increase their resources and capacity for coping, planning and problem-solving in the forms of increased confidence, psychological acceptance, and slight increases in community supports. It was apparent that increases in self-efficacy and psychological well-being were also related to positive long-term outcomes such as changes in fitness, behaviour and mental health, improvements in academic functioning and reductions in criminal activity.

Based on these findings, it would be predicted by the WTOC that families in this study experienced a Wraparound process guided by NWI Wraparound principles and phases, a Wraparound process characterised by problem-solving and planning, respect for culture and expertise, collaboration, opportunities for choice, individualisation, strategy evaluation, the celebration of success and a process driven by the family. As a result, families have been able to benefit from the achievement of short-term outcomes such as team follow-through, helpful team strategies based on strengths, better service coordination, experiences of success and satisfaction with the process. It is predicted that families will continue to achieve long-term positive outcomes such as stable home placements, improved mental health, improved school functioning, increased assets and an experience of an improved quality of life, amongst others (Walker, 2008a).

These results contribute to an increased knowledge about the intricate ways in which Wraparound achieves positive outcomes for families. It can be suggested that enhanced effectiveness of service-delivery helps families gain increased motivation and a commitment to remain engaged and working with Wraparound services. It can also be suggested that participation in Wraparound increases internal resources and capacity for coping, planning and problem-

solving such as self-efficacy, which then directly contribute to positive long-term outcomes for both young people and their families.

This information can be offered to Wraparound service providers and encourage their engagement in a process of quality assurance with a focus on:

- assessment and evaluation of programs delivered by the service;
- ensuring the voice of young people and families is present in all service planning and development processes;
- placing an increased emphasis on building relationships with social and community support services which can lead to enhanced service coordination encouraging an enhanced service delivery to families;
- placing more emphasis on team planning processes ensuring service planning includes the voice of young people and families

Further, this information can be offered to families to demonstrate the possible positive outcomes of Wraparound participation with a focus to include:

- a strengthening of relationships between close and extended family members such as siblings, parents, caregivers, grandparents, or biological parents;
- increases in understanding and acceptance of present and past experiences for themselves and others;
- increases in feelings of confidence both generally and in specific areas such as communication and parenting strateies;
- increases in feelings of genuine support from services;

- long-term positive outcomes such as improvements in academic and occupational achievement, improvements in mental and physical well-being, and maintenance of behaviour changes

This research explores the WTOC and offers an acknowledgement of the validity of the theory through an in-depth analysis of the experience of families who have participated in a Wraparound process that has demonstrated adherence to the Wraparound model. The results are positive within the context of Aotearoa New Zealand where Wraparound can lead to overcoming common barriers to care such as accessing effective service provision. Further, the close associations between Wraparound and Te Tiriti o Waitangi demonstrate Wraparound as a promising practice for the high number of Māori requiring services for high and complex needs within an Aotearoa New Zealand context (Kirkwood, 2014; Shailer et al., 2013).

Wider Implications

The emergence of philosophies such as those used in Wraparound represents a postmodern paradigm shift in family therapy. Family therapists over time have embraced an ecological systems perspective and now expand their relationship beyond the family of origin and extended family to include other systems impacting families (White, 2014). Postmodern family therapies include Family Systems Therapy, Solution-Focused Therapy and Narrative Therapy (Prochaska & Norcross, 1994). Postmodern family therapists stress the socially constructed nature of reality for clients, use strengths-based approaches, emphasise the need for therapists to partner with families, aim to restore and maintain social justice, and investigate the gender and ethnicity of clients and

their own attitudes toward these. Such perspectives help family therapists learn to respect diversity and see strengths in the families they partner with (Gushue, Sciarra, & Mejía, 2010). Thus, it appears reasonable that Wraparound philosophical principles can and should be applied in contexts beyond Wraparound. It seems plausible that principles of family voice and choice, team-based, natural supports, collaboration, community-based, culturally competent, individualised, strengths-based, persistence and outcome-based should be used in everyday practice as they are transferrable to any postmodern therapeutic context for young people and their families.

It is difficult to underscore the importance of supporting young people within the context of their environment – it is those surrounding the young people that hold the most powerful influence to impact their development and futures, which is why the inclusion of systems and supports are crucial, as demonstrated in the WTOC (Kilmer et al., 2011). The current research, by way of the WTOC, highlights that many of the important qualities needed to support young people and their families already lie within them. In some instances, these skills may simply need further development through the support of others. The development of these innate qualities was highlighted in the present research such as increased self-efficacy, increased connectedness within the family and psychological acceptance. With a focus on achieving short- and long-term goals within Wraparound such as improved service coordination and stable placements, and the ongoing implementation of Wraparound philosophical principles and processes, these qualities were able to be developed and may continue to go on and influence their lives in numerous, and sometimes unexplainable, ways. Each

young person and family holds their own solutions. The difficulties that families present with may be similar, but the solutions for each are individual.

Personal Reflections

It is hoped that these reflections will assist others wanting to undertake research in this highly deserving area. I believe that this type of reflection is an important aspect of research, as one cannot be so completely immersed in this area without being personally influenced.

I was deeply moved and humbled by all of the interactions I was privileged enough to have with the families in this study. They were all such resilient, strong, warm and capable people in spite of extremely difficult circumstances. They opened up their entire lives to me, cried with me, laughed with me - a complete stranger - all in the hopes that others might become aware of the magnificent work that the NZWP do, and how impactful Wraparound has been in their lives. The NZWP have become a source of light for all of these families. Rarely has any sole person or team ever been so reliable and dedicated to bettering the lives of these families. After years of experiencing marginalisation, misdiagnoses, and unjust treatment, for the first time in many of these young peoples' lives, they get to be excited about a future that until recently has been very uncertain. It is baffling to think that all of the wonderful outcomes they spoke about have been as a result of services working together with the whānau for goals that the young people and their family have set for themselves. A solution that on paper seems so simple; is that perhaps…because it is?

The work that I have done towards this research has been invaluable in terms of guiding my future career as a clinician, and in shaping the way I view the

world through my learnings about post positivist research. It is more evident to me than ever how fundamental it is to work with clients in a holistic collaborative nature and that each person's truth is an individual experience. It has also become apparent to me how important the Wraparound philosophical principles are to apply in all forms of therapeutic practice. I have also gained many skills with regard to information gathering that will aid my career as a clinical psychologist and the use of a scientist-practitioner approach. I will be influenced by this research and the principles it has instilled in me for the rest of my career. I have been so incredibly fortunate to be engaged in this area at such a critical time in my clinical development. I can only hope that the NZWP staff and incredible young people and their families in this study know just how much they have touched my life.

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Appendices

Appendix A: Interview Schedule

Introduction: I'm going to ask about your family life since you began wraparound. This is your opportunity to give any feedback that you might have about your work with NZWP, please feel free to share any of your thoughts to do with this process.

General

What changes have you noticed in your life since beginning Wraparound?

What was the best part of Wraparound for you or your family?

What did you need more of from Wraparound?

Are there any other comments that you would like to make about your Wraparound experience or any changes you have noticed in your family's lives since beginning Wraparound that you would like to discuss?

Achievement of team goals

What did you hope to gain from Wraparound?

When you started Wraparound, what were the goals that were in your plan? Where are you at with these now?

How well do you feel that you have achieved these goals?

Increased resources and capacity for planning, coping and problem solving

Prompts* What have you noticed about your… e.g. Family? School? Friends? Have these things changed since starting Wraparound? Bonding?

How are things going for you now?

Overall, are things better for you? Or worse? In what way? Tell me more about that…

What were your expectations when you started Wraparound? What are they now?

What aspects of Wraparound didn't work for you? Why do you think that is? How could it have been improved?

How does life during/after Wraparound compare to life before?

Have you learned to solve problems as a family differently since being in Wraparound? If so how is it different?

How well do you think you have learned to plan things as a family?

How are you handling difficult situations differently?

Self-Efficacy, empowerment, optimism, self-esteem

Do you feel like you have changed? If yes, how?

Do you see yourself differently in any ways since starting Wraparound? How so?

How have you changed the way you work with or understand your son/daughters mental health concerns?

Social support and community integration

Describe the ways in which you feel you have received support from your friends, family, service providers or your community as a result of Wraparound

Enhanced effectiveness of services and supports, individually and as a "package"

Which services were involved with your Wraparound team?

Did they match your needs from Wraparound (relevant)? In what ways?

How comfortable would you feel as a family to contact these services after Wraparound ends? How well do you think they worked together as a team? Why/why not?

Appendix B: Wraparound Fidelity Index-Short Version (Caregiver NZ Form)

FOR USE BY PROGRAM STAFF ONLY
This form was: ☐ Completed by the caregiver/parent ☐ Completed by program staff as part of an interview

Wraparound Fidelity Index Short Form (WFI-EZ)
CAREGIVER FORM

This survey is for a **caregiver** of a youth in wraparound. We want to ask you about the experiences that you and your family have had as part of the Wraparound program, so we can make it better. You do not have to answer any questions that you don't want to, and you may stop your participation at any time.

Thank you very much for your time.

Youth Information

Form completed on...
__/__/____

Youth/Family ID (The person who gave you this survey will give you this ID, or fill it in for you):
_____

Wraparound Site Location:
_____

What is the child's ethnicity?
- ☐ New Zealand European
- ☐ Maori
- ☐ Asian
- ☐ Pacific Island
- ☐ Middle Eastern
- ☐ Latin American
- ☐ African
- ☐ Other (please specify) _____

Who has legal custody of the child?
- ☐ Two birth parents OR one birth parent and one step parent
- ☐ Birth mother only
- ☐ Birth father only
- ☐ Adoptive parent(s)
- ☐ Foster parent(s)
- ☐ Sibling(s)
- ☐ Aunt and/or uncle
- ☐ Grandparent(s)
- ☐ Friend(s)
- ☐ Child, Youth & Family Services (CYFS)
- ☐ Other (please specify):

_____

Wrap-Facilitator ID (The person who gave you this survey will give you this ID, or fill it in for you)
_____

What is your child's birthday?
____/_____/_____ (DD/MM/YYYY)

How old is your child?
_____

Child's Gender:
☐ Male ☐ Female

How many months have you been participating in Wraparound? _____

What is your relationship to the child?
- ☐ Birth parent
- ☐ Adoptive parent
- ☐ Foster parent
- ☐ Live-in partner of parent
- ☐ Sibling
- ☐ Aunt or uncle
- ☐ Grandparent
- ☐ Cousin
- ☐ Other family relative
- ☐ Step parent
- ☐ Friend (adult friend)
- ☐ Other (please specify):

_____

Section A: Basic Information

For the following questions, please respond either "Yes," or "No."	Yes	No
A1: My family and I are part of a team (e.g., "wraparound team," "child and family team"), AND this team includes more people than just my family and one professional.	☐	☐
A2: Together with my team, my family created a written plan ("plan of care" or "wraparound plan") that describes who will do what and how it will happen.	☐	☐
A3: My team meets regularly (for example, at least every 30-45 days).	☐	☐
A4: Our wraparound team's decisions are based on input from me and my family	☐	☐

Section B: Your Experiences in Wraparound

For the following statements, please think about all of your experiences with wraparound. You will be asked whether you "Strongly Agree," " Agree," "Neutral," "Disagree," "Strongly Disagree," or "Don't Know."

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't Know
B1: My family and I had a major role in choosing the people on our wraparound team.	☐	☐	☐	☐	☐	☐
B2: There are people providing services to my child and family who are **not** involved in my wraparound team.	☐	☐	☐	☐	☐	☐
B3: At the beginning of the wraparound process, my family described our vision of a better future to our team.	☐	☐	☐	☐	☐	☐
B4: My wraparound team came up with creative ideas for our plan that were different from anything that had been tried before.	☐	☐	☐	☐	☐	☐
B5: With help from members of our wraparound team, my family and I chose a small number of the highest priority needs to focus on.	☐	☐	☐	☐	☐	☐
B6: Our wraparound plan includes strategies that address the needs of other family members, in addition to my child.	☐	☐	☐	☐	☐	☐
B7: I sometimes feel like our team does **not** include the right people to help my child and family.	☐	☐	☐	☐	☐	☐
B8: At every team meeting, my wraparound team reviews progress that has been made toward meeting our needs.	☐	☐	☐	☐	☐	☐
B9: Being involved in wraparound has increased the support my child and family get from friends and family.	☐	☐	☐	☐	☐	☐
B10: The wraparound process has helped my child and family build strong relationships with people we can count on.	☐	☐	☐	☐	☐	☐
B11: At each team meeting, our wraparound team celebrates at least one success or positive event.	☐	☐	☐	☐	☐	☐
B12: Our wraparound team does **not** include any friends, neighbours, or extended family members.	☐	☐	☐	☐	☐	☐
B13: My family was linked to community resources I found valuable.	☐	☐	☐	☐	☐	☐
B14: My wraparound team came up with ideas and strategies that were tied to things that my family likes to do.	☐	☐	☐	☐	☐	☐
B15: Members of our wraparound team sometimes do not do the tasks they are assigned.	☐	☐	☐	☐	☐	☐
B16: Our wraparound team includes people who are not paid to be there (e.g., friends, family, faith).	☐	☐	☐	☐	☐	☐
B17: I sometimes feel like members of my wraparound team do not understand me and my family.	☐	☐	☐	☐	☐	☐
B18: Our wraparound plan includes strategies that do not involve professional services (things our family can do ourselves or with help from friends, family, and community).	☐	☐	☐	☐	☐	☐

B19: I am confident that our wraparound team can find services or strategies to keep my child in the community over the long term.	☐	☐	☐	☐	☐	☐

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't Know
B20: Because of wraparound, when a crisis happens, my family and I know what to do.	☐	☐	☐	☐	☐	☐
B21: Our wraparound team has talked about how we will know it is time for me and my family to transition out of formal wraparound.	☐	☐	☐	☐	☐	☐
B22: At each team meeting, my family and I give feedback on how well the wraparound process is working for us.	☐	☐	☐	☐	☐	☐
B23: I worry that the wraparound process will end before our needs have been met.	☐	☐	☐	☐	☐	☐
B24: Participating in wraparound has given me confidence that I can manage future problems.	☐	☐	☐	☐	☐	☐
B25: With help from our wraparound team, we have been able to get community support and services that meet our needs.	☐	☐	☐	☐	☐	☐

Any additional comments about your family's experiences in wraparound, or about your wraparound experiences in general?

