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**Wraparound New Zealand:
An Evaluation of Fidelity and Experiences**

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

Serious mental health disorders are complex clinical problems which interfere with a youth's ability to live functionally within their family and community. The wraparound process is an intensive individualised coordination and care planning process for youth with serious mental health disorders and their families who present with multiple, complex, and expansive needs. Originating from the United States of America the wraparound process was introduced on a limited basis in one District Health Board in New Zealand in 2004. Although deemed a promising practice internationally, no independent research, to our knowledge, had been conducted on this process within a New Zealand context. Therefore, the studies in this thesis aimed to evaluate the wraparound process in New Zealand. Study one reviewed the needs of youth with serious mental health disorders in New Zealand, the interventions currently available, and introduced the wraparound practice model as a potential solution to the service gaps and limitations. Study two and three investigated the fidelity to, and the experiences of, the wraparound process from the perspectives of wraparound facilitators, caregivers, youth, and team members who made up 16 wraparound teams. Overall the results from these studies indicated that the wraparound process in New Zealand was experienced as positive and helpful and was being implemented as it was intended with an overall fidelity score in the above average range. The positive experience was related to four interconnected themes: the role of the wraparound facilitator; support; wraparound's philosophies and principles; and the outcomes achieved. Importantly, a degree of consistency was also found across studies between the level of adherence to wraparound principles and phases in the fidelity study and those which were perceived as important or in need of improvement in the qualitative study. Taken together the results of this research

project confirmed that the wraparound process was a viable and useful intervention for New Zealand youth and families with high and complex needs. However, future research is recommended using larger more representative sample sizes which include quantitative outcome measurement to establish the effectiveness of the process.

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Chapter 1: Thesis Overview

The current research project resulted, in part, from a request by the manager implementing the wraparound process in New Zealand. This request originated due to frustration at the lack of understanding around this model and increased inconsistency in the use of the term ‘wraparound’ to describe a number of interagency models. The wraparound process used by the service is that defined by the National Wraparound Initiative as an intensive and individualised care coordination and planning process for youth with serious mental health disorders and their families (Burns & Goldman, 1999). First implemented in one District Health Board service in 2004, it is a relatively new intervention in New Zealand and no independent research had yet been conducted on the process in this context (The Intensive Clinical Support Service, 2004). In line with the needs of the service and the wider wraparound literature the current thesis was developed.

The main purpose of this thesis is to be an independent exploratory evaluation into the fidelity and experiences of the wraparound process being delivered in New Zealand. The research questions relating to this purpose include evaluating (1) the level of adherence (e.g., fidelity) to the wraparound process practice model and (2) the experiences and feedback of those delivering and receiving the wraparound process.

Overall, the current research project has the potential to advance our understanding of the wraparound process, in particular, around what aspects are working and what may need to be improved. It constitutes the first efforts to evaluate the wraparound process within a New Zealand context. Taken together, it is aimed that this thesis will provide a preliminary insight into the wraparound process in New

Zealand which can inform future implementation and provide the basis for future research.

Structure of the Thesis and Overview of Manuscripts

This thesis is written by publication and structured into six chapters, three of which are presented as manuscripts for journal submission. The first manuscript, presented in Chapter 2, provides the context for this research project by reviewing the literature on the characteristics and interventions available for youth with serious mental health disorders in New Zealand and introduces the wraparound process. Next, Chapter 3 outlines how the wraparound process is delivered in New Zealand and the service it is implemented within. Chapter 4 serves as a preface to the later manuscripts by discussing the relevant ethical and methodological considerations given. The second manuscript, presented in Chapter 5, investigates the fidelity to the wraparound process implemented in New Zealand using a cross-sectional survey design. The third manuscript, presented in Chapter 6, uses a qualitative research design to investigate the experiences of the wraparound process from those involved with the service. Finally, Chapter 7 concludes the thesis with a general discussion of the findings, implications and limitations of the research project, recommendations for the future, and includes the principal researchers own personal reflections.

As this is a thesis by publication some repetition was unavoidable to ensure that each manuscript could be read in isolation from this thesis. Across manuscripts this included a degree of repetition in the introduction and methods sections, particularly, regarding the description of the wraparound process. Some repetition is also contained in the general discussion and conclusions chapter. Manuscripts two and three refer to appendices not required for journal submission. For consistency across chapters, references for all manuscripts are located at the end of the thesis.

Manuscript one (chapter 2). When evaluating the use of a new intervention it is useful to consider the population served and services currently available. Therefore, paper one reviewed the peer-reviewed literature to determine the needs of youth with serious mental health disorders and their families and current interventions available in New Zealand. Whilst strengths existed, a number of limitations were also highlighted (Shailer, Gammon, & de Terte, 2013). To address the limitations encountered, the wraparound process was proposed as a valuable addition to these services, which had the potential to more effectively meet youth and family need. This manuscript has been published in the Australian and New Zealand Journal of Family Therapy.

Manuscript two (chapter 5). Whilst wraparound is considered to be a promising intervention there was a dearth of research available within a New Zealand context. The literature on wraparound has continuously indicated the importance of investigating model fidelity as a first step in program evaluation to ensure that the process is being implemented as it was intended (Borrelli, 2011; Bruns, Suter, & Leverenz-Brady, 2008; Murphy & Gutman, 2012). Specifically, as determining the degree of adherence allows more valid conclusions to be made regarding its efficacy (Mowbray, Holter, Teague, & Bybee, 2003; Ogles et al., 2005; Rast & Bruns, 2003). Therefore, study two was designed with the aim of investigating the level of fidelity to the wraparound process in New Zealand.

Manuscript three (chapter 6). Exploring the experiences and perceptions of service providers, consumers, and other key team members through the use of qualitative enquires has become an increasingly relevant and important part of service evaluation (Peters, 2010). This type of enquiry is particularly useful when investigating new and complex interventions as the perceptions gathered give rich

and contextual information which allow for new themes to emerge (Elliott, 2010; Pope & Mays, 1995). This can lead to clearer articulation and more complete understanding of the intervention delivered by generating knowledge about what components are important or could be improved (Peters, 2010). Consistent with this, study three focuses on exploring the experiences and perceptions of wraparound teams to gain a better understanding of the process.



MASSEY UNIVERSITY
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**STATEMENT OF CONTRIBUTION
TO DOCTORAL THESIS CONTAINING PUBLICATIONS**

(To appear at the end of each thesis chapter/section/appendix submitted as an article/paper or collected as an appendix at the end of the thesis)

We, the candidate and the candidate's Principal Supervisor, certify that all co-authors have consented to their work being included in the thesis and they have accepted the candidate's contribution as indicated below in the *Statement of Originality*.

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Youth with Serious Mental Health Disorders: Wraparound as a Promising Intervention in New Zealand

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The candidate was responsible for the design, data collection, analysis, and write up of the manuscripts. Supervisors have contributed to the manuscripts to the same level as for a usual thesis chapter: by providing guidance and feedback including input regarding decisions made around research process, data analysis, and formatting of the thesis. This contribution has been recognised by Dr Ruth Gammon and Dr Ian deTerte being included as co-authors for the manuscripts which make up this thesis

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Chapter 2: Youth with Serious Mental Health Disorders: Wraparound as a Promising Intervention in New Zealand

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Abstract

Youth with serious mental health disorders present with a complexity of challenges for the mental health system, schools, youth justice, care and protection, and their communities. Research shows their needs are best achieved by providing coordinated intensive, multidisciplinary, and individualised services. This article outlines the prevalence and characteristics of youth with serious mental health disorders. It also discusses community-based interventions used in New Zealand and their limitations. It introduces wraparound, an intensive individualised coordination and care planning process as a promising practice for youth with serious mental health disorders and their families. Key principles and phases underpinning the wraparound process are presented along with a case vignette to exemplify the process. Its theory of change, the challenges experienced in practice, and a brief overview of the evidence base are also discussed.

Keywords: wraparound, family, youth, mental health, interventions

Youth with Serious Mental Health Disorders: Wraparound as a Promising Intervention in New Zealand

The complex mental health presentation of youth increasingly requires multiagency involvement and innovative family therapy interventions (Bruns & Walker, 2008; Fergusson & Horwood, 2001; Mitchell, 2012; VanDenBerg & Grealish, 1996). Whilst a number of interventions are currently available, many of these youth continue to experience poor long term outcomes. Merely seeing a therapist weekly is no longer enough and evidence-based interventions that result in better long-term outcomes are required. Those working with youth and their families are seeking alternative treatments as well as interventions that are more holistic and comprehensive (Burns, Hoagwood, & Mrazek, 1999; Burns, Schoenwald, Burchard, Faw, & Santos, 2000; Mitchell, 2012; VanDenBerg & Grealish, 1996).

In this context of effective treatment for youth with serious mental health disorders, *the wraparound process* in New Zealand described in this article is a promising family-centred approach. It reduces the fragmentation of services often experienced by youth and their families by coordinating multiagency involvement and provides comprehensive care that focuses on their individualised needs (Bruns & Walker, 2010; J. S. Walker & Bruns, 2006b).

Youth with Serious Mental Health Diagnoses

Mental health disorders have been described by the *World Health Organization* as the most common cause of disability for youth aged 10-24 years (Gore et al., 2011). Unless otherwise stated or implied, for the purpose of this article, when the term young person or youth is used, it refers to individuals aged between 10 and 24 years diagnosed with a serious mental health disorder. In New Zealand, it has been estimated that 25-43% of youth meet the criteria for at least one mental health

diagnosis (Fergusson & Horwood, 2001; Horwood & Fergusson, 1998; Oakley-Browne, Wells, & Scott, 2006). Of these youth, approximately 10% meet the criteria for a serious mental health disorder, which equates to 3% of the total New Zealand youth population (Fergusson & Horwood, 2001; Oakley-Browne et al., 2006).

Serious mental health disorders are defined as a “diagnosable mental disorder that undermines the psychosocial development of a young person and causes significant distress in the way they interrelate” (Ministry of Health, 1998, p. 14). This definition also encompasses those youth who are referred to as having serious emotional and/or behavioural disturbances (Church & Special Education Division, 2003).

Reflective of New Zealand’s demographic, these young people come from a variety of cultural and ethnic backgrounds (Fergusson & Horwood, 2001; Oakley-Browne et al., 2006; The Intensive Clinical Support Service, 2006). However, there is an overrepresentation of youth from families with low socio-economic status and, in particular, single parent families. Unstable living situations and impaired family relationships, including a history of neglect, physical, and/or sexual abuse are also commonly experienced by these youth (Horwood & Fergusson, 1998; The Intensive Clinical Support Service, 2006). More often than not, perhaps as a response to the combination of environmental and mental health stressors, these youth frequently present with academic difficulties, criminal and general oppositional or defiant behaviour (e.g. running away from home, truancy, refusal to take medication or attend therapy appointments), peer relationship problems, and overall poor psychosocial adjustment (Fergusson & Horwood, 2001; Oakley-Browne et al., 2006; VanDenBerg & Grealish, 1996).

Youth with serious mental health disorders often present as clinically complex with comorbid mental health and/or medical diagnoses, family dysfunction, and

social disadvantage. Further, these youth have extensive and multifaceted needs that span health, psychological, emotional, cognitive, and social areas (Fergusson & Horwood, 2001; Kessler, Chiu, Demler, & Walters, 2005; Ministry of Health, 1998; Oakley-Browne et al., 2006; VanDenBerg & Grealish, 1996). Their needs are frequently referred to as high and complex (High and Complex Needs Unit, 2005). In part, this is because their behaviours can pose a risk to themselves or others and may include substance and/or alcohol abuse, self harm, suicide attempts, violent or aggressive behaviour, and sexual promiscuity (Bruns, Burchard, & Yoe, 1995; Fergusson & Horwood, 2001; High and Complex Needs Unit, 2005; Oakley-Browne et al., 2006). These behaviours commonly result in extreme stress for them and their family, which puts them at high risk for out-of-home placements (e.g., foster care, group homes or institutionalised care facilities; Burns et al., 1999; High and Complex Needs Unit, 2005). In addition, youth and families with high and complex needs typically require multiagency involvement as their needs transcend the service specification of a single agency (Fergusson & Horwood, 2001; Mitchell, 2012; VanDenBerg & Grealish, 1996). These youth are often known to several public systems including mental health, child protection, juvenile justice, and alternative education. Further, the parents and family members of these youth may themselves have also had a history of involvement with justice or child welfare systems in their youth and be known to adult mental health and welfare systems (High and Complex Needs Unit, 2005; Ministry of Health, 1998). Rankin (2011) reported that 41-65% of youth who come to the attention of *Child Youth and Family* (CYF), the child welfare and juvenile justice department in New Zealand, also have mental health, emotional, or behavioural problems. This is consistent with international research which estimates that between 40-90% of youth in foster care and 50-70% involved in

juvenile justice systems present with at least one mental health diagnosis (Shufelt & Cocozza, 2006; The Werry Centre, 2009; Vig, Chinitz, & Shulman, 2005).

While the prevalence of serious mental health disorders may appear small numerically, youth diagnosed with serious mental health disorders are said to represent the main burden of illness for mental health services (Kessler et al., 2005; Merikangas et al., 2010). In the United States of America (USA) VanDenBerg and Grealish (1996) estimated these youth consume at least a third of all available human resources. *The Mental Health Commission* (2011) report stated that similar data has not been calculated for New Zealand. However, there is no reason to suggest that the amount of agency services and budget consumed by New Zealand youth presenting with a serious mental health disorder would be any different. This disproportionate use of resources is not limited to the mental health system, but applies across all agencies providing services and includes the often high, unseen personal, familial, and community costs (Baker & Calderon, 2004; Oakley-Browne et al., 2006; VanDenBerg & Grealish, 1996).

Long term outcomes for this population have also been poor. Even with access and support provided by mental health treatment and other services, a high proportion of these youth will have persistent mental health issues throughout their adolescent life and into adulthood (Armstrong, Dedrick, & Greenbaum, 2003; Burns et al., 1999; Dunnachie, 2007; Greenbaum et al., 1996; Mitchell, 2012). Therefore, investigation and development of interventions to best serve these youth has received increased attention over the past decades (Burns et al., 1999; Huang et al., 2005; Mental Health Commission, 2012).

Effective Interventions for Youth

The range of needs presented by this population are complex and require interventions to be intensive, individualised, and specialised (Burns et al., 2000; Mitchell, 2012). Historically, such intensive interventions were delivered in restrictive institutions in the form of residential treatment centres or inpatient units. As a result, youth often spent long periods of time away from their families and communities (Burns & Hoagwood, 2002).

Since the 1960s, there has been a gradual movement to deinstitutionalise treatment for youth towards the use of community-based treatment models and approaches, where they remain within their family and community (Stroul, 2002). This movement was prompted by the realisation that institutionalised care was expensive and produced poor outcomes (Burns & Hoagwood, 2002). There is evidence that institutionalised care, in particular long term institutionalisation, can delay normal psychosocial development in regards to educational progress, entering the workforce, and developing the necessary social, behavioural, and relationship skills needed to function effectively within the community (Frensch & Cameron, 2002; J. Green, 1992; Haynes, Eivors, & Crossley, 2011).

This has often led to youth experiencing problems with readjustment when returning to their community, as well as issues with self-esteem, identity, and increased feelings of disconnection (Frensch & Cameron, 2002; J. Green, 1992; Haynes et al., 2011). When successes or gains were made by youth within these settings they were rarely maintained and tended to dissipate over time when they returned to their communities (Frensch & Cameron, 2002). Approximately 50-75% of youth placed in institutionalised care were reported as having to be readmitted to an

institutionalised care facility or placed in another out-of-home placement following discharge (Asarnow & Aoki, 1996; Greenbaum et al., 1996).

Effective interventions need to be long term, flexible, community-based, culturally competent, and take an integrative multimodal or biopsychosocial approach (Bruns et al., 2010; Burns et al., 2000; Henggeler et al., 2003; Ministry of Health, 1998; Mitchell, 2012; VanDenBerg & Grealish, 1996). More recent treatment models recognise that a young person's natural ecology and context plays a significant role in effective treatment (Burns & Hoagwood, 2002; Burns et al., 2000). Family participation and engagement have also been evidenced to be essential in the effective implementation of community-based services (Burns et al., 1999; VanDenBerg & Grealish, 1996). This has led to a change in the traditional model of service delivery.

Families and youth are now viewed as partners and even drivers of treatment plans and interventions. Families are acknowledged as experts on their young person and the interventions which will be most effective for them (J. S. Walker, Bruns, Conlan, & LaForce, 2011). This movement has resulted in the development of a range of treatment options predicated on collaborative community-based care and maintaining the young person within their environment (Burns & Hoagwood, 2002).

Interventions used in New Zealand

There are now a number of approaches and therapeutic interventions available in the community in addition to the more traditional institutional-based care (Burns & Hoagwood, 2002; Dunnachie, 2007; Ministry of Health, 1998; Mitchell, 2012; The Werry Centre, 2009). While to our knowledge a comprehensive review of such community-based interventions within New Zealand does not exist, there are some reports which discuss certain interventions and services (Dunnachie, 2007; Ministry of Health, 1998; Mitchell, 2012; The Werry Centre, 2009).

Whilst not an exhaustive list, Table 1 includes the most commonly used community-based approaches for youth with mental health or serious mental health disorders in New Zealand, with at least some evidence-based support.

Limitations of Current Services and Interventions

Despite the range of interventions, treatments, auxiliary supports and services available both in and out of the community, few have demonstrated long term outcomes and sustained effectiveness for youth with serious mental health disorders, that is, excluding those youth with a sole diagnosis of conduct disorder or serious antisocial problems (Armstrong et al., 2003; Burns et al., 1999; Greenbaum et al., 1996). While all of these interventions have effective components and each have their place, they also have limitations in their ability to treat a very diverse and complex clinical population with persistent mental health, behavioural, and emotional issues (Burns & Hoagwood, 2002).

A potential explanation for a lack of positive long term outcomes for this population is that many of the interventions currently provided may not be:

1. Intensive enough on their own, e.g. auxiliary supports, Child and Adolescent Mental Health Services (CAMHS), group homes, Multisystemic Therapy (MST) and Strengthening Families (Farmer, Dorsey, & Mustillo, 2004; Henggeler et al., 2003; Ministry of Social Development, 2001a; The Intensive Clinical Support Service, 2006);
2. Able to provide sufficiently individualised treatment or long term care due to their manualised and time-limited nature, e.g. MST (Henggeler et al., 2003);
or

Table 1

Community-based interventions in New Zealand for youth with serious mental health disorders

| Intervention | Description | Strength | Weakness |
|--|--|--|---|
| Child and Adolescent Mental Health Services (CAMHS) | District Health Board delivered comprehensive mental health and addiction assessment and treatment services provided for youth with moderate to serious mental health disorders (Ministry of Health, 2011; Wille, 2006). | Teams provide targeted intervention to youth with evidenced-based treatment approaches in the form of individual therapy, group therapy, and/or medication (Dunnachie, 2007; The Werry Centre, 2008; Wille, 2006). | Youth rather than families are often the predominant focus of interventions (Wille, 2006). Youth can require a more intensive level of mental health service than can reasonably be provided by CAMHS (The Intensive Clinical Support Service, 2006). |
| Multidimensional Treatment Foster Care (MTFC) | An intensive, therapeutic, out-of-home placement within the youth's community which lasts approximately 6 to 12 months (Chamberlain, 2003; Fisher & Chamberlain, 2000). | MTFC uses behavioural strategies to shape pro-social behaviours (Chamberlain, 2003; Fisher & Chamberlain, 2000). Delivered by trained foster parents who work one on one with youth (Chamberlain, 2003; Fisher & Chamberlain, 2000). Model involves the biological parents or family members so changes can be transferred to the youth's family living environment (Chamberlain, 2002; Fisher & Chamberlain, 2000). Individual child and family treatment (Chamberlain, 2003) as well as case management and liaison services are provided during MTFC placement (Chamberlain & Reid, 1991). Relatively strong evidence base for juvenile justice and foster care populations (Chamberlain, 2003; Chamberlain & Reid, 1991; Price et al., 2008; Westermarck, Hansson, & Olsson, 2011; | Predominately used for youth involved with the juvenile justice system in New Zealand (Youth Horizons, 2008). Only available in one New Zealand city (Youth Horizons, 2008). Requires the youth to be placed outside of their families for an extended amount of time (Chamberlain, 2002, 2003). Most of the research has been conducted by the MTFC model developers (Farmer et al., 2004). Evidence base for youth with serious mental health disorders is promising but limited (Chamberlain & Reid, 1991; K. J. Moore & Chamberlain, 1994). Treatment gains made in MTFC may not be maintained once youth return to their families and communities, especially in the long term (Biehal, Ellison, & Sinclair, 2011). Follow up |

| Intervention | Description | Strength | Weakness |
|------------------------------------|---|---|--|
| Multisystemic Therapy (MST) | A manualised multimodal family and community-based treatment delivered within the youth's family context (Burns et al., 2000; Henggeler, 2011). | <p>Westermarck, Hansson, & Vinnerljung, 2008). Has been adapted for youth with serious mental health issues which include additional pre-service training for foster parents, tailored intervention components specific to meet the needs of this population (e.g. emotion regulation work), and the availability of on call mental health services and therapists for crisis situations (Chamberlain & Reid, 1991; K. J. Moore & Chamberlain, 1994).</p> <p>MST therapists provide intensive clinical support and care (on call 24/7) and systemic intervention (Burns et al., 2000; Henggeler, 2011).</p> <p>Focuses on addressing the multiple determinants of youth's problem behaviour directly with the young person, their family and community in their home environment (Burns et al., 2000; Henggeler, 2011).</p> <p>Most extensive research base of all community-based intervention and has been established as an effective evidence-based intervention both in the short and long term for youth with serious antisocial behaviour who are involved in the juvenile justice system (Curtis, Ronan, & Borduin, 2004).</p> <p>Has been adapted for use with serious mental health disorders and shown promising short term outcomes for decreasing psychiatric and externalising symptoms (Henggeler & Rowland, 1997). Adaptation's to the MST model include reducing case loads to three families per therapist and the addition of: child and adolescent psychiatrists and crisis caseworkers into the MST team, pharmacological interventions where necessary, specific training</p> | <p>data from Biehal et al. (2011) suggests that outcomes achieved during MTF, of reduced reoffending, reconviction, and entry into custody, were no longer significant within one year post-treatment.</p> <p>Time limited and manualised treatment (4 to 6 months; Burns et al., 2000; Henggeler, 2011).</p> <p>No coordination of services.</p> <p>Mostly used in New Zealand for juvenile justice populations.</p> <p>MST has yet to show the capacity to sustain long term outcomes for youth with serious mental health diagnoses with follow-up data indicating that outcomes achieved were not sustained and in fact dissipated by 12 months post-treatment (Henggeler et al., 2003).</p> |

| Intervention | Description | Strength | Weakness |
|-------------------------------|--|---|--|
| Strengthening Families | Strengthening Families is a New Zealand initiative based on care management. | <p>regarding working with youth and families in psychiatric crisis, clinical booster sessions to address any deficits in knowledge, increased supervisory time, and contracts with respite services to decrease length of hospitalisation stay after a crisis (Henggeler & Rowland, 1997; Henggeler et al., 2003; Schoenwald, Ward, Henggeler, & Rowland, 2000). Psychosocial interventions were also adapted to emphasise caregivers as the primary agent of change in addition to increasing emphasising the development of natural supports within the community (Henggeler et al., 2003).</p> <p>Families and youth work with a coordinator who assists them in gaining access to services and to develop a plan between agencies to meet their needs (Strengthening Families, 2010).</p> <p>Aims to decrease fragmented service delivery for youth and families between the welfare, justice, health, and education sectors (A. Walker, 2006).</p> <p>Outcomes from selected case studies indicate that the Strengthening Families process increased coordinated support and improved social, health, and educational outcomes for youth and families (Ministry of Social Development, 2001b; Strengthening Families, 2011).</p> | <p>Strengthening Families' often does not have the level of mental health focus or the intensity of service delivery required for young people with serious mental health disorders.</p> <p>The evidence base is limited and varied regarding outcomes achieved (Ministry of Social Development, 2001b; A. Walker, 2006).</p> <p>Outcomes from an exploratory study of the experience of clients in six selected regions in New Zealand indicated the majority of families were significantly dissatisfied with Strengthening Families' outcomes. Families reported that they were dissatisfied due to the agencies involved providing inadequate service, the lack of follow through on what was agreed to, and the poor communication between agencies and families (Ministry of Social Development, 2001a).</p> |

| Intervention | Description | Strength | Weakness |
|-------------------------------|--|--|--|
| Auxiliary supports | Other services which provide necessary auxiliary supports in addition to any therapeutic intervention such as family group conferences, respite care, school-based approaches, family support and education, mentoring, and health care support (Burns et al., 1999; Child Youth and Family, 2009; Pinkard & Bickman, 2007). | Supplements community-based interventions. Provides additional support to families in key life domains. Provides or increases the support received by the young person from their community (Farmer et al., 2004). | Quality and accessibility of these services depend on their availability within the community. Are not sufficient on their own to support youth with serious mental health disorders. A number of the auxiliary supports have either not been formally investigated or have a limited evidence base supporting their use, in particular, for youth with serious mental health disorders (Farmer et al., 2004). |
| Out of home placements | Placements provided in non-restrictive settings outside of the young person's home, such as nontherapeutic foster care and group homes (Farmer et al., 2004). | Out-of-home placements provide a less restrictive option than institutionalised care if the youth is unable to be with their family (Baker & Calderon, 2004; Burns et al., 1999). | Limited in home support (usually only one or two caregivers for five to ten youth). Groups youth with similar problems together (Farmer et al., 2004). No therapeutic content. Unable to manage high risk behaviour or those youth with serious mental health disorders in the long term. Evidence base is unclear due to the paucity of research (Farmer et al., 2004). |

3. Based within the young person's home environment and community, which can lead to dissipation of positive outcome effects once treatment has finished, e.g. Multidimensional Treatment Foster Care (MTFC; Biehal et al., 2011; Chamberlain, 2003).

Given the multifaceted needs of these youth it is unlikely a singular intervention holds the solution (English, 2002). Care is optimal when systems are in place to facilitate multiagency involvement and interventions to work together, complement each other, and provide the required ongoing support (English, 2002). Unfortunately in reality, the service and intervention delivery across agencies is often fragmented, uncoordinated, and not as cohesive or effective as would be desired (Bruns, Rast, Peterson, Walker, & Bosworth, 2006; Mental Health Commission, 2012; A. Walker, 2006). While these community-based interventions often work with multiple systems, none of them provide a comprehensive, individualised approach which coordinates all of the agencies, services, and supports involved with these youth and their families. A possible exception is *Strengthening Families* but it has a limited evidence base and implementation in practice may not live up to its promise in principle (Ministry of Social Development, 2001a, 2001b).

Although there is a shift to more coordinated service delivery, agencies are still largely working like silos, with limited communication, or information flow, and each creating their own plan for the young person and their family (A. Walker, 2006). Each separate agency plan may have conflicting goals, priorities, or recommendations on the best way forward (Mitchell, 2012; Rosengard, Laing, Ridley, & Hunter, 2007). This frequently culminates in the young person and their family being left in a state of disarray, confused and frustrated, and with little comprehension of how to proceed or get the support they require (Rosengard et al.,

2007). Moreover, intervention and support may not be provided in the most optimal manner. What is needed is an individualised, sophisticated process, coordinating all appropriate interventions, supports and services across agencies, and contexts (e.g. school, home, community individual) into one comprehensive treatment plan (Burns & Goldman, 1999; Cook & Kilmer, 2004; English, 2002; VanDenBerg & Grealish, 1996).

The Wraparound Process

The wraparound process emerged to remedy the problem of fragmented service delivery and the shortcomings of available interventions (Burns et al., 2000). It developed out of a need to work effectively with youth and their family in their community and coordinate interventions and service delivery between multiple agencies (J. S. Walker & Bruns, 2006b). At the same time, systems of care were set up to remove barriers between systems serving youth and families by establishing seamless funding and communication (Winters & Metz, 2009). In the USA, wraparound is implemented within a system of care service delivery model (Winters & Metz, 2009). Wraparound is currently available across the USA and internationally, including in one District Health Board of New Zealand. Evidence supports wraparound as a promising practice for youth who present with multiple, complex, and expansive mental health needs (Bruns, Burchard, Suter, Leverentz-Brady, & Force, 2004; Burns et al., 2000; Suter & Bruns, 2008; VanDenBerg, 2008).

What is wraparound? Wraparound is an intensive, family-driven, and individualised team-based collaborative care planning process, which coordinates supports and services for youth and their families in a culturally relevant manner (Burns & Goldman, 1999). It is most commonly defined as a “philosophy of care that includes a definable planning process involving the child and family that results

in a unique set of community services and natural supports individualised for that child and family to achieve a positive set of outcomes” (Burns & Goldman, 1999, p. 13). The wraparound process is specifically designed to target youth with serious mental health disorders who present with the most complex and intensive needs, are involved with multiple agencies, and are at risk of being removed from their families and communities into out-of-home placements (Bruns & Walker, 2008; Bruns et al., 2010; VanDenBerg & Grealish, 1996). In essence it helps families with the most challenging young people utilise their strengths and natural supports to develop individualised treatment plans to meet their needs so that they can remain and function more effectively in the community (Bruns & Walker, 2010; J. S. Walker & Bruns, 2006b).

The wraparound planning process is based on ten principles and four phases (Bruns, Walker, et al., 2004; J. S. Walker et al., 2004). The ten principles listed and described in Table 2 provide the philosophy and value base for wraparound (Bruns, Walker, et al., 2004). The four phases provide a guideline for what activities need to be completed:

1. Engagement and team preparation including an introduction to the activities of wraparound;
2. Initial plan development;
3. Plan implementation and refinement; and
4. Transition (J. S. Walker et al., 2004).

Table 2

Ten principles of the wraparound process

| Principle | Description |
|----------------------------|---|
| 1. Family voice and choice | Family and youth/child perspectives are intentionally elicited and prioritized 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 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 out 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. Individualized | 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. |

Note: Description of ten principles of wraparound reproduced with permission from Bruns, E.J., Walker, J.S., Adams, J., Miles, P., Osher, T.W., Rast, J., VanDenBerg, J.D. & National Wraparound Initiative Advisory Group (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.

It should be noted the term *wraparound* has been used in a variety of different contexts to describe a number of services, interventions, supports, or approaches (Miles, Brown, & The National Wraparound Initiative Implementation Work Group, 2011). The wraparound process as described here is the approach specified by the *National Wraparound Initiative*. Under this model, in order to be considered

wraparound, the process should adhere to both the ten principles and four phases as depicted in Figure 1 (Bruns, Walker, et al., 2004).

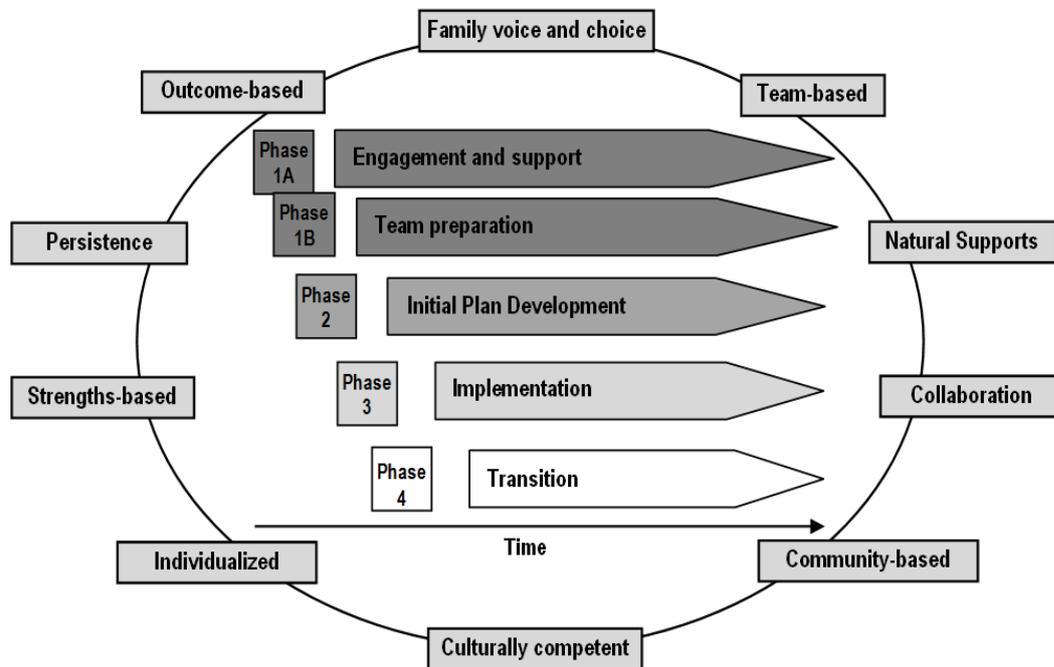


Figure 1. The ten principles and four phases of the wraparound process. This figure illustrates that the ten principles of wraparound should be continually embraced throughout the four phases.

Wraparound differs from other interventions in three ways. First, the young person and their family drive the process, both in terms of decision-making and planning. Second, the focus is on identifying and supplementing the strengths of the family and young person. Finally, continuity of care and long term support is provided for as long as the family, young person, and wraparound team deems it necessary (Malysiak, 1998; Wyles, 2007). In addition, there is a focus on cultural competence, which is of particular relevance to New Zealand due to its bicultural society (Bruns, Walker, et al., 2004). This is reflected through wraparound’s central theme of family voice and choice (see Table 2; Bruns, Walker, et al., 2004), which is consistent with the Māori concept of *whānau* (family or extended family) and is an

inherent and integral part of New Zealand culture (The Intensive Clinical Support Service, 2006).

Practice illustration: Julie. The wraparound process is implemented by individualised teams, lead by a care coordinator or facilitator and directly involves the young person and their whānau/family. Collectively with a wraparound facilitator the family identify and bring together all key individuals, formal and informal supports, and relevant agencies involved in their life (VanDenBerg & Grealish, 1996). Other members on the team may include mental health professionals, social workers, educators, family therapists, community members, extended family members, family friends, or any relevant others who are salient in the young person's life (Bruns & Walker, 2008).

The following case vignette follows Julie, a 14-year-old girl, through her and her family's experience of the wraparound process to illustrate how it can be effective with youth and families. It is structured through the four phases of wraparound and the principles used in each phase are highlighted throughout.

Julie, a 14-year-old Māori girl, was referred to the wraparound process through a joint referral from CYF and CAMHS. She presented with multiple mental health diagnoses (Major Depressive Disorder, Oppositional Defiant Disorder, in addition to some trauma symptoms and attention problems) and care and protection involvement. CYF was involved due to the substantiated claim of sexual abuse by her stepfather and her level of self harm. She also presented with a number of high risk behaviours including staying out late, associating with the wrong crowd, sexual promiscuity, truancy, experimenting with substances, and was caught shoplifting. Julie lived with her mum, Marama, and her two younger siblings Darian aged 8 years and Mia aged 6. Her biological father, Jake, had not contacted any of the children

since the birth of Mia. Since the sexual abuse claims were substantiated, Marama had ended the relationship with her partner who was no longer living with them. The reason for referral was to reduce self-harm behaviours and trauma symptoms from the abuse. Additional goals included Julie returning to school full time and improving the relationship between mother and daughter.

Engagement and team preparation. The wraparound facilitator met individually with Marama and Julie to introduce and explain the process. During this engagement phase, understanding the family's story and background are essential (Bruns & Walker, 2008). It is important to know what has or has not worked in the past, areas of family strengths as well as available and useful formal and informal supports (*family voice and choice, strengths-based*). Marama identified limited family support in the area, and even though she was able to identify one friend whom she was close with, she did not want to involve her in the wraparound meeting because of the shame she felt about the abuse (*family voice and choice*). During the engagement phase, Julie was withdrawn, resistant, and untrusting. Julie felt no problems existed and did not want any of her friends involved.

Initially, the team consisted of the wraparound facilitator, a Māori cultural advisor, Marama, Julie, her siblings, Julie's CYF social worker and her CAMHS worker (both a mandatory part of the wraparound process in New Zealand), and a representative from Julie's school. The wraparound facilitator met with each team member to explain the wraparound process and identify Julie and Marama's strengths (*team and strengths-based*). Marama requested that the wraparound meetings be held after 5:00 p.m. so she would not miss any more work and at her home, as transport and childcare were difficult for her (*family voice and choice and individualised*).

Initial plan development. Once established and oriented to the wraparound process, the team creates a multidimensional plan geared towards the individual needs of the young person and family by developing unique and specific goals with clear actions steps and timeframes for accountability. This initial plan development occurs within the first one or two wraparound meetings (Bruns, Suter, Force, Sater, & Leverentz-Brady, 2009; Bruns & Walker, 2008; VanDenBerg, 2008). During the first wraparound meeting, family strengths were shared and two life domains were prioritised by the family: safety and education (*strengths-based, family voice and choice*). Action steps developed in the first meeting and an overview of the initial plan developed for Julie and her family are illustrated in Table 3.

In addition to the initial wraparound plan, a detailed crisis management and safety plan was created which identified each member's role in a crisis (*collaboration, outcome- and team-based*). This crisis plan included early warning signs that Julie was becoming unwell, what Julie and other members can do if they notice these signs, and a contact list with identified support people (*collaboration*).

Table 3

Examples of the action steps created from Julie's wraparound team meetings

| Need | Action Step | Who | By When |
|--|---|--|-----------|
| Safe sexual behaviour | Go to family planning for health check and birth control | Julie and Marama | 2 weeks |
| Regular mental health sessions to improve wellbeing | Assist with transport to CAMHS appointment | Therapist and wraparound facilitator | Weekly |
| Julie to attend school regularly | Julie to meet with mentor afterschool | Mentor | Daily |
| | School staff will provide Julie with any extra support needed | School Staff | As needed |
| Increase Julie's positive peer relations | Mentor to find positive afterschool activities with Julie | Mentor and Julie | Weekly |
| Improve family relationships and mother-daughter communication | Wraparound facilitator to help Marama and Julie find a family therapist | Wraparound facilitator, Marama and Julie | 2 weeks |

| | | | |
|-------------------------------|---|--------------------------|---------|
| Stabilise financial situation | Social worker to assist Marama to get in contact with Work and Income New Zealand | Social Worker and Marama | 2 weeks |
|-------------------------------|---|--------------------------|---------|

Plan implementation and refinement. Once a plan is made the team meets regularly (usually every 4-6 weeks) to implement, monitor, and ensure its success (VanDenBerg & Grealish, 1996). The plan is assessed and reviewed to ensure its applicability and effectiveness, adjust things not working, and assign new tasks to team members and family as the process progresses. Commonly, this involves incorporating both informal and formal supports that can be wrapped around the young person for as long as needed in order to reach their goals (Burns & Goldman, 1999). In between meetings, the wraparound facilitator continues to keep in contact with all team members including the family, to check in, follow up any action steps, and troubleshoot any problems that arise to ensure continuing team connection and cohesion (Bruns & Walker, 2008). In New Zealand, the wraparound facilitator also has at least once weekly contact with the family by phone and/or home visits.

Over the course of the wraparound process, Julie had started to stabilise within the family and other domains were added to the original plan. Overall nine domains were included in the wraparound plan: safety and health, education, emotional/psychological, family relationship, financial and transport, culture, behaviour, community activities, and social. Marama and Julie had made substantial gains regarding safety and health concerns with a reduction in self harm behaviours, sexual promiscuity, and regular attendance with her therapist. Communication between Julie and her mum had improved, there were consistent house rules now followed by Julie, and she was attending school about 70% of the time, up from 50% (*strengths- and outcome-based*).

While Julie's behaviour significantly improved, there were still periodic incidents over the next 9 months. Each of these incidents was addressed and behavioural management plans were put in place. Unfortunately, when such incidents occurred Marama felt as if all the progress they made went out the window. The wraparound facilitator helped Marama to recognise how things had shifted and what she had accomplished with her daughter consistently highlighting the improvements (*persistence, strengths-based*). Despite some occasional setbacks, schooling continued to go well and Julie started to play netball and sing again, two things she enjoyed before she became unwell (*community-based, natural supports*).

To support Julie, the wraparound team funded some singing lessons which she attended after school. The team also helped out with transport to and from these lessons with Marama taking this over as time went on (*natural supports, team-based, collaboration, community-based, individualised*). Community supports for Marama were also identified and she became involved with people from her iwi (in Māori language the word *iwi* is used to describe a collection of people or tribe, normally united through a common ancestor; *community-based, culturally competent*). As the process continued, Marama felt less shameful about her daughter's behaviour and the sexual abuse and therefore comfortable about bringing her *whānau* into the process, an ongoing source of support and resources for her (*individualised, family voice and choice, natural support*).

As Marama developed more community supports she was able to spend more time with Julie, as the younger children were able to visit family and friends and be cared for by them. The sense of security, stability, and time together helped Julie and Marama to rebuild their relationship, and work through the abuse she experienced. Through the wraparound process and as the family became more involved with their

community, more team members came on board such as Julie's mentor, extended family, and a support person for Marama from her *iwi*.

Transition. The wraparound process continues until all members of the wraparound team agree they have achieved the goals and mission of the plan and the formal wraparound process is no longer needed. In the transition phase, the team works with the family to prepare them to leave the process. A transition plan is created which includes a plan for the future, who the family can call on if they need help, a post-transition crisis management plan, and who will continue to be involved to support the family after wraparound has finished (Bruns & Walker, 2008).

Thirteen months after entering the process the family was doing well, they continued to bring new goals to the wraparound meetings, and developed their own strategies to deal with them (*persistence*). The family and the team concluded the intensive and formal wraparound process was no longer required, as the family had resources and supports within the community (e.g. school, *iwi*, extended family), which allowed them to access what they needed to resolve their issues (*community-based, culturally competent, natural supports*). A final discharge meeting was held with all the family and team members to celebrate their successes and progress. A summary was provided to the family so that they could see the changes they had made and how far they had come from the beginning of the process (*outcome- and strengths-based*). At the end of wraparound the family was discharged back to CAMHS, and CYF closed the case which was a huge celebration for the family, in particular Marama. Overall, the family reported feeling stronger and Julie felt she was able to talk and feel safe with her mum again.

Wraparound theory of change. Wraparound developed from values and principles rather than from one specific theory (Burchard, Bruns, & Burchard, 2002;

Burns et al., 2000; J. S. Walker, 2008a). However it has implicit associations with numerous theories of psychosocial development, such as Munger's (1998) environmental ecology, Bronfenbrenner's (1979) social-ecological systems theory, Bandura's (1977) social learning theory, and Maslow's (1970) hierarchy of needs (Burchard et al., 2002; Burns et al., 2000; J. S. Walker, 2008a). Postmodern family therapy theories are also consistent with wraparound's approach as the values and underlying principles are very similar (Olson, 2006). Both emphasise the importance of social construction and collaboration with families such as viewing parents as partners and empowering families to develop their own unique solutions (Graves & Shelton, 2007; Olson, 2006; J. S. Walker, 2008a). Empowerment has been identified as a powerful mechanism of change (Graves & Shelton, 2007). In particular, Graves & Shelton (2007) have indicated that family empowerment may be more significant for change than family centred care itself and is one of the most important elements in treatment success.

A specific theory of change for wraparound has only recently been developed, which explains how its principles and practice model lead to short and long term outcomes for families (J. S. Walker, 2008a). According to J. S. Walker's (2008a) theory of change, positive outcomes are achieved in wraparound by two primary routes, both of which increase the family members' sense of empowerment and efficacy (J. S. Walker, 2008a). First, as the family and team drive the process, wraparound results in personalised services and supports to meet the needs of the youth and their family increasing the effectiveness of these services (J. S. Walker, 2008a). As demonstrated in the case vignette, the wraparound meetings were individualised to meet the family's needs, for example, by being held at their home after 5:00 p.m. Traditional services were also adapted with the CAMHS worker and

wraparound facilitator transporting Julie to and from appointments. Second, as wraparound activities focus on the family developing their own plan through identification of strengths and resources, their ability to problem solve, cope, and experience success improves (J. S. Walker, 2008a). In the case vignette, as the plan was reviewed, the family experienced success, felt more confident to identify their resources, and problem solve which became internalised as empowerment. Marama started to feel more effective as a parent because she had strategies to deal with Julie's behaviour and re-established parent-child boundaries. These levels of empowerment allowed Marama to feel stronger as a parent, set limits, and effectively support her daughter. Julie experienced empowerment by understanding how to gain her desired independence through earning her mother's trust while building a strong relationship that allowed her to feel cared for, safe, and secure.

Practice challenges for wraparound. The wraparound process appears deceptively simple in practice, but actually involves complex implementation at both a family and systems level, which can be a difficult task (Bruns & Walker, 2008; Miles et al., 2011). Both a strength and weakness is that every process is implemented slightly differently according to the local conditions (Miles et al., 2011). Some of the key challenges are around natural supports, process and role clarity, and family voice and choice.

Developing long lasting and sustainable natural supports that continue to support the family when agency-driven assistance ceases and wraparound has finished is pivotal (Bruns & Walker, 2008; Miles et al., 2011). Families with young people with complex mental health needs are often isolated, feel shame, and a sense of hopelessness about their situation, as illustrated in the case example. Wraparound facilitators work very hard to link young people and their family with natural

supports within their community, extended family, and friends so the dependency on agencies and systems is reduced. Further, as wraparound facilitators are not responsible for providing direct clinical interventions or services, the quality of interventions and services delivered to youth and families is highly dependent on what is available in the community (Miles et al., 2011). Close collaboration and a team-based thinking process are required to ensure the necessary support and interventions are provided to families. The process also requires a well established network within community-based services so interventions and supports can be easily accessed (Bruns & Walker, 2008; Miles et al., 2011).

The lack of consistency in the use of the term *wraparound* across a number of different services and agencies can also create a sense of confusion (Miles et al., 2011). It is important that families and professionals have clarity on what it is and how it differs from other interventions and services (Miles et al., 2011). Role clarity is also essential with every member, including the professionals, understanding their role and the shared responsibilities and accountability (Bruns & Walker, 2008; Miles et al., 2011). For example, professionals are required to actively participate in the wraparound team rather than simply referring or handing the case over (Kamradt, 2001; A. Walker, 2006). In practice, process and role clarity are defined during the engagement and initial planning phase (J. S. Walker et al., 2004).

Negotiating the central principle of family voice and choice is no easy task. However, each small gain empowers families to make long lasting change (Bruns, Walker, et al., 2004; J. S. Walker, 2008a). Shifting the responsibility for decision-making to families can be a challenging task and is often a new experience for them with the young person's voice and choice being the most exigent to manage, integrate, and involve. This shift can also be problematic for professionals who are

accustomed to facilitating what they believe is the optimum approach, rather than allowing the family to lead the process of choosing and deciding for themselves what best they need (Bruns & Walker, 2008; Miles, 2011). Throughout the wraparound process it is imperative that the young person is an active participant expressing their choices and perspectives in a manner they are comfortable with. This may necessitate step-wise inclusion, for example, allowing the youth to attend only part of any meeting. A further option may be for the wraparound facilitator to meet with them before and after the team meeting so their voice is still heard and they are informed of any suggestions made (Bruns & Walker, 2008). Although the application and integration of wraparound principles can at times be exacting, it is these principles that make the most difference to the overall success of the process for youth and families (Bruns & Walker, 2008; Miles et al., 2011).

Wraparound as evidence-based practice. Evidence is still cumulating regarding wraparound (Bruns & Walker, 2010; Bruns et al., 2010; Suter & Bruns, 2008). Although deemed a promising practice, there is still mixed scientific support on the efficacy of the wraparound process (Stambaugh et al., 2007; Suter & Bruns, 2008; Suter & Bruns, 2009). Overall, investigations of the wraparound process have predominantly used pre-post methodologies, no control group, small samples sizes, and no measurement of treatment adherence or fidelity (Suter & Bruns, 2008; Walter & Petr, 2008, 2011). Irrespective of the research design used, an essential component of building wraparound's evidence base is the inclusion of fidelity measurements in outcomes studies. Fidelity measurements can confirm what is delivered to youth and families was implemented as it was intended and makes it possible to attribute any outcomes achieved for the youth and their families to the wraparound process (Bruns, 2008b; Ogles et al., 2005).

Several studies that have examined the wraparound process have found positive treatment outcomes such as: (i) improved behavioural, emotional, academic, and overall functioning (Bruns et al., 1995; Kamradt, 2001; Vernberg, Jacobs, Nyre, Puddy, & Roberts, 2004); (ii) reductions in juvenile justice involvement and recidivism (Kamradt & Meyers, 1999; Pullmann et al., 2006); (iii) decreased restrictiveness in living situation (Mears, Yaffe, & Harris, 2009; Yoe, Santarcangelo, Atkins, & Burchard, 1996); and (iv) reduced levels of impairment in daily life (Anderson, Wright, Kelley, & Kooreman, 2008; Bruns et al., 2006). Long term outcomes have also been supported with decreases in clinical impairment and increases in functioning sustained up to two years post-treatment (Anderson et al., 2008; Pullmann et al., 2006).

In contrast, other studies have found no improvements for the youth involved in the wraparound process (Copp, Bordnick, Traylor, & Thyer, 2007), or no significant difference between wraparound versus either a control or other treatment group (Bickman, Smith, Lambert, & Andrade, 2003; Stambaugh et al., 2007). In the studies conducted by Copp et al. (2007) and Bickman et al. (2003) a fidelity measurement was not used. Therefore, it was not possible to determine whether it was the program implementation or the wraparound process itself that led to the lack of significant findings and outcomes.

Methodological weaknesses are a key issue in establishing wraparound as an evidence-based treatment (Suter & Bruns, 2008; Walter & Petr, 2008, 2011). However, evaluating the wraparound process in practice with strong methodological designs is difficult due to the individualised nature of the process and the client group served (Stambaugh et al., 2007). That said, despite these difficulties and the variability in results and outcomes achieved by the wraparound process a meta-

analysis conducted by Suter and Bruns (2009) demonstrated an overall effect size for the wraparound process in the medium range (0.33). This indicated that even with the diverse range of study effect sizes, on average, youth receiving wraparound achieved better overall outcomes than those receiving conventional services (Suter & Bruns, 2009).

Conclusion

Wraparound, through its focus on collaborative care and long term support, shows promise as a viable community-based intervention for youth with serious mental health disorders and their families (Bruns et al., 2010; J. S. Walker & Bruns, 2006b). A particularly useful feature is the ability to use any service and support that best fits the youth and family needs. Thus, any number of interventions or treatments, can be included in the process (Burns & Goldman, 1999). Wraparound applies common sense to practice with regard to integrating supports and systems for youth and their families (Burchard et al., 2002; Burns & Goldman, 1999; VanDenBerg, 2008). It puts families and young people back in the driver's seat giving them a voice and choice about their plan, increasing engagement and participation, ensuring that it is consistent with their values and beliefs, and what is important to them. The focus is taken off problems, and put on to strengths and solutions (Bruns, Walker, et al., 2004; Malysiak, 1997). Frustration is reduced because all services and agencies are involved in the planning process resulting in a singular family plan to which every agency contributes (Bruns & Walker, 2008). Finally, wraparound provides long term continuity of care, which means the youth and family, is supported for as long as needed. This continues until they have built up enough natural supports to feel confident the formal wraparound process is no longer required (Bruns, Walker, et al., 2004). Overall, this process fits well within a

New Zealand context and culture, and is consistent with other models attempting to increase cohesion between agencies and service delivery for families such as Strengthening Families (Strengthening Families, 2010; A. Walker, 2006).

Wraparound is currently being piloted in one District Health Board in New Zealand and appears well received and practical. However, implementation of this process in practice is far from simple and further research is needed to confirm its effectiveness and status as an evidence-based intervention (Bruns & Walker, 2010; Bruns et al., 2010; Burns et al., 2000; Suter & Bruns, 2008). In particular, research is needed on the wraparound process within the New Zealand context. Although the majority of studies report positive findings, there are particular difficulties with evaluation, as each plan is highly individualised and presentations of each youth and their family varies considerably (Rast & Bruns, 2003).

A challenge for investigators and implementers of the wraparound process is to bridge the gap between the research and practice (Bruns, 2008a; Walter & Petr, 2011). This requires careful consideration of sample size, intervention and follow-up times, and the inclusion of control groups. More controlled studies using robust research designs to evaluate high quality wraparound are still needed. Alternatively, investigators might consider the use of single subject designs to provide an idiographic account of the process (Suter & Bruns, 2009). Based on findings from studies examining the outcomes of the wraparound process in the USA, research evaluating outcomes produced within a New Zealand context will be of particular interest and relevance.

In summary, a range of interventions and treatment options providing a continuum of care are now available for youth with serious mental health disorders and their families. This includes the more traditional institutionalised settings and

those which are community and family-centred (Burns et al., 1999; Farmer et al., 2004). Institutionalised settings are often required, but they are best used as a short term rather than a long term solution (J. Green, 1992; Vargas & Brambila, 2005; Zimmerman, Shapiro, Welker, & Pierce, 2000). Interventions which show the most promise are those which are holistic and based in the youth's home and community environment (Burns et al., 2000; Mitchell, 2012). Although a number of community-based treatments are now available, such as CAMHS, MTFC, MST, and Strengthening Families, long term outcomes for youth with serious mental health disorders are still poor and care remains fragmented at a systems level (Burns & Hoagwood, 2002; A. Walker, 2006). The wraparound process may offer a more refined model for interagency service delivery in New Zealand, which results in improved long term and positive outcomes for youth with serious mental health disorders and their families.

Chapter 3: The Wraparound Process in New Zealand – Service and Programme Description

The wraparound process was brought to New Zealand in 2004 through a redesign of a tertiary level specialist mental health care service called the Intensive Clinical Support Service (ICSS). This was the first time the wraparound process, as described by the National Wraparound Initiative, was delivered within a New Zealand context (The Intensive Clinical Support Service, 2004). It is therefore useful to describe and understand the way in which this service is implementing the process and any adaptations made to fit within a New Zealand context and culture.

The Intensive Clinical Support Services

ICSS is a tertiary level specialist mental health service which exists within four government funded district health boards. Each of the four ICSS teams implements a different intervention model depending on client need and population (e.g., Multisystemic Therapy and wraparound). The aim of ICSS is to provide intensive and comprehensive clinical assessment and treatment services to youth with serious mental health disorders who are involved with the Department of Child Youth and Family (CYF) and Child and Adolescent Mental Health Services (CAMHS; Ministry of Health, 2009).

Service specification. While models implemented across ICSS teams may differ, the ICSS service provision requires that they must: provide evidenced-based therapeutic interventions; have collaborative processes for managing entry and exit from the service; have a mobile service which has flexible hours of operation; develop interagency teams and individualised interagency plans specific to each client's need; and provide training and/or support for caregivers. Due to its intensive and specialist nature each ICSS team has low caseloads of approximately 5-10

clients per clinician (Ministry of Health, 2009; The Intensive Clinical Support Service, 2006).

Target population. Youth eligible for this service are those up to 17 years old (up to 20 if under the guardianship of the Director General of CYF), have a serious and complex mental health diagnosis and have ongoing and active involvement with CYF and CAMHS (The Intensive Clinical Support Service, 2006, p. 10).

In addition to the above criteria, the young person must meet one or more of the following criteria:

- Has contact with multiple health and social services and requires active service co-ordination to develop and manage the number and complexity of services required to improve outcome;
- Requires a more intensive level of mental health clinical services than can reasonably be provided by CAMHS;
- Is not able to have his/her needs met by ‘Strengthening Families’ protocols 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 CYF (or status with the Department; The Intensive Clinical Support Service, 2006, p. 11).

The Beginnings of Wraparound in New Zealand

The use of the wraparound practice model was first considered by one ICSS team after a service redesign when service provision difficulties were encountered in their original model (The Intensive Clinical Support Service, 2004). In order to find

a new model of service, a review was conducted of all effective and promising interventions internationally, which would meet their service criteria and had some evidence supporting their use. This review elicited two models that fit their requirements; Multisystemic Therapy and wraparound. After careful consideration of the needs of the client group served, the advantages and disadvantages of each model, and discussion with other ICSS teams, the wraparound process was chosen. The final decision to use wraparound as a treatment model was based on: the alignment of the model with the service specification; its allowance for flexibility and creativity; minimal cost; its ability to be implemented across a variety of settings; having no time limits to intervention; the process being family centred; and the emerging evidence base in the United States of America (USA; The Intensive Clinical Support Service, 2004).

At the time of this research project only one ICSS team was implementing the wraparound process. However, another team has since begun to implement the model. The following discussion only applies to the ICSS team originally implementing the wraparound process as each ICSS team may differ in their implementation and processes.

The Wraparound Process in New Zealand

The Intensive Clinical Support Service team. The ICSS service providing the wraparound process in New Zealand is a small team consisting of eight full time staff. This includes one full time team manager, a half-time psychiatrist, a half-time administrator, and six full time wraparound facilitators. Each wraparound facilitator employed by ICSS holds at least a tertiary level qualification. At the time this investigation was completed, wraparound facilitators consisted of two social workers, two registered nurses, one clinical psychologist and one psychotherapist.

Supervision. Staff receive intensive supervision on at least a fortnightly basis with the ICSS team manager and psychiatrist. Weekly team meetings are also held to discuss workload and cases to provide wider team support. Team building and team planning days are held throughout the year to support staff cohesion and unity.

Training. All staff were initially trained using Mary Grealish's wraparound training program when they entered the service (Grealish, 2000). A team training day is also held once yearly with all staff to ensure that practice is up to date. In addition to these training days, Dr Eric Bruns and Bruce Kamradt from wraparound initiatives in the USA have come to New Zealand to provide training, technical support, and presentations on the wraparound process.

The wraparound practice model. The wraparound model implemented by ICSS in New Zealand was that described by the National Wraparound Initiative as outlined in Shailer et al. (2013) which includes the embodiment of ten core principles (family voice and choice; team-based; natural supports; collaboration; community-based services; culturally competent; individualised; strengths-based; persistence and outcome-based services) and four phases (engagement, initial plan development, plan implementation and refinement, and transition; Bruns, Walker, et al., 2004; VanDenBerg & Grealish, 1996; J. S. Walker et al., 2004). Additional information on the key activities to be completed within each phase of the wraparound process in New Zealand are presented in Table 4. For a more detailed explanation of the wraparound practice model including the key activities to be completed within each phase please refer to J. S. Walker et al. (2004).

Table 4

Key activities to be completed in each wraparound phase

| Phase 1: Engagement and Team Preparation | Phase 2: Initial Plan Development |
|--|--|
| <p>Phase 1 should be completed quickly within 1-2 weeks, if possible.</p> <p>Key activities and objectives:</p> <ul style="list-style-type: none"> - Facilitate conversations and engage with the youth and family including listening to the family’s story <ul style="list-style-type: none"> o Wraparound facilitator meets with the family to discuss the wraparound process and listen to the family’s story o Discuss concerns, needs, hopes, dreams, strengths, beliefs and traditions - Create the vision <ul style="list-style-type: none"> o Listen to the family’s vision for the future - Orient the family and youth to wraparound including an explanation of the process - Assess for safety and make a provisional crisis and safety plan if needed <ul style="list-style-type: none"> o Stabilise any current crises or safety concerns - Obtain strengths - Ascertain struggles (to be addressed in planning and implementation phases) - Start to build the team by identifying people who care about the family as well as those people the family have found helpful for each family member - Engage other team members - Make necessary meeting arrangements - Complete assessment psychometrics <p>At the end of phase 1 the family should be engaged in the process and there should be an agreement about who will come to the first wraparound meeting to develop the plan and where that meeting should be held.</p> | <p>Phase 2 should be completed during the first 1-2 team meetings.</p> <p>Key activities and objectives:</p> <ul style="list-style-type: none"> - Conducting the first wraparound team meeting with people who are providing services to the family as well as people who are connected to the family in a supportive role - During these first meetings the team aims to: <ul style="list-style-type: none"> o Determine ground rules for wraparound team meetings and collaboration o Discuss and document strengths of the family, team members, and community o Develop a mission statement or family vision about what the team will be working on together – which is defined as a vision and agent for change o Identify and/or review youth and family need. This may be done by picking three life domains of highest importance to prioritise needs/goals <ul style="list-style-type: none"> ▪ The domains of safety and legal are always included and addressed first ▪ Family to choose other domains o Develop an initial plan of care to meet youth and family need o Develop or finalise a crisis and safety plan o Have a clear plan on how outcomes will be achieved <ul style="list-style-type: none"> ▪ Brainstorm and select strategies to meet family and youth needs that match strengths where possible ▪ Action steps are specified to meet these outcomes (including who will be responsible, by when, and how often) o All team members are assigned roles and responsibilities <p>At the end of phase 2 the wraparound team should have: a written a plan of care including action steps; received team member’s commitment to the plan; and the team plans to come together regularly to ensure the plan’s success (usually every 4-6 weeks).</p> |

| Phase 3: Plan Implementation and refinement | Phase 4: Transition |
|---|---|
| <p>The activities of phase 3 are repeated until the team’s mission and plan is achieved and formal wraparound is no longer required. This includes the continuous review of team progress and success towards the plan and changes being made to the plan as needed.</p> <p>Key activities and objectives:</p> <ul style="list-style-type: none"> - Implement the initial wraparound plan - Review progress at each meeting by keeping track of progress on action steps and what has been accomplished throughout the process (e.g., what has been done, what has been going well, what has not been going so well) - Review and celebrate achievements and successes throughout the process <ul style="list-style-type: none"> o Evaluate the success of strategies - Review, change and update the plan as necessary <ul style="list-style-type: none"> o Continually assesses whether the strategies within the plan have been working to achieve the family’s goals o Adjust strategies in the plan that aren’t working and consider new strategies as necessary - Assign new tasks to team members. - Build and maintain team cohesiveness, engagement and trust - Necessary documentation and logistical tasks are completed as required - Complete a report on the families progress <p>At the end of phase 3 the family’s needs as defined by the plan should have been met, and the team and the family feel able to move into the final transition phase.</p> | <p>Phase 4 occurs when the family and team have decided that the mission and goals in the plan have been achieved, the family are doing well, and the formal wraparound process is no longer required.</p> <p>Key activities and objectives:</p> <ul style="list-style-type: none"> - To create a plan for the cessation of formal wraparound services <ul style="list-style-type: none"> o The process and plan is modified to reflect transition planning o A purposeful transition plan is created out of wraparound to a mix of formal and natural supports in the community as determined by the family o A post-transition crisis management plan is developed where necessary <ul style="list-style-type: none"> ▪ Sometimes transition steps include the family and their supports practicing responses to crises or problems that may arise o Detailed in the plan includes who the family can call on if they need help or if they need to re-convene their team o A plan for periodical follow up with the family is created to ensure ongoing success - Create a commencement - document the teams work and celebrate successes <ul style="list-style-type: none"> o This may involve a final meeting of the whole team, a small celebration, or simply the youth and family deciding they are ready to move on - Complete discharge psychometrics to measure outcomes - Necessary documentation is completed including a written discharge summary <ul style="list-style-type: none"> o This includes that the youth and family receive a record of what work was completed as well as a list of what was accomplished - Handover of youth and family (e.g., return to referring agencies) <p>At the end of phase 4 the youth and family are formally discharged from ICSS and the wraparound process and the client case file is closed.</p> |

Note: The key activities and phases described in this table are the activities completed in practice by the Intensive Clinical Support Service which are based on the 32 activities, grouped into four phases described in Walker, J. S., Bruns, E. J., VanDenBerg, J. D., Rast, J., Osher, T. W., Miles, P., . . . National Wraparound Initiative Advisory Group. (2004). Phases and activities of the wraparound process. Portland, OR: National Wraparound Initiative, Research and Training Center on Family Support and Children’s Mental Health, Portland State University

Referral process. Referrals to the ICSS wraparound process must be made jointly by CYF and CAMHS. Once a referral is made for those youth who are eligible to enter the service they are presented and processed by the ICSS team. Consultation with the referring agencies, CYF and CAMHS, takes place and additional information is obtained as required. Referrals can be made at any point as long as the youth meets the referral criteria. A governance group consisting of a representative from the wraparound service, CYF, and CAMHS meets quarterly to review and give updates on accepted referrals.

If the referral is accepted the family is given a description of the wraparound process including information sheets, expectations of the family (e.g., working with transparency, partnership, and integrity), and asked to sign a consent form in order for wraparound services to begin. After the consent form is signed a wraparound facilitator is assigned to the family on a case by case basis depending on family need and preference (e.g., culture, gender) as well as facilitator availability.

Although youth are referred to ICSS, as the wraparound process aims to create service integration through care coordination and planning, the responsibility of the young person is not solely held by the ICSS team or wraparound. Rather it brings services and supports together to generate a cohesive plan and provide more intensive support. The main clinical and mental health responsibility of the young people in wraparound still remains with the CAMHS service while the legal and welfare responsibility remains with the CYF.

The role of the wraparound facilitator. The wraparound facilitator is responsible for the overall coordination and facilitation of the wraparound process including: coordinating and developing wraparound teams with the youth and family; facilitating wraparound team meetings and development of the plan;

documenting the plan including sending out meeting minutes; and organising support, interventions, and services to achieve outcomes (Miles, 2008b; VanDenBerg, 2007). They also ensure that the values and steps of the process are delivered as they were intended (VanDenBerg, 2007).

In New Zealand, wraparound facilitators provide intensive support and availability to families who are referred to their service. Wraparound facilitators act as a key point of contact for families and complete considerable amounts of ‘in between meeting work’. They are often in contact with families at least once a week, but this can extend to daily in the form of telephone calls, emails, texts, home visits, or transportation. Dependent on family need, wraparound facilitators may also provide additional services or supports including: regular home visits and transporting youth and/or families to and from appointments; advocacy on behalf of families; addressing family risk and safety issues, development of a safety plan, and managing crises when they occur; debriefing and defusing situations as required; providing training and support to caregivers; providing out of meeting support to the young person; and providing behavioural modification plans where necessary.

The services and support wraparound facilitators provide in New Zealand may differ from some other wraparound processes where this role is often filled by a ‘family support partner’ or another member on the team (Miles, 2008a). Family support partners are a core part of the wraparound process in the USA, but this concept has not yet been established in New Zealand. In brief, family support partners are typically those who have first-hand experience with mental health services (e.g., through their child or loved one; Miles, 2008a; Penn & Osher, 2008). While their role varies between each wraparound service, generally they provide peer support for family members from the perspective of someone who has either

been through the process or had experience within other mental health systems and can act as an advocate for the family (Miles, 2008a).

Wraparound teams. Wraparound teams consist of people chosen by the youth and family who are relevant to the youth's life and would be of benefit to include in the team (Bruns & Walker, 2008). The teams range in size and team membership varies based on family need. It is aimed that the team consists of equal numbers of formal (e.g., professional agencies and services) and informal natural supports (e.g., family members and friends). In New Zealand, a representative from CYF (usually the youth's social worker) and a representative from the CAMHS (usually the youth's key mental health worker) are mandatory members of the team. This requirement was set to ensure the two key referring agencies remain actively involved with families throughout the wraparound process.

How often do wraparound teams meet? Formal team meetings are held approximately once every four to six weeks. Formal meetings tend to be more frequent at the beginning of the process (e.g., once every 2-3 weeks), but taper off near the end of the process.

Interventions, supports, and services offered through wraparound.

Specific interventions offered within the wraparound process depend on family's needs as well as the formal and informal supports available within the community providing the process (Miles et al., 2011). Some examples of the interventions offered and provided may include: medication trials; general funding and assistance with basic needs (e.g., petrol, transport, food); caregiver training and support; mentors; family therapy; and crisis support.

24/7 availability. The service provides 24/7 telephone availability to support families through an on-call system which is rotated by staff. This allows families to ring the service at any time or day of the week when they need support.

Length of treatment. The length of the wraparound process greatly depends on family and youth need. However, the process generally lasts anywhere between 1 to 28 months and has an average duration of 11 months in New Zealand.

Discharge. Discharge from the wraparound process occurs after: the key activities of the wraparound process have been achieved; the goals of the family's individualised wraparound plan are met; and the team agrees that wraparound services are no longer required. In some cases discharge can occur earlier than this if the family move out of the area, either CYF or CAMHS discharges the family, or the youth ages out of a service. At the end of the wraparound service a discharge summary is written which includes the final diagnoses and reasons for discharge. The case is then closed and transitioned back to the lead agency.

System and community support. For wraparound to work effectively collaboration with a number of system and community level supports are needed (Miles et al., 2011). In New Zealand this includes: a quarterly governance group which meets to review referrals with representatives from ICSS, CYF, CAMHS and the Ministry of Education; a monthly child and adolescent liaison service between ICSS and CYF which provides assistance and advice on cases which CYF are considering referring to the wraparound process; and a dedicated liaison person from the ICSS team with each CYF site. Additional system supports include ICSS presence on relevant CYF meetings and in the management team for CAMHS. Key relationships and collaboration with community partners (e.g., non-governmental organisations, education, youth groups) have also been established to aid in

providing supports and services to families within their community. Finally, to increase awareness and ensure ongoing education about the wraparound process, the ICSS team also offers presentations and training to key agencies and services.

Funding. The ICSS team is funded by the Ministry of Health and this includes flexible funding to support families. Currently, this funding is predominately spent on mentoring, supporting family and pro-social activities, youth incentives, food, and a small percentage on respite or therapy. It should be noted that this funding is not allocated or used to stabilise youth in crisis in New Zealand as this falls within CAMHS responsibility.

Chapter 4: Ethical and Methodological Considerations

Practice based research with vulnerable populations, such as youth with serious mental health disorders, requires careful consideration of ethical and methodological issues (Drotar, 2008; Garland, McCabe, & Yeh, 2008; Hoagwood, Jensen, & Fisher, 2014). Therefore, the purpose of this chapter is to briefly discuss the key ethical and methodological challenges raised throughout the planning and development of this research project. Consideration was given to sample size, recruitment, study design, choice and adaption of a fidelity measure, processes for gaining informed consent and assent, protection of participants through managing risk, privacy and confidentiality, compensation for participation, and culture.

Population and Sample Size

From the outset of planning this research project it was acknowledged the total number of participants that could be recruited would be low. There was only one District Health Board implementing the wraparound process, serving a maximum of 20 to 30 clients per year, for an average duration of 11 months (The Intensive Clinical Support Service, 2004, 2006). Recruitment challenges were expected due to the characteristics of the population under investigation. Specifically, youth and families referred to wraparound have high and complex needs including youth diagnosed with serious mental health disorders and involved with the Department of Child Youth and Family (CYF) for youth justice or care and protection concerns (The Intensive Clinical Support Service, 2006). Therefore, it was predicted that some youth may not have been well enough to take part, to assent, or be motivated to partake in the research. While it was identified that the sample size would be small, it was agreed that the research project was still of value as an exploratory investigation, and could make a meaningful contribution to our knowledge of the

wraparound process in New Zealand and scientific evidence regarding wraparound. However, this required careful consideration of research methodology; in particular with regard to the fidelity study.

Study Design and Measures

Conducting a valid investigation of fidelity to any program requires: (1) a participant sample which is representative of the total population; and (2) a measure which adequately captures the construct under investigation (Bruns, 2008c). When the total population is small, as was the case in the current research project, a representative sample of participants is often analogous with the inclusion of all members of the total population with a high enough response rate to adequately represent the population (Bruns, 2008c; Check & Schutt, 2011). While no standard minimum response rate has been agreed upon, Bruns (2008c) advises a response rate of at least 70% in wraparound fidelity research (Fowler, 2014). This response rate is considered to capture enough of the total population to adequately reduce the risk of response bias (Bruns, 2008c; Check & Schutt, 2011). Therefore, when designing the fidelity study, it was necessary to include all clients involved in the wraparound process in the sampling frame in order to gain as representative sample as possible. A cross sectional design was chosen as this allowed for all clients involved in the wraparound process to be invited to participate in the fidelity study at one point in time (Liu, 2008). It was concluded that if all clients in the wraparound process were invited to take part in the research project and a response rate of 70% or higher was achieved, despite small numbers, a representative estimate of wraparound fidelity in the year the study was conducted could be obtained (Bruns, 2008c; Check & Schutt, 2011).

The next step was to find a measure which would adequately capture the construct of fidelity to the wraparound process. To do this the peer review literature was consulted for measures which assessed wraparound fidelity. The choice of potential measures was based on the ability to address the research question, being an empirically validated measure evidencing good psychometric properties (e.g., reliability and validity), and the usefulness and feasibility in practice (Groth-Marnat, 2009). A total of three potential fidelity measures were identified; all part of the Wraparound Fidelity Assessment System (WFAS) developed by the Wraparound Evaluation and Research Team (WERT; Bruns, 2008c). These measures included: (1) the Wraparound Fidelity Index, version 4 (WFI-4; Bruns et al., 2009) which is a set of four brief semi-structured interviews that measure perceived fidelity to the wraparound process; (2) the Team Observation Measure (TOM; Bruns & Sather, 2007) which involves the external observation and evaluation of adherence during wraparound team meetings; and (3) the Community Supports of Wraparound Inventory (CSWI; J. S. Walker & Sanders, 2011) which evaluates the necessary conditions of successful wraparound implementation in the system context from a local stakeholder perspective. A brief version of the Wraparound Fidelity Index (WFI-EZ; Wraparound Evaluation & Research Team, 2012) was also in the pilot stage of development. However, due to this it was not considered a measure of choice for the current investigation (Sather, Bruns, & Hensley, 2012).

After a thorough investigation of each measure the WFI-4 was chosen. This measure was considered best suited to the research question due to its ability to investigate the fidelity to the wraparound practice model as a whole (Bruns et al., 2009). An additional benefit was that it allowed for a multi-perspective investigation of fidelity from wraparound facilitators, caregivers, youth, and team members. While

each measure had basic psychometric data available, the WFI-4 was the most well validated demonstrating good reliability (test-retest reliability, internal consistency and inter-rater reliability) and validity (content, construct, concurrent and discriminant validity; Bruns, 2010). Finally, the WFI-4 was the most commonly used measure in published research which allowed for the comparison of the research findings to the wider wraparound fidelity literature (Bruns, 2008b).

The WFI-4 was developed in the United States of America (Bruns et al., 2009). Therefore, with permission from the WFI-4 developers the following information was adapted to ensure it was relevant to a New Zealand context and demographic: ethnicity, schooling, and legal custody information. A section in the demographic portion of this measure was also included to specify the young person's mental health diagnosis. The demographics included were in consultation with the service providing wraparound and with consideration of ethnicity, schooling, and legal status of the New Zealand population. A copy of the adapted demographic part of the WFI-4 can be found in Appendix A.

The research project also aimed to explore the experiences of the wraparound process. This led to the development of a qualitative study. A series of 13 qualitative questions in the form of a semi-structured interview were designed to follow on from the WFI-4 interview schedule (see Appendix B). These questions were developed in consultation with the Intensive Clinical Support Service providing wraparound based on what was believed to be useful to understand and improve the service.

The robustness of qualitative research does not centre on the number of participants, as it does in quantitative research, with small sample sizes often being acceptable and preferred. Therefore, numbers were not a pertinent issue in this design (O'Reilly & Parker, 2014). However, as this was an exploratory investigation,

it was considered appropriate to attempt to include all participants involved in the fidelity study to provide a comprehensive and complimentary account of experiences.

Recruitment

It was determined early on in this investigation that success or failure in recruiting families into this research project was reliant, in part, on wraparound facilitators due to their previously established relationship with families and team members. After a presentation of the project was given to those involved in implementing wraparound it was agreed that the wraparound facilitators who consented to take part in the research would be the best people to initially approach families. Wraparound facilitators also had critical knowledge about families including the young person's stability and risk level. It was decided that in the first instance, all families would be advised about the research project by their wraparound facilitator and be asked whether they would be willing to participate. If families were interested, an information pack was provided including information sheets, consent forms, and the principal researchers contact details (see Appendices C to H).

This strategy raised its own ethical issues around ensuring families consent to participate in the research project was completely voluntary and free from coercion (Alderson & Morrow, 2011; O'Reilly & Parker, 2014). For example, as wraparound facilitators had strong therapeutic relationships with families and acted as their key contact and support person, families may have felt in some way obligated to participate, or at the very least may have found it difficult to say no. In order to mitigate this, the principal researcher was given a list of all the families whom had received an information pack and expressed an interest in the studies so they could

be contacted by phone. When the principal researcher first called families the research project was explained in greater detail. Their rights as participants were made clear including that participation was voluntary, they could withdraw at any time, and if they chose not to take part in the research project it would in no way affect the service given. Any risks and/or benefits were also explained and questions they had answered. As they had not met the principal researcher yet, it was believed that this would give families the opportunity to decline participation if they had previously felt any perceived duress or obligation. Participants were also advised that information sessions were being offered if they wanted to know more about the studies. However, these were deemed unnecessary by participants as they were able to obtain enough information through the principal researcher, facilitators, and information sheets. Approximately one to two weeks after the principal researcher had made initial contact with families the principal researcher followed up with those families who had not completed and sent back consent forms to ask if they would like to be a part of the research project.

Only after the family consent and assent process had taken place were team members recruited. For each participating family, the principal researcher asked wraparound facilitators to provide a list of three to five formal support wraparound team members who could then be selected and contacted to participate in the studies. The team members' roles were grouped into eight separate categories (i.e., social worker, child and adolescent mental health worker, school representative, family member, community member, mentor, house parent, and other service clinician). The selection process focused on securing as representative sample as possible from each of the eight possible role categories. A random number allocation formula was used in excel $(=(\text{RAND}()*8)+0.5)$ to assign the order in which the team members

would be contacted. The first team member on the list was contacted to participate in all instances. After being explained the studies if they were not available, or did not express interest to take part in the research project, the next team member on the list would be contacted and so forth.

Informed Consent and Assent

When including youth under the age of 16, special consideration needs to be given to how consent for their participation is obtained (Hoagwood et al., 2014). This is especially relevant as youth, in particular those receiving mental health treatment, are considered to be part of a vulnerable population (Drotar, 2008; Valentine, Butler, & Skelton, 2001). Informed consent ethically requires that a participant has the competence or capacity to give their consent, has been given and understands information regarding the research, and is participating voluntarily (DuBois, 2008; Gallagher, 2009; Kirk, 2007). Youth under the age of 16 are not usually considered able to solely provide their informed consent, that is, legal permission to participate in research. Therefore, consent must be sought and provided from a parent or caregiver (Health and Disability Ethics Committees, 2015). Although it is not legally binding, assent in the form of affirmative agreement from the young person themselves is also often considered best practice (Drotar, 2008; DuBois, 2008; Vitiello, 2008). Gaining youth assent gives them their own choice regarding participation, helps to ensure they are a voluntary participant, and aids with engagement (Cocks, 2006; V. Lambert & Glacken, 2011). In the current research project both caregiver consent and youth assent were obtained. If one or the other was not given the youth was not included as a participant in the studies. However, even if youth assent was not given, as caregivers could be participants in their own right, they could still consent to partake in the research project themselves.

Youth referred to the wraparound process required active and ongoing involvement with CYF, therefore, consideration also needed to be given to the process of consent should they have legal guardianship. In this case, CYF consent for the youth to participate in the research project was legally required. However, as caregivers or parents were also participants, while not legally required, it was believed their consent for their young person's participation should be obtained. This raised the issue of what would occur if one party gave consent but the other did not. Assuming youth assent, in the case that CYF had legal guardianship and declined consent the case was clear; the youth would not participate in the research project (Health and Disability Ethics Committees, 2015). This would become slightly more complex if CYF gave consent, but the caregiver or parent did not. In order to respect caregivers and parents it was decided that, regardless of legal standing, should a caregiver or parent not give consent for their young person to participate this would be respected. Fortunately, this situation did not occur as none of the caregivers who consented to take part in the research project and had youth under the custody of CYF declined to give consent for their youth.

Information sheets and consent forms were developed for all respondent groups (see Appendices C to H). A particular emphasis was placed on developing a specific information sheet and assent form for youth that was age-appropriate and free from jargon to ensure understanding (see Appendix G; Health and Disability Ethics Committees, 2015; Vitiello, 2008). All forms were developed by the principal researcher. Once information sheets had been read and understood all individuals signed consent and assent sheets to confirm their participation. Consent and assent forms were either returned to the principal researcher directly or to their wraparound facilitator who then passed these on to the principal researcher.

Consent was considered as an ongoing and renegotiable process with participants having the opportunity to withdraw from the research project at any stage (Kirk, 2007). There was often sometime between when informed consent or assent had occurred and when the interview took place. Therefore, before beginning the interview, the purpose of the research project was again explained to participants and their consent or assent was reconfirmed. This was believed to be particularly salient for youth to empower their choice to participate.

Mitigation of Risk

All measures were taken to keep participants safe. The current research project was determined to have minimal risk of harm to participants and as such went through the Health and Disability Ethics Committee expedited review process. However, a number of potential risks were identified in the planning of this research project which needed to be taken into account. First, it was predicted that many interviews would be carried out in family's homes by the principal researcher. In order to ensure safe practice for both participants and the principal researcher, supervision from three qualified and experienced psychologists was used. To ensure the procedures and interviews were carried out responsibly, practice interviews were also held before participant interviews were conducted and the majority of interviews were recorded which could be audited at random by the principal research supervisor. All participants were able to stop interviews at any point, ask to have the voice recorder turned off, or refuse to answer any question.

Second, to ensure the principal researcher's own safety when going into participant's homes, before the interview and after informed consent and assent had been obtained, the principal researcher consulted with their wraparound facilitator regarding any safety issues. In addition, before each visit the principal researcher

would inform the service where she was going and the projected finish time. The principal researcher would then contact the relevant person after the interview was complete.

Third, it was possible that parents, caregivers, or youth may become distressed during the interview. In this situation, if for any reason a parent, caregiver, or youth participant became distressed, the interview would be ceased and the participant would first be offered support by the principal researcher. If further support was required this could be obtained through either the participant's wraparound facilitator or one of the clinical supervisors. Once the immediate distress was resolved the individual would be reminded of their rights as a participant. If the participant wished to continue with the studies they would be able to proceed with the interview when they were ready.

Finally, processes needed to be considered in the case that sensitive information was disclosed during the interview (e.g., potential harm to self or others; Kirk, 2007; O'Reilly & Parker, 2014). Before the interview and after written consent or assent was obtained the principal researcher checked with wraparound facilitators about any significant mental health risks. At the beginning of each interview, confidentiality statements were provided so that all participants were aware of the nature and limits of confidentiality. This included the extent to which any case sensitive or concerning information would be disclosed. When interviews took place it was also planned that at least one registered clinical psychologist be available for supervision if required.

Privacy and Confidentiality

Confidentiality and anonymity has been stated as particularly important to consider in research which includes youth participants (Gallagher, 2009; Kirk, 2007;

O'Reilly & Parker, 2014; Powell, Fitzgerald, Taylor, & Graham, 2012).

Considerations include the need to have a safe and private physical location to conduct the research, the protection of participant's identity through anonymity, and the assurance of confidentiality of the data collected (Powell et al., 2012). In the current research project, participants could choose where the interview took place based on where they felt most comfortable. This often included conducting interviews in participant's homes and workplaces. To mitigate against any potential confidentiality issues, participants were asked if there was a private space available to conduct the interview.