_____

_____

_____

_____

_____

Section C: Satisfaction

For the following statements, please think about your satisfaction with wraparound. Indicate how much you agree with each statement.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't Know
C1: I am satisfied with the wraparound process in which my family and I have participated	☐	☐	☐	☐	☐	☐
C2: I am satisfied with my child or youth's progress since starting the wraparound process	☐	☐	☐	☐	☐	☐
C3: Since starting wraparound, our family has made progress toward meeting our needs	☐	☐	☐	☐	☐	☐
C4: Since starting wraparound, I feel more confident about my ability to care for my child/youth at home	☐	☐	☐	☐	☐	☐

Any additional comments about your satisfaction with wraparound?

_____

_____

_____

_____

_____

Section D: Outcomes

For the following questions, please respond either "Yes," "No," or "Don't Know."	Yes	No	Don't Know
D1: Since starting wraparound, my child or youth has had a new placement in an institution (such as detention, psychiatric hospital, treatment center, or group home)	☐	☐	☐
D2: Since starting wraparound, my child or youth has been treated in an Emergency Room due to a mental health problem	☐	☐	☐
D3: Since starting wraparound, my child or youth has had a negative contact with police	☐	☐	☐
D4: Since starting wraparound, my child or youth has been suspended or expelled from school	☐	☐	☐

	Very much	A good deal	A little bit	Not at All	Don't Know
In the past month, my child or youth has experienced...					
D5: Problems that cause stress or strain to me or a family member	☐	☐	☐	☐	☐
D6: Problems that disrupt home life	☐	☐	☐	☐	☐
D7: Problems that interfere with success at school	☐	☐	☐	☐	☐
D8: Problems that make it difficult to develop or maintain friendships	☐	☐	☐	☐	☐
D9: Problems that make it difficult to participate in community activities	☐	☐	☐	☐	☐

Any additional comments about your satisfaction with wraparound, or about what has happened to your child/youth since the start of wraparound?

_____

_____

_____

_____

Again, thank you very much for your time.

Appendix C: Wraparound Fidelity Index-Short Version (Wraparound Facilitator NZ Form)

FOR USE BY PROGRAM STAFF ONLY
This form was: ☐ Completed by the Facilitator ☐ Completed by program staff as part of an interview

Wraparound Fidelity Index Short Form (WFI-EZ)
FACILITATOR FORM

This survey is for a **facilitator** involved in wraparound. We want to ask you about the experiences that this family has had as part of the Wraparound program. You do not have to answer any questions that you don't want to, and you may stop your participation at any time.

Thank you very much for your time.

Youth Information

Form completed on...
__/__/____

Youth/Family ID
_____

Wraparound Site Location:
[redacted]

Who has legal custody of the child?
☐ Two birth parents OR one birth parent and one step parent
☐ Birth mother only
☐ Birth father only
☐ Adoptive parent(s)
☐ Foster parent(s)
☐ Sibling(s)
☐ Aunt and/or uncle
☐ Grandparent(s)
☐ Friend(s)
☐ Child, Youth & Family Services (CYFS)
☐ Other (please specify):
_____

Wrap-Facilitator ID
_____

What is the child's birthday?
____/_____/_____ (DD/MM/YYYY)

How old is the child?
_____

Child's Gender:
☐ Male ☐ Female

How many months has the family been participating in Wraparound? _____

What is the child's ethnicity?
☐ New Zealand European
☐ Maori
☐ Asian
☐ Pacific Island
☐ Middle Eastern
☐ Latin American
☐ African
☐ Other (please specify) _____

Section A: Basic Information

For the following questions, please respond either "Yes," or "No."	Yes	No
A1: The family is part of a wraparound team AND this team includes more members than just the family and one professional (e.g., yourself)	☐	☐
A2: The family has a written plan (wraparound plan or plan of care) that describes strategies, action steps, and who is responsible.	☐	☐
A3: The team meets regularly (at least every 30-45 days)	☐	☐
A4: The wraparound team's decisions are based on input from the family.	☐	☐

Section B: Your Experiences in Wraparound

For the following statements, please think about all of your experiences with wraparound. You will be asked whether you "Strongly Agree," " Agree," "Neutral," "Disagree," "Strongly Disagree," or "Don't Know."

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't Know
B1: The family had a major role in choosing the people on their wraparound team	☐	☐	☐	☐	☐	☐
B2: There are people providing services to this child and family who are **not** involved in their wraparound team.	☐	☐	☐	☐	☐	☐
B3: At the beginning of the wraparound process, the family described their vision of a better future, and this statement was shared with the team.	☐	☐	☐	☐	☐	☐
B4: The family's wraparound team came up with creative ideas for its plan that were different from anything that had been tried before.	☐	☐	☐	☐	☐	☐
B5: With help from its wraparound team, the family chose a small number of the highest priority needs to focus on.	☐	☐	☐	☐	☐	☐
B6: The wraparound plan includes strategies that address the needs of other family members, in addition to the identified child or youth.	☐	☐	☐	☐	☐	☐
B7: I am concerned that this family's team does **not** include the right people to help the child and family.	☐	☐	☐	☐	☐	☐
B8: At every meeting, the wraparound team reviews progress that has been made toward meeting each of the family's needs.	☐	☐	☐	☐	☐	☐
B9: Through wraparound, the family has increased the support it gets from friends and family.	☐	☐	☐	☐	☐	☐
B10: Through wraparound, the family has built strong relationships with people they can count on.	☐	☐	☐	☐	☐	☐
B11: At each team meeting, the wraparound team celebrates at least one success or positive event.	☐	☐	☐	☐	☐	☐
B12: The wraparound team does **not** include any natural supports such as friends, neighbours, or family members.	☐	☐	☐	☐	☐	☐
B13: Through wraparound, this family was linked to new community resources that were critical to meeting their needs.	☐	☐	☐	☐	☐	☐
B14: The wraparound plan included strategies that were linked to things the family likes to do.	☐	☐	☐	☐	☐	☐
B15: Members of the wraparound team sometimes do not do the tasks they are assigned.	☐	☐	☐	☐	☐	☐
B16: The wraparound team includes people who are not paid to be there (e.g., friends, family, faith).	☐	☐	☐	☐	☐	☐
B17: I sometimes feel like members of this wraparound team do not understand or respect the family.	☐	☐	☐	☐	☐	☐
B18: The wraparound plan includes strategies that do not involve professional services, and are things the family can do itself or with help from friends, family, and community.	☐	☐	☐	☐	☐	☐
B19: I am confident that the wraparound team can find services or strategies that help keep this youth succeed in school and stay in the community over the long term.	☐	☐	☐	☐	☐	☐

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't Know
B20: An effective crisis plan is in place that ensures this family knows what to do in a crisis.	☐	☐	☐	☐	☐	☐
B21: The wraparound team and the family have talked about how they will know it is time to transition out of formal wraparound.	☐	☐	☐	☐	☐	☐
B22: The family gives feedback about how the wraparound process is working for them at each team meeting.	☐	☐	☐	☐	☐	☐
B23: It is possible that the wraparound process could end before the family's needs have been met.	☐	☐	☐	☐	☐	☐
B24: Because of the wraparound process, I am confident that the family will be able to manage future problems.	☐	☐	☐	☐	☐	☐
B25: The family has been connected to community support and services that meet their needs	☐	☐	☐	☐	☐	☐

Any additional comments about this family's experiences in wraparound, or about this wraparound experiences in general?

_____

_____

_____

Section D: Outcomes

For the following questions, please respond either "Yes," "No," or "Don't Know"	Yes	No	Don't Know
D1: Since starting wraparound, this child or youth has had a new placement in an institution (such as detention, psychiatric hospital, treatment center, or group home)	☐	☐	☐
D2: Since starting wraparound, this child or youth has been treated in an Emergency Room due to a mental health problem	☐	☐	☐
D3: Since starting wraparound, this child or youth has had a negative contact with police	☐	☐	☐
D4: Since starting wraparound, this child or youth has been suspended or expelled from school	☐	☐	☐

	Very Much	A Good Deal	A Little Bit	Not at All	Don't Know
In the past month, the child or youth has experienced…					
D6: Problems that disrupt home life	☐	☐	☐	☐	☐
D7: Problems that interfere with success at school	☐	☐	☐	☐	☐
D8: Problems that make it difficult to develop or maintain friendships	☐	☐	☐	☐	☐
D9: Problems that make it difficult to participate in community activities	☐	☐	☐	☐	☐

Any additional comments about your satisfaction with wraparound, or about what has happened to this child/youth since the start of wraparound?

_____

_____

_____

Appendix D: Wraparound Fidelity Index-Short Version (Team Member NZ Form)

FOR USE BY PROGRAM STAFF ONLY
This form was: ☐ Completed by the Team Member ☐ Completed by program staff as part of an interview

Wraparound Fidelity Index Short Form (WFI-EZ)
TEAM MEMBER FORM

This survey is for a **team member** involved in wraparound. We want to ask you about the experiences that this family has had as part of the Wraparound program. You do not have to answer any questions that you don't want to, and you may stop your participation at any time.

Thank you very much for your time.

Youth Information

Form Completed On... ___/___/_____

Youth/Family ID

_____

Your Name (Or assigned ID)

_____

Wraparound Site Location:

[redacted]

Are you a part of the family's "wraparound team"?
☐ Yes ☐ No

How long have you KNOWN the family?

_____

How long have you been working with this youth/family on this wraparound team?

_____

What is your relationship to the youth/child?

- ☐ Birth/Adoptive parent
- ☐ Stepparent
- ☐ Foster parent
- ☐ Live-in partner of parent
- ☐ Sibling
- ☐ Aunt or Uncle
- ☐ Grandparent
- ☐ Cousin
- ☐ Other Family Relative
- ☐ Adult Friend
- ☐ Youth friend
- ☐ Parent support partner/peer professional
- ☐ Mentor
- ☐ Therapist/Clinician
- ☐ Case Worker
- ☐ Respite Worker
- ☐ Residential/Group home staff
- ☐ Probation officer
- ☐ Teacher/school staff
- ☐ Minister/faith based
- ☐ Youth support partner
- ☐ Community Member (please specify): _____
- ☐ Other (please specify): _____

Section A: Basic Information

For the following questions, please respond either "Yes," or "No."	Yes	No
A1: The family is part of a wraparound team AND this team includes more members than just the family and one professional (e.g., Facilitator)	☐	☐
A2: The family has a written plan (wraparound plan or plan of care) that describes strategies, action steps, and who is responsible.	☐	☐
A3: The team meets regularly (at least every 30-45 days)	☐	☐
A4: The wraparound team's decisions are based on input from the family.	☐	☐

Section B: Your Experiences in Wraparound

For the following statements, please think about all of your experiences with wraparound. You will be asked whether you "Strongly Agree," "Agree," "Neutral," "Disagree," "Strongly Disagree," or "Don't Know."

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't Know
B1: The family had a major role in choosing the people on their wraparound team	☐	☐	☐	☐	☐	☐
B2: There are people providing services to this child and family who are **not** involved in their wraparound team.	☐	☐	☐	☐	☐	☐
B3: At the beginning of the wraparound process, the family described their vision of a better future, and this statement was shared with the team.	☐	☐	☐	☐	☐	☐
B4: The family's wraparound team came up with creative ideas for its plan that were different from anything that had been tried before.	☐	☐	☐	☐	☐	☐
B5: With help from its wraparound team, the family chose a small number of the highest priority needs to focus on.	☐	☐	☐	☐	☐	☐
B6: The wraparound plan includes strategies that address the needs of other family members, in addition to the identified child or youth.	☐	☐	☐	☐	☐	☐
B7: I am concerned that this family's team does **not** include the right people to help the child and family.	☐	☐	☐	☐	☐	☐
B8: At every meeting, the wraparound team reviews progress that has been made toward meeting each of the family's needs.	☐	☐	☐	☐	☐	☐
B9: Through wraparound, the family has increased the support it gets from friends and family.	☐	☐	☐	☐	☐	☐
B10: Through wraparound, the family has built strong relationships with people they can count on.	☐	☐	☐	☐	☐	☐
B11: At each team meeting, the wraparound team celebrates at least one success or positive event.	☐	☐	☐	☐	☐	☐
B12: The wraparound team does **not** include any natural supports such as friends, neighbours, or family members.	☐	☐	☐	☐	☐	☐
B13: Through wraparound, this family was linked to new community resources that were critical to meeting their needs.	☐	☐	☐	☐	☐	☐
B14: The wraparound plan included strategies that were linked to things the family likes to do.	☐	☐	☐	☐	☐	☐
B15: Members of the wraparound team sometimes do not do the tasks they are assigned.	☐	☐	☐	☐	☐	☐
B16: The wraparound team includes people who are not paid to be there (e.g., friends, family, faith).	☐	☐	☐	☐	☐	☐
B17: I sometimes feel like members of this wraparound team do not understand or respect the family.	☐	☐	☐	☐	☐	☐
B18: The wraparound plan includes strategies that do not involve professional services, and are things the family can do itself or with help from friends, family, and community.	☐	☐	☐	☐	☐	☐
B19: I am confident that the wraparound team can find services or strategies that will help this youth succeed in school and stay in the community over the long term.	☐	☐	☐	☐	☐	☐

☐

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't Know
B20: An effective crisis plan is in place that ensures this family knows what to do in a crisis.	☐	☐	☐	☐	☐	☐
B21: The wraparound team and the family have talked about how they will know it is time to transition out of formal wraparound.	☐	☐	☐	☐	☐	☐
B22: The family gives feedback about how the wraparound process is working for them at each team meeting.	☐	☐	☐	☐	☐	☐
B23: It is possible that the wraparound process could end before the family's needs have been met.	☐	☐	☐	☐	☐	☐
B24: Because of the wraparound process, I am confident that the family will be able to manage future problems.	☐	☐	☐	☐	☐	☐
B25: The family has been connected to community support and services that meet their needs	☐	☐	☐	☐	☐	☐

Any additional comments about your family's experiences in wraparound, or about your wraparound experiences in general?

_____

_____

_____

Appendix E: Wraparound Fidelity Index-Short Version (Youth NZ Form)

FOR USE BY PROGRAM STAFF ONLY
This form was: ☐ Completed by the youth ☐ Completed by program staff as part of an interview

Wraparound Fidelity Index Short Form (WFI-EZ)

YOUTH VERSION

This survey is for a **youth** in wraparound. We want to ask you about the experiences that you and your family have had as part of the Wraparound program, so we can make it better. You do not have to answer any questions that you don't want to, and you may stop your participation at any time. ***Thank you very much for your time.***

Youth Information

Form Completed on.... __/__/____ (DD/MM/YYYY)

Youth/Family ID (The person who gave you this survey will give you this ID, or fill it in for you):
_____

When is your birthday?
____/_____/_____ (DD/MM/YYYY)

Are you a...
☐ Male ☐ Female

Wraparound Site Location:
[redacted]

Section A: Basic Information

For the following questions, please respond either "Yes," or "No."	Yes	No
A1: Do you have a wraparound team? (A wraparound team is a group of people who make plans about how to help you and your family)	☐	☐
A2: Does your team have a written plan (wraparound plan or "plan of care") that says who will do what and how it will happen?	☐	☐
A3: Does your team meet regularly (at least every month or so)?	☐	☐
A4: Do you help make the decisions about your wraparound plan and the services you get?	☐	☐

Section B: Your Experiences in Wraparound

For the following statements, please think about all of your experiences with wraparound. You will be asked whether you "Strongly Agree," " Agree," "Neutral," "Disagree," "Strongly Disagree," or "Don't Know."

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't Know
B1: My family and I had a major role in choosing the people on our wraparound team.	☐	☐	☐	☐	☐	☐
B2: There are important people who help my family and me who are <u>not</u> involved in my wraparound team.	☐	☐	☐	☐	☐	☐
B3: At the beginning of wraparound, my family and I described our vision of a better future to our team.	☐	☐	☐	☐	☐	☐
B4: Our wraparound team came up with ideas for my plan that were different from anything that we tried before.	☐	☐	☐	☐	☐	☐
B5: My family and team chose a few really important things to focus on.	☐	☐	☐	☐	☐	☐
B6: Our wraparound plan tries to help all members of my family, not just me.	☐	☐	☐	☐	☐	☐
B7: I sometimes feel like our team does <u>not</u> include the right people to help me and my family.	☐	☐	☐	☐	☐	☐
B8: At every meeting, our team goes over the progress that has been made on our needs	☐	☐	☐	☐	☐	☐

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't Know
B9: Because of wraparound, I feel like I get more support from friends and family.	☐	☐	☐	☐	☐	☐
B10: Wraparound has helped me build relationships with people who I can count on.	☐	☐	☐	☐	☐	☐
B11: At every meeting, our team celebrates at least one success or positive event.	☐	☐	☐	☐	☐	☐
B12: Our wraparound team does **not** have any friends, neighbours, or family members involved.	☐	☐	☐	☐	☐	☐
B13: Wraparound has helped my family and me get connected to services that were really helpful.	☐	☐	☐	☐	☐	☐
B14: Wraparound helps me get involved in things that I like to do.	☐	☐	☐	☐	☐	☐
B15: Sometimes the people on our team don't do the things they're supposed to do.	☐	☐	☐	☐	☐	☐
B16: Some of the people on our team are people who are not paid to be there, like friends, family, or church members.	☐	☐	☐	☐	☐	☐
B17: Sometimes I feel like people on my wraparound team don't understand me or my family.	☐	☐	☐	☐	☐	☐
B18: Some of the ideas that our wraparound team comes up with are things our family can do ourselves or with help from friends and family.	☐	☐	☐	☐	☐	☐
B19: My wraparound team helps me get along with my family, do well in school, and stay out of trouble.	☐	☐	☐	☐	☐	☐
B20: Because of wraparound, if there is a crisis or emergency, my family and I know what to do.	☐	☐	☐	☐	☐	☐
B21: Our team has talked about how we will know it is time to end wraparound.	☐	☐	☐	☐	☐	☐
B22: At team meetings, I have a chance to tell everyone how I think wraparound is going.	☐	☐	☐	☐	☐	☐
B23: I think the wraparound process could end before my family's needs have been met.	☐	☐	☐	☐	☐	☐
B24: Wraparound helps me and my family solve its problems.	☐	☐	☐	☐	☐	☐
B25: Wraparound has connected my family to people and services that really help us.	☐	☐	☐	☐	☐	☐

Any additional comments about your family's experiences in wraparound, or about your wraparound experiences in general?

_____

_____

_____

Section C: Satisfaction

For the following statements, please think about your satisfaction with wraparound. Indicate how much you agree with each statement.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't Know
C1: I am satisfied with the wraparound process in which my family and I have participated	☐	☐	☐	☐	☐	☐
C2: I am satisfied with the progress I have made since starting wraparound.	☐	☐	☐	☐	☐	☐
C3: Since starting wraparound, my family and I have started to meet our needs.	☐	☐	☐	☐	☐	☐
C4: Since starting wraparound, I feel like things have improved at home with my family.	☐	☐	☐	☐	☐	☐

Any additional comments about your satisfaction with wraparound?

_____

_____

_____

_____

_____

Again, thank you very much for your time.

Appendix F: Health and Disability Committee Ethical Approval

Health and Disability Ethics Committees

Health and Disability Ethics Committees
Ministry of Health
C/- MEDSAFE, Level 6, Deloitte House
10 Brandon Street
PO Box 5013
Wellington
6011

0800 4 ETHICS
hdecs@moh.govt.nz

11 September 2014

[redacted]
Wellington 6017

Dear Ms McNatty

Re:	Ethics ref:	14/NTB/125
	Study title:	Wraparound and the Theory of Change: An Investigation into What promotes Changes Within Wraparound

I am pleased to advise that this application has been *approved* by the Northern B Health and Disability Ethics Committee. This decision was made through the HDEC-Full Review pathway.

Conditions of HDEC approval

HDEC approval for this study is subject to the following conditions being met prior to the commencement of the study in New Zealand. It is your responsibility, and that of the study's sponsor, to ensure that these conditions are met. No further review by the Northern B Health and Disability Ethics Committee is required.

Standard conditions:

1. Before the study commences at *any* locality in New Zealand, all relevant regulatory approvals must be obtained.

2. Before the study commences at a *given* locality in New Zealand, it must be authorised by that locality in Online Forms. Locality authorisation confirms that the locality is suitable for the safe and effective conduct of the study, and that local research governance issues have been addressed.

NOTE FROM CHAIR:

3. Still some minor changes needed on most PIS's and CF's. On all documents HDEC name needs changing to the Northern B Health and Disability Ethics Committee. Other changes described in the comments box next to each document. Please revise and email through to hdecs@moh.govt.nz for the Secretariat to review.

After HDEC review

Please refer to the *Standard Operating Procedures for Health and Disability Ethics Committees* (available on www.ethics.health.govt.nz) for HDEC requirements relating to amendments and other post-approval processes.

Your next progress report is due by 11 September 2015.

Participant access to ACC

The Northern B Health and Disability Ethics Committee is satisfied that your study is not a clinical trial that is to be conducted principally for the benefit of the manufacturer or distributor of the medicine or item being trialled. Participants injured as a result of treatment received as part of your study may therefore be eligible for publicly-funded compensation through the Accident Compensation Corporation (ACC).

Please don't hesitate to contact the HDEC secretariat for further information. We wish you all the best for your study.

Yours sincerely,

Raewyn Sporle
Chairperson
Northern B Health and Disability Ethics Committee

Encl: appendix A: documents submitted
appendix B: statement of compliance and list of members

Appendix G: District Health Board Ethical Approval

[redacted]

0980712849 **Wraparound and the Theory of Change: An Investigation into what Promotes Changes within Wraparound**

Project Personnel

[redacted]

Project type Observational research

Status PENDING

Dept [redacted]

Project duration 06/10/2014 to 01/10/2016

Service District Mental Health Services

Project Description The current research is a cross-sectional investigation divided into two parts, consisting of brief self-report questionnaires to be completed by youths, caregivers, team members and group facilitators in the wraparound process [redacted] will administer [redacted] to some of their clients. The second part of the investigation requires qualitative interviews to be conducted by Grace with the youth and caregivers. Families who agree will be involved in each part of the study.

The first part of the study focuses on evaluating the fidelity and treatment integrity of the wraparound initiative. In order to assess the Wraparound Theory of Change (Walker, 2008), it needs to be established that the family has been involved with true wraparound as it was intended to be implemented by the NWI. Wraparound fidelity will be assessed using a self-report form called the Wraparound Fidelity Index-EZ (WFI-EZ). The WFI-EZ takes around ten minutes to complete and will be completed by the caregiver, youth, the group facilitator and a team member.

The second part of the study will involve face-to-face qualitative questioning between the primary investigator and participants to gather the participants' views about the wraparound program and establish the outcomes achieved by the wraparound process. Each semi-structured interview will begin with questions which have been informed by the Wraparound Theory of Change. Similar questions will be administered with both the parents and youths separately. Interviewing both caregivers and youth will allow the researcher to obtain multiple perspectives involved within the wraparound process service delivery. Slight variation with wording of questions will be used with youths and their caregivers for enhanced user-friendliness. Interviews are expected to take around one and a half hours.

Locality Review *The undersigned agree to the following statements:*

- The study protocol or methodology has merit.
- The study does not require Health & Disability Ethics Committee (HDEC) review.
- The local lead investigator is suitably qualified, experienced, registered and indemnified.
- Resources, facilities and staff are available to conduct this study, including access to interpreters if requested.
- Cultural consultations have occurred or will be undertaken as appropriate.
- Appropriate confidentiality provisions have been planned for.
- Conducting this study will have no adverse effect on provision of publicly funded healthcare.
- There is a stated intent that the results of the study will be disseminated and, where practical and appropriate, the findings will be translated into evidence based care.

Awhina Research & Knowledge can assist in the determination of ethics approval requirements, budgets, contracts, funding applications and statistics consultations. Enquiries to research@waitematadhb.govt.nz or (09) 4868920 ext 2071.

Dept/Service/Org	Role	Name (Print clearly)	Signature	Date
MENTAL HEALTH Services Group	Clinical Governance Group	[redacted]		

<<END OF REPORT>>

Appendix H: Letter of Cultural Consultation

[redacted] [redacted]

4th August 2014

[redacted]

To whom it may concern,

RE: Grace McNatty and research project – Wraparound and the Theory of Change: An Investigation into what Promotes Changes within Wraparound

Grace McNatty has been in contact with myself and the [redacted] District Health Board regarding her research project in relation to consultation with Maori. We have met face to face in a meeting held here in [redacted] on July 21st 2014. I have been given copies of documents relating to her study such as the information sheets, consent forms and ethics application.

- I am the Kaitiaki at [redacted] and cultural support person.
- From our meeting and the documents provided I am confident that Grace is sensitive/competent to the cultural needs of all participants and I will monitor this throughout her research project.
- In specific regard to Maori – that Grace and Ruth are aware of the related issues, the related Article of the Treaty of Waitangi and how the wraparound process and underlying values fits in with the Treaty of Waitangi.
- Grace, Ruth and I will make sure that considerations regarding Maori and local iwi are taken into account.
- I represent local iwi and Maori e.g. based in [redacted] and have awareness and understanding of local iwi and Maori.
- I will provide support should any cultural requirements arise for the duration of this research if necessary.

I am sure the research will contribute significantly to furthering our knowledge and understanding of the wraparound process and its outcomes for families and youth with high and complex needs. I am pleased to support her efforts.

Please do not hesitate to contact me should you require any further information.

Yours sincerely,

[redacted]

[redacted]

Making a healthy difference

Appendix I: Study Information Sheet for Families

Massey University
PSYCHOLOGY CLINIC, WELLINGTON

Wraparound and the Theory of Change: Information Sheet for Caregivers and Youth

An Investigation into what promotes the changes within wraparound as proposed by the Theory of Change

The Research Study

This study is a joint project between Massey University and the [redacted] wraparound team. Massey University and [redacted] are committed to providing high-quality care to young people and families/whanau.

You are invited to take part in a voluntary study which is designed to help us explore:

1. The outcomes or changes (if any) you and your family have experienced since beginning the wraparound process, and;
2. The quality and integrity of wraparound service provided to you and your family/whanau.

The focus is on getting the perspectives from you as a family relating to how your lives have changed since starting wraparound.

If you accept this invitation, you (the caregiver/s) and the youth in your care will be asked to each complete a short survey and then take part in an interview. The survey will be done at the start of a wraparound meeting (or another time of your choice). The interview will take place where and when suits you best, and involves the researcher (Grace) asking you some questions about the changes (if any) in your life since starting wraparound. These interviews will be audio and video recorded. This is so that Grace can ensure that all information has been captured and to enable her to transcribe what has been said.