To ensure confidentiality of information, all data including interview forms, audio recordings, summaries, and transcripts were stored securely. Electronic data was kept under password protection and physical documents were stored in a locked cabinet situated in a locked office which was only accessible by the principal researcher and research supervisors. In order to protect participants identity all participants were assigned a random confidential number in all data sets and all identifying information was removed. After the completion of this research project, all data will be securely held for a minimum five year period and subsequently destroyed in accordance with Massey University policy.

Compensation through Koha and Reciprocity

There is still debate in the literature regarding payment of research participants with some suggesting it as bribery and others fair compensation (Gallagher, 2009; Powell et al., 2012). In the current research project it was considered important to acknowledge and provide compensation to family participants (e.g., caregivers and youth) for the time and effort they contributed to the research. In New Zealand, this compensation is often given in the form of a small koha (gift) which is considered

culturally appropriate and signifies reciprocation on behalf of the researcher to participants (Berryman, SooHoo, & Nevin, 2013; Hudson, 2004). Therefore, a small koha (gift) was given in the form of a \$20 voucher to caregivers and a \$10 voucher to youth. These gift vouchers were given at the conclusion of each interview in order to reduce any influence on participation. The concept of koha can also be used in other ways and is not limited to money (Berryman et al., 2013). For example, another way the principle of koha was used in this research project was by providing a toll free telephone number for participants to contact the principal researcher throughout the studies.

Cultural Considerations

Cultural consultation was sought and carried out with Ms Trish Young, Māori Student Research Development Advisor at Massey University and Mr Tauke Kirkwood, senior tribal member of Ngai Tai ki Tamaki and Māori liaison for the Intensive Clinical Support Service. While the current investigation did not raise any direct cultural issues, there were a high number of Māori youth and whānau (family) involved in the wraparound process. The research project was discussed in depth over email correspondence with Ms Young and in person with Mr Kirkwood. A formal letter of support was provided by Mr Kirkwood (see Appendix I).

Due to the nature of the research project, all participants were active partners and participants. Where Māori ethnic identity was established as important to the participant the principal researcher endeavoured to meet any desires or needs specified in accordance with the Treaty of Waitangi and best practice. This included offering all participants the opportunity to have a whānau member or other support person present during the interview. In one case this also involved going to the participant's home with their wraparound facilitator before the research interview

was conducted to build engagement and whakawhanaungatanga (relationships). The opportunity to seek cultural consultation and supervision was available throughout this research project from the wraparound team and Massey University.



MASSEY UNIVERSITY
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**STATEMENT OF CONTRIBUTION
TO DOCTORAL THESIS CONTAINING PUBLICATIONS**

(To appear at the end of each thesis chapter/section/appendix submitted as an article/paper or collected as an appendix at the end of the thesis)

We, the candidate and the candidate's Principal Supervisor, certify that all co-authors have consented to their work being included in the thesis and they have accepted the candidate's contribution as indicated below in the *Statement of Originality*.

Name of Candidate: Jacinda Shailer

Name/Title of Principal Supervisor: Dr Ruth Gammon

Name of Published Research Output and full reference:

An Investigation of the Fidelity to a Wraparound Process in New Zealand

In which Chapter is the Published Work: Chapter 5

Please indicate either:

- The percentage of the Published Work that was contributed by the candidate:
and / or
- Describe the contribution that the candidate has made to the Published Work:

The candidate was responsible for the design, data collection, analysis, and write up of the manuscripts. Supervisors have contributed to the manuscripts to the same level as for a usual thesis chapter: by providing guidance and feedback including input regarding decisions made around research process, data analysis, and formatting of the thesis. This contribution has been recognised by Dr Ruth Gammon and Dr Ian deTerte being included as co-authors for the manuscripts which make up this thesis

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Chapter 5: An Investigation of the Fidelity to a Wraparound Process in New

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Abstract

Wraparound was first piloted in New Zealand in 2004, but currently no research has been conducted on the delivery of the process within a New Zealand context. Fidelity research is essential to determine the level of adherence to the wraparound practice model. This study aimed to investigate: (a) the level of fidelity to the wraparound process for combined and individual respondent groups overall and for the ten principles and four phases; (b) whether the whole wraparound process or only specific principles and phases were being delivered as intended; and (c) whether there was a significant difference between the ratings of fidelity between the four respondent groups. Participants included 16 wraparound teams, which included 10 youth, 16 caregivers, 16 team members, and 6 wraparound facilitators. The results from this study supported that overall the wraparound process, for this one program in New Zealand, has been delivered as it was intended to an above average level of fidelity. These results give a preliminary insight into how the wraparound process in this program is being delivered in New Zealand, what aspects of the wraparound process are being delivered well, and where delivery can be improved.

Keywords: Fidelity, Mental Health, New Zealand, Wraparound, Youth

An Investigation of the Fidelity to the Wraparound Process in New Zealand

In recent years, there has been a growing emphasis on providing evidence-based treatments in the mental health field, in particular in child and adolescent mental health, to ensure accountability of services provided and to obtain better outcomes (American Psychological Association, 2006; Burns et al., 1999; Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald, 2001). One intervention with an evidence base currently deemed as promising is the wraparound process. Wraparound is an intensive and individualised care planning process guided by ten philosophical principles and four phases which coordinates interventions, supports, and services for young people with serious mental health disorders and their families (Bruns, Walker, et al., 2004; Bruns et al., 2010; Burns et al., 1999). Originally pioneered in the United States of America (USA) in the 1980s it has since become increasingly popular and adopted around the world, including in New Zealand, as a community-based intervention to help young people remain and function more effectively in their communities (Bruns, Burchard, et al., 2004; Burns et al., 2000; Shailer et al., 2013). Studies investigating this process have indicated improved youth outcomes including reduced rates of hospitalisations, maintenance of youth within the community, reductions in mental health symptoms, and improved overall functioning (Anderson et al., 2008; Bruns et al., 1995; Kamradt, 2001; Mears et al., 2009; Vernberg et al., 2004; Yoe et al., 1996). However, currently only limited research is available on this process within New Zealand (Shailer et al., 2013).

Despite wraparound's popularity and studies supporting positive outcomes it has yet to be established as an evidence-based treatment (Bruns & Walker, 2010; Bruns et al., 2010; Suter & Bruns, 2008). A key constraint to further implementation of the wraparound process is its lack of evidence base in a New Zealand context

(Bruns & Walker, 2010; Bruns et al., 2010; Burns et al., 2000; Suter & Bruns, 2008).

An important part of confirming wraparound or any intervention as evidence-based is to demonstrate its effectiveness in practice settings (American Psychological Association, 2006). To do this it must first be ensured that interventions have been implemented as they were intended by determining treatment fidelity so that conclusive statements can be made about treatment effects (Borrelli, 2011; Bruns et al., 2008; Dusenbury, Brannigan, Falco, & Hansen, 2003; Murphy & Gutman, 2012). In agreement, Walter and Petr (2008) assert that one of the main barriers to wraparound establishing a stronger evidence base is due to a lack of fidelity research.

The investigation of fidelity is particularly relevant for those interventions, such as wraparound, which are complex in their delivery and also serve complex populations (Leeuw, Goossens, de Vet, & Vlaeyen, 2009; Pullmann, Bruns, & Sather, 2013; Rast & Bruns, 2003). Measuring fidelity determines how adequately a programme, or in this case the wraparound process, has been delivered in practice compared to its original specification and design (Mowbray et al., 2003; Walter & Petr, 2008). For wraparound, measuring fidelity requires an assessment of the adherence to the basic philosophy, principles, phases and activities of the wraparound process as well as the supports and organisational systems in place (Bruns, 2008b). A number of fidelity tools have been developed to assess the degree of wraparound implementation including interviews, team observation measures, and document reviews (Bruns, 2008c; Bruns et al., 2006; Epstein et al., 2003; J. S. Walker & Sanders, 2011). The most commonly used tool in wraparound fidelity research is the Wraparound Fidelity Index; now in its fourth version (WFI-4; Bruns et al., 2009).

The WFI-4 provides a comprehensive assessment of fidelity by obtaining the perspectives of four different categories of respondents involved in the wraparound process on its delivery, namely wraparound facilitators, caregivers, youth, and team members (Bruns et al., 2009). A particular advantage of the WFI-4 is the ability to assess the entire wraparound process, wherever a given wraparound team is at in the process, through a single interview with a member of each respondent group.

According to the standards of fidelity proposed by Bruns et al., (2008) for the WFI, the majority of studies using this as their fidelity measure have been found to be delivering the wraparound process as it was intended to an adequate or above average level of fidelity as determined by a score of 75% or higher (Bruns, 2010; Effland, Walton, & McIntyre, 2011; M. A. Moore & Walton, 2013; Painter, 2012; J. S. Walker, Pullmann, Moser, & Burns, 2012).

By evaluating wraparound fidelity, researchers, and service providers are able to make comparisons across wraparound programmes, assess programme drift and provide quality assurance. Information on the adherence to the wraparound process is also required to effectively and reliably measure the outcomes achieved and allow valid conclusions to be made on its effectiveness (Mowbray et al., 2003; Ogles et al., 2005; Rast & Bruns, 2003; Toffalo, 2000). In particular, to determine whether unsuccessful outcomes are due to a failure of the wraparound process itself or a failure to implement the wraparound process as it was intended (Bruns, 2008b; Mowbray et al., 2003; Perepletchikova, Treat, & Kazdin, 2007).

The importance of treatment fidelity is also relevant to client outcomes (Bruns, Suter, Force, & Burchard, 2005; Cox, Baker, & Wong, 2009). A number of studies into the fidelity of wraparound have found a relationship between higher model fidelity and positive client outcomes such as greater improvements in youth's

functioning, wellbeing and problem behaviour including internalising and externalising behaviour (Bruns et al., 2005; Cox et al., 2009; Effland et al., 2011; Graves, 2005; Graves & Shelton, 2007). Bruns et al. (2005) found that wraparound fidelity was able to predict change in both child behavioural strengths and caregiver's perception of child progress. A bidirectional relationship between wraparound fidelity and client outcomes has also been suggested (Barfield, Chamberlain, & Corrigan, 2005). Barfield et al. (2005) found that youth who received high fidelity wraparound exhibited significantly better outcomes whilst those who received low fidelity wraparound had poorer outcomes with overall Child Behaviour Checklist scores that deteriorated across involvement in the wraparound process. Findings like these clearly highlight the significance of fidelity research in wraparound implementation and the need to include fidelity measurements in outcome studies to accurately determine effectiveness (Bruns, 2008b).

In 2004, wraparound was implemented as a pilot programme in one District Health Board in New Zealand and has served approximately 200 clients. It was introduced to a further District Health Board in 2013. However, it has yet to be determined how the wraparound process is being delivered in New Zealand. Fidelity investigations have been indicated to be of particular importance when a model has been first implemented in a new country and different cultural context to ensure adequate implementation (Randall, Wakefield, & Richards, 2012). Therefore, fidelity research confirming that the wraparound process adheres to the practice model is essential. Conducting such research is also a first step along the continuum of establishing an evidence base for wraparound in New Zealand (Bruns, 2008b; Ogles et al., 2005; Randall et al., 2012; Walter & Petr, 2008).

The current study investigated the fidelity of the wraparound process in New Zealand using the WFI-4. It was aimed to investigate: (a) the level of fidelity to the wraparound process for combined and individual respondent groups overall and for the ten principles and four phases as measured by the WFI-4; (b) whether the whole wraparound process or only specific principles and phases were being delivered as intended; and (c) whether there was a difference between ratings of fidelity between the different respondent groups interviewed with the WFI-4. It was hypothesised that: (a) the overall fidelity to the wraparound process in New Zealand, based on both combined and individual respondent groups, would be of at least an adequate level (75% or over; Bruns et al., 2008); (b) all elements, namely the four phases and ten principles, would be delivered to at least an adequate level of fidelity (75% or over); and (c) wraparound facilitator fidelity scores would be significantly higher when compared to other respondent groups of caregivers, youth, and team members. The last hypothesis was generated as when validating the WFI-4, wraparound facilitators were found to rate the fidelity to the wraparound process higher than caregivers, youth, and team members (Bruns, 2010). Therefore, it was believed that the same pattern could be predicted for the current investigation.

Methods

Research Design

A quantitative descriptive theory based evaluation of the wraparound process using a between-subjects, cross-sectional survey design was employed for this study.

Participants

Participants included 16 wraparound teams, which included 10 youth (6 females; 4 males) diagnosed with serious mental health disorders who ranged in age from 12 to 16 years ($M=14.80$; $SD=1.62$), 16 caregivers (14 females; 2 male), 16

team members (10 females; 6 males) and 6 wraparound facilitators (4 females; 2 males). The demographic data for youth in the 16 wraparound teams who consented to take part in this study is presented in Table 5. As 6 youth did not complete the WFI-4, the demographic data was also broken down by those youth who did and did not participate in the WFI-4 interview. All 16 wraparound teams were delivered the wraparound process from the same site and at the time of data collection had been in the wraparound process from 2.53 to 18.67 months (M=9.56, SD=4.9). The majority of the families identified as New Zealand European (37.5%, n = 6), followed by New Zealand Māori (18.8%, n = 3), New Zealand Māori/European (12.2%, n=2), Middle Eastern (12.5%, n=2), Other European (12.5%, n=2) and South African (6.3%, n=1). The majority of youth had been in school in the last 30 days (87.5%).

Table 5

Youth Demographic information

| | Total Sample (n=16) | Youth who completed WFI-4 (n=10) | Youth who did not complete WFI-4 (n=6) |
|---|--------------------------------|---|---|
| Age (years) | | | |
| Range | 12-17 | 12-16 | 14-17 |
| Mean (SD) | 14.94 (1.44) | 14.80 (1.62) | 15.17 (1.17) |
| Time in Wraparound (months) | | | |
| Range | 2.53-18.67 | 4.27-16.83 | 2.53-18.67 |
| Mean (SD) | 9.56 (4.9) | 8.81 (3.9) | 10.83 (6.45) |
| Gender | | | |
| Female | 9 (56.25%) | 6 (60%) | 3 (50%) |
| Male | 7 (43.75%) | 4 (40%) | 3 (50%) |
| Ethnicity | | | |
| New Zealand European | 6 (37.5%) | 3 (30%) | 3 (50%) |
| New Zealand Māori | 3 (18.75%) | 2 (20%) | 1 (16.67%) |
| New Zealand European/Māori | 2 (12.5%) | 1 (10%) | 1 (16.67%) |
| Middle Eastern | 2 (12.5%) | 2 (20%) | - |
| South African | 1 (6.25%) | 1 (10%) | - |
| Other ethnicity | 2 (12.5%) | 1 (10%) | 1 (16.67%) |
| Number of Mental Health Diagnoses* | | | |
| One mental health disorder | 5 (31.25%) | 3 (30%) | 2 (33.33%) |
| Two mental health disorders | 8 (50%) | 6 (60%) | 2 (33.33%) |
| Three or more mental health disorders | 3 (18.75%) | 1 (10%) | 2 (33.33%) |
| Living Situation | | | |
| Single parent household | 6 (37.5%) | 4 (40%) | 2 (33.33%) |
| Dual parent household | | | |
| Both biological parents | 3 (18.75%) | 2 (20%) | 1 (16.67%) |
| Biological mother and stepfather | 2 (12.5%) | 2 (20%) | |

| | | | |
|---------------------------|-----------|---------|---------|
| Non-biological caregivers | 1 (6.25%) | 1 (10%) | |
| Out of home placement | 4 (25%) | 1 (10%) | 3 (50%) |
| Custody | | | |
| Family Whānau Agreements | 12 (75%) | 9 (90%) | 3 (50%) |
| Full custody | 4 (25%) | 1 (10%) | 3 (50%) |

*For specific mental health diagnoses see Appendix J

The wraparound process for the 16 teams was coordinated by one of six facilitators employed by the District Health Board. The wraparound facilitators had varying numbers of cases that participated in the study. One facilitator had five teams (31.25%), two facilitators had three (18.75%), another two facilitators had two (12.5%), and one facilitator had only a single wraparound team participate (6.25%).

Wraparound teams ranged from 6 to 13 members, with an average of 9.81 (SD = 1.94) team members. Direct family (e.g. birth mothers and fathers, adoptive parents, siblings and youth themselves) made up 35% of the total team composition. Natural supports (e.g. extended family, school and other support people identified by the family) made up 21% of team composition while formal supports (e.g. mental health workers, social workers, mentors) made up the majority at 44%.

The majority of caregivers who consented to be part of the research were the biological parents of the youth (81.25%, n=13). Other caregivers consisted of an adoptive parent (6.25%, n=1), an aunt who had full custody (6.25%, n=1) and a house parent from an out of home placement (6.25%, n=1). Team members included teachers or other school staff such as deans and school counsellors (31.5%, n=5), the young person's child and adolescent mental health worker (25%, n=4), the young person's social worker (18.8%, n=3), mentors (12.5%, n=2), a residential group home staff member (3.3%, n=1), and a counsellor (6.3%, n=1).

Sampling. Participants for the current study were recruited from the same District Health Board delivering the wraparound process in a metropolitan city in New Zealand. They were a self-selected sample derived from all participants who

met the study criteria and who agreed to participate in the research. In order to be eligible to gain access to the wraparound service the youth must be diagnosed with a serious mental health disorder and have ongoing and active involvement with a community mental health service and a child welfare and/or youth justice service (The Intensive Clinical Support Service, 2006).

All clients over the age of 11 and enrolled in the wraparound process for at least 30 days (one month) between September 2012 and May 2013 were approached to participate in the study. Clients who did not meet these criteria were excluded from the study as specified by the WFI-4 administration manual (Bruns et al., 2009). A total of 31 clients were served by the wraparound process between September 2012 and May 2013. Twenty-six out of the 31 clients met eligibility criteria for this study and were approached along with their families by their wraparound facilitators to participate in the study. Of the 26 eligible clients who were approached, 16 consented to participate; this equated to approximately 61% of the total available sample.

Measure

Wraparound Fidelity Index – 4 (WFI-4). The fidelity of the wraparound process was measured using the WFI-4. The WFI-4 is a brief semi-structured interview which is administered either face-to-face or over the telephone to four types of respondents: parents or caregivers; youth (11 and over); wraparound facilitators; and team members. Examples of the types of questions included in the WFI-4 are: “did the family members select the people who would be on their wraparound team?”; “did the family and its team create a written plan of care that describes how the team will meet the child’s and family’s needs?”; and “are the

supports and services in the wraparound plan connected to the strengths and abilities of the child and family” (Bruns et al., 2009).

The caregiver, facilitator, and team member WFI-4 forms consist of 40 items, whilst the youth interview form consists of 32 items. All items are scored as either No (0), Sometimes/Somewhat (1) or Yes (2). Higher scores indicate greater wraparound fidelity. The WFI-4 interviews are organised on the four phases of wraparound (engagement, planning, implementation and transition). It is designed to evaluate the extent to which these four phases along with the ten principles of wraparound have been adhered to in the implementation of the wraparound process based on respondents’ perception of experience. Total measure scores are obtained through an item average score. Interviewers are trained in how to administer and score the WFI-4 including inter-rater reliability criteria (Bruns et al., 2009; Pullmann et al., 2013).

The WFI-4 has indicated good psychometric properties (Bruns, 2010; Bruns et al., 2005; Pullmann et al., 2013). The total score demonstrates adequate ($\alpha=.83$) to high ($\alpha=.92$) levels of internal consistency for all respondent types (Bruns, 2010). However, alpha coefficients for phase subscales were not as high ranging from .51 to .82 and even lower again for the ten principles subscales ranging from .30 to .60, indicating caution when examining any between-group differences in WFI-4 subscale scores (Bruns, 2010). Construct validity has been supported using a Rasch partial credit model which indicates that the items on the WFI-4 capture a uni-dimensional construct (Pullmann et al., 2013). Good concurrent validity has been evidenced when correlated with the Team Observation Measure ($r=.86$; Bruns, 2010; Pullmann et al., 2013). There have also been consistent findings regarding the scores

of the WFI-4 discriminating between wraparound and other types of service delivery conditions (Bruns, 2010; Bruns et al., 2009).

As the WFI-4 was developed based on demographics from the USA, it was necessary to adapt the demographic part of the WFI-4 index to fit a New Zealand context and demographic. A copy of the adapted demographic part of the WFI-4 is included in Appendix A.

Procedure

Consent. Informed written consent was obtained from wraparound facilitators, team members, youth, and their legally responsible caregiver who participated in the study. All participants were informed both verbally and in writing that participation was voluntary and would in no way affect the service they would be given or their employment status. Before written consent was obtained information sheets were provided outlining the nature of the research project, their rights as participants, and what would be involved in the study including any benefits or risks (see Appendices C and D for information sheets provided to families and team members).

All participants confirmed participation once the information sheet had been read and formal agreement was recorded through signature of the informed consent and assent sheets (see Appendices E, F, G and H). All wraparound facilitators employed by the District Health Board delivering the wraparound process consented to take part in the research project. Although only 10 youth decided to participate in the interview part of the study, consent from all 16 families was given to access data on their mental health files. Once consent was obtained from caregivers and youth, team members were selected. To ensure a representative sample as possible team members' roles were grouped into eight separate categories (i.e., social worker, child and adolescent mental health worker, school representative, family member,

community member, mentor, house parent, and other service clinician) and randomly selected. Some team members were unable to be contacted as they were on annual leave during study recruitment or indicated that they would be on leave during the interview period. All team members selected and contacted agreed to participate.

Interviews. All interviews with the four categories of participants in a wraparound team were completed within no more than 30 days (one month) of each other. Interviews were conducted in person at a variety of locations and were completed where the participant felt most comfortable. All wraparound facilitator interviews were conducted in a room at the District Health Board where they worked. Caregiver and youth interviews were mostly conducted at their homes while team members were predominantly interviewed at their place of work. If caregivers, youth, or team members did not want or were unable to be interviewed at their homes or places of work then the interviews were conducted in a room at the District Health Board. Each participant was interviewed individually except for some youth where the primary caregiver was present as the interview was carried out in the family home. Wraparound facilitators were interviewed first in most cases, so that any relevant information about risk or mental state could be communicated before the principal researcher went into the family's home. No specific order of interviewing was followed for caregivers, youth, and team members; rather it was based on participants' availability.

Confidentiality statements were provided so all participants were aware of the nature and limits of confidentiality including the extent to which any case sensitive or concerning information would be disclosed. Participants were advised the interview would be recorded. Participants confirmed their consent and were given the opportunity to ask any questions before interviews proceeded.

For all participants the interview consisted of the WFI-4 interview followed by a series of qualitative questions developed specifically for this research project. This paper only focuses on the results of the WFI-4 interview. At the end of each interview participants were asked if they had anything else to add and were debriefed. Caregivers and youth were given a donation (koha) of shopping vouchers to thank them for their participation in the study at the end of their interviews.

If indicated on the consent form participants would be mailed a summary of the results once the research had been completed. This process was followed for all participant groups (e.g., facilitators, families and team members; see Appendices K-M). This study was approved by the Northern Y Regional Health and Disability Ethics committee (see Appendix N).

Results

Representativeness of Sample

To ensure the sample was representative of the larger population served by the wraparound service a chi-squared test was calculated for gender and considered for ethnicity. A Mann-Whitney U was used for age at referral and amount of time in service.

The chi-squared analysis indicated that the sample did not differ by gender $X^2(1, N=203)=1.48, p=0.23$. Consideration was also given to compare ethnicity of the two groups, but the data was not sufficient to meet the assumptions of the test. The data obtained in this study is therefore able to be generalised based on gender, but not based on ethnicity.

The amount of time the young people were in the service did not significantly differ between the general wraparound service population (mdn = 271 days; mean rank 100.04) and the sample population (mdn = 347 days; mean rank 124.88) based

on the number of days in service, $U=1130.00$, $p>0.05$ (ns), $r=-0.11$. However, age at referral for the larger wraparound service population was significantly lower (mdn = 13 years; mean rank 99.51) than the age of the study population (mdn=14 years; mean rank 131.09), $U=1030.50$, $p<0.05$, $r=-0.15$. This result was likely due to the age cut off of 11 used for this study to meet the specifications of the WFI-4.

Wraparound Fidelity Calculation

Bruns et al. (2009) recommend that an item average score is calculated and then divided by the total possible item score to get a fidelity percentage when some items either have a response of ‘I don’t know’ or ‘not applicable’, which was true for this data set. To determine the level of fidelity to the wraparound process, fidelity percentages were calculated based on item average scores for combined and individual respondent groups.

An item average calculation was used for two reasons. First, to ensure the fidelity score would not be artificially deflated and affect the validity of the results based on the missing data. Second, it was used because there were six youth forms which were unable to be collected due to the young person being too unwell or in crisis, having an intellectual disability, or the young person or parent not consenting for them to take part in the research. The missing youth forms meant that the total number of items when all forms were combined was different for those with uncompleted youth forms. An item average score provided a more robust calculation as it allowed the fidelity calculation to be consistent across all respondents even if there was an uncompleted form (e.g., youth form).

The standards of fidelity determined by Bruns et al. (2008) were used to provide a metric for comparison and levels of fidelity. Bruns et al. (2008) advise that wraparound fidelity percentage scores on the WFI of: 85 to 100 indicate high

fidelity; 80 to 85 above average fidelity; 75 to 79 average fidelity; 70 to 74 below average fidelity; and scores below 69 indicate a non-wraparound level of fidelity (Bruns et al., 2008).

Wraparound Fidelity

The first question of this study was to evaluate the level of fidelity to the wraparound process in regards to overall delivery of the process based on combined and individual respondent groups. In addition, evaluation of the fidelity ratings of the ten principles and four phases was sought. In this article total mean item averages were provided on the WFI-4 for 16 families and a total of 48 participants.

Total fidelity. The overall fidelity of the wraparound process rated across all respondent groups was 81.83% (SD = 6.53) which falls in the above average range. The wraparound facilitator respondent group rated the overall fidelity the highest at 88.25% (SD=6.99) indicative of high fidelity wraparound, followed by youth (M=81.08; SD=11.45) and team members (M=79.71; SD=9.09) both scoring the wraparound process within the above average fidelity range. The caregiver respondent group rated the overall fidelity of the wraparound process the lowest at 78.74% (SD=8.49), but this score still indicates adequate wraparound fidelity falling in the average range. Figure 2 illustrates these findings. These results supported the hypothesis that the overall fidelity of the wraparound process would be at least of an adequate level (75% or above) for combined respondents and individual respondent groups.

Fidelity by phase. The mean fidelity percentage score for combined respondents across the engagement (M=84.31; SD = 6.78) and planning (M= 81.62; SD = 8.97) phases fell within the above average range. The implementation phase had the highest mean fidelity score for combined respondents falling in the high

fidelity range (M=85.19; SD=5.74). The transition phase was rated the lowest falling in the below average range (M=73.63; 15.18). The hypothesis that all phases would be delivered to at least an adequate level was not supported.

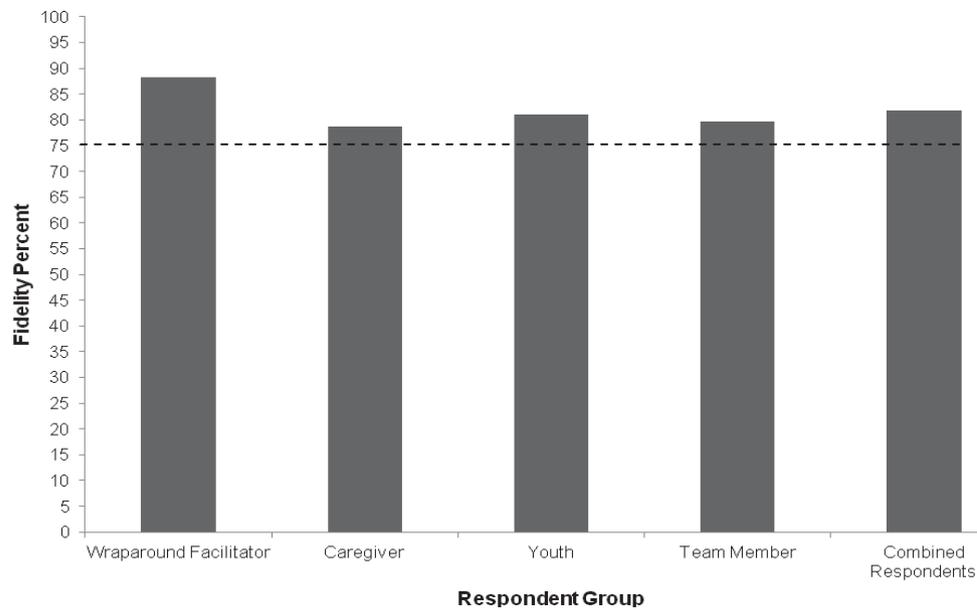


Figure 2. WFI-4 total fidelity percentage overall and by respondent group

When broken down by respondent group the transition phase had the lowest mean fidelity score for the wraparound facilitator (M=84.94; SD=14.26), team member (M=72.69; SD=21.24) and caregiver (M=67.75; SD=22.76) respondent groups. Caregivers rated this phase the lowest out of all respondents. Despite the implementation phase receiving the highest mean fidelity score for combined respondents (M=85.19; SD=5.59), when analysed individually, only youth respondents rated this phase the highest (M=89.10; SD=9.75). The engagement phase was rated highest by the wraparound facilitator (M=90.25; SD=11.23), followed by the caregiver (M=86.69, SD=10.10) and team member (M=84.94; SD=13.08) respondent groups. Youth respondents, on the other hand, had the lowest mean fidelity rating for the engagement phase (M=69.30; SD=16.66). Figure 3

illustrates the average fidelity percentage as rated by combined respondents and individual respondent groups.

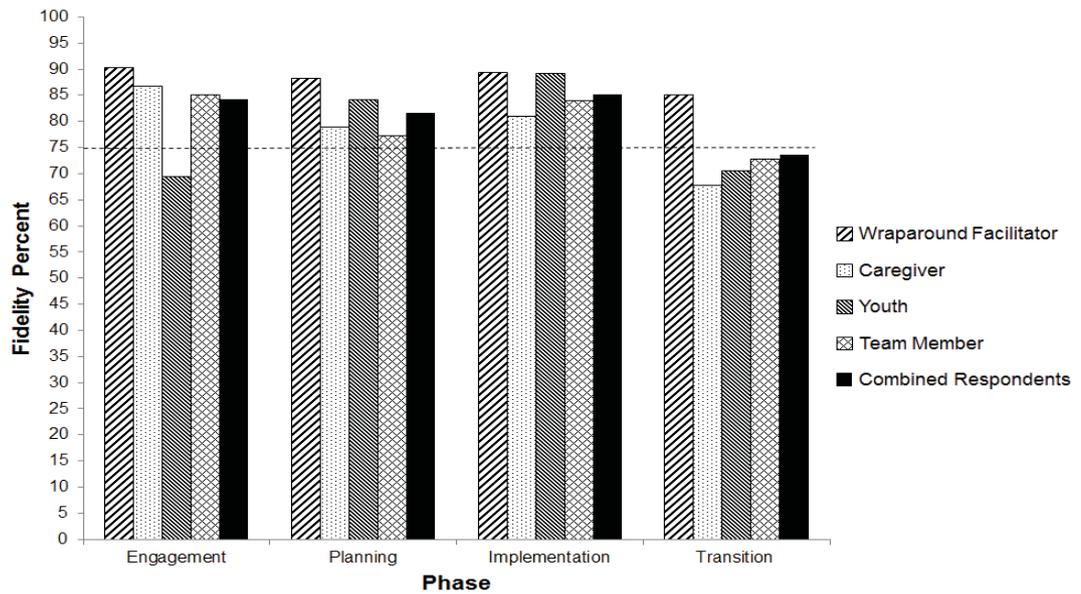


Figure 3. WFI-4 fidelity percentage by phase and respondent group

Comparison between phases for combined respondents. To test whether there was a significant difference between the total mean fidelity ratings of each phase for combined respondents the Kruskal-Wallis test was used. A significant difference was found between the engagement (mean rank=36.25), planning (mean rank=32.16), implementation (mean rank=39.44) and transition (mean rank=22.16) phases, with $H(3)=7.89$, $p=0.05$. Pairwise comparisons with adjusted p-values showed that the statistically significant difference was between the implementation and transition phase ($p=.05$, $r=0.46$). The implementation phase (mean rank=39.44) was ranked significantly higher than the transition phase (mean rank=22.16). No other significant differences between the four phases were found at the $p<0.05$ significance level.

Fidelity by principle. The hypothesis that all wraparound principles for combined respondents would be rated at an adequate level of fidelity was not

supported as two principles fell in the below average range of fidelity or lower (i.e., community-based services and natural supports). When combined respondent fidelity scores were analysed by principle, eight out of the ten principles were rated at an average level of fidelity or higher. Figure 4 illustrates these findings. Those principles which had high fidelity ratings included: culturally competent (M=96.29, SD=3.59), collaboration (M=91.88, SD=6.53), family voice and choice (M=90.28, SD=3.59), collaboration (M=91.88, SD=6.53), family voice and choice (M=90.28, SD=9.89), and persistence (M=86.95, 9.22). The principles of team-based (M=82.36, 7.23) and strength-based (M=80.15; SD=12.85) were rated at an above average level of fidelity, while the principles of outcome-based (M=78.12, SD=15.86) and individualised (M=74.69, SD=10.40) were rated at an average level of fidelity. The principles rated the lowest were community-based services (M=73.63, SD=13.42) falling in the below average level of fidelity and natural supports (M=66.90, SD=15.16) falling into the non-wraparound level of fidelity. That is, the delivery of natural supports was perceived by combined respondents as not having met the criteria for wraparound.

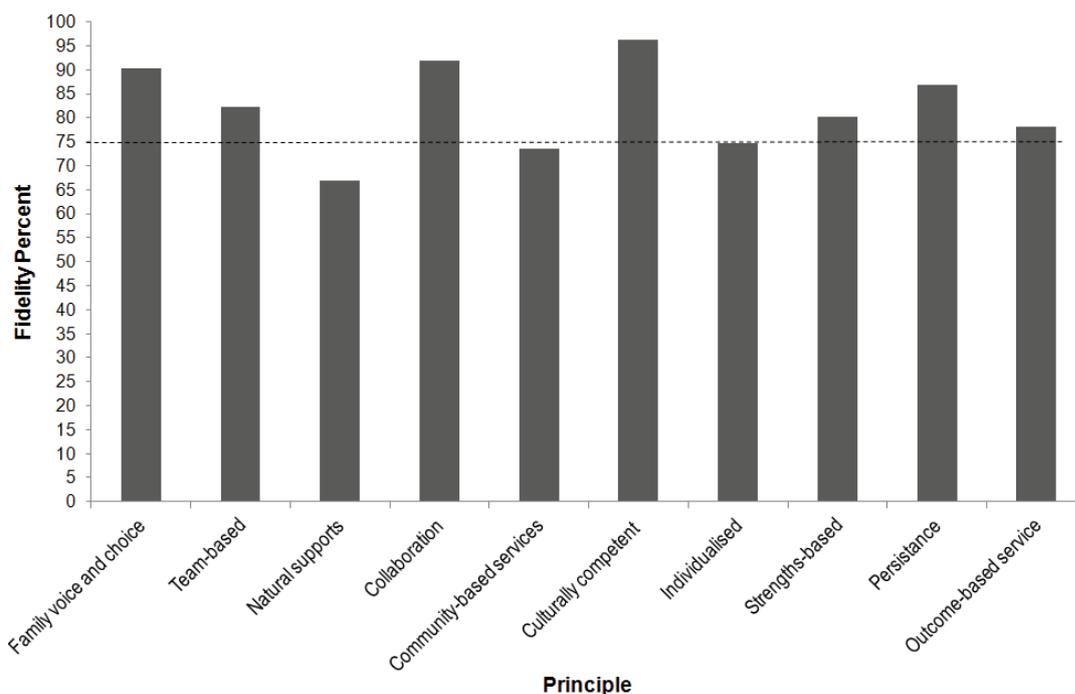


Figure 4. WFI-4 fidelity percentage by principle for all combined respondents

Comparison between principles for combined respondents. The Kruskal-Wallis test was also used to determine whether there was a significant difference between the mean fidelity ratings of the ten principles. A significant difference was found between the ten principles, $H(9)=69.44$, $p=0.00$. Mean ranks and significant differences are listed in Table 6.

Table 6

Kruskal-Wallis mean ranks for ten principles

| Principle | N | Mean Rank |
|----------------------------|----|-----------|
| Culturally competent* | 16 | 135.44 |
| Collaboration** | 16 | 114.28 |
| Family voice and choice*** | 16 | 109.22 |
| Persistence**** | 16 | 95.06 |
| Team-based | 16 | 74.97 |
| Strengths-based | 16 | 72.38 |
| Outcome-based | 16 | 68.5 |
| Community-based services | 16 | 49.41 |
| Individualised | 16 | 48.44 |
| Natural supports | 16 | 37.31 |

*Culturally competent was ranked significantly higher than the principles of natural supports ($p=0.00$, $r=1.09$), individualised ($p=0.00$, $r=0.94$), community-based services ($p=0.00$, $r=0.93$), outcome-based ($p=0.00$, $r=0.72$), strengths-based ($p=0.01$, $r=0.68$), and team-based ($p=0.01$, $r=0.65$).

**The principle of collaboration was ranked significantly higher than the principles of natural supports ($p=0.00$, $r=0.83$), individualised ($p=0.00$, $r=0.71$) and community-based services ($p=0.00$, $r=0.70$).

***Family voice and choice was ranked significantly higher than the principles of natural supports ($p=0.00$, $r=0.78$), individualised ($p=0.01$, $r=0.66$) and community-based services ($p=0.01$, $r=0.65$).

****The principle of persistence was ranked significantly higher than the principle of natural supports ($p=0.19$, $r=0.62$).

Differences in fidelity ratings between respondent groups. A one-way ANOVA was used to test whether there was a significant difference between the ratings of fidelity between the four respondent groups. A significant difference was found $F(3, 54)=3.77$, $p=0.02$, $w^2=0.13$. Hochberg post-hoc comparisons indicated that the wraparound facilitator respondent group rated the fidelity of the wraparound process significantly higher than the caregiver ($p=0.02$, $r=0.88$) and team member ($p=0.02$, $r=0.75$) respondent groups. Comparison between the wraparound facilitator and youth respondent group was not statistically significant ($p=0.26$, $r=0.70$). No

statistically significant differences were found between the fidelity ratings of the respondent groups whom received the wraparound process, namely, caregivers, team members, and youth. As there was no significant difference between the wraparound facilitator and youth fidelity ratings, the hypothesis that the wraparound facilitator respondent group would rate the fidelity to the wraparound process significantly higher than the other respondent groups was only partially supported.

Due to six youth not completing the WFI-4 an exploratory one-way ANOVA was conducted, with the data removed for those cases which did not have youth forms, to determine whether the significant difference between ratings of fidelity remained without these six cases. When cases were removed for those which did not have youth data no significant difference remained between the mean fidelity score of the four respondent groups $F(3, 36) = 2.60, p > 0.05, w^2 = 0.11$.

Discussion

Fidelity research is an essential component in confirming that models in practice are being delivered as they were intended. This study aimed to investigate the overall fidelity and implementation of the wraparound process in New Zealand based on combined respondents as well as the fidelity of the essential elements which make up wraparound, namely its ten principles and four phases. As perception often differs across individuals and groups the study also sought to examine whether the four different respondent groups interviewed with the WFI-4 differed in their perceptions of the fidelity to the wraparound process (Bruns, 2010).

The results confirmed, that overall, the wraparound process in New Zealand is being implemented as it was intended. In support of hypothesis one, individual and combined respondents rated the fidelity to the wraparound process to at least an average level or higher on the WFI-4. High fidelity elements included the

implementation phase, and the principles of cultural competence, collaboration, family voice and choice, and persistence. Low fidelity elements of the process were identified as the transition phase, as well as the principles of natural supports and community-based services. The low fidelity scores in these areas did not support hypothesis two that all elements of the wraparound process would be delivered to at least an adequate level of fidelity. Finally, wraparound facilitators were found to rate the fidelity to the wraparound process significantly higher than team members and caregivers. However, no significant difference was found between the fidelity ratings of wraparound facilitators and youth. This finding only partially supported hypothesis three; that wraparound facilitators would rate the fidelity to the process significantly higher than other respondent groups.

Combined Respondents: Fidelity, Phases, and Principles

The overall fidelity score for combined respondents reached an above average level of fidelity based on the criteria established by Bruns et al. (2008). This fidelity rating is relatively consistent with studies of wraparound fidelity using the WFI-4 (Bruns, 2010; Effland et al., 2011; M. A. Moore & Walton, 2013; Painter, 2012; J. S. Walker et al., 2012). The high and low fidelity ratings of the four phases and ten principles were also in line with previous findings (Bruns, 2010; Cox et al., 2009; M. A. Moore & Walton, 2013). Research into the fidelity of wraparound consistently indicates low fidelity scores in the areas of transition, natural supports, and community-based services and high scores in areas such as implementation, cultural competence, persistence, and family voice and choice (Bruns, 2010; Cox et al., 2009; M. A. Moore & Walton, 2013). These findings indicate a degree of consistency in both the prescribed elements and the overall delivery of wraparound in New Zealand compared to established wraparound processes in the USA (Bruns, 2010; Cox et al.,

2009; Effland et al., 2011; M. A. Moore & Walton, 2013; Painter, 2012; J. S. Walker et al., 2012)

Of those studies which provide fidelity data for the phases of wraparound the transition phase appears most difficult to establish adherence to. In the validation study of the WFI-4, similar trends to the current study across phases were found, with the implementation phase having the highest fidelity rating and the transition phase the lowest (Bruns, 2010). M. A. Moore and Walton (2013) corroborated this finding of low fidelity to the transition phase in their study. Natural supports and community-based services have also been commented in the wraparound literature to be the most difficult to establish and connect with (Cox et al., 2009; M. A. Moore & Walton, 2013). In particular, the principle of natural supports has often been reported as the lowest scoring principle (Cox et al., 2009; M. A. Moore & Walton, 2013). Due to the low fidelity ratings of community-based services and natural supports, both of which are the long term support system for families and young people, it is therefore not surprising that the transition phase was also rated at below average fidelity.