The Researcher

The primary investigator is Grace McNatty. She is a Doctoral Clinical Psychology student at the Massey University campus in Wellington. She is currently in her first year of Doctoral Study, her 8th year of studying psychology altogether. She has a Bachelor's and Master's degree from Canterbury University that both major in Psychology also. Her supervisors for this project are Dr. Ruth Gammon, Dr. Ruth Tarrant and Dr. Keith Tuffin (all from the Massey School of Psychology).

Who Can Take Part?

All families and youth (over the age of 11) currently involved with the [redacted] wraparound service can participate in this study. Preferably you and your family/whanau will have been involved with wraparound for around six months, but we welcome all families/whanau who wish to take part.

Taking part in this study is voluntary. It is completely your choice whether you take part in this research study or not. You do not have to participate in an interview in order to receive services. If you do not wish to participate, you are welcome to say no and there will be no change in the services you receive or how you are treated. You are also welcome to say no to the youth in your care taking part the research (they will be interviewed separately to you). However, it would be greatly appreciated if you decide to help us to improve wraparound by participating.

Massey University
PSYCHOLOGY CLINIC, WELLINGTON

What Are My Rights as a Participant?

You are under no obligation to accept this invitation. If you do decide to participate you have the right to:

- Decline to answer any particular question in the survey or interview
- Ask for the recorder to be turned off at any time during the interview
- Withdraw from the study during the survey or interview (or within 1 week of data being collected)
- Ask any questions about the study at any time during participation or before it begins
- Provide information with the understanding that your name will not be used unless you give permission to the researcher
- Be given access to a summary of the findings from the project when it has concluded
- Withdraw your data from the study at any time
- Bring a support person to your interview should you choose to

What is Involved?

1. If you agree to participate we will ask you (the caregiver/s) and the youth in your care (if they over the age of 11) to each complete a short survey and then each take part in an interview with Grace. The short survey takes around ten minutes to complete, and asks you and the youth in your care to answer if you 'strongly disagree' or 'strongly agree' with statements about the services you have received since beginning wraparound. An example of one of the statements in the short survey is, "Our wraparound team's decisions are based on input from me and my family." Your group facilitator will give you each these surveys at the beginning of a wraparound meeting, or you can choose to complete them at a different time.
2. [redacted] Clinical Coordinator at [redacted] or your group facilitator will then organise a time that suits you to have an interview with Grace.
3. The interview will take place. It could take place at the [redacted] office, at your home, or another location that you choose - whichever is most convenient for you. This interview will last about an hour and a half and will ask about the kinds of changes (if any) you and your family have noticed since beginning wraparound. For example a question might be "How well do you think that you and your family have learned to solve problems?" **There are no right or wrong answers to either the questions Grace asks you in the interview or the questions in the survey.** Please keep in mind that if you choose to have the interview at home, other family/whanau members or friends at home who enter the interview will be recorded too. Anything they say will be kept private. If you choose to interview at home, it might be a good idea to let everybody at home know that your interview is taking place, and when that is.
4. As a thank you for your time and for sharing your experiences, we will provide you and the youth in your care with a small koha. This will include something like a $20 Westfield voucher for your youth and a $20 Westfield voucher for yourself.

Can I Bring Someone?

You are welcome to bring a family/whanau member or friend for support to the interview. This can be discussed with Grace when arranging the interview time and location.

Massey University
PSYCHOLOGY CLINIC, WELLINGTON

Are There any Benefits or Risks?

There are minimal to no risks to participants who take part in this study.

The central benefit to you and the youth in your care participating in the study is that you will assist the [redacted] team and future teams who implement wraparound in New Zealand. Your contribution will help [redacted] and others to modify and be aware of what contributes to the changes that occur in families and youths with high and complex needs when engaged with wraparound. Your participation will also help us to gather information so that other wraparound initiatives in future will deliver the best possible service to families and youths who need it.

You get a voice for how the wraparound process is helping you and your family. These surveys and interviews provide you with an opportunity to directly and independently express your experiences with the wraparound process and do so in confidence.

What Happens to the Information I Provide?

The things you share in the interview and in the survey will be kept confidential and used for research purposes only. Grace will analyse the information that you provide her with. If for some reason you indicate to Grace that you are at risk of harming yourself or somebody else, Grace will have to tell someone (i.e. someone from the [redacted] team). She will let you know before she calls them if she is going to do this. Otherwise, everything you say will be kept private.

This study involves the audio and video recording of the interview with you (the caregiver/s) and the interview with the youth under your care. The purposes of recording are purely for transcribing the interviews for analyses. The video recordings will aid the audio recordings, as they may help to match voices to particular participants in interviews where more than one family member or support persons are present. These recordings will remain confidential and only the researchers will have access to the tapes and their contents, which will be stored securely and password protected. Nobody's names or any other identifying information from the family will be associated with the recordings or resulting transcripts. Once the researcher has completed transcribing the interviews, all tapes will be erased.

Transcripts from interviews with you (the caregiver/s) and the youth under your care may be reproduced in whole or in part for use in presentations or written products that result from this study. Information resulting from the transcripts may also be used for presentations at academic conferences or journal articles. Again, nobody's names or any other identifying information from the family will be used in these presentations or articles.

All data resulting from survey responses and interview transcriptions will be securely stored at Massey University. Data will be stored for ten years after the youth respondents have turned 16. After this time, data will be destroyed.

It is very important to note that **all data will be anonymous**. No material that identifies you or anybody in your family in any way will be used when reporting on this study. Information such as the names of people or places will be removed or changed. The data from your family will be given a number and that will be used to help the researcher organise data. The only people that will have access to the data after it has been made anonymous and been coded will be Grace, her supervisors, and [redacted] and [redacted] from [redacted]

Massey University
PSYCHOLOGY CLINIC, WELLINGTON

Finding out the Results of the Study

If you would like to find out the results of the study, please circle the YES option on the consent form. After the study is completed, the results will be mailed to the address you provide us with. There may be a delay between when you take part in the study and when the results of the study are known.

Contacts for the Study

If you would like more information, have any questions, or would like to talk to someone about this research in any capacity, please feel free to contact us. Our contact details are as follows:

Grace McNatty
DClin Psyc Candidate
Massey University
grace.mcnatty@gmail.com
08 801 5799 ext 62528

Dr Ruth Gammon
School of Psychology
Massey University
r.gammon@massey.ac.nz
08 801 5799 ext 62029

Our *postal address* is:
Psychology Clinic
Massey University
24 King Street
PO Box 756
Wellington 6140

If you have any concerns about your rights as a participant in this research you can contact an independent health and disability advocate. This is a free service provided under the Health and Disability Commissioner Act. Their contact details are as follows:

Free phone (NZ wide): 0800 11 22 33
[redacted]one: 09 373 1060
[redacted]: 09 373 1061
Email: hdc@hdc.org.nz
Postal address: PO Box 1791, Auckland, New Zealand

If you want to talk to someone who isn't involved with the study, you can contact an independent health and disability advocate on:

Phone: 0800 555 050
Fax: 0800 2 SUPPORT (0800 2787 7678)
Email: advocacy@hdc.org.nz

Thank you so much for considering taking part in this study!
We are extremely grateful for your input.

This study has received ethical approval from the
Health and Disability Ethics Committee of New Zealand

Appendix J: Consent Form for Caregivers

Massey University
PSYCHOLOGY CLINIC, WELLINGTON

Wraparound and the Theory of Change: Informed consent for caregivers

Caregiver Acknowledgement of Informed Consent

By signing this consent form you are agreeing to the following:

I have read and understand the information for volunteers taking part in this study. I have been given a description of this evaluation and had the opportunity to discuss this study and to ask questions about it, and these have been answered to my satisfaction. I understand that I have had the opportunity to use family/whanau support or a friend to help me ask questions to help understand the study. I understand what the procedures of this study are and have had the potential risks and benefits explained to me. I have had the time to consider whether or not I want to take part.

I understand that this study is designed to help Massey University and the [redacted] wraparound team to understand and explore: a) the outcomes my family/whanau and I have experienced since beginning the wraparound process and; b) the quality and integrity of wraparound service provided to me and my family/whanau.

I also understand the following:

- That my participation is voluntary (my choice), and that I may refuse to participate or withdraw at any time without penalty and this will in no way affect the services provided to me.
- That I am allowing the researcher to audio record my own and the child in my care's interviews as part of this research.
- That anything I say will remain confidential and material which could identify me will not be used in any reports on this study. All identifying information will be removed and only group results will be reported.
- That the findings from this study may eventually be published.
- That I am able to bring a support person to my interview should I choose to do so.
- That I may withdraw my data at any time
- That if I reveal something in my interview with Grace that indicates that I may be in danger of hurting myself or somebody I know, Grace will have to breach confidentiality. She will make me aware before she does this.

I have been told that if I want to ask more questions about the evaluation I may contact:

Grace McNatty
DClin Psyc Candidate
Massey University
grace.mcnatty@gmail.com
08 801 5799 ext 62528

Dr Ruth Gammon
School of Psychology,
Massey University
r.gammon@massey.ac.nz
08 801 5799 ext 62029

The *postal address* is:
Psychology Clinic
Massey University
24 King Street
PO Box 756
Wellington 6140

Massey University
PSYCHOLOGY CLINIC, WELLINGTON

Caregiver Consent Form

I agree to participate in this study.

I (full name) .....
hereby consent to take part in this study.

I consent to my interviews being audio-recorded.....YES / NO

Name of Youth Under My Care (please print): .....

Age of Youth.....

I consent to this youth participating in this study..... YES / NO

I consent to this youth's interview being audio-recorded..... YES / NO

Signature: ..... **Date**: .....

Address and phone number where I may be contacted:

Street number and name: .....

Town and postcode:.....

Phone number:.....

I would like to receive a copy of the results ..... YES / NO
(There may be a long delay between when you take part and when the results are available)

Please send the results to (email or postal address if different than above):

.....

.....

I have had this project explained to me by:.....

Thank you so much for considering taking part in this study!
We are extremely grateful for your input.

This study has received ethical approval from the
Health and Disability Ethics Committee of New Zealand

Appendix K: Information Sheet and Assent Form for Youths

Massey University
PSYCHOLOGY CLINIC, WELLINGTON

Wraparound and the Theory of Change
Information Sheet and Assent Form for Youth

What is the Project About?

Massey University and the [redacted] team want to know about the wraparound service used with young people and their families. In particular, we want to know what (if any) changes have happened for you and your family/whanau since you started using the wraparound service. We also want to know what the young people and families using wraparound think about the service they are being given. We will be asking you questions about how much you feel like your wraparound team and community help you, your thoughts on how well you handle different situations and how you feel about yourself. What you choose to tell us is completely up to you. What you tell us will help the [redacted] team to help you, other people your age and their families using wraparound.

What do I do in the Project?

1. Your group facilitator at [redacted] will ask you to fill out a short survey which asks you yes or no questions like "Do you help make the decisions about your wraparound plan?" This will be filled out at [redacted] before you commence a wraparound meeting (or another time that suits you) and will take around 10 minutes.

2. [redacted] at [redacted] or your group facilitator at [redacted] will call you to set up a time to meet in person so that Grace, a Doctoral student from Massey University can ask you some questions about wraparound.

3. After you have set up a time with [redacted] your interview will take place. This interview could take place at [redacted] your home, or anywhere else that is easiest for you. You are welcome to bring a support person to this interview if you choose. One of the questions Grace asks you might be "What were your original team goals for the wraparound process?" The meeting with Grace will take around an hour and a half. **There are no right or wrong answers to either the questions Grace asks you or the questions in the survey.**

Please note: The meeting with Grace will be audio [redacted] recorded. This is so that Grace can make sure that she hasn't missed anything you have said and to help her to write down what you tell her. Nobody will have access to these [redacted] audio recordings apart from Grace, two team members from [redacted] and Grace's supervisors (sort of like teachers). The recordings will be deleted after Grace has written down what you and her talked about together. Please keep in mind that if you choose to have the interview at home, other family/whanau members or friends at home who enter the interview will be recorded too.

Massey University
PSYCHOLOGY CLINIC, WELLINGTON

Anything they say will be kept private. If you choose to interview at home, it might be a good idea to let everybody at home know that your interview is taking place, and when that is.

All of the things you tell Grace in the interview will be kept private and no one outside of the research team will know what you have said (not even your parents or caregiver). We will not tell anybody anything that you have said that can be directly identified as being said by you (like your name or where you go to school).
Your caregiver who takes part in wraparound with you will also be interviewed for this project. Your caregiver will be answering the same questions as you answer in their interview. The answers that your caregiver gives us in their interview will also be kept private. We will not be able to give you any of their answers, just as we will not give them any of yours.

If you agree to participate, please remember the following things:

1. You may stop the survey or interview at any time, and doing so will not affect any of the services you are currently involved with.
2. You are allowing the researcher (Grace) to audio [redacted] record you during your interview.
3. Anything you say will be kept private and confidential. Nobody apart from the researchers will know how you answered the questions.
4. The information you tell Grace in the interview will help improve services for other people your age.

If you have ANY questions at all, please feel free to contact:

Grace McNatty
DClin Psyc Candidate
Massey University
grace.mcnatty@gmail.com
08 801 5799 ext 62528

Dr Ruth Gammon
School of Psychology
Massey University
r.gammon@massey.ac.nz
08 801 5799 ext 62029

Our *postal address* is:
Psychology Clinic
Massey University
24 King Street
PO Box 756
Wellington 6140

Massey University
PSYCHOLOGY CLINIC, WELLINGTON

Youth Assent Form

I have read and I understand the information above for youth who wish to take part in this study. I understand that I have had the opportunity to use family/whanau support or a friend to help me ask questions and understand the study. I am happy with the answers that I have been given. I understand what participation in this study means for me and I have had the time to consider whether to take part.

I have been told that if I want to ask more questions about the evaluation who I can contact.

If you still agree to participate, please sign below:

Name (please print): .....

Signature:..... **Date**:.....

I agree to my interview being audio-recorded: ..... YES / NO

I have had this study explained to me by:.....

Thank you so much for considering taking part in this study!
We are extremely grateful for your contribution.

This study has received ethical approval from the
Health and Disability Ethics Committee of New Zealand

Appendix L: Information Sheet for Wraparound Facilitators

Massey University
PSYCHOLOGY CLINIC, WELLINGTON

Wraparound and the Theory of Change: Information Sheet for Group Facilitators

An Investigation into what promotes the changes within wraparound as proposed by the Theory of Change for Families in New Zealand

The Research Study

This study is a joint project between Massey University and the [redacted] wraparound team. Massey University and [redacted] are committed to providing high-quality care to young people and families.

You are invited to take part in a voluntary study which is designed to help us explore:

1. The outcomes or changes (if any) the family you are working with have experienced since beginning the wraparound process, and;
2. The quality and integrity of wraparound service provided to that family.

The focus is on getting the perspectives from families relating to how their lives have changed since starting wraparound.

If you accept this invitation, you (the group facilitator) will be asked to complete a short survey. These surveys help to identify the quality and integrity of the wraparound service you have been involved with for the chosen family. This survey should take around 10 minutes to complete.

The Researcher

The primary investigator is Grace McNatty. She is a Doctoral Clinical Psychology student at the Massey University campus in Wellington. She is currently in her first year of Doctoral Study, her 8th year of studying psychology altogether. She has a Bachelor's and Master's degree from Canterbury University that both major in Psychology also. Her supervisors for this project are Dr. Ruth Gammon, Dr. Ruth Tarrant and Dr. Keith Tuffin (all from the Massey School of Psychology).

Who Can Take Part?

Any group facilitator participating in wraparound with a family can take part. Preferably the family will be in the third or fourth phases of the wraparound process.

Taking part in this study is voluntary. It is completely your choice whether you take part in this research study or not. If you do not wish to participate, you are welcome to say no. It would be greatly appreciated if you decide to help us to improve wraparound by participating.

What Are My Rights as a Participant?

You are under no obligation to accept this invitation. If you do decide to participate you have the right to:

- Decline to answer any particular question
- Withdraw from the study during the survey (or within 1 week of data being collected)
- Ask any questions about the study at any time during participation or before commencement
- Provide information with the understanding that your name will not be used unless you give permission to the researcher
- Be given access to a summary of the findings from the project when it has concluded

Massey University
PSYCHOLOGY CLINIC, WELLINGTON

What is Involved?

You will be asked to complete a short survey asking you to answer to what extent you 'agree or disagree' with statements about the wraparound process you have been involved with. An example of one of the statements in the short survey is, "The wraparound team's decisions are based on input from the family." **There are no right or wrong answers to the questions in the survey.**

The survey will be given to you by [redacted] at [redacted] and may be filled out at your leisure before giving it back to her.

Are There any Benefits or Risks?

There are minimal to no risks to participants who take part in this study.

The central benefit is that you will assist your [redacted] team and future teams who implement wraparound in New Zealand. Your contribution will help to contribute to your own and others awareness of the changes that occur in families and youths with high and complex needs when engaged with wraparound. Your participation will also help the researchers to gather information so that other wraparound initiatives in future will deliver the best possible service to families and youths who need it.

You get a voice for how the wraparound process is helping the family you are involved with. These surveys provide you with an opportunity to directly and independently express your experiences with the wraparound process and do so in confidence.

What Happens to the Information I Provide?

The things you share in the survey will be kept confidential and used for research purposes only. Grace will analyse the information that you provide her with.

Information resulting from the surveys may be used for presentations at academic conferences or journal articles. No names or any other identifying information will be used in these presentations or articles.

All data resulting from survey responses will be securely stored at Massey University. Data will be stored for ten years after the youth respondents have turned 16. After this time, data will be destroyed.

It is very important to note that **all data will be anonymous**. No material that identifies you or anybody in the family you are working with in any way will be used when reporting on this study. Information such as the names of people or places will be removed or changed. The data from your survey will be given a number and that will be used to help the researcher organise data. The only people that will have access to the data after it has been made anonymous and been coded will be Grace, her supervisors, and [redacted] and [redacted] at [redacted].

Finding out the Results of the Study

If you would like to find out the results of the study, please circle the YES option on the consent form. After the study is completed, the results will be mailed to the address you provide us with. There may be a delay between when you take part in the study and when the results of the study are known.

Massey University
PSYCHOLOGY CLINIC, WELLINGTON

Contacts for the Study

If you would like more information, have any questions, or would like to talk to someone about this research in any capacity, please feel free to contact us. Our contact details are as follows:

Grace McNatty
DClin Psyc Candidate
Massey University
grace.mcnatty@gmail.com
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Our *postal address* is:
Psychology Clinic
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24 King Street
PO Box 756
Wellington 6140

If you have any concerns about your rights as a participant in this research you can contact an independent health and disability advocate. This is a free service provided under the Health and Disability Commissioner Act. Their contact details are as follows:

Free phone (NZ wide): 0800 11 22 33
[redacted]one: 09 373 1060
[redacted]: 09 373 1061
[redacted]hdc.org.nz
Postal address: PO Box 1791, Auckland, New Zealand

If you want to talk to someone who isn't involved with the study, you can contact an independent health and disability advocate on:

Phone: 0800 555 050
Fax: 0800 2 SUPPORT (0800 2787 7678)
Email: advocacy@hdc.org.nz

Thank you so much for considering taking part in this study!
We are extremely grateful for your input.

This study has received ethical approval from the
Health and Disability Ethics Committee of New Zealand.

Appendix M: Consent Form for Wraparound Facilitators

Massey University
PSYCHOLOGY CLINIC, WELLINGTON

Wraparound and the Theory of Change: Informed consent for group facilitators

Group Facilitator Acknowledgement of Informed Consent

By signing this consent form you are agreeing to the following:

I have read and understand the information for volunteers taking part in this study. I have been given a description of this evaluation and had the opportunity to discuss this study and to ask questions about it, and these have been answered to my satisfaction. I understand that I have had the opportunity to use family/whanau support or a friend to help me ask questions to help understand the study. I understand what the procedures of this study are and have had the potential risks and benefits explained to me. I have had the time to consider whether or not I want to take part.

I understand that this study is designed to help Massey University and the [redacted] wraparound team to understand and explore: a) the outcomes the family I am working with have experienced since beginning the wraparound process and; b) the quality and integrity of wraparound service provided to that family.

I also understand the following:

- That my participation is voluntary (my choice), and that I may refuse to participate or withdraw at any time without penalty.
- That anything I say will remain confidential and material which could identify me will not be used in any reports on this study. All identifying information will be removed and only group results will be reported.
- That the findings from this study may eventually be published.
- That I am able to bring a support person to my interview should I choose to do so.
- That I may withdraw my data at any time.

I have been told that if I want to ask more questions about the evaluation I may contact:

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08 801 5799 ext 62528

Dr Ruth Gammon
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Massey University
24 King Street
PO Box 756
Wellington 6140

Massey University
PSYCHOLOGY CLINIC, WELLINGTON

Group Facilitator Consent Form

I agree to participate in this study.

I (full name) .....
hereby consent to take part in this study.

I consent to participating in this study..... YES / NO

Signature: ..... **Date**: .....

Address and phone number where I may be contacted:

Street number and name: .....

Town and postcode: .....

Phone number: .....

I would like to receive a copy of the results..... YES / NO
(There may be a long delay between when you take part and when the results are available)

Please send the results to (email or postal address if different than above):

.....

.....

I have had this project explained to me by: .....

Thank you so much for considering taking part in this study!
We are extremely grateful for your input.

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Health and Disability Ethics Committee of New Zealand

Appendix N: Information Sheet for Team Members

Massey University
PSYCHOLOGY CLINIC, WELLINGTON

Wraparound and the Theory of Change: Information Sheet for Team Members

An Investigation into what promotes the changes within wraparound as proposed by the Theory of Change for Families in New Zealand

The Research Study

This study is a joint project between Massey University and the [redacted] wraparound team. Massey University and [redacted] committed to providing high-quality care to young people and families.

You are invited to take part in a voluntary study which is designed to help us explore:

1. The outcomes or changes (if any) the family you are working with have experienced since beginning the wraparound process, and;
2. The quality and integrity of wraparound service provided to that family.

The focus is on getting the perspectives from families relating to how their lives have changed since starting wraparound.

If you accept this invitation, you (the team member) will be asked to complete a short survey. These surveys help to identify the quality and integrity of the wraparound service you have been involved with for the chosen family. This survey should take around 10 minutes to complete.

The Researcher

The primary investigator is Grace McNatty. She is a Doctoral Clinical Psychology student at the Massey University campus in Wellington. She is currently in her first year of Doctoral Study, her 8th year of studying psychology altogether. She has a Bachelor's and Master's degree from Canterbury University that both major in Psychology also. Her supervisors for this project are Dr. Ruth Gammon, Dr. Ruth Tarrant and Dr. Keith Tuffin (all from the Massey School of Psychology).

Who Can Take Part?

Any team member participating in wraparound with a family can take part. Preferably the family will be in the third or fourth phases of the wraparound process.

Taking part in this study is voluntary. It is completely your choice whether you take part in this research study or not. If you do not wish to participate, you are welcome to say no. It would be greatly appreciated if you decide to help us to improve wraparound by participating.

What Are My Rights as a Participant?

You are under no obligation to accept this invitation. If you do decide to participate you have the right to:

- Decline to answer any particular question
- Withdraw from the study during the survey (or within 1 week of data being collected)
- Ask any questions about the study at any time during participation or before commencement
- Provide information with the understanding that your name will not be used unless you give permission to the researcher
- Be given access to a summary of the findings from the project when it has concluded

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What is Involved?

You will be asked to complete a short survey asking you to answer to what extent you 'agree or disagree' with statements about the wraparound process you have been involved with. An example of one of the statements in the short survey is, "The wraparound team's decisions are based on input from the family." **There are no right or wrong answers to the questions in the survey.**

The survey will be given to you by the wraparound facilitator at the beginning of a wraparound meeting and may be filled out at your leisure before being given back to them.

Are There any Benefits or Risks?

There are minimal to no risks to participants who take part in this study.

The central benefit is that you will assist the [redacted]am and future teams who implement wraparound in New Zealand. Your contribution will help[redacted]nd others to modify and be aware of what contributes to the changes that occur in families and youths with high and complex needs when engaged with wraparound. Your participation will also help us to gather information so that other wraparound initiatives in future will deliver the best possible service to families and youths who need it.

You get a voice for how the wraparound process is helping the family you are involved with. These surveys provide you with an opportunity to directly and independently express your experiences with the wraparound process and do so in confidence.

What Happens to the Information I Provide?

The things you share in the survey will be kept confidential and used for research purposes only. Grace will analyse the information that you provide her with.

Information resulting from the surveys may be used for presentations at academic conferences or journal articles. No names or any other identifying information will be used in these presentations or articles.

All data resulting from survey responses will be securely stored at Massey University. Data will be stored for ten years after the youth respondents have turned 16. After this time, data will be destroyed.

It is very important to note that **all data will be anonymous**. No material that identifies you or anybody in the family you are working with in any way will be used when reporting on this study. Information such as the names of people or places will be removed or changed. The data from your survey will be given a number and that will be used to help the researcher organise data. The only people that will have access to the data after it has been made anonymous and been coded will be Grace, her supervisors, and a team member from the [redacted]

Finding out the Results of the Study

If you would like to find out the results of the study, please circle the YES option on the consent form. After the study is completed, the results will be mailed to the address you provide us with. There may be a delay between when you take part in the study and when the results of the study are known.

Massey University
PSYCHOLOGY CLINIC, WELLINGTON

Contacts for the Study

If you would like more information, have any questions, or would like to talk to someone about this research in any capacity, please feel free to contact us. Our contact details are as follows:

Grace McNatty
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08 801 5799 ext 62528

Dr Ruth Gammon
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[redacted] 09 373 1060
[redacted] 373 1061
Email: hdc@hdc.org.nz
Postal address: PO Box 1791, Auckland, New Zealand

If you want to talk to someone who isn't involved with the study, you can contact an independent health and disability advocate on:

Phone: 0800 555 050
Fax: 0800 2 SUPPORT (0800 2787 7678)
Email: advocacy@hdc.org.nz

Thank you so much for considering taking part in this study!
We are extremely grateful for your input.

This study has received ethical approval from the Health and Disability Ethics Committee of New Zealand.

Appendix O: Consent Form for Team Members

Massey University
PSYCHOLOGY CLINIC, WELLINGTON

Wraparound and the Theory of Change: Informed consent for team members

Team Member Acknowledgement of Informed Consent

By signing this consent form you are agreeing to the following:

I have read and understand the information for volunteers taking part in this study. I have been given a description of this evaluation and had the opportunity to discuss this study and to ask questions about it, and these have been answered to my satisfaction. I understand that I have had the opportunity to use family/whanau support or a friend to help me ask questions to help understand the study. I understand what the procedures of this study are and have had the potential risks and benefits explained to me. I have had the time to consider whether or not I want to take part.

I understand that this study is designed to help Massey University and the [redacted] wraparound team to understand and explore: a) the outcomes the family I am working with have experienced since beginning the wraparound process and; b) the quality and integrity of wraparound service provided to that family.