A large part of the transition phase is around preparing families and young people to leave the formal wraparound process which involves transitioning the family to informal and natural supports within their community (J. S. Walker et al., 2004). Natural supports and community-based services provide families and young people with ongoing support to create a sense of safety and security after the wraparound process has ended (Bruns, Walker, et al., 2004). The transition phase is always hard for families as an intensive service is stepping out and there can be uncertainty and concerns regarding the future. However, if natural supports and community-based services are not established and integrated into the family's life

this can make transition even more difficult and is likely, as was the case in the current study, to lead to lower perceived adherence to this phase.

A potential reason for low fidelity to the principle of community-based services in the current study is the limited range of community-based services available in the area that wraparound is being delivered in New Zealand. The service delivering the process has indicated that in their operational and catchment area there are less community-based services available to them than in other areas. The limited range of community-based services has been an ongoing barrier and struggle for wraparound in New Zealand to establish a community network to support families and young people with high and complex mental health needs. The service providing the wraparound process is continuing to develop and form relationships with community agencies in the area and recognise this is an area for improvement.

In New Zealand, developing and including natural supports in the wraparound process has also been identified as a key challenge (Shailer et al., 2013). Many of the families who come into the wraparound process are isolated from their extended family and their communities meaning they have a limited natural support system. While one of the aims of the process is to enhance natural supports for families, this also requires the commitment of the family, youth, and team to identify, reach out, engage with, and bring on board natural supports from the family's extended family or community (Bruns & Walker, 2008). Unfortunately, families with natural supports may feel too ashamed about their situation to include them in the process (Dalder, 2006). Therefore, families' and young people's reluctance to share what could be viewed as personal family issues may have impacted or constrained the ability to include or increase natural supports in the wraparound process leading to the low fidelity to this principle (Dalder, 2006).

One strategy used by the wraparound process in the USA to increase the involvement of families' natural supports is the incorporation of 'family support partners' or 'peer counsellors' who are employed to support families (Miles, 2008a). These are individuals that have been through the wraparound process or mental health system and bring that perspective to the family and team (Miles, 2008a; Penn & Osher, 2008). By discussing their own experiences they can often help to normalise the need for, and inclusion of, natural supports for families who may be reluctant or concerned (Meyers & Miles, 2003). This peer support system is not yet available in New Zealand, but it is currently in the process of being advocated for, as it could potentially provide a bridge to helping families reach out to natural supports. However, due to the driving principle of family voice and choice in regards to their wraparound team, if families do not want extended family or other community members involved in their wraparound process this choice must be respected (Penn & Osher, 2008).

Individual Respondent Groups

Individual respondent groups of wraparound facilitators, caregivers, youth, and team members all confirmed the fidelity of the wraparound process. As was shown in this study, wraparound facilitators have consistently been evidenced to rate the fidelity to the wraparound process as high (Bruns, 2010; Painter, 2012). Previous research has also supported the finding that wraparound facilitators rate the fidelity significantly higher than other respondent groups (Bruns, 2010). The high fidelity ratings by wraparound facilitators is theorised to be at least partially due to the fact that they were rating their own delivery of service which may have led to an inflation of fidelity scores (Painter, 2012).

Inconsistent with previous findings, all respondent groups who received the wraparound process in New Zealand, namely caregivers, youth, and team members, perceived the delivery of the process relatively consistently. In research investigating wraparound fidelity, caregivers and team members have been found to report higher levels of fidelity than youth (Bruns, 2010; J. S. Walker et al., 2012). In the current study, no significant differences were found between the ratings of perceived fidelity between caregivers, youth, and team members

In the sample, six youth did not complete the WFI-4 as consent was not provided by the youth and/or caregiver. This was primarily because the young person declined to participate, was in crisis or was deemed by the caregiver to be too unwell or did not have the intellectual capacity to participate. An interesting finding was that when the wraparound facilitator, caregiver, and team member fidelity data for these six cases were removed a consistent perception of fidelity to the wraparound process was indicated across all four respondent groups. This insignificant finding could be due to the loss of statistical power to detect significant differences between respondent groups based on a reduced sample size (Field, 2013). Alternatively, a preferred explanation is that this finding suggests the variation in scores between wraparound facilitators, caregivers, and team members may have been due to the differences in fidelity ratings for these six youth. Consistent with this theory, studies investigating youth non-participation have suggested that youth who do not consent or participate in mental health research may represent a particular subset of clients (de Winter et al., 2005; Groves, Cialdini, & Couper, 1992; Noll, Zeller, Vannatta, Bukowski, & Davies, 1997). These youth may exhibit higher levels of psychopathology, lower cognitive ability, and maladjustment (de Winter et al., 2005; Noll et al., 1997). This could have impacted on respondents' perceived fidelity

to the process and potentially led to artificially high fidelity scores for the youth respondent group without these six cases, and lowered fidelity scores for caregivers and team members with the inclusion of these six cases.

Limitations and Future Research

A number of limitations to this study should be noted. At the time this study was conducted only one service was delivering the wraparound process in New Zealand. This meant the current study involved only one self-selected service implementing the wraparound process which was well established. This may impact on the ability to generalise the current findings to other wraparound processes, in particular, to new wraparound processes which may be set up in New Zealand in the future. As wraparound processes which are considered to be in the later stages of development, have been found to have higher levels of fidelity, than those in earlier stages of development (Effland et al., 2011). Future research could potentially investigate the fidelity between well established and newly formed wraparound processes in New Zealand. This research could help to identify mechanisms which could be put in place to quickly facilitate the delivery of high fidelity wraparound.

The clearest limitation in this study is the small sample size which may have impacted on the ability to detect significant effects in the analysis due to insufficient statistical power. In addition, since the sample was from the same service many of the families involved in this study also had the same wraparound facilitator, which increased the likelihood of confounded results and restricted the variance in fidelity scores (Bruns et al., 2005). Equally, as wraparound facilitators were serving more than one family involved in the study they completed the WFI-4 for each family they served, which could have led to additional inflation of the wraparound facilitators ratings of fidelity.

Participants in this study were a self-selected sample of those families who were willing and consented to be part of this research. As families self-selected to be part of this research they may not have been a representative sample of all families involved in the wraparound process and could have been more likely to be experiencing success through the process (Bruns et al., 2005; Olsen, 2008). The representativeness of the sample is particularly worthy to note regarding ethnicity. In the current study the sample was predominantly New Zealand European and could not be generalised based on ethnicity. Therefore, although high fidelity to the principle of cultural competence indicates great promise for this process in a New Zealand context, this result should be interpreted with caution as the current findings are unable to be generalised to those of different ethnicities. Future research studies in New Zealand should investigate this process and its fidelity with those of different ethnicities and cultures, in particular, for New Zealand Māori. This may also need to include an adaption of some questions in the WFI-4 to be more relevant to New Zealand cultural values and beliefs, such as the integration or reflection of the principles from the Treaty of Waitangi, which are an integral part of New Zealand culture and in the delivery of culturally responsive interventions for Māori (Durie, 1989, 2011; Herbert, 2002).

Finally, it could be considered a limitation of this study that client outcomes were not evaluated. However, in the current study it was only aimed to establish whether and how well the wraparound process was being implemented in New Zealand. An advantage of solely focusing on fidelity was that multiple perspectives could be obtained on wraparound delivery. This allowed for a comprehensive understanding of the adherence to the wraparound process. Nevertheless, future research needs to be conducted regarding the outcomes of this process and its

effectiveness as well as the relationship between outcomes and fidelity within this setting.

One difficulty in comparing fidelity ratings across studies which have used the WFI-4 is that different studies use different respondent forms to evaluate fidelity. Effland et al. (2011) used fidelity ratings only from the wraparound facilitator form while J. S. Walker et al. (2012) assessed the fidelity of the wraparound process using the caregiver and youth forms. Alternatively, Painter (2012) and M. A. Moore and Walton (2013) determined fidelity through the use of the caregiver, youth, and wraparound facilitator forms. The total fidelity score on the WFI-4 of a given wraparound process is determined by combining all respondent groups interviewed. However, each study has only used certain respondent groups to obtain their fidelity score. This makes it difficult to directly and accurately compare the fidelity of the wraparound process across studies; especially considering that most published studies only report the total fidelity score for combined respondents (Effland et al., 2011; M. A. Moore & Walton, 2013; Painter, 2012; J. S. Walker et al., 2012). Future research could potentially consider standardising the use of all forms to allow for accurate comparisons between the implementation of wraparound in different areas.

Implications and Conclusions

The findings from this study aid in understanding how this process is being delivered within a New Zealand context from both a consumer and delivery perspective. It provides an initial model of adherence for the wraparound process which may act as a baseline for future studies. It is also the first step in beginning to establish an evidence base for the use of the wraparound process in New Zealand.

Overall, the results indicated that the wraparound process is being delivered as it was intended and adhering closely to its practice model. However, not

surprisingly, those who deliver the model (e.g., wraparound facilitators) were found to perceive adherence higher than those who were consumers of the process and this was significant for caregivers and team members. Then again, while not all youth participated in the study, those that did rated the adherence to the wraparound practice model the highest out of all consumers. This is particularly salient considering higher perceived adherence has been related to better outcomes (Bruns et al., 2005; Cox et al., 2009; Effland et al., 2011; Graves, 2005; Graves & Shelton, 2007).

The principles which were rated with high fidelity were those which the wraparound facilitator or service had some direct impact or control over such as providing a culturally competent service, working collaboratively, persisting with service delivery, and giving young people and families a voice and choice. Low fidelity aspects of the model included the transition phase, natural supports, and community-based services which appear to be consistent with other wraparound sites in the USA (Bruns, 2010; Cox et al., 2009; M. A. Moore & Walton, 2013). The principles which had a low rating of fidelity were those which the wraparound facilitators had limited control over and depend more on community or family supports such as natural supports and community-based services. Although consistent with the wraparound fidelity literature these findings support the need for greater community and natural supports involvement in New Zealand. This may include continued relationships being formed with community agencies and the introduction of formal or informal peer support consistent with ‘family support partners’ used in the USA (Miles, 2008a). Such peer support may be a valuable inclusion to the wraparound process in New Zealand to increase fidelity to the principle of natural supports as these individuals have faced similar issues and are

familiar with the wraparound process (Miles, 2008a; Penn & Osher, 2008). They would bring firsthand experience of the usefulness of natural supports within the community and understand the personal challenge of reaching out to friends and families. Providing peer support may help to increase family's willingness to access and include natural supports in their wraparound process and lives (Meyers & Miles, 2003; Penn & Osher, 2008).

The findings of the current study clearly indicate the need for more research on the wraparound process within a New Zealand context. Continued research should be conducted on the fidelity of the process which employs a larger, more culturally diverse sample, and includes outcomes in their investigation. Future studies should also include data from more than one wraparound site (whether from New Zealand or overseas) so that relationships between populations served, processes, fidelity, and outcomes can be explored.



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**STATEMENT OF CONTRIBUTION
TO DOCTORAL THESIS CONTAINING PUBLICATIONS**

(To appear at the end of each thesis chapter/section/appendix submitted as an article/paper or collected as an appendix at the end of the thesis)

We, the candidate and the candidate's Principal Supervisor, certify that all co-authors have consented to their work being included in the the is and they have accepted the candidate's contribution as indicated below in the *Statement of Originality*.

Name of Candidate: Jacinda Shailer

Name/Title of Principal Supervisor: Dr Ruth Gammon

Name of Published Research Output and full reference:

Multiple Perspectives of Wraparound: Qualitative Analysis into Teams' Experiences of a New Zealand Wraparound Process

In which Chapter is the Published Work: Chapter 6

Please indicate either:

- The percentage of the Published Work that was contributed by the candidate:
and / or
- Describe the contribution that the candidate has made to the Published Work:

The candidate was responsible for the design, data collection, analysis, and write up of the manuscripts. Supervisors have contributed to the manuscripts to the same level as for a usual thesis chapter: by providing guidance and feedback including input regarding decisions made around research process, data analysis, and formatting of the thesis. This contribution has been recognised by Dr Ruth Gammon and Dr Ian deTerte being included as co-authors for the manuscripts which make up this thesis

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Chapter 6: Multiple Perspectives of Wraparound: Qualitative Analysis into

Teams' Experiences of a New Zealand Wraparound Process

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Abstract

The purpose of this qualitative study was to explore wraparound facilitators', caregivers', youths', and team members' experience of wraparound to gain a multi-perspective insight into the process. Fifty six semi-structured interviews were conducted with a total of forty six participants from sixteen wraparound teams (6 wraparound facilitators who were interviewed for each wraparound team they served resulting in 16 interviews, 16 caregivers, 8 youth and 16 team members). Thematic analysis gave way to seven themes organised into three broad domains of: (1) key elements of *the wraparound process* including the wraparound facilitator, wraparound's philosophies and principles, and the supportive nature of the process; (2) the *outcomes* achieved throughout the process including family empowerment and hope, improved family dynamics and relationships as well as individual parent and youth change; and (3) the *challenges and feedback* respondents identified through the process which included personal and systemic challenges, improved transition and continuity of care, role clarity, and accessibility of the service. Overall, the findings from this study predominately support wraparound as an effective process for young people and their families in New Zealand and indicate the importance of key aspects of the process. They also suggest some improvements that could be made to increase the efficacy and accessibility to the process in New Zealand.

Keywords: Wraparound, family experiences, youth, mental health, interventions

Multiple Perspectives of Wraparound: Qualitative Analysis into Teams' Experiences of a New Zealand Wraparound Process

Wraparound is an intensive, family-driven, and team-based collaborative care coordination and planning process, guided by ten core principles and four phases, that works holistically with youth and families with high and complex needs in their community (Bruns et al., 2010; Burchard et al., 2002; VanDenBerg & Grealish, 1996). The wraparound process has received increased interest internationally and an emerging evidence base suggests it has the potential to help a number of families who have youth diagnosed with serious mental health disorders (Burns et al., 2000; Shailer et al., 2013). Multifaceted and complex in its delivery and design, the wraparound process aims to provide services and supports which are individualised and specifically tailored to each youth and families presenting issues (Bruns, Walker, et al., 2004; Burchard et al., 2002). Due to the customised and personalised approach, no two wraparound processes are exactly the same in terms of the plan, goals, and mission created or the services and supports involved. In order to capture and understand these individualised experiences a research design which reflects this ideography, such as qualitative analysis, is useful (Elliott, 2010; Pope & Mays, 1995). A number of empirical studies have supported wraparound as a promising practice which results in positive outcomes (e.g., improved mental health symptoms and quality of life) when the process is delivered with high fidelity. Less is known about wraparound from the perspectives of those who participate in the process (Bruns et al., 2005; Suter & Bruns, 2009).

Those involved in mental health services are able to provide unique insights and knowledge into interventions which can assist in making them more effective. These individuals can also help providers and researchers gain a better understanding

into how change occurs in complex processes which can lead to a better theoretical as well as practical understanding of the intervention delivered. The use of qualitative research to understand and explore the experiences and perceptions of clients, service providers, and team members has become a vital and valuable tool in mental health service delivery and evaluation; both as an adjunct to empirical research to enhance knowledge gained and in its own right (Peters, 2010). Using qualitative methods allows researchers to gain deeper insight and understanding of interventions, such as wraparound, which are difficult to capture through standard measurements. Additionally such methodology provides contextual knowledge which helps to explain findings in the 'real' world (Peters, 2010). Many studies in mental health research now employ qualitative designs to investigate the perspectives and experiences of those who deliver, are part of, or receive interventions (Hodges, Hernandez, Pinto, & Uzzell, 2007; Peters, 2010; Tighe, Pistrang, Casdagli, Baruch, & Butler, 2012).

A number of qualitative studies have been conducted on the wraparound process (Hodges et al., 2007). These studies have predominately focused on caregivers' experience through thematic analysis (Breault, Lewis, & Taub, 2005; Lazear, Worthington, & Detres, 2004; Painter, Allen, & Perry, 2011). Outcomes of these studies support the underlying principles and philosophies of wraparound (see Table 7) aligning with what is important to caregivers (Breault et al., 2005; Lazear et al., 2004; Painter et al., 2011). Other emerging themes from this research emphasise the support wraparound and its facilitators provide (Breault et al., 2005; Lazear et al., 2004; Painter et al., 2011). Qualitative studies with stakeholders have also been conducted in the aim to improve service delivery (J. S. Walker & Bruns, 2006a; J. S. Walker & Sanders, 2011).

Table 7

Ten principles of the wraparound process

| Principle | Description |
|--------------------------|--|
| Family voice and choice | Family and youth/child perspectives are intentionally elicited and prioritized 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 family values and preferences. |
| 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. |
| Natural supports | The team actively seeks out 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. |
| 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. |
| 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. |
| 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 |
| Individualized | To achieve the goals laid out in the wraparound plan, the team develops and implements a customized set of strategies, supports, and services. |
| 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. |
| 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. |
| 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 reproduced with permission from Bruns, E.J., Walker, J.S., Adams, J., Miles, P., Osher, T.W., Rast, J., VanDenBerg, J.D. & National Wraparound Initiative Advisory Group (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.

The majority of research which has sought to understand the experiences of the wraparound process has focused on a single perspective (e.g., wraparound facilitators, stakeholders, or caregivers; Breault et al., 2005; Lazear et al., 2004;

Painter et al., 2011; J. S. Walker & Bruns, 2006a; J. S. Walker & Sanders, 2011). A few studies have broadened the perspective to the inclusion of both caregivers and youth (Painter et al., 2011). However, no published research to date has attempted to research the experiences of key figures of the wraparound team in unison to develop a multidimensional and integrated perspective of the wraparound process as it was experienced by different members (e.g., wraparound facilitators, caregivers, youth, and team members). It is considered relevant to investigate the perspectives of a number of different respondent groups involved in the team as it has often been cited that service providers or professionals (e.g., wraparound facilitators and formal support team members) can have different views when compared to families of what is important or effective (Friesen, Koren, & Koroloff, 1992). Further, young people's views also often diverge from what caregivers or parents deem to be important or effective.

Therefore, the present qualitative study aimed to explore wraparound facilitators', caregivers', youths', and team members' experiences of the wraparound process using thematic analysis. Specifically, it focused on investigating what each respondent group liked most, found helpful and beneficial, considered to be most important or influential, as well as what could be changed or improved about the process. Choosing to interview four different respondent groups within each wraparound team was considered appropriate because each group was believed to have a valuable and potentially different perspective given their role and the individualised nature of the process. The overall desire and intent of this paper was to provide insight into how each respondent group and each participant viewed and experienced the wraparound process. Thematic analysis was chosen due to its ability to preserve and directly represent caregivers', youths', team members', and

wraparound facilitators' accounts of their experiences, beliefs, and perceptions of the wraparound process (Braun & Clarke, 2006).

Methods

Setting

This study was part of a wraparound fidelity investigation conducted to determine the degree to which a wraparound process in New Zealand was being implemented as it was intended. In addition to fidelity, an investigation of respondents' experience of the wraparound process was conducted through a series of qualitative interviews with all participating facilitators, families, and team members. All participants in this study were recruited from one wraparound service delivered by a District Health Board in a metropolitan city in New Zealand between September 2012 and May 2013. To be included in the fidelity investigation, wraparound teams had to have youth over the age of 11 years and been involved in the wraparound process for at least 30 days.

Participants

The wraparound teams took part in a qualitative interview which included a series of qualitative questions at the end of their fidelity interview. All 16 wraparound teams who participated in the wraparound fidelity investigation agreed to participate. The sample consisted of a total of 46 participants (33 females; 13 males) from 16 wraparound teams which included 6 wraparound facilitators (4 females; 2 males), 16 caregivers (14 females; 2 male), 8 youth (5 females; 3 males) who ranged in age from 13 to 16 years ($M=15$; $SD=1.41$) and 16 team members (10 females; 6 males).

There were six wraparound facilitators who coordinated the wraparound process for all wraparound teams who participated in this study. Each wraparound

facilitator had one to five families participate in the study and they completed a qualitative interview for each wraparound team they facilitated. This resulted in sixteen wraparound facilitator interviews being conducted and an overall total of fifty six interviews (with only forty-six participants) when combined with other respondent group interviews.

Caregivers who agreed to participate and be interviewed were predominately biological mothers (75%, n=12). Other caregivers included one biological father, one adoptive parent, one aunt who had full custody and a house parent from an out of home placement. Eight young people did not participate in this study, due to being too unwell, in crisis, a diagnosis of intellectual disability, or parental or youth non-consent. The wraparound teams without youth interviews were kept in the analysis along with the eight wraparound teams which included youth interviews to prevent bias towards positive outcomes.

The young people in the 16 wraparound teams, including the 8 not interviewed, had multiple mental health diagnoses (68.75%, n=11), ranged in age from 12-17 years (M=14.94; SD=1.44), and included 9 females and 7 males. When interviewed, 87.5% (n=14) of youth were attending school and 68.75% (n=11) were living at home with at least one of their biological parents. The majority of the families identified as New Zealand European (37.5%, n = 6), followed by New Zealand Māori (18.8%, n = 3), New Zealand Māori/European (12.2%, n=2), Middle Eastern (12.5%, n=2), Other European (12.5%, n=2) and South African (6.3%, n=1). A team member on each of the wraparound teams was also interviewed for their perspective. Team members interviewed included school staff (31.5%, n=5), mental health workers (18.8%, n=3), social workers (18.8%, n=3), mentors (12.5%, n=2), a

residential group home staff member (6.3%, n=1), and a formal support team member (6.3%, n=1).

Intervention

All 16 wraparound teams were being served by the same tertiary level mental health service in one District Health Board which had been delivering the wraparound process since 2004. The wraparound process practice model used within the setting was the model defined and specified by the National Wraparound Initiative which includes the embodiment and adherence to ten core principles and four phases (Bruns, Walker, et al., 2004; J. S. Walker et al., 2004). At the time the qualitative interviews were conducted, families had been in the process from 2.53 to 18.67 months (M=9.56, SD=4.9). The six wraparound facilitators were employed by the District Health Board and held at least tertiary level qualification. All wraparound teams involved in this study had completed the Wraparound Fidelity Index (fourth version; Bruns et al., 2009). Participating teams received above average fidelity wraparound with a fidelity rating of 81.83% (Shailer, Gammon, & de Terte, 2014).

Qualitative Interviews

A series of 13 qualitative questions were developed to explore caregivers', youths', team members', and wraparound facilitators' experiences of the wraparound process (see Appendix B for the qualitative questions used). The same questions were used for all four categories of respondents. Questions were designed to be open-ended and capture both positive and negative experiences. The main areas covered included: what they liked most and worked best about the wraparound process; what could have been done better and what they would change; what was the most important or influential part of wraparound; what the hardest part was; how

wraparound benefited their life; whether they would recommend the process; what they would like other families to know; the main differences from other services; and their overall experience of the process including a 1-10 rating.

Procedure

This study was approved by the Northern Y Regional Health and Disability Ethics committee (see Appendix N). Information and informed consent for participation in the qualitative interview was included as part of the fidelity investigation information pack (see Appendices C to H). Informed written consent from wraparound facilitators, caregivers, and team members and assent from youth was obtained prior to the interview for all participants. All interviews were conducted by the principal researcher, who was trained in conducting interviews and was independent from the facilitators and service that provided the wraparound process. The qualitative interview was conducted directly after the WFI-4 interview.

The majority of caregiver (94%, n=15) and youth (44%, n=7) interviews were conducted at their family home, while team member (94%, n=15) and wraparound facilitator (100%, n=16) interviews were predominately conducted at their place of work. For those caregivers, youth, or team members who were unable or did not want to be interviewed at their home or workplace, interviews were conducted in a room at the District Health Board delivering the wraparound service.

Each participant was interviewed individually except for two youth who requested to have their primary caregiver present. The caregiver was asked to refrain from helping the young person from answering the questions so that the youth's personal experiences of the wraparound process could be obtained. The majority of interviews were digitally audio recorded (84%, n=47), and participants previously given consent was checked again before the interview began. Interviews not

recorded were due to either the equipment being unavailable or equipment failures.

In these cases, detailed notes were taken during the interview, as close to the participants wording as possible, and transcribed immediately following the interviews.

Confidentiality statements were provided at the beginning of each interview so that all participants were aware of the nature and limits of confidentiality including the extent to which any case sensitive or concerning information would be disclosed. At the end of each interview participants were asked if they had anything else to add and were debriefed. Following the completion of the interviews youth were given a \$10 gift voucher and caregivers were given a \$20 gift voucher. The average duration of the qualitative interviews ranged from 10 to 30 minutes.

Analytic Procedure

All interviews were transcribed verbatim and analysed using thematic analysis based on the general steps and methods described in Braun and Clarke (2006) with the aid of Nvivo qualitative data analysis software. Thematic analysis as defined by Braun and Clarke (2006) is a “method for identifying, analysing and reporting patterns (themes) within data. It minimally organises and describes the data set in (rich) detail” (p.79). Thematic analysis was chosen because it is an epistemologically flexible and uncomplicated technique that works to preserve the whole story of a participant.

The approach and level of qualitative analysis could be considered broadly aligned to a contextualist approach or critical realism epistemology which recognises the context dependent nature of knowledge and its importance in understanding individual’s experiences (Braun & Clarke, 2006, 2013). The analysis used a semantic approach focused on surface level interpretations of the data in an attempt to

maintain participants own representations of their experience (Braun and Clark, 2006). Further, data analysis was driven by both an inductive data-driven and deductive theory driven approach. The analysis took an inductive data-driven approach in order to capture respondents own experience of the wraparound process. Once themes had been identified from the data they were then categorised based on theoretical perspectives and core components of the wraparound process (Braun & Clarke, 2006, 2013).

Before analysing the data, transcripts were re-checked against recordings for accuracy. Because of the large volume of data collected, the data was first analysed separately based on respondent group's and then looked at together. Transcripts were analysed as a whole rather than by individual questions as it was likely that themes would emerge across questions during the conversational type interview. In order to identify codes and potential themes within the data, each transcript was coded line by line, by ascribing each sentence in the interviews a code that described its main essence. The codes generated could be considered as both inductive and deductive, as they originated both from the principal researchers own understanding of the wraparound process and from the experiences described by participants in each respondent group. Codes were grouped into potential themes which were considered to represent the main experiences of each respondent group. Data which did not have enough support to be considered a theme on its own but was still of interest was coded separately, while the rest were excluded from analysis. Potential themes were then reviewed and checked to ensure that each was internally coherent and consistent as well as being clearly distinct from other themes in the analysis. During this phase some themes were condensed or collapsed while others were expanded (Braun & Clarke, 2006, 2013).

Data validity was ensured through discussions with the principal research supervisor who was experienced in qualitative analysis to ensure themes were coherent and consistent. If there were any differences in interpretation, this was resolved based on a discussion and presentation of evidence for each view point. Whichever view point had the stronger rationale was favoured.

Results¹

The analysis generated 7 themes, some with several subthemes (see Table 8), grouped into three broad domains. The first domain relates to the respondent groups experiences of the wraparound process and aspects they found helpful. The second domain relates to the outcomes families achieved through the wraparound process. The third domain relates to what respondent groups found challenging or believed could be improved about the process. Similar to the wraparound process itself the themes are complex and have some overlap. The themes incorporate all wraparound facilitators', caregivers', youths', and team members' views on the process both within and across wraparound teams. Where wraparound facilitators', caregivers', youths', and team members' views are different, the group that supported the theme is specified in text. The prevalence of themes across respondent groups are also indicated in Table 8. When the terms '*all respondents*' or '*respondents*' are presented without specifying a group, this indicates that it represents the view of wraparound facilitators', caregivers', youth, and team members'. Each separate wraparound team is indicated by a research identification number (e.g., WF1, CG1, YP1, and TM1).

¹ For an extended results section please see Appendix O

Table 8:

Summary of Domains, Themes and Subthemes by Respondent group

| | Wraparound Facilitators (n=16) | | Caregivers (n=16) | | Youth (n=8) | | Team Members (n=16) | |
|--|--------------------------------|------|-------------------|------|-------------|------|---------------------|------|
| Domain 1: The Wraparound Process | | | | | | | | |
| 1. The overall experience was positive | 10 | 63% | 15 | 94% | 6 | 75% | 14 | 88% |
| 2. Wraparound facilitator | 13 | 81% | 15 | 94% | 5 | 63% | 14 | 88% |
| Therapeutic relationship and engagement with facilitator | 13 | 81% | 15 | 94% | 5 | 63% | 13 | 81% |
| Non-judgemental | 5 | 31% | 7 | 44% | - | - | 3 | 19% |
| Facilitation and coordination | 4 | 25% | 10 | 63% | - | - | 9 | 56% |
| 3. Wraparound Philosophies and Principles | 16 | 100% | 16 | 100% | 8 | 100% | 16 | 100% |
| Holistic, whole family focused, full picture | 8 | 50% | 12 | 75% | 2 | 25% | 15 | 94% |
| Team-based, everyone together, collaboration | 12 | 75% | 13 | 81% | 7 | 88% | 14 | 88% |
| Family and youth voice and choice driven | 13 | 81% | 15 | 94% | 3 | 38% | 11 | 69% |
| Individualised, flexible, tailored | 8 | 50% | 12 | 75% | 7 | 88% | 9 | 56% |
| Strengths-based | 7 | 44% | 2 | 13% | - | - | 9 | 56% |
| Outcome-based | 12 | 75% | 12 | 80% | 5 | 63% | 8 | 50% |
| 4. It's a Supportive Process | 12 | 75% | 15 | 94% | 7 | 88% | 16 | 100% |
| Emotionally | 8 | 50% | 12 | 75% | - | - | 11 | 69% |
| Safe service | | 0% | 7 | 44% | - | - | 8 | 50% |
| Practically | 7 | 44% | 10 | 63% | - | - | 11 | 69% |
| Professional | - | - | - | - | - | - | 8 | 50% |
| Domain 2: Outcomes | | | | | | | | |
| 5. Outcomes, change, and progress | 14 | 88% | 15 | 94% | 8 | 100% | 14 | 88% |
| Empowerment and hope | 8 | 50% | 8 | 53% | - | - | - | - |
| Family dynamics and relationships | 10 | 63% | 7 | 47% | 8 | 100% | 8 | 50% |
| Individual change | 10 | 63% | 14 | 93% | 7 | 88% | 13 | 81% |
| Parent | 5 | 31% | 10 | 67% | - | - | 7 | 44% |
| Young person | 9 | 56% | 11 | 73% | 7 | 88% | 7 | 44% |
| Domain 3: Challenges and Feedback | | | | | | | | |
| 6. Challenges | 7 | 47% | 6 | 38% | 5 | 63% | 6 | 38% |
| Personal challenges | 2 | 13% | 5 | 33% | 3 | 38% | 2 | 13% |
| Systemic challenges | 6 | 38% | 1 | 7% | 2 | 25% | 5 | 31% |
| 7. Feedback | 2 | 13% | 7 | 47% | 1 | 13% | 9 | 56% |
| Continuity of care and transition | 2 | 13% | 4 | 25% | 1 | 13% | 5 | 31% |
| Role clarity | - | - | - | - | - | - | 4 | 25% |
| Accessibility of service | - | - | 5 | 31% | - | - | - | - |

The Wraparound Process

1. The overall experience was positive. The overall experience of the wraparound process was deemed by all respondent groups to be positive (82%) with 63% of wraparound facilitators, 94% of caregivers, 75% of young people, and 88% of team members describing their experience of wraparound as positive and helpful.

Absolutely positive. If there was any agency I'd want involved with us it would be wraparound. Absolutely 100%. CG6

Additionally, almost all caregivers (94%), youth (100%), and team members (88%) indicated that they would recommend the wraparound process to other families and young people if they needed it.

Q: Would you recommend wraparound to other families or friends if they needed it, and why?

Yeah, it's really good. It seemed to work out for me, and I had a pretty difficult circumstance, so think it could work out for many people. YP3

2. Wraparound facilitators. The role of the wraparound facilitator was found to be a key overarching theme which was central to the process and resonated throughout themes across the four respondent groups. The close personal relationships wraparound facilitators formed with each individual was commented on by all respondent groups, including wraparound facilitators (81%), and valued by the majority of caregivers (94%), youth (63%), and team members (81%).

WF1 was great. I really like, we have dealt with so many health professionals and she was just great. I think YP1 would've liked to have kept it on just so she could have a relationship with WF1 (laughs). She misses WF1. Because she was so calm and collected and good, and she just, you know, let YP1 say her thing and just, she was great, she was really really good...was the best of them. CG1

This relationship was considered by both wraparound facilitators and caregivers as essential to family's engagement and experience of the process; with one caregiver directly stating that: *"I'm sure if I had to deal with a person I didn't like very much then I wouldn't be so keen on it [the wraparound process]. It does make a big difference when you like the person you are dealing with"* (CG10).

Caregivers (63%) and team members (56%) also spoke highly of the process having an effective wraparound facilitator to coordinate and organise both in the background and in wraparound meetings as it was perceived to enhance team cohesion and the efficacy of the process.

If you have a facilitator, that's umm, absolutely really good at running a meeting, and running things to par, and keeping things going, that's the main thing. Other things as well, you know,

the mental health side is all good. But if it wasn't for her running the actual wraparound service, umm yeah, I don't think you would have had a lot of outcome. CG4

Key attributes embodied by wraparound facilitators that were valued and considered as important was their availability, reliability, genuine care and empathy, non-judgmental support, understanding, and commitment to the family.

It's a journey. Umm, which is unpleasant at times but I definitely felt with both kids throughout the journey, that the people who were in charge care, and they want to succeed as much as you do. It's a very personal service as well. It depends a lot about having that connection. CG11

Of particular salience to 44% of caregivers, 19% of team members and 13% of youth was the non-judgmental support and non-blaming approach taken by wraparound facilitators which was a positive and occasionally eye opening experience.

Not judging me. Umm, not throwing it back into my face. Like with what was happening with YP6's behaviour, and my way of parenting, I suppose. I don't know. Not saying it's my fault or things like that, but working with us, working with me to work with YP6, you know. Talking me through, listening to me you know, about how shitty my week was...and she was really good, you know, she didn't judge me... CG6

Wraparound doesn't always bring up everything in your past as much as [the Child Welfare Service]. Because [the Child Welfare Service] brings up everything in your past and goes on and on about it. Wraparound tries and moves forward, instead of backwards. Focusing on the future instead of focusing on the past and going on about it, just reminding you of all the things you've done. YP5

3. Wraparound principles and philosophies. The majority of respondents noted the holistic family approach taken by wraparound as well as concepts analogous to the wraparound principles of team-based, collaboration, family voice and choice, individualised, strengths-based, and outcome-based in their experience of the wraparound process.

Based on systemic family therapy theory, the wraparound process by design takes a holistic approach to the problem and is about the needs of the whole family rather than just the young person. While not a wraparound principle this approach to working with families is part of what makes the wraparound process.

Wraparound looks at the needs of everyone holistically and works on all of those needs at the one time, rather than having people go away and get frustrated with not having everything dealt with. WF15

Consistent with this, 50% of wraparound facilitators, 75% of caregivers, 25% of youth, and 94% of team members discussed the wraparound process as one that looked at the family and problem holistically and gave support to all family members which they viewed as important and helpful. For some caregivers, it was the first time an intervention or program had looked at the full picture.

Nobody was seeing the full picture. Nobody was involved, [the Eating Disorder Service] was only concerned with the eating disorder, [the Community Mental Health Service] was only concerned with the self-harm and the suicidal ideation, and [Child Welfare] didn't actively participate and didn't want to be involved in the behaviour. And what wraparound is, what they were able to take on board, could offer, and knew, that's the thing. Wraparound they knew what [Child Welfare] could do, what [the Eating Disorder Service] could do, what [Community Mental Health] could do, and who to go to for what we needed. CG3

Other services just focus on the child not on the parent. But the parent is dealing with the child and often needs help too. This process focuses on both. It's not just the child affected by issues it's the parent as well. CG5

When asked about their understanding of the wraparound process, most respondents understood it to be a team-based process which brought all relevant individuals together in one forum to work collaboratively with the young person and their family towards a common goal (75% of wraparound facilitators; 81% of caregivers; 88% of youth; and 88% of team members). Respondents also identified, in their own way, either indirectly or directly, having a plan that the team had created and were accountable to throughout the process. By bringing everyone together as a team, especially in the form of wraparound meetings, respondents felt that it provided a more effective way to communicate between various agencies and individuals which saved time, decreased repetition, and ensured that everyone was on the same page.

I think more or less it's quite an inclusive process, in that you know everyone who is going to be working with that young person will be involved, and you know plans will be discussed and everyone has a part to play in it. I think usually you can have the clinician's goals, you'll have what the client's goals are and then, maybe what the accommodation and support services' goals are, and they are all quite different. Where with the wraparound process, I think everyone

is on the same page, and all the goals are sort of negotiated between everyone. So that's probably, for me, the most positive thing. CG2

From what I understand it's sort of taking the family and putting a big hug around them, I suppose. Just kind of getting everything together. Because before wraparound we kind of just had people like [the Child Welfare Service] and [the Community Mental Health Service] all over the place and they weren't really connected. It was just having to tell our story over and over again to heaps of different people. But wraparound, kind of took everything in and wrapped it together, and that made it so much better. And everyone coming together and hearing it at the same time. Yeah. YP13

Respondents particularly appreciated the collaboration between team members and families which occurred through this team-based approach. By collaboratively “*fact finding and knowledge sharing*” (CG7) and being “*a big collective*” (CG8) it led to a shared understanding of the family's issues and allowed for the development of a comprehensive plan which everyone was involved in creating and working towards.

That it's a collaborative process. Wraparound isn't doing the work, they are part of the team that's doing the work, and the family is a part of that too. TM12

The concept and importance of family voice and choice within the wraparound process also resonated throughout 81% of wraparound facilitators', 94% of caregivers', 38% of youths', and 69% of team members' interviews.

It's about the family's voice and choice. It's about the family driving the process forward. Identifying what is important for that family or whānau (family) and for the team to come together to support them to achieve those goals and outcomes. WF4

Caregivers liked “*feeling very heard and having a real voice in the process*” (CG7). They valued and felt respected by being given the opportunity to have a say in decisions and make choices about their family. Team members also experienced the wraparound process as one that “*actually gives power to the family*” (TM9) which was considered to be positive. By being driven by family voice and choice and taking a holistic approach many wraparound facilitators (50%), caregivers (75%), youth (88%), and team members (56%) believed the wraparound team and facilitator were able to provide customised services and supports to meet the individual needs of youth and families.

I think we're more user friendly, umm, we're more focused on flexibility and meeting the needs of the family, when and where the family want those needs met. WF15

Young people, in particular, liked the fact they were able to go out and do things they enjoyed, such as activities with their wraparound facilitator, and didn't have to sit in a room and talk which had previously been described as boring or ineffective.

It's not boring, well it is, but it is not as boring as most of the other services. You actually get to go out and do stuff instead of just sitting in a room doing nothing but talking. YP7

Overall, since the process and interventions delivered were able to be tailored according to each family's individual needs, many respondents felt wraparound was a more personal experience rather than a one size fits all approach.

The hugest difference I think is, umm, with other services they kind of just give you the pieces of paper with the instructions of what to do, you know what I mean, like "oh here's some breathing exercises and things you can do". But this felt a lot more personal, like they couldn't pull out a sheet of paper that magically applies to everyone. YP13

First it was more personal, less formal. They came to our house, they saw where we lived, they saw how we lived. They umm, both of them, opened up about their families, and their experience in life, and they made me, me personally, feel very comfortable. CG13

Additionally, while often not directly spoken about by caregivers (13%) and youth (0%), 44% of wraparound facilitators and 56% of team members identified wraparound as a strength-based process "*that strengthens the family [AND] strengthens the young person*" (TM9).

I loved the way that they the start with the positive, bring out all your strengths and get you to see those. CG8

Finally, by continuously monitoring the progression towards goals in the plan and revising the plan when necessary, 75% of wraparound facilitators, 80% of caregivers, 63% of youth, and 50% of team members identified being able to see forward progression and change throughout the process which was considered to be aligned with the outcome-based principle of wraparound.

The process created an environment for change to happen, because it was so regular, we didn't get lost...it was the change, it was because we were able to actively move forward. We always had a plan to keep things moving. CG3

I suppose the plan was helpful because you could also see that something was happening and that some things were okay. Because you got so caught up in this whole, you know, it's like Groundhog Day, that you couldn't really see that things were changing. And you kind of thought well what was the point of that? But then, yeah WF9 was good, because he actually put it out in front of you that these things were happening. CG9

4. It's a supportive process. The majority of all respondent groups spoke about the concept of support or the support they experienced through the wraparound process (total: 75% of wraparound facilitators; 94% of caregivers; 88% of youth; and 100% of team members). The concept of support took a number of forms and could be broadly categorised into three subthemes of practical, emotional and professional.

Approximately two thirds of caregivers (63%) and team members (69%) made reference to the practical support provided by both wraparound facilitators and the wraparound process. Whereas, 44% of wraparound facilitators discussed how they themselves and the team could practically support families to make their life healthier and more manageable. The experience of practical support often originated from the delivery of individualised services (e.g., providing in home support, parenting strategies, access to resources, and knowledge) and supports (e.g., financial aid and professional assistance) to meet the families' needs. This day to day practical support was often believed by wraparound facilitators to help families reduce stress and burden so they could start to get back on track.