I also understand the following:

- That my participation is voluntary (my choice), and that I may refuse to participate or withdraw at any time without penalty.
- That anything I say will remain confidential and material which could identify me will not be used in any reports on this study. All identifying information will be removed and only group results will be reported.
- That the findings from this study may eventually be published.
- That I am able to bring a support person to my interview should I choose to do so.
- That I may withdraw my data at any time.

I have been told that if I want to ask more questions about the evaluation I may contact:

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Dr Ruth Gammon
School of Psychology,
Massey University
r.gammon@massey.ac.nz
08 801 5799 ext 62029

Our *postal address* is:
Psychology Clinic
Massey University
24 King Street
PO Box 756
Wellington 6140

Massey University
PSYCHOLOGY CLINIC, WELLINGTON

Team Member Consent Form

I agree to participate in this study.

I (full name) .....
hereby consent to take part in this study.

I consent to participating in this study ..... YES / NO

Signature: ..... **Date**:.....

Address and phone number where I may be contacted:

Street number and name: .....

Town and postcode:.....

Phone number: .....

I would like to receive a copy of the results..... YES / NO
(There may be a long delay between when you take part and when the results are available)

Please send the results to (email or postal address if different than above):

.....

.....

I have had this project explained to me by:.....

Thank you so much for considering taking part in this study!
We are extremely grateful for your input.

This study has received ethical approval from the
Health and Disability Ethics Committee of New Zealand

Appendix P: Internship Case Study

Student ID 13119066

Wraparound and the Theory of Change:

A case study of research and reflection

Grace Ellexandra Dunnachie McNatty

Massey University DClinPsyc Candidate

Intern Psychologist at Adult Community Outpatients and
Child and Adolescent Mental Health Services

Taranaki District Health Board

This case study represents the research of Grace McNatty during the first two years of the DClinPsyc program and the resultant reflections during her internship in 2016.

Abstract

The aim of the present study was to explore the changes that young people with high and complex needs and their families' experience through involvement with a Wraparound process, also, to investigate if these changes aligned with those proposed by the Wraparound Theory of Change (WTOC; Walker, 2008). While there has been qualitative work done within the area of Wraparound, few studies have adopted IPA. Further, little Wraparound work has been done within the context of Aotearoa New Zealand. Finally, the WTOC is yet to be assessed and thus remains a theory. A fidelity measure was administered and semi-structured interviews took place with five young people and six caregivers at the New Zealand Wraparound Program (NZWP) in the 'plan implementation and refinement' (third) phase of Wraparound. Findings indicated NZWP families experienced changes in the areas of family connectedness, psychological acceptance, self-efficacy, and supports. These findings were related to the pathways to change proposed by the WTOC which include (1) enhanced effectiveness of services and supports, individually and as a "package" and leading to increased commitment to engage with services and (2) increased resources and capacity for coping, planning and problem solving. Findings suggest the WTOC is accurate in its predictions for how changes come about for families involved in a Wraparound process. Such research supports future Wraparound refinement and evaluation. Additional international qualitative longitudinal research exploring

change is required with young people and caregivers involved in Wraparound.

A reflection during the internship year was undertaken by the researcher as to the impacts of Wraparound research in clinical practice. The internship took place within a multidisciplinary team for adults, children and adolescents and the researcher found multiple similarities between the Wraparound team and the multidisciplinary team which are discussed.

Wraparound

Wraparound is an ecologically based process and approach to care planning, building on the collective actions of a committed group of family, friends, community, professional, and cross-system supports. The process gathers resources and talents from a variety of sources resulting in the creation of a plan of care, that is the best fit between the family vision and story, team mission, strengths, needs, and strategies (Bruns et al., 2004; VanDenBerg et al., 2008). Services and supports lead to the collection of various resources and talents for the family. The services and supports work as a team to produce a care plan that, importantly, is driven and owned by the family and the youth. The team continually monitors the individualised plan and adapts it as needed (Bruns et al., 2008).

While Wraparound programs vary internationally, an evidence-based model has been established by the National Wraparound Initiative (NWI: Walker, Bruns, Conlan, & Laforce, 2011). According to their model, the planning process is based on 10 philosophical principles and four phases that offer a guideline for which activities need to be completed through the Wraparound process (Burchard et al., 2002). The 10 philosophical principles encompassing the Wraparound process are: (1) family voice and choice, (2) team-based, (3) natural supports, (4) collaboration, (5) community-based, (6) culturally competent, (7) individualised, (8) strengths-based, (9) persistence and (10) outcome-based (Bruns et al., 2004). The four activity phases of wraparound are (1) an introduction to the activities of Wraparound; (2) initial plan development; (3) plan implementation and refinement; and (4) transition (Bruns et al., 2004; VanDenBerg & Grealish, 1996). Table 1 taken from

Shailer and colleagues (2013) details each of the Wraparound principles developed by the NWI.

Table 1

Ten Principles of the Wraparound Process

Principle	Description
1. Family voice and choice	Family and youth/child perspectives are intentionally elicited and prioritised during all phases of the Wraparound process. Planning is grounded in family members' perspectives, and the team strives to provide options and choices such that the plan reflects the family values and preferences.
2. Team based	The Wraparound team consists of individuals agreed upon by the family and committed to them through informal, formal, and community support and service relationships.
3. Natural supports	The team actively seeks and encourages the full participation of team members drawn from family members' networks of interpersonal and community relationships. The Wraparound plan reflects activities and interventions that draw on sources of natural support.
4. Collaboration	Team members work cooperatively and share responsibility for developing, implementing, monitoring, and evaluating a single Wraparound plan. The plan reflects a blending of team members' perspectives, mandates, and resources. The plan guides and coordinates each team member's work towards meeting the team's goals.
5. Community-based services	The Wraparound team implements service and support strategies that take place in the most inclusive, most responsive, most accessible, and least restrictive settings possible; and that safely promote child and family integration into home and community life.
6. Culturally competent	The Wraparound process demonstrates respect for and builds on the values, preferences, beliefs, culture, and identity of the child/youth and family, and their community.

7. Individualised	To achieve the goals laid out in the Wraparound plan, the team develops and implements a customized set of strategies, supports, and services.
8. Strengths based	The Wraparound process and the Wraparound plan identify, build on, and enhance the capabilities, knowledge, skills, and assets of the child and family, their community, and other team members.
9. Persistence	Despite challenges, the team persists in working toward the goals included in the Wraparound plan until the team reaches agreement that a formal Wraparound process is no longer required.
10. Outcome-based service	The team ties the goals and strategies of the Wraparound plan to observable or measurable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly.

A Theory of Change for Wraparound

The Wraparound Theory of Change (WTOC) is a recent model which proposes how desired outcomes from Wraparound occur (Walker, 2008a). The WTOC describes how and why the Wraparound model is effective and has evolved from historical models of team behaviours and processes over time (Walker & Matarese, 2011).

For the development of the WTOC, Walker (2008a) conducted a literature review based on principles and areas related to mechanisms of change in behaviour (Walker & Matarese, 2011). Fields related to change included self-efficacy, social support, empowerment, optimism, resilience, teamwork and collaboration (Walker & Matarese, 2011). Through this work, Walker (2008) was able to predict the types of outcomes families may gain through wraparound, and how team behaviours might be linked to these

outcomes through a causal chain (Walker & Matarese, 2011; Walker & Schutte, 2005). What resulted was the WTOC (Walker, 2008a).

For the WTOC to be realised, it is assumed Wraparound has been delivered as a service in its truest form, adhering to the ten Wraparound principles and four phases as closely as possible (Walker & Matarese, 2011). In achieving the long-term goals from Wraparound, the WTOC predicts families experience two interacting 'routes' on their path to these life changes. These routes are seen in the WTOC as 'Intermediate Outcomes' (Walker and Matarese, 2011).

The WTOC prioritises outcomes which are not often measured, namely the Intermediate Outcomes or pathways to change. The Intermediate Outcomes in the WTOC are an enhanced effectiveness of services and supports, individually and as a package; and increased resources, self-efficacy, social support and achievement of team goals. Intermediate outcomes are proposed to come about due to short-term outcomes and Wraparound processes, as well as reinforcing short- and long-term outcomes, in a constant, iterative cycle (Walker, 2008a). The WTOC suggests not measuring these significant outcomes may underestimate the usefulness of Wraparound, as intermediate outcomes and their impacts on short- and long-term Wraparound outcomes can change the lives of youths and their families (Walker, 2008a; Walker & Matarese, 2011). That is, Wraparounds' intermediate outcomes need assessment because the WTOC has not been tested, therefore remains a theory (Bertram et al., 2011). This study evaluates the changes young people and their families experience through the Wraparound process, and examines if these changes can be attributed by the 'Intermediate Outcome' or pathway to change

of enhanced effectiveness of services and supports, individually and as a package.

New Zealand Wraparound Program

The New Zealand Wraparound Program (NZWP) provides Wraparound to high and complex needs young people and their families in a large metropolitan city in New Zealand. To be eligible to receive Wraparound support from the NZWP, clients must meet the following criteria: be between 6 and 17 years old; have a serious mental health problem; and/or have ongoing/active Child, Youth and Family Services (CYFS) and/or Child and Adolescent Mental Health Service (CAMHS) involvement. They must also meet one of the following: have an escalating pattern of multiple risk behaviours; have multiple home/living placements within the past 6-12 months, have worked with multiple health and social services and require active service coordination to develop and manage the number and complexity of services; unable to have their needs met by the usual network of health and social services; require a more intensive level of mental health clinical services than can be provided by CAMHS; circumstances placing the family or caregivers under extreme stress; or were under custody of CYFS (New Zealand Wraparound Program, 2006). The name of the service has been changed to protect identity of the clients.

Research Questions

1. Does the NZWP adhere to satisfactory fidelity ratings to ensure their service delivery is wraparound as described by the NWI's model of Wraparound?

2. What outcomes are achieved from the Wraparound process as perceived by families?
3. To what extent do the described outcomes of Wraparound align with the intermediate outcomes (also known as ‘pathways to change’) as proposed by the Wraparound Theory of Change?

Aim

The current research aims to advance an understanding of how and why Wraparound performs. Knowing more about how the pathways operate within Wraparound will contribute to future refinement of the Wraparound practice and more effective ways to measure outcomes (Bertram et al., 2011; Bruns & Walker, 2011; Walker & Matarese, 2011; Walker, 2008a).

Method

This study was approved under the full review pathway by the Health and Disability Ethics Committees of New Zealand.

Procedure

The principle researcher of this study convened with the Clinical Case Coordinator at NZWP who assisted in identifying all families involved in their third (plan implementation and refinement) or fourth (transition) phases of Wraparound. These phases were selected because families would have been involved with Wraparound for at least 90 days (as required by the fidelity measure described below and to ensure families had been involved with Wraparound for a satisfactory amount of time). The NZWP Clinical Case Coordinator convened with each family’s Wraparound Facilitator to assess their suitability for inclusion in the study. All families available for the study were coincidentally in the third

phase of Wraparound resulting in no participants in the fourth phase of Wraparound.

In order to explore if the families involved in the study had been involved with a true Wraparound process as intended by the NWI, a fidelity measure (described below) was completed by participants privately and returned in individual sealed envelopes to the NZWP Clinical Case Coordinator who returned them unopened to the researcher.

Measure

Wraparound fidelity was assessed using a 37-item self-report questionnaire called the Wraparound Fidelity Index – Short Version (WFI-EZ), a succinct version of the Wraparound Fidelity Index, version 4 (WFI-4). The WFI-4 is a semi-structured interview conducted with four team members involved in the Wraparound process: (1) youth (aged 11 and over); (2) parents or caregivers; (3) Wraparound Facilitator and (4) another team member (Bruns et al., 2009). The WFI-EZ is a relatively new and valid and reliable measure of adherence to Wraparound principles which is less time consuming than the WFI-4. The WFI-EZ has strong internal consistency (Cronbach's Alpha = .937; Sather, Bruns, & Hensley, 2012). With regards to validity, the correlation of total scale scores from the 37 WFI-EZ items with total scores from WFI-4 interviews is significant at $p=.001$, $r(42) = .548$, (Bruns et al., 2012; Sather et al., 2012). The WFI-EZ covers four sections including basic information, experiences with Wraparound, perception of outcomes and satisfaction with services. There are yet to be peer-reviewed adherence norms created for the WFI-EZ, as such, there is currently no singular minimum fidelity score that deems families have been involved with a

‘true’ Wraparound process. However, Key Element Scores compared favourably to USA national means, surpassing USA means in each key Wraparound process. As such, the results indicated satisfactory adherence to key Wraparound processes by the NZWP for this study. The measure took on average ten minutes to complete. According to the WFI-EZ manual and WrapTrack, as 3 of the 6 youth answered more than 8 of their WFI-EZ items with “Don’t know”, this accordingly represents “missing substantial data”. Overall WFI-EZ scores are as such seen to be compromised (Sather et al., 2013). Fortunately, due to the high completion rate of the WFI-EZ forms from each of their caregivers, Wraparound Facilitators, and Wraparound Team Members (with no other participants responding with 8 or more “Don’t know”), their WFI-EZ Key Element and Total Fidelity Scores continued to have internal consistency and were still useful data to include in the study (Sather et al., 2013).

Participants

One young person chose not to go on to be interviewed and their interview was attended only by their caregiver, resulting in five youths and six caregivers being interviewed. Their data is included in the following participant information of interviewees.

Participants included two male, three female and one transgender youth and their caregivers. Youths were aged between 12 and 17 with a mean age of 15.5. With reference to ethnicity, three youths identified themselves as Māori; one as New Zealand European/Māori; one as British and one as South African. Mental health and behavioural concerns experienced by the youths included aggression, anorexia nervosa, attachment issues, attention deficit hyperactivity disorder,

criminal offending, depression, encopresis, enuresis, gender identity issues, learning difficulties, partial seizures, self-harm, sexual abuse, social phobia, substance abuse and suicidality. All participant names have been changed to protect confidentiality. Families involved with the study were yet to complete their Wraparound process, with length of involvement ranging from five to 18 months.

Interviews

Semi-structured interviews were conducted and informed by the WTOC were conducted (Walker, 2008a). Enquiry encompassed changes in familial, community and service relationships, problem-solving and coping strategies, self-perception, and interpretations of Wraparound strengths and weaknesses (e.g. what changes have you noticed in your life since beginning Wraparound? What did you hope to gain from Wraparound?). Interviews occurred with caregivers and youths separately, where possible, however some youths chose to be interviewed with caregivers present. All interviews were audio recorded and then transcribed for analysis.

Analysis

Interpretive Phenomenological Analysis (IPA) was selected for analysis of interviews. IPA resulted in a set of subordinate and superordinate themes. Associated subordinate themes were grouped together and recurrently checked against the transcript in an iterative process. The primary researcher was repeatedly checking her sense-making against participant accounts. A table of themes was produced, identifying clusters of themes attempting to capture participant responses to each particular theme. These clusters were then each

given names, signifying superordinate themes. After subordinate and superordinate themes had been produced, those related to the pathway in the WTOC describing increased capacity for coping, planning and problem solving were extracted and are presented as follows.

Findings

After completing the Interpretative Phenomenological Analysis (IPA), five superordinate themes were identified: changes in the family unit, changes in psychological acceptance, changes in self-efficacy, and changes in supports. As suggested by Braun and Clarke (2006), each theme has superordinate themes to help give structure to subordinate themes and to demonstrate the level and depth of findings within each theme. These themes are displayed in Table 3.

Answering the Research Questions

Research Question One: Does the NZWP adhere to satisfactory fidelity ratings to ensure their service delivery is Wraparound as described by the NWI's model of Wraparound?

The fidelity percentage ratings obtained in this study are displayed in Table 1 and 2.

Table 1

Participant Key Element Scores with Means and USA National Means

	Key Element Scores				
Youth**	Effective teamwork	Natural/ Community supports	Needs-based	Outcomes-based	Strength-and-family-driven
1*	67.5	72.5	75.0	77.5	77.5
2	77.5	85.0	72.5	78.9	81.6
3	77.5	65.0	86.1	76.4	81.3
4*	78.6	80.0	90.0	88.3	85.0
5	76.3	68.4	68.4	78.9	68.4
6*	82.7	50.0	64.3	83.3	75.0
Mean	76.7	70.2	76.1	80.2	78.1
USA Mean	72.7	67.0	68.8	76.6	80.6

*Missing substantial data - 8 or more items answered “don’t know”

**WFI-EZ scores are combined from forms completed by the Youth, Caregiver, Wraparound Facilitator and Wraparound Team Member to give one WFI-EZ fidelity score for each Youth

The Total Fidelity Score (the overall average of Key Element Fidelity Scores) was also calculated for each of the six youths in this study. Table 2 shows the Total Fidelity scores for youths in Part A. The USA means for Total Fidelity Scores were unavailable at time of data analysis and as such are not displayed here.

Table 2

Part A: Total Fidelity Scores for Participants Partaking in Wraparound at the New Zealand Wraparound Program

Youth**	Adherence to Wraparound as determined by WFI-EZ (%)
1*	74.0
2	79.1
3	77.1
4*	84.5
5	72.1
6*	70.7
Mean	76.3

*Missing substantial data - 8 or more items answered “don’t know”

**WFI-EZ scores are combined from forms completed by the Youth, Caregiver, Wraparound Facilitator and Wraparound Team Member to give one WFI-EZ fidelity score for each Youth

There are yet to be peer-reviewed adherence norms created for the WFI-EZ, however WFI-EZ is shown to be a reliable and valid measure, comparable to the WFI-4, upon which it is based. An average of the WFI-EZ WrapTrack norms was calculated in October of 2014 and adherence percentages compared favourably to USA national means, surpassing USA means in all but one key Wraparound process. These results indicated satisfactory adherence to key Wraparound processes by the NZWP in this study.

According to the WFI-EZ manual and WrapTrack, as 3 of the 6 youth answered more than 8 of their WFI-EZ items with “Don’t know”, this accordingly represents “missing substantial data”. Overall WFI-EZ scores are as such seen to be compromised (Sather et al., 2013). Fortunately, due to the high completion rate of the WFI-EZ forms from each of their caregivers, Wraparound Facilitators, and Wraparound Team Members, their WFI-EZ Key Element and Total Fidelity Scores continued to have internal consistency and were still useful data to include in the study (Sather et al., 2013). Further, the exclusion of participants in interviews for Part B for any reason would undermine research that aims to be inclusive and investigate individual experiences of a Wraparound process from the voice of those who have themselves experienced it. Thus, all youths and their caregivers were invited to be interviewed for Part B of the study.

Research Question Two: What outcomes are achieved from the Wraparound process as perceived by families?

After the researcher completed the Interpretative Phenomenological Analysis (IPA), four superordinate themes were identified, which all related to change in a Wraparound process. These themes were changes in the family unit,

psychological acceptance, changes in self-efficacy and changes in supports. As mentioned, each superordinate theme has subordinate themes to help give them structure and to demonstrate the level and depth of findings within each theme (Braun & Clarke, 2006). Along with descriptions of each in previous chapters, the superordinate themes and their corresponding subordinate themes found in this study are displayed in Table 1.

Table 1

Findings: IPA Themes Identified by WTOC Interviews

Superordinate IPA Themes	Subordinate IPA Themes
Changes in family unit	Connectedness
Psychological acceptance	Understanding selves
	Understanding others
Changes in self-efficacy	Confidence
Changes in supports	Clarity
	Feeling unheard and overwhelmed
	Friends, neighbourhood
	Personalisation
	Wraparound team

Families were spoke about many positive changes they were able to experience as a result of involvement in a Wraparound process. Caregivers and youths developed stronger relationships with each other and their wider family members, they were able to learn more about each other and themselves which afforded them a level of acceptance and understanding about their past and future, they developed confidence in many areas of their lives, and they gained new supports from services on their Wraparound team. These positive changes were

also helpful in families making other changes in their lives related to home-living, academia, mental and physical health, and reduction in criminal activity.

Related to supports, young people felt unheard at times by the Wraparound team in meetings. They also found it difficult to connect with their peers even though this was desired. Young people and caregivers felt overwhelmed at times by the number of people in attendance at Wraparound meetings. These factors did not appear to impact their engagement with Wraparound or commitment to continue with the process due to the many other positives they spoke about such as those described above. Families were impressed with the individualised nature of their Wraparound process, the clarity of team plans and follow-through of these plans leading to them feeling more motivated and committed to remain involved. According to the WTOC, the support given to families by way of individualised programs, clarity and follow-through indicate that services and support strategies have matched the functional strengths of the family and have been specifically designed to address their identified needs; which should lead to improved access, engagement, retention and commitment to services by families (Walker, 2008a).

In Chapter Six, Jaden's caregiver demonstrated increased self-efficacy in feeling able to move forward with, plan and cope with their lives. However, as described in Chapter Five, some families felt such relevant and positive support from the Wraparound Team they did not yet feel ready or capable to continue on without Wraparound. These results suggest positive increases in support from a Wraparound process but slower increases in self-efficacy. As discussed, it will be useful for Wraparound services such as the NZWP to continue to adhere to Wraparound principles such as strengths-based, family voice and choice, community-based and natural supports so that families may continue to develop

autonomy and feelings of success and take these through with them to their lives post-Wraparound. Further, it may be beneficial for Wraparound teams to discuss issues of age-determined closure in the planning phases of Wraparound for caregivers that are not yet aware that Wraparound ends for youths at the age of 18 (unless under the continued care of CYFS, ending age 20), as specified by the Aotearoa New Zealand Government agency Child, Youth and Family (discussed under 'The New Zealand Wraparound Program' in Chapter Two). Qualitative research conducted in New Zealand indicated that young people with high and complex needs and their caregivers who experienced a transition of care value pre-transition information, being listened to, family involvement, culturally appropriate care, and follow-up care after the transition (Embrett et al., 2015; Geary et al., 2011; Munford & Sanders, 2015). Impacts of fragmented transition of care can result in young people moving back and forth between a state of dependence and independence, and in some cases a perceived lack of caring from their caregivers (Rogers, 2011). Such findings suggest that the topic of youth and their families transitioning out of Wraparound needs special consideration (Haber et al., 2012). According to the NWI, a high-quality, high fidelity Wraparound will focus on transition during the initial engagement activities (Walker et al, 2008a).

Research Question Three: To what extent do the described outcomes of Wraparound for families align with the intermediate outcomes as proposed by the Wraparound Theory of Change?

Diagrams or theories tend to denote a linear or left-to-right process. The uniqueness of families within Wraparound paired with an ever-developing plan and multiple strategies contributes to a complex series of progressions. Such progressions may travel in more directions than can be explained by a theory or

diagram (Walker, 2008a). In this instance, the intermediate outcomes of the Wraparound Theory of Change relate to one another and are not able to be completely teased apart. Each time one outcome is strengthened, the other may become stronger also. In this way, the Wraparound process involves a complex loop, continually strengthening each individual concept, resulting in the continual strengthening of each intermediate pathway. This recirculating and reinforcing of pathways demonstrates that the phenomena that take place within a family during the process of Wraparound are unlikely to be able to be assessed in entirety. Therefore, this study is limited by the extent to which it is able to assess the WTOC as it is unlikely any diagram or related research would be able to explicitly assess or specify how families involved with Wraparound experience evolving changes in their lives.

All of the themes identified by the IPA appear to be associated with experiences of change. All themes were also associated with the changes Walker (2008a) predicts to be intermediate outcomes in the WTOC. The IPA themes associated with the pathways to change Walker (2008a) describes in the WTOC are displayed in Table 2.

Table 2

IPA Themes Associated With Intermediate Pathways of the WTOC

Intermediate pathways of the WTOC as proposed by Walker (2008a)	Superordinate IPA themes to related to intermediate pathways of the WTOC
Enhanced effectiveness of services and supports, individually and as a "package" as evidenced by:	
Choice and motivation	Changes in self-efficacy

Relevance and feasibility	Changes in supports
Shared expectations	Changes in supports
Strengths-based understanding of behaviour	Changes in self-efficacy
Whole-family focus	Changes in family unit
Increased resources and capacity for coping, planning, and problem solving as evidenced by:	
Self-efficacy, empowerment, and self-determination	Changes in self-efficacy
Social support and community integration	Changes in supports
Other	Psychological acceptance

As demonstrated by Table 2 and Chapters Five and Six, all themes identified by the IPA relate to the WTOC intermediate pathways. As described by Walker (2008a), the high-quality Wraparound team adheres to Wraparound phases and principles and the team is characterised by blended perspectives, respect for background and expertise, collaboration and creative problem solving. These characteristics not only lead to the achievement of team goals but also desired outcomes are predicted to occur via two routes or pathways to change.

One route to change in the WTOC states a unified team whose decisions are driven by the family's values, will select, access and adapt formal services and natural supports so that, as a 'package', the services and supports complement each other and work better than services and supports that are provided outside of a Wraparound process (Walker, 2008a). The collaboration of the services actually enhances each of the supports and strategies, leading to increased family commitment to and engagement with those services and supports. Increased

motivation to engage with services is predicted to come about due to a Wraparound process that emphasises choice and motivation, is relevant and feasible for the family, has shared expectations, and adopts a strengths-based understanding of behaviour and whole family perspective. Wraparound outcomes represented by themes in the IPA related to this WTOC pathway were suggested by families. Analysis identified themes of feeling supported by their Wraparound team with a personalised, clear process with a focus on their strengths; and a connectedness to the wider family. These findings map onto the concepts described by Walker (2008a) as displayed by Table 2. Although families reported a lack of peer support, this is typical in Wraparound generally and may still occur as their Wraparound process evolves. Further, although the inclusion of natural and family supports is an important Wraparound principle; it typically is less adhered to than other principles (Shailer et al., 2013; Walter & Petr, 2011).

Based on these findings, it can be suggested that change for families involved in Wraparound may come about in part due to enhanced effectiveness of services and supports, individually and as a package as predicted by the WTOC (2008a). Enhanced effectiveness of services resulted in families having improved access, commitment to and engagement with services.

The NZWP demonstrated their Wraparound program led to services and supports implementing strategies that were well matched to the functional strengths of the family to support them in the attainment of their goals and vision, with families able to meet program-specific positive outcomes that each service was designed to deliver. The findings also suggest service practitioners were able to change their approach based on information gathered through the team to address needs and build on strengths. Changes in approach by services in

Wraparound led to improved access, engagement, retention and commitment from families and higher cohesion between family needs and how their needs were addressed. To continue to evaluate this particular route to change, Walker (2008a) recommends continued assessment of caregiver and youth perceptions of service relevance, coordination and helpfulness.

The other route to change in the WTOC emphasises that family participation in a high-quality, high fidelity Wraparound process produces benefits that are largely independent from the specific services and supports that the family receives which can directly contribute to long-term positive outcomes (Walker, 2008a; Walker & Matarese, 2011). The WTOC suggests that participation in Wraparound leads to increased resources for families for coping, planning and problem solving such as improved self-efficacy, empowerment and self-determination, and social support (Walker, 2008a). In the present study, Wraparound themes related to these concepts were suggested by families. The IPA identified themes of confidence, psychological acceptance, support, and achievement of long-term positive outcomes. As with the other pathway to change, these findings map onto Walker's concepts as displayed by Table 2. Findings suggest that family participation in the NZWP with a committed, optimistic, focused, strategic and prepared team was able to build family assets through the experiencing proactive planning and coping and the reinforcement of family strengths leading to them derive new meaning from their situations and experiences (Walker, 2008a; Walker & Matarese, 2011). The NZWP and other Wraparound service providers who find lower adherence to the provision of natural supports for families may want to consider placing more emphasis on this, and continue ongoing monitoring of the achievement of this with families.