Being an extra support when mum just couldn't physically do everything, so sometimes I took YP1 to some appointments and things like that. So kind of practically being an extra pair of hands. WF1

Caregivers, in particular, identified the value of this practical support and at times were even humbled by the unassuming and modest support provided, in particular, by the wraparound facilitator.

And they're there to support, and even like going to WINZ (Work and Income New Zealand), that's not what I expected that they would do...I'm just amazed at their resources, yeah, it's just full on. CG15

Emotional support was discussed in 50% of wraparound facilitator interviews, 75% of caregiver interviews, and 69% of team member interviews. The experience of being emotionally supported was more complex but was often derived from families feeling heard and having a group of people, including facilitators and team members, available to support them in whatever form they needed.

I really liked how it makes me feel emotionally, like I feel very emotionally supported by it. And, very much less isolated, like not lost in the dark on my own anymore...What makes it so valuable is that through so much of the stuff you just feel so kind of a drift and alone. That can make you feel very despairing. And then when you lose hope you get very de-motivated, it's like hard to know what to do and where to go, and you kind of freeze, you know, like a possum in the headlights. So when you feel emotionally supported and you're not feeling so bleak about everything, you can be a lot more action focused and get things done. CG7

As a result, 44% of caregivers described feeling a sense of safety, security, and shared responsibility throughout the process which was perceived as invaluable.

Q: What do you like most about the wraparound process, and why?

The big thing was we felt safe. We'd felt really unsafe before wraparound...we were terrified that something was going to happen to our son...and I think when wraparound came, they said we deal with children like this, we can help. We definitely felt safe in the fact that we weren't on our own. And maybe because, it wasn't just going to be us who were going to be responsible. CG8

Interestingly, some wraparound facilitators noted that practical support often provided the foundations of engagement and trust necessary for caregivers to be receptive to receiving this emotional support.

You know the direct face to face contact with them and helping them. Like I said, helping CG16 at home, with tidying up the house, that kind of stuff. Because I can actually see it's got an immediate impact on her mental state. It's been able to, it's allowed me to, develop that, umm, therapeutic relationship with her. Whereby now she is starting to open about stuff to me and that helps me to understand her situation better and the context of it. But also, it's allowed me to, allowed her to be umm, be a bit more open and able to process some of the suggestions that I've made. WF16

Finally, for 50% team members another subtheme of professional support was elicited in their experience of the process. These team members discussed how the team and facilitator supported them in their roles as professionals, working with high risk youth and families, because they had other professionals working alongside them which also created a sense of shared responsibility.

Certainly as a clinician, it was really positive for me because this is quite a tricky family to manage. Not in terms of personalities or anything, but just in terms of how much they had on. You know YP1 was really risky, kind of, in terms of not being able to have much insight around self-harm and suicidal behaviour. So it was really helpful not only to have a support of a colleague, but also to have someone who knew the family really really well, and was kind of working alongside. TM1

Outcomes

5. Outcomes, change and progress. The outcomes, change, and progress noticed by wraparound facilitators and team members and experienced by caregivers and young people were many but could be broadly categorised into three subthemes of: empowerment and hope; improvement in family dynamics and relationships; and individual improvement in caregiver and young person. About half of wraparound facilitators (50%) and caregivers (53%) identified the concept of empowerment and hope in their interviews. For caregivers, hope was created from the change in theirs and their young person's lives and the support given by facilitators and team members walking alongside them and building them up throughout the process.

The way it's built me up, yeah. Like I never thought that they, that anyone could, in any service, could actually make me feel so confident that I'm doing a good job, and you know, that I'm doing the right thing, and yeah. So that's really good. CG14

I think the hope has just been the most important part, you know. I mean some of this stuff, as odd as it is, seems like an answer to prayer for me... CG16

A second outcome identified by 63% of wraparound facilitators, 47% of caregivers, 100% of youth, and 50% of team members was the improvement in family dynamics and relationships. Each respondent group spoke about the improvement in family dynamics and relationships slightly differently based on their own experience and perspective. However, they all emphasised the family coming back together as a unit and the improvement of relationships between family members, particularly between the caregiver and young person.

I think they've come together as a greater family whānau (family). I think they've come together, with a greater understanding and they've got a will and commitment to work together and be more integrated as a family. WF4

Good, it's like helped us. And umm, oh we get on more as a family now. And my family understands my needs more. YP8

For some caregivers and youth, the role of their facilitator in this process was seen as essential in helping them to safely build up communication and understanding.

I think that the most important thing between me, WF13, and YP13 is umm, that to start with WF13 needed to be there, for us to communicate. Not physically, but you know, she needed to hear me, she needed to hear her, and working between us. And umm, she slowly, gradually stepped out and now me (CG13) and YP13 are able to communicate... CG13

Outcomes were also identified at an individual level for both the caregiver and the youth. Wraparound facilitators (31%) and team members (44%) discussed caregivers' growth and change in terms of them gaining a better understanding of the issues, accepting that they themselves may have some things to work on, taking on board new strategies or alternative ways of dealing with things, and changing their own behaviours and how they interacted or responded as caregivers with their child.

I think that them having to look at their own issues. They were initially in denial that the issue was just YP12's, and they had sort of objectified YP12 as the bad person within the family. Umm, so it was only when they actually started realising that each family member had a part to play in that, that there were changes made within the family. WF12

Additionally, caregivers (63%) found they obtained insights about themselves and their child: they were able to understand their child better; look at things differently; and were given the tools to better themselves as caregivers.

Well it's given me skills to parent different, to be a better mother to my son. It's taught me to give him what he needs in a way that works for me. And you can't get better than that. CG3

A few caregivers also identified their perspective and opinion of mental health services changed.

I suppose the most influential part was probably learning that there are umm (laughs), that all the professional people aren't that umm, stuck up (laughs). I think that was the most eye opening. It was like, oh my gosh, okay maybe you're not so wanktified as I thought you were, you know, that kind of thing. So there are nice people that are in there, you know, and it's not like looking down... But yeah no, it's a real eye opener, eye opener that they're really caring people that want to just help. CG4

While the young person's mental health disorder was still present in some cases due to the severity of the disorder, 56% of wraparound facilitators, 75% of caregivers, and 44% of team members discussed substantial and noticeable improvements in their general wellbeing, functioning, mental health symptoms, and community engagement throughout the wraparound process. However, the most significant changes noted across respondents were considered to be the young person's reduced risk level, return home if in an inpatient setting, and the ability for them to be safely and effectively managed within the community.

The most important part is having him home and having him happy, and he's reasonably healthy. So yeah, I think if you look at the mission statement, he's reasonably healthy, he's reasonably happy, he has achieved a life worth living, and he has got healthy relationships. He's communicating well...its better, so I can feel like somebody's mother, it's huge. I feel loved, he openly hugs me, or he never rejects me now. He's definitely independent. So I think we achieved our mission. We achieved what we set out to do. It is huge, because it has only been a year. You know last year he was on a bridge, and now he's studying and wants to go to school, and wants to achieve. I am happy with that. CG3

Similarity, the majority of young people interviewed (88%) also indicated that the process was helpful for them and created change in their life in terms of: reducing their mental health symptoms; increasing their ability to manage their mental health diagnosis by learning new strategies and skills; improving their general life situation (e.g., family, school); and increasing their acceptance of themselves or facilitating a different outlook on life.

I think I am a lot more optimistic, umm, more smiles. I'm a lot more social and go out with friends more. I talk to friends more. YP11

I have better social skills and my depression is not as bad...Like, I mean I haven't been hospitalised since starting wraparound. So I've noticed a difference. YP1

Q: What has been the most influential or important part of wraparound for you?

Well I gained self-acceptance, umm yeah, I think that was a really big thing for me YP12

Challenges and Feedback

6. Challenges. When asked about the hardest part of the wraparound process, a small percentage of wraparound facilitators (13%), caregivers (20%) and young people (13%) discussed either the personal or professional challenges they faced. For

example, some caregivers found it difficult to manage their own vulnerability and emotions that came up throughout the process.

Sometimes asking for their help has been really hard because I felt quite weak and quite crumbly...Knowing that they're not going to judge me has been the easy side of it. But yeah, sometimes, texting them or calling them up saying I'm not coping has been difficult. Or asking them to help YP15 when I know she is going to reject it is quite difficult. I don't like, it's embarrassing for me to see her, you know, shunning them. So that's always a little bit difficult or embarrassing. CG15

A more global issue experienced by 38% of wraparound facilitators, 7% of caregivers, 25% of youth, and 31% of team members was the systemic challenges involved with wraparound in New Zealand. This included challenges related to finding funding, placements, and other resources needed by families as currently in New Zealand as one team member aptly put it "*wraparound is a process working within other peoples' processes*" (TM2).

It's those service limitations. But this is what I'm trying to say, that's what I find doesn't work here in New Zealand. I'm sure New Zealand is not the only country with the issue but this is what's not working here. But that's the dilemma with us here in New Zealand, we don't have the pooled funding, and that's what I think is really our biggest barrier. WF16

These challenges were particularly difficult for wraparound facilitators, not just in terms of accessing the required resources, but also because sometimes it meant they could not provide families with some things that were initially planned for.

Funding can sometimes take a while to come through and some don't in time. We put some funding in for a mother and daughter holiday, in the hope that we would be able to do it for the holidays, but it didn't come through in time. WF15

7. Feedback. When asked about feedback or areas for improvement in wraparound, while not a strong theme or experienced by the majority of respondents, transition disjointedness and/or wraparound stepping out at a point which seemed too soon, was discussed in some cases (13% of wraparound facilitators; 25% of caregivers; 13% of youth; 31% of team members). At a minimum team members indicated that a slower transition period including "*tapering off*" (TM8) supports over a longer period of time "*instead of stopping cold turkey*" (TM8) would have

been useful. For at least one young person, progress made while in wraparound deteriorated after wraparound transitioned out.

Twenty-five percent of team members also believed improved clarity around roles and expectations would have been helpful for them to better understand their role in the team as well as how their agency was to work with wraparound.

Q: What do you think could have been done better, and why?

Between services, and that's part of, within [the Community Mental Health Service], we didn't have a clear understanding, consistent understanding of how to work with wraparound...I guess we could have talked more about this in the first meeting with WF4, which was me not articulating or communicating that enough myself. Aside from that we could have had a discussion about how we work together and any potential difficulties. I think it's interfered so it would have been useful. TM4

Finally, a subset of caregivers (31%) felt that the wraparound process in New Zealand was difficult to access and that it was a service that not many people, even professionals, knew about. By being an "*unknown service*" (CG13) that was difficult to access these caregivers felt that wraparound ended up being the ambulance at the "*bottom of the cliff*" (CG7) after everything else had been tried. These caregivers would have preferred wraparound to have been available sooner as they believed it could have prevented some of the issues from occurring.

About the process probably nothing. What I would say is that it took us 5 years and nearly losing YP7 repeatedly before we accessed this. Like we didn't know about it, nobody, no professionals told us about it along the way. It was only right at the end, when we got accepted with [the Community Alcohol and Drug Service] and [clinician name] putting, you know, she took it on herself to put an application in. And she was the first person. So I guess one of my things would be somehow making it so that people know about this as an option. And that you don't have to wait till the person is nearly dead and the family has fallen apart before you get access to it. You know like, it was totally at the bottom of the cliff. If it could be at the top somewhere that would be fantastic. And it would probably save the state a huge amount of money ultimately. Because I know it's an expensive process, well I presume it is, but when I look at all the other outcomes and ultimately, hospitalisations, imprisonment, mental homes, those cost a lot of money to the state. Don't they? CG7

Discussion

In this study it was aimed to explore the experiences of the wraparound process from the perspectives of those involved in the process and who formed wraparound teams (the wraparound facilitator, caregiver, young person, and a formal

support team member). Aligned with the wraparound process itself, this approach allowed us to explore the individual experiences of the wraparound process and take a holistic approach to understanding each wraparound teams experience from multiple perspectives.

The majority of participants identified their overall experience of the wraparound process to be positive and in line with the wraparound practice model. As shown in Figure 5, participants' positive experiences were related to three overarching and interrelated themes which included: the role of the wraparound facilitator; the holistic and whole family approach taken which included the embodiment of a number of wraparound principles; and the support provided throughout the process. Together these themes contributed to positive treatment outcomes which included (1) family empowerment and hope; (2) individual change in both the parent and youth; and (3) changes in family dynamics and relationships. In addition to these positive aspects, some systemic challenges and improvements in regards to the accessibility to service, role clarity, and continuity of care were also noted.

Themes were found to be relatively consistent across the four respondent groups. However, the importance or endorsement of certain themes appeared to slightly differ. Youth, for example, appeared to value doing things in their community which was outside of a therapy room (e.g., activities, going for coffee). They also identified being able to actually see change occurring, in particular, in the family dynamics and relationships as important. For caregivers two things were deemed most valuable: the therapeutic relationship with the wraparound facilitator, specifically, having someone there who supported them and their young person; and having a voice and choice in the process. Wraparound facilitators, consistent with

caregivers, also identified both the therapeutic relationship with the family and eliciting their voice and choice as paramount. Finally, team members valued the professional support they received by being part of the wraparound team and found benefit in the holistic approach used as it gave them better insight into the family.

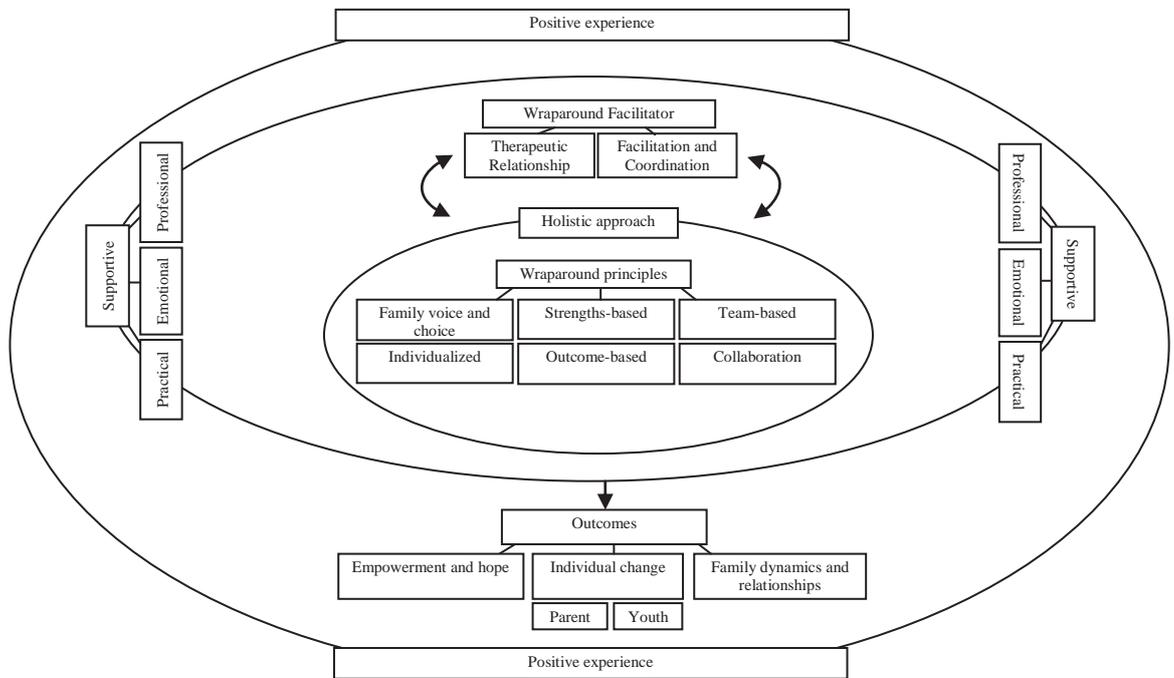


Figure 5. Theme map. This figure pictorially demonstrates the themes elicited by respondent groups and their interrelationship.

Wraparound Facilitator

The wraparound facilitator stood out as particularly salient both in terms of therapeutic relationship and facilitation and coordination of the process. The role of the wraparound facilitator was strongly related to respondent group's positive experience and engagement. In addition, the facilitators' ability to engage and form positive therapeutic relationships with families and team members was considered important in the achievement of positive outcomes. This finding is consistent with previous research which has demonstrated a positive association between therapeutic relationship and positive outcomes (M. J. Lambert & Barley, 2001; Martin, Garske, & Davis, 2000). Similarly, studies that have explored caregivers and families

experiences of wraparound have repeatedly highlighted the therapeutic relationship, in particular the relationship with the young person, as being important to families viewing the process as beneficial (Lazear et al., 2004; Painter et al., 2011).

A number of wraparound facilitator characteristics were identified as being important to the formation and continuation of the therapeutic relationship. In the current study, caregivers, youth, and team members emphasised a number of wraparound facilitator characteristics such as their genuine care, empathy, and commitment to the family as being important and contributing to the therapeutic relationship formed. These characteristics are in line with previous findings on therapist characteristics which positively influence the therapeutic relationship (Ackerman & Hilsenroth, 2003; M. J. Lambert & Barley, 2001).

Therapeutic alliance has been found to contribute to approximately 22-30% of the variance in client outcome (M. J. Lambert & Barley, 2001; Martin et al., 2000). The current findings continue to highlight the importance of the therapist and therapeutic relationship in achieving positive outcomes and experience of any intervention no matter what the modality. It also supports the importance of continued focus, training, and education on wraparound facilitator's therapeutic relationship skills including the facilitator's ability to adapt their style to how families define or experience helpfulness. As while the characteristics identified by respondents are not considered unique to wraparound facilitators, the collaborative, supportive, and non-judgmental approach emphasised in participants responses are considered to be especially important. In particular, in the context of families who have often felt judged in the past and are likely sensitive or weary of working with professionals (Lazear et al., 2004; Norcross, 2010; Pagkos, 2011; Painter et al., 2011).

Wraparound Philosophies and Principles

Qualitative accounts of respondent groups' experience of the wraparound process were consistent with a number of wraparound's principles and philosophies (Bruns, Walker, et al., 2004). Based on the family and life domain based nature of wraparound, participants' experience of the process was one that was holistic both in terms of looking at the whole family and all areas of need (Bruns et al., 2010; Burns et al., 2000). Without being directly asked the majority of participants identified six out of ten wraparound principles in their interviews indicating the importance of the values, principles, and philosophies that wraparound brings to working with families and teams (Bruns, Walker, et al., 2004). The parallel between qualitative accounts of the process with wraparound principles found in the current study is in line with previous research on caregivers experiences of the wraparound process (Painter et al., 2011). This finding supports the growing fidelity literature in wraparound regarding the importance of adhering to the wraparound practice model (Bruns, 2008b; Bruns et al., 2005; Cox et al., 2009).

A number of the principles highlighted in the qualitative interviews were also those which were rated as being adhered to in a fidelity study conducted with the same participants by Shailer et al. (2014). This finding indicates a degree of consistency between fidelity ratings and respondent groups experience of the process. However, the principle of cultural competence which was rated with high fidelity was not mentioned in the qualitative interviews. Additionally, the principle of persistence which was also rated with high fidelity was considered as a point of feedback in the current study for some families. This may indicate a disparity between what families consider persistence or continuity of care and the questions asked in the wraparound fidelity interviews. Providing further support for the

continued focus and inclusion of natural supports and community-based services in wraparound, both of which fell within the below average range of fidelity in Shailer et al. (2014), was the fact that these concepts were similarly not elicited in respondents' interviews.

Support

Whole family support, in particular for caregivers, has been implicated to improve treatment engagement, retention, and outcomes (Morrissey-Kane & Prinz, 1999). In the present study, all respondents groups considered the process overwhelmingly supportive, both in terms of practical and emotional support provided for families. The support experienced was identified as surpassing solely supporting the young person, but was also support for the caregiver and wider family unit. A particularly salient and beneficial experience identified by caregivers, was that this support often led to a sense of security and feeling of unburdening, as they no longer felt solely responsible for their at risk young person. This feeling of support is consistent with two previous qualitative studies on wraparound conducted with caregivers (Breault et al., 2005; Painter et al., 2011). Similar to these studies, the current results indicated that both practical support in term of transport, home visits, and navigating systems as well as the emotional support of encouragement and feeling cared about by wraparound facilitators and teams, were essential parts of the process (Breault et al., 2005; Painter et al., 2011). Interestingly, practical support often facilitated caregivers being more open to receiving emotional support.

An important aspect of the wraparound process, not previously highlighted in the research, is the value of professional support for team members. For mental health care professionals and those working with high needs youth and families, burnout is a significant issue. A recent study estimated that between 21-67% of

professionals experience high levels of burnout (Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012). In the current study, team members identified the value of wraparound providing them with professional support. In particular, having a committed team, with other professionals to go to and bounce ideas off, who were working towards the same goal, was identified as particularly beneficial in supporting them in their role. Support from other team members or colleagues, including work group cohesion, has been significantly related to feelings of competence and job satisfaction both of which positively influence professional well-being, quality of services provided to clients, and act as a protective factor against burnout (A. E. Green, Albanese, Shapiro, & Aarons, 2014; Lasalvia et al., 2009). Therefore, it appears that the support provided through the wraparound process is beneficial for both families and professionals.

Outcomes

The outcomes experienced from the wraparound process were numerous for the majority of families involved. The main outcomes achieved through the process were identified by all respondent groups to be more than just behavioural or mental health indicators of change for the young person. Instead a complex array of changes were observed in regards to family dynamics, communication, empowerment and hope, skill building, increased understanding and insight, as well as specific individual parent and youth change. These outcomes are consistent with both the theory of change literature on the wraparound process as well as outcome studies (Anderson et al., 2008; Bruns et al., 1995; Graves & Shelton, 2007; J. S. Walker, 2008a). Many of these outcomes are not currently being measured in New Zealand (e.g., increased parental confidence and skills and empowerment and hope). Therefore, it could be proposed, that if evaluation of the wraparound process is not

using outcome measures which capture the changes which are emphasised in wraparound, then its effectiveness may be underestimated (J. S. Walker, 2008a). These findings clearly indicate the need for the incorporation of measures which specifically capture these outcomes as they are clearly indicators of success for families and provide the foundation for future success.

Theory of Change

Respondents' experiences were consistent with the proposed theory of change identified by J. S. Walker (2008a). This theory purports that adherence to the wraparound principles and practice model facilitates positive short and long term outcomes through a 'positive spiral' by increasing "the effectiveness of services and supports and by developing capacity and resources for coping, planning, and problem solving" (J. S. Walker, 2008a, p. 7).

Specifically, in the current study the embodiment of the identified wraparound principles (e.g., family voice and choice, team-based, collaboration, individualised, strengths- and outcome-based), led to what was perceived as a collaborative team-based approach which was considered to be more efficient, as it decreased repetition, and allowed for a better understanding of the whole picture with everyone working towards common goals. As families were treated as equal team members, with their voice and choice being heard and prioritised throughout the process, respondents felt the wraparound team was in a better position to tailor make and personalise each wraparound process specifically for the young person and family based on their needs. This individualisation of services, based on family need, voice, and choice, appeared to have resulted in respondent groups experiencing increased service effectiveness; supporting J. S. Walker's (2008a) first route to change. The

individualisation of services and supports worked particularly well with young people and their engagement in the process.

J. S. Walker's (2008a) second route to change proposes that as wraparound activities focus on the family developing their own plan, they develop skills and resources which lead to an improved ability to problem solve and cope, increasing self-empowerment and efficacy. Family empowerment and efficacy have been recognised as important in leading to future positive outcomes as it increases belief in the ability to make positive life choices and reduces feelings of helplessness (Graves & Shelton, 2007). Consistent with this route, respondents identified that increased family confidence, empowerment, and efficacy developed by families being in the driver's seat, making choices about their plan, and seeing their goals and plans come to life. All respondent groups appreciated being able to plan and then see change occurring identifying this as an important part of the process which helped them start to see a different future.

Feedback and Improvements

Two major points of feedback or improvements identified in interviews were the access to the wraparound service in New Zealand and the system challenges for those involved in the process, potentially due to not having a system of care to facilitate wraparound implementation. Many families identified needing to get the service sooner and the lack of knowledge of and/or about the wraparound process by other professionals. It has been previously estimated that between 3-10% of New Zealand youth meet criteria for a serious mental health disorder (Fergusson & Horwood, 2001; Oakley-Browne et al., 2006). Unfortunately, a substantial proportion of youth with serious mental health disorders do not receive mental health services and if they do it may not be to an adequate level or intensity (Merikangas et

al., 2011; Shailer et al., 2013). Therefore, continued work should be done to ensure professionals and those working with families are aware of the wraparound process and referral criteria.

An additional challenge identified from this study from all respondent groups was the system challenges in regards to accessing required funding and resources through other agencies. The wraparound process in New Zealand has access to a level of flexible funding, but it is still greatly dependent on other agencies providing access to resources through their systems and processes (e.g., placements, funding for external therapy, funding for school uniforms), thus not providing a true integrated system of care. This can lead to delays as well as agency and family frustrations. The experiences from all respondent groups indicate this is clearly an area which would benefit from improvement. A pooled funding system, such as those exemplified by Wraparound Milwaukee in the United States of America or the High and Complex Needs Unit in New Zealand, could provide potential models for a more comprehensive funding system across agencies which could be of benefit to the identified system challenges (High and Complex Needs Unit, 2005; Kamradt, 2002). However, research into the practicality and viability would be warranted.

Two other points of feedback related to role clarity and transition out of the wraparound process. Team members specifically identified that clarification of their roles within the wraparound process could at times be clearer. Although the majority did identify that roles had been discussed at the beginning, the wraparound process is often a different way of working with families, supports and agencies, and a new way to work for team members. This feedback highlights the needs to continually ensure clarification of roles and responsibilities throughout the process, particularly for team members, who are working both within their own system and the

wraparound process. To start with this may require extra work on behalf of the wraparound facilitators, particularly, for those who are new to the process. Finally, continuity of care and transitioning out of wraparound was commented on by caregivers, young people, and team members. Consistent with fidelity research and other qualitative studies, at times these respondent groups felt the transition was abrupt or that longer involvement would have been beneficial (Bruns, 2010; M. A. Moore & Walton, 2013; Painter et al., 2011). Therefore, it appears that better preparation for transition out of wraparound is important so that families and teams feel ready and supported to leave the process.

Limitations and Future Research

Although based on a relatively large sample size for a qualitative study participants were recruited from only one site delivering the wraparound process in a metropolitan city in New Zealand. Therefore, caution should be taken in generalising these findings to other wraparound processes. These findings should not be considered as the experiences of all families and team members participating in the wraparound process, as a potential positive bias in the sample cannot be ruled out because participants self-selected to partake in interviews. It is possible, that those who were involved in the wraparound process at the time of the study that declined to be interviewed may have held more negative views, or held views that were different than those families and team members who chose to be a part of this study. It is also possible that those youth who declined to participate also had differing views than their respective wraparound teams.

Another limitation to this study is related to the quality of participants accounts based on when and how the interviews were conducted. The qualitative interviews in this study were part of a larger fidelity study which aimed to investigate adherence to

the wraparound process in New Zealand. The qualitative interviews were conducted after the fidelity interview. Therefore, participant's information may have been subjected to a recall bias towards the facets of wraparound which were asked about in the fidelity study. Although the qualitative interviews were structured differently and asked about different aspects of the process, future research which solely includes qualitative interviews would be of interest, to confirm the current findings and minimise this potential bias. Additionally the qualitative interviews were relatively short compared to most qualitative studies and therefore only represented a small snapshot of respondent group's experiences. Once again to obtain a more in-depth and full account of participant's experiences a solely qualitative study which focuses on the full wraparound experience would be of use in order to make sure that participants experience was fully captured.

Further, even though there were respondent groups from different ethnicities in this study, it did not represent a balanced cultural account of the wraparound process as the majority of participants (families, team members, and wraparound facilitators) were New Zealand European. Future research into the experiences of the wraparound process from New Zealand Māori and other cultural perspectives would be of interest to see whether similar values and experiences of the process align with the current findings. Nevertheless, the information gained provides a valuable multi-perspective insight into the wraparound process in New Zealand and contributes to our knowledge of the process.

Implications and Conclusions

Qualitative research is important in order to give those involved in the wraparound process a voice through communicating what aspects worked best for them and what could be improved. The present study was unique in the fact that it

elicited four different voices and perspectives from key members in wraparound teams to allow for a holistic view of the process. Although emphasis of certain themes differed between wraparound facilitators, caregivers, youth, and team members, themes were relatively consistent. Themes were also consistent with previous research and the proposed theory of change, identifying the importance of the role of the facilitator, the holistic approach and the wraparound principles, the support it provides, and the outcomes it achieves.

The therapeutic relationship has been shown to contribute to both positive client outcome and positive experience (M. J. Lambert & Barley, 2001; Martin et al., 2000). However, in the current study, the wraparound practice model in terms of the principles and approach was also considered to be as important in contributing to respondent groups experience with six out of the ten wraparound principles being able to be identified in participants' interviews. There appeared to be an interconnected relationship between both the practice model that the wraparound process is based on and the wraparound facilitator's therapeutic relationship and coordination of the process (Pagkos, 2011). These findings highlight the central role of the wraparound facilitator and how their relationship influences change through the principles of taking an individualised, strengths-based, collaborative, team- and outcome-based approach that is respectful and driven by family voice and choice.

Due to the inductive approach of qualitative research two important aspects about how support was experienced and developed were discovered. First, the practical support provided by wraparound facilitators and teams was found to be a mechanism by which therapeutic relationship would develop and emotional support would be sought, in particular, by caregivers. Second, wraparound was found to not only be supportive for families but also for team members, as the process 'wrapped'

supports around both families and team members. This could be as much of a protective factor for team members as it is for families in particular against burnout. The development of support from practical to emotional and the potential protective factor of support for team members would be two areas of interest for future research.

The consistency of respondents answers with the core values, beliefs, and philosophies of wraparound and the theory of change suggested by J. S. Walker (2008a) provide additional support for the inclusion of fidelity measurements to ensure wraparound is being delivered as it was intended (Rast & Bruns, 2003; Walter & Petr, 2008). Aligned with the findings in the wraparound fidelity and outcome literature, respondent groups experiences indicate that those wraparound processes which are adhering more closely to the wraparound model, will most likely be meeting family's needs more effectively. The results also emphasise the importance of tracking plans made so that families have a clear account of change and can see and measure the change occurring. A concrete and tangible representation of change throughout the process helps continual engagement in the process as well as empowerment and hope for the future. In addition, considering the central importance of the wraparound facilitators in families and team members experience in the process, selection and training of wraparound facilitators is clearly important in order to ensure that they are best able to embody wraparound principles and establish strong relationships with families.

Overall, the present study confirms the complexity of the wraparound process both in its delivery and how change occurs. The wraparound process helps families to grow, develop, and come together. By having a cohesive plan which is followed up regularly and a team walking alongside them, families not only feel supported to

make the change required, but can also see change occurring which provides hope for the future. With the focus on empowering families and strengths, wraparound assists them in realising their own potential and ability to manage and handle situations. Therefore, the outcomes achieved through wraparound, are more than just a reduction of mental health symptoms and dysfunctional behaviour, but rather an increase in skills and tools which provide ongoing benefit. Families have increased confidence, awareness, and understanding as they learn more about one another and themselves, as well as how to work together and communicate as a family unit, which enhances self-efficacy and leads to a greater sense of perceived control. Taken together, the experiences elicited in this study are not only in line with the principles, philosophies, and theory of how change occurs, but highlight how the wraparound process in itself, through the team, can be a therapeutic intervention in its own right which provides invaluable support by its presence in families' lives.

Chapter 7: General Discussions and Conclusions

The wraparound process has been identified as a potential option for high and complex needs youth with serious mental health disorders. After a thorough literature review it was deemed a promising model for New Zealand. Therefore, the current research project evaluated one wraparound program in operation in New Zealand. First, it was considered necessary to ensure that the process was being implemented as it was intended. Thus, a fidelity study was conducted which showed the program had above average fidelity. Second, it was sought to understand from consumers and those who delivered wraparound their experiences and thoughts regarding the process. This study resulted in themes which corresponded with both the principles and values of wraparound identified by the National Wraparound Initiative (NWI) and the results of the fidelity study. The importance of the therapeutic relationship formed between the wraparound facilitators in this program with consumers' engagement and experiences, the support from the wraparound team, and the outcomes respondent groups experienced was also highlighted.

While each paper discussed these findings and contributions separately it is important to look at the findings and implications across studies. Therefore, this final chapter ties together the major themes that have arisen from this thesis and the contribution it has made to the wraparound literature. Next, the general limitations of the research project are discussed with suggestions being made for future research. Finally, this chapter concludes with the principal researchers own self reflections on this thesis and the personal learning that occurred.

Implications and Recommendations

This research project represented a first step in evaluating the wraparound process in New Zealand. The results from this project indicated that the wraparound

process was being implemented as it was intended and predominately experienced as a positive and helpful process. In combination with the wider research on wraparound in the United States of America (USA), these preliminary findings suggest wraparound as a potential effective process for youth and families with high and complex needs in New Zealand (Bruns & Suter, 2010; Bruns et al., 2010; Suter & Bruns, 2009). It is therefore recommended that the wraparound process continue to be used within this context. However, improvements were suggested which will be discussed in the following sections. Future research should also be conducted to increase its evidence base and ensure effectiveness.

Fidelity and experience. An insight was gained through this thesis into the delivery of the wraparound process in New Zealand and how it is experienced by those involved in the service (e.g., wraparound facilitators, caregivers, youth, and team members). A degree of consistency was found across studies between respondent group's fidelity ratings and the aspects of the process which they considered to be important or needing to be improved. Specifically, a number of the principles and phases which were adhered to were positively commented on in the qualitative study, whereas, those which had low adherence were either not commented on or noted as an area of improvement.

The level of adherence to the model could be hypothesised as a potential contributing factor in the teams' experiences of the process. In the current research project, no direct relationship or comparison can be made regarding whether fidelity impacted on experience. However, the wider wraparound literature, suggests that greater adherence is associated with more positive outcomes (Barfield et al., 2005; Bruns et al., 2005; Cox et al., 2009; Effland et al., 2011; Graves, 2005; Graves &

Shelton, 2007). It would be of benefit for this hypothesis to be tested in future within a New Zealand context.

The findings from the qualitative study also gave further evidence to the importance of engagement, therapeutic relationship, support, and increasing empowerment and hope in teams' positive experiences. Although not unique to wraparound, what was implied in the qualitative study was how the conditions for these elements may be created through the implementation of wraparound principles and the engagement phase. However, again, future research is needed to empirically determine whether there is a relationship between fidelity and the positive aspects highlighted as important in the current investigation (e.g., therapeutic relationship, support).

Ongoing fidelity measurement. Consistent with previous research, the results continued to support the importance of adherence to the wraparound practice model and the inclusion of fidelity measures (Bruns, 2008b; Rast & Bruns, 2003). The philosophy, principles, and phases of wraparound were found to generally align with what respondent groups perceived as important, beneficial, and different about the process and what needed to be improved. Therefore, to ensure ongoing adherence to the model across time, continued measurement of fidelity to the wraparound process in New Zealand as part of standard practice and in future research investigations would be advised.

In line with this recommendation, the Wraparound Fidelity Index, fourth version (WFI-4; Bruns, 2010; Bruns et al., 2009) was found to be a useful and effective measure of wraparound adherence within New Zealand. However, while the WFI-4 was generally able to be transferred and applied with minimal adaption, some questions were not always applicable or understood by families. For example,

as residential placements occur less frequently and at a different level in New Zealand, when compared to the USA, the question 2.9 “*Do you feel confident that, in the event of a major crisis, your team can keep your child or youth in the community*” was often observed by the principal researcher to be confusing for families. Thus, if the WFI-4 is used as an ongoing measure, some slight modifications may need to be made beyond demographic information to ensure it fits within a New Zealand context and culture which could be the focus of future research. Overall, with consideration to the suggestions above, the WFI-4 would be recommended as an ongoing and valuable instrument to measure fidelity to the wraparound process in New Zealand.

After the collection of the fidelity data, insights were gained regarding the practicalities of ongoing fidelity measurement. In the current research project, fidelity data was collected through the use of face-to-face WFI-4 interviews. In addition to completing the fidelity interview and analysing the data collected, a considerable amount of time was taken up contacting family’s and team member’s to arrange, and at times reschedule interviews, as well as travelling to their homes and work places. Interviews with families also often had to be completed after the youth returned home from school in order to interview both the caregiver and youth. For ongoing fidelity measurement across time this approach may be difficult to maintain.

In order to reduce the time and resources needed it would be recommended that ongoing fidelity measurement could occur in one of two ways. First, the WFI-4 could be completed through telephone rather than face-to-face interviews which would reduce travel and scheduling difficulties. This method is commonly recommended by the NWI and is the most frequently used method for conducting the WFI-4 in the USA (Bruns et al., 2009). However, this approach would still

require that interviewers be trained to administer the WFI-4, complete the interviews which can take 45-60 minutes, and manually enter the data which results in administrative burden (Bruns, 2008c; Bruns et al., 2009). Therefore, the second alternative would be the purchase and implementation of the Wraparound Fidelity Index-Brief version (WFI-EZ; Wraparound Evaluation & Research Team, 2012). The WFI-EZ, which was being piloted when the current investigation took place, is a brief, self-report version of the WFI-4 (Sather et al., 2012). It can be completed either by pencil and paper or electronically through a web-based survey which reduces administrative burden and can be completed by clients in their own time (Wraparound Evaluation & Research Team, 2012). However, as the applicability of the WFI-EZ was not explored in the current research, this would warrant investigation in the future to determine whether this would be a valid tool to measure wraparound fidelity in New Zealand.

Improvements. This thesis has increased our understanding of what could be improved about how the wraparound process is delivered which allows for recommendations to be made regarding its implementation in future. While there were several areas of improvement indicated across papers (e.g., increasing adherence to low fidelity elements, role clarity, accessibility of the service and systems to support wraparound), focusing on increased training to wraparound staff and education to those working with wraparound would be essential (Bruns et al., 2006). Dadler (2006) provided a number of useful practical recommendations for wraparound facilitators that are aimed at increasing wraparound teams' adherence to the principles of natural supports and community-based services. This in turn, can help to provide the foundations for better and more purposeful transition out of wraparound for families and teams. Subsequent to any training implementation, a

follow-up fidelity investigation to ensure training effectiveness would be useful (Bruns et al., 2006).

While increased education and training is imperative, the current limitations may imply the need for a larger system level change. In the USA, the wraparound process is implemented within a system(s) of care service delivery model (Winters & Metz, 2009). In accordance with the improvements identified in the current research, in the past, systems of care have focused on improving the availability and access of services, reducing service and funding fragmentation, and increasing the skills and knowledge of service providers (Child Welfare Information Gateway, 2008). In addition, as systems of care embraces the same values and philosophies of wraparound at a systems level, it means that all services (e.g., primary, secondary, tertiary) are on the same page and have a shared understanding of the wraparound process (Stroul, 2002; Stroul, Blau, & Friedman, 2010). Therefore, the development of a similar organisational system in New Zealand may be beneficial.

Implications for other models. Implications can also be taken from this research project in relation to other mental health services and interagency approaches. Services are continuously moving towards the use of interagency approaches due to the realisation that no one agency is able to adequately provide services for these youth on their own (English, 2002). For example, currently in New Zealand, there are a number of varying 'wraparound type' interagency models being implemented by different governmental agencies (e.g., Children's teams, Intensive Wraparound Service, Strengthening Families). Each of these programmes aim to provide a holistic service and facilitate multiagency involvement for youth and families with high and complex needs (Social Policy Evaluation and Research Unit, 2014; Strengthening Families, 2010). However, often the main difference between

such approaches and wraparound is the philosophies and principles embraced which have been considered important to effective service delivery (Bruns, Walker, et al., 2004). In addition, key phases set out what activities need to occur throughout the wraparound process in order to ensure fidelity, outcomes, and efficacy (J. S. Walker et al., 2004).

While other interagency approaches certainly embrace some of the philosophies and principles specified in wraparound, they do not embrace them all in unison, which at times results in inconsistent and unsatisfactory service delivery (Ministry of Social Development, 2001b; A. Walker, 2006). For example, in the literature review, when introducing and evaluating the Strengthening Families Program, families were dissatisfied with the process due to the agencies involved providing inadequate service, the lack of follow through on what was agreed to, and the poor communication between agencies (Ministry of Social Development, 2001a). Comparatively, when analysing the qualitative results these same issues were highlighted as beneficial, helpful, or contributing to teams' positive experience of wraparound and directly correspond to the principles of team-based, collaboration, and outcome-based. This demonstrates the value of having a clear practice model guided by principles and phases. Without a clear practice model it also makes it difficult to investigate model implementation, delivery, and in turn any outcomes it achieves. Therefore, an important focus for other interagency approaches in New Zealand is to ensure their own, preferably evidenced-based, practice model.

The influx of newly developed interagency models which is currently occurring in New Zealand parallels what occurred in the USA which resulted in the initial formalisation of the wraparound process practice model (VanDenBerg, 2008; J. S. Walker, 2008b; J. S. Walker & Bruns, 2006a). This formalisation stemmed

from ongoing confusion and disparity about what was actually considered a ‘wraparound’ approach by consumers, practitioners, and policy makers (J. S. Walker & Bruns, 2006a). This model is now considered to be one of the most commonly used care coordination processes in the USA (Bruns & Walker, 2010; J. S. Walker & Matarese, 2011). Therefore, it stands to reason, that a similar formalisation process which results in one consistent interagency model in New Zealand would be advantageous.