Ongoing fidelity assessment may also be beneficial as high Wraparound fidelity is predicted to be associated with more positive outcomes (Bruns et al., 2005). Further, Walker (2008a) recommends continued assessment of caregiver and youth empowerment, self-efficacy and optimism to monitor this pathway to change.

As discussed, psychological acceptance is related to self-efficacy, increased increased problem solving, and has been shown to increase the psychological resilience of youths with chronic mental health issues (Kalapurakkel et al., 2014; Snead, 2013). Psychological acceptance is also associated with better school functioning, and fewer depressive and anxiety symptoms (Sikorskii et al., 2015; Snead, 2011). In this instance, psychological acceptance appeared to be occur from a Wraparound process emphasising strengths. Although related to the concept of self-efficacy, it was seen as important by the primary researcher to include psychological acceptance as a standalone resource for coping, planning and problem-solving. Acceptance appeared supportive in the increase of self-efficacy in some instances, but was in and of itself a supportive resource for families in this study. Further, it appears increases in psychological acceptance could have also been related to achieving the long-term positive outcomes families discussed such as improvements in mental health. As such, it is predicted that increases in psychological acceptance is likely to directly lead to other long-term positive outcomes in the WTOC such as improved resilience and quality of life. Further, the researcher predicts psychological acceptance alone to endure as a long-term outcome for families as a result of participation in the Wraparound process. Psychological acceptance could be considered to be included in WTOC pathway to change emphasising increased

resources and capacity for coping, planning, and problem solving, as well as a long-term outcome. Ongoing assessment of changes in psychological acceptance is recommended in future research assessing the WTOC.

In answering Research Question Three, findings suggest that the WTOC (Walker, 2008a) is accurate in its predictions that change comes about for families in Wraparound by way of an enhanced effectiveness of services and supports, individually and collectively leading to family motivation to commit to and engage with services, as well as by way of increased resources and capacity for coping, planning and problem solving through Wraparound participation.

Families in the study experienced an enhanced effectiveness of services and supports leading to high levels of family commitment and motivation to engage with services and supports included on the Wraparound plan. Increased motivation and commitment for engagement was highlighted by family reports related to relevance and feasibility, shared expectations, a focus on strengths, and a whole-family focus. Families were also able to increase their resources and capacity for coping, planning and problem-solving in the forms of increased confidence, psychological acceptance, and slight increases in community supports. It was apparent that increases in self-efficacy and psychological were also related to positive long-term outcomes such as changes in fitness behaviour and mental health, improvements in academic functioning and reductions in criminal activity.

Based on these findings, it would be predicted by the WTOC that families in this study experienced a Wraparound process guided by NWI Wraparound principles and phases, a Wraparound process characterised by planning solving

and planning, respect for culture and expertise, collaboration, opportunities for choice, individualisation, strategy evaluation, the celebration of success and a process driven by the family. As a result, families have been able to benefit from the achievement of short-term outcomes such as team follow-through, helpful team strategies based on strengths, better service coordination, experiences of success and satisfaction with the process. It is predicted that families will continue to achieve long-term positive outcomes such as stable home placements, improved mental health, improved school functioning, increased assets and improved quality of life, among others (Walker, 2008a).

Study Limitations

It was a limitation of this study that there were no families involved who were in their fourth (transition) phase of Wraparound. Interviewing families during this phase may help to better explain the long-term changes that families experience and further determine their achievement of team goals – a suggestion for further research. It may be viewed as a limitation that during one of the interviews it was not possible to interview the youth and caregiver separately, as this was the choice of the participants. This may have resulted in less candour from both the caregiver and youth. There were also multiple extraneous variables in the immediate environment to negotiate such as the entry and exit of others and the resulting volume of interviewees. One interview also only consisted of the caregiver and not the youth as they chose not to be interviewed. These aspects may have influenced the balance of information shared between youths and caregivers. In future research it may be advantageous to engage in focused interviewing with specific participants in the Wraparound process. This may result in more open sharing of experiences from those being interviewed and a

blance of information. For the purpose of this study, it was seen as appropriate to interview caregivers and youths in the configuration of their choice. This was due to the research ethical considerations, which would have deemed it as unethical to refuse participants support in interviews from family members of their choice. For this reason, there is variation throughout interviews related to who is present, which influenced the resulting amount of input from both caregivers and youths, and the resulting findings.

Exploration of Wraparound outcomes for families at multiple Wraparound programs internationally beyond the NZWP is recommended. Due to the qualitative nature of this work and the assessment of fidelity, there is also a possibility of the Hawthorne effect being present which states that people change or improve an aspect of what they are saying or doing due to an awareness of being observed (Jung & Lee, 2015). Finally, the data were collected at one point in time. The Wraparound process involves continual personal development and as such a longitudinal study looking at the changes that families experience over time would be recommended.

Recommendations

The following recommendations will typically already be present in a Wraparound program with high adherence to the principles. However, as reported by Miles and colleagues (2011), Wraparound fidelity should not be considered synonymous with Wraparound quality; a Wraparound team or initiative that scores high on getting the basic Wraparound “steps” done may still need improvements in the quality of its work. With this in mind, adherence may have achieved at a high level by the NZWP as recorded by fidelity measures but not always have resulted in Wraparound principles being

achieved. For this reason, although they may be typical recommendations in high-fidelity Wraparound models, the following recommendations are made in light of the findings from the present research with the NZWP.

It was evident that many youths were not receiving support from their peers. This is consistent with previous research and as such, it is the recommendation of this and previous research that there be particular focus placed on the strengthening of peer supports for youths when engaged with a Wraparound service (Kernan & Morilus-Black, 2010). It is expected that this focus will also help to strengthen both intermediate outcomes in the WTOC, as the effectiveness of supports will be enhanced and social support contributing to increased resources for coping, planning and problem solving will be developed.

Concerning effectiveness of supports, it is also recommended that families have a more defined role in helping select which services be included in their Wraparound team. Also consistent with previous research (Walker et al., 2012), young people did not appear motivated to take part in Wraparound meetings, feeling unheard by the Wraparound team. Presenting opportunities for young people to make choices and voice opinions on what elements of Wraparound they feel comfortable taking part in may result in heightened motivation and involvement in Wraparound over time. By raising youth motivation and involvement, it is probable that Wraparound services and supports will become more effective for young people.

Another indicator of low motivation to take part in Wraparound meetings from both youths and their caregivers was the feeling of being

overwhelmed by the number of people attending meetings. It may therefore be necessary to place a limit on how many people are in attendance at Wraparound meetings and decide upon this number whilst in the Wraparound planning stages. These changes in decision-making processes would emphasise the Wraparound principles of family voice and choice and individualised. Inclusion of the caregivers and youths in such decisions will also ideally increase motivation in Wraparound attendance. It may also be beneficial for Wraparound teams to discuss issues of age-determined closure in the planning phases of Wraparound for caregivers that are not yet aware that Wraparound ends for youths at the age of 18, as specified by the Aotearoa New Zealand Government agency Child, Youth and Family Services (unless under extended care until the age of 20).

Clinical Implications

The emergence of philosophies such as those used in Wraparound represents a postmodern paradigm shift in family therapy. Family therapists over time have embraced an ecological systems perspective and now expand their relationship beyond the family of origin and extended family to include other systems impacting families (White, 2014). Postmodern family therapies include Family Systems Therapy, Solution-Focused Therapy and Narrative Therapy (Prochaska & Norcross, 1994). Postmodern family therapists stress the socially constructed nature of reality for clients, use strengths-based approaches, emphasise the need for therapists to partner with families, aim to restore and maintain social justice, and investigate the gender and ethnicity of clients and their own attitudes toward these. Such perspectives help family therapists learn to respect diversity and see strengths in the families they

partner with (Gushue et al., 2010). Thus, it appears reasonable that Wraparound philosophical principles can and should be applied in contexts beyond Wraparound. It seems plausible that principles of family voice and choice, team-based, natural supports, collaboration, community-based, culturally competent, individualised, strengths-based, persistence and outcome-based should be used in everyday practice as they are transferrable to any postmodern therapeutic context for young people and their families.

It is difficult to underscore the importance of supporting young people within the context of their environment – it is those surrounding the young people that hold the most powerful influence to impact their development and futures, which is why the inclusion of systems and supports are crucial, as demonstrated in the WTOC (Kilmer et al., 2011). The current research, by way of the WTOC, highlights that many of the important qualities needed to support high and complex needs young people and their families already lie within them. In some instances, these skills may simply need further development through the support of others. The development of these innate qualities was highlighted in the present research such as increased self-efficacy, increased connectedness within the family and psychological acceptance. With a focus on achieving short- and long-term goals within Wraparound such as improved service coordination and stable placements, and the ongoing implementation of Wraparound philosophical principles, these qualities were able to be developed and may continue to go on to influence their lives in numerous, and sometimes unexplainable, ways. Each young person and family holds their own solutions. The difficulties that families present with may be similar but the solutions for each are individual.

Personal Reflections

Since beginning my internship at the beginning of 2016, I have had the privilege of working two days per week in the Taranaki Child and Adolescent Mental Health Service and two days per week at the Taranaki Adult Outpatient Community Mental Health Service. Through this internship, I have had the good fortune of reflecting how my Doctoral research in the area of Wraparound has influenced my clinical ideas and practice.

This was my first experience of working within a multidisciplinary team (MDT). The similarities between an MDT and Wraparound team have been quite remarkable to me. Both scenarios require a team of specialists in different areas involved in the clients care, coming together in the best interest of the client. The largest difference here of course, is that in the MDT the client is not present. Perhaps if there were the time and resources available to District Health Boards to conduct MDTs with the clients present, the service provision for clients could be improved even further. I feel that one of the most important principles focused on in Wraparound is ‘family voice and choice’. This principles proposes that it is the client/family/young person themselves that are also one of the ‘professionals’. It stipulates that care plans are created by and for the client, and the team all work collaboratively to provide service options and choices that are reflective of the values and preferences of the client/family/young person. One of the most common pieces of feedback elicited from service users within any public health system is feeling as though their wishes are not taken into consideration with regards to their treatment. This may be in relation to type and amount of medication, therapy style, clinician fit, cultural values, etc. The most likely reason for this feedback is that

the public health system is incredibly stretched in terms of funding, staffing and timing. It may be completely unfeasible to conduct the style of meeting seen in a Wraparound model in a public health setting. However, based on the potential positive impact of clients feeling heard and given treatment they are involved with planning and that fits their values, the costs may well be worth it in the long-term. Further, MDTs are a time where a client is given a three-monthly review. What better way to find out how a client is managing in their lives than hearing it from the client themselves?

I found that there are also many similarities between a Keyworker and Wraparound Facilitator. This is the 'key' person that facilitates the care of each client. In each situation, the client/family/young person calls on this person when needing support with care coordination or risk management. These roles are also slightly differed between the Wraparound model and the District Health Board. Within the Wraparound model, the Wraparound Facilitator is essentially available to the family around the clock, and the Keyworker is widely available but perhaps not as much as the Wraparound Facilitator. One of the key differences is that within the District Health Board, the Keyworker assumes this role alongside their profession. For example, a social worker or psychologist has their regular case load and on top of this 'Keyworks' for a handful of clients. The Wraparound Facilitator is a Facilitator for many families, and come from a background of a range of professions; however their dedicated role is to be the Wraparound Facilitator, and to coordinate the care of the families on their caseload. I feel that the Keyworker and Wraparound Facilitator are crucial roles in the care of clients. For this reason, my personal reflection would be that the Keyworker would be perhaps more effective if

they were given the capacity to fulfil this role full time. If people are stretched across many roles, based on what I have observed during my internship I would be concerned that they might a) burnout, b) be less effective when adhering to their other professional role and c) clients may lose out as the Keyworker dedicated to them are managing a caseload as well as coordinating the care of many clients with a wide range of needs. Again, this system will be in place due to the stretched resources of the public system and as such there are reasons as to why it may not be feasible to have dedicated 'Keyworker' roles.

The work that I have done towards this research has been instrumental in terms of guiding my future career as a clinician. Through my internship I have learned how much the Wraparound principles are present or would further enhance work within a clinical setting. The principles of family voice and choice, team-based, natural supports, collaboration, community-based, culturally competent, individualised, strengths-based, persistence and outcome-based are all extremely valuable principles to keep in mind when working with any clinical population. If any of these principles are not being worked toward, the application of any of them could greatly improve the client experience. Further, it has become more evident to me than ever how fundamental it is to work with clients in a holistic collaborative nature. I have also gained invaluable skills with regard to information gathering that will aid my career as a clinical psychologist and the use of a scientist-practitioner approach.

Finally, I was deeply affected and humbled by all of the interactions I was privileged enough to have with the families in this study. They were all such resilient, strong, warm and capable people in spite of extremely difficult

circumstances. They opened up their entire lives to me, cried with me, laughed with me - a complete stranger. This privilege has continued into my internship, where I have been able to work with young people, their whanau and adults who have to varying degrees experienced marginalisation, misdiagnoses, and unjust treatment in their lives. I hope that I can be a contributing member of my team that can support people in the way that Wraparound does. I hope that our collaborative team work can result in clients becoming able to be excited about a future that until recently has been uncertain.

I will be influenced by this research and the principles it has instilled in me for the rest of my career. I have been so incredibly fortunate to be engaged in this area at such a critical time in my clinical development. I can only hope that the NZWP staff and incredible young people and their families in this study know just how much they have touched my life.