While families did not report feeling judged within the wraparound process, some families, professionals, and facilitators identified the judgement that they faced before wraparound. Although the judgement felt may or may not have been intended, the guilt and shame these families experience, in particular caregivers, may impede on them accessing needed help and assistance from both professionals and their natural support network (Winkworth, McArthur, Layton, Thomson, & Wilson, 2010). This implies the need for continued efforts to be directed within the community and services to help reduce feelings of guilt, shame, and any ongoing judgement, stigma or negative attitudes held, in particular, within the key agencies that regularly work with these families. This may include ongoing education to professionals working with families about mental health issues or training in evidence-based principles and strengths-based approaches to decrease blaming and judgement for families and ensure respect.

General Limitations and Future Research

The limitations for each of the two studies in this thesis have been discussed in depth in previous chapters. Therefore, the following section considers the broader limitations of the thesis beginning with the sample size and its representativeness. One of the main limitations, discussed across studies, was the limited ability to

generalise the findings due to the small sample size and participants being a self-selected sample from one wraparound site. As only one District Health Board was implementing the wraparound process at the time of this research project, and there were no other programmes identified as using this model in New Zealand, a larger sample size from more than one site was considered unfeasible.

Regardless of sample size, when conducting fidelity research, it is considered important to obtain a representative sample of the population. This has been cited to equate to a response rate of at least 70% (Bruns, 2008c; Check & Schutt, 2011). This ensures the results a study achieves are representative of the larger population and bias is reduced. Despite the principal researcher's best efforts only a 61% response rate was obtained and the youth sample was found to not be culturally or age representative. Therefore, the findings cannot be said to represent the views of all wraparound teams involved in the wraparound process at the time of this research. In order to ensure the integrity of the current findings regarding adherence to and experiences of the wraparound process, further research should be conducted using similar methods with larger more representative samples.

Another limitation, which was briefly discussed in the fidelity study, was the lack of quantitative outcomes. While this research was not an outcome study such outcomes would be beneficial to the wraparound research in New Zealand. Therefore, it would be recommended that future research include quantitative outcome measures alongside fidelity and qualitative investigations to increase the validity of the research and to determine the effectiveness of the process. Part of the difficulty with outcome studies in wraparound is the focus on specific long term outcomes (e.g., improved mental health symptoms). Therefore, it would be important to ensure that any outcome measures used, target the constructs of change proposed

in wraparound's theory of change, which were also supported by respondent group's experiences in the current research (J. S. Walker, 2008a). Unfortunately developing such a measure was beyond the scope of this research project.

Data for this thesis was also collected at a single point in time with families who had been receiving wraparound for varying amounts of time. Although both the WFI-4 and the qualitative questions were designed to capture the entire wraparound process at one point in time, the wraparound process is considered to be a dynamic model (J. S. Walker & Schutte, 2004). Therefore, it is possible that fidelity to the process and experiences may differ depending on how long, or what phase, a family or team is at in the process. Providing anecdotal support for this, was that in the fidelity study, it was observed that wraparound teams who had been in the wraparound process longer had slightly higher fidelity ratings (e.g., under 8 months – 80%; over 8 months – 84%). However, future research would be needed to provide evidence for this finding.

There was also number of items on the WFI-4 which had an 'I don't know' or 'not applicable' response. Although no wraparound teams were lost and procedures were followed to minimise any effect missing items would have, it is unknown how this missing data may have affected fidelity ratings. Further, six youth in the fidelity study and eight youth in the qualitative study did not participate. Analysis was conducted in the fidelity study to determine the potential effect of the lack of data from these six youth. However, it was unable to be determined what effect this may have had in the qualitative analysis.

Finally, while four respondent groups were used in order to gain a multiple perspective understanding of the process, the information obtained was entirely based on self-report. In particular, regarding the adherence to the process, the use of

direct observation in combination with the WFI-4 would have increased the validity of the findings in the fidelity study. It would be recommended that future research assessing wraparound fidelity include a direct observation measure such as the Team Observation Measure (TOM; Bruns & Sather, 2007; Bruns et al., 2014) in addition to a self-report measure such as the WFI-4. Alternatively, the Wraparound Structured Assessment and Review (WrapSTAR) process could be used which provides a comprehensive evaluation of wraparound implementation by integrating a variety of wraparound fidelity and implementation measures (Wraparound Evaluation & Research Team, 2015).

Personal Reflections

Even before I began this thesis and a degree in clinical psychology, I had a passion and interest in child and adolescent mental health. However, through this research project I believe I have gained invaluable insights, understanding, and knowledge about what is important for youth and families with high and complex needs. This has been and will continue to be transferred into my clinical practice. While it is impossible to summarise all of what I have taken away and learnt from this thesis, at the top of the list are that: when there is a youth and family with high and complex needs everyone benefits from and in some cases needs support; the blame and judgement felt by families is devastatingly real and it can be paralysing; families and individuals don't fail, the plan does; and wraparound principles are helpful guidance for good practice no matter whom you are working with.

Although this research project was on the wraparound process, it also helped me understand the long, disempowering, and lonely journey some youth and families go through before they access wraparound or sometimes any service. This was saddening, but, at the same time had implications for how I work. Ensuring the

clients that I have contact with in future do not fall within system gaps and gain the support they require is now an ongoing priority. It has also increased my passion for bridging the gap between policy and practice in New Zealand. This includes continuing to advocate for a system that is more integrated and works better for all consumers no matter what their entry point into services is. It is currently an exciting time of innovation and reorganisation for New Zealand with increased funding and initiatives being directed at improving our services and systems for youth and families with high and complex needs. I hope this focus continues and that a cohesive system is developed which facilitates and enhances care for these youth and families.

Having the opportunity to travel to the service delivering wraparound and meeting with the team and participants was believed to be a vital part of this project. Without this, it is unlikely that I would have gained the level of practical understanding about how the wraparound process is delivered in practice in New Zealand as well as the benefits and challenges of this process. The service delivering wraparound was also observed to have an incredibly cohesive, passionate, and dedicated team of staff with low turnover. While this was not analysed as part of this investigation, as it was beyond the scope of the research project, the team cohesion and dedication was admirable and may be another factor which contributed to the overwhelmingly positive feedback given by families and youth about their facilitators which is worthy of future investigation.

Overall, interviewing wraparound teams, in particular hearing youth and families stories and experiences of the process, was an honouring and humbling experience. I hope that the families also had a positive experience of participating in this research project and that through this research their voices continue to be heard.

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Appendices

Appendix A: Adaption of WFI-4 Demographic Form

Wraparound Fidelity Index 4

Demographics Form

July 15, 2009 version



This form is to be completed by the Wraparound Facilitator. If the Wraparound Facilitator is not available for interview, then this form is to be completed by the caregiver.

Youth's name: _____

Caregiver's name: _____

Facilitator's name: _____

Interviewer's name: _____

Today's date: Month _____ Day _____ Year _____

Administration method: 1 Face-to-face 2 Phone

| | |
|----------------------|--|
| Project ID: | |
| Youth/ Family ID: | |
| Caregiver ID: | |
| Facilitator ID: | |
| Interviewer ID: | |
| Timeframe: | |

1. Youth's DOB Month _____ Day _____ Year _____

2. What is the youth's gender? 1 Male 2 Female

3. What is the youth's race? (*Check all that apply*)

- | | |
|---|---------------------|
| 1. New Zealand European / Pakeha | 2. Māori |
| 3. Other European (please specify) | 4. Pacific Islander |
| 5. Asian | 6. Indian |
| 7. Mixed race _____ (<i>Please specify</i>) | |
| 8. Other _____ (<i>Please specify</i>) | |

4. Is child/youth CYFs Custody (if so what section are they under):

- | | |
|------------------------|----------------------|
| Under agreement | Under Court order |
| __ section 139 | __ section 78 |
| __ section 140 | __ section 101 |
| Under emergency action | __ section 102 |
| __ section 39 | __ section 110(2)(a) |
| __ section 40 | __ section 238(1)(d) |
| __ section 42 | __ section 345 |
| __ section 48 | __ section 311 |

WFI 4-Demographics Form

July 15, 2009 version

5. Has the youth been in school anytime during the last 30 days?

1 No 2 Yes

If Yes, go to question #6.

If No, Why was the youth not in school?

- | | |
|--|------------------------------------|
| 1. Dropped out of school before legal age | 2. Dropped out after legal age |
| 3. Expelled/Suspended | 4. Too young to go to school |
| 5. Finished college or achieved NCEA level 3 | 6. Taught at home (home-schooled) |
| 7. Physical illness | 8. Refused to go to school |
| 9. In juvenile detention or jail | 10. Ward of the State/CYFs custody |
| 11. School holidays | |
| 12. Other _____ (Please specify) | |

6. Which grade is the youth in now or will be in for the new school year?

- | | |
|---|--------------------------------------|
| 1. Year 1 (Junior 1/Primer 1) – Primary | 9. Year 9 (3rd form) – College |
| 2. Year 2 (Junior 2/Primer 2) – Primary | 10. Year 10 (4th form)- College |
| 3. Year 3 (Standard 1) – Primary | 11. Year 11 (5th form) – College |
| 4. Year 4 (Standard 2) – Primary | 12. Year 12 (6th form) – College |
| 5. Year 5 (Standard 3) – Primary | 13. Year 13 (7th form) – College |
| 6. Year 6 (Standard 4) – Primary | 14. Alternative Education Course |
| 7. Year 7 (Form 1) - Intermediate | 15. Post secondary school |
| 8. Year 8 (Form 2) – Intermediate | 16. No grade level in child's school |

7. Any Mental Health Diagnoses (tick all that apply)

Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence

- Attention Deficit Hyperactivity Disorder
- Learning Disorder
- Mental Retardation
- Developmental Delay
- Developmental Co-ordination Disorder
- Reactive Attachment Disorder
- Separation Anxiety
- Asperger's Disorder
- Conduct Disorder
- ODD
- Tic Disorder
- Tourette's Syndrome

Substance Use Disorder specify substance

Mood Disorder specify type e.g. depression

Psychotic disorder specify type

Eating Disorder specify type

Anxiety disorder specify type e.g. separation anxiety/PTSD

Dissociative Disorder

Adjustment Disorder specify with

Personality Disorder specify type

Other please specify

Page 2

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Appendix B: Qualitative Questions

1. What is your understanding of wraparound?
2. What do you like most about the wraparound process, and why?
3. What do you think worked best for you, and why?
4. What do you think could have been done better, and why?
5. What was the hardest part of the wraparound process for you, and why?
6. If you could change anything about the process what would it be?
7. How has wraparound benefited or made a change in your life?
8. What has been the most influential or important part of wraparound for you?
9. What would you like other youth, families, parents/caregivers to know about the wraparound process?
10. Would you recommend wraparound to other families or friends if they needed it, and why?
11. What would you say are the main differences between wraparound and the services you were previously receiving?
12. How would you describe your overall experience of the wraparound process?
13. On a scale to 1-10, overall, how would you rate this service, and why?

Appendix C: Information Sheet for Families and Youth



MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGĀ TĀNGATA

Wraparound New Zealand: Information Sheet for Families and Youth

Quality of service, experience and outcomes of a wraparound service

The Research Project

This study is a joint project between Massey University and two members of the ICSS wraparound team. Massey University and ICSS 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 quality of services the ICSS Wraparound-Systems of Care process provides to its children, youth and families.
2. What you and your daughter or son think about the service and
3. What outcomes you and your daughter or son have achieved from the service. This includes looking at how you and your family are progressing towards your wraparound goals/plans as well as how the wraparound process is making a difference in your life.

The focus is on getting you and your family's perspectives and experience of the wraparound process.

If you accept this invitation you and your daughter or son will be asked to complete two 40-50 minute interviews at 6 monthly intervals. These interviews will be audio recorded to ensure that all information is fully captured.

You and your daughter or son will also be asked to fill out monthly questionnaires with your wraparound facilitator on your young person's progress and behaviour through the wraparound process.

The researcher

My name is Jacinda Shailer. I am a Doctoral Clinical Psychology student at the Massey University campus in Wellington. I am currently in my first year of Doctoral Study. My supervisors for this project are Dr Ruth Gammon (School of Psychology) and Dr Ian de Terte (School of Psychology).

Who can take part?

All families and youth (over the age of 11) currently involved with the ICSS wraparound service can participate in this study.

Taking part in this study is voluntary

It is your choice whether you take part in this research study or not. You do not have to participate in these interviews in order to receive services. If you do not want to participate, you can say no and there will be no change in the services you receive or how you are treated.

You can also say no when you or your daughter or son is called and asked to participate in the interview. However, we hope that you will decide to help us to improve the wraparound services by participating.

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

- Decline to answer any particular question
- Ask for the recorder to be turned off at any time during the interview
- Withdraw from the study during the interview or within one week after the interview
- Ask any questions about the study at any time during participation
- Provide information on the understanding that your name will not be used unless you give permission to the researcher
- Be given access to a summary of the project's findings when it is concluded

What's involved?

If you agree to participate we will ask you and your daughter or son (over the age of 11) to take part in two interviews with me. These interviews will last about 40-50 minutes and will ask about the kinds of services that you and your family have received, and what you and your daughter or son thinks about those services. For example what things have been most helpful for you and your family or what could have been done better.

The interviews may take place at the ICSS office, at your home, or another location of your choosing whatever is most convenient for you.

We will also ask your facilitator and members of your team to take part in a similar interview. We will use the information we collect to help improve the quality of services you and other families receive.

To effectively evaluate the wraparound process we will also need access to your mental health files. We may also ask for you and your daughter or son to participate in the completion of questionnaires every month with your wraparound facilitator so we can see exactly how the wraparound process is helping your family. In the future we may also require access to records from other agencies your family may be involved with. If we do need access to information from other agencies aside from the District Health Board we will obtain your written consent prior to obtaining any such record.

To say thanks for your time and sharing your experience we are looking into providing you and your son or daughter a small koha. This may include something like a \$5 McDonalds voucher for your son or daughter and a \$25 New World voucher for you.

Can I bring someone?

You are welcome to bring family or whānau support to the interview. If you wish to have a whānau member or other support person present during the interview this can be discussed with the principal investigator Jacinda Shailer.

Are there any benefits or risks?

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

The main benefit to you and your family participating in this study is that you will assist the ICSS team and future teams who implement wraparound in New Zealand to modify and be aware of what works best for families and youth with high and complex needs. This will help the ICSS team to provide a better service in future to you and your family along with other families who receive this service in future. It will also help us gather information and evidence so that other wraparound initiatives around New Zealand in future will deliver the best possible service to the youth and families it serves.

You get a voice for how the wraparound process is helping you and your child. These interviews provide you with a space to independently and directly express your experience of the wraparound process with the knowledge that information will be kept confidential.

What happens to the information?

I will analyse the information given. The things you say, or the information we gather about you, will be kept confidential and used for research purposes only.

This study involves audio recording of yours and your child's wraparound fidelity interviews with me. Neither yours or your child's name nor any other identifying information will be associated with the audio recording or the transcript. Only the research team will be able to listen to the recordings. The tapes will be transcribed by the researcher and erased once the transcriptions are checked for accuracy. Transcripts of yours and your child's interview may be reproduced in whole or in part for use in presentations or written products that result from this study. Neither your name nor any other identifying information will be used in presentations or in written products resulting from the study.

All recordings and data will be securely stored. We will keep the data securely stored for ten years after your son or daughter has turned 16, after which point it will be destroyed.

The information in write up form will be shared through academic conference presentation and journals.

All data will be anonymous. No material that identifies you will be used in any report on this study. All identifying information (like names of people or places) will be removed or changed. Your family will be given a number and every endeavour will be made to ensure that the material given to us remains confidential and that you and your family are not identifiable. The only people that will have access to the anonymised data after it has been coded will be myself, my supervisors and two members from the Intensive Clinical Support Service.

Finding out about the results of the study

If you would like to find out the results of the study, please circle the YES box on the consent form. After the study is completed, we will mail you the results. There may be a long delay between when you take part and when the results are known.

Contacts for the project

If you would like more information, have any questions at all, or would like to talk about this research project with anyone, then please feel free to contact one of us directly. Alternatively, your wraparound facilitator can put you in contact with us.

Student Researcher

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Our postal address is:

Psychology Clinic, Massey University, 24 King Street, Wellington

OR

School of Psychology, Massey University, PO Box 756, Wellington

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

Free phone (NZ wide): 0800 11 22 33

Auckland Phone: 09 373 1060

Auckland Fax: 09 373 1061

Email: hdc@hdc.org.nz

Postal address: PO Box 1791, Auckland, New Zealand

This study has received ethical approval from the Northern Y Regional Ethics committee.

Appendix D: Information Sheet for Team Members



MASSEY UNIVERSITY
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AND SOCIAL SCIENCES
TE KURA PŪKENGĀ TĀNGATA

Wraparound New Zealand: Information Sheet for Team Members

Quality of service, experience and outcomes of a wraparound service

The Research Project

This study is a joint project between Massey University and two members of the ICSS wraparound team. Massey University and ICSS 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 quality of services the ICSS Wraparound-Systems of Care process provides to its children, youth and families.
2. What you as a team member thinks about the service and
3. What outcomes are being achieved for the young person and family in your wraparound team. This includes looking at how the wraparound team is progressing towards the wraparound goals/plans as well as how the wraparound process is making a difference for the young person and family.

The focus is on getting your perspective and experience of the wraparound process as part of the wraparound team.

If you accept this invitation you will be asked to complete two 40-50 minute interviews at 6 monthly intervals. These interviews will be audio recorded to ensure that all information is fully captured.

The researcher

My name is Jacinda Shailer. I am a Doctoral Clinical Psychology student at the Massey University campus in Wellington. I am currently in my first year of Doctoral Study. My supervisors for this project are Dr Ruth Gammon (School of Psychology) and Dr Ian de Terte (School of Psychology).

Who can take part?

Any member of a wraparound team which involves a young person over the age of 11 currently involved with the ICSS wraparound service can participate in this study.

Taking part in this study is voluntary

It is your choice whether you take part in this research study or not. You do not have to participate in these interviews in order to receive or be involved in services. If you do not want to participate, you can say no and there will be no change in the services you receive or how you are treated.

You can also say no when you are called and asked to participate in the interview. However, we hope that you will decide to help us to improve the wraparound services by participating.

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

- Decline to answer any particular question
- Ask for the recorder to be turned off at any time during the interview
- Withdraw from the study during the interview or within one week after the interview
- Ask any questions about the study at any time during participation
- Provide information on the understanding that your name will not be used unless you give permission to the researcher
- Be given access to a summary of the project's findings when it is concluded

What's involved?

If you agree to participate we will ask you to take part in two interviews with me. These interviews will last about 40-50 minutes and will ask about the kinds of services that your wraparound team have received, and what you think about those services. For example what things have been most helpful or what could have been done better.

The interviews may take place at the ICSS office, at your home/office, or another location of your choosing whatever is most convenient for you.

We will also ask the young person the process is centred around (over the age of 11), their parent/caregiver and the wraparound facilitator to take part in a similar interview. We will use the information we collect to help improve the quality of services provided by ICSS.

Can I bring someone?

You are welcome to bring family or whānau support to the interview. If you wish to have a whānau member or other support person present during the interview this can be discussed with the principal investigator Jacinda Shailer.

Are there any benefits or risks?

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

The main benefit to you participating in this study is that you will assist the ICSS team and future teams who implement wraparound in New Zealand to modify and be aware of what works best for you as well as families and youth with high and complex needs. This will help the ICSS team to provide a better service in future to you and your wraparound team along with other families who receive this service in future. It will also help us gather information and evidence so that other wraparound initiatives around New Zealand in future will deliver the best possible service to the youth and families it serves.

You also get a voice for how the wraparound process is working for you and your team. These interviews provide you with a space to independently and directly express your experience of the wraparound process with the knowledge that information will be kept confidential.

What happens to the information?

I will analyse the information given. The things you say, or the information we gather about you, will be kept confidential and used for research purposes only.

This study involves audio recording of your wraparound fidelity interviews with me. Neither your name nor any other identifying information will be associated with the audio recording or the transcript. Only the research team will be able to listen to the recordings. The tapes will be transcribed by the researcher and erased once the transcriptions are checked for accuracy. Transcripts of your interview may be reproduced in whole or in part for use in presentations or written products that result from this study. Neither your name nor any other identifying information will be used in presentations or in written products resulting from the study.

All audio recordings and data will be securely stored. We will keep the data securely stored for at ten years after the young person in your wraparound team has turned 16, after which point it will be destroyed.

The information in write up form will be shared though academic conference presentation and journals.

All data will be anonymous. No material that identifies you will be used in any report on this study. All identifying information (like names of people or places) will be removed or changed. The wraparound team you are involved in will be given a number and every endeavour will be made to ensure that the material given to us remains confidential and that you and your team are not identifiable. The only people that will have access to the anonymised data after it has been coded will be myself, my supervisors and two members from the Intensive Clinical Support Service.

Finding out about the results of the study

If you would like to find out the results of the study, please circle the YES box on the consent form. After the study is completed, we will mail you the results. There may be a long delay between when you take part and when the results are known.

Contacts for the project

If you would like more information, have any questions at all, or would like to talk about this research project with anyone, then please feel free to contact one of us directly. Alternatively, your wraparound facilitator can put you in contact with us.

Student Researcher

Jacinda Shailer
jacinda.shailer@gmail.com
0274208025

Supervisors

Dr Ruth Gammon
School of Psychology, Massey University, Wellington
r.gammon@massey.ac.nz
0800 MASSEY (0800 627 739) ext 62029

Dr Ian de Terte
School of Psychology, Massey University, Wellington
I.deTerte@massey.ac.nz
0800 MASSEY (0800 627 739) ext 62033

Our postal address is: Psychology Clinic, Massey University, 24 King Street,
Wellington OR School of Psychology, Massey University, PO Box 756, Wellington

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

Free phone (NZ wide): 0800 11 22 33

Auckland Phone: 09 373 1060

Auckland Fax: 09 373 1061

Email: hdc@hdc.org.nz

Postal address: PO Box 1791, Auckland, New Zealand

This study has received ethical approval from the Northern Y Regional Ethics committee.

Appendix E: Informed Consent Form for Wraparound Facilitators



MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪRENGA TANGATA

Wraparound New Zealand: Informed consent for wraparound facilitators

Wraparound Facilitator Acknowledgement of Informed Consent

I have read and I 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 I have had the opportunity to use family/whanau support or a friend to help me ask questions and 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 to take part.

I understand that this study is designed to help Massey University and the Intensive Clinical Services Support wraparound team to understand and explore: (a) the quality of services provided to children and families involved in the wraparound-systems of care service; (b) what you as a team member thinks about the wraparound process and service you are receiving including feedback on what worked or what could have been done better and; (c) what outcomes are being achieved for the young person and family in your wraparound team.

I 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 my employment status with the Intensive Clinical Service Support team.
- That I am allowing the researcher to audio tape me during my wraparound fidelity 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 evaluation may eventually be published

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

Jacinda Shailer
DClin Psyc Candidate
Massey University
Email: Jacinda.shailer@gmail.com
Phone: 0274208025

Dr Ruth Gammon,
School of Psychology,
Massey University
Email: r.gammon@massey.ac.nz
Phone: 0800 MASSEY (0800 627 739)
ext 62029

Our postal address is:

Psychology Clinic, Massey University, 24 King Street, Wellington
OR
School of Psychology, Massey University, PO Box 756, Wellington

I agree to participate in this evaluation, and I have received a copy of this signed form.

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

I consent to my interviews being audio-taped YES / NO

Signature

Telephone number(s) where I may be reached:

Home: _____ Other: _____

Address where I may be contacted:

Street: _____

City/Zip: _____

I would like to receive a copy of the results YES / NO

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

(There may be a long delay between when you take part and when the results are known)

I have had this project explained to me by

This study has received ethical approval from the Northern Y Regional Ethics committee

Appendix F: Informed Consent Form for Parents/Caregivers



MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGĀ TANGATA

Wraparound New Zealand: Informed consent for parents/caregivers

Caregiver Acknowledgement of Informed Consent

I have read and I 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 I have had the opportunity to use family/whanau support or a friend to help me ask questions and 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 to take part.

I understand that this study is designed to help Massey University and the Intensive Clinical Services Support wraparound team to understand and explore: (a) the quality of services provided to children and families involved in the wraparound-systems of care service; (b) what my family and I think of the wraparound process including feedback on what worked or what could have been done better and; (c) what outcomes my family and I have achieved.

I 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 tape me and my child's wraparound fidelity 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 evaluation may eventually be published

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

Jacinda Shailer
DClin Psyc Candidate
Massey University
Email: Jacinda.shailer@gmail.com
Phone: 0274208025

Dr Ruth Gammon,
School of Psychology,
Massey University
Email: r.gammon@massey.ac.nz
Phone: 0800 MASSEY (0800 627 739)
ext 62029

Our postal address is:

Psychology Clinic, Massey University, 24 King Street, Wellington
OR
School of Psychology, Massey University, PO Box 756, Wellington

I agree to participate in this evaluation, and I have received a copy of this signed form.

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

I consent to my interviews being audio-taped YES / NO

Name of Youth (Please Print) Age of Youth

Signature I agree that my child may be participate in this evaluation

I consent to my child's interviews being audio-taped YES / NO

Telephone number(s) where I may be reached:

Home: _____ Other: _____

Address where I may be contacted:

Street: _____

City/Zip: _____

I would like to receive a copy of the results YES / NO

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

(There may be a long delay between when you take part and when the results are known)

I have had this project explained to me by

This study has received ethical approval from the Northern Y Regional Ethics committee

Appendix G: Information Sheet and Assent Form for Youth



MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGĀ TĀNGATA

Wraparound New Zealand: Assent for Youth

Information Sheet and Assent form for Youth

Massey University and the Intensive Clinical Support Services team want to know how good the wraparound-systems of care services provided for young people and their families are. We also want to know what the young people and families in the process think about the wraparound-systems of care service. We want to know how the wraparound service is going for you and how you and your family are progressing in the wraparound process so far and in the future. We will be asking questions each month on how things like behaviour, school and socialising have changed and what's different about it.

We would also like to interview you in person every 6 months to find out your opinions about the services you have been receiving. This is a chance for you to let people know what you think about services and what things you would like to see changed. What you tell us will help the ICSS team to better understand how to help you and other kids and families like you that go through the wraparound process.

All of the things you tell us in the interview will be kept completely confidential and no one outside of our research team will know what you said. We will not report any data that can be directly identified as coming from you.

To do this evaluation, Jacinda a doctoral student at Massey University will call you to set up a time to meet in person to ask you questions related to the services you receive. For example, she will ask if you are involved in deciding what services are most helpful for you. Another question will ask you if the team helps you to get involved in activities that you like or do well. She will also ask you and your parents or caregivers whether it is ok to access your files and wraparound goals and plans. This interview will take about 40-50 minutes and you get to help decide where it takes place.

If you agree to participate, you need to understand the following:

1. That you may stop at any time, and it will not affect any of the services you are presently receiving.
2. That you are allowing the researcher to audio tape you during your wraparound fidelity interview as part of this research.
3. That anything you say will be kept confidential. No one other than the people doing the evaluation will know how you answered the questions.
4. The information you provide will help improve services for other youth, like yourself.

I have read and I understand the information above for youth who wish to take part in this study. I understand 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 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 I may contact:

Jacinda Shailer
DClin Psyc Candidate
Massey University
Email: Jacinda.shailer@gmail.com
Phone: 0274208025

Dr Ruth Gammon,
School of Psychology,
Massey University
Email: r.gammon@massey.ac.nz
Phone: 0800 MASSEY (0800 627 739)
ext 62029

Our postal address is:

Psychology Clinic, Massey University, 24 King Street, Wellington

OR

School of Psychology, Massey University, PO Box 756, Wellington

If you still agree to participate, please sign below:

Youth's Signature

Date

Youths Name (please print)

I consent to my interviews being audio-taped

YES / NO

This study has received ethical approval from the Northern Y Regional Ethics committee.

Appendix H: Informed Consent Form for Team Members



MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGĀ TĀNGATA

Wraparound New Zealand: Informed consent for team members

Team member Acknowledgement of Informed Consent

I have read and I 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 I have had the opportunity to use family/whanau support or a friend to help me ask questions and 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 to take part.

I understand that this study is designed to help Massey University and the Intensive Clinical Services Support wraparound team to understand and explore: (a) the quality of services provided to children and families involved in the wraparound-systems of care service; (b) what you as a team member thinks about the wraparound process and service you are receiving including feedback on what worked or what could have been done better and; (c) what outcomes are being achieved for the young person and family in your wraparound team.

I 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 tape me during my wraparound fidelity 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 evaluation may eventually be published

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

Jacinda Shailer
DClin Psyc Candidate
Massey University
Email: Jacinda.shailer@gmail.com
Phone: 0274208025

Dr Ruth Gammon,
School of Psychology,
Massey University
Email: r.gammon@massey.ac.nz
Phone: 0800 MASSEY (0800 627 739)
ext 62029

Our postal address is:

Psychology Clinic, Massey University, 24 King Street, Wellington
OR
School of Psychology, Massey University, PO Box 756, Wellington

I agree to participate in this evaluation, and I have received a copy of this signed form.

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

I consent to my interviews being audio-taped YES / NO

Signature

Telephone number(s) where I may be reached:

Home: _____ Other: _____

Address where I may be contacted:

Street: _____

City/Zip: _____

I would like to receive a copy of the results YES / NO

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

(There may be a long delay between when you take part and when the results are known)

I have had this project explained to me by _____

This study has received ethical approval from the Northern Y Regional Ethics committee

Appendix I: Māori Consultation Letter of Support



*Intensive Clinical Support Service
Private Bag 93-503
Takapuna
Auckland 9
Tel: 0-9- 489 0555
Fax: 0-9-488 4656*

27th June 2012

**Re: Tauke Kirkwood;
Senoir Tribal member of Ngai tai ki tamiki.
Marae :Umupuhi me Whatapaka**

To whom it may concern,

Re: Jacinda Shailer and research project - An evaluation of the fidelity and short term outcomes of a Wraparound Initiative in New Zealand

Jacinda Shailer has been in contact with myself and the Waitemata 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 Auckland on 2nd April 2012, and I have been given copies of documents relating to her study such as the information sheets, consent forms and ethics application.

- Tauke Kirkwood Kaitiaki at ICSS and cultural support person.
- From our meeting and the documents provided I am confident that (Jacinda) 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 Jacinda 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
- Make sure that considerations regarding Maori and local iwi are taken into account
- Tauke represents local iwi and Maori e.g. based in Auckland and has awareness and understanding of local iwi and Maori
- We have Tauke Kirkwood who if necessary will provide support should any cultural requirements arise for the duration of this research

I am sure the research will contribute significantly to furthering our knowledge and understanding of the wraparound process in New Zealand for families and youth with high and complex needs. I am pleased to support her efforts in any possible way.

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

Yours sincerely,

Tauke Kirkwood
Intensive Clinical Support Services, Waitemata District Health Board
021 2733671

Appendix J: Youth Mental Health Diagnoses

| Mental Health Diagnoses | Total Sample (n=16) | Youth who completed WFI-4 (n=10) | Youth who did not complete WFI-4 (n=6) |
|--|------------------------|--|--|
| Mood disorder | 6 (18.75%) | 4 (23.53) | 2 (16.67%) |
| Major Depressive Disorder | 3 | 1 | 2 |
| Dysthymia | 3 | 3 | - |
| Attention Deficit Hyperactivity Disorder | 4 (12.5%) | 1 (5.88%) | 3 (25%) |
| Conduct Disorder | 4 (12.5%) | 1 (5.88%) | |
| Anxiety Disorder | 4 (12.5%) | 2 (11.76%) | 2 (16.67%) |
| Posttraumatic Stress Disorder | 1 | - | 1 |
| Generalised Anxiety Disorder | 1 | 1 | - |
| Anxiety NOS | 2 | 1 | 1 |
| Borderline Personality Disorder Traits | 3 (9.38%) | 2 (11.76%) | 1 (8.33%) |
| Anorexia | 2 (6.25%) | 1 (5.88%) | 1 (8.33%) |
| Psychosis NOS | 2 (6.25%) | 1 (5.88%) | 1 (8.33%) |
| Substance Abuse | 2 (6.25%) | 2 (11.76%) | - |
| Oppositional Defiant Disorder | 1 (3.13%) | 1 (5.88%) | - |
| Developmental Delay | 1 (3.13%) | - | 1 (8.33%) |
| Reactive Attachment Disorder | 1 (3.13%) | - | 1 (8.33%) |
| Asperger's Disorder | 1 (3.13%) | 1 (5.88%) | - |
| Diagnosis deferred | 1 (3.13%) | 1 (5.88%) | - |

Appendix K: Summary of Findings for Wraparound Facilitators

[XX] May 2015

Wraparound New Zealand: An Evaluation of Fidelity and Experiences Wraparound Facilitator Feedback Sheet – A Summary of Findings

Dear [name]

First and foremost I would like to thank you for participating in this research. Without your willingness to participate, this research would not have been possible. I truly appreciate you inviting me into your team, willingly giving up your time, help with recruitment, and your overall enthusiasm about this research.

The study

This was a joint research project conducted in 2012-2013 between Massey University and the Intensive Clinical Support Services (ICSS) team.

The purpose of this research was to explore:

1. The *quality of service* the ICSS Wraparound-Systems of Care process provided to its children, youth, and families; and
2. Wraparound teams *experiences*, thoughts, and feelings about the service.

To do this, you as a wraparound facilitator, the young people the wraparound process was centred around, their parents/caregiver, and wraparound team members took part in interviews with me, Jacinda Shailer, which asked about the kinds of services you delivered and what you thought about those services.

A total of 16 wraparound teams participated in this research. In the consent form you indicated that you would like to receive a summary of the findings from this research. Therefore, I have included a brief overview of these below.

Quality of service

High quality wraparound requires adherence to the wraparound practice model. The wraparound practice model is based on 4 phases and 10 principles. All together wraparound teams rated the overall quality of the wraparound process received in the above average range. This means that the ICSS wraparound process was being delivered as it was intended and adhering closely to the wraparound practice model. When broken down into groups, each group indicated adequate to high quality wraparound delivery. You as wraparound facilitators rated the quality of service the highest, followed by youth, team members, and caregivers.

Elements of wraparound that were delivered well according to most people was the actual implementation of the plan, being culturally competent, working collaboratively, listening and respecting the family's voice and choice, and persisting in working towards the team's goals until wraparound was no longer required.

Elements of the process that were not delivered as well was the preparation for exiting out of the wraparound process, including services and supports from the community, and involving natural supports from the family's life such as extended family and friends into the wraparound team.

Experiences

The majority of teams identified their overall experience of the wraparound process to be positive and helpful. In addition, almost all team members, caregivers, and youth said they would recommend the wraparound process to other families and young people if they needed it.

Key aspects which were valued or highlighted as important in yours and other's experiences of wraparound were:

- Your role as wraparound facilitators which included the close personal relationship you formed with families and teams, your non-judgmental approach, and your facilitation and coordination of the process;
- The holistic and whole family approach taken. This was described as looking at the family and problems as a whole and giving support to all family members. You as wraparound facilitators believed this approach was an essential part of the wraparound process for families and that it was by looking at all the needs of the family and young person holistically that helped to make a difference. Consistent with this, some families identified that was the first time an intervention or program had looked at the full picture which they valued. Some teams members also found by using a holistic and multifaceted approach, it allowed them to gain a better picture of the young person and their family. This was noted to be particularly helpful in their role in working with families, as based on this knowledge, they described being able to meet the family's or young person's needs more effectively.
- Wraparound principles such as being a team-based process that worked collaboratively, listening to the family's voice and choice, focusing on strengths, individualising services and supports to meet the family's needs, and being accountable to the plan and tracking change;
- The emotional and practical support provided to families throughout the process and the professional support provided to team members; and
- The outcomes the family achieved throughout the process including increased empowerment and hope, changes in family dynamics and relationships as well as individual change in both the caregivers/parents and the young person.

In addition to these positive aspects challenges and feedback were also noted. Some caregivers/parents, wraparound facilitators, and team members highlighted either the personal or professional challenges they faced while in wraparound. Others indicated the need for better systems to support wraparound to make it easier to gain access to funding and resources. For a small number of wraparound teams it was believed that wraparound could have stayed on longer or had a slower transition period in terms of tapering off supports. Some team members also believed improved role clarity around roles and expectations would have been helpful for them to better understand their role in the team as well as how their agency was to work with wraparound. Finally, a few caregivers felt that the wraparound process was difficult to access and that it was a service that not many people, even professionals, knew about. These caregivers advocated for better knowledge about and access to the wraparound process so that it can be more available to families in future.

Overall, these aspects were found to be relatively consistent across groups but the importance of certain themes appeared to slightly differ. As wraparound facilitators, you identified both the relationship with families and encouraging their voice and choice to be essential. Caregivers also deemed these two things to be most valuable: the close personal relationship with you as the wraparound facilitator, specifically, having someone there who

supported them and their young person; and having a voice and choice in the process. Youth, however, appeared to value doing things in their community which was outside of a therapy room (e.g., activities, going for coffee). They also identified being able to actually see change occurring, in particular, in the family dynamics and relationships as important. Finally, team members valued the professional support they received by being part of your wraparound team and found benefit in the holistic approach used as it gave them better insight into your family.

Summary

This research represented a first step in evaluating the wraparound process in New Zealand. The results from this research indicated that the wraparound process was being implemented as it was intended and predominately experienced as a positive and helpful process.

In the qualitative study, you as wraparound facilitators were considered to be the “*cornerstone of the process*” as both the coordinator and support person. Your role was found to be a key overarching theme which was central to the process and resonated throughout themes across respondent groups. Without you as an effective wraparound facilitator, many of the themes found in the current study, could not have occurred. Overall, the ICSS service was observed to have an incredibly cohesive, passionate and dedicated team of staff. While this was not analysed as part of this investigation, the team cohesion and dedication you all displayed was admirable and likely had an effect on the overwhelmingly positive feedback given by families and youth about you as facilitators and your team.

Thank you again for helping to contribute to our knowledge about the wraparound process in New Zealand. I hope the findings from this research have helped your service and research in the future. If you would like more information about any aspect of this research please feel free to contact me.

Kind Regards,

Jacinda Shailer
Doctor of Clinical Psychology Candidate
Massey University
Wellington
Email: Jacinda.shailer@gmail.com

Appendix L: Summary of Findings for Families and Youth

[XX] May 2015

Wraparound New Zealand: An Evaluation of Fidelity and Experiences Family Feedback Sheet – A Summary of Findings

Dear [name],

First and foremost I would like to thank you for participating in this research. Without your willingness to participate, this research would not have been possible. It was a privilege to meet you and your family. Thank you for welcoming me into your home and sharing your experiences of the wraparound process.

The study

In late 2012 or early 2013 you and your [son/daughter] participated in a joint research project between Massey University and the Intensive Clinical Support Services (ICSS) team.

The purpose of this research was to explore:

3. The *quality of service* the ICSS Wraparound-Systems of Care process provided to its children, youth, and families; and
4. You and your child's *experiences*, thoughts, and feelings about the service you received.

To do this you, your [son/daughter], your wraparound facilitator and a member of your wraparound team took part in an interview with me, Jacinda Shailer, which asked about the kinds of services you received and what you thought about those services.

Including your family a total of 16 wraparound teams participated in this research. In the consent form you indicated that you would like to receive a summary of the findings from this research. Therefore, I have included a brief overview of these below.

Quality of service

High quality wraparound requires adherence to the wraparound practice model. The wraparound practice model is based on 4 phases and 10 principles. The 4 phases provide a guideline for what activities need to be completed throughout the wraparound process and include:

1. Engagement and team preparation including an introduction to the activities of wraparound;
2. Initial plan development;
3. Plan implementation and refinement; and
4. Transition

The 10 principles essential to any wraparound process which provide the philosophy and value base for wraparound are:

1. Family voice and choice;
2. Team-based;
3. Natural supports;
4. Collaboration;
5. Community-based services;
6. Culturally competent;

7. Individualized
8. Strengths-based;
9. Persistence; and
10. Outcome-based

All together wraparound teams rated the overall quality of the wraparound process received in the above average range. This means that the ICSS wraparound process was being delivered as it was intended and adhering closely to the wraparound practice model. When broken down into groups, each group indicated adequate to high quality wraparound delivery. Wraparound facilitators rated the quality of service the highest, followed by youth, team members, and caregivers.

Elements of wraparound that were delivered well according to most people was the actual implementation of the plan, being culturally competent, working collaboratively, listening and respecting you and your child's voice and choice and persisting in working towards your family's goals until wraparound was no longer required.

Elements of the process that were not delivered as well was the preparation for exiting out of the wraparound process, including services and supports from the community and involving natural supports such as your family and friends into the wraparound team.

Experiences

The majority of teams identified their overall experience of the wraparound process to be positive and helpful. In addition, almost all caregivers, youth, and team members said they would recommend the wraparound process to other families and young people if they needed it.

Key aspects which were valued or highlighted as important in yours and other's experiences of wraparound were:

- The role of the wraparound facilitator which included the close personal relationship they formed with families and teams, their non-judgmental approach, and their facilitation and coordination of the process;
- The holistic and whole family approach taken. This was described as looking at the family and problems as a whole and giving support to all family members. For some of you, it was identified as the first time an intervention or program had looked at the full picture;
- Wraparound principles such as being a team-based process that worked collaboratively with you and your family, listening to you and your child's voice and choice, focusing on strengths, individualising services and supports to meet your needs, and being accountable to the plan and tracking change;
- The emotional, practical, and professional support provided throughout the process; and
- The outcomes achieved throughout the process including increased empowerment and hope, changes in family dynamics and relationships as well as individual change for both you as caregivers/parents and your young person.

In addition to these positive aspects challenges and feedback were also noted. Some caregivers/parents, wraparound facilitators, and team members highlighted either the personal or professional challenges they faced while in wraparound. Others indicated the need for better systems to support wraparound to make it easier to gain access to funding and resources. For a small number of wraparound teams it was believed that wraparound could have stayed on longer or had a slower transition period in terms of tapering off

supports. Some team members also believed improved role clarity around roles and expectations would have been helpful for them to better understand their role in the team as well as how their agency was to work with wraparound. Finally, a few caregivers felt that the wraparound process was difficult to access and that it was a service that not many people, even professionals, knew about. These caregivers advocated for better knowledge about and access to the wraparound process so that it can be more available to families in future.

Overall, these aspects were found to be relatively consistent across groups but the importance of certain themes appeared to slightly differ. For you as caregivers, two things were deemed to be most valuable: the close personal relationship with your wraparound facilitator, specifically, having someone there who supported you and your young person; and having a voice and choice in the process. On the other hand, your [son/daughter] appeared to value doing things in their community which was outside of a therapy room (e.g., activities, going for coffee). They also identified being able to actually see change occurring, in particular, in the family dynamics and relationships as important. Your wraparound facilitator also identified both the relationship with you and your family and encouraging your voice and choice as essential. Finally, team members valued the professional support they received by being part of your wraparound team and found benefit in the holistic approach used as it gave them better insight into your family.

Summary

This research represented a first step in evaluating the wraparound process in New Zealand. The results from this research indicated that the wraparound process was being implemented as it was intended and predominately experienced as a positive and helpful process. As a result of you and your [son/daughter's] participation we were able to feedback to the ICSS team what aspects of the wraparound process were being delivered well and what areas needed to be improved. This has helped to make their service even better for families in future.

Thank you again for helping to contribute to our knowledge about the wraparound process in New Zealand. I was truly humbled by yours and your family's journey into and through the process and the strength you all possessed. I hope you and your family have been doing well since participating in this research and I wish you all the best for the future. If you would like more information about any aspect of this research please feel free to contact me.

Kind Regards,

Jacinda Shailer
Doctor of Clinical Psychology Candidate
Massey University
Wellington
Email: Jacinda.shailer@gmail.com

Appendix M: Summary of Findings for Team Members

[XX] May 2015

Wraparound New Zealand: An Evaluation of Fidelity and Experiences Team Member Feedback Sheet – A Summary of Findings

Dear [name],

Re: [Insert young person/family name]

First and foremost I would like to thank you for participating in this research. Without your willingness to participate, this research would not have been possible. It was a privilege to meet you. Thank you for allowing me to come to your workplace and fitting me into your busy schedule.

The study

In late 2012 or early 2013 you and a wraparound team participated in a joint research project between Massey University and the Intensive Clinical Support Services (ICSS) team.

The purpose of this research was to explore:

5. The *quality of service* the ICSS Wraparound-Systems of Care process provided to its children, youth, and families; and
6. Your *experiences*, thoughts, and feelings about the service you received.

To do this, you as a team member, the young person the wraparound process was centred around, their parents/caregiver, and the wraparound facilitator took part in an interview with me, Jacinda Shailer, which asked about the kinds of services you received and what you thought about those services.

Including your team a total of 16 wraparound teams participated in this research. In the consent form you indicated that you would like to receive a summary of the findings from this research. Therefore, I have included a brief overview of these below.

Quality of service

High quality wraparound requires adherence to the wraparound practice model. The wraparound practice model is based on 4 phases and 10 principles. The 4 phases provide a guideline for what activities need to be completed throughout the wraparound process and include:

5. Engagement and team preparation including an introduction to the activities of wraparound;
6. Initial plan development;
7. Plan implementation and refinement; and
8. Transition

The 10 principles essential to any wraparound process which provide the philosophy and value base for wraparound are:

11. Family voice and choice;
12. Team-based;
13. Natural supports;
14. Collaboration;
15. Community-based services;

16. Culturally competent;
17. Individualized
18. Strengths-based;
19. Persistence; and
20. Outcome-based

All together wraparound teams rated the overall quality of the wraparound process received in the above average range. This means that the ICSS wraparound process was being delivered as it was intended and adhering closely to the wraparound practice model. When broken down into groups, each group indicated adequate to high quality wraparound delivery. Wraparound facilitators rated the quality of service the highest, followed by youth, team members, and caregivers.

Elements of wraparound that were delivered well according to most people was the actual implementation of the plan, being culturally competent, working collaboratively, listening and respecting the family's voice and choice, and persisting in working towards the team's goals until wraparound was no longer required.

Elements of the process that were not delivered as well was the preparation for exiting out of the wraparound process, including services and supports from the community, and involving natural supports from the family's life such as extended family and friends into the wraparound team.

Experiences

The majority of teams identified their overall experience of the wraparound process to be positive and helpful. In addition, almost all team members, caregivers, and youth said they would recommend the wraparound process to other families and young people if they needed it.

Key aspects which were valued or highlighted as important in yours and other's experiences of wraparound were:

- The role of the wraparound facilitator which included the close personal relationship they formed with families and teams, their non-judgmental approach, and their facilitation and coordination of the process;
- The holistic and whole family approach taken. This was described as looking at the family and problems as a whole and giving support to all family members. For you as a team member, by using a holistic and multifaceted approach, it allowed you to gain a better picture of the young person and their family. This was noted to be particularly helpful in your role in working with families, as based on this knowledge, you described being able to meet the family's or young person's needs more effectively.
- Wraparound principles such as being a team-based process that worked collaboratively with you and the family, listening to the family's voice and choice, focusing on strengths, individualising services and supports to meet the family's needs, and being accountable to the plan and tracking change;
- The emotional and practical support provided to families throughout the process and the professional support provided to you as team members.
- The outcomes the family achieved throughout the process including increased empowerment and hope, changes in family dynamics and relationships as well as individual change in both the caregivers/parents and the young person.

In addition to these positive aspects challenges and feedback were also noted. Some caregivers/parents, wraparound facilitators, and team members highlighted either the personal or professional challenges they faced while in wraparound. Others indicated the need for better systems to support wraparound to make it easier to gain access to funding and resources. For a small number of wraparound teams it was believed that wraparound could have stayed on longer or had a slower transition period in terms of tapering off supports. Some team members also believed improved role clarity around roles and expectations would have been helpful for them to better understand their role in the team as well as how their agency was to work with wraparound. Finally, a few caregivers felt that the wraparound process was difficult to access and that it was a service that not many people, even professionals, knew about. These caregivers advocated for better knowledge about and access to the wraparound process so that it can be more available to families in future.

Overall, these aspects were found to be relatively consistent across groups but the importance of certain themes appeared to slightly differ. As team members, you valued the professional support received by being part of the wraparound team and found benefit in the holistic approach used as it gave you a better insight into the family. Youth, however, appeared to value doing things in their community which was outside of a therapy room (e.g., activities, going for coffee). They also identified being able to actually see change occurring, in particular, in the family dynamics and relationships as important. For caregivers, two things were deemed to be most valuable: the close personal relationship with the wraparound facilitator, specifically, having someone there who supported them and their young person; and having a voice and choice in the process. Finally wraparound facilitators, consistent with caregivers, also identified both the relationship with families and encouraging their voice and choice as essential.

Summary

This research represented a first step in evaluating the wraparound process in New Zealand. The results from this research indicated that the wraparound process was being implemented as it was intended and predominately experienced as a positive and helpful process. As a result of your participation we were able to feedback to the ICSS team what aspects of the wraparound process were being delivered well and what areas needed to be improved. This has helped to make their service even better for families and team members in future.

Thank you again for helping to contribute to our knowledge about the wraparound process in New Zealand. If you would like more information about any aspect of this research please feel free to contact me.

Kind Regards,

Jacinda Shailer
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Appendix N: Ethics Approval



Northern Y Regional Ethics Committee
c/- Ministry of Health
Level 3, Bridgewater Building
130 Grantham St
Hamilton 3204
Phone: (07) 9293612
Email: northern_y_ethicscommittee@moh.govt.nz

29 June 2012

Ms Jacinda Shailer
234 Adelaide Road
Bottom Flat, Newtown
Wellington

Dear Jacinda -

Re: Ethics ref: **NTY/12/EXP/030** (please quote in all correspondence)
Study title: Phase 1: An evaluation of the fidelity and short term outcomes of a Wraparound Initiative in New Zealand
Investigators: Ms Jacinda Shailer, Dr Ian de Terte, Ms Jan Tosswill, Ms Diana van Vugt

This study was given ethical approval by the Northern Y Regional Ethics Committee on 29 June 2012.

Approved Documents

- Study Protocol version 2 dated 3 June 2012.
- Screening questionnaire 2012
- Information sheet for Families and Youth
- Information sheet for team members
- Informed Consent for parents/caregivers
- Informed Consent for team members
- Information Sheet and Assent for youth

This approval is valid until 3, December 2013 provided that Annual Progress Reports are submitted (see below).

Amendments and Protocol Deviations

All significant amendments to this proposal must receive prior approval from the Committee.

Significant amendments include (but are not limited to) changes to:

- the researcher responsible for the conduct of the study at a study site
- the addition of an extra study site
- the design or duration of the study
- the method of recruitment
- information sheets and informed consent procedures.

Significant deviations from the approved protocol must be reported to the Committee as soon as possible.

Annual Progress Reports and Final Reports

The first Annual Progress Report for this study is due to the Committee by 29 June 2013. The Annual Report Form that should be used is available at www.ethicscommittees.health.govt.nz. Please note that if you do not provide a progress report by this date, ethical approval may be withdrawn.

A Final Report is also required at the conclusion of the study. The Final Report Form is also available at www.ethicscommittees.health.govt.nz.

Statement of compliance

The committee is constituted in accordance with its Terms of Reference. It complies with the [Operational Standard for Ethics Committees](#) and the principles of international good clinical practice.

The committee is approved by the Health Research Council's Ethics Committee for the purposes of section 25(1)(c) of the [Health Research Council Act 1990](#).

We wish you all the best with your study.

Yours sincerely



Amrita Kuruvilla
Northern Y Ethics Committee Administrator
Email: amrita_kuruvilla@moh.govt.nz

Appendix O: Extended Qualitative Results

Overall Experience

1. **Positive.** The overall experience of the wraparound process was deemed to be positive by all respondent groups (82%). Specifically, the majority of wraparound facilitators (63%) indicated, despite some challenges and frustrations, that the process was productive and rewarding for everyone involved. They also identified it as a positive process for families to go through which was helpful and produced good outcomes.

I think, it's just been a very positive process, for everyone really. WF7

I think generally for YP13, positive, with some elements of frustration. In that we haven't been able to kind of (pause) completely change the dynamics between her parents, but we've been able to support and equip YP13 out of a difficult place, and strengthen her, and reaffirm her as a person, in her own right. So yeah good, but with some frustrations as well. WF13

The positive experience discussed by wraparound facilitators was also reflected in caregiver, youth and team member interviews. When asked about their overall experience of the wraparound process the majority of caregivers (94%), team members (88%), and young people (75%) found it to be a positive and helpful experience. In particular, caregivers believed that it was a valuable process to go through which was enjoyable and beneficial for their family.

Extremely positive, encouraging, effective, highly supportive. I think it's a great model, I really do CG7

Absolutely positive. If there was any agency I'd want involved with us it would be wraparound. Absolutely 100%. CG6

A positive experience knowing that there's a team out there to help me, help these boys. We all have the same goal of making them productive citizens and we work together, and I'm glad. I'm very glad for it. CG16

Young people also found it to be a good service, process, and experience because it was helpful, worked, and had a “*good effect*” (YP11) over their life.

It was cool. I enjoyed it. I hope one day, I will be able to do it again, because I really did enjoy it. It really did have a good effect over my life. YP11

I reckon it's just such a good service. YP8

The experience of wraparound was also considered as positive by team members both in terms of the effect it had for families and for themselves as professionals.

My overall experience has been highly positive, yeah. I'll be sad to see the departure of wraparound, just because, I think they've made massive contribution and it's been really great working with those people. It's been a real privileged. So I guess that's an end for me as well. So, I've really enjoyed the process, but I'll also be delighted that the transition happens, as it's the right thing for the family. It's just a privileged to liaise with really good people. TM12

It was all positive, every hui (meeting) that we had, it was a huge laugh, you know. It wasn't like an interview, no one was nervous, it was everyone who was there was happy to come to the meeting. TM8

As a result, almost all caregivers (94%), youth (100%), and team members (88%) indicated that they would recommend the wraparound process to other families and young people if they needed it.

Q: Would you recommend wraparound to other families or friends if they needed it, and why? Yeah, it's really good. It seemed to work out for me, and I had a pretty difficult circumstance, so think it could work out for many people. YP3

The Wraparound Process – Central Elements and Principles

2. Wraparound facilitators. Wraparound facilitators were considered to be the “*cornerstone of the process*” (TM12) as both the coordinator and support person. The role of the wraparound facilitator was found to be a key overarching theme which was central to the process and resonated throughout themes across the four respondent groups. Without an effective wraparound facilitator, many of the themes found in the current study, could not occur. Effective wraparound facilitators embody what is wraparound including the philosophies and principles to those who are part of the process. In the current study wraparound facilitators were talked about predominantly in two ways: (1) their personal connection and relationship with families; and (2) their role in coordinating and facilitating the wraparound process.

Therapeutic relationship, personal connection and engagement with the wraparound facilitator. The importance of engagement with family members and

their commitment to therapeutic intervention is paramount. Engagement and therapeutic alliance have been cited as important factors in successful therapeutic intervention and have been consistently related to better outcomes and more positive experiences (Lambert & Barley, 2001; Martin, Garske, & Davis, 2000).

The majority of wraparound facilitators (81%) identified engagement and forming relationships and trust with families as important parts of the process, in particular, during the engagement phase. Most wraparound facilitators felt that they spent time engaging and building relationships with families both before the first meeting and throughout the process.

So in this case, there was a lot of work done before. There's a lot of engagement, individual engagement, getting to know all of the individuals in the team. WF4

Clearly engagement was really important because I was coming in as a second and kind of clinical case coordinating at a time of major crisis. Major crisis of a suicide attempt, and a pregnancy discovery, so it was how I think that was managed. To really hear and listen to everyone's view and give people time to process everything that was going on. WF7

In beginning a wraparound process with a new family, several wraparound facilitators found that building relationships and engaging some families, and especially young people, challenging. This may have been because families could have initially perceived wraparound as just another service that they were to be involved with.

Q: What was the hardest part of the wraparound process for you, and why?

I think for YP15, the multiple people was really difficult. CG15 has been very engaging and very receptive to anything we talked about or suggested. Yeah YP15's been, trying to engage with her, has been really difficult. WF15

Q: What was the hardest part of the wraparound process, and why?

I think it was initially engaging with dad, because of his sort of attitudes and him sort of not wanting to engage with yet another professional. Because he did have, he was engaging with [another wraparound facilitator's name] my colleague, and also the person doing counselling with him. So yeah it was difficult. WF13

Therefore, a constant consideration for wraparound facilitators is how to effectively engage with families and youth.

I guess I always wonder with someone like CG4 (pause), sorry, YP4, how we could have engaged her more. She has been involved in the wraparound, but not so actively. But I think that's because of the fact of her age and her particular personality and shyness. WF4

A number of wraparound facilitators identified that forming engagement and building relationships worked best in non-therapeutic environments, in particular for young people, but for caregivers as well.

Q: Anything that you've done that's worked particularly well?

I think engaging with her (YP13) in a sort of non-threatening, untherapeutic environments, like Starbucks, or just going to a café. WF13

Q: What do you like most about the wraparound process, and why?

The direct face to face contact with them and helping them. Like I said, helping CG16 at home with tidying up the house, that kind of stuff, because I can actually see it's got an immediate impact on her mental state. It's allowed me to develop that therapeutic relationship with her. Whereby now she is starting to open about stuff to me that helps me to understand her situation better and the context of it. But also, it's allowed her to be a bit more open and able to process some of the suggestions that I've made. WF16

For those who received the service, the persistence by the wraparound facilitator in regards to engagement succeeded as the majority of caregivers (94%), young people (63%), and team members (81%) spoke highly of their wraparound facilitator based on the work they did with the family and the relationships formed with each individual.

WF1 was great. I really like, we have dealt with so many health professionals and she was just great. I think YP1 would've liked to have kept it on just so she could have a relationship with WF1 (laughs). She misses WF1. Because she was so calm and collected and good, and she just, you know, let YP1 say her thing and just, she was great, she was really really good...was the best of them. CG1

I don't know. If they had WF3, I'd tell them to treat WF3 as a demi-god.

Q: Why is that?

I don't know. She's pretty smart. YP3

Q: How would you describe your overall experience of the wraparound process?

A good process and definitely worthwhile. Particularly in this case, because of so many people being involved that YP5 trusted and believed would advocate for her good. She had a great mistrust and wraparound provided security coming into a new place. Having someone else to care for her and coming to grips with that. Her relationship with WF5 stabilised her and gave her a secure relationship. TM5

For some caregivers, the relationship formed with their wraparound facilitator was likened to a friendship rather than a professional doing their job.

Q: What do you think worked best for you, and why?

The relationship with WF5. Just knowing WF5 was there. She could really tell how I was feeling and I could tell her how I was really feeling. She was like a friend. We were really close. I miss her now. CG5

Nearly all caregivers viewed their wraparound facilitator as someone who was working for them and who genuinely cared about them and their family. The

wraparound facilitator listened, heard, and provided genuine empathy and understanding which was perceived as invaluable to caregivers.

Having someone like WF6 who has a real empathy and understanding of a family situation. Yeah. And finding her to be so genuine is just, I have been so lucky this time around. CG6

The intensity. All the phone calls and follow ups, and making sure, and you really feel that someone's working for you. Where we weren't sure before, you know, when things kept falling apart. CG11

An aspect which helped build this relationship for caregivers and also noted by team members was the reliability and availability of their wraparound facilitator.

Just her availability. You know. She always came back. If I text her, she would ring me. CG3

That's I suppose the big difference, is that wraparound are there when they say they are going to be there...If I have a problem with YP8, I ring up WF8, and if it's a Saturday I ring up WF8 and he's available. So he's been available. TM8

For caregivers and young people, having a person that they were able to rely on who would be available to them when needed was considered important in establishing their trust.

The daily contact with WF7. The fact that there have been crises through this process and WF7 is very calming. She just restores the calm. You know, it's like okay, we've got this crisis, this is what we need to do. Like let's just get a grip, let's just do this and this, and it will all come right. And so, just having someone to hold your hand, when the anxiety levels go up through the roof, is really good. Umm, she is always true to her word. Like she never says, ever says, she'll do something and doesn't do it. Like if she says it, then she does it, and it's always done straight away. Umm so, there is a lot of trust. And YP7 really trusts her as well. CG7

Young people enjoyed having someone who they felt able to talk to, who understood, and who was able and willing to help them in their situation.

For me it was definitely meeting and speaking to someone who was willing to get things changed and done, and someone who can understand. Of course my psychologist, [name], she understood, but with her I kind of just went and talked to her, and she didn't really feedback. But with WF13, she did, and you got to discuss things, and how to change things, and before that didn't happen. YP13

I don't know whether it's just WF11, or the whole wraparound service, but it's a lot easier to talk to them. I mean at first I was nervous, and I didn't like to share information, like I had stated before. But yeah, throughout time I just talked more and more. You know, after talking I felt good. YP11

Q: What has been the most influential or important part of wraparound for you?

Having someone to talk to that won't straight away disagree with me. Also having someone around that doesn't get fazed by anything that I say. Like recently there have been a few things that I have told WF7 that most people when, or if I tell them stuff, other people would say what the f*ck and stress out. But WF7 just says okay well what can we do to sort this out and how about we plan a meeting. YP7

Caregivers also appreciated the relationship the wraparound facilitator had with their young person and vice versa. Both caregivers and youth were pleased that the other had someone that they connected with and could go to for support and assistance. In particular, a few young people appreciated the wraparound facilitator reducing their parents stress and worry. For some caregivers and youth, it was surprising that the wraparound facilitators were able to form these effective relationships, as it was inconsistent with their previous experience with professionals.

I think the biggest thing was getting YP3 on board. They got him on board. She snuck in and got him. CG3

I can't actually pull anything out that's been most influential except for the personal influence that WF12 had over YP12. CG12

Most influential, umm, the first thing that pops to mind is mum really got along very well with WF13. They connected really well which I'd never seen happen before. That has helped a lot because mum felt the kind of stress and the worrying subside a little. YP13

Probably having someone there for my mum to go through to talk about stuff, rather than going mad, you know. YP3

Wraparound facilitators felt forming a strong therapeutic relationship allowed them to work more effectively with families. In particular, the relationship allowed them to challenge and bring up issues which were sometimes difficult, but were considered necessary, in order for the family to progress forward.

We've been able to challenge the family on things that early in the process nobody thought would be possible. Umm, and I think that's due to the engagement, and the relationships that we've built up. WF12

This was also reflected by caregivers where the concept of personal connection and liking their wraparound facilitator was identified to be an important part of the efficacy of the process. In addition, it was discussed that without this connection caregivers may not have been as engaged with the process.

WF1 is really nice, she's a really nice person to deal with. I'm sure if I had to deal with a person I didn't like very much, then I wouldn't be so keen on it. It does make a big difference when you like the person you are dealing with. CG1

It's a journey. Umm, which is unpleasant at times but I definitely felt with both kids throughout the journey, that the people who were in charge care, and they want to succeed as

much as you do. It's a very personal service as well. It depends a lot about having that connection. CG11

The concept of how engagement and the therapeutic relationship links to family's experience of the process was clearly exemplified by one family who found engagement, in particular, the young person's engagement with wraparound challenging.

[The hardest part of the process was] YP9 not engaging with the process and not wanting to be helped. Just frustrating. We're offering him something, but he doesn't think he has an issue, so he didn't engage with the process. CG9

The levels of frustration around the family not totally engaging in the process. That was hard. TM9

Non-judgmental. Many of the families who become involved in the wraparound process had felt judged from other professionals or agencies. An interesting concept which came through from some wraparound facilitators (31%) was their role in changing professional judgment or perceptions of the family.

I think one of the issues in this whole process was that there were judgments. There were professional judgments sitting out there when we became engaged. A lot of judging of CG4 whānau (family) that actually they weren't interested or that they were always late or missing meetings because they didn't care. But actually, that's not correct. Umm, I don't know what could have been done better to bring it to the notice, or sooner to bring to the notice of the team that actually that wasn't the case. I don't think anything differently necessarily could have happened. Because I think people have now come to understand that it's just that CG4 has got so much on her plate. So many little ones and it's just, she is what she is, and you work with people in the place that they are, and you support them, and walk along side them, and you get outcomes that way. WF4

I liked helping and allowing mum to have someone not to be judgmental and with a forum to speak calmly and allow YP13 to chat and receive praise in a non-threatening way. WF13

This non-blaming way of working and the wraparound facilitator's non-judgmental approach was also commented on by some caregivers (44%), team members (19%) and one young person (13%).

The support. The willingness to help and not judge. CG15

Wraparound doesn't always bring up everything in your past, as much as [the Child Welfare Service]. Because [the Child Welfare Service] brings up everything in your past and goes on and on about it. Wraparound tries and moves forwards, instead of backwards. Focusing on the future, instead of focusing, on the past and going on about it, just reminding you of all the things you've done. YP5

It's really non-blaming as well, like nobody got blamed, nobody's blaming anybody. I quite like that. It's kind of refreshing professionally to see that happen. TM11

In particular, caregivers noticed they were treated as partners by the wraparound facilitator and therefore didn't feel shame asking for help. Not being judged was a positive and occasionally eye opening experience for caregivers and was another factor considered to be crucial in forming the close therapeutic alliance with caregivers who had been made to feel bad in the past.

Not judging me. Umm, not throwing it back into my face. Like with what was happening with YP6's behaviour, and my way of parenting, I suppose. I don't know. Not saying it's my fault or things like that, but working with us, working with me to work with YP6, you know. Talking me through, listening to me you know, about how shitty my week was...and she was really good, you know, she didn't judge me... CG6

Just how amazing it's been. They make you feel like you are doing a good job. Umm, they, you know, if you're not doing a good job they're not going to put you down about it, they're just going to assist you in changing. Yeah it's just that. It's that that nonjudgmental support that they, that they give. CG15

WF9 personally was really good. Like he's dedicated to what he does, and has a good understanding and he didn't put unrealistic expectations onto me, and never judged me. He knew how hard YP9 was to deal with, so he knew that everything I achieved was a really big milestone. Like even getting him to appointments, and getting him to school, he knew how hard it was bringing him round to cooperate. He was always good and he would always compliment things when I was doing well. He was really good at that. CG9

Facilitation and coordination. Equally as important as the therapeutic relationship was the wraparound facilitator's role in coordinating and facilitating the process with families. Wraparound facilitators alongside families have a central role in bringing everyone together, making sure everyone is informed of the plan, and that the tasks assigned from the plan are followed through by the team. Twenty-five percent of wraparound facilitators spoke directly about their roles as facilitators and coordinators, identifying their role to at times be challenging. In particular, in terms of coordinating the teams availability and commitment to come to wraparound meetings, developing interagency relationships, and facilitating a process in which all members, especially other professionals or agencies, embrace and adhere to the philosophies of the wraparound process.

Q: What was the hardest part of the process for you, and why?
Just sometimes coordinating people's availability...Just the general logistics... WF10

Q: What was the hardest part of the process for you, and why?

When [the inpatient unit] took over and did not adhere to the wraparound process. [The inpatient unit] often went against the family's wishes and took voice away from the family. WF3

Q: Is there anything that you think could have been done better?
The fact that [the Child Welfare Service] haven't (pause) been actively involved in attending meetings has been quite frustrating. Frustrating for us but more so for the family as well because they don't know what's going on from a [Child Welfare Service] perspective. WF15

Q: If you could change anything about the process what would it be?
Relationships between the key agencies of wraparound; social services and mental health. WF2

However, despite these challenges, some wraparound facilitators did allude to how the structure of wraparound and the bringing of systems together was helpful for families.

Look I think throughout the process, I think what's happened is that the system and the explicit nature of the wraparound process and the structure that it's got helped guide people. They knew what was coming, they knew what was expected, there was clarity of what they needed to do. It's like you know, your job, my job, I think that was really helpful. WF4

Caregivers (63%) and team members (56%) talked highly of the process having an effective wraparound facilitator. Both groups appreciated the effectiveness of the facilitator in guiding and running the meetings as well as their ability to coordinate the process and all of the agencies to be together. They also commented on the ability of the facilitator to pool resources and share information.

If you have a facilitator, that's umm, absolutely really good at running a meeting, and running things to par, and keeping things going that's, the main thing. Other things as well, you know, the mental health side is all good. But if it wasn't for her running the actual wraparound service, umm yeah, I don't think you would have had a lot of outcome. CG4

So having someone to kind of just link GP, dental appointments, and umm, I don't know all those types of things. Like contact with [the Child Welfare Service], contact with the police more recently, the school, you know, somebody to just help when the family is swamped, to coordinate yeah. TM15

In particular, for just under half of team members (44%), the wider out of meeting work that kept everyone up to date and informed, such as the email chains, were of great benefit.

Yes. Especially with like, say you get them professional meetings and that and they're useful, but having that wider out of the meeting work really makes a difference. The work that coordinates. TM4

I know it sounds a bit stupid but the email chain that goes around certainly helps. So that we're all getting the same information. TM9

By maintaining a constant connection with the wraparound team it was considered to enhanced team cohesion and connection.

I think that there's a consistent connection with all the participants that's maintained. Well I guess sometimes some participant won't keep themselves involved. But actually, I think the wraparound staff always makes an effort to include everybody. I guess because other services might try to liaise with another agency and if they don't get a response they might give up on them. But wraparound are persistent. I was thinking about it in terms of, it's also a bit dependent on relationships, but kind of less so than say with [the Child Welfare Service] liaising with [the Community Mental Health Service]. I think sometimes when there's just those two agencies and there's a difficult relationships they're going to end up with those two agencies just not communicating but I think the wraparound process gets over that a bit. TM13

3. Holistic, whole family focused, full picture. Based on systemic and family therapy theory, the wraparound process by design is about the whole family rather than just the young person. While not a wraparound principle, using a holistic approach and focusing on the whole family is part of the fabric of what makes the wraparound process. Using this type of approach with families is considered of particular importance as in addition to the young person, caregivers, or other family members also often have needs which require assistance. Therefore a comprehensive, holistic family focused approach is warranted to address not only the young person's needs but their family's needs as well. Half of wraparound facilitators commented on the holistic whole family approach as an essential part of wraparound for families and that it was by looking at all the needs of the family and young person holistically that helped to make a difference.

Wraparound looks at the needs of everyone holistically and works on all of those needs at the one time, rather than having people go away and get frustrated with not having everything dealt with. WF15

Caregivers (75%) and team members (94%) liked the holistic approach provided both in terms of the family and needs indicating that this approach was beneficial; whereas, the majority of young people did not comment specifically on this approach. However, one youth did recognise they were working on multiple different areas.

It looks at the family sort of holistically and what would work so that's good. CG12

That it's a holistic approach to young people. Umm, so taking family, school, health concerns, and everything to him. TM9

Caregivers, in particular, found the holistic approach to understanding and working with their whole family helpful because the focus was not solely on the young person.

I love that they work on other members of the family. Umm, it's not all about YP8, it's a big collective. CG8

Other services just focus on the child not on the parent. But the parent is dealing with the child and often needs help too. This process focuses on both. It's not just the child affected by issues it's the parent as well. CG5

It's not just YP15, you know, they're thinking about things I need, and what [sibling name of YP15] needs, and stuff. So you know, that's the wraparound thing, it's not just concentrating on one person, it's about the whole family. CG15

Caregivers were also encouraged and often mentioned the attempts in wraparound to cover all life domains rather than just focusing on mental health needs. Unlike other interventions, caregivers felt that wraparound looked at the family and the presenting problem as a whole rather than in parts. For some, it was the first time an intervention or program had looked at the full picture.

Nobody was seeing the full picture. Nobody was involved, [the Eating Disorder Service] was only concerned with the eating disorder, [the Community Mental Health Service] was only concerned with the self harm and the suicidal ideation, and [Child Welfare] didn't actively participate and didn't want to be involved in the behaviour. And what wraparound is, what they were able to take on board, could offer, and knew, that's the thing. Wraparound they knew what [Child Welfare] could do, what [the Eating Disorder Service] could do, what [Community Mental Health] could do, and who to go to for what we needed. CG3

Well I think that in the meeting we discuss a broader open minded approach with everything that YP10's doing than other services. Whereas when we go to the [Eating Disorder Services], and YP10's father and I just go, we just discuss what we can do, and what they can do, to just focus on the eating disorder. In wraparound we talk about more generalised things, yeah. CG1

They made a huge effort to look at the problem from all angles. Not just from how does the patient feel, but everybody involved with the patient, how did they feel and what do they think. I like that. I like the democracy of it I guess. CG12

Team members also felt, by looking at all life domains and using a holistic and multifaceted approach, it allowed them to gain a better picture of the young person and their family. This was noted to be particularly helpful for them in their role in working with families, as based on this knowledge, they were able to meet the family's or young person's needs more effectively.

I think it's made a difference for me hearing the different professionals and the input they have at the meetings and how they've seen different aspects of YP6. And it's made me have a greater understanding of what I can do with YP6 at his level of understanding. TM6

It enables me to get a better picture of YP10's life and the impact of various factors on it. TM10

There are different perspectives which I think help build a clearer picture of where the young person is at. TM9

4. Team-based, everyone together, collaboration. The wraparound process is a team-based approach which centres on collaboration between agencies and with families. The wraparound facilitator may be the cornerstone of the process, but it is the family and the formal and informal supports they identify which provide the bricks for the building.

The majority of respondents commented on the team-based collaborative approach (75% of wraparound facilitators, 81% of caregivers, 88% of youth, and 88% of team members). When asked about their understanding of the wraparound process, most respondents understood it to be a team-based process which brought all relevant individuals together in one forum to work collaboratively with the young person and their family towards a common goal.

That it's a process where everyone comes together to help the young person and family. CG5

That it's a team which is put together to meet the needs of the patient for a relatively short to medium term intervention. CG12

It's a strengths-based process and looks at the needs of YP4 and her family and gets everyone together in the same room. TM4

However, youth tended to understand the wraparound process more in terms of "*meetings*" (YP5 & 8), but like caregivers and team members, also appreciated everyone coming together.

Basically it's a group of people, umm all my support workers or whatever, gathering together to set up a plan together instead of it being all scattered. So there is no miscommunication or whatever. YP12

Wraparound facilitators particularly highlighted the importance of the team and bringing everyone together to form a cohesive unit which works collaboratively with the family.

Bringing everybody together and then through a template allowing some discussion that isn't just from the clinical leads perspective. WF10

The collaboration of all of the professionals, umm and every professional advocating for the family has been really powerful. WF12

While all respondent groups emphasised the importance of the wraparound team, facilitators, caregivers, and team members also prioritised the value of everyone being together in one place for the wraparound meetings. By bringing everyone together respondents felt it created a feeling of comradery and “*that everyone is all in this together*” (WF8). Caregivers and team members particularly enjoyed the collaboration which occurred as it allowed for a blending of perspectives between team members and families. Caregivers also appreciated the opportunity to hear different team member's perspectives in order to assist them in their pathway forward.

I think the fact that having a team first of all was great umm...having the therapist, and the key worker, and the social worker, and the two parents sitting together and brainstorming to see what we can do to make her feel better was brilliant. CG13

Hearing other professionals and her parents' perspectives so that I could build up a much better understanding of YP10 and where she is at TM10

I just think...if we hadn't had those sit down meetings where everyone could come it would be kind of someone rings someone about something. But actually in that case, CG1 could kind of say what was working and not working and we could kind of have everyone in the room. TM1

Caregivers, team members, and some youth felt that this approach led to a collective understanding of the family's issues and a more effective means of communicating what needed to be done as it decreased repetition to the various agencies they were involved with. This also led to everyone being able to be involved in developing and working towards a comprehensive plan with the same goals and outcomes.

I think for them, what the most important thing is, is for them to see that everybody is sitting around the table, so everybody's talking about the same thing. Everybody is aware of what's going on for them in their house and what it is that they are experiencing. It's providing that consistent approach because everybody's got the same awareness of what's going on and so therefore you can get that same response that generates just the one plan. WF16

I think the ability for them to be together with common goals. That commonality about we're here for YP11. WF11

With the wraparound process I think everyone is on the same page and all the goals are sort of negotiated between everyone. So that's probably, for me, the most positive thing. CG2

I think it's good with the meetings. It gets everyone together to see and observe how things are going without everyone ringing you and repeating yourself. CG9

Wraparound was kind of central and communicates with all the people involved instead of, you know, me having to repeat the same things over to each person. YP12

For a few team members the collaborative aspect of working with families rather than working on families was noted to be a point of difference, and was embraced.

This one is team with and not on. That's the difference. That covers everything really. Everything comes from the place of the team and the team is with, not on. TM11

That it's a collaborative process. Wraparound isn't doing the work, they are part of the team that's doing the work, and the family is a part of that too. TM12

Finally, although team members found wraparound meetings and everyone coming together on the most part beneficial, a subset (38%) identified these meetings and the follow up in wraparound, as one of the hardest parts of the process for them. Specifically, the extra time commitments in terms of meetings was often a challenge for team members; with them sometimes finding it difficult to attend the wraparound meetings because of their own work commitments and the length of the meetings.

I guess it has been (pause) with it being an extra service involved and meetings there has been, and it's just part of it, there is additional pressure to be available at short notice or quickly available for the meetings and that. And so that was a matter of just kind of trying to manage these things. TM4

It was just a bit of a time struggle at times for the family and the professionals....just a bit of a time struggle. TM1

The hardest part umm, probably in communicating with others. I have a lot of communication with WF16. WF16 communicates a lot with me and I would say that takes up time which I could communicate with the family. Or the wraparound [meeting] takes up so much time that, it doesn't take up a whole lot of time in the scheme of things, but you know trying to find time. That probably comes away from what time I give to the family or to YP16. Not that it's been kind of excess I think it's just there's more people involved and you're talking with more people and finding the balance there. TM16

5. Family voice and choice. One of the central principles of wraparound and arguably at the heart of the wraparound process is family voice and choice. Bringing out family's voice and choice is considered particularly important because it has

been linked to family empowerment which is important in producing long term change and outcomes (Graves & Shelton, 2007; Walker, 2008).

Family voice and choice is about eliciting and prioritising family member's perspectives throughout the wraparound process, in particularly in the planning phase, by placing them as experts in their own life and by reflecting their values and preferences in the plan. While wraparound teams, including the wraparound facilitator, provide options to families, it should be the family who make the choices in regards to their plan and drive the pathway forward. Not surprisingly, the concept of family voice and choice resonated throughout the majority of wraparound facilitator interviews in their delivery of the process (81%). Wraparound facilitators' responses reflected the importance of finding the family's voice, it being heard throughout the process, and ensuring the family's choices were the driving force.

It's about the family's voice and choice. It's about the family driving the process forward. Identifying what is important for that family or whānau (family) and for the team to come together to support them to achieve those goals and outcomes. WF4

I think most importantly that the voice of YP7 was heard and the voice of family was heard. WF7

That it is a process delivered by families and clients. That wraparound facilitators are there to advise but at the end of the day it comes down to their choice WF3

That it's their plan, their voice, their choice, and that everything's done in collaboration with them. That they're the driving force behind it. WF15

Family voice and choice was experienced by 94% of the caregivers, who liked "*feeling heard and having a real voice in the process*" (CG7). Similarly, although not a clear theme for youth, some mentioned being given the opportunity to have a say in decisions and make choices.

That people actually let me do my own thing and give me choices. YP7

They don't (pause) after a point's been pushed, it's been pushed. It's not a matter of oh maybe we should mention it again just in case his mind's been changed. They understand when it's enough time to drop a point. They understand that, you know, if I've said no, it's a no. YP3

Caregivers also appreciated that they were asked what they thought about things, were listened to, and then aided in communicating their views to the team if

needed. Most caregivers felt through the wraparound process they were able to make choices about their families and that their choices would be respected.

I am not good at putting towards or communicating what my needs are and what I want and she (WF3) can sift through all the rubbish and get to the point. So I like having the one person contact and her ability to get people together all in the same room and put forward what our views were. Especially with the [Child and Family Unit], they would take a branch of what we were saying and turn it into a tree, and WF3 didn't do that she really just took the branch. CG3

The last meeting that we had there was umm, not pressure but suggestions, that he should take some medication. But he still refused. And that was okay because we're not (pause) he's in no way forced to take medication. When he made that decision not to and we told the doctor he's not taking the medication anymore and he's good without it then they kind of accepted that. CG14

For the most part, team members (69%) recognised the process was about giving families and young people the ability to say and make choices about what they wanted for their family. Team members enjoyed being given the opportunity to hear the families and young person's perspective and experienced the wraparound process as one that "*actually gives power to the family*" (TM9) which was considered to be positive.

That it's driven by them, by what they want, by how much or how little contact they want. TM15.

I think it's important because it actually gives power to the family as well which I think is really really good. I have been in some sort of [Family Group Conference] processes where the family has almost been sidelined. But with this process everyone is equal at the table. Yeah I just think it is very positive. It is good. TM9

I like that it gives members of the family an equal opportunity to speak. I think it's quite good with children and young people where they might not have spoken if there was just family there. There's quite an emphasis on everyone's views are important. TM13

6. Individualised, flexible, and tailored to meet family and youth need.

By listening to family voice and choice, taking a holistic and whole family approach, and families being drivers of the wraparound process it was believed by the majority of respondents that the team and facilitator were able to provide customised services and supports to meet the individual needs of youth and families (64% total). Fifty percent of wraparound facilitators explicitly felt as if the process was able to be tailored according to family's needs which included having the flexibility to work with them in their homes and communities.

I think we're more user friendly. We're more focused on flexibility and meeting the needs of the family when and where the family want those needs met. WF15

Wraparound facilitators, caregivers, youth, and team members all gave examples of the ways in which the process catered their service delivery to meet family and youth need.

Just being out and about and identifying strategies that would really help her and meet her needs. WF13

It's not clinical which is really good. You know we go and have a meeting at a cafe and it's just fantastic. We went to WINZ (Work and Income New Zealand) yesterday and we were early so we went to cafe. It's just like sweet. CG15

I just think the whole process for YP1 especially being able to be more practically focused. Kind of have the funding to go out and buy a box for her, buy little things, and craft activities, because that's what worked for her. And even things like WF1 giving her phone cards and things so she could be in touch. TM1

They are more flexible when it comes to going to you or taking you somewhere. YP12

As the process and the interventions delivered were tailored to meet theirs and their family's individual needs 75% of caregivers and 88% of young people felt the wraparound process was a more personal experience rather than just a one size fits all approach.

The hugest difference I think is, umm, with other services they kind of just give you the pieces of paper with the instructions of what to do, you know what I mean, like "oh here's some breathing exercises and things you can do". But this felt a lot more personal, like they couldn't pull out a sheet of paper that magically applies to everyone. YP13

First it was more personal, less formal. They came to our house, they saw where we lived, they saw how we lived. They umm, both of them, opened up about their families, and their experience in life, and they made me, me personally, feel very comfortable. CG13

Young people, in particular, liked the fact they were able to go out and do things they enjoyed, such as activities with their wraparound facilitator, and didn't have to sit in a room and talk which had previously been described as boring or ineffective.

It's not boring, well it is, but it is not as boring as most of the other services. You actually get to go out and do stuff instead of just sitting in a room doing nothing but talking. YP7

Q: What do you like most about the wraparound process, and why?
Getting to do activities...like I go bowling or trampolining. YP3

It just helps you through things, get you stuff, take you out all the time, give you your own space, yeah. YP5

They do like some physical activities and stuff. And just not everything's like theory and on paper. YP8

However, two young people (25%) indicated that services could have been better tailored to meet their need. In these two examples, the importance of listening to the young person's voice and choice was clearly highlighted in order to deliver individualised services and supports.

Q: If you could change anything about the process what would it be?

I would have quite liked if they would've done more things with just me, rather than my whole family. Like some special time with just me. I sometimes got special time, but it was mostly with my brothers and sisters, and they would kind of take over too. YP8

Q: What was the hardest part of the wraparound process for you, and why?

WF11 assigned me to the school for kids who have trouble with school and I hated it. I despised it actually. One day I decide not to go to that school either, and they kept trying to encourage me, and I didn't want to go. I would get bullied there because there was a lot of bigger and umm, much more aggressive kids there and I just hated so I decide to stop going. That was pretty hard. That was a tough phase. YP11

Consistent with the majority of respondents, approximately half of team members (56%) also found the flexible way of working and the constant effort to tailor services for families helpful. Above all team members liked that the process was not rigid in the way things were done and that there was a level of creativity in some of the interventions provided which was a point of difference.

That it is a young person with mental health difficulty and that the service is quite flexible according to the family needs. That it is inclusive of the whole family and that I suppose it's not, I guess it's that flexibility on what they offer, so it's based on needs rather than just criteria. So depending on what they need, finances can be looked at, what times of the day, more individualised and tailored. TM15

That creative stuff as well as whatever it takes. Some of the interventions are quite creative and that makes it different. TM11

7. Strengths-based. Wraparound operates from a strengths-based approach which brings out and uses the skills and assets of the family and team to their advantage throughout the process. Forty-four percent of wraparound facilitators and fifty six percent of team members explicitly identified the wraparound process as a strengths-based approach which focuses and builds on individual and family strengths.

Look I think it can be a life changing process, both for the young person and their family, and umm I think it's the focus on strengths. WF4

We've seen quite significant gains within the family. Umm, each of them individually are more able to build on their own personal strengths. The family unit as such is a lot stronger than what it was. WF15

It's a strengths-based process and looked at the needs of YP4 and her family. TM4

Q: What do you like most about the wraparound process?

That it looks at the whole family and their individual needs and strengths TM3

Wraparound facilitators and team members identified focusing on family strengths helped to shift the perspective to a more positive outlook and empowered families to solve their own problems. Both groups felt this approach “*really strengthens people*” (WF3) and that “*...it's a process that strengthens the family [and] strengthens the young person*” (TM9) which helps to provide resilience in future.

Absolutely. I mean it's their strengths that they've now developed which will enable them to move forward and for us to discharge. Knowing that there is a strong supportive unit that will manage any issue that are coming up. WF7

Surprisingly, no young people and only two caregivers specifically talked about wraparounds strengths-based approach in their interviews. Caregivers, however, did talk about the lack of judgment and support provided to them throughout the process which in a way relates to the strengths-based nature of wraparound. Therefore, it is hypothesised that families may not have the exact language to describe this “strength-based approach” which is a term predominately used by mental health professionals.

I loved the way that they the start with the positive, bring out all your strengths and get you to see those. CG8

WF13, I thought she's not going to reach YP13 as WF13 came with a different strategy. She ignored YP13s, not ignored but while acknowledging YP13's issues, she looked at what YP13 likes and what she wants to do. YP13 pointed out singing, which I had never heard. I didn't know YP13 was into singing. And umm, WF13 worked towards it, and she got the funding for YP13s singing lessons, and YP13 was just, was just slowly, we definitely could see the improvement in her feelings. At some point she even said “mum WF13 is so good, I am so happy with her”. And I was too. CG13

8. Outcome-based. The theme which was identified as outcome-based was commented on by 75% of wraparound facilitators, 80% of caregivers, 63% of young people, and 50% of team members. Analogous with the principle, the concept of the

wraparound process being outcomes-based was underlined by the wraparound team being accountable to the plan created and by continuously monitoring the progression towards the goals in the plan to ensure its success. An important part of effective delivery is that a clear plan with realistic and achievable steps is created so that progress can be measured throughout the process. Consistent with this all respondent groups identified, in their own way, either indirectly or directly, having a plan that the team had created and were accountable to throughout the process.

Accountability and commitment to the plans generated by the team is an essential part of the process to ensure outcomes. Measuring change is particularly important for families as change can be subtle and sometimes difficult to see. As those who are often responsible for following up on the plan in wraparound meetings, 50% of wraparound facilitators highlighted the importance of accountability, follow through, and review of the plan created to ensure the family's goals are met.

There's accountability. So that if the roles and responsibilities are really clear and it is followed up on that 4-6 weekly basis there is an ongoing process of review and planning forward. WF4

You know I think as a wraparound team we're really good on ensuring that the original goals of the plan are followed through on and that anything that comes up in between is altered so that it's followed through on as well. WF15

A proportion of caregivers (60%) and team members (25%) appreciated the level of sustained commitment, accountability and follow through on the plan and goals throughout the process.

It keeps everyone that's involved on task and actually holds the people accountable for what they haven't done, if they hadn't done it, in a nice manner CG6

The consistency. Umm, the action, like they said they talk the walk, they walk the talk. CG15

The follow up was great. CG4

I think it was good because nearly everything off the plan was followed through with. TM1

At times it's hard for professionals to follow through on everything and so I think it holds that accountability. Not that people aren't already accountable but it holds that a bit more within the team context and people can kind of address anything that's not being met. TM1

I think that they've had a sustained commitment and that they haven't varied from the mission or their commitment to the mission. TM12

Caregivers, in particular, found the follow up and continual checking of plans by the wraparound facilitator useful in helping the team stay on track.

Committed. Wraparound umm, it's almost like I always say to my husband I wonder if they have a thing they have to fill out. Because they won't let something go, you know. Like if there's a plan and a goal it must be completed and ticked off. Whereas other services will say they'll do stuff but it kind of doesn't pan out sometimes. Yeah committed. See it through. CG8

Just how structured it was and the way WF1 ran it with the meetings and stuff. How everyone had to give feedback on how they were getting on with achieving their stuff. You know, because sometimes you can get caught up in the systems of stuff and it feels like forever to get any of it, but this was quite sort of checked. It just yeah, helped us understand on how we were getting along in the steps, we could track it a bit and see... Yep, it was good. CG1

This accountability to the plan and follow through was identified by all respondent groups to lead to a feeling of forward progression and change which in turn helped to develop empowerment and hope for families (63% of wraparound facilitators; 67% of caregivers; 63% of youth; 38% of team members).

The process created an environment for change to happen. Because it was so regular we didn't get lost...It was the change. It was because we were able to actively move forward. We always had a plan to keep things moving. CG3

I suppose the plan was helpful because you could also see that something was happening and that some things were okay. Because you got so caught up in this whole, you know, it's like Groundhog Day, that you couldn't really see that things were changing. And you kind of thought well what was the point of that? But then, yeah WF9 was good, because he actually put it out in front of you that these things were happening. CG9

With the outcomes that started off as a theory in the plan, as in this is what we'd like to have happen, have actually been realistic expectations and achievable and they've got there, you know. TM12

I guess it's just the umm, it feels like a real drive for change. It's quite focused rather than drifting. It's quite driven and you feel like it's quite noticeable and measurable. TM14

9. It's a supportive process. All respondent groups spoke about the concept of support or the support they experienced through the wraparound process (75% of wraparound facilitators; 94% of caregivers; 88% of youth; 100% of team members). Specifically, caregivers, youth and team members indicated feeling incredibly supported throughout the wraparound process due to the wraparound facilitator, the team, and the holistic, strengths-based, individualised and family-driven nature. Alternatively, while wraparound facilitators inherently believed that wraparound was

a supportive process for families, their perspective was more from how the support was provided.

The concept of support took a number of forms and could be broadly categorised into two subthemes of practical (e.g. providing in home support, parenting strategies, access to resources, knowledge, financial aid, and professional support) and emotional (e.g. family being heard, families needs being met, and availability of wraparound facilitator and other professionals). For team members another subtheme of support was elicited where they felt professionally supported by the team and wraparound facilitator. These aspects of support, as to be expected, have some overlap with the previous themes as they provided the conditions for support to be experienced by families and team members.

Practical support. The experience of practical support often originated from the delivery of individualised services and supports to meet the families' needs. Sixty three percent of caregivers and sixty nine percent of team members made reference to the practical support provided by both wraparound facilitators and the wraparound process. Whereas, forty four percent of wraparound facilitators discussed how they and the team could practically support families to make their life healthier and more manageable.

Wraparound facilitators themselves identified supporting families by being in their home, being an extra pair of hands, and sharing responsibilities with the caregivers which included providing transport to appointments, financial support, and knowledge and expertise. This day to day practical support was often believed by wraparound facilitators to help families reduce stress and burden so they could start to get back on track.

Being an extra support when mum just couldn't physically do everything, so sometimes I took YP1 to some appointments and things like that. So kind of practically being an extra pair of hands. WF1

I think for CG4 it is really hard getting to the appointments at [the Community Mental Health Service]. I think that has been a hard situation and I think what we've tried to do is support her by sharing that responsibility, and sharing the responsibility by 7.30am calls to remind her, and by taking turns at transporting YP4. WF4

Prior to us coming on board YP14's contact with [the Community Mental Health Service] was very intermittent. It's more stable now because we are doing the transport to the therapy session. So she's able to make use of those more and she's starting to put some of the strategies she's learning into practice. WF15

In addition to day to day support, wraparound facilitators, caregivers and team members identified that the process helped to increase family's access to extra supports and resources from professional or community-based services. This was indicated to help families achieve their goals and outcomes.

I think they're getting more support, and particularly YP1, is getting support for her mental health and desire to live, and then to make friends, and feel a bit more normal and part of life. And just yeah, for the family in general to feel supported and also to have the right supports in place and the supports they are entitled to. Not just for YP1 and her Asperger's but for the younger sister as well because before that they didn't have any kind of disability support and services. They were really burnt out. WF1

I feel that there are options out there and even financially. I feel like if I were to say, wouldn't it be great if he could be doing this but I don't know how we are going to get this done, I feel like there is a team out there. And it isn't just money, but it could also be getting him there or things like that that would help. CG16

I guess that it's an opportunity to gain quite a bit in terms of just access to community resources and information and that kind of thing. TM15

Overall, the access to flexible funding, extra resources, and the wraparound facilitator's ability to go out into families homes made team members feel as if the process was more practically supportive for families and young people within their daily lives compared with some other services.

So it's really refreshing to have people to come in, who are really practical, who have got skills that they can apply right there. It's just triage. TM12

It's got a little bit more scope and especially being able to go out to the community a bit more. For instance, because we wouldn't go over to nana's place and provide that support in the house really. We would ask them to kind of come in and try to problem solve in here. So we can't provide in home supports at all really. Well we can go in and do some work, but not like that. TM4

There's certainly a multifaceted funding model which helps. If it is just left up to us, or left up to [the Community Mental Health Service] or whoever, it's hard to get that. TM9

This was also reflected by caregiver's who valued this practical support and at times were even humbled by the unassuming and modest support provided, in particular, by the wraparound facilitator.

They're there to support, and even like going to WINZ (Work and Income New Zealand), that's not what I expected that they would do...I'm just amazed at their resources, yeah, it's just full on. CG15

They were very supportive. Financially but also to me as well. CG5

However, because wraparound is individualised to families' needs a few caregivers felt that they did not know what services and supports could be offered through the process. Caregivers felt that it would have been useful to know more about what could be accessed so that they could get a better idea of what might be beneficial to them.

I didn't know what they could offer, like they didn't come along and say we could do this and we could do this. Like there wasn't a umm, it wasn't something they told you, but I think it would have been appropriate. So maybe saying what sort of services they could offer to families. CG3

Q: If you could change anything about the process what would it be?
Just knowing what services were available, you know, there were things that would have benefited me earlier had I known about them. CG9

Emotional support. The theme of emotional support was discussed in 50% of wraparound facilitator interviews, 75% of caregiver interviews and 69% of team member interviews. The experience of being emotionally supported was more complex but was often derived from families feeling heard and having a group of people, including facilitators and team members, available to support them in whatever form they needed.

I really liked how it makes me feel emotionally, like I feel very emotionally supported by it. And, very much less isolated, like not lost in the dark on my own anymore...What makes it so valuable is that through so much of the stuff you just feel so kind of a drift and alone. That that can make you feel very despairing. And then when you lose hope you get very demotivated, it's like hard to know what to do and where to go, and you kind of freeze, you know, like a possum in the headlights. So when you feel emotionally supported and you're not feeling so bleak about everything, you can be a lot more action focused and get things done. CG7

Just people being there. Just people being there when you need them, you know, and prepared to drop everything when you need them. And ring you when you need them. Like YP10 had a meltdown a couple of weeks ago, everybody rang me and said what's going on, what can we do, we need to discuss this, lets come in. And yeah, people just being there, and knowing that they are there really, yeah. CG10

I feel very supported. Like I have some where to turn.

Q: How do you feel supported?

Well I have people I trust on the team. Umm, I have more than one person to go to. YP12

Wraparound facilitators identified feeling that both they and the wraparound team emotionally supported families by walking alongside them throughout their journey of the wraparound process. In particular, wraparound facilitators and team members believed the intensive but non-threatening support provided by wrapping a number of people around families in the form of the wraparound team created the feeling of emotional support.

I think the security of knowing there was a team and there was a structure. That provided family with support and YP7 knowing that she was also provided with support. As they went along that journey to health, to heal their relationships, that there were backs up there. There was someone walking along side them supporting them. WF7

I think it takes a village to raise a child. I know it's a cliché, but it really does. We need people around us to support us. TM9

So rather than being one single professional trying to think "crap how am I going to help this family", you've got like 5 or 6 people there saying "actually have you tried this" or "we can do this" and I think it's a really helpful process. So I think for families, that's like 6 heads are better than one. TM1

Caregivers also discussed how a great sense of emotional support came from having people around them to help and share in the responsibility of their young person who was unwell and/or at risk

Oh I suppose being able to hand over responsibility to some extent. I mean obviously one remains responsible as a parent, but when there is a problem it's really really nice to be able to phone someone and say this is what happening and they just take over. There are times where you just can't do it yourself. You just haven't got it in you anymore. And sometimes, you know, I mean WF12 can be saying exactly the same thing to YP12 as we've been saying. But because it's not us, because it's someone else she will listen, but that's normal. That's what's really helpful. CG12

I guess for us as parents umm, good involvement with both kids has taken a lot of burden off our shoulders. For the kids, I don't know, I mean they seem very happy. They're settled. CG11

This emotional support network was believed by caregivers (44%) and team members (50%) to create a sense of safety and security for families.

Q: What do you like most about the wraparound process, and why?

The big thing was we felt safe. We'd felt really unsafe before wraparound...we were terrified that something was going to happen to our son...and I think when wraparound came, they said we deal with children like this, we can help. We definitely felt safe in the fact that we weren't on our own. And maybe because, it wasn't just going to be us who were going to be responsible. CG8

I think we're talking really high risk young people, for lots of reasons, and I think that wraparound really meets that need. It really has a realistic grasp of how critical that interface is. You can underestimate that, and I think young people are really vulnerable and impulsive and stuff, and I just feel like they have stopped and checked at every corner, at every

intersection. Like where are we up to, how are things going, and if it's not safe, then we don't proceed until it is safe to proceed. I think that there's a level of delivery of service that's just yeah, I can't fault it. TM12

Interestingly some wraparound facilitators noted that the practical support provided often formed the foundations of the engagement and trust necessary for caregivers to be receptive to receiving this emotional support. Consistent with this, for caregivers and youth, the experience of emotional support was often identified as something which developed over time, as their trust in the team increased.

You know the direct face to face contact with them and helping them. Like I said, helping CG16 at home, with tidying up the house, that kind of stuff. Because I can actually see it's got an immediate impact on her mental state. It's been able to, it's allowed me to, develop that, umm, therapeutic relationship with her. Whereby now she is starting to open about stuff to me and that helps me to understand her situation better and the context of it. But also, it's allowed me to, allowed her to be umm, be a bit more open and able to process some of the suggestions that I've made. WF16

Professional support. For 50% team members another subtheme of professional support was elicited in their experience of the process. These team members discussed how the team and facilitator supported them in their roles as professionals, working with high risk youth and families, because they had other professionals working alongside them which also created a sense of shared responsibility.

Certainly as a clinician, it was really positive for me because this is quite a tricky family to manage. Not in terms of personalities or anything, but just in terms of how much they had on. You know YP1 was really risky, kind of, in terms of not being able to have much insight around self-harm and suicidal behaviour. So it was really helpful not only to have a support of a colleague, but also to have someone who knew the family really really well, and was kind of working alongside. TM1

Its nice working alongside other clinicians...Especially with our structure here we work very isolated and do a lot of work by ourselves. We are a MDT (Multidisciplinary team) and stuff but not alongside much. So that's really nice. TM4

Supportive for the family and also it's been in my work with them as well. TM4.

Outcomes, Change and Progress

Throughout the process respondents were able to see change and progress which resulted in a number of perceived outcomes being identified in their interviews. The outcomes, change, and progress noticed by wraparound facilitators

and team members and experienced by caregivers and young people were many but could be broadly categorised into three themes of: empowerment and hope; improvement in family dynamics and relationships; and individual improvement in caregiver and young person.

10. Empowerment and Hope. The wraparound process aims to foster family empowerment and create hope for the future. Consistent with this, 50% of wraparound facilitators and 53% of caregivers identified the concept of empowerment and hope in their interviews; with one wraparound facilitator directly stating that it “*is an empowering process for families*” (WF5). However, neither young people nor team members specifically mentioned these concepts. For caregivers (53%), hope was created from the change in theirs and their young person’s lives and the support given by someone walking along side them throughout the process.

Oh it’s been incredibly challenging, I think. Umm, but very rewarding in many ways and very process orientated. We’ve worked in steps, in gradual steps to give everybody time to get confidence, and to re-establish hope and belief, and learn to work together as a unit. WF7

Engaging with YP1 and in gaining her trust. Empowering her to really lead a lot of the wraparound process. Implementing the right supports that visibly made a huge difference to her and her family’s life. I think the relationship with [the Community Mental Health Service] and a lot of co-working in the therapeutic process. A lot of trust and mutual respect. WF1

The way it’s built me up, yeah. Like I never thought that they, that anyone could, in any service, could actually make me feel so confident that I’m doing a good job, and you know, that I’m doing the right thing, and yeah. So that’s really good. CG14

I think the hope has just been the most important part, you know. I mean some of this stuff, as odd as it is, seems like an answer to prayer for me... CG16

11. Improvement in family dynamics and relationships. A second outcome identified by 63% of wraparound facilitators, 47% of caregivers, 100% of youth, and 50% of team members was the improvement of family dynamics and relationships.

Each respondent group spoke about the improvement in family dynamics and relationships differently based on their own experience and perspective. Wraparound facilitators emphasised the family coming back together as a unit and the

improvement of relationships between family members, in particular, between the caregiver and young person. They discussed that slowly, through the wraparound process, family's started to change their perception of the problem to that of a family issue rather than an individual issue. Families also learned to value each other, work together, and be more integrated. This led to families coming together for their young person, to form their own support system, which was seen as a valuable outcome for future family functioning.

I think they've come together as a greater family whānau (family). I think they've come together, with a greater understanding and they've got a will and commitment to work together and be more integrated as a family. WF4

Relationships. I think relationships. I think this family was at a point where they may never had any contact with one another ever again. I think they have actually come together as a very cohesive unit. A supportive caring unit of people who actually have fun together, who enjoy each other, who value each other, and who are working with each other. I don't think more could be hoped for in this situation. WF7

It's strengthened that mother daughter bond that was never there before. Umm, YP12's mum had quite a horrific upbringing herself and there were a lot of intergenerational issues. So it has, I guess in some way it's broken those intergenerational issues, in terms of mother daughter relationships. WF12

Caregivers also commented on the improvement of the caregiver-child relationship which occurred and its importance. This included being able to talk to their young person again and understanding one another better. For some caregivers and youth, the role their facilitator had in strengthening and nourishing this relationship was seen as essential in helping them to safely build up communication and understanding. Similarly, a number of wraparound facilitators indicated that their role in providing insights and strategies to families helped to change, improve and reform this bond which had often become fragmented.

A massive one is getting my relationship back with my daughter. That's right at the top of the list. CG7

I think that the most important thing between me, WF13, and YP13 is umm, that to start with WF13 needed to be there, for us to communicate. Not physically, but you know, she needed to hear me, she needed to hear her, and working between us. And umm, she slowly, gradually stepped out and now me (CG13) and YP13 are able to communicate... CG13

I think it's given us both a confidence to ask for help and to talk to each other a little bit better, yeah. Because they do share certain things with each of us. Umm, so stuff that YP15 may not want to tell me directly she can tell through them. So it has let me (CG15) understand YP15 a

little bit better and let YP15 understand me a little bit better. Which has been really beneficial, instead of just us two yelling at each other. CG15

All young people (100%) identified an improvement in family dynamics and relationships which was considered to be an important change. In particular, young people noticed their family being happier, having better relationships and a change in the communication between themselves and their caregiver. Young people indicated their family was calmer which included: less arguments; being more able to talk to their caregivers again; everyone getting on better; and it becoming easier to communicate their needs which lead to their family understanding them more.

Well my improved relationship with my mum, definitely. Umm, funding for things like mother daughter therapy. Umm, it's been easier to communicate my needs. Yeah. YP12

Good, it's like helped us. And umm, oh we get on more as a family now. And my family understands my needs more. YP8

It has made me and my family communicate easier. Everyone knows what they are meant to do so life is less stressful. Everyone knows what they are doing. YP7

It's made my family better...Umm, we don't argue as much. We don't like, we're not violent any more. We don't hit each other anymore. We haven't hit each other, in like, ages. Nobody throws things around anymore. That arguing was just...(inaudible)...no throwing or getting violent. It's a big change, better. YP5

If you saw our family, like 9 months ago it would be a totally different family than what you're seeing now. And it's all thanks to WF11 and WF13 and wraparound. YP11

Eighty one percent of team members also acknowledged improvement in family dynamics, relationships, and communication. They appreciated the work done through the wraparound process which helped to facilitate these outcomes.

It has helped the family to improve their relationships and allow YP3 to still be a part of the family. TM3

I think what's been best for them is the supports about navigating between the two families and improving relationships TM4

Getting those parents to work together rather than in opposition with each other and putting the kids in between. Very modernist idea that, isn't it, some of the ideas of wraparound. De-clouding parental conflict and clarifying the parental motivations of what we are here for, their purpose, and their missions as parents. TM11

12. Individual improvement in parent and young person. Outcomes were also able to be seen and identified in respondent group's accounts at an individual level for caregivers and the youth. Individual changes for caregivers and/or youth were discussed in 63% of wraparound facilitator interviews, 93% of caregiver

interviews, 88% of youth interviews, and 81% of team member interviews.

However, youth change was often more commonly talked about.

Caregiver. Wraparound facilitators (31%) and team members (44%) discussed caregiver's growth and change in terms of them taking on board new strategies, trying alternative ways of dealing with things, changing their own behaviors and how they interacted or responded as caregivers with their child. An important foundation for these changes was believed to stem from caregivers gaining a better understanding of the issues and accepting that they themselves may have some things to work on.

One of the parts has been changing the behaviour and the insights they have gained throughout the process. Certainly CG7's way of responding to YP7 was very aversive previously, and it caused the cycle where YP7 felt that she wasn't worth anything, and then she would start withdrawing and reacting. CG7's learned a different way of responding, and this way of responding is more positive, more thoughtful, and gives YP7 time to do her own reflection. And YP7 is making the changes. So there has been a huge learning. WF7

I think that them having to look at their own issues. They were initially in denial that the issue was just YP12's, and they had sort of objectified YP12 as the bad person within the family. Umm, so it was only when they actually started realising that each family member had a part to play in that, that there were changes made within the family. WF12

With CG15 she's on antidepressants, we've made her, not made her, but we've got her to the understanding that there's an issue on her behalf as well. WF15

I mean she gave up pot, and that was big, because she didn't want her son to deal with it. TM14.

Over half of caregivers (63%) also commented on the outcomes they experienced through the process. Caregivers found they obtained insights about themselves and their child, they were able to understand their child better, look at things differently and were given the tools to better themselves as caregivers.

Well it's given me skills to parent different, to be a better mother to my son. It's taught me to give him what he needs in a way that works for me. And you can't get better than that. CG3

It's opened my eyes. Taught me how to try, and how to keep going, and how to better myself. How to feel what I was feeling take it in and let it out. CG5

Looking at the reality of the situation. You know, she (WF6) helped me to realise the reality of the situation sometimes. Because like sometimes it would be for me, it's like oh my son will be fine, I don't need to put the knives away, you know. But in reality, and even I would know, that it's not fine and it's the fact that I can't trust him. It's not because he's being naughty, it's just that's how it is. That comes from the safety and crisis plan thing. She sort of helped me pull me back into reality which was good thing. CG6

A few caregivers also identified their perspective and opinion of mental health services changed. Based on the process, from facilitators and team members, caregivers learnt that there were actually caring people out there who were willing to help.

I suppose the most influential part was probably learning that there are umm (laughs), that all the professional people aren't that umm, stuck up (laughs). I think that was the most eye opening. It was like, oh my gosh, okay maybe you're not so wanktified as I thought you were, you know, that kind of thing. So there are nice people that are in there, you know, and it's not like looking down... But yeah no, it's a real eye opener, eye opener that they're really caring people that want to just help. CG4

[It's been enlightening] to actually realise that there are people out there that are seriously trying to help. And yeah, I mean it's amazing, it's just been fantastic. CG5

It was very hard for me to get help. To get someone involved. It's a very, it can be intrusive, you know. But then I guess if you had to make a Hollywood movie out of it, you know, I would say I've learned that sometimes it's okay to ask for help and get people involved with my family (said in a cliché voice). CG11

Young person. While the young person's mental health disorder was still present in some cases, due to the severity of their disorder, 56% of wraparound facilitators, 75% of caregivers, and 44% of team members discussed substantial improvements in the young person's overall functioning through the wraparound process.

YP5 can now communicate her needs more readily and has more confidence. She is more able to express herself. TM5

I don't know statistically, data wise, whether she's self-harming less often or not or what. But I can, my understanding is that, YP2 was out of school for a long period of time, and she has now had 2 full years within school other than when she was in hospital for 3 months. So to me that has to be successful. You know, she's a young woman who was out of school for a long time and walked in and achieved level 1 NCEA, which says a lot about YP2. And now she's continued our plan for her this year, which was to do year 12, but then repeat year 12 next year. So that she was doing year 12 and picking up some credits without stress knowing that she would have the opportunity to redo them or whatever next year. And she's done extremely well with that. TM2

Wraparound facilitators indicated significant and noticeable differences in the young person's wellbeing including decreased mental health symptoms and improvements in their functioning and engagement within the community. They also commented on seeing the young person grow and mature through the process by developing a greater understanding of themselves, their family, and their situation.

Wraparound facilitators believed that the young people had been empowered to take ownership of their own life by discovering what they wanted and what they could do to affect it.

Even in these early stages, we are seeing some changes, within the family, and within YP15's persona. WF15

Seeing the family, seeing YP12 as an individual grow and seeing the family unit grow, has been quite rewarding. Umm, seeing YP12 come from a place where she wasn't able to go into groups umm, anymore than a 1-1 she got severely anxious, to the point that she was able to facilitate both a wraparound and [another group]. I think has been amazing. WF12

YP11 is at school. YP11 is no longer umm suicidal. His relationships are better with his dad, variable with his mum, depending on her mood. There is growth in YP11, some maturity, and some resilience. WF11

Both wraparound facilitators and team members found it rewarding to see the growth and change in the young person during the process.

Q: What did you like most about the wraparound process?

Watching YP7 grow and her self-management, her communication, her lovely personality coming though as she felt heard. WF7

I guess, just for the rest is actually the reward for seeing the differences in YP6 and CG6. TM6

Similarly, caregivers, and team members also indicated substantial change in the young person and their mental health presentation. However, for caregivers, the most significant changes included the young person's reduced risk level, return home if in an inpatient setting and the ability to be safely and effectively managed within the community. Many of the young people had suicide attempts and/or were in dangerous situations to the point of potential loss of life at the start of the process. The wraparound process achieved a result which allowed the young person to be at home, get back into school, and to be happy and more content.

The most important part is having him home and having him happy, and he's reasonably healthy. So yeah, I think if you look at the mission statement, he's reasonably healthy, he's reasonably happy, he has achieved a life worth living, and he has got healthy relationships. He's communicating well...it's better, so I can feel like somebody's mother, it's huge. I feel loved, he openly hugs me, or he never rejects me now. He's definitely independent. So I think we achieved our mission. We achieved what we set out to do. It is huge, because it has only been a year. You know last year he was on a bridge, and now he's studying and wants to go to school, and wants to achieve. I am happy with that. CG3

It's translated into an incredible turn around for my daughter which has been an incredible turn around therefore in my life. Because it was like, the all consuming thing, you know, you couldn't see anything else above the crises. CG7

The goal for YP13 was umm, to accept herself, to love herself, to feel better and at some point she did. So it is achievable. CG13

YP11 is going to school happily, enjoys his school, seems a lot happier definitely than what he was 6-7 months ago. CG11

The main thing I probably got out of it is that it got YP9 into school. So that was probably the main overall achievement. CG9

The majority of young people interviewed (88%) also indicated that the process was helpful for them and created change in their life in terms of: reducing their mental health symptoms; increasing their ability to manage their mental health diagnosis by learning new strategies and skills; improving their general life situation (e.g., family, school); and increasing their acceptance of themselves or facilitating a different outlook on life.

I think I am a lot more optimistic, umm, more smiles. I'm a lot more social and go out with friends more. I talk to friends more. YP11

I have better social skills and my depression is not as bad...Like, I mean I haven't been hospitalised since starting wraparound. So I've noticed a difference. YP1

Q: What has been the most influential or important part of wraparound for you?

Well I gained self-acceptance, umm yeah, I think that was a really big thing for me YP12

They've helped, umm, get me out of hospital and into school and that's been big. YP3

These changes had a life changing result for young people and their family.

Life changing. Definitely. Umm, I honestly can't put into words how much it's helped me and my family. YP13

Challenges and improvements

13. Challenges in wraparound. Two main types of challenges were identified by respondents: (1) the personal and professional challenges faced as part of the process; and (2) the wider system level challenges which were experienced in regards to coordinating and accessing different resources.

Personal and professional challenges. While predominately experienced as a positive and supportive process which resulted in beneficial outcomes wraparound was at times also considered challenging. When asked about the hardest part of the wraparound process, a small percentage of wraparound facilitators (13%), caregivers (20%), and young people (13%) discussed either the personal or professional

challenges they faced. For two wraparound facilitators, professional challenges identified related to concerns around personal safety and really supporting and following the family's voice and choice.

Q: What do you think could have been done better, and why?

Probably maybe the facilitator management of meeting earlier on would have helped. But as I had never been in a situation like that, where everyone was yelling, and I was getting yelled at. So I had my own anxieties and concerns around my own safety due to the level of verbal abuse to deal with as well. WF5

Like we talked about it a little bit before, is my morals and values in regards to how I would tackle things, either in my personal life or from a professional knowledge basis. Versus how they are running their family and, umm, and what morals and values they are making decisions on. So it is really about that. Knowing your professional boundaries in regards to it is their plan, it is not my plan, you know. I would certainly do things differently than what they're doing it. But all I can do is give them suggestions which may mean that quite a few of them they may reject, because it just doesn't that work for their family, or not according to their opinion.WF16

Alternatively, caregivers identified managing their own vulnerability and the emotions that came up throughout the process as most difficult. Other challenges commented on included participating in family work, asking for help and waiting for the plan to come to fruition.

Q: What was the hardest part of the wraparound process for you, and why?

Sometimes asking for their help has been really hard because I felt quite weak and quite crumbly...Knowing that they're not going to judge me has been the easy side of it. But yeah, sometimes, texting them or calling them up saying I'm not coping has been difficult. Or asking them to help YP15 when I know she is going to reject it is quite difficult. I don't like, it's embarrassing for me to see her, you know, shunning them. So that's always a little bit difficult or embarrassing. CG15

Q: What was the hardest part of the wraparound process for you, and why?

Not so much the wraparound process, but just some of the emotions that have come up, in some of the various crises that we have been addressing in the wraparound meetings. You know, at times it's got emotional for me. But I mean, it would have in any process, it's just my process that's going on. CG7

Q: What was the hardest part of the wraparound process for you, and why?

Controlling my mouth with YP5 when she yelled at me. CG5

Q: What was the hardest part of the wraparound process for you and why?

The stuff that we did with WF1 on strengthening the relationships within the family was quite a hard part. Just the whole process. Yeah. It was definitely worthwhile, but it was probably the hardest thing to do. CG1

Young people, on the other hand, found personal growth, such as coming to accept things the way they were rather than the way they wished them to be, most challenging.

I think one of the hardest things is for my parents to talk, I guess. Because like I said nothing was being done. Everyone was just all talk. And we'd tried family counselling, and tried all sorts of stuff, and I think they kind of just gave up a bit. And so we'd have these moments in the meetings where WF13 would talk, or [psychologist name] would talk, or [social worker name] would talk, or I would talk. But mum and dad, when they got their opportunity, they wouldn't. It was just kind of those silences, and that was one of the hardest things I guess. Yeah, I wanted their input and their voice. They are getting better now. YP13

Although parts of the wraparound process were hard, caregivers and youth felt that it was a necessary part of the process which was beneficial.

Umm, (sigh) probably being pushed slightly out of my comfort zone. But, it was probably a good thing in the end, although it was hard at the time. YP12

Finally, while the process was not considered by team members to be directly challenging for them, they did acknowledge that parts of the process were hard for youth and families.

For YP2, I think when we made the plan about what would happen following self harm, she didn't like it at all. But that is how it has to be. TM2

System and funding challenges. A more global issue experienced by 38% of wraparound facilitators, 7% of caregivers, 25% of youth, and 31% of team members was the systemic challenges involved with wraparound in New Zealand. This included challenges related to finding funding, placements and other resources needed by families as currently in New Zealand as one team member aptly put it "*wraparound is a process working within other peoples' processes*" (TM2).

It's those service limitations. But this is what I'm trying to say, that's what I find doesn't work here in New Zealand. I'm sure New Zealand is not the only country with the issue but this is what's not working here. But that's the dilemma with us here in New Zealand, we don't have the pooled funding, and that's what I think is really our biggest barrier. WF16

These challenges were particularly difficult for wraparound facilitators, not just in terms of accessing the required resources, but also because sometimes it meant they could not provide families with some things that were initially planned for.

Funding can sometimes take a while to come through and some don't in time. We put some funding in for a mother and daughter holiday, in the hope that we would be able to do it for the holidays, but it didn't come through in time. WF15

Q: What do you think could have been done better, and why?

I guess one of the regrets that I have is around [service name], umm and the fact that we weren't able to, secure the finances for that. I think it would have been the best environment possible for YP12. WF12

These systemic difficulties were also commented by some caregivers, team members and even young people to impact on their experience due to difficulties accessing funding, supports or services needed.

We've been trying to get some funding through the [Child Welfare Service] and umm, although he was offering it, he wasn't forthcoming so it was a bit difficult. He was offering support that he couldn't really offer because, you know, it's not his to offer. He has to take it back to his superiors and then they make the decision. CG14

Q: If you could change anything about the process what would it be?

The way budgeting is done. Yeah.

Q: Tell me more about that?

Well the way they approve stuff, is long, and inefficient.

Q: So what was your experience of that?

I don't know. They've screwed it up. It just makes everything longer, and harder, and more boring. It was just the everyday type thing, yeah. YP3

In this case, [the Child Welfare Service] had, were asked to fund mums work. Because she had a relationship with somebody who she preferred and she was positioned as the expert of her knowledge of what she needed and who funds that. There was a bit of a, kind of, delay on who is going to fund this therapy. I don't think that was helpful. A quick decision on \$800, you know. This kid is suicidal, he's in and out of hospital, one admission will be more than that. It just didn't make economical sense, let alone moral or ethical sense. Especially when there were two kids and a baby involved. Just go, actually this is problem solving, let's just do it. That funding delay, it did get funded, it was just the delay...Wasn't so good. The only thing I would change about is that, kind of, flexible funding thing. TM11

14. Feedback and improvements.

Continuity of care and transition out of services. Ideally, wraparound provides continuity of care and long term support to families for as long as needed until all team members agree that the formal wraparound process is no longer required. However, when asked about feedback or areas for improvement, the continuity of care and the transition out of the wraparound process was discussed in some cases (i.e., 13% of wraparound facilitators; 25% of caregivers; 13% of youth; 31% of team members).

In particular, some team members thought that the process was too short for a few of the families and believed that staying on longer would have been beneficial.

Too short. We really shouldn't have bowed out when we did, because the issue is huge, and I would hate to see it repeated again. TM14

The work was kind of alright, but it wasn't long enough. The time limit that was set on it limited the work really. TM11

At a minimum team members indicated that a slower transition period including “*tapering off*” (TM8) supports over a longer period of time “*instead of stopping cold turkey*” (TM8) would have been useful. For at least one young person, progress made while in wraparound deteriorated after wraparound transitioned out.

Maybe staying on a little bit longer. Just to have seen the results and maybe come away from it a little bit. So stayed on a little bit longer, but not so much engagement. So umm, instead of every week, it'd be every fortnight, and then once a month, and then slowly tapered off from there, instead of stopping cold turkey. I didn't really get to see what the families result was, I just got to see the kids, because they would text me. TM8

We had to close the case and I just wonder if we kept it going for a bit longer what we could have achieved. And I think that was a bit more about time and money rather than (trails off)...From that closing of the case, his school work declined, his truancy increased. This is when we had trouble with knives at school and some of the issues around drugs came back to school. We had sort of dealt with a lot of that which has certainly led to him finishing with us. But we can't keep going forever I'm realistic about that. And I don't know if they necessarily felt like they were abandoned, but there wasn't a tapering off of supports, which is what we wanted to have. Umm, but maybe we could have gone for another 3 more months, at least to the end of the academic year. But what happened, happened. TM9

Three caregivers and one young person also mentioned that the process either tried to or suggested transition prematurely before they felt ready which was experienced as unsettling. Interestingly, the same family who struggled with engagement also indicated difficulties transitioning out of wraparound where the transition phase was experienced as somewhat abrupt.

I did find it quite scary when (manager's name) came in to look at closing the case. It gave me a shock as I felt that it was premature. Whereas this time I'm seeing it, when then I wasn't. Now I am seeing, yes we are all okay and we can do this ourselves and we can, you know, the skills that we have learnt, we can. CG3

They were great, but like I said, there was that time where I felt like they were going to pull out and everything. Well they were going to pull out. YP12

Wraparound facilitators also acknowledged that in two cases transitioning out of wraparound either didn't work well or happened sooner than was to be expected or ideal for families.

The transition phase happened sooner than anticipated so there wasn't that clear planning around this phase. Ongoing needs kept coming up and they were not able to all be completed during the time before the case was closed. WF6

Obviously the transition didn't work well (laughs) because we're back again. WF12

Role clarity for team members. Twenty five percent of team members believed improved clarity regarding roles and expectations would have been helpful to better understand their role in the process. This related to both their role in the team as well as how their agency was to work with wraparound.

Q: If you could change anything about the process what would it be?

So I think, thinking about that, I guess when the wraparound process is beginning, it would be useful to talk a bit more about peoples roles. I guess in terms of me not saying anything, I guess I was leaving wraparound to the people to deal with things that were almost therapeutic intervention in a way. TM13

Q: What do you think could have been done better, and why?

Between services, and that's part of, within [the Community Mental Health Service], we didn't have a clear understanding, consistent understanding of how to work with wraparound...I guess we could have talked more about this in the first meeting with WF4, which was me not articulating or communicating that enough myself. Aside from that we could have had a discussion about how we work together and any potential difficulties. I think it's interfered so it would have been useful. TM4

Improved accessibility of wraparound to families. Finally, a subset of caregivers (31%) felt that the wraparound process in New Zealand was difficult to access and that it was a service that not many people, even professionals, knew about. By being an “*unknown service*” (CG13) that was difficult to access these caregivers felt that wraparound ended up being the ambulance at the “*bottom of the cliff*” (CG7) after everything else had been tried. These caregivers would have preferred wraparound to have been available sooner as they believed it could have prevented some of the issues from occurring.

About the process probably nothing. What I would say is that it took us 5 years and nearly loosing YP7 repeatedly before we accessed this. Like we didn't know about it, nobody, no professionals told us about it along the way. It was only right at the end, when we got accepted with [the Community Alcohol and Drug Service] and [clinician name] putting, you know, she took it on herself to put an application in. And she was the first person. So I guess one of my things would be somehow making it so that people know about this as an option. And that you don't have to wait till the person is nearly dead and the family's fallen apart before you get access to it. You know like, it was totally at the bottom of the cliff. If it could be at the top somewhere that would be fantastic. And it would probably save the state a huge amount of money ultimately. Because I know it's an expensive process, well I presume it is, but when I look at all the other outcomes and ultimately, hospitalisations, imprisonment, mental homes, those cost a lot of money to the state. Don't they? CG7

First that it is available, yeah, because we didn't know. It is available. As I said it was hidden, it was like a hidden service you need, that nobody knows about. So people need to know that it is available CG13.

I think that they're very hard to access and I think that was such a shame. But I've brought that up with them and I've brought it up with [the Community Mental Health Service]. That it was

way too late when we got them and I think that still goes on today. I know families that have tried for wraparound and haven't got them. It's quite elite. It's really hard to get. You've got to have some pretty serious problems. And I think, the funny thing is, you don't need to wait. Those problems wouldn't have happened if you got them earlier. But then, there's so many people needing it I suppose. CG